STORIAN BLONG YUMI
PROJECT EVALUATION

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2 Executive Summary

The purpose of this evaluation is "to assess whether or not the Community Scorecard (CSC) approach as adapted to Vanuatu through the *Storian Blong Yumi pilot* (SBY) project offers a viable model for community-centred social accountability in Vanuatu and to document lessons from the pilot for future application".

The *Storian Blong Yumi* project (SBY) tested the Community Scorecard approach for the first time in the Pacific, applying the CSC to Sexual and Reproductive Health services delivered by Vanuatu MoH health facilities serving 4 communities in Tafea Province:

- Dillon's Bay, also known as William's Bay, on the island of Erromango
- Port Narvin on Erromango
- Iarkei on the island of Tanna
- Isini and Launapkamim on Tanna.

The CSC is a tool first developed by CARE Malawi in 2002 for promoting social accountability. This term refers to mechanisms that can be used by citizens to hold states and service providers accountable for the delivery of services. The tool integrates rights-based principles, including:

- Access to information
- Participation in decision-making processes
- Accountability
- Transparency
- Equity
- Shared responsibility.

It brings together service users and service providers to identify service access, utilisation and provision challenges, to generate solutions, and to work in partnership to implement and track the effectiveness of those solutions in an ongoing process of improvement.

The *Storian Blong Yumi* pilot of the CSC model in Vanuatu demonstrated results in the following areas, most strongly in the first two areas:

Stimulating dialogue between service providers and communities and overcoming social taboos to open up discussion within the community on SRH issues. Across all groups, including young men, who were the group that proved most difficult to engage, participants valued the process of community discussion. This dialogue appears to have been the basis for establishing better understanding and relationship between service providers and community members. This in turn seems to have laid the foundations for increased access to services by community members and responsiveness by service providers.

Increasing awareness of the SRH services available within their local health facility. Across groups of older and younger men and women in all locations people were aware of what family planning and STI services were available to them and what the role of the health staff were. in all locations, people who participated in the evaluation were more aware of what family planning and STI services were available to them and what the role of the health staff were. Men in all locations reported that they didn't previously know what happened in the health centre regarding SRH, but now they have a better understanding.

Enabled some community members, particularly young people, to feel comfortable about accessing SRH services. Service providers in Port Narvin reported that prior to the project, family planning commodities "used to stay on the shelf" but now, the health facility has run out of condoms and implants. They reported that more young people are attending the health centre and young men were requesting condoms for the first time, whereas previously, only young women were. They also noted that prior to the project, there had been no demand for implants. Following the project, young women are requesting *Jadelle*, a levonorgestrel-releasing, 'fit and forget' implant that works for up to 5 years.

Strengthened the agency of young women. Young women appear to have gained an increased sense of agency through their involvement with the project. In Port Narvin, young women said they have become aware that "they can protect themselves from unwanted pregnancy and STIs". In Dillon's Bay, young women learnt that they should be "confident about SRH matters and ask people who are there to ask about such things; the nurse, will advise on these things and if there are problems with family planning methods, they will help us deal with it and find a better method".

Prompted service providers to respond to community needs. In all communities, the CSC model has resulted in increased responsiveness to community needs. Service providers in all communities undertook awareness raising activities on SRH for the first time. Women in Dillon's Bay and Port Narvin noted that previously the health staff "stayed in the health facility" whereas now, they were out and about, talking to people about SRH. Service providers in Port Narvin noted "before, I was keeping quiet in the centre" but that following the SRH training they received as a result of the action planning process, they felt more confident to go out. In Iarkei, as a result of the action planning process, there is now a public duty roster at the Whitesands Health Centre and a mobile number has been put up on the notice board so that community members can call the service provider if no one is in attendance.

There have been more limited results in the area of the social accountability of the health system. This has taken place primarily by service providers making information available that provides the basis for community members to engage them on service delivery performance. Action planning performance information is one example of this contained within the CSC model itself. The other, a result of the action planning process in Iarkei is that there is now a public duty roster at the Whitesands Health Centre and a mobile number has been put up on the notice board so that community members can call the service provider if no one is in attendance.

The results are significant given:

- A short, 12-month implementation period for the model at community level, with only four months of Action Plan implementation

- The complete novelty of the concept of social accountability to both communities and service providers and

- The sensitivity of the topics tackled by the CSC.

The CSC process implemented in other countries shows strongest results after at least 4 6-month cycles of implementation. In this case, there were only 2 cycles and the implementation of action planning in the first cycle faced challenges. The first cycle allows communities to experience the process for the first time. In this case, the concept of being invited to publicly and legitimately voice opinions on a service was entirely new, particularly for women and young people. Subsequent scoring activities allow communities to become more comfortable with the process itself and the topics discussed. Third and fourth cycles give time for action plans to be implemented and for results to be seen. This builds further confidence and trust in the process. It appears that this was starting to

happen in Vanuatu. CARE staff observed that during the first cycle, communities tended to be unrealistic in their planning. In the second cycle, communities agreed on more considered and limited action points with more specificity about implementation responsibilities.

The evaluation team was unable to get interviews with people living with a disability. While CARE staff reported that concerted efforts were made, the project encountered difficulties in engaging and maintaining engagement of people with disabilities in the project. Few people with clear disabilities participated in the scoring process and left after a short time. Only two stayed long enough to have their scores recorded. CARE team reported the following reasons for this:

- People with a disability are socially excluded, even to the extent that they are kept at home, out of school
- People with a disability are often illiterate.

Both these factors would mean the CSC process would be intimidating. CARE staff also noted that they didn't feel confident about how to engage people living with a disability to overcome these obstacles. For the CSC process to better engage people living with a disability, it's recommended that disability expertise be brought on board to review the CSC process paying particular attention to access and usability aspects and make recommendations for adaptation of the CSC to ensure a more disability-friendly process for Vanuatu.

In order for scale-up, a number of factors should be addressed in order to strengthen effectiveness of the model and sustainability.

The piloting process has demonstrated that the model can produce good results. In order for scale-up, a number of factors would need to be addressed in order to strengthen effectiveness of the model and sustainability. The following recommendations are made:

- **extend the scorecard testing period** from two to four cycles to allow for embedding of the process and implementation of action plans

- **review and embed the Role Delineation Policy** requirements and service delivery standards within the socialisation and scorecard process. This may help to strengthen the accountability aspects of the CSC as it provides a strong platform for accountability and will ensure a better linkage to MoH system expectations for staff

- **strengthen the focus on and engagement with the Provincial level MoH** as the primary management unit for health service delivery. In particular, explore with the province how the benefits of the CSC model can be better communicated, or the model adapted, to support service delivery objectives and make clear linkages between the CSC, expected service delivery standards and how the CSC can add value to specific roles and responsibilities. There may be promising opportunities in using a digital CSC approach to address a key challenge for remote management, for example by identifying priority issues for support and action plans involving service provider

- **test the model at the aid post level**, through the Village Health Worker program. The aid post is the most numerous and accessible health facility for most people living in rural areas of Vanuatu and, although run by the MoH, is community-owned

- **in order to support sustainability, test the use of the health committee as the primary mechanism for co-ordinating implementation of the CS**C. The *Health Committee Act* 2003

requires the appointment of health committees for health centres, dispensaries and aid posts. Interviews with the MoH indicated that while Health Committees may not have received sufficient attention given their legal mandate for community engagement within the health system, with only HCs at the aid post level receiving capacity development through the Village Health Worker program in the past, they are now being re-emphasised. There are potential synergies here. The CSC could be used as the main tool to facilitate all of these functions of the Health Committee. The CSC process would provide an engagement and accountability framework and process that the HC model currently lacks. Training in CSC could serve as a platform to build community skills in community planning, engagement, activity co-ordination and monitoring. These are skills that are now required by the 'community driven development approach' being pursued by the Ministry of Internal Affairs (MoIA) pursuant to the Decentralisation Act but which appear to be in short supply.

- **focus on identifying and developing networks or coalitions of potential champions** for the CSC approach in each community. Develop a tailored engagement strategy to this end. In order to ensure that this is effective, use a simple, community-level 'power mapping' tool to identify key actors, including chiefs, church leaders and women leaders, and any others previously trained by other projects, their level of influence and their interests/positions in relation to the CSC and the linkages/relationships between them

- **For the CSC process to better engage people living with a disability**, it's recommended that disability expertise be brought on board to review the CSC process, paying particular attention to access and usability aspects and to make recommendations for adaptation of the CSC to ensure a more disability-friendly process for Vanuatu

- **explore the potential for the CSC to support the decentralisation agendas of both the MoH and the provincial administration** by testing the tool to facilitate bottom-up planning processes required under area council planning.

3 The Evaluation

The purpose of this evaluation of the *Storian Blong Yumi pilot* (SBY) project is "to assess whether or not the Community Scorecard approach as adapted to Vanuatu through the SBY project offers a viable model for community-centred social accountability in Vanuatu and to document lessons from the pilot for future application". The Evaluation Terms of Reference noted: 'the main purpose of the evaluation is to assess the results and learning emerging from the testing of the pilot model with a view to assessing its viability and best replicable form. In this way the evaluation is in itself a critical project deliverable in finalizing an appropriate, adapted model'. Each of the specific evaluation questions from the Terms of Reference are addressed in the Key Findings, section 5 below.

3.1 Evaluation Methodology

The project evaluation was conducted in three phases.

Firstly, in order to develop a thorough understanding of the project design and reported implementation, a literature review of key project documents was conducted by the consultant. These included the project proposal, the two six-monthly reports and key deliverables such as the CSC field manual, digital communications strategy, participatory videos together with CARE and other literature on Community Scorecards.

Secondly, interviews were conducted remotely with a number of key informants including CARE and partner staff closely involved in project management and implementation, such as the CARE Governance Advisor, the Country Director and the Research Manager at LoveFrankie.

Thirdly, in-country evaluation work was conducted from February 25th-March 12th. This included 11 days visiting communities and health facilities in the four project sites on the islands of Erromango and Tanna and three days spent in the capital, Port Vila, to observe the final national reference group meeting and interview national level stakeholders involved in the project including staff of the MoH, WHO, UNICEF and DFAT. The consultant also visited the Ministry of Internal Affairs, Department of Local Government to better understand the current decentralisation process and potential synergies with this project.

Data collection was primarily qualitative, using focus group discussions (FGDs) and semi-structured interviews. One hundred and forty-eight participants were involved as detailed in the table below. While attempts were made to access MoH HIS data on SRH service provision at the project sites, this had not been made available by the time of finalising this report. Within the MEL framework, the main source for baseline data identified was the first-round scores. Observations and reflections throughout the CSC project identified that changes between the first and second round scores do not necessarily reflect a linear change in the quality of the service for the issue being scored, which may limit their appropriateness as the sole form of baseline data. There may be a variety of reasons for the change in the second-round scores, including potentially an increase in understanding of the issue for some groups, rather than necessarily reflecting the quality of the service increasing or decreasing. This has been identified as a limitation in the use of scores alone for baselines, and should be considered in future program designs.

Focus group discussions (FGDs) were conducted with community members, service providers and health committee members in each project location and semi-structured interviews were conducted with community leaders, such as chiefs and members of the provincial administration in each location. FGDs and interviews were conducted using topic guides prepared specifically for service users, service providers, community leaders and service managers. Separate FGDs were conducted with young

females, older females, younger men and older men and service providers, the same groupings with which the scorecard process was conducted. FGDs were mostly facilitated by CARE staff – female staff with female groups and male staff with males - and conducted in local languages, mainly Bislama. Notes of each FGD were taken in Bislama by a specific note taker. Interviews were mostly conducted by the consultant in English or translated into Bislama. At the end of each visit to a project site, the consultant sat with the note-takers and facilitators to translate the notes into English and discuss clarificatory questions.

