

## A Process Evaluation of the Stepping Stones Program in Fiji, Solomon Islands, Vanuatu and Kiribati



## List of Abbreviations

<b>AIDS</b>	Acquired Immune Deficiency Syndrome
<b>CDO</b>	Capacity Development Organisation
<b>FSPI</b>	Foundation of the Peoples of the South Pacific International
<b>HIV</b>	Human Immunodeficiency Virus
<b>M&amp;E</b>	Monitoring and Evaluation
<b>NAC</b>	National AIDS Council Committees
<b>PRHP</b>	Pacific Regional HIV/AIDS Project
<b>PLWHA</b>	People living with HIV and AIDS
<b>SPC</b>	Secretariat of the Pacific Community
<b>SS</b>	Stepping Stones
<b>STIs</b>	Sexually Transmitted Infections

## 1.0 Executive Summary

The process evaluation of the Stepping Stones (SS) program in Fiji, Solomon Islands, Vanuatu and Kiribati was conducted throughout June 2009 to January 2010 period. The aims of the evaluation were to; 1) describe and share the lessons learnt on the different processes used to deliver the program in current countries, 2) make recommendations on the future sustainability and strategic direction of the program and 3) to make recommendations on the monitoring and evaluation (M&E) methodologies to ensure accurate and reliable collection of SS data for future outcome orientated evaluations

Also included in this report is a historical look at all regional and national level activities that have been held since the commencement of SS in the Pacific in June 2006. Findings and recommendations made in this report include the urgent need to strengthen M&E data collection of the current SS program. While in-country the Health Promotion Adviser attempted to collate SS data but found there were huge gaps and in many cases data was not available at all. These inadequacies and lack of evidence to support behaviour change in the earlier stages of program implementation were identified as a reason for recent loss of support from an Asian Development Bank (ADB) grant. There also exists a need for community facilitators to collect more rigorous quantitative data in order to triangulate M&E information. It was found through this evaluation that while community facilitators were given a note book to collect information on attendance, sex disaggregated data etc that in reality this did not occur. One reason that was thought to contribute is that community facilitators forgot what sort of data they were supposed to collect, therefore didn't collect any. It was therefore recommended and accepted that a 'Stepping Stones Community Facilitator' journal be developed and in-country M&E training be delivered in each SS country prior to any future facilitator trainings.

Further funding restraints and sustainability was also identified as a future challenge for the SS program. As one of the current SS grants will finish in July 2010 countries will be required to be much more strategic and planned in relation to SS activities. They will need to complete and submit individual grant proposals with well mapped out activities and M&E strategies in order to satisfy donor requirements, a definite benefit to overall country SS planning and implementation.

Other findings from the evaluation included site and facilitator selection, competing community commitments and improving multi-agency involvement as other factors that need to be considered for future implementation.

## 2.0 Introduction

Stepping Stones (SS) is a community mobilisation package which was first implemented in Africa in the mid nineties. The program was designed to assist communities to engage in discussions around sexual and reproductive health, (including HIV, STI's and unplanned pregnancy), domestic violence and drugs and alcohol. The ultimate aim of the program is to improve gender relations, community participation and knowledge of risk-taking behaviour.

Implementation of the SS program began in the Pacific in June 2006, with the inaugural trainings held in Fiji and the Solomon Islands. In March 2007 an evaluation of the SS program in Fiji was undertaken by the Pacific Regional HIV/AIDS Project (PRHP). Scaling up and future roll out of the program was based on recommendations from the 2007 evaluation report. In May of that same year, Vanuatu and Kiribati became involved in the program through a Regional facilitator training held in Suva, Fiji.




The Pacific SS program consists of a 17-module manual that is ideally implemented over an eight to sixteen week period in communities. Each session builds upon the one before with the ultimate aim of enabling positive behaviour change to take place. It involves participants working in age and gender appropriate peer groups in order to create a non-threatening environment and encourage openness in discussions on taboo topics such as; sexual health, relationships and gender inequality. At designated points throughout the program the different peer groups come together to make presentations on key issues using drama and/or skits.

Upon completion of the program, participants are given the opportunity to present 'special requests' to their community, which may involve asking their community to change in relation to such things as violence, unsafe sex, alcohol consumption or other risk-taking behaviour.

Currently regional funding for the pacific SS program is managed by the Foundation of the Peoples of the South Pacific International (FSPI). FSPI and the Secretariat of the Pacific Community (SPC) have partnered to provide regional technical assistance and support to in-country organisations implementing the program.

### 2.1 Purpose of the Evaluation

This evaluation was carried out as part of FSPI's and SPC's monitoring and evaluation (M&E) of the SS program in Fiji, Solomon Islands, Vanuatu and Kiribati. It came at a time when FSPI and SPC had been successful in securing a further three years of funding for regional support and technical assistance through the Pacific Island HIV and STI Response Fund. The evaluation aim was to describe and assess the current Pacific SS program with an emphasis on the processes by which each country has implemented the program to date. Further aims were to:

-  Describe and share the lessons learnt on the different processes used to implement SS in Solomon Islands, Vanuatu, Kiribati and Fiji
-  To make recommendations on the future sustainability and strategic direction of SS
-  To make recommendations on the M&E methodologies to ensure accurate and reliable collection of SS data for future outcome orientated evaluations

A Terms of Reference (ToR) was prepared for the FSPI Health Promotion Adviser to work with the SS in-country coordinators, facilitators and communities to carry out the evaluation. Focus areas of the TOR included:

### **Coordination and Planning**

1. How is SS supported in each country?
2. What ongoing support and mentoring is provided?
3. What are the Human Resource requirements for the lead agency or CDO? (are they too high or manageable?)
4. Are there ongoing capacity development activities that are provided to SS facilitators by the CDO/lead agency?
5. How many in-country agencies are involved in the implementation of SS?
6. Is there adequate support provided to CDO/lead agency from SPC/FSPI, what has it been and how could it be improved?
7. What other support do SS facilitators/lead agencies require for future implementation?

### **Implementation of SS program in communities**

1. How many communities have implemented SS in each country?
2. Did they complete all SS modules?
3. How long did it take to implement?
4. What was the feedback from communities?
5. What can be done to improve implementation of SS at the community level?
6. Has SS had an impact on the capacity development of program implementers?

### **Monitoring, Evaluation and Reporting**

1. What data has been collected in country?
2. How is the collection of data happening?
3. Who is responsible for the collection of data?
4. Is data analysed and utilised in-country, if yes, how and provide examples on each of the M&E Toolkit components (G Scale, MSC, Pre and Post assessments?)

### **Additional M&E duties:**

5. Collect case studies on how the M&E Toolkit is used that can be shared at the International Congress on AIDS in Asia Pacific (ICAAP) – Bali (early August 2009)
6. Recommendations from SS National facilitators/ Coordinators in order to finalise and publish the SS M&E Toolkit in time for ICAAP – Bali

## **2.2 National versus Community Facilitators**

Throughout this report, the term ‘national’ and ‘community’ SS facilitator is used. The term ‘national’ is used to describe facilitators who have greater skills and experience in relation to the planning, design, implementation and M&E of SS. These include people who are currently working within the sexual and reproductive health field and generally have a number of years experience with the implementation of community based health projects. Most commonly, national facilitators work for Community Based Organisations.

The term ‘community’ facilitator is used to describe facilitators who are members of the community where they are delivering SS. While through the SS facilitator selection process some of these people may have had experience in HIV or sexual and reproductive health this has not been essential. Community facilitators are usually well respected individuals who show a desire and passion to be involved in the project. Due to this, community facilitators require greater support and capacity building in relation to SS skills. Ideally, the national facilitators are the people that provide this ongoing support in-country.

## **2.3 Evaluation Methods and Tools**

The methodology selected for this evaluation was based on participatory, qualitative approaches and comprised of a combination of methods, namely: document review; semi-structured focus group discussions; key informant interviews and national facilitator capacity mapping.

### **2.3.1 National Facilitator Capacity Mapping**

A capacity mapping exercise was carried out with available national SS facilitators and presented as timeline graphs. These graphs were used to self-assess five areas of SS capacity: facilitation skills, knowledge on gender issues, knowledge on sexual and reproductive health, ability to monitor and support SS and ability to carry out M&E using the SS M&E Toolkit. These terms were clearly explained to the facilitators at the start of the exercise. A “0” score represented “no capacity” and a “10” score represented “best possible capacity”. Facilitators were asked to score themselves along the SS timeline to date commenting on any improvements that had occurred. National facilitators in the Solomon Islands, Vanuatu and Kiribati underwent the capacity mapping exercise. As all current SS implementation in Fiji is delivered by community facilitators no national facilitator capacity mapping was carried out. Fiji community facilitators were however involved in in-depth interviews with the FSPI Health Promotion Adviser.

### **2.3.2 Community Focus Group Discussions**

Single-sex focus-group discussions (FGDs) were carried out with two SS communities in Solomon Islands and four communities in Fiji. As will be explained later in the report there were no community FGD’s in Vanuatu or Kiribati however focus group discussions were held with the community SS facilitators in both of these countries. The in-country SS Coordinators were responsible for the recruitment of participants for the FGDs.

### 2.3.3 Communities included in the evaluation

Solomon Islands	Dadave		Single sex focus group discussion
Vanuatu	Paunagisu		Key informant interview
	Samma		Focus group discussion (with Community facilitators)
	Emua		
Kiribati	Bikenibeu		Key informant interviews Focus group discussions (with Community facilitators)
Fiji	Navutulevu		Key informant interviews and FGD's (with youth) Key Informant interviews (with community facilitators)
	Rakiraki Koro		Key informant interviews with community facilitators and Peace Corps
	Lavena – Taveuni		Key informant interviews with community facilitators and Peace Corps
	Tacilevu – savusavu		Key informant interviews with community facilitators and Peace Corps Focus group discussion with SS participants

### 2.3.4 In-depth Interviews with National facilitators

National facilitators from the Solomon Islands, Vanuatu and Kiribati were interviewed by the Health Promotion Adviser during in-country visits. There was occasion twice in the Solomon Islands and Kiribati where a national facilitator was not available for in-depth interview as they were off island. The interviews lasted for between 35-50 minutes depending on facilitator feedback. As stated above, as no national facilitators are currently involved in the implementation in Fiji in-depth interviews were carried out with community facilitators and Peace Corps volunteers.

### 2.3.5 Number of National Facilitators Interviewed

SS Country	Number of facilitators Interviewed	Male	Female
Kiribati	3	1	2
Solomon Islands	5	2	3
Vanuatu	1	1	0
Fiji	12	6	6
<b>Total</b>	<b>21</b>	<b>10</b>	<b>11</b>

### 2.3.6 Interviews with Organisational Managers

Where possible, while on country visits the Health Promotion Adviser met with organisational managers to discuss financial and human resource issues relating to SS. These interviews were semi-structured in nature and also acted as an opportunity for managers to clarify or ask questions regarding future funding for SS.

## 3.0 Background to SS in the Pacific

### 3.1 Key Regional SS Activities Carried Out to Date

Before the presentation of each country's M&E data there is an overview of SS implementation to date. There were however activities which were either regional in nature or had a significant impact on the roll-out of SS and are relevant to all countries. Explanations of these activities are given below followed by separate country overviews.

#### 3.1.1 Inaugural Stepping Stones Facilitator Training (Fiji and Solomon Islands)

The inaugural SS facilitator trainings were held in Fiji between 13<sup>th</sup>-23<sup>rd</sup> June 2006 and the Solomon Islands from 10<sup>th</sup>-21<sup>st</sup> July 2006. Both of these trainings were organised and supported by PRHP and SPC and delivered by two experienced SS facilitators from Africa. Training participants were taken through a 10-day program where they experienced being an, 'SS community' in order to understand the unique methodology of the program. In each country, participants for the training were recruited through consultation with in-country partners and consisted of government, NGO and NGO community representatives.

In Fiji, the Health Promotion Department of the Ministry of Health (MoH) was identified and agreed to take on the ongoing support of SS implementation post training. In the Solomon Islands, PRHP Capacity Development Organisation (CDO) Oxfam took on the in-country support role.



### 3.1.2 Fiji Stepping Stones Support Workshop

Following the inaugural training and a period of initial implementation, a five day support workshop for Fiji SS facilitators was held from the 30<sup>th</sup> Oct-3<sup>rd</sup> Nov 2006. The objectives of this workshop were to;

- ✚ Review the progress of SS within communities
- ✚ Review evaluation tools used
- ✚ Provide an opportunity for facilitators to contribute to the design and content of a Pacific SS Manual

Findings and recommendations from this support workshop guided much of the early roll out of the Regional SS program.

Key challenges identified by Fiji facilitators at the support workshop included:

- ✚ Lack of confidence to conduct SS sessions without support from PRHP or MOH staff
- ✚ No male or female counterpart to co-facilitate sessions – there had been poor facilitator selection at the inaugural Fiji facilitator training
- ✚ Many community members (SS target group) were seasonal workers (sugar cane farmers) and were not in the village when programs were planned or were not able to commit to a set program
- ✚ Large geographical distance between facilitators within the same division made travelling to common communities and the provision of support difficult
- ✚ Heavy workload for MOH support personnel meant providing site visits and constant support was difficult. It was also noted that as SS was not formally in the TOR of MoH staff hence, there was less motivation/willingness to dedicate time to support and capacity building of community facilitators.

All SS facilitators until this time had been utilizing the African version of the SS manual. There had been a number of comments and suggestions from in-country partners and facilitators that this manual lacked appropriateness for a Pacific context. The then SPC Behaviour Change Communication Team, (now known as Prevention Team) took the lead in designing a new 'Pacific' SS Manual. Robyn Drysdale, Prevention Adviser utilised the Fiji support workshop as an opportunity to gain feedback and recommendations for the 1<sup>st</sup> draft of a Pacific SS Manual.

Recommendations that were made as a result of the SS support workshop in Fiji included:

- ✚ The design of a Pacific SS manual
- ✚ A future selection criteria used to select appropriate SS facilitators
- ✚ The identification of appropriate in-country organisation to support SS, (which must include funds for support)
- ✚ Further capacity building of SS facilitators to assist in SS implementation (in particular, facilitation skills and sexual and reproductive health)
- ✚ More time and support given to facilitators in order to practice skills and gain confidence to deliver the program

### 3.1.3 Fiji Stepping Stones Evaluation

In May-June 2007 PRHP carried out an evaluation of the Fiji SS pilot program. This evaluation was; 1) an AusAID requirement in order to secure further funding for the Pacific pilot program, 2) an opportunity to describe and assess the implementation of SS in Fiji to date and 3) used to pilot possible future M&E tools that could be used to gather information on individual and community level change brought about by SS.