Evaluation Participant Group	Dillon's Bay	Port Narvin	Iarkei/ Whitesands	Isini/ Lenakel	National	Total
Younger Women	6	13	4	4		**27**
Older Women	4	18	11	4		**37**
Younger Men	4	12	4	0		**20**
Older Men	9	9	2	6		**26**
Female Leaders	0	2	0	0		**2**
Male Leaders	2	3	0	0		**5**
Service Providers	5	5	1	8		**19**
National MoH and partners					8	**8**
CARE and partners					4	**4**
Total	**30**	**62**	**22**	**22**	**12**	**148**

An initial analysis of data from all FGDs and interviews in one location revealed a number of broad common themes. These themes were used to analyse and categorise the data from other sites and any new themes were added as additional data demanded. Once final, the entire set of themes and the data in them was reviewed to reveal common patterns and differences. This analysis was then triangulated with data from the learning reports, revealing considerable commonality.

4 The Project

4.1 Context

The Republic of Vanuatu is made up of over 80 islands of which 68 are inhabited. Its population of approximately 250,000 people is scattered across 12,336 km^2 and its most northerly and southerly outer islands situated about 1,300 km apart.

People reside mainly in the coastal areas of rugged mountainous islands of volcanic origin, although there are several outer atoll islands. Approximately seventy five percent (75%) of the population live in rural areas and are engaged in subsistence livelihoods. The Government of Vanuatu faces significant challenges providing infrastructure and delivering basic services such as education and healthcare.

4.2 Health service delivery in Vanuatu

Vanuatu has one of the lowest ratios of health workers per capita in the Pacific, exacerbated by significant inequalities in service distribution. Access to health services is hampered by dispersed population density, geographical inaccessibility and high transport costs.

The *Vanuatu Health Sector Strategy 2017-2020* reaffirms the Government's commitment to Primary Health Care as a key approach to meeting the *National Sustainable Development Plan 2016-2030* policy objective to 'ensure … equitable access to affordable, quality health care through the fair distribution of facilities that are suitably resourced and equipped'. The strategy prioritizes universal

coverage to quality, affordable clinical services; establishment of enabling environments which promote healthy behaviours and choices; and empowering communities to assume control of their health and social needs.

4.3 Project objectives

The overarching goal of the *Storian Blong Yumi* project is:

> *to contribute to improved health outcomes in Vanuatu through **piloting a community centred social accountability model for the health sector** which leverages community engagement and digital media to increase effectiveness.*

At the heart of this 'community centred social accountability model' is the 'Community Score Card' (CSC) tool, first developed by CARE Malawi in 2002 as a strategy to improve health services and described in further detail below. The CSC approach has subsequently been implemented by CARE, the World Bank, DFID and others in a wide range of contexts globally. The CSC approach has been evaluated as highly effective in other regions of the world. Research by ODI into CARE's experience in Ethiopia, Malawi, Rwanda, and Tanzania revealed that CSCs contributed to strengthening service provision and community-state relations through:

- improved trust and mutual respect (between service users and providers)
- changed attitudes and behaviours (of users and providers)
- improved performance and discipline of frontline providers
- infrastructure construction and rehabilitation
- changes in resource allocation[1].

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4.4 Key elements of the SBY project

The SBY pilot had the following key elements:

1. <u>The adaptation and testing of CARE's community scorecard and action-planning model for the Vanuatu context</u>

The process of adaptation of the model to Vanuatu and subsequent testing of the model was carried out in component one ("analysis and adaptation of the CSC model for the Vanuatu context") and component three ("piloting the CSC approach") of the project.

2. <u>Influencing key health stakeholders on SRH issues identified by the pilot communities as priorities</u>

To the standard CSC model implemented elsewhere, CARE Vanuatu added an influencing element

[1] *CARE's experience with Community Score Cards: what works and why?* Wild, Leni, Joseph Wales, with Victoria Chambers. Overseas Development Institute, 2015.

based on dialogue and learning. National and provincial health stakeholders were invited to participate, together with CARE, in a learning process to understand CSC and how it could be used in Vanuatu. To do this, the project used these strategies:

- Establishing national and provincial reference groups for the project consisting of key MoH staff and development partner health stakeholders. These reference groups would provide fora for dialogue and learning based on discussion about the information generated through project implementation, in particular the scorecard process and the participatory video, as well as provide steering advice for the project, facilitating implementation and addressing bottlenecks where required

- Enabling community members to develop and tell their own stories about SRH challenges faced by their communities through participatory video production. This process encompassed six videos were made in the community of Dillon's Bay. Some of these videos contained specific asks of MoH decision-makers. The final videos were shown in communities and to managers and decision-makers at the provincial and national levels and can be found here https://bit.ly/2CR7HTz

- Providing data to managers and decision-makers on community-defined and service-deliverer defined priorities and action plans at the community level in the form of a 'digital scorecard', a web-based, interactive digital dashboard that presents, in a user-friendly format, data entered into handheld 'tablet' computers by community members. This was developed by social change creative agency LoveFrankie, with facilitation inputs from DSIL Global, as a Minimum Viable Product through a process based on principles of 'User Centred Design'. The MVP can be found here: https://bit.ly/2CR7HTz

- Advocacy actions identified in the community level action plans.

4.5 Implementation details

The SBY project was implemented by CARE International Vanuatu in partnership with the Vanuatu Ministry of Health public health team over an 18-month period from November 2017 to March 2019. Major inputs were provided by LoveFrankie for the digital storytelling activity and for the design and testing of a Digital Scorecard 'Minimum Viable Product'. Other inputs were provided on the Minimum Viable Product by DSIL Global on 'human-centered design'.

The project was funded in the amount of AUD 550,000 by the Australian Department of Foreign Affairs and Trade through the InnovationXChange facility (https://ixc.dfat.gov.au), managed by AECOM Ltd.

4.6 Project sites

Port Narvin in North Erromango

Port Narvin, with a population of 558 people, is situated on a remote bay in the north east of the island of Erromango. The village is surrounded by steep mountains and while there is a track to the village, it is most easily accessed by a 1.5-hour banana boat ride from Ipota/Cooks Bay, the site of the closest airport. Port Narvin is a self-sustaining subsistence economy with productive community gardens and fishing grounds. Port Narvin is served by a dispensary located in the community. CARE has worked there since 2011.

Dillon's Bay/William's Bay in South Erromango

Dillon's Bay, with a population of 570, is situated on the western coast of the island of Erromango.

The village consists of six areas along the coast and a river. Most of the population originally comes from other communities in Erromango, drawn by access to services such as the school, health centre, and the airport from which fish and lobster is sent to market to the capital, Port Vila and the island of Tanna. The residents of Dillon's Bay play host to 50-60 sailing yachts annually who visit on their way from Fiji to Port Vila and from which they derive income selling handicrafts, hosting the sailors in guesthouses and conducting visits to sites of cultural interest including a 'skull cave'. There are only three landowners and with the arrival of newcomers, there is increased pressure on access to land and it appears this is constant source of conflict in the community. Dillon's Bay is served by a dispensary located in the community. CARE has worked in Dillon's Bay since 2011.

Iarkei in the Whitesands area of Tanna

Iarkei, with a population of 186, is part of the Whitesands area of East Tanna. Iarkei is served by the Whitesands Health Centre, a short walk to from Iarkei. However, this health centre serves the entire Whitesands area with a population of 6,733. The area is directly affected by periodic ashfall from the Yasur volcano which destroys food production from community gardens. CARE has worked in Whitesands since 2015 but never specifically with Iarkei until this project.

Isini & Launapkamim in the Lenakel area of Tanna

The communities of Isini and Launapkamim, with a combined population of 540, are located near Lenakel, the main town and administrative centre in Tafea province. Lenakel Hospital is the health facility serving these communities but it is also the provincial referral hospital and thus its focus is on clinical services with for the entire province which has a population of 37,050[2]. CARE had not worked in these communities prior to this project.

4.7 CARE's Community Score Card (CSC)

CARE describes the Community Score Card (CSC) as:

> "a two-way and ongoing participatory tool for assessment, planning, monitoring and evaluation of services. It brings together the demand side ("service user") and the supply side ("service provider") of a particular service or program to jointly analyse issues underlying service delivery problems and find a common and shared way of addressing those issues".

The main goal of the Community Score Card is to 'positively influence the quality, efficiency and accountability with which services are provided'. The core strategy to achieve this is a structured dialogue process involving both service users and service providers.

[2] *2016 Population and Housing Mini Census*, Government of Vanuatu.

The CSC - a five phase process

The standard CARE CSC process consists of five phases, as illustrated in the diagram above:

1. **Planning and preparation** to mobilize communities and service providers to be involved in the scorecard process

2. **Conducting the Scorecard with Communities**

In Vanuatu this involved:

- participatory problem identification by four groups of SRH service users - young women, young men, older women and older men

- separate ranking/scoring by each of the groups of these problems to identify priority problems.

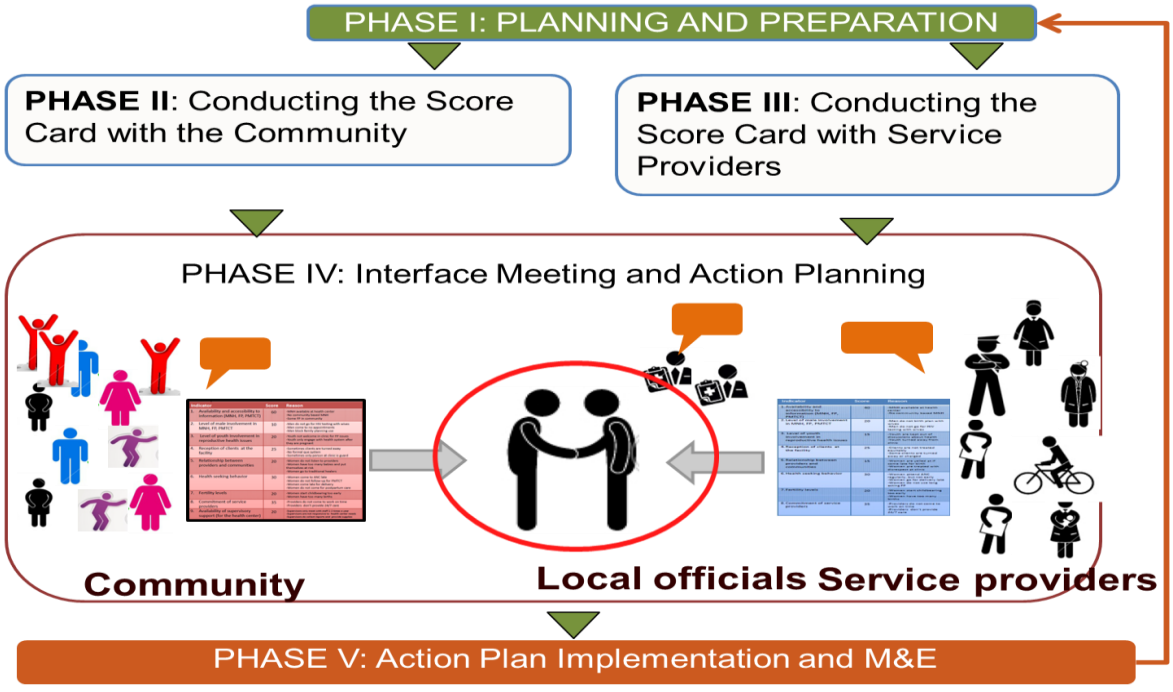
3. **Conducting the Scorecard with Service Providers**, involving the same steps as in phase 2

4. **Conducting interface meetings and action planning**

Through an "interface" meeting between the service users and service providers in each community, agreement was developed on joint community-wide priorities to be addressed. The community members and service providers then developed a community-level action plan to address the priority issues selected. These plans should, as much as possible, be capable of being implemented by the local service providers and/or community from within their own resources or where these are beyond local control, then through advocacy to relevant levels of management within the service provider institution and/or levels of government decision-makers. In this pilot, the main service provider institution was the Ministry of Health.

5. **Implementation and monitoring**

The initial scorecard process usually takes place over an eight-week period as shown in the **Typical Community Score Card Timeline** diagram below. In this pilot, due to geography-related access



problems, it happened in two different ways. On the remote island of Erromango, the process was conducted in intensive blocks of time, facilitated by CARE staff visiting from their provincial base on Tanna. In Tanna staff were able to visit communities in an ongoing manner. Following this initial round of scoring, the scoring process is then repeated with the user and provider groups every 6 months. This repeat scoring allows for a comparison of scoring over time and provides monitoring data for the implementation of the action plans. CARE's experience elsewhere suggests that it takes four rounds of scoring, for the best results to be seen. The first cycle allows communities to experience the process for the first time. In this case, the concept of being invited to publicly and legitimately voice opinions on a service were entirely new, particularly for women and young people. Subsequent scoring activities allow communities to become more comfortable with the process itself and the topics discussed. Third and fourth cycles give time for action plans to be implemented and for results to be seen. This builds further confidence and trust in the process. In the Vanuatu pilot, only two cycles of scoring, were possible due to the time frame of the donor contract offered.

In the SBY model, CARE added an influencing element to the 'standard' CSC model of problem identification, problem prioritisation and action planning shown above. Strategies and spaces were created by the project in order to bring community voices from the periphery to provincial and national administrative centres (Lenakel in Tanna and Port Vila) and to create dialogue amongst health managers and decision-makers in these locations around the issues raised. Within this influencing element, CARE Vanuatu added two innovations, firstly digital storytelling, and secondly the development of an online digital dashboard to display the scorecard data.

Typical Community Score Card Timeline

Community Score Card Phases	**Weeks**								**Every 6 Months**
	1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	
Phase I: Planning and Preparation									
Phase II: Conducting the Score Card with Communities									
Phase III: Conducting the Score Card with Service Providers									
Phase IV: Interface Meetings and Action Planning									
Phase V: Implementation and Monitoring									

5 Key findings

The findings for each of the specific evaluation objectives - which are listed in full at Annex 1 - are presented below and in section six, which addresses the overall question of the replicability of the model.

5.1 Greater shared understanding between communities and health sector stakeholders

The main project mechanisms to promote shared understanding between communities and health sector stakeholders of community health concerns were:

- the socialisation process conducted in each community. Staff spent a good deal of time explaining what SRH is and what SRH services are available to communities
- the scoring processes
- interface meetings between the service users and local service providers, the action planning processes that were held in each community
- The stakeholder influencing activities described in section 4. The effectiveness of these is discussed below at 5.6.

Three matters need to be highlighted when assessing the outcomes of this project which are particularly at the community level. These are all rooted in *kastom*; firstly, and this was mentioned consistently across all communities, there exist strong taboos on the public discussion of sexual matters in general and between women and men and parents and children in particular. Secondly, there are traditional prohibitions on women speaking up in public discussions. Thirdly, matters of community governance and decision-making, which encompass planning for the community, are the preserve of men. The usual space where this takes place, the *nakamal*, is predominantly a male space and while some women may attend it, they may not speak or must ask permission to[3].

All these taboos are directly challenged by the SBY model with its emphasis on creating pubic discussion on SRH matters and facilitating participatory action planning - for the whole community, not just women, on these matters *and* involving women and men, of different age groups, in these activities. So, these factors mean that all these communities presented difficult settings to implement this type of intervention with its particular focus.

Even so, the project succeeded in mobilising community members to discuss such topics, stimulated public discussion and dialogue between sexes and between age groups and between service providers and the community in relation to SRH matters. In all communities, priorities were discussed and agreed on and action plans were produced - in a participatory manner.

This has been very significant for women and young women participants who had never before been asked their opinion nor spoken up in public. And while a number of young women in three of the communities spoke of being very shy and scared about speaking up, “We were shy to talk about the issues in front of the whole community. We felt afraid and felt our heart bumping in our ribs”, they nonetheless did it and reported it to the evaluation team, which is indicative of the importance they

[3] *Gender Analysis CARE Vanuatu Resilience Program (Tafea),* S Whitfield, 2015

placed on it.

Young women appear to have gained an increased sense of agency through their involvement with the project. In Port Narvin, they have become aware that "they can protect themselves from unwanted pregnancy and STIs". In Dillon's Bay, they reported that they learnt that they shouldn't rely on boyfriends' advice on what is expected to happen when they first have sex "because they can lie". And that they should stand up for themselves and make their feelings known about sex; "This is not right for me". They also learnt that they should be "confident about SRH matters and ask people who are there to ask about such things – e.g. the nurse, who will advise on these things and if there are problems with family planning methods, they will help them deal with it and find a better method". In Isini, young women reported that they found the process of discussion and prioritisation very interesting because it gave them a clearer understanding of the SRH services that are available in the clinic.

In Port Narvin, men noted that the fact that the discussion process led to SRH issues being out in the open - "he knows what I know", "we've all talked about in the open" - rather than hidden as usual, meant that people then felt more comfortable about discussing these issues with each other and with the service providers. The process had 'broken the ice'. This seems to have been important for helping people feeling less embarrassed about accessing services as well as for service providers going out into the community to talk about these issues. There's been freer discussion of family planning in the community, "nomo hide-hide, "nomo custom story".

Even health committee members in Port Narvin noted that "Before we didn't understand what was happening in the clinic. Now we understand what is happening and what's our role is in the clinic. We know the issues in the community…. previously we were afraid to approach the nurses and talk about SRH issues. CSC has made it easier for us to come down and discuss freely with service providers because the issues are out in the open".

Across groups of older and younger men and women in all locations people were aware of what family planning and STI services were available to them and what the role of the health staff were. Men in all locations reported that they didn't previously really know what happened in the health centre regarding SRH but now they have a better understanding. In Dillon's Bay and Port Narvin, young women reported that rumours and misconceptions they had previously held about family planning methods had been dispelled, specifically that family planning medications had been developed on monkeys and would lead to infertility. Men in Isini reported a good deal of miscommunication and fear amongst men in their community surrounding discussion of SRH issues, including concerns about lack of confidentiality and the fear of being judged by service providers and other community members for seeking condoms, in particular, accusations that they were seeking condoms so they could be unfaithful to partners. However, they noted that the CSC process was important and positive because it helped them to discuss these things, it helped them "get the fear out".

The evaluation team was unable to get interviews with people living with a disability. While CARE staff reported that concerted efforts were made, the project encountered difficulties in engaging and maintaining engagement of people with disabilities in the project. Few people with clear disabilities participated in the scoring process and left after a short time. Only two stayed long enough to have their scores recorded. CARE team reported the following reasons for this:

- People with a disability are socially excluded, even to the extent that they are kept at home and out of school
- People with a disability are often illiterate.

Both these factors would mean the CSC process which is both public and a written process would be intimidating. CARE staff also noted that they didn't feel confident about how to engage PWD to overcome these obstacles. For the CSC process to better engage PWD, it's recommended that disability expertise be brought on board to review the CSC process paying particular attention to access and usability aspects and make recommendations for adaptation of the CSC to ensure a more disability-friendly process for Vanuatu.

5.2 Increased engagement by communities in health and SRH

Increased engagement by the community in health and SRH has occurred at different levels.

Most obviously, the model itself facilitates engagement by bringing groups of people together to discuss SRH, list problems/issues in relation to SRH services and to determine priorities to be addressed. The interface meeting brings service providers and community members of different ages and sexes together to agree on joint priorities and come up with an action plan. None of these kinds of community-wide discussion and planning activities had happened in any community previously. Male leaders mentioned that they learnt how to prioritise for the first time.

Action plans were developed in every community, to be delivered, as far as possible, using resources available at the community level. These were published as charts and put up in public places, for example at the community market-house in Port Narvin, the Area Council building in Dillon's Bay and the Health Centre in Whitesands. However, there have been challenges in the implementation of action plans thus far. There appear to be a number of reasons for this:

- there is no one with clear responsibility for co-ordinating implementation across the different groups of people involved in the community. As a result, it appears that following up on implementation has happened when CARE staff visit, and this means that momentum is lost. In communities where it was difficult to maintain active support from chiefs, the project had difficulty mobilising communities beyond the initial phases of the CSC, particularly in implementing action plans. To address this the action plan process will need to be better embedded in community structures. The Health Committee provides an existing avenue for this. Alternatively, provincial administration and area council representatives could be involved. This would require a broadening of the process beyond the MoH

- the number of actions to be taken within the first round of action plans may have been unrealistic given the time frame and the resources available. CARE staff observed that during the first cycle, communities tended to be unrealistic in their planning. In some cases, service providers had 12 action points to follow up. This is probably too ambitious when one considers the other, non-SRH responsibilities of service providers. However, in the second cycle, communities took the action planning process more seriously, agreeing on more considered and limited action points with more specificity about implementation responsibilities

- leaders in Dillon's Bay noted some concerns about how the scorecard process and action plans fit in with the planning and co-ordination processes of the Area Council and the community obligations under that. Under the national decentralisation reform process, which is led by the Department of Local Authorities (within the Ministry of Internal Affairs), communities have a role in Provincial governance through participation in Area Councils, of which Erromango has two and Tanna, six. These councils are comprised of representatives of different community groups: chiefs, churches, women, youth, business and people with disabilities. Bottom-up community planning processes, which encompass all aspects of government service delivery, are included, with the intention that community priorities are reflected in Area Council

development plans and business plans.

Increased access to or uptake of services by the community is a good indicator of increased engagement in health. In this regard, service providers in Port Narvin reported that prior to the project, family planning commodities "used to stay on the shelf" but now, the health facility has run out of condoms and implants. They reported that more young people are attending the health centre and young men were requesting condoms for the first time, whereas previously, only young women were. They also noted that prior to the project, there had been no demand for implants. Following the project, young women are requesting Jadelle, a *levonorgestrel*-releasing, 'fit and forget" implant that works for up to 5 years. In Dillon's Bay, service providers reported that demand for contraceptive products was so poor, that condoms and pills would expire before they could be given out. The registered nurse there noted that previously he would have to take a box of condoms and burn them because they'd reached their expiry date. Female condoms would reach expiry. Whereas now, the challenge is ensuring that he has enough contraceptive products to give out. In Iarkei, older women reported that because of the questions asked during the process, they've opened up to discuss SRH issues and gained confidence in doing so. Older men in the community noted that as a result of the scorecard process, they'd come to know more about family planning and STIs and were encouraging the younger men to access these services.