Findings identified by this evaluation included a number of inspiring client and implementer Most Significant Change (MSC) stories from Waikubukubu and Sasa village and improvements in gender-equitable attitudes among men who participated in SS training.

Lessons learnt and recommendations identified by the evaluation included:

- ✚ A minimum of one female and one male facilitator from each participating community should be identified as facilitators
- ✚ Potential SS facilitators need to undergo a selection process
- ✚ More planning into ways for retaining male SS facilitators and participants
- ✚ SS communities should implement the entire 17 module package as opposed to 'part' implementation or utilization of SS activities within other prevention programs
- ✚ Development of a Pacific SS M&E Toolkit that measures individual and community level change brought about by the program

Upon completion and submission of the Fiji evaluation PRHP applied for and was successful in obtaining funds from a Rapid Response Grant to the value of AUD \$200,000 to continue with and support SS in the Pacific.

### 3.1.4 Regional Stepping Stones Facilitator Training

Based on the recommendations and findings from the Fiji support workshop and evaluation, PRHP and SPC held a second 10-day facilitator training in Fiji from 14<sup>th</sup> to 25<sup>th</sup> May 2007. Countries involved in this training included; Fiji, Vanuatu, Solomon Islands, Kiribati and Tuvalu. Fiji and Solomon Islands were included as they were involved in the original piloting in 2006 and upon consultation by PRHP with in-country partners; Vanuatu, Tuvalu and Kiribati all expressed interest and commitment to be involved. This regional training used the new Pacific SS manual that was compiled and completed by the SPC Prevention Team. Four participants, (2 male and 2 female) from Vanuatu, Solomon Islands and Tuvalu along with six from Kiribati attended the training. It was planned that these participants would form the core group of SS facilitators for initial implementation in their countries. Twenty-four participants from Fiji attended; this was seen an opportunity to train additional facilitators in communities that had lost previous SS facilitators and to expand into more communities than current capacity allowed.

While there is no international selection criteria for SS facilitators it was acknowledged and recommended in the Fiji pilot evaluation that a basic set of personal qualities and skills be utilized to increase retention and success of trained facilitators. For the Regional training these were identified as;

- ✚ Training and facilitation skills & experience in implementing training and/or running groups
- ✚ Understanding of sexuality
- ✚ Knowledge on HIV & STI (completed HIV/STI 101)
- ✚ Good working relationships with different communities (own community)
- ✚ Experience working in HIV/STI/reproductive health related areas
- ✚ Good reading/understanding level of English (the language of the Stepping Stones training manual)
- ✚ Committed to prepare for & run SS workshop sessions over 3-4 months



Photo's from the 2007 Regional facilitator training held in Suva Fiji

Upon further lessons learnt from the Fiji support workshop the Regional training also included six site visits to a number of communities so facilitators could practice delivering SS sessions during the training. In addition to this, the last day of the training was put aside for participants to work in country groups to map out and plan pilot programs in their respective countries.

Of the countries that completed the Regional training, the Solomon Islands, Kiribati, Vanuatu and Fiji went on to implement pilot projects. SPC and PRHP attempted to engage and motivate Tuvalu in the implementation of their nominated pilot project but they felt strongly about the provision of incentives for facilitators and participants. As the current SS grant was unable to pay for these incentives, and Tuvalu was not able to source their own means of financing they did not implement a pilot project and have to date not completed or been involved in any SS activities. Tuvalu does however have SS implementation in their 2010 HIV and STI work-plan.

## 4.0 Country Level Activities

### 4.1 Fiji – the story so far...

As mentioned above, SS was first piloted in Fiji at the inaugural training in June 2006. It was planned for MoH to take on the support of the SS communities through their Health Promotion Officers at a divisional level, (north, central and western) however in reality this did not happen. Reason given for this included conflict of duties and SS support duties not worked into Health Promotion Officer's TOR. There were a total of twenty-eight participants (14 male and 14 female) from ten communities present at this augural 2006 training.

In October 2006 PRHP held a support workshop to review SS progress and action plans. There were fifteen facilitators from six communities present at this support workshop. The remaining 13 facilitators were no longer active in SS and had dropped out of the program. The support workshop highlighted that there had been implementation problems for many of the SS facilitators when they returned to their

communities to put their new knowledge and skills into practice. Facilitator selection carried out by MoH was also identified as poor as many of the facilitators did not come from the same village therefore carrying out the sessions on a weekly basis became a difficult task due to long distance for community facilitators to travel. There was however 5 communities that had implemented SS to differing degrees post the 2006 training.

In March-April of 2007 PRHP carried out an evaluation of the five communities that had implemented SS in Fiji. A copy of this report can be found on the International Stepping Stones website ([www.steppingstonesfeedback.org](http://www.steppingstonesfeedback.org)). This evaluation report highlighted a number of positive outcomes such as; a number of inspiring client and implementer Most Significant Change (MSC) stories from Waikubukubu and Sasa villages, improvement in 'gender-equitable' (equal participation of men and women in decision-making and in delivering and receiving services) attitudes among men who participated in SS training, and the creation of a Youth Council in Sasa village, which was initiated as a direct result of young men and women completing the SS program.

A total of 15 MSC stories were collected from participating communities as part of the Fiji pilot evaluation. One domain, improved HIV-related behavior was chosen among two categories (client and implementers).

Evidence from the 15 stories collected (10 client and 5 implementer) showed that SS had facilitated improved HIV-related behaviour change among both clients and implementers of SS. Of the 10 client stories collected, six reported an improvement in communication with their community, family or sexual partner, and spoke of new skills and confidence to speak about HIV and sexual health issues. This in-turn led to clients reporting improved relationships with sexual partners, less community fighting and better communication and trust between parents and children.

Seven of the 10 sampled client stories and three of the five implementer stories reported that SS had facilitated an increase in HIV-related knowledge, particularly modes of transmission and prevention strategies. Six client stories also reported an increase in positive HIV-related skills such as assertive communication and 'I statement' skills.

Recommendations for the future implementation of SS were provided by the 2007 evaluation report and in May 2007 PRHP and SPC carried out a Regional facilitator training in Fiji, (Solomon Islands, Vanuatu and Kiribati were also present at this training). Continual support to these countries was provided to in-country organisations by PRHP.

Before the May 2007 training PRHP worked with the Fiji Council of Social Services, the then Fiji Capacity Development Organisation (CDO) to identify community facilitators to be involved in the regional training. Experienced community facilitators trained in 2006 were also asked to co-facilitate at this training. Twenty-four participants from four rural communities and two urban communities were selected to attend the training. Two support personnel from Fiji's CDO were also present at this training and were expected to take on the on-going support in their respective communities. A total of four of the communities, (3 rural and 1 urban) ended up implementing SS. Intensity and time required for ongoing support was identified by the CDO as a challenge and reason for drop out from the other two communities.

In June 2008 PRHP piloted the partnering with the US Peace Corps organisation as a support structure within SS communities. The philosophy behind partnering with Peace Corps was to provide communities and community SS facilitators with a more intensive support structure throughout the duration of the program. The Peace Corps volunteers acted as informational reference points on SS content and maintained motivation and momentum of the community peer groups. The Peace Corps national office identified four villages to be involved in the training. Four community facilitators (older and younger male and female) plus one Peace Corp volunteer from each village attended the 10-day training. The four Peace Corps communities involved in the project were Tacilevu village on savusavu Islands, Lavena village on Taveuni Island, Rakiraki Koro on viti levu and Malomalo village on the coral coast.

Three out of the four Peace Corps villages were visited as part of this process evaluation. Malomalo village did not commence SS implementation due to community conflicts within the village. The community conflicts were long standing issues and were not related to SS. The Peace Corps national office had attempted to support their volunteer through these issues without success. It was felt that after months of negotiations the SS program should not be implemented within this community.




#### **4.2 Solomon Islands - the story so far...**

Previous Oxfam Country Representative Dolores Devesi reported first hearing about SS through a capacity building training delivered by Oxfam Australia in Melbourne. Once back in the Solomon Islands she pursued further research and gained financial support from PRHP and SPC for the Solomon Islands to be involved in the inaugural July 2006 training. Thirty-five NGO and Government representatives from the Western Guadalcanal region attended the training. Oxfam Solomon Islands was identified by PRHP and SPC as the in-country support organisation for SS activities. Upon completion of the inaugural training, some participants reported utilising activities from the SS manual but there was no 'full' implementation of the program in a community.

In May 2007, the Solomon Islands attended the Regional SS training held in Suva Fiji. There were four participants present from the Solomon Islands and all were NGO representatives and had previously attended the July 2006 training. On the final day of the training participants were asked to work in country groups and map out an SS pilot program that was to be implemented upon return to country. The Solomon Islands participants identified two communities, Dadave (rural) and Tuaruhu (urban) as their pilot communities.

It was agreed that World Vision Solomon Islands would take the lead for the implementation and support of the rural SS program (Dadave) and Oxfam International for the urban pilot program (Tuaruhu).

The aims for the pilot programs as identified by SS facilitators included:

-  To provide a learning environment for all SS facilitators on the Pacific manual
-  To pilot SS in one rural and one urban community setting and identify associated strengths and weakness
-  To empower training participants on sexual and reproductive health information including HIV/AIDS, gender and communication and relationship skills



National level SS facilitators from the Solomon Islands

#### 4.2.1 Dadave pilot (rural setting)

Upon completion of consultation meetings with leaders and community members implementation of SS began on the 17<sup>th</sup> September 2007. Sessions were run Monday-Thursday 7pm-12pm until completion of the whole 17 module Pacific manual. SS facilitators from World Vision Solomon Islands (WV), Solomon Island Planned Parenthood Association (SIPPA), Oxfam Solomon Islands and Ministry of Health Solomon Islands (MoH) were involved in the facilitation of the pilot project.

A unique aspect of the Dadave pilot program was the creation of a children's SS group. This initiative grew out of the need identified by national facilitators for someone to look after the children of the mothers who were attending the program. It was observed by facilitators that the children were distracting to their parents and affected participant involvement. In response to this, Oxfam staff initiated the children's program to occupy them while their parents participated in their sessions. Topics covered in the children's sessions included issues such as; personal hygiene, dental care, food and nutrition and communication skills. This was seen as a highly successful activity and the children's peer group were able to present 'special requests' to their parents at the final request ceremony. Issues presented by the children included the desire for parents to be more involved in their school lives, for parents to help them with their homework and for parents to save enough money to continue with their school fees. The Solomon Islands plan to compile the first children's SS manual but to date this has not been completed.

#### 4.2.2 Strengths of the Dadave pilot identified by facilitators included:

- ✚ Organisational support (funding for the pilot was provided by WV and Oxfam Solomon Islands)
- ✚ There were already strong relationships with the community due to WV's past project experience. This allowed for easier acceptance and agreement for SS with community members and leaders
- ✚ The team environment and commitment from a number of organisations and facilitators created a good support network
- ✚ Facilitators commented that they thought the SS process was much more detailed and therefore realistic in terms of facilitating behaviour change
- ✚ The women's group reported an improvement in mother-daughter relationships post SS
- ✚ Facilitators observed reduced stigma and discrimination against PLWHA during SS role plays

- ✚ Both groups reported more open conversations regarding sex and relationships
- ✚ Women reported enjoying and gaining new knowledge regarding contraceptives and sexual health and anatomy
- ✚ The children's SS sessions were seen as a unique and successful outcome of the Dadave pilot

#### **4.2.3 Challenges identified by participants and facilitators included:**

- ✚ Inconsistent participation
- ✚ The male peer group moved through the manual faster than the women
- ✚ It was noted that the male group was more knowledgeable and open to topic discussions while the women were more reserved
- ✚ Participants who attended the training were from different sub-communities within Dadave with different religious backgrounds, values, beliefs and priorities
- ✚ The program timing (7pm-12pm) was a challenge for facilitators as they had to travel most nights and were not provided with extra salaries or time in lieu by the managers for carrying out this work
- ✚ As the program was run at night there were at times lighting issues (generator problems etc)

#### **4.2.4. Tuvaruhu pilot (urban setting)**

Tuvaruhu community was selected based on the multi-ethnic representation within the community and the visible number of young people who remain unemployed. The SS facilitators promoted the program through poster promotion, church announcements and an open community meeting.

There were a total of three trials required before the SS program in Tuvaruhu was successfully completed.

##### **1<sup>st</sup> trial**

SS was implemented two days per week (Tuesday and Thursday) between 6-9pm for one month. All four peer groups were targeted however older men did not show up. SS facilitators completed sessions A and B and then had to stop due to low participation and venue difficulties.

##### **2<sup>nd</sup> trial**

SS facilitators returned to Tuvaruhu community and consulted with community church leaders to identify an appropriate training venue. The South Sea Evangelical Church (SSEC) was identified as an available venue. Upon completion of the first training session a number of church leaders from other denominations disputed the use of the church as a venue as they saw it inappropriate to deliver SS in such a venue. The training continued the following session under a mango tree. The SS training went for a week and then stopped due to what was identified as cultural and religious barriers.

### 3<sup>rd</sup> trial

Solomon Island facilitators decided to attempt implementation one final time in Tuvaruhu in order to continue to identify key learning initiatives and gain further insight into what makes SS implementation successful in an urban setting. Thirty to thirty five young people between the ages of 14-25 years participated in the third trial. The 3<sup>rd</sup> trial was successfully completed in the 3<sup>rd</sup> week of April 2008.