5.3 Contribution to responsiveness and social accountability of the health system to community needs

CARE defines 'Social Accountability' as:

> "citizen-driven accountability, i.e. an approach that relies on civic engagement to exact accountability. The aim is to strengthen citizens' mobilisation and voice, support the generation of citizen-generated information and provide spaces for organised citizens to engage with service providers and other power-holders to influence decision making and hold them accountable, usually around commitments to allocate resources and improve service delivery"[4].

This definition contains a number of elements: (1) mobilising citizen voice (2) citizen-generated information (3) spaces for engagement between citizens and service providers (4) influencing and accountability. The SBY model addresses all of these; the first three elements correspond to phases 1-4 of the CSC process while phase 5 of the CSC - action planning implementation and monitoring - corresponds to element (4). In addition, SBY included the influencing strategies described in section 4.4.

Responsiveness has been defined in the academic literature as:

> 'changes made to the health system on the basis of ideas or concerns raised by, or with, community members through formally introduced decision-making mechanisms'[5].

In all communities, the CSC model has contributed to responsiveness and social accountability of health services, although this was reported more in the communities on Erromango than on Tanna. Potential reasons for this variation are explored in section 5.4.

[4] *Inclusive Governance Guidance Note,* CARE. 2016.

[5] *"Community accountability at peripheral health facilities: a review of the empirical literature and development of a conceptual framework,"* Molyneux, Sassy, Martin Atela, Vibian Angwenyi, and Catherine Goodman. 2012. Health Policy and Planning 27(7):541-54.

Contribution to responsiveness and social accountability to community needs in Erromango

- Prior to the pilot, no awareness raising on SRH had been conducted in Port Narvin. Since the pilot, awareness raising has been conducted in the school and in the different zones/areas in the community

- As a result of the process in Port Narvin, the two service providers, a Registered Nurse and the Nurse Aide recognised the need to improve their own knowledge and skills and this became part of the action plan. In addition, two young people (one female, one male) nominated by the community went to Tanna for specific SRH training. When they returned, they ran awareness raising sessions in the community on adolescence and puberty. For the first time, condoms and advice were provided directly to young people through the two young people who attended training in Tanna. The service providers had a change in perspective, seeing the importance of reaching out to the community and recognising that engaging youth was a strategy for reaching the community

- Service providers in Port Narvin secured an autoclave, paid for by the MoH, as a result of including a request to the national level for this in their first-round action plan.

- Women in Dillon's Bay and Port Narvin noted that previously the health staff 'stayed in the health facility' whereas now, they were out and about, talking to people about SRH. Service providers in Port Narvin noted "before, I was keeping quiet in the centre" but that following the SRH training they received, they felt more confident to go out

- In Dillon's Bay, service providers noted that there had been a reduction in referrals as a result of premature labour. This was because awareness raising activities conducted by the service providers on Ante Natal Care (ANC) had resulted in more women booking in ANC appointments and not just waiting until labour to come into the health facility.

Contribution to responsiveness and social accountability to community needs in Tanna

- Women in Iarkei noted that nurses' attitudes to women in the Whitesands health centre had improved since the project

- In Iarkei, both groups of young and older men noted that there is now a public duty roster at the Whitesands health centre, so they know who is on duty and a mobile number has been put up on the notice board so that community members can call the service provider if they aren't there. Previously, a woman gave birth on the ground in front of the centre because no health service provider was in attendance

- The Whitesands health centre has dedicated a waiting room for mothers attending antenatal check-ups. Previously they had to wait outside

- In Isini, a service provider noted that as a result of the project, emergency contraception, the STI package and pregnancy tests are available at the 24hour outpatients clinic.

Broader health system effects

System effects beyond the community-service provider dimension were fewer. This is unsurprising given the short implementation period. However, there were two reported instances:

- it appears that the project has influenced specific national level MoH actions such as the prioritisation of infrastructure support to three health facilities in Erromango at Port Narvin, Dillon's Bay and Ipota.

- The request by Port Narvin health staff for an autoclave noted above had a much broader impact, in that it led to a discussion at the national level about the kinds of equipment that should be available at the dispensary level. As the MoH was in the process of finalising its *Role Delineation Policy* at the time, this led to the inclusion of this equipment for Primary Health Care Facilities in the RDP.

5.4 The suitability and effectiveness of the model in different contexts and conditions

The most consistently significant results of the model were reported in Port Narvin. This was followed by Dillon's Bay and drops significantly to the project sites in Tanna, with the weakest outcomes in Isini, close to the Lenakel hospital.

Examination of the contextual issues across the project sites, as well as the advice provided by service providers and community leaders for future implementation of the model, help shed light this.

Success Factors

There were a number of factors in Port Narvin that help to explain the success of the model there and provide a useful frame for considering results in other areas:

The support of chiefs

In every community, the support of chiefs was highlighted as the most pivotal factor for community engagement in the project. In Port Narvin, at least three of the chiefs, including the paramount chief were supportive of the project. Women in Port Narvin noted that without it, the project would not have succeeded in addressing such a sensitive topic. During the project, one of the chiefs intervened to solve a community conflict that arose because one of the young men would not permit his girl-friend to use contraception but her family were insistent. The chief publicly intervened and persuaded the young man to change his mind. This was pointed out by others as something that a chief would not normally do for this kind of dispute and so this underscored their support of the project. This can be contrasted with Isini, where due to lack of clarity about succession on the death of a paramount chief, there were many chiefs and confusion in the community – and conflict between them - about what their authority and roles were. CARE staff reported that this had made organising activities difficult here. During the evaluation itself, it transpired that the chief that the CARE team had communicated with to organise community participation in focus group discussions, was not the right chief to do so and thus the expected participants did not turn up. In discussing factors behind the rare examples of functional and successful Health Committees in Vanuatu, a couple of respondents within the MoH highlighted that leadership from the paramount chief was critical. In Dillon's Bay, chiefs were active at the outset but did not sustain their involvement. The paramount chief there has prioritised economic development initiatives for his attention and appears to view health initiatives as a matter for the health facility staff. There, it was the Administrator, together with the Chairman of the Community Disaster Coordinating Committee and the Registered Nurse who pushed project implementation forward.

In terms of the factors that contribute to winning the support of chiefs, a number of points were raised:

- a relationship of trust needs to be established between CARE workers and the community, but the chief in particular

- this trust is best developed by CARE workers being present in the community, specifically taking lodging amongst community members and sharing food and *storian.* One community level service provider in Tanna noted that if CARE people stay in the guesthouse, rather than with villagers, they're perceived as "white-men who have money" and it will become difficult to build the necessary rapport:

  "You need to come, live, eat, storian. Then they see you as fitting in their shoes. If you come for two or three days, they don't trust you. If a chief sees you in the guesthouse, he'll say "CARE workers don't live in community, they slept in the guesthouse", he'll say that you're a white man, that you have money. The malaria program was successful because we slept in the community. Establishing relationships is very important. That family that you stay with becomes your instrument for connecting with the community. When you hear them say "brother sister belong mi", you know you've connected. Sharing your meal/per diem with the community, then you'll get connected. These people are the people that will mobilise the community for you.

- understanding the perspectives and interests of chiefs and persuading them on this basis. So, where the chief is primarily interested in promoting economic development in their community – and this was generally the most mentioned priority issue for chiefs – then it's important to frame the argument for SRH in those terms. For example, two chiefs highlighted that SRH awareness and family planning services were important because of the economic impacts of teenage and unplanned pregnancy; the pregnant teenager has to give up school and the child becomes an additional economic burden on her family. These become issues that chiefs may end up having to deal with indirectly. Where household gardens are key to household food security and land disputes arise because of insufficient access to gardens, where theft in the community results when people don't have access sufficient for family/household needs, these are matters that have to be addressed by chiefs. Such land disputes were commonly cited. One chief pointed out that if you have a family with a large number of children and little access to a garden, theft will follow.

The support of the local administration

In Port Narvin, the Area Secretary actively supported the project because he saw the project as furthering the objectives of the decentralisation reforms. In particular, he saw the CSC as an effective tool for promoting the emphasis on "bottom-up" in the decentralisation process and thus supporting his own objectives as a representative of the provincial administration; a 'win-win'. He highlighted that, in his view, the CSC process had strengthened awareness of people in Port Narvin that they had a role in government and in their own development, that this was not something external to them, done just by the state. The process had "brought them under the flag", awakening a sense of having a role to play as a citizen. This was something that in 18 years of working in Port Narvin, he had not seen. In Dillon's Bay, the Administrator for Erromango, who is resident there, took a proactive role along with the Chairman of the Community Disaster Coordinating Committee and the Nurse. It was highlighted there that it was difficult to mobilise the community to implement action plans and that without the active engagement of these people individuals, the action plans would not have happened. Where the chiefs are not actively involved in co-ordinating and pushing for implementation, then it appears that the support of other leaders is necessary, but this does not guarantee community participation.

Support of women community leaders

The support of women community leaders is needed to mobilise other women. In Port Narvin, the

women's' representative to the Erromango Area Council and the Child Protection officer were selected by the project as community mobilisers for women. They worked together to visit every household in the community to encourage women to be involved. This level of consistent support did not exist in the other communities. In Dillon's Bay, the midwife, who had been actively engaged at the start, dropped out during implementation, in order to focus on income-generating activities. Both of the women leaders in Port Narvin were strong advocates for gender equity and had initiated another initiative, a "girls program" to support women and girls in the community. Both had been previously trained by other projects in women's rights and leadership.

Community cohesion

Port Narvin is the most socially cohesive of the pilot communities. This is probably the result of a number of factors. Firstly, Port Narvin is geographically small and contained; its physical space is a small, narrow coastal plain bounded by steep mountains surrounding it to the bay which opens onto the open ocean. The health facility, a dispensary, serves a population of no more than six hundred. In contrast, the community of Iarkei is served by the Whitesands health centre, which covers the entire Whitesands area with a population of 6-8,000. The health facility serving the pilot communities of Isini and Launapkamim is the Lenakel Hospital. This also serves the entire Tafea province.

Apart from the chiefs, the *nakamal* and the extended family, the key social and cultural institution at the village level is the church. In the village, churches are more influential over people's lives, attitudes and beliefs than the institutions of the state. Researchers on Vanuatu have noted that the state is distant in the lives of most ni-Vanuatu. It's important to note that community level institutions are highly entwined; thus, a chief is also likely to be an elder or hold another leading role in the church. In Port Narvin, there are only two churches while in Dillon's Bay, there are six and in the Whitesands area, more than 11. It was reported that churches are demanding of villagers' time and resources, with church activities taking place in the evenings. This reportedly also acts as a limit on the time that people have to be engaged in group activities outside their own churches and with others outside church congregations. In Port Narvin, the churches – Presbyterian and Seventh Day Adventist were supportive. In fact, many of the evaluation discussions were held in the Presbyterian church. In Dillon's Bay, one male church leader reported support for SRH, organising youth programs with the registered nurse to raise awareness on SRH. In other communities, church leaders appeared far less visible in the project. While church leaders did not appear to have blocked the project, it's unclear the extent to which they were deliberately engaged by the project and had publicly demonstrated support. This highlights the importance of an engagement strategy that identifies and engages church leaders prior to commencement of activities, to understand their views and positions on SRH issues, address any potential sensitivities and identify potential champions.

5.5 Effect of project advocacy

In practice, specific advocacy work undertaken during the project appears to have been focused vertically, and has been primarily directed at creating fora for dialogue amongst health sector stakeholders at the provincial and national levels.

The primary advocacy strategies were:

1. establishing national and provincial reference groups consisting of key MoH staff and health stakeholders

2. facilitating community voices to develop and tell their own stories about the SRH challenges they face through the medium of participatory video

3. collecting and presenting data to decision-makers on community-defined and service deliverer defined priorities through the development of a 'digital scorecard' and a web-based, interactive digital dashboard.

These will be considered in turn.

1. Establishing national and provincial reference groups

National and provincial reference groups were established during the first six months of the project. They have served multiple purposes: for providing steering advice, facilitating implementation and addressing bottlenecks where required, mechanisms for dialogue on the information arising through implementation and channels for facilitating uptake and replication should the model prove to be successful.

The national reference group was chaired by the Director of Public Health and included representatives from the MoH's public health, corporate planning, and clinical departments, as well as stakeholders from the World Bank, Vanuatu Family Health Association (VFHA), the Australian High Commission (DFAT), World Health Organization (WHO), UNICEF and Vanuatu Society for People with Disability (VSPD). The national reference group held four quarterly meetings and in participated in stakeholder workshops at the outset of the project.

In addition to the national reference group, a Tafea Province reference group was established following the stakeholder workshops in October 2017. It includes representatives of the provincial government and service providers in Tafea.

At the national level, the meetings have been well-attended and have garnered and maintained the interest of staff across the MoH, particularly the Director of Public Health. The Director visited the Port Narvin project site as a result. All national MoH stakeholders interviewed noted their support of the project for various reasons:

- it reinforces the Primary Health Care approach. In particular, it encourages community level facility staff, who largely view themselves as clinically-oriented, to take a more proactive and preventive role.

- It helps community members to recognise that they also have a role to play in ensuring their own health; it's not just a service-provider responsibility.

- The project enabled them, sitting in the capital, to connect with the realities of their ultimate customers and colleagues 'on the ground', in locations where they seldom go. Thus, it's easy to lose sight of the challenges these people face.

- it provides another, useful, way of conducting a community diagnosis – something that Village Health Workers are responsible for.

The aid co-ordination officer at the MoH noted that CARE was one of the few INGOs that proactively engaged with the MoH and didn't need to be chased for information. As these meetings were the primary mechanism for engaging decision-makers, these positive attitudes indicate that these meetings have been successful. The reason why they've been successful appears to be the approach taken on bringing MoH stakeholders along on a 'learning journey', the innovative nature of the model (never tried in Vanuatu), the promise of the model in terms of strengthening health service delivery at the community level and a combination of interesting content and the support of the

Director of Public Health.

2. Facilitating community voices through participatory video

Of all project activities, participatory video appears to have had the most impact on MoH staff at the provincial and national levels. This is discussed at 5.8.

3. Collecting and presenting data to decision-makers through a digital scorecard and dashboard

This is discussed in section 5.9.

In addition, to the above, for the first time, staff at the dispensary level in Port Narvin engaged in advocacy with the national level of the MoH. With the assistance of CARE staff, the nurse in change and the nurse aid wrote to the national level to request an autoclave and a truck. This seems to have empowered at least one of them: "What I've seen with this CSC is that we don't feel frightened to talk to the Director General or whoever". What's not clear from this example is the extent to which such advocacy was based on an understanding of what should be in place within a health facility. Neither did there seem to be an understanding of MoH planning processes and if and how they could contribute their needs through this process. No health staff on Erromango had participated in such planning processes and reported that none of them recently had a supervision visit. And this may have created an idea that to get results, one needs to go straight to the top. With the finalisation of the MoH's *Role Delineation Policy* in late 2018, there is a now an opportunity to use this more explicitly as the basis for engaging service providers in the CSC. The phase 1 socialisation process provides the opportunity for familiarising service providers staff about the standards set out in the RDP.

5.6 Critical success factors and 'failures'

As noted above, implementation in the different contexts appear to have revealed a number of Critical Success Factors.

Firstly, the sustained involvement of chiefs for all phases of the CSC process; prioritisation, action planning and implementation. Secondly, the engagement of other leaders to mobilise the community to participate and implement action plans. This becomes critical where chiefs are not as engaged or disengage as appears to have happened in Dillon's Bay. Ideally, potential champions should be identified from amongst chiefs, the provincial administration, churches and women's leaders should be identified and specific efforts made to link these and build a network or coalition of champions for change. This would help to build broad support and manage implementation risk. It appears that the support of chiefs will be required for community wide prioritisation and planning. In order to build this network or coalitions, it will first be necessary to understand leadership structures, authority and roles in community governance, including the relationships between chiefs and other leaders, particularly the church. For this reason, it is recommended that prior to implementation, a simple 'power mapping' type of exercise is conducted in each community. This would then be used to develop an engagement strategy to support coalition building. From an implementation perspective, this is more likely to be feasible when the scorecard is part of a broader development initiative, rather than a standalone activity. Several respondents noted that if SRH hadn't been the topic of the community scorecard, but something else of broader importance across the community such as economic development or water, and uncomplicated by community taboos, then it would have been easier to sustain the engagement of chiefs and push implementation of the action plans. This underscores the importance of dedicating time prior to implementation to identify potential champions and conduct socialisation.

The role of the health committee and its obligations under the *Health Committee Act* give rise to

synergies with the CSC that could be better integrated. CARE staff noted that health committees appear to be largely non-functional across Vanuatu. While Health Committees were not meeting regularly in all project locations, they do not appear to have received any support from MoH or others in terms of capacity development. In Dillon's Bay, the nurse in charge of the health facility noted that "I myself, doing things alone, will not work" and so, while he sees CSC as a valuable tool for promoting public health in generally. "I cannot do this without the support of the Health Committee". It will be critical to address this matter because in the absence of wider support, health facility staff who been trained in community engagement who already face significant challenges in delivering services and will become disheartened and will opt out of the process. To address this, it's recommended that capacity development of the Health Committee is undertaken alongside the scorecard process. This is discussed further at 5.11.

5.7 The role and influence of digital story-telling

Of all project activities, participatory video appears to have had the most impact on MoH staff at the provincial and national levels. Nine videos were made, one each by the different gender and age groups in the community of Dillon's Bay; young women, older women, young men and older men, an introductory video with reference group members for use in communities, and 2 recommendations videos with representatives from all communities including a social media version and a long version.

Some of the videos are documentary in nature with the service providers taking the viewer into the Dillon's Bay dispensary and showing us the facilities and equipment. Another, made by the young women of the community, involves a series of sequences in which each in turn hold up a card on which their thoughts on SRH and their requests of decision-makers are written. There isn't any dialogue or narration in this video, driving home the public silence of young women on these issues. The video made by the men of Dillon's Bay dramatizes the challenges of transporting a pregnant woman with complications to the dispensary in Dillon's Bay. This particular video was highlighted by a few national and provincial stakeholders. The videos have had the effect of powerfully reminding national level managers in particular of the challenges faced by their staff and people in remote communities that the MoH is charged with serving, but that are quite removed from their day to day work in Port Vila. Interviewees noted that while some of this information may have already been presented to them in documents, people directly telling their stories on camera were far more powerful in communicating the reality and prompting a response; "pictures speak a thousand words" according to a national level MoH manager. This is unsurprising given that "storian" is the main cultural mode for communication and discussion. What's not clear is the extent to which requests made in videos were informed by an understanding of what services should be provided. It will be important to ensure that in future, the socialisation process in phase 1 communicates the service delivery standards set out in the Role Delineation Policy and the opportunities for participation in service delivery planning.

The men who participated in the making of the video reported that this was the project activity that they had enjoyed the most and gained personally from. They both had fun and learnt new skills. They developed a story-board, acted and filmed for the first time. The sense that they had created a message that would be listened to outside of Dillon's Bay, and particularly with decision-makers within the MoH who had the potential to address the issues raised, was a source of pride. This process was thus not just a means of crafting messages for advocacy purposes but a tool for immersing men in an issue that they normally regard as women's business and would not engage with. Because the process was a group/team process, involved exciting new skills and was fun, it seems to have helped bring down barriers. Given the importance of engaging men, something that appears to have been a problem in the Tanna communities particularly, participatory, digital story-

telling should be further tested in other communities as a strategy not just for developing messages but for developing men's engagement.

The issue of the 'cost effectiveness' of participatory video is difficult to answer because it involves measuring the effectiveness of this intervention in producing desired outcomes in this context and comparing its cost to the cost of other interventions that produce the same outcomes in this context, the data for which is not available. In terms of outcomes produced, it appears that participatory video has resulted in a deeply felt appreciation by a number of decision-makers in the Ministry of Health of the challenges faced by community members and service providers in accessing and delivering SRH services. This has contributed to their sustained support and engagement of the project and this has resulted in tangible changes. For example, the Director of Public Health visited Port Narvin and an autoclave was procured for Dillon's Bay and Port Narvin. As noted above, men's involvement in participatory video appears to have been successful in facilitating the engagement of men with SRH issues. While this activity has been resource-intensive, due to the use of a professional firm to facilitate video production, this is an upfront establishment cost. Were this activity to be seen as an ongoing process for engagement and monitoring, communities would become more skilled and confident about using these methods to record change on their own and these costs would be spread over a longer period. Also, there are a number of recent initiatives, in the Pacific, such as Oxfam's *Raising Pacific Voices* project, which have successfully trained young people to storyboard and use their smart phones and free apps to produce short videos for social media. This could be an alternative, cheaper, approach to produce such content in future.

5.8 The contribution of Human Centred Design

The Human Centred Design (HCD) approach was supported by DFAT's InnovationXchange for inclusion in the project model. After some initial difficulties identifying suitable experts, DSIL Global was contracted to provide advice on integrating HCD into the project. This was done through two inputs. The first, was during the stakeholder workshop held in October 2017. This was conducted to assist stakeholders and the project team to better understand HCD and facilitate discussions on the design of the first iteration of the Minimum Viable Product. The second input was provided together with LoveFrankie in July 2018.

It is difficult to assess the extent of the contribution of HCD. The report produced by DSIL Global following its October 2017 input doesn't clearly set out the approach and how it would be applied to this specific case. Interviews with a few participants indicate that they were uncertain that HCD had added much to what was already considered standard practice in program design and implementation by development NGOs, in particular the emphasis on "people-centred approaches" that arose in the 1980s and 1990s. These prioritise beneficiary participation at all stages of the program cycle. This means designing interventions based on a thorough understanding of project context and 'beneficiary' perspectives, arrived at through research methods such as "participatory rural appraisal" that include a range of techniques to draw out the perspectives of unheard voices, such as illiterate and other marginalised groups. Solutions, contained within a 'project' or 'program', are designed to address identified problems with a view not just to their technical feasibility but for ensuring uptake by intended beneficiaries. This is often addressed within the perspective of ensuring the "sustainability" of an intervention.

However, what HCD appears to offer that is new to development practice is the emphasis on *rapid* ideation, testing and refinement of solutions. This lends itself to the development of discrete products and processes to address concrete and specific design challenges. This is where a more specific application of the HCD approach, User Centred Design, added value, in refining the digital scorecard and dashboard after the initial round of testing. User Centred Design consisted of:

- Identify the users who will use the product, what they will use it for, and under what conditions they will use it
- Identify any requirements or user goals that must be met for the product to be successful
- Create design solutions and evaluate the design through testing.