#### 4.2.5 Challenges and Recommendations Identified from the Tuvaruhu Pilot

- ✚ Implementation and support of SS was time intensive which was further hampered by the fact that all facilitators worked on other programs and SS was not included in their TOR
- ✚ Young people tended to be more interested in participating in SS. The older peer groups, (especially men) proved more difficult to maintain momentum and eventually older peer groups discontinued in Tuvaruhu. For any future urban SS programs it was recommended by Solomon Island facilitators that the program target youth groups
- ✚ Community motivation was a challenge in an urban context. Facilitators felt that this was mainly due to the fact that urban communities tended to have less cohesiveness and sense of community obligation and duties. It was noted that SS was a methodology that better suited a rural community context
- ✚ Finally, it was identified there was too much mobility of training participants in an urban setting and quite often a larger amount of ethnic and religious diversity which made session delivery difficult

Post pilot the Solomon Islands presented activities, findings and recommendations to their National AIDS Committee (SINAC). All facilitators supported further implementation of SS in the Solomon Islands and requested SINAC support to carry this out. Facilitators and organisations involved in SS formed a National SS Committee which was officially recognised by SINAC. Those involved in the committee included; SIPPA, Oxfam, MoH, Church of Melanesia (COM) and WV. In early 2008 SINAC endorsed SS as a behavioural change prevention initiative naming the program in the country's National Strategic Plan (NSP) on HIV and AIDS and country work-plan on HIV activities

#### 4.2.6 Solomon Islands Stepping Stones Retreat

Oxfam Solomon Islands organised an SS retreat for national facilitators from the 25<sup>th</sup>-28th April 2008. This was an opportunity for the facilitators to share ideas and lessons regarding SS to date and plan for 2009 implementation in an informal environment. Also present at the retreat was Robyn Drysdale (SPC Prevention Adviser) and Robert Verebasaga (then PRHP Project Officer).



Photos from Solomon Islands SS retreat April 2008



Lessons learnt from the SS rollout to date included;

- ✚ Work load of trained national facilitators was high as SS was not the only HIV prevention program being implemented in Solomon Islands. All national facilitators noted that they didn't feel they had enough time to prepare and plan for community SS sessions due to other work commitments
- ✚ Not all national facilitators were present at the 2007 Regional facilitators training in Fiji therefore some were not familiar with the Pacific SS manual
- ✚ While there is good organisational support for SS, most organisations do not include the program in their strategic plan or core prevention activities
- ✚ Lessons from the urban and rural piloting found that SS was a community mobilisation package more suited for a rural context. Urban settings tended to have too high community mobility and many sub-populations (ethnic and religious groups); all of which negatively affected implementation
- ✚ SS was more relevant and appropriate for Community Based Organisations (CBO's) as they traditionally had better relationships and practical experience of working within communities

Next steps identified by national facilitators included;

- ✚ The establishment of an SS coordinator who would oversee the integration and roll out within the existing organisations HIV programs and communities
- ✚ Approach MoH and SINAC to endorse and recognise appropriately trained facilitators as 'certified' Community Based SS Facilitators
- ✚ Promote SS to organisational line managers and attempt to get SS recognised within work plans and TOR
- ✚ Ongoing capacity building of facilitators, especially in the area of M&E and cross-cultural exchanges
- ✚ National facilitators felt strongly that community facilitators should be identified and trained up in the implementation of SS. It was recommended that Oxfam, WV, COM and SIPPA all identify four facilitators, (younger and older male and female) from two or three communities to be trained as community SS facilitators.

#### **4.2.7 1<sup>st</sup> In-country Community Facilitators Training**

Based on recommendations from the pilot program and SS retreat the first in-country community facilitator training was held from the 3<sup>rd</sup>-14<sup>th</sup> November 2008. The planning and preparation for the training was very much a joint effort with the SS Committee meeting regularly and sharing all tasks and responsibilities. Each organisation involved in SS selected two or three communities where they had established relationships. Four participants from each, (in-line with SS methodology) were invited to attend. To ensure appropriate participants were identified, a selection criteria and application form was provided. It was planned that the national facilitators would be responsible for support and M&E of their individual community facilitators. A total of 60 community facilitators attended the November training with 51 completing the entire 10-day program. On the final day of training facilitators worked in their community groups to plan the rollout of SS in their communities. Also present at the training was Robyn Drysdale (SPC Prevention Adviser) to provide support to the SS committee and national facilitators.

#### **4.2.8 Cross –country facilitator sharing**

In July 2008 two Solomon Islands national facilitators were involved in the first cross-country facilitator exchange activity to. Due to similarities between Bislama and Solomon Islands pidgin one male and one female Solomon Islands national facilitator travelled to Vanuatu to co-facilitate the 1<sup>st</sup> community training in North Efate. The second facilitator exchange occurred in November 2009 with a Solomon Islands national facilitator travelling to the Federated States of Micronesia to co-facilitate in their first in-country training. This activity was initiated in order to support continued capacity development of facilitators and also promote local transfer of knowledge and sustainability. Support and financing of future cross country exchanges is a key activity in the current Regional SS support grant and is seen as a vital component for the sustainability of the project. Both participants from the Vanuatu training and the national facilitators from the Solomon Islands reported finding the experience very rewarding. The SS community facilitators being trained in Vanuatu commented that it was excellent to have ‘real’ SS facilitators co-facilitating so that they could ask practical questions about how implementation occurs in the village context. Many others also liked being able to ask questions and receive answers in Bislama as they were then confident they had understood responses correctly. Like-wise the Solomon Islands national facilitators found the exchange a very positive initiative and one that had improved their skills as facilitators. The national facilitator who co-facilitated at the training in the Federated States of Micronesia reported being very nervous the day before commencing training but found that at the end of the first day they felt confident in their ability as an experienced SS facilitator. He also stated it showed him that while SS was an extremely intensive program he saw how far the Solomon Islands had come in relation to implementation when compared with other SS countries.

#### **3.3 Kiribati - the story so far...**

Kiribati first became involved in the SS program through attendance at the Regional facilitator training held in Suva, Fiji. Six representatives, (2 Government, 4 NGO) participated in the training. All participants had previous experience in sexual and reproductive health. At the training, Kiribati SS facilitators identified three communities in Betio; Takoronga Community, Bahai Faith Community and the Temakin Kiribati Protestant Church Community as their pilot communities.

The Kiribati Association of Non-Government Organisations (KANGO) was identified as the focal point to support the SS roll out. When back in country, SS facilitators carried out consultations with the three nominated pilot communities to gain support and agreement for the program. Facilitators conducted a needs assessment with the three communities to gather background information regarding issues affecting them; this was also an opportunity to provide information regarding SS and seek approval for participation.

Further consultation with community leaders was scheduled, however, only Takoronga community leaders participated in this consultation. The community and SS facilitators therefore agreed that the SS pilot program would be scheduled from September-November 2007 in Takoronga community.

#### **Takoronga**

The Takoronga community program was carried out three days per week over a six week period. There were initially 40 participants enrolled in the program however after the first two sessions 11 participants dropped out. This left a total of 29 (11 male, 18 female) participants who completed the 17 module

package. Participants were divided into two groups, (male and female) and not into age groupings (older/younger) as this would have meant peer groups were too small to allow for adequate discussion. Facilitators did however manage to split into smaller age appropriate groups during smaller break-out sessions.

The collection of M&E data before and after the Takoronga program was very weak. Like all SS countries to date both national and community facilitators had failed to collect reliable and useful data. Qualitative feedback however from SS participants was positive although this was still documented in a haphazard manner.

Upon the completion of the Takoronga community pilot the Kiribati facilitators felt that it was necessary for the SS manual to be translated into I-Kiribati. SPC therefore sourced an appropriately qualified translator which was funded through an SS grant. A contract was signed with the translator in July 2007. To date, this manual translation has not been finalized but at the time of the process evaluation it was in its final stages and estimated to be completed within 2-3 months.

In late 2008, PRHP agreed to finance a part-time SS Coordinator based at KANGO who would be responsible for the support and co-ordination of the program in Kiribati. The salary for this position was also funded through the SS grant.

In October 2008 it was suggested by the in-country SS Coordinator for all SS national facilitators to run a 2<sup>nd</sup> pilot program in Bikenibeu community. It was felt that national facilitators needed to continue to practice using the SS Pacific manual and skills to improve future implementation. This pilot program was also an opportunity to identify possible community facilitators that would then be trained up in Bikenibeu and Takoronga community. The second pilot program of SS was carried out by national facilitators in November 2008.

From 2<sup>nd</sup>-13<sup>th</sup> March 2009 Kiribati carried out its first in-country SS program to train community facilitators from the two piloted communities. A total of 33 participants attended this community facilitator training (18 females/15 males). This training was also used as an opportunity to trial the 1<sup>st</sup> draft of the I-Kiribati SS manual. As all participants attending the training had already be involved as participants in the 1<sup>st</sup> and 2<sup>nd</sup> piloting and at the end of the first day they requested a change to the training program. Participants requested that they be given the opportunity to facilitate sessions themselves as this was a training to prepare them to become community facilitators. The national SS facilitators therefore became support for the training participants. Project officers Emi Chutaro and Robert Verebasaga were also present as technical support personnel.

An outcome and recommendation of the community training was that the current draft of the I-Kiribati manual used language which was too formal and complicated for the facilitators. It was decided that the national and community facilitators would work together to make changes to the manual translation to simplify its language.

As part of this evaluation the Health Promotion Adviser spoke with three of the national SS facilitators and visited the Bikenibeu community to speak with ten of the community facilitators present at the March training. Focus group discussions were held with the community facilitators and interviews carried out which contributed to evaluation findings and the production of a SS DVD.

### 3.4 Vanuatu - the story so far...

Vanuatu first became involved in the SS program through attendance at the 2007 Regional training held in Fiji. PRHP and SPC worked through Wan Smol bag (WSB) to recruit participants for this training. Four participants, (2 male, 2 female) were recruited from the Adolescent Reproductive Health Program (2) and WSB Theatre (2).

#### Blacksands

Upon completion of the Fiji training, Blacksands was nominated as the pilot community. Prior to implementation at Blacksands one of the male facilitators dropped out as they gained full-time employment, and one of the female participants dropped out due to illness. The two younger facilitators carried out the pre-assessment data collection for the community and started implementation in November 2007. A total of eight sessions were run but then implementation stopped due to lack of participation. An additional factor thought to affect implementation was that Blacksands community is an urban community, therefore faced many of the same problems as the Solomon Islands urban community pilot; high mobility and multi-ethnic background of community members. One of the SS facilitators, (a French speaker) reported having trouble with the English manual. Through funding from the Rapid Response grant Vanuatu began translation of the SS manual into Bislama. To date, none of the facilitators trained at the 2007 Fiji training are actively involved in SS.

After consultation between PRHP and WSB In early July 08 it was felt that facilitator selection and drop out of the older male and female facilitators had a big impact on the younger facilitators not being able to continue with implementation. Vanuatu therefore held an in-country community facilitator training in North Efate in June 2008. This training was facilitated by Emily Miller, then Health Promotion Officer at PRHP and Jovesa Saladoka, then Behaviour Change Communication Officer, SPC. As mentioned above, one female and one male national SS facilitator from Solomon Islands were brought over to co-facilitate at this training. There were three communities present at this training including; Emua, Paunagisu and Samma. These communities were all located within a short distance of each other on North Efate. There were 13 males and 15 female community facilitators present at this training. In addition, WSB hired an SS Coordinator which was funded through the SS grant. Each community nominated a facilitator who would act as SS Chairperson and would call community meetings and SS sessions.



Photo taken during 1<sup>st</sup> community facilitator training June 2008

Many of the community facilitators present at the training requested payment for attendance and for implementation of the program in their communities. PRHP, SPC and WSB agreed to pay facilitators for

their presence at the 10-day training as it was acknowledged that earnings were potentially lost. Due to the nature of the program however it was not possible for ongoing payment for all SS sessions run in the community. This continues to be a reason identified by facilitators for lack of implementation to date.

As part of this evaluation the Health Promotion Adviser met with the WSB SS Coordinator and travelled to North Efate to speak with community SS facilitators.

## 4.0 RESULTS FROM PROCESS EVALUATION

### 4.1 FIJI

#### 4.1.1 Key informant Interviews with Community facilitators

A total of 12 community facilitators and three Peace Corps volunteers were interviewed and gave feedback on the SS roll out in their communities in Fiji. Breakdown of community facilitators and Peace Corps volunteers can be seen in the below table.

Village	Peace Corp volunteer	Community facilitator		Total
		Male	Female	
Lavena, Taveuni	1	2	1	4
Tacilevu, savusavu	1	1	2	4
Navutulevu, Viti Levu		2	1	3
Rakiraki	1	1	2	4
Total	3	6	6	15

At the time of the evaluation SS had been implemented (either fully or in part) in four communities during the 2008 to 2009 period. Site visits to the 2006-2007 communities were made but no further implementation had occurred. Since these communities were included in the 2007 evaluation they were not included in this process evaluation.

Only two of the community facilitators trained had previous experience in sexual and reproductive health. The older female from Nuvutulevu and older male from Tacilevu were the current community health nurses within the village and had participated in previous HIV and STI awareness trainings carried out by other NGO's and/or MoH. Both of these facilitators stated that this was a real advantage in terms of their confidence and ability to facilitate SS sessions. It was observed that with Tacilevu where the community health nurse was an older male this had had a very positive effect on SS implementation. They were able to call meetings within the village and the older males responded much more positively to them and the training program. They were also an excellent support and reference point for the other three community facilitators and were able to explain and answer any queries they had regarding SS content.

All community facilitators interviewed stated that gaining commitment of community members to attend all SS sessions was difficult. This was particularly true for the older male sessions as traditionally it was not seen as an appropriate or necessary topic for them to participate in.

The two facilitators who were also the community health nurses (Tacilevu and Nuvutulevu) stated that they thought the SS program and manual should be divided into two or three sections were communities get breaks through-out the year to allow for seasonal work such as sugar cane farming to continue. They stated that while they supported all the content and the methodology of SS, communities were simply not use to such intensive programs being run in the village over such an extended time period. They felt that breaks to allow for other community programs to be run would be necessary in order to gain real community participation.

Of the three Peace Corps volunteers who reported findings for this evaluation all stated that SS was a worthwhile and needed program within their communities. Despite this, all but one (Tacilevu) had some form of continued difficulty implementing the program. Again, factors such as length of the program and competing community commitments were identified as problems they were not able to overcome.

### **Tacilevu**

Tacilevu community did however manage to implement the entire SS program with three peer groups (older and younger men were combined). Implementation did however occur over an extended period, from November 2008 – August 2009. There were breaks taken from the program over the Christmas and Easter periods and for one month during sugar cane cutting season. This wasn't seen as a negative factor but rather the community determining priorities and other commitments that needed to be completed and this supported the recommendation that SS implementation in Fiji may need to consider a staggered implementation plan. The Peace Corps volunteer reported to the Health Promotion Adviser that the younger peer groups enquired about the program over these 'break periods' and were keen to find out when implementation would recommence signifying good motivation by youth.

In addition to this, the community facilitators in Tacilevu reported being very well supported by their community nurse facilitator and Peace Corps volunteer. Weekly SS feedback meetings were held with facilitators where they discussed issues that arose from previous sessions, asked questions to gain clarification on SS topics and held practice run sessions with each other. While the Peace Corps volunteers in the other two locations attempted to call support meetings they were not as successful. This again points to the importance of the older male facilitator who in the instance of Tacilevu village had the ability to call for and gain support from the other community facilitators and village members.

### **Lavena**

There were several attempts to implement SS in Lavena village on Taveuni. The Peace Corps volunteer reported a number of attempts to get the program underway but was unsuccessful. The community also lost their younger female facilitator soon after returning from the training therefore the older female facilitator combined female peer groups.

A suitable venue to hold the trainings was also cited as a difficulty in Lavena. The village did not have a community hall and finding a space big enough which also had access to power was a continual problem. In the end, after several attempts the village ended up commencing implementation with only the youth in the village. Sessions were run while all youth were in the village over the school holidays. Lavena village was able to implement up until session 'J' (drugs and alcohol) by the time this evaluation was carried out and before youth returned back to school.



Photos of SS implementation in Lavena village, Taveuni

Competing community commitments and length of the program was again identified as a major hurdle in Lavena. When asked if he would do anything differently the Peace Corps volunteer said he was happy with the selection of community members to become SS facilitators although stated he didn't fully grasp how intensive the program was before involving his village. This Peace Corps volunteer has since completed his volunteer placement in Lavena village and is working part-time with the national Peace Corps office in Suva and part-time with FSPI on their SS program. He is now working with FSPI and Peace Corps to better identify communities and inform them of the SS program and facilitator selection before they become involved in the program.

#### **Rakiraki Koro**

Rakiraki Koro started implementation of SS in September 2008. While implementation commenced relatively quickly post training the male peer groups stopped and started a number of times and eventually did not complete the whole program stopping at session E. The female facilitators ended up combining their sessions with older and younger peer groups and managed to complete implementation in April 2009. Again, implementation stopped a number of times due to other community commitments and two funerals that occurred in the village over this period.

The rakiraki older female community facilitator cited struggles with the male facilitators and male community involvement and support of the program. While the village had expressed interest and support for the program before attending the training, once back in the village the male community members were not fully engaged or motivated. The older female community facilitator who had previous experience as a Red Cross peer educator stated that the community had always struggled to engage men in discussions around sexual and reproductive health. Difficulty in engaging men seemed to be an issue in all settings across the region and once again pointed to the importance of appropriate selection of the older male facilitator.

#### **Nuvutulevu village**

Nuvutulevu was the final community that was visited as part of this evaluation. They commenced implementation after the 2007 regional training held in Suva and implementation was going relatively smoothly until a religious community conflict arose in the village. Up until this time the female peer groups were undergoing regular meetings and participants reported enjoying the meetings, especially the sessions around body mapping and sexuality. At the time of the community conflict all SS meetings stopped for a 5 month period. When implementation recommenced the momentum of the older peer groups was lost and implementation was only completed with the younger male and female peer groups. Additionally, throughout the conflict period the younger female facilitator dropped out and the older male facilitator gained employment in a nearby resort therefore was not able to commit to facilitating future sessions.

Incentives also became an issue in Nuvutulevu community and the younger male facilitator and older female facilitator noted having to provide sweets and refreshments to ensure the youth participated in the sessions. This was self financed and when occurred, involvement from the youth was high.

When the younger male and older female facilitator met with the Health Promotion Adviser for this evaluation they stated that if they were to run the program in their village again they would need to provide refreshments for the participants. There had been a number of other development programs run in the village over the years and participants and facilitators were always provided with some sort of remuneration, therefore it was an expectation within the village. They didn't see the program working any other way and suggested that it be worked into future SS funding. Manual translation, especially for community facilitators was also noted as something that should occur for future implementation.

The youth that did attend SS sessions in Nuvutulevu and that met with the Health Promotion Adviser stated that they enjoyed the sessions and that they learnt new information, especially around their bodies and STI prevention. The older female facilitator who was also the community nurse began distributing condoms as she saw this as a need during the SS sessions. She reported many youth now coming to her and requesting condoms regularly and felt that this happened as a result of the trust she had established with the group throughout the SS meetings. This was also confirmed by a number of the youth who reported to the Health Promotion Adviser that they now access condoms through their community nurse, something they did not do prior to SS. The community nurse regularly accesses condoms from the nearby community health centre and reports giving out a minimum of one box (144 condoms) per month (number assessed through her regular record keeping). The Health Promotion Adviser visited the community health centre as part of this evaluation and was told that the Nuvutulevu community nurse regularly comes into the centre to pick up condoms for her community.



Photo's of SS implementation in Tacilevu village, savusavu

Overall there were a number of implementation problems in Fiji. The leading reasons given for this included length of the SS program, community involvement and commitment, competing community demands and in a number of instances community fighting (unrelated to SS). In the communities where SS was implemented facilitator selection was identified as an important factor. The involvement and training of the existing community health nurses was seen as a positive in two of the SS communities and should be considered as a future methodology. These facilitators had much more knowledge and confidence to educate the community on issues around HIV and STI's but also found it easier to call community meetings and SS sessions.

Consideration should also be given to staggered implementation over a longer period of time. Currently ideal SS implementation is recommended to occur over an eight to sixteen week period however this did not happen in any Fijian community. Community commitments in rural villages are high and all community members have other roles or duties to carry out. Mapping these commitments and breaking



the SS manual up into smaller sections should be considered for future implementation. This however needs to be balanced with continual motivation so community members remain active in the program.

## **4.2 SOLOMON ISLANDS**

There are currently seven national and twenty-three community facilitators in the Solomon Islands being supported by five organisations (4 NGO and 1 Government). At the time of the process evaluation SS had only been completed in the two original pilot communities, (Dadave and Tuvaruhu) and there had been no implementation of SS as a result of the November 2008 community facilitator training. In the months since this evaluation, implementation had begun in three communities but the Health Promotion Adviser was not able to meet these communities as implementation started post her M&E country visit.

### **4.2.1 FINDINGS FROM KEY INFORMANT INTERVIEWS**

A total of five national facilitators and three organizational managers were interviewed during in-country visits. The interviews brought out the following findings:

#### **4.2.2 National Facilitator Interviews**

All national facilitators interviewed were already working in HIV or sexual and reproductive health at the time they were recruited as SS facilitators. All but one facilitator was currently still working on SS and all were active members of the SS Committee at the time of the interviews.

Much of the support for SS in the Solomon Islands stems from the commitment and motivation of the national facilitators and is based on their extensive experiences with other prevention programs. One national facilitator reported to the Health Promotion Adviser that she thought SS was the best behaviour change program that she had used. She acknowledged all the challenges around the program, (intensive support and community commitment) but stated that was in-fact a challenge of behaviour change, not necessarily SS. She commented that she thought SS had enough institutional support in the Solomon Islands and would continue regardless of future funding provided by regional support agencies.

All SS facilitators reported being supported by their organisational managers to implement SS, although three out of the five commented that in reality they weren't able to manage their existing workload on top of providing the intensive support SS required. National facilitators felt very strongly that they needed to have a dedicated SS coordinator to carry out support, reporting and M&E visits to the community. The SS Committee had identified one of the national facilitators to take over this role and the position was to be supported by SINAC. The identified individual currently works within the MoH and while the head of the HIV unit is very supportive of an SS Coordinator, the nuts and bolts of creating such a position are yet to be finalised.

All facilitators interviewed said they thought Oxfam had to date done an excellent job as the primary support agency for SS. They felt the HIV Prevention Officer was very responsive to their requests for funding and called regular SS Committee meetings so that everyone maintained regular contact.

The Oxfam HIV Prevention Officer, (and national facilitator) commented that she thought the amount of time and work required to support SS was too high and intensive for Oxfam to continue without the

dedicated support of another staff member. Currently, Oxfam has high commitments with other prevention programs and is the CDO for the Pacific Islands HIV and STI Response Fund.

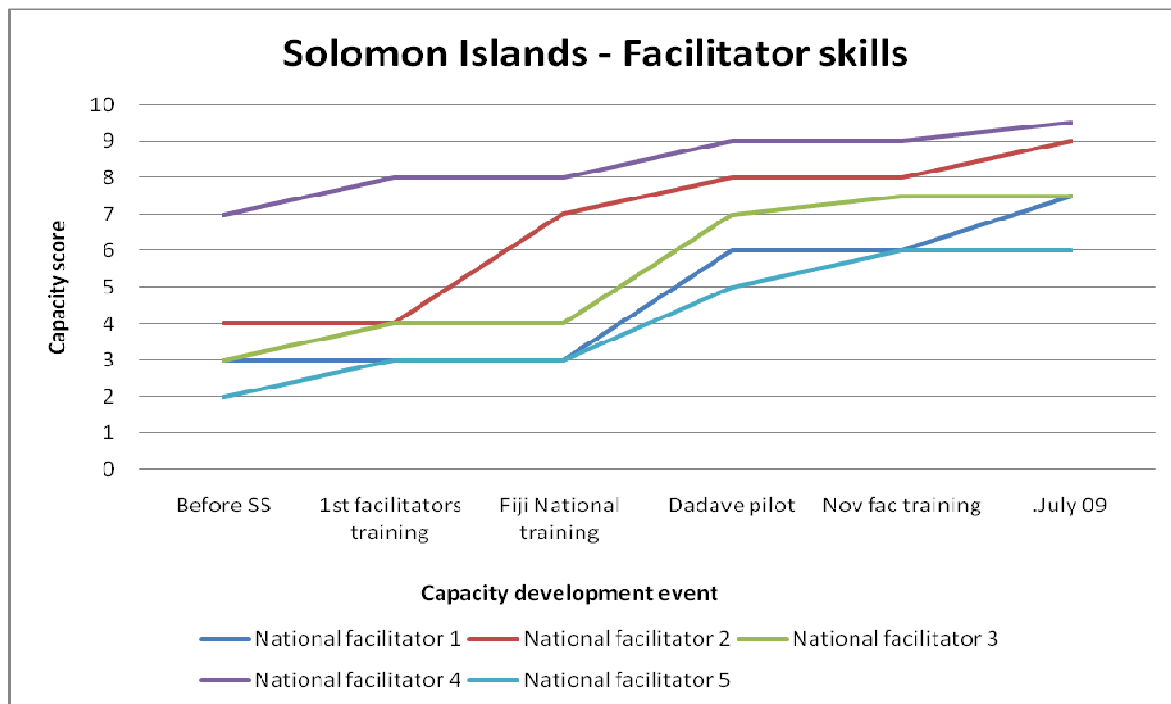
The national facilitators were asked questions regarding the November 2008 Community Training and the lack of implementation by community facilitators to date. SIPPA, Oxfam and WV all reported struggling with trying to provide the community facilitators with the intensive support required to build confidence. The HIV Program Coordinator from WV had also just returned from 3 months maternity leave at the time of the process evaluation. This person had been seen as a pivotal person for SS implementation within WV communities. WV community facilitators who were interviewed reported wanting to wait for this facilitator to return from leave before commencing activities. At the time of writing this report WV had just started implementing SS in 3 communities.

All national facilitators saw the training of community facilitators and the creation of an SS Coordinator as the only way to implement SS successfully in the Solomon Islands. It was however noted that if this occurred much more capacity development in relation to gender sensitization and community facilitation would have to be provided. It is unrealistic to expect community facilitators without intensive support to be skilled enough to engage participants in the complex discussions around domestic violence and gender roles.

#### 4.2.3 National Facilitator Capacity Mapping

As noted above, facilitators require a wide range of skills and personal traits in order to effectively implement SS, skills that in most cases need to be nurtured and continually developed. As part of this evaluation, national facilitators were asked to rank themselves (out of ten) against 5 key capacity development areas.

#### FACILITATION SKILLS



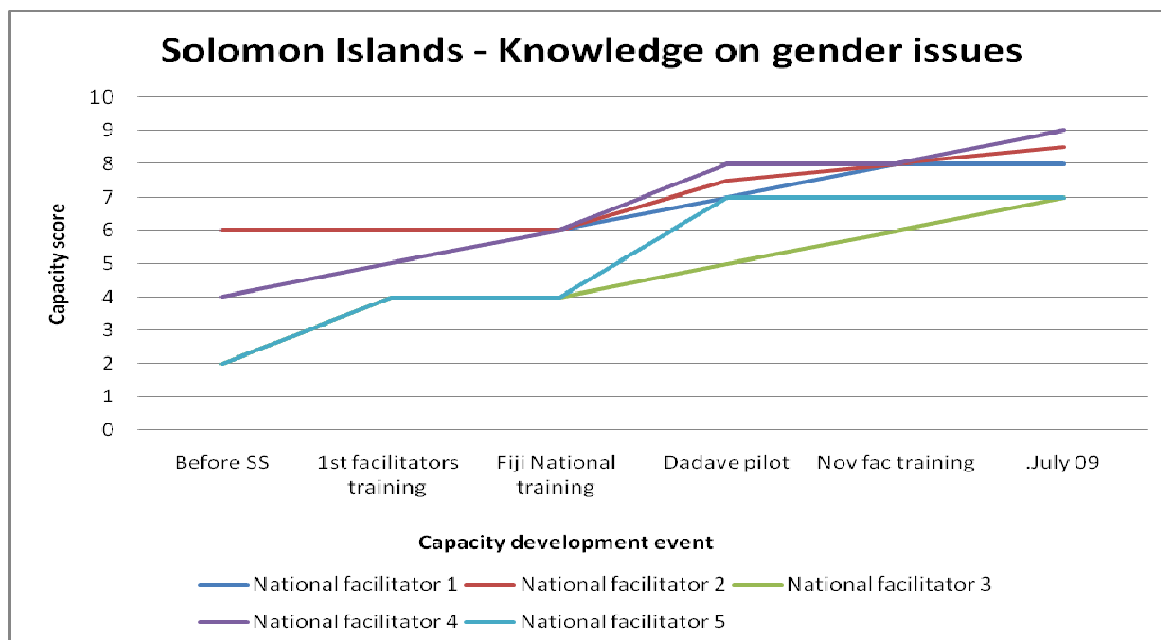
All national facilitators showed an increase in capacity in relation to facilitation skills, (minimum increase 2 ½ points, maximum increase 5 points). Three out of five of the national facilitators (NF 1, 3 and 5) commented that the Dadave pilot was the leading cause of increased capacity as it allowed them to implement and practice skills they had learnt during the facilitator trainings.