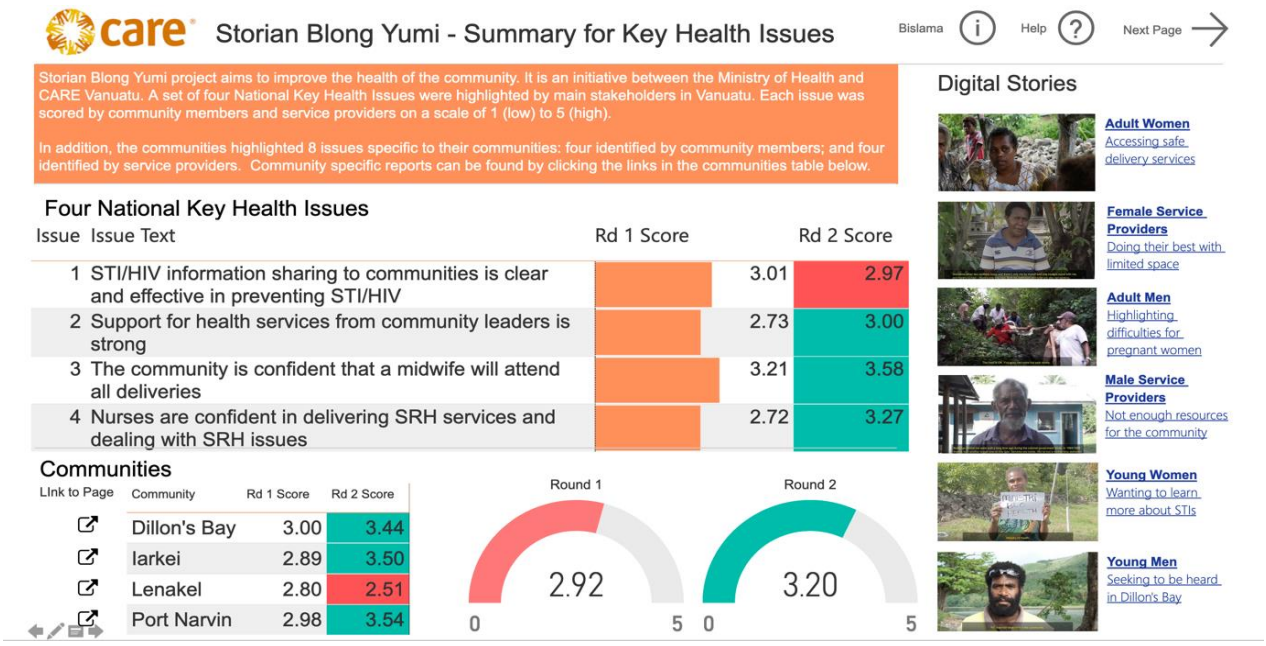
This is further discussed at 5.10.

5.9 The Minimum Viable Product

Led by LoveFrankie, the project has developed, for the first time, a 'digital scorecard' and dashboard product – a Minimum Viable Product (MVP).

The testing of the MVP took place in two phases. In April 2018, the MVP was used during the first phase of the CSC pilot to collect data from the communities and the results were shared with select stakeholders through the dashboard. In July 2018, Love Frankie together with DSIL, conducted a series of user centred workshops with CARE staff, key government officials, community members, and health service providers to review the MVP and gain feedback on how to improve the MVP. This was incorporated into the second iteration of the MVP.

The MVP has digitised the data collection and display elements of the CSC. The scoring component of the CSC process, normally done onto a paper form, is done directly by the scorer onto an Android smartphone or tablet using the *KoBo Collect* app, which CARE staff and partners were already familiar with. This data is then uploaded from the device via an internet connection to *KoboToolbox*. The data is then exported from there to a digital dashboard built on *PowerBI*, a Microsoft platform, the interface of which would be familiar to, and therefore readily navigable, by the many users familiar with the Microsoft suite of products. This dashboard consists of multiple screens or pages that display scorecard analytics and action plans for each community and can be viewed by anyone with an internet connection through a standard web-browser. The first of these screens, which also contains links to the digital stories produced by the project can be seen below.



This final dashboard MVP is viewed by national MoH stakeholders very positively. In particular,

respondents noted that the way in which data was presented was useful and attractive to engage with. However, MoH stakeholders noted the need for summary analysis of this data to be produced. Since the evaluation field-work was concluded, CARE's Governance Advisor to the project has produced detailed analyses on the scorecard data for each location as well as a comparative, cross location analysis. Some key insights provided in this analysis are:

- community groups from every pilot site prioritised issues related to community knowledge and access to information on SRH issues, demonstrating a particularly high appetite for more information

- most of the lowest average community and service provider scores were all given for non-standard issues. This seems to indicate that the standard issues (all based on the Ministry of Health's national strategy) do not capture many of the areas of most acute concern at the local level

- service providers may be underestimating the importance of privacy to service users. In the two locations where communities added an indicator relating to privacy, thereby indicating its importance, service providers tended to score much higher than communities

- In most communities, clear concerns surfaced around the level of information possessed by men and male youth, the degree to which they understand the SRH challenges women and female youth face, and how much youth (and particularly female youth) feel supported and provided with safe and comfortable environments for accessing information and services

- service providers appear to believe that communities have greater SRH awareness than communities themselves feel they do[6].

Further thought needs to be given to how the CSC data can be used as a complement to data that will be produced by DHIS2, the MoH HIS system that is currently being finalised. HIS staff do not appear to have been directly engaged in the CSC process.

In terms of replication of the MVP elsewhere, the approach to developing the MVP used existing, easily accessible software platforms rather than developing a custom solution. This not only minimised the additional build, maintenance and hosting costs but also means that barriers to uptake of the product by others are reduced. Kobo has the advantage of being used for data collection in the Pacific by a number of government departments, intergovernmental agencies and other NGOs including government departments in Fiji and PNG and by SPC, SPREP and Oxfam. As noted, PowerBI is a Microsoft product with a familiar interface, thus reducing risks associated with the onboarding and training costs of new adopting new technology.

5.10 Strategies for sustainable application

The sustainability of the CSC rests on two fundamental pillars, the buy-in and support of the service provider and the communities in which services are delivered.

The CSC model requires:

[6] Rebecca Hain, *Cross-community Analysis of Results from Whitesands/Larkei and Lenakel Hospital and surrounding communities, Tanna, and Dillon's Bay and Port Narvin, Erromango*, CARE Vanuatu.

- front-line MoH staff to participate in scoring, prioritisation and implementing action plans
- support from the provincial level staff who are directly responsible for the supervising health facility staff at the community level
- policy setting, direction and M&E support at the national level
- community level engagement in scoring and implementation of action plans.

Through the pilot, the support of front line and national level MoH staff have been maintained. While key members of the provincial department of public health viewed the approach positively, their ability to fully participate in the implementation of the approach has been constrained by workload. The project falls under the Public Health Manager who is responsible for seven public health coordinators who in turn manage SRH staff. Of the 11 government managed health facilities in Tafea, four are completely without staff. At the Lenakel hospital, only a couple of staff appear to have been active in activity implementation. This has been constrained by the clinical orientation and workload of staff at the tertiary hospital level, a lack of leadership and the absence of any suitable existing mechanism to co-ordinate implementation of action plans. It was noted by the Public Health Manager that greater attention needs to be given to engaging service providers before the implementation of the CSC to remind them of their roles and obligations as service providers to end "customers" and to demonstrate how the CSC helped them in this regard. This highlights the need to consider how the CSC links to specific requirements and standards of service providers set in the *Role Delineation Policy* finalised in 2018 and to frame a socialisation/communication strategy for service providers accordingly. An opportunity for communicating these would be during the phase 1 socialisation process.

At the community level, service providers have been directly engaged in the scorecard process. The action planning and monitoring processes have created an accountability relationship with the surrounding community that has facilitated and encouraged service providers to remain engaged. This is particularly the case in Port Narvin and Dillon's Bay, which are relatively small communities and thus in which service providers are constantly visible, more so than in Whitesands and Lenakel. However, it is important to note that health facility staff regard themselves as providers of clinical services, not preventive services. Health staff interviewed had not been trained in community engagement. Until this project, none of them had been undertaking community outreach and awareness-raising. All the facilities were short-staffed. For this reason, one of the service providers noted that he was dependent on the Health Committee (HC) to fulfil its role as mobiliser for community involvement in health. He didn't have the time to do this, his non SRH responsibilities, as well as undertake new SRH-related activities prompted by the CSC process.

The role of the Health Committee in mobilising the community, in facilitating the scorecard process and in co-ordinating action-planning needs to be explored and better integrated into the model. Interviews with the MoH indicated that while Health Committees may not have received sufficient attention given their legal mandate for community engagement within the health system, with only HCs at the aid post level receiving capacity development through the VHW in the past, they are now being re-emphasised. A strong engagement with Health Committees, could address key issues facing both service provider and community participation in the CSC. There are potential synergies here given the role of the Health Committee in facilitating community engagement, support to the service provider and monitoring of the health facility. The CSC could be used as the main tool to facilitate all of these functions of the Health Committee. The CSC process would provide an engagement and accountability framework and process that the HC model currently lacks. Training in CSC could serve as a platform to build community skills in community planning, engagement, activity co-ordination and monitoring. These are skills that are now required by the 'community driven development approach' being pursued by the *Ministry of Internal Affairs* (MoIA) pursuant to the *Decentralisation*

Act but which appear to be in short supply. This involves community representatives, including women, youth and disability representatives, in Area Council planning and monitoring mechanisms. So, there is the potential to reinvigorate Health Committees through the scorecard process and bring new members, particularly young people on board.

To do this, a package of capacity building of the Health Committee would need to be developed and one of the key constraints on HC functioning in Vanuatu, that of incentives, would need to be addressed. HCs are meant to be elected every two years but this hasn't happened in any community. This provides opportunity for new elections and new members to be brought on board. A range of different incentives could be trialled such as opportunities for certified training. Given the decentralisation mandates of both MoH and MoIA, there is scope to investigate a collaborative approach to this capacity development that would meet the needs of both agencies.

6 Conclusion

6.1 Results

The CSC approach, with its focus on service improvement and community empowerment, and demonstrated success in resource constrained settings offers a relevant model for supporting implementation of these health policy objectives.

In Vanuatu, the CSC model has demonstrated strongest results in:

- stimulating dialogue between service providers and communities
- opening up discussion within the community on SRH issues that have been neglected and avoided by both communities and service providers due to cultural taboos
- increasing awareness amongst all groups of the SRH services available within their local health facility.

In addition, the model has:

- enabled some community members, particularly young people, to feel comfortable about accessing SRH services
- prompted service providers to respond to voiced community needs, particularly in the area of service providers conducting community outreach and awareness raising activities on SRH
- appears to have led to increased uptake of family planning products

There are also some indications of effects beyond the community and the community level service provider interface:

- project may have influenced specific national level MoH actions such as the prioritisation of infrastructure support to three health facilities in Erromango at Port Narvin, Dillon's Bay and Ipota.

- the request by Port Narvin health staff for an autoclave led to a discussion at the national level about the kinds of equipment that should be available at the dispensary level. As the MoH was in the process of finalising its *Role Delineation Policy* at the time, this may have contributed to the inclusion of this equipment for Primary Health Care Facilities in the RDP.

It appears that the CSC process – by catalysing, facilitating and providing a structure for dialogue - has strengthened the relationship between the local service provider and the community. That seems to have been the foundation for increased access, and uptake of services. This means that a

CSC model based on direct community participation, such as that trialled here, rather than a CSC model implemented at a higher level, based on representative participation of community groups, is likely to be more effective.