*“I worked with the other facilitators to implement in Dadave. This was when I really got to practice my SS skills. I think you can only learn so much at trainings. It isn’t until you are in the community and discussing issues (especially issues such as domestic violence) that you get better as a facilitator...”*

*National facilitator 3*

The above quote and mapping exercise reinforced the importance of pilot projects and immediate practice of SS skills post facilitator trainings. Future countries wishing to implement SS should ensure that they have a well mapped out pilot program and implementation plan before commencing SS facilitator trainings.

### KNOWLEDGE ON GENDER ISSUES

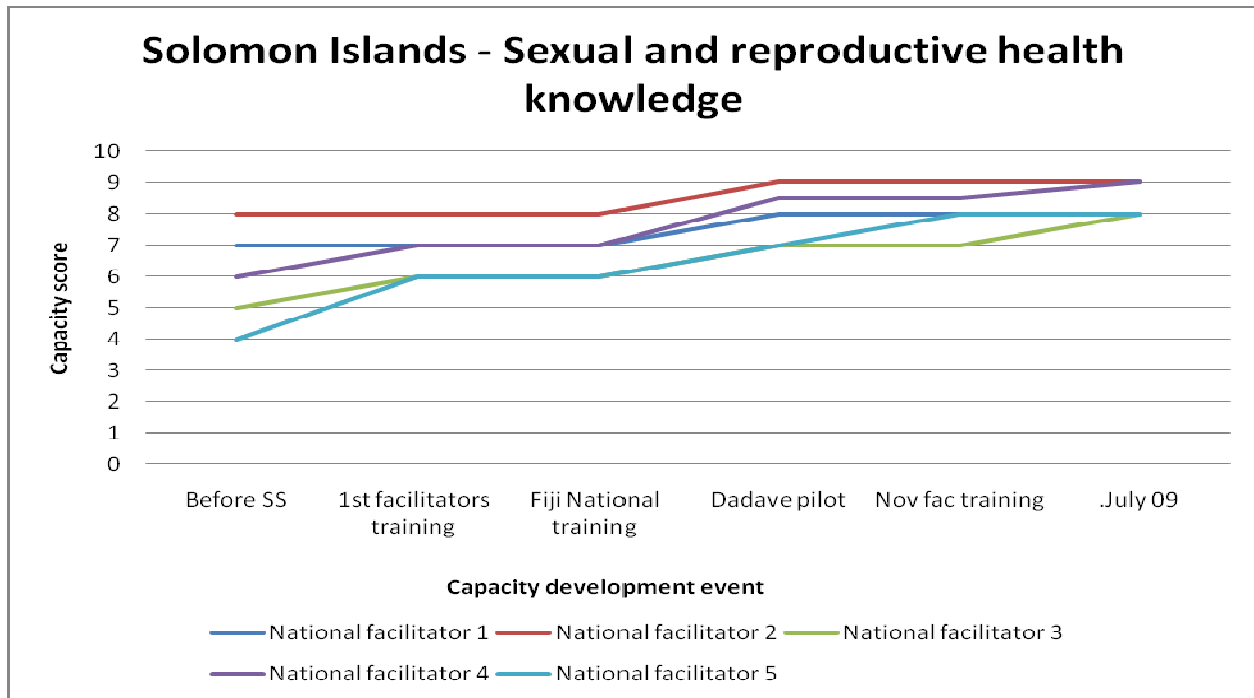


There was an average of a 3.9 point improvement in ‘knowledge relating to gender issues’ as a result of SS. Through conversations with the national facilitators the Health Promotion adviser noted the increase in knowledge in relation to terminology such as ‘sex’ versus ‘gender’ however, felt there was overestimation in capacity in relation to understanding and explaining the link between gender inequalities and women’s vulnerability to HIV and STI’s. In addition, skills in relation to facilitating discussions that provoke thought and increase chances of behaviour change in relation to gender equality are skills that were found to require further development.

*“SS is the first program in Solomons that asks communities to talk about how men treat women. We don’t talk about that here but a lot of men treat their wives not in a good way. There was a big improvement in my knowledge and skills about gender and about how it impacts on women. I don’t think you can not talk about or acknowledge these issues and SS has taught me a lot about this.”*

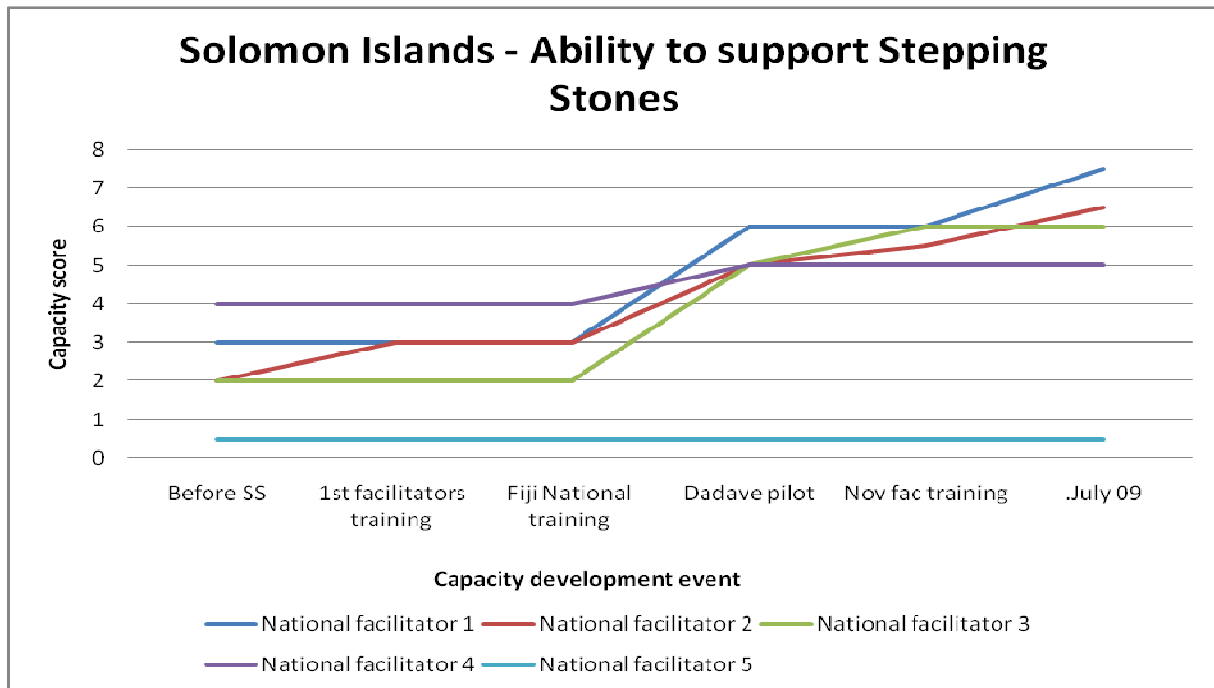
*National facilitator 1*

## SEXUAL AND REPRODUCTIVE HEALTH KNOWLEDGE



There had been less significant improvement in regards to sexual and reproductive health (SRH) knowledge which was reflective of the experience of national facilitators in the Solomon Islands. All national facilitators were employees of organisations that worked in HIV prevention with many coming to SS with extensive SRH knowledge and experience. Prior experience of national facilitators in relation to SRH knowledge had a positive effect on SS implementation in the Solomon Islands and was also demonstrated in the high self confidence and facilitation skills noted by facilitators.

## ABILITY TO SUPPORT STEPPING STONES



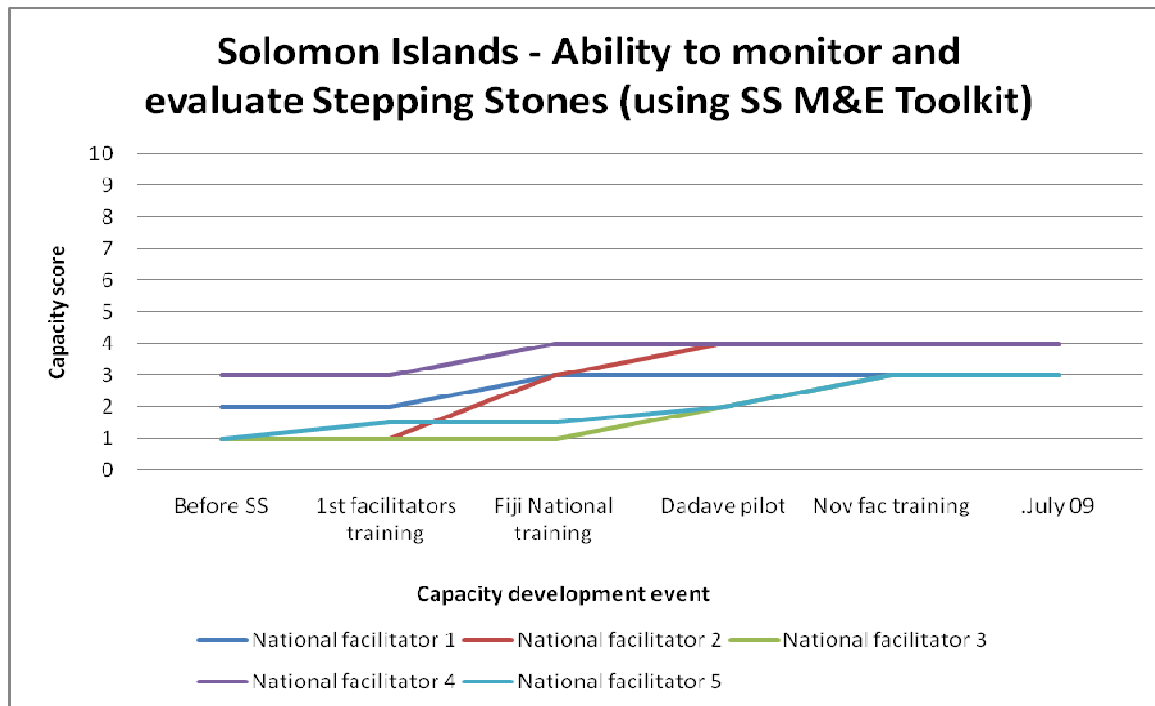
Not surprisingly, specific skills such as, 'ability to support SS' showed significant improvements by national facilitators during self-reported capacity mapping. Again, the practical implementation of skills was the driving force of capacity improvement for this area.

'Ability to support SS' prior to the Dadave pilot was noted as low to medium by all facilitators. The main reason cited for this was the inaugural training hadn't involved any capacity development in relation to community support techniques required to carry out the program. Capacity in relation to support improved after the 2007 Fiji training and again more significantly once practical skills could be implemented during the Dadave pilot.

All current SS support to communities is provided by NGO organisations in the Solomon Islands. MoH staff offer technical assistance and are members of the SS Committee but do not actually implement of support MoH communities through SS. Facilitator '5' as an MoH employee therefore reported not being involved in the ongoing support of the SS program and felt they were unable to map themselves against this capacity area.

*"...SS is a very intensive support program and requires a lot of time. I have to become much better at organising my other work and I've noticed I'm more efficient with my time now."*

## ABILITY TO MONITOR AND EVALUATION STEPPING STONES



All national facilitators self-reported capacity as very low to low across the life of SS implementation in the Solomon Islands. This was reinforced to the Health Promotion Adviser as availability of M&E data was very poor to date. There were many attempts to gain information and access to M&E data collected but facilitators were not able to locate or provide this information. One national facilitator reported collecting pre assessment data but commented that they didn't know what to do with this information therefore had never utilised it and wasn't able to access it. In addition to this no quantitative information from any of the SS programs, (such as participant numbers or sex) had been collected to date. The Health Promotion Adviser also used this M&E trip to gain feedback from national facilitators on the draft SS M&E toolkit. All facilitators requested specific M&E training and capacity development in relation to collection and analysis of these tools.

*"...I know that our M&E of SS is not strong. This is due to not having enough time to collect the data and also that SS is already a time consuming program. I see that the sessions work in the community. People always tell me they think they are good and that they want them to continue. As a development worker I know we have to be able to prove this in a more accurate way. We need more help to do this..."*

Overall, the self assessment mappings show that SS has had an improvement on the capacity of national facilitator's skills, particularly in the area of facilitation and support in the Solomon Islands. While there had been less improvements on knowledge regarding gender and SRH this was not necessarily unexpected as most national facilitators had extensive experience with the delivery of HIV prevention and educational sessions. All national facilitators stated that they felt SS had contributed to their skills as community health workers and that the unique methodology used by SS meant that their skills as facilitators and support agents had improved. The most significant capacity development event as identified by almost all of the interviewed facilitators was the practical implementation of skills through the Dadave pilot. There does remain an urgent need to improve the M&E data collection from SS communities, in particular the use of the recently finalised SS M&E toolkit.

#### 4.2.4 Organisational Manager Interviews

##### SIPPA

SIPPA Executive Director (ED) reported being very supportive of the SS program, a fact which was supported by the SIPPA national facilitator. He commented that he thought their SIPPA national facilitator was coping well with the SS program but this was in part at the expense of their other community prevention programs. SIPPA are considering having their national facilitator concentrate solely on SS implementation and support as they view it as an excellent community mobilization tool however, they would need to find the funds to employ another community health worker to implement their other projects. Funding restraints are the main issues preventing this from occurring. The ED can recall one situation in the last 6 months where he had to turn down a request by the SIPPA national facilitator to do a support visit to their SS communities in Tulagi as there were more pressing issues with other project sites. A request to FSPI and SPC was made to assist SIPPA in identifying ways around funding issues to allow for a dedicated SS person. Suggestions for this are provided in the 'future funding issues' in the lessons learnt and recommendations section of this report.

SIPPA were carrying out planning at the time of this report to look at financial support required to meet program obligations. At this point in time the ED reported currently considering how much financial support would be allocated for SS implementation but commented that he didn't want to see one project getting a large amount of funding at the expense of other commitments and programmes.

*"The scope of SRH and family planning is very wide and we will have to ensure that we distribute our available resources to ensure as wide a coverage as possible. Our spending on SS for this year was quite substantial in terms of our total available resources... I like to mention to the network here that I really support SS but it is a matter of what we can afford to spend on the program."*

SIPPA will be continuing their support of Tulagi's SS program into 2010 but the ED is yet to decide about the Temotu community, mainly due to financial constraints. It was noted by the ED that even before any

evaluation of the roll out to date they had received positive feedback from communities that had been involved in the project.