These results are significant given:

- the complete novelty of social accountability to both communities and service providers
- the sensitivity of the topics tackled by the CSC
- a short, 12-month implementation period at the community level. Although this was an 18-month project, the first 5 months of the project were spent primarily on project start-up, partnership development and adaptation of the model. Adaptation included conducting an SRH context analysis, developing a CSC field manual for testing and a digital story telling strategy.

6.2 Recommendations

The piloting process has demonstrated that the model can produce good results. In order for scale-up, a number of factors would need to be addressed in order to strengthen effectiveness of the model and sustainability. The following recommendations are made:

- **extend the scorecard testing period** from two to four cycles to allow for embedding of the process and implementation of action plans

- **review and embed the Role Delineation Policy** requirements and service delivery standards within the socialisation and scorecard process. This may help to strengthen the accountability aspects of the CSC as it provides a strong platform for accountability and will ensure a better linkage to MoH system expectations for staff

- **strengthen the focus on and engagement with the Provincial level MoH** as the primary management unit for health service delivery. In particular, explore with the province how the benefits of the CSC model can be better communicated, or the model adapted, to support service delivery objectives and make clear linkages between the CSC, expected service delivery standards and how the CSC can add value to specific roles and responsibilities. There may be promising opportunities in using a digital CSC approach to address a key challenge for remote management, for example by identifying priority issues for support and action plans involving service provider

- **test the model at the aid post level**, through the Village Health Worker program. The aid post is the most numerous and accessible health facility for most people living in rural areas of Vanuatu and, although run by the MoH, is community-owned

- **in order to support sustainability, test the use of the health committee as the primary mechanism for co-ordinating implementation of the CSC.** The *Health Committee Act* 2003 requires the appointment of health committees for health centres, dispensaries and aid posts. The health committee is the existing, legally mandated mechanism for community engagement in primary health care. Interviews with the MoH indicated that while HCs had been neglected in the past, they are now being re-emphasised. The CSC process provides a simple, proven framework and process for both community engagement and accountability that the HC model currently lacks. There are clear synergies that warrant further development testing

- **focus on identifying and developing networks or coalitions of potential champions** for the CSC approach in each community. Develop a tailored engagement strategy to this end. In order to ensure that this is effective, use a simple, community-level 'power mapping' tool to identify key

actors, including chiefs, church leaders and women leaders, and any others previously trained by other projects, their level of influence and their interests/positions in relation to the CSC and the linkages/relationships between them

- **For the CSC process to better engage people living with a disability**, it's recommended that disability expertise be brought on board to review the CSC process, paying particular attention to access and usability aspects and to make recommendations for adaptation of the CSC to ensure a more disability-friendly process for Vanuatu

- **explore the potential for the CSC to support the decentralisation agendas of both the MoH and the provincial administration** by testing the tool to facilitate bottom-up planning processes required under area council planning.

7 Annex 1: Objectives of the Evaluation from Terms of Reference

The specific objectives are:

1. Assess whether the CSC model as adapted and piloted through the SBY project, offers a replicable model for community-centred accountability, which is appropriate to Vanuatu and potentially other Pacific contexts.

2. Assess the extent to which the pilot has demonstrated the potential for the model to contribute to:
   1) Greater shared understanding between communities and health sector stakeholders of community health concerns, in particular the needs of women, girls and people living with a disability;
   2) Increased engagement by communities in health and SRHR in particular, including identifying and implementing local solutions to health issues;
   3) Greater responsiveness and social accountability of the health system to community needs, especially the needs of women, girls and people with disability.

3. Assess and document the learning from the pilot and make recommendations about the design and roll out of the model, considering issues including, but not limited to:
   1) The suitability and effectiveness of the model in different contexts and conditions, considering geographic, social and institutional factors (e.g. comparing project sites, remote villages vs town-based hospital settings, level of health facilities, community settings and characteristics, staffing considerations etc);
   2) The extent to which the project's advocacy has leveraged both vertical (from community to national policy makers) and horizontal (between community and front-line service providers) influence and what advocacy strategies could maximize impact in future;
   3) Critical success factors and elements that have enhanced the effectiveness of the model and 'failures', pitfalls to be avoided in future, and elements which could be added or strengthened in future to increase effectiveness;
   4) The role and influence of digital story-telling in the CSC model and cost-effective options for the future;
   5) The extent to which Human Centred Design was used in the project and its contribution;
   6) The digitization of the CSC and the suitability of the digital components of the MVP for future use in Vanuatu or elsewhere;
   7) The potential for scale up of the model and what recommended strategies for application at a larger scale may be (including timing and phasing considerations), as well as recommendations about prioritization if the program continues to be delivered at a smaller scale;
   8) Strategies for sustainable application of the model in the future, including consideration of the role of Ministry of Health and other partners.

8 Annex 2: Vanuatu Evaluation Schedule: 26 February-12 March 2019

Sunday 24 February	**Consultant travels to Vanuatu**
Monday 25 February **AM** **PM**	**Port Vila** • National Reference Group Meeting • Planning meetings with evaluation team
Tues 26 February	**Travel day:** • Air from Port Vila to Tanna • Air from Tanna to Ipota on Erromango • boat from Cooks Bay to Port Narvin
Wed 27 February **AM** **PM**	**Erromango: Port Narvin** • Community Meeting to introduce the team and purpose of visit • FGD: older women • FGD: older men • Interview: Remy Nambil, Area Secretary • FGD: young women • FGD: young men
Thurs 28 February **AM** **PM**	**Erromango: Port Narvin** • Interview: Nancy Patrick – President of Erromango Women & Women's Representative to the Area Council • Interview: Community Leaders • FGD: Service Providers
Friday 1 Mar	Travel to Cooks Bay
Saturday 2 Mar **AM** **PM**	**Erromango: Dillon's Bay** • Travel Ipota to Dillon's Bay • Interview with Chief Jason Mete, paramount chief and Chairman of the Area Council
Sunday 3 Mar **PM**	**Erromango: Dillon's Bay** • FGD: young women • FGD: older men • FGD: older women
Monday 4 Mar **AM** **PM**	**Erromango: Dillon's Bay** • Interview: Kenia Tick, Administrator North and South Erromango • FGD: Service Providers • Interview: Nurse in charge of dispensary • FGD: Young men
Tuesday 5 Mar	• Dillon's Bay to Tanna • Team meetings at CARE office

Wednesday 6 Mar	**Tanna: Whitesands Health Centre & Iarkei**
AM	• Service Provider Interview: Nurse Practitioner in charge of Whitesands Health Centre • FGD: Older Women • FGD: Older Men
PM	• FDG: Young Men • FGD: Young Women
Thursday 7 March	**Tanna: Isini & Lenakel Hospital**
AM	• FGD: Older Women • FGD: Older Men • FGD: Young Women
PM	• FGD: Service Providers Lenakel Hospital
Friday 8 March	**Lenakel**
AM	• Interview - Simon Saika, Provincial Health Manager
PM	• Team Debrief • Interview with former Acting Secretary General TAFEA • **Travel to Port Vila** • Interview with Rebecca Hain, Governance Advisor, Care International
Saturday 9 Mar	
Sunday 10 Mar	
Monday 11 Mar	**Port Vila** Health Stakeholder Interviews with: • Nelly Ham, MoH • Dr Tsogzolmaa Bayandorj, WHO • John Jovi, MoH • Surenchimeg Vanchinkhuu, UNICEF
Tuesday 12 Mar	Health Stakeholder Interviews with: • Myriam Abel, MoH • Rachel Takoa & Michael Buttsworth, MoH • Carol Rovo, MoH • Ben Tabi, Manager Decentralisation, Department of Local Government, Ministry of Internal Affairs
Wednesday 13 March	
AM	• Consultant and Team debrief with Megan Chisholm and Sharon Alder, CARE Vanuatu CARE • Exit briefing with Megan Kybert, DFAT
PM	• **Consultant departs Vanuatu**

9 Annex 3: Focus Group Discussion & Interview Guides

Focus Group Discussion Guide – Service Users

Note to the FGD facilitator:

- **6-10 participants only.**
  - 'Young people' in separate group to 'adults'.
  - Females in separate group to males.
  - **Separate note taker** is required to document key points raised during the discussion.
- **Equipment:** Flip chart paper, markers and smiley-face cards to facilitate expression of negatives *(confirm)*
- **Timing:** up to 45 mins on topic 1, an hour on topic 2.
  - **Take a 10-minute break** half way after topic 1. Provide the participants with refreshments.

- **Purpose:** We want to understand the range of ideas / thoughts / beliefs / opinions that the participants have about **the topics** that will be discussed.
- **Important!! The questions in this guide are only a tool for exploring the topics. So, the questions listed are indicative only. Adapt them as you wish i**n order to facilitate understanding. The important thing is that we enable participants in the discussion to express their views on the topic.
- **Your role is to facilitate as natural a discussion as you can**, to stimulate the discussion, to **help each of the participants to express their views on the topics** and to keep the conversation flowing. You can do this by asking questions ("probes") such as *"why do you say that?" "anything else?" "tell me more."*
- So, **you need to create an environment in which the participants feel comfortable about having a conversation with you *and each other***. We want to hear from them, you should not be contributing your own ideas or seeking to influence what they say.
- Remember, *don't* try to lead the discussion, or teach or inform the participants, **help them to talk**.

Date: **Start/End Time (if available):**	**Location of FGD. Please list the names of the area/s where participants live:**
Focus group discussion facilitator:	
Note-taker:	
Translation used for interview: Yes No **If 'yes':** **Translation from** _____ (language) **to** _____ (language)	
Number of participants in this group (total):	
Gender of FGD participants:	
☐ Females, specify number: _____ ☐ <18 years, specify number: _____ ☐ 18-24 years, specify number: _____ ☐ 25-49 years, specify number: _____ ☐ 49+ years, specify number: _____	☐ Males (specify number) _____ ☐ <18 years, specify number: _____ ☐ 18-24 years, specify number: _____ ☐ 25-49 years, specify number: _____ ☐ 49+ years, specify number: _____

Session Introduction (for all topics)
Facilitator:

> *Hello, my name is xxxxx. I am conducting a study for CARE Vanuatu. We would like to understand the views of people in this community about the Storian Belong Yumi project. That is why we've invited you to participate in this group discussion. I will be conducting group discussions such as this one in other communities too. The information we collect will be analyzed together with information from those other communities. Your individual information will remain anonymous and confidential.*

Check that all the participants are happy to continue to participate. If any are not, answer any concerns that they may have and if they are still not happy, then let them leave the discussion.

Use an ice-breaker exercise to help start the discussion if necessary (recommended for groups of young people).

Ask each person in the group to introduce themselves, how old they are and where they are from. **Make a note of this information**.

Facilitator: *OK, today I'd like to talk with you about two topics* – **(1) Health and SRH issues in your community** *(2)* **Your involvement in Storian Belong Yumi project** *(adjust as necessary):*

Topic 1: General

1. Has everyone here been involved with the Storian Belong Yumi project?

2. How did you become involved with *Storian Belong Yumi project? (probes: asked to participate (by whom)? heard about it and asked someone to be involved)*

3. What activities were you involved with? How did you participate/What did you do?

4. Could you share any thoughts you have on these activities? (Explore positives and challenges).

Probes:

- What did you enjoy?
- Was there anything you found difficult about the process?
- Did you learn anything new? What?

5. What do you think you have gained from your involvement with the project?

Topic 2: SRH Services

1. What do you think are the main SRH challenges for people in this community?
2. What do you think the role of the health facility is in addressing these challenges?
3. Who else has a role to play in addressing SRH in the community? (If necessary, probe if they think they have a role)
4. What kinds of SRH services does the health facility provide? (list on flip chart)
5. Who has used the SRH services here? (hands up, note taker to note number)
6. Do you have any thoughts on these services? (question is directed to entire group, use smiley faces against listed items)
7. Have you seen any changes in these services since this project began?
    - What?
8. Do you have any thoughts on why these changes have happened?
9. What do you think, if any, are the benefits of the CSC process (record and rank on flip chart, probe reasons for ranking)?

***Storian Belong Yumi* end of project Evaluation – Vanuatu, February 2019**

Focus Group Discussion Guide – Service Providers

Note to the FGD facilitator:

- **6-10 participants only.**
  - Females in separate group to males.
  - **Separate note taker** is required to document key points raised during the discussion.
- **Equipment:** Flip chart paper, markers and smiley-face cards to facilitate expression of negatives *(confirm)*
- **Timing:** up to 45 mins on topic 1, an hour on topic 2.
  - **Take a 10-minute break** half way after topic 1. Provide the participants with refreshments.

- **Purpose:** We want to understand the range of ideas / thoughts / beliefs / opinions that the participants have about **the topics** that will be discussed.
- **Important!! The questions in this guide are only a tool for exploring the topics. So, the questions listed are indicative only. Adapt them as you wish i**n order to facilitate understanding. The important thing is that we enable participants in the discussion to express their views on the topic.
- **Your role is to facilitate as natural a discussion as you can**, to stimulate the discussion, to **help each of the participants to express their views on the topics** and to keep the conversation flowing. You can do this by asking questions ("probes") such as *"why do you say that?" "anything else?" "tell me more."*
- So, **you need to create an environment in which the participants feel comfortable about having a conversation with you *and each other***. We want to hear from them, you should not be contributing your own ideas or seeking to influence what they say.
- Remember, *don't* try to lead the discussion, or teach or inform the participants, **help them to talk**.

Date: **Start/End Time (if available):**	**Location of FGD. Please list the names of the area/s where participants live:**
Focus group discussion facilitator:	
Note-taker:	
Translation used for interview: Yes No **If 'yes':** **Translation from** _____ (language) **to** _____ (language)	
Number of participants in this group (total):	

Gender of FGD participants:	
☐ Females, specify number: _____	☐ Males (specify number) _____
☐ <18 years, specify number: _____ ☐ 18-24 years, specify number: _____ ☐ 25-49 years, specify number: _____ ☐ 49+ years, specify number: _____	☐ <18 years, specify number: _____ ☐ 18-24 years, specify number: _____ ☐ 25-49 years, specify number: _____ ☐ 49+ years, specify number: _____

Session Introduction (for all topics)
Facilitator:

> *Hello, my name is xxxxx. I am conducting a study for CARE Vanuatu. We would like to understand the views of people in this community about the Storian Belong Yumi project. That is why we've invited you to participate in this group discussion. I will be conducting group discussions such as this one in other communities too. The information we collect will be analyzed together with information from those other communities. Your individual information will remain anonymous and confidential.*

Check that all the participants are happy to continue to participate. If any are not, answer any concerns that they may have and if they are still not happy, then let them leave the discussion.

Use an ice-breaker exercise to help start the discussion if necessary (recommended for groups of young people).

Ask each person in the group to introduce themselves, how old they are and where they are from. **Make a note of this information**.

Facilitator: *OK, today I'd like to talk with you about 2 topics (adjust as necessary):*

1. *Your thoughts about SRH services in this community.*
2. *Your thoughts about the Storian Belong Yumi project.*

Topic 1: SRH Services

10. What do you think are the main SRH challenges for people in this community?
11. Who do you think has responsibility for addressing these challenges?
12. What do you think the role of the health facility is in addressing these challenges?
13. What kinds of SRH services does the health facility provide? (list on flip chart)
14. Who in this group is involved in SRH service delivery?
15. How? What do you do? (list)
16. What do you enjoy about what you do?
17. What challenges do you face in delivering services? (*probe: training, equipment, support from community/leaders/management, supervision etc)*

Topic 2: The Project

1. Has everyone here been involved with the Storian Belong Yumi project?

2. How did you become involved with *Storian Belong Yumi project? (probes: asked to participate (by whom)? heard about it and asked someone to be involved)*

3. What activities were you involved with? How did you participate/What did you do?

4. Could you share any thoughts you have on these activities? (Explore positives and challenges).

Probes:

- What did you enjoy?
- Was there anything you found difficult about the process? What?
- Did you learn anything new? What?

5. Have you changed anything in the way you work with the community your work? How?

6. What do you think the benefits are of implementing the CSC (scoring and action planning (record and rank on flip chart, probe reasons for ranking)?

7. What do you think the challenges are of implementing the CSC (scoring and action planning)? record and rank on flip chart, probe reasons for ranking)

***Storian Belong Yumi* end of project Evaluation – Vanuatu, February 2019**

Focus Group Discussion Guide – Community Leaders
(if less than 6 available, conduct as a group interview, using questions only)

Note to the FGD facilitator:

- **6-10 participants only.**
  - 'Young people' in separate group to 'adults'.
  - Females in separate group to males.
  - **Separate note taker** is required to document key points raised during the discussion.
- **Equipment:** Flip chart paper, markers and smiley-face cards to facilitate expression of negatives *(confirm)*
- **Timing:** up to 45 mins on topic 1, an hour on topic 2.
  - **Take a 10-minute break** half way after topic 1. Provide the participants with refreshments.

- **Purpose:** We want to understand the range of ideas / thoughts / beliefs / opinions that the participants have about **the topics** that will be discussed.
- **Important!! The questions in this guide are only a tool for exploring the topics. So, the questions listed are indicative only. Adapt them as you wish i**n order to facilitate understanding. The important thing is that we enable participants in the discussion to express their views on the topic.
- **Your role is to facilitate as natural a discussion as you can**, to stimulate the discussion, to **help each of the participants to express their views on the topics** and to keep the conversation flowing. You can do this by asking questions ("probes") such as *"why do you say that?" "anything else?" "tell me more."*
- So, **you need to create an environment in which the participants feel comfortable about having a conversation with you *and each other***. We want to hear from them, you should not be contributing your own ideas or seeking to influence what they say.
- Remember, *don't* try to lead the discussion, or teach or inform the participants, **help them to talk**.

Date: **Start/End Time (if available):**	**Names, roles, locations of participants.** Please list the names, leadership roles and area where the participant exercises this role.
Focus group discussion facilitator:	
Note-taker:	
Translation used for interview: Yes No **If 'yes':** **Translation from** _____ (language) **to** _____ (language)	
Number of participants in this group (total):	
Gender of FGD participants:	
☐ Females, specify number: _____ ☐ <18 years, specify number: _____ ☐ 18-24 years, specify number: _____	☐ Males (specify number) _____ ☐ <18 years, specify number: _____ ☐ 18-24 years, specify number: _____

☐ 25-49 years, specify number: _____ ☐ 49+ years, specify number: _____	☐ 25-49 years, specify number: _____ ☐ 49+ years, specify number: _____

Session Introduction (for all topics)
Facilitator:

> *Hello, my name is xxxxx. I am conducting a study for CARE Vanuatu. We would like to understand the views of people in this community about the Storian Belong Yumi project. That is why we've invited you to participate in this group discussion. I will be conducting group discussions such as this one in other communities too. The information we collect will be analyzed together with information from those other communities. Your individual information will remain anonymous and confidential.*

Check that all the participants are happy to continue to participate. If any are not, answer any concerns that they may have and if they are still not happy, then let them leave the discussion.

Use an ice-breaker exercise to help start the discussion if necessary (recommended for groups of young people).

Ask each person in the group to introduce themselves, how old they are and where they are from. **Make a note of this information**.

Facilitator: *OK, today I'd like to talk with you about two topics* – **(1) Health and SRH issues in your community** *(2)* **Your involvement in Storian Belong Yumi project** *(adjust as necessary):*

Topic 1: Your involvement in Storian Belong Yumi project

7. Has everyone here been involved with the Storian Belong Yumi project?

8. How did you become involved with *Storian Belong Yumi project? (probes: asked to participate (by whom)? heard about it and asked someone to be involved)*

9. What activities were you involved with? How did you participate/What did you do?

10. Could you share any thoughts you have on these activities? (Explore positives and challenges).

Probes:
- What did you enjoy?
- Was there anything you found difficult about the process?
- Did you learn anything new? What?

11. What do you think you have gained from your involvement with the project?

Topic 2: Community Health & SRH Services

18. What do you think are the main health challenges for people in this community? (List. If SRH is not mentioned explore why?)
19. What are the main health programs/activities being implemented in this community?
20. What do you think are the main SRH challenges for people in this community? (List)
21. What do you think the role of the health facility is in addressing these challenges?
22. Who else has a role to play in addressing SRH in the community? (If necessary, probe if they think they have a role)
23. What kinds of SRH services does the health facility provide? (list on flip chart)
24. Who has used the SRH services here? (hands up, note taker to note number)
25. Do you have any thoughts on these services? (question is directed to entire group, use smiley faces against listed items)
26. Have you seen any changes in these services since this project began?
    - What?
27. Do you have any thoughts on why these changes have happened?
28. What do you think, if any, are the benefits of the CSC process (record and rank on flip chart, probe reasons for ranking)?

***Storian Belong Yumi* end of project Evaluation – Vanuatu, February 2019**

Semi-Structured Interview Guide

For Service Decision Makers, Managers/Supervisors, including from key health partners.

Date: _____

Interviewer: _____

Note-taker: _____

Location: _____

Facility/Department_____

Position: _____

The purpose of the interview is to **explore the topic**. Questions are indicative only and can be adapted to suit the interviewee and facilitate the flow of the interview.

Topic 1 - General SRH: explore:

- What in your view are the main SRH challenges facing community/province/nation (*Ask for prioritisation and reasons why?)*
- What SRH-related services (direct or indirect) are provided by your facility/team?
- What's your specific role in this?
- *Explore reporting role and decision-making roles in the structure.*
- *Explore timing of and involvement in planning and budgeting process.*
- *Explore information and data collection requirements.*
- What in your view are the main challenges faced in providing SRH services at the community level (*Ask for prioritisation and reasons why?)*

Topic 2: The *Storian Belong Yumi* model

- What has your involvement been in the CSC process?
- Could you share any reflections/thoughts on the process?
- What do you see to be the main benefits of the CSC model?
- What do you see to be the challenges?
- Have you observed any changes in either the provision or demand for services over the last year? What? *Explore reasons behind this.*

Topic 3: Replication / scale up

- Do you know of any examples where a new approach or model for health service delivery at the community level has been piloted/tested in the health system and it has shown promising results? If yes, what is the model? What were the promising results?

- Do you know if any of these approaches/models have been adopted by the health system and replicated or scaled-up? Which one(s)? *Explore reasons behind this happening / reasons why it hasn't happened.*

- Do you see any benefits from using the *Storian Belong Yumi* CSC model elsewhere? What benefits? *Explore reasons behind this thinking.*

- Do you see any potential for integrating the CSC model, or components of it, into existing health initiatives at the community level? If yes, which existing initiatives and what components of the CSC model?

- What do you think would need to happen to support replication/scale up of the model? (explore what decisions would need to be made /who would make decisions)

- What challenges to do you see for replication/scale up?

- Do you have any advice to give to CARE as it considers replication/scaling up?