### **Oxfam**

A meeting was held with the current Oxfam Country representative. They reported knowing about SS and being supportive of Oxfam's role in the support and implementation of the program. They were however new to the organisation and position and therefore stated they were still familiarizing themselves with the ins and outs of all the projects. At the time of the evaluation Oxfam were strategizing what their future role as SS support organisation would look like. They were currently submitting another proposal to continue with the role of CDO for the Response Fund and therefore thought they would need to employ a specific SS Coordinator if activities were to be properly supported.

### **Church of Melanesia**

The ED for the Church of Melanesia (COM) reported having SS already in their work plan for 2010. They were very supportive of the program and wanted to train up a number of new SS facilitators who would work out of their offices in Honiara. The ED from COM feels that the organisation has the human and financial resources to manage SS implementation. COM also stated being very pleased with the support provided by Oxfam to-date although wanted to see another opportunity in early 2010 for a number of new COM facilitators to be trained in SS.

### **World Vision**

The World Vision Acting Country Representative was not in-country at the time of the process evaluation. Attempts to contact him via email were made but no responses to the interview questions were given. The National Facilitator working out of WV commented that management within the organisation was very supportive of the program.

## **4.2.5 Community Focus Group Discussions**

### **Dadave Community**

A site visit to Dadave community was made during the process evaluation country visit. There were a total of 14 males and 11 females that participated in this FGD. Men and women were broken into gender groups and taken through a semi-structured interview questions.

A majority of the males that attended the FGD had attended all SS sessions, (with an average attendance rate of around 75%). Findings from the males group identified improved relationships and communication with partner and decrease in community alcohol and kava use. Ten out of the fourteen males present reported their partners or wives attended the female SS sessions. Of those who did have partners or wives attending, all reported talking about the sessions at home therefore felt that their communication with their partners had improved as a result of the program. Ten of the males present said they thought SS was a good program and would recommend it to other communities.

The females attending the FGD in Dadave were much more reserved and less forth coming to the Health Promotion Adviser. The Oxfam HIV Prevention Officer therefore carried out the interviews as language



barriers were thought to be a factor. Four of the women present said they thought the contraceptive and reproductive health sessions were really useful as they had never had the opportunity to look at and learn about all the contraceptive methods available in the Solomon Islands. Three of the women commented that they thought there needed to be more follow-up after SS as very little had been done in the community since. Improvement in communication within the family, particularly with daughters was noted as a positive outcome by two female's present and two younger girls felt they were more confident to negotiate condom use as a result of SS.



Photo's of FGD's in Dadave, Solomon Islands

A noted success of the Solomon Islands SS rollout to date was the multi-sectoral involvement of agencies in the programs implementation. The creation of the SS Committee and the organisational support from managers were all cited as high and having a positive impact on the program. The communication between facilitators and regular meetings meant that all facilitators felt connected and actively involved in the project.

Implementation however post the November community facilitator training has been disappointing although is now currently underway. The main factors cited by all national facilitators and organisational managers were the competing work commitments of their national facilitators and lack of time and finances to adequately carry out support visits and monitoring. Future funding and ability to mainstream SS within NGO work-plans are factors that are yet to be fully resolved within the Solomon Islands. The SS Committee has however marked these issues as critical and will be considered in 2010 activities. SS remains a program that current implementing agencies are committed to with work plan development and activities not solely dependent on regional funding.

### **4.3 KIRIBATI**

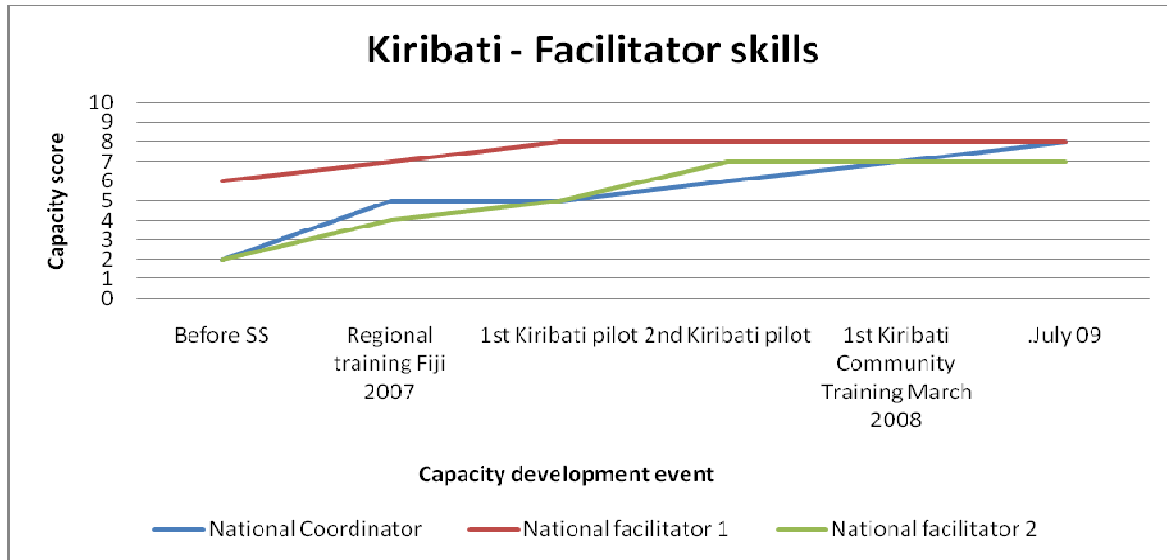
The FSPI Health Promotion Adviser made a country visit to carry out the process evaluation and collect video footage for an SS DVD from the 14-28<sup>th</sup> July 2009. During this country visit she met with three of the five national SS facilitators trained at the 2007 Regional training in Fiji, (two national facilitators were off island) and made site visits to the Bikenbeu community.

At the time of the process evaluation SS had still only been completed in the original two pilot communities. Community facilitators who were trained in the March training still reported being very motivated to implement SS in their community but to date implementation hadn't commenced. When asked why, community facilitators reported wanting to wait for the finalized i-Kiribati manual. The Health Promotion Adviser spoke with the SS Coordinator regarding her concerns about lack of implementation to date and the amount of time passing between the Community Facilitator Training

and implementation. At the point of writing this report, Bikenibeu community facilitators with the support from the SS Coordinator had started the implementation of SS.

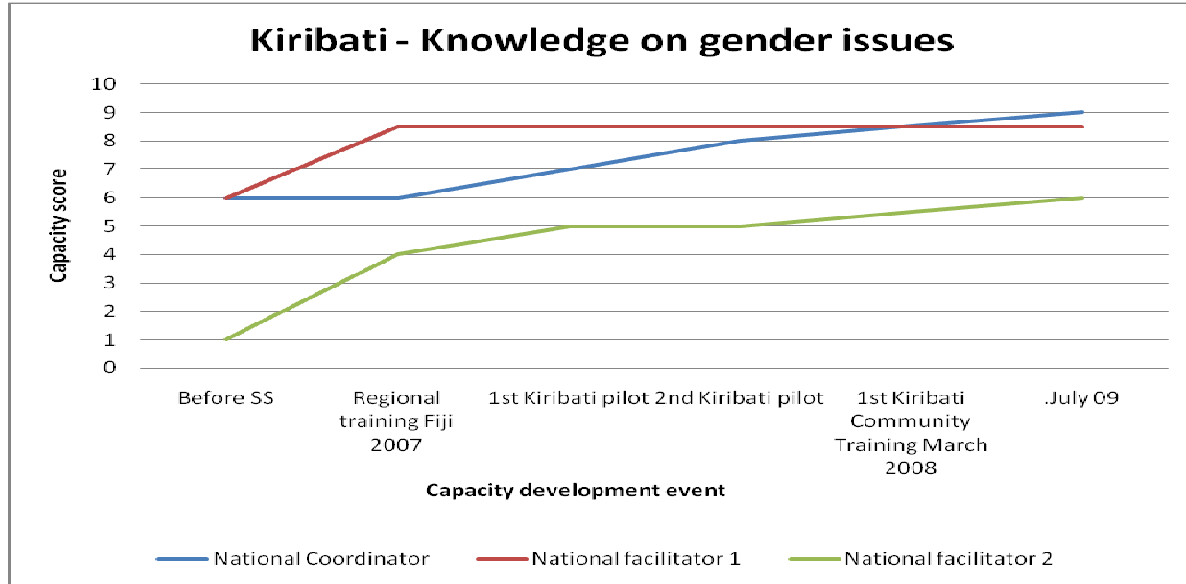
#### 4.3.1 Capacity mapping of National SS Facilitators

##### FACILITATION SKILLS



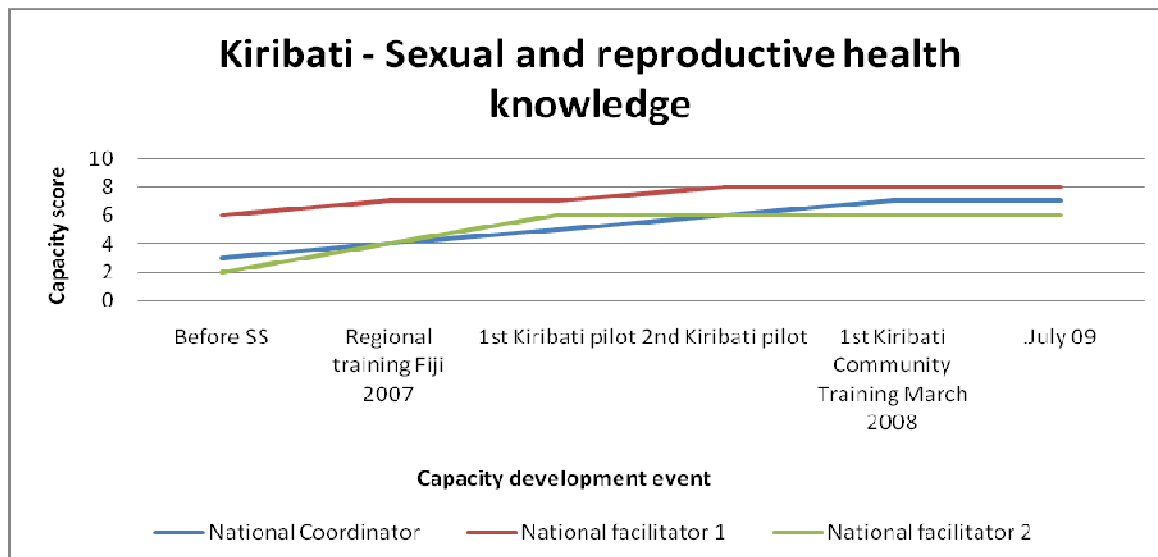
Self-reported improvements were noted by all facilitators regarding their ability to facilitate SS sessions. Like in the Solomon Islands this wasn't a huge improvement as all facilitators had experience in delivering community educational programs. The national coordinator did state though that while she had experience in facilitation she thought that SS had improved her skills in facilitation around sensitive topics such as domestic violence. Once again practical implementation of skills and a well planned pilot project was the leading factor cited for improvements in capacity.

## KNOWLEDGE ON GENDER ISSUES



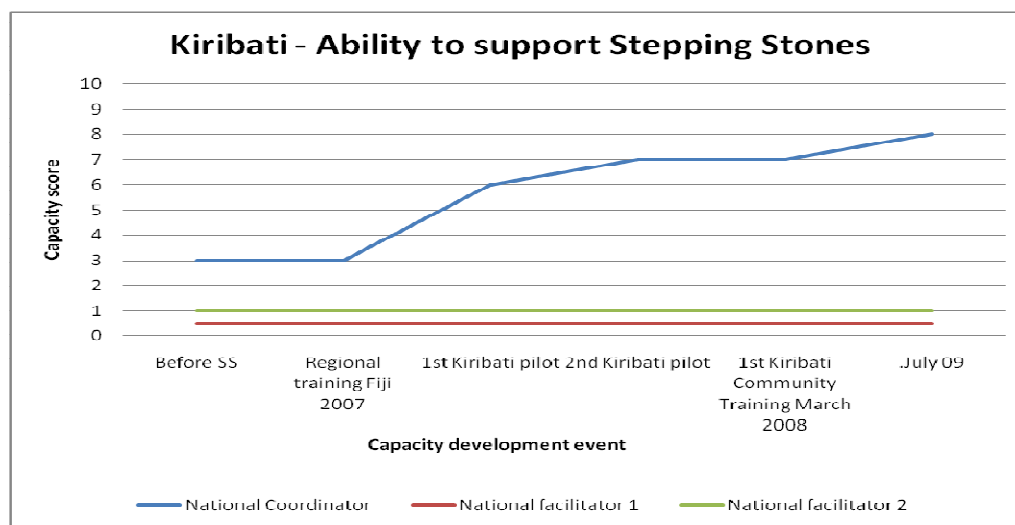
Knowledge on gender issues showed improvement, especially for national facilitator two, an improvement from 1-6. They reported implementation of SS as the leading agent of change in relation to this capacity area although it was noted that there has been an increase in programs aimed at ending violence against women in Kiribati. Again the Health Promotion Adviser noted that while self-reported capacity had improved there was a need for further capacity development in regards to facilitators knowledge on linkages between gender stereotyping and HIV and STI vulnerability. There was evidence of many deeply entrenched gender values amongst the male and female national facilitators and something that needed to be urgently addressed for future SS facilitator training.

## SEXUAL AND REPRODUCTIVE HEALTH KNOWLEDGE



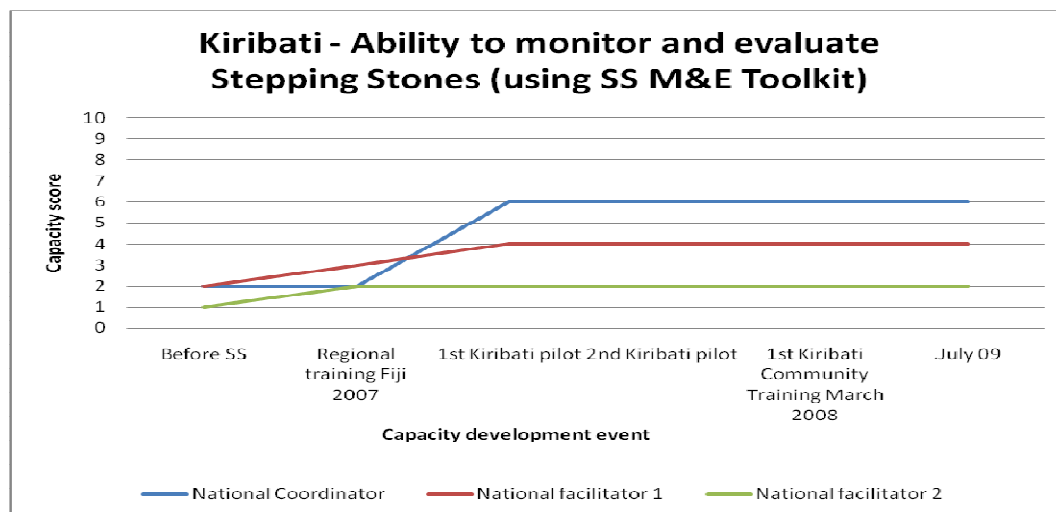
The National Coordinator and facilitator 2 cited the biggest improvement to SRH knowledge as a result of being involved in SS with the 2007 regional training and 1<sup>st</sup> pilot project the leading agent of increased capacity. National facilitator 1 came to the regional training with greater experience in SRH therefore less capacity development occurred. Both the national coordinator and facilitator 2 noted the need to approach an SRH nurse to come to the training sessions on contraceptives as the knowledge in this area was self-reported as weak. The involvement of SRH nurses on these topics has always been supported by regional partners involved in SS as SS facilitators have never been expected to become experts in contraceptive methods. While the national coordinator and facilitator 2 stated they thought they would continue with the community nurse involvement they had both requested further information and training in contraceptive methods available in Kiribati.

### ABILITY TO SUPPORT STEPPING STONES



The national coordinator is the only person currently involved in the ongoing support of SS in community's therefore national facilitator one and two reported not being able to comment on this area. The national coordinator stated that there had been significant improvement in their skills (from 3 to 8) as a result of supporting both of the pilot programs and felt that this had also contributed to their skills as a community development worker on other programs. The other national facilitators commented that they would like to have more involvement in the ongoing support of SS in Kiribati and felt it was important for KANGO to include more organisations in the rollout in order to increase success. The Health Promotion Adviser feed this information back to the national coordinator and organisational manager of KANGO and a stakeholder meeting was called for SS. Other organisations working with HIV and sexual and reproductive health were called together for a meeting in August 2009. Four NGO's (Red Cross, MoH Kiribati, AMAK and Foundation of the Peoples of the South Pacific Kiribati) were present at this meeting and KANGO is planning on a facilitator training involving support personnel from other organisations for 2010.

## ABILITY TO MONITOR AND EVALUATE STEPPING STONES



Their ability to carry out M&E was also ranked as low (4) throughout the life of the project and areas that they felt needed to be developed further. These scores are supported by the lack of M&E data and number of organisations involved in SS in Kiribati.

Overall, while there have been some improvements in the capacity of national facilitators; particularly in the area of facilitation skills, SRH Knowledge and gender issues there remains a gap in support for and M&E of the program. Unlike Solomon Islands, Kiribati's support for SS is carried out by only one organisation. During consultation meetings with stakeholders in Kiribati, (FSPK, AMAK, MoH) there was little awareness or understanding of the SS program. This was seen as a negative factor as there existed some excellent opportunities to partner and share skills and resources amongst other organisations. This is further commented on in the lessons learnt and recommendations section of this report.

### 4.3.2 Community visit to Bikenibeu

The Health Promotion Adviser met with 11 (6 women/5 males) of the community members who were trained as Community Facilitators in the March 09 training. As stated above, at the time of the country visits none of the community facilitators had started implementation in their community hence no community FGD was held. Community facilitators had carried out a community meeting with members and spoken with leaders to gain support but reported wanting to wait for the completion of the I-Kiribati manual before commencing implementation.

Three out of five of the male facilitators reported feeling like the Stepping Stones training was a useful program that their community would benefit from with one facilitator saying:

*"...it is particularly important for the youth in our community to help them deal with what dating and alcohol and especially peer pressure... there is a lot of peer pressure."*

All women stated they thought SS had assisted them with talking with their partners and that the male facilitators who were trained up were helpful in acting as positive role models for behaviour change. One woman reported, *"...women in the village, they get hit. You see it with black eyes. It's bad, especially after lots of alcohol. I think we need programs like this to help us talk about and not stay quiet anymore."*

Whilst there was a great deal of support for SS and still evidence of good motivation to implement it was disappointing to see no implementation by community facilitators. The Health Promotion Adviser asked community facilitators, if, apart from manual translation there were any other reasons for the lack of implementation. The community facilitators reported the following issues:

- ✚ There is difficulty discussing sexual and reproductive health in Kiribati communities, especially Catholic communities
- ✚ They thought they would have difficulty facilitating the domestic violence sessions
- ✚ The lack of payment made to facilitators
- ✚ The lack of payment and/or refreshments supplied at the training

#### **4.3.3 Interviews with National SS facilitators**

In-depth interviews were carried out with three of the five national SS facilitators. Key findings and comments provided by the facilitators are captured below as:

- ✚ All facilitators identified understanding of gender and how it impacts on HIV vulnerability as a significant gap in the current SS training program. They all noted that the 10-day training did not prepare them to facilitate convincingly the implications and cultural and ethical implications of domestic violence from a human rights perspective
- ✚ Payment to community facilitators and training participants was raised as an issue by all national facilitators. This has continued to be an issue for Kiribati since the commencement of the SS program
- ✚ *"My boss doesn't really understand the SS philosophy and how it relates to my work. It is an intensive program which involves a lot of out of hours work in communities but we are not provided with additional salary for this"*
- ✚ There were large gaps in the M&E data collected to date. National facilitators reported finding this process a lengthy and time consuming one and without a specifically designed SS journal format reported forgetting key information or questions required
- ✚ There were questions raised regarding coverage of the SS program in Kiribati. It was suggested that KANGO needed to actively recruit and promote SS to other organisations working within community development in order to increase support and motivation for implementation

#### **4.3.4 Organisational Manager**

The Health Promotion Adviser had a meeting with the Executive Director of KANGO and reported preliminary findings from the process evaluation visit. KANGO management was very supportive of the SS program and wished to continue with the support of the program. It was however noted and expressed to the Executive Director (ED) that in order for SS to continue successfully in Kiribati, (and all countries) community coverage and financial inputs will need to be considered. SS does however

provide a unique opportunity for bringing a wide range of stakeholders together to collectively engage in the process of gender equity and SRH rights. With a country such as Kiribati with its many scattered islands and geographical location this is of even greater importance. There were a number of opportunities identified by the Health Promotion Adviser for greater NGO involvement and collaboration in SS implementation and support. One such example was the involvement of AMAK and FSPK, both NGO's working towards improving gender equitable norms and community development within Kiribati. In addition to this, there are possibilities for KANGO to work with other programs, such as FSPK's rural development initiative to target rural islands and utilise existing community development workers as SS facilitators. There is a need for KANGO to partner with such agencies so quality and coverage of SS can improve. The KANGO ED was very supportive of this idea and since the process evaluation visit the SS Coordinator has called a consultation meeting of partners to try and gauge interest and support for a multi-organisational approach to future SS activities.

#### **4.4 VANUATU**

It would be fair to say that SS has encountered the most difficulty in Vanuatu, with to date, only one community program successfully completed. A brief look at each community's attempt at implementation is provided below.

##### **4.4.1 Emua Community**

After the community facilitator training Emua planned to start implementation as soon as possible. The community assessment using the SS M&E Toolkit was conducted in late July 08. After consultation and a number of site visits by the SS Coordinator the program commenced in Emua on the 18<sup>th</sup> August 2008. Between August and December 2008 a total of 15 SS sessions were called however only eight were successfully completed. The two major barriers to SS implementation noted by the community facilitators were; 1) community commitments (work, farming and women busy with household duties) and 2) a community conflict which occurred in October 2008. With intensive support from the WSB SS Coordinator, at the close of 2008, Emua had completed sessions A-D.

*“Emua village was working very well at the beginning of stepping stones. Our community had decided after the training that we wanted to start our activities as soon as possible. Our problem was that there was a land dispute between me (SS Chairmen) and the chief of our village because that new road which a company from New Zealand came to Vanuatu to complete round the island. That's were me and chief start ague because chief wants the money and we have dispute. Because I am the chairmen for stepping stones and it affect stepping stones also. It will be better next year because we need to solve that issue. We will try very best next year to get improve and we still interested on stepping stones project to complete in our village.”*

*Emua SS Chairperson*

In early 2009 Emua community had recommenced SS activities. At the time of this process evaluation a total of another 13 sessions had been held for the Jan-June period. The SS Chairperson for Emua had

been very committed in calling the sessions although attendance continued to be an issue, especially for the men's peer group. Various incentives were tried, such as; providing kava for the men at the end of the sessions and screening episodes of the 'Love Patrol' drama prior to community sessions. Each of these incentives worked for awhile and then attendance once again dropped off. At the end of June 2009, Emua community had finished session H.

During the October-December 2009 period a total of 7 sessions were carried out which saw Emua community finish the entire SS program. The last session was carried out on the 30<sup>th</sup> November 2009.

Experience with this community showed that it was very difficult to get the community members committed to SS every week. Despite assurances from the community leaders, it took a very long time to complete all sessions. Towards the end of the year, the SS coordinator and the facilitators agreed to hold more than one meeting a week in order to ensure that all sessions were completed before the end of 2009. A total of 42 males (25 older men and 17 younger men) along with 61 females (35 older and 26 younger) attended SS sessions

#### **4.4.2 Paunagisu Community**

The community pre-assessment for Paunagisu took place on the 24<sup>th</sup> September 2008 and the first session was held on the 1<sup>st</sup> October. There were only 2 sessions run in Paunagisu when the village stopped the program for the Christmas season.

*"It was a big challenge in 2008. We've been trying some ways to get SS workshop run in our community but it was difficult for some reason (the community not really working well together and two of the community facilitators dropping out of the program). I am hoping for 2009 because they will be a new (village) council that I will work very close with them so that they can help and we set up stepping stones and try to continue. I do still believe that one day stepping stones will help our community for a good leadership and better health in the future".*

Paunagisu SS Chairperson

The SS Coordinator made a number of visits to Paunagisu but encountered various problems trying to re-start the program after the Christmas break. The SS Coordinator reported that there was only one SS facilitator who was interested in continuing with SS. The issues and challenges facing Paunagisu included the long Christmas break period and lack of community mobilization. The SS Coordinator eventually stopped trying to engage community facilitators in implementation as it was apparent they had little motivation.

#### **4.4.3 Sama village**

The SS Coordinator again made a number of visits to Sama village in an attempt to assist facilitators with implementation. Despite all efforts the facilitators were unable to get the community to come together. The facilitators and Coordinator both commented that the community was not committed to the program and every time a session was called, (3 or 4 attempts were made) no one would turn up. The SS

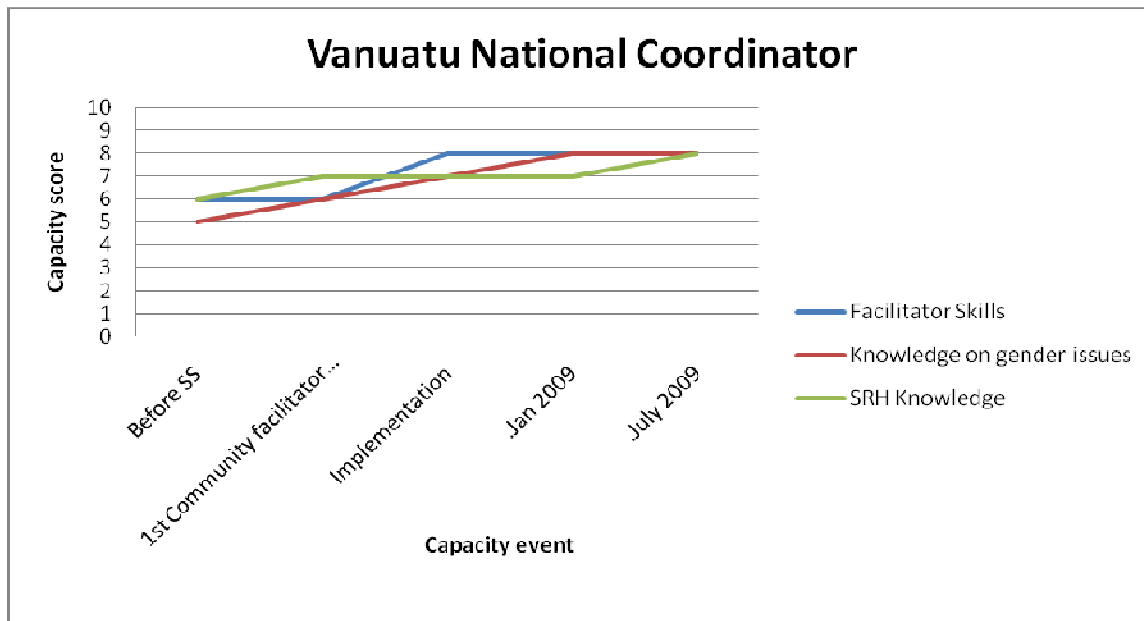


Chairperson for Sama told the SS Coordinator that it looks like community members were not interested in the program and he believed there was no point in carrying on. The decision was made to discontinue efforts to implement SS in Sama.

In hindsight the June-July Community Facilitator Training raises questions regarding site selection. The three communities on North Efate were originally selected because of their location and access to Port Vila, along with previous working relationships that WSB had with the village leaders. In reality, there was a lot of community fighting happening in two of the communities and their location in relation to Port Vila meant that there were high rates of community mobility. In addition, there were a number of other NGO's who had previously worked within these communities, contributing to saturation and lack of motivation by many community members.

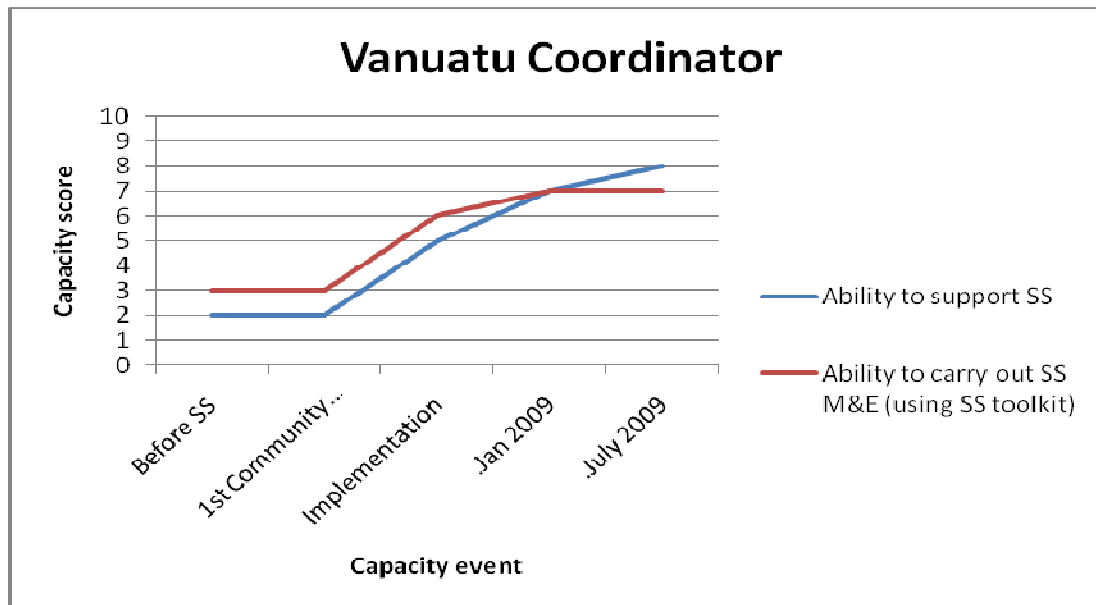
#### 4.4.4 Capacity Mapping for National Facilitators

##### FACILITATION SKILLS, KNOWLEDGE ON GENDER ISSUES AND SEXUAL AND REPRODUCTIVE HEALTH



The SS Coordinator had many years experience in the delivery of HIV peer education programs therefore reported quite high capacity for both facilitation and SRH Knowledge prior to involvement in SS. The biggest improvement to capacity was reported as 'knowledge on gender issues', with a 3 point improvement. He reported the 1<sup>st</sup> facilitator training in 2008 and the implementation in Dec as the events that contributed to this increase in capacity.

## ABILITY TO SUPPORT AND ABILITY TO MONITOR AND EVALUATE STEPPING STONES



As noted above, whilst the Vanuatu SS Coordinator has had many years experience in peer education and HIV prevention programs, he noted substantial increases in ‘ability to support’ and ‘ability to carry out M&E’ as a result of SS. He commented to the Health Promotion Adviser that SS was unlike any other program he had been involved in as it was much more intensive and long term than previously implemented community educational sessions. He acknowledged that this was one of SS greatest challenge and also its strength. The felt that the challenges that he has faced with SS have meant that his community negotiation skills have developed a great deal over the last 18 months.

***“I can see SS as one of the programs that could work very well... but working with the community so this happens is very difficult. I don’t think communities in Vanuatu are use to this type of program, (one that takes over 3 months). They like much shorter and much quicker programs. Also, they are use to food and money been given and SS doesn’t have the funds for this. This is our biggest challenge and I don’t know the answer to these problems... I have been working very hard, traveling every week to North Efate but still SS isn’t running like we hoped.”***

***Vanuatu SS Coordinator***

### 4.4.5 Interview with National SS Facilitator

The SS Coordinator reported many challenges associated with SS implementation and support. The main issues involved community fighting and lack of community attendance and motivation to attend SS.

When asked if he thought SS should continue in Vanuatu he identified site selection as a critical component. He believed that more rural communities who didn’t have such high levels of mobility or

historical access to HIV and SRH programs should be the future direction if any SS in Vanuatu was to continue. More remote islands were identified as an option that could possibly benefit from a program such as SS as many NGO's weren't able to access these locations but WSB had a presence in many of these locations.

While in-country the Health Promotion Adviser also met with the Peace Corp Health Coordinator as it was identified that volunteers were active in rural and remote settings. The Health Coordinator believed the program was something that could be successful in their communities as they were not able to keep up with the request for community health programs from this area. Also, community members rarely travel off Island and she felt commitment and willingness to attend sessions would be much higher than in urban or semi urban settings. Finally, it was felt by WSB and Peace Corps that islands which were a further distance from Port Vila would not have the same expectations regarding incentives and payment.

#### 4.4.6 FOCUS GROUP DISCUSSIONS WITH SS COMMUNITY FACILITATORS

As there had been no completion of the entire SS package at the time of the in-country visit, (Emua community completed the final session in November) and two communities had ceased implementation the Health Promotion Adviser met with and held a FGD with community facilitators not SS participants. Eight of the thirteen males and twelve of the fifteen females were present for this FDG.

The biggest challenge identified by community facilitators was motivation of community to attend the SS program. All communities reported many attempts to motivate and engage community participation but all attempts other than those of Emua had failed. Facilitators reported the following reasons as told to them by community members;

- ✚ The SS program involved too much of a commitment and community members could not commit to the whole program
- ✚ There were no incentives or financial rewards provided for attending such training
- ✚ There was significant fighting occurring in 2 communities (unrelated to SS) which had contributed to lack of community cohesiveness
- ✚ Many participants were regularly out of the village and in town for work purposes
- ✚ The program was viewed mainly as an HIV prevention program and community members didn't view this as relevant (current rates of HIV in Vanuatu are very low)



Photo's of process evaluation consultations in North Efate, Vanuatu.

Community facilitators also reported not understanding the extensive nature of SS prior to involvement in the SS training. Many of the men present at the FGD said they were not able to dedicate such time to

SS preparation and weren't aware of this before the training. Site and facilitator selection was identified as a major barrier to implementation in North Efate.

## 5.0 Lessons Learnt and Recommendations

### 5.1 Monitoring and Evaluation

M&E was identified as a particularly weak component of SS to date. When the Health Promotion Adviser attempted to collate SS data there were huge gaps and in many cases data was not available at all. These inadequacies and lack of evidence to support behaviour change in the earlier stages of program implementation were identified as a reason for recent loss of support from an Asian Development Bank (ADB) grant.

As SS is a program that is delivered over many months monitoring becomes a particularly vital M&E process. There exists a need for community facilitators to collect more rigorous quantitative data in order to triangulate M&E information. While community facilitators were given a note book to collect information on attendance, sex disaggregated data etc it was found through in-depth interviews with national facilitators that this in reality did not occur. One reason that was thought to contribute is that community facilitators forgot what sort of data they were suppose to collect, therefore didn't collect any. It was therefore recommended and accepted that a 'Stepping Stones Community Facilitator' journal be developed and an outline included as an annex to the finalised M&E Toolkit.

While many of the communities were still implementing SS, it was noted by the Health Promotion Adviser that there was a failure for communities that had completed implementation to document 'final requests' made by each peer group. This was identified as a wasted M&E opportunity and made it difficult for national facilitators to monitor if final requests had been implemented by communities. Due to this finding the finalised SS M&E Toolkit now contains a section for final request documentation.

There is also a need to find out if the same people are returning to SS sessions, not necessarily just how many are coming each time. It was recommended that a table at the front of the facilitator journal is designed for community facilitators to use throughout the whole SS program. If new people come to SS sessions facilitators could add their name to the table but most importantly they could keep an easy track of who is coming to SS sessions regularly. This will also be a simple way to see if someone hasn't turned up for a few weeks, therefore the facilitator can check up on the participant and find out why they aren't attending. It would also be a useful tool in data triangulation.

Finally, but perhaps most importantly, upon finalisation of the toolkit it is important that specific M&E training be provided to the national facilitators as they are the responsible parties for collecting the pre and post data. Currently there were situations where data has not been utilised as facilitators were unable to analyse and interpret results. This is perhaps reflective of the high technical assistance required for the program and low human resources available. None-the-less, in-country M&E training is vital in order to improve the quality of M&E data collected and must be worked into the work-plans of technical staff.

**Recommendation for action: strengthen collection of quantitative data from community facilitators through the use of an SS facilitator journal. In addition to this, specific SS M&E training (utilising the finalised SS M&E toolkit) should be carried out prior to or immediately preceding any future facilitator trainings.**

## 5.2 Future Funding for Stepping Stones

An important consideration in relation to the sustainability of SS within current countries is the identification of future sources of funding. Currently, in-country support is provided through a Rapid Response grant although this grant is due to finish in June 2010. SPC and FSPI were successful in obtaining a regional support grant from the Pacific Island HIV and STI Response Fund, however, this grant is only meant to cover technical assistance to in-country facilitator trainings, cross cultural exchanges of current SS facilitators, manual and resource development, a quarterly SS newsletter and moderation of an SS e-forum. Funds for the delivery of all future in-country facilitator trainings and support costs have become the responsibility of each country.

During the grant design/application process, countries need to finally resolve and agree upon actions regarding the issue of incentives. To date, no real incentives have been provided through the Rapid Response grant. If however countries feel strongly that incentives need to be provided to facilitators and or participants then these costs must be considered in all future funding submissions. It is unlikely that monetary incentives will be possible if SS is to be scaled up, as the program runs over a number of months, however, the provision of refreshments should be considered.

Further funding restraints and the completion of the Rapid Response grant will require countries to be much more strategic and planned in relation to SS activities. They will need to complete and submit grant proposals with well mapped out activities and M&E strategies in order to satisfy donor requirements, a definite benefit to overall country SS implementation.

**Recommendation for action: All country partners implementing SS need to be aware of the potential resources required to implement such a program. There exist a number of options through the Response Fund, namely; 1) country NSP allocations, Competitive Grants or a smaller National AIDS Committee Grant.**

## 5.3 Site and Facilitator Selection

As noted in the Solomon Islands and Vanuatu, communities that were situation too close to urban centre's had more difficulty completing SS. Facilitators reported multi-ethnic make-up of the community and travelling to town for work as the main reasons for these high rates of participant drop out. Urban communities have also often been saturated with various HIV prevention activities as communities are more accessible.

It must however be noted that in many instances, urban Pacific communities, with high rates of unemployment and alcohol issues are perhaps most in need of a program such as SS. If countries do wish to implement SS within urban communities, further consideration will need to be given to the project design, consultation process, marketing and perhaps the provision of incentives.

**Recommendation for action: It is recommended for future SS site selection that more intensive community mapping is carried out to find out what other HIV prevention programs have been run in the past. Potential communities should also undergo more rigours profiling such as; seasonal calendar and daily routine profiling before commitment to SS is made.**

#### **5.4 Advisory Committees and Multi-Agency Implementation**

In the Solomon Islands, the establishment of an SS Committee or advisory group was a practical way of promoting support and multi-agency involvement for SS. The shared vision and commitment in the Solomon Islands was seen as a definite success in-country. Vanuatu and Kiribati lacked this multi-agency approach, and this was seen as one key area for improvement for their countries SS implementation.

As identified by the above evaluation, questions such as; does the organisation have the required human resources and funding capacities to implement and support SS must be considered. As identified above the Response Fund offers some potential funding avenues for involvement in SS.

**Recommendation for action: Before any further countries consider taking on SS, issues of organizational and community commitment must be considered and mapped out. Like in the Solomon Islands, the formation of an SS Committee and multi-agency collaboration should be established prior to any future SS facilitator trainings.**

#### **5.5 Increase the Pool of Technical Assistance Available to Stepping Stones**

For SS to continue there is an urgent need in the Pacific to increase the pool of technical assistance available for the SS project. In the last 12-18 months, the SS program has lost four of their original and most experienced regional facilitators. Due to this, experienced Solomon Islander national facilitators have been involved in cross-cultural exchanges and the provision of technical assistance at in-country facilitator trainings. This is seen as a positive in relation to national facilitators continued capacity development but there still remains an urgent need to increase the pool of regional technical assistance. In an attempt to overcome this urgent need FSPI will involve a number of their experienced community development workers in the next facilitator training to be held in Fiji. These community development workers have a great deal of experience in community negotiation training and will only require orientation to SS content. It is planned for them to be involved and mentored in cross country sharing soon after involvement in the Fiji training to ensure momentum and utilisation of skills.

**Recommendation for action: FSPI and SPC need to train up a number of regional technical staff at the next Fiji facilitator training which has been mapped out for April 2010. FSPI has already identified three experienced community facilitators within their existing program team who will be mentored over the 6-9 months to become regional technical staff on the program.**

#### **5.6 Community versus National Facilitators**

There have been many discussions to date regarding the strengths and weaknesses of community and national facilitators. As seen in the Solomon Islands, national facilitators struggle to provide support to SS in addition to other work. The Solomon Islands identified community facilitators as an important component of SS implementation, however, it is noted as unrealistic to expect community facilitators, with extremely limited knowledge of gender issues, HIV, STI's and facilitation to have the capacity to deliver such training. The potential to do more harm than good in such situations is too great. If organisations and countries wish to continue with community facilitators there must be acknowledgement and commitment to continued capacity development and more intensive gender sensitization training. This support and capacity development needs to be mapped out and considered prior to any further SS facilitator training.

In response to this finding, FSPI recently submitted and was successful in a Competitive Grant proposal to the Response Fund to train a cadre of well qualified male gender advocates that will run intensive gender and human rights training with all future community and national facilitators prior of SS implementation. In addition to this it is recommended that wherever possible the methodology of utilising community health nurses as facilitators and support personnel as a positive initiative.

**Recommendation for action: SS in the Pacific requires a more intensive focus on the gender component of the training. All facilitators require further capacity development in facilitating conversations around gender inequity and domestic violence. While this evaluation was being carried out FSPI was successful in obtaining a grant to work with SS facilitators and strengthening this component of the program. The findings from the evaluation strongly support this work for 2010 implementation.**

### **5.7 Timing of Community Facilitator Trainings**

It was noted in almost all capacity mapping exercises that practice fast utilisation of SS skills was an important factor in self-reported improvement of capacity. In addition, it was noted that countries that held Community Facilitator Trainings in the second half of the year were less likely to implement straight away due to community commitments and obligations around the Oct-Dec period. It is vital for community facilitators to begin implementation of SS as soon as possible so as to practice skills and increase confidence. In situations where this isn't possible a clear and immediate implementation strategy needs to be mapped out with national facilitators committed and able to follow up and support communities.

**Recommendation for action: Taking into consideration these factors it is recommended that all future SS facilitator trainings happen within the first 3-6 months of the year to allow ample opportunity for immediate implementation and practice of SS skills.**