



Franco-Australian Pacific Regional HIV/AIDS and STI Initiative

Behaviour Change Communication

Training Needs Assessment Report

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Robyn Drysdale
SPC Behaviour Change Communication Specialist

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Abbreviations

BCC	Behaviour change communication
BCI	Behaviour change intervention
CBO	Community-based organisation
CSO	Civil society organisations
IEC	Information, education and communication
FBO	Faith-based organisation
FSP	Foundation of the South Pacific
KAP	Knowledge, attitudes, practice
MoH	Ministry of Health
NAC	National AIDS Council
NGO	Non-government organisation
PICTs	Pacific Island Countries and Territories
PRHP	Pacific Regional HIV/AIDS Project
SPC	Secretariat of the Pacific Community
TNA	Training needs assessment

1. INTRODUCTION

A role of the Pacific Regional HIV/AIDS and STI Initiative within the Secretariat of the Pacific Community (SPC) will be to assist Pacific Island Countries and Territories (PICTs) to strengthen their health promotion responses to HIV/AIDS & STI and to strengthen behaviour change initiatives that target risk behaviours.

The design document for the Pacific Regional HIV/AIDS Project (PRHP) identified the role of the project in the development of regional behaviour change communication materials and methodologies¹. A key task is to identify regional training needs in behaviour change communication (BCC) and conduct training for Pacific Island Countries' government and civil society partners. In order to do so training needs analysis has been undertaken. This needs analysis precedes the development and evaluation of behaviour change strategies and materials and the provision of training in BCC methods.

An analysis of training needs in behaviour change communication among government and civil society organizations (CSOs) involved in HIV prevention programs was undertaken to assess the current level of knowledge and skills on BCC in the region, to provide an overview of the guide the development of a training program in BCC. The training needs analysis also provides data on other training / capacity development needs (outside of BCC) for the Pacific Regional HIV/AIDS Initiative and other technical and regional agencies.

1.1 The importance of Behavioural Change

The centrality of behaviour change in combating HIV has been recognized since the beginning of the epidemic². One of the main goals of HIV prevention has been to promote behaviour change from high risk to low risk sexual activities – for example, having fewer sexual partners, or using condoms during every act of sexual intercourse.

Behaviour change is therefore central to most effective responses to the HIV epidemic. It can be important to:

- Reduce further transmission of HIV
- Reduce discrimination against the people most directly affected by HIV/AIDS (those infected and affected)
- Mobilise community-wide responses including political support
- Build consensus about legal, ethical and human rights concerns
- Minimise harm associated with drug use and expansion of the sex industry
- Organise community-based care for those who are ill, their dependents and the survivors of those who die.

Early approaches to behaviour change assumed that all that people need to know about HIV, how it was spread and what the results and impact of infection were, and they would take concrete steps to change their behaviour. This approach helped raise awareness but was insufficient to promote or sustain behaviour change. Clearly, the prevention of HIV infection is about developing a range of strategies and interventions that support behaviour change.

¹ pg. 43, Pacific Regional HIV/AIDS and STI Project, Project Design Document ,2003

² UNAIDS. Communications programming for HIV/AIDS: An annotated bibliography, 1999a. UNAIDS. Summary Booklet of Best Practices. Geneva, Switzerland, Joint United Nations Programme on HIV/AIDS, 1999b

It has become clear that effective HIV risk reduction interventions extend beyond basic information giving and help: sensitise people to personal risk, improve couples sexual communication, increase individual's condom use skills, the perception of lower risk practices as an accepted social norm, and help people receive support and reinforcement for their efforts at changing³.

1.2 Definitions

Behaviour change intervention (BCI): A combination of activities/ interventions tailored to the needs of a specific group and developed with that group to help reduce risk behaviours and vulnerability to HIV by creating an enabling environment for individual and collective change.

Behaviour change communication (BCC): An interactive process with communities (as integrated with an overall program) to develop tailored messages and approaches using a variety of education and communication channels to develop positive behaviours; promote and sustain individual, community and societal behaviour change; and maintain appropriate behaviours. BCC should encourage individual behaviour change and also help create environmental conditions that facilitate personal risk reduction.

In the context of the HIV/AIDS epidemic, BCC is an essential part of a comprehensive program that includes both services (medical, social, psychological and spiritual) and commodities (e.g. condoms, needles and syringes). Before individuals and communities can reduce their level of risk or change their behaviours, they must first understand basic facts about HIV and AIDS, adopt key attitudes, learn a set of skills and be given access to appropriate products and services. They must also perceive their environment as supporting behaviour change and the maintenance of safe behaviours, as well as supportive of seeking appropriate treatment for prevention, care and support.

In most parts of the world, HIV is primarily a sexually transmitted infection (STI) and this is certainly the case in the Pacific region. National and community-wide discussion of relationships, sex and sexuality, risk, risk settings, risk behaviours and cultural practices that may increase the likelihood of HIV transmission are necessary if an environment that supports effective prevention efforts is to be developed. A supportive environment is also one that deals, at the national and community levels, with stigma, fear and discrimination, as well as with policy and law.

The HIV/AIDS epidemic forces societies to confront cultural ideals and practices that can contribute to HIV transmission. Effective BCC is vital to setting the tone for compassionate and responsible interventions. It can also produce insight into the broader socio-economic impacts of the epidemic and mobilise the political, social and economic responses needed to mount an effective program.

³ UNAIDS. Sexual behavioural change for HIV: Where have theories taken us? 1999.

1.3 Methodology

Undertaking the BCC training needs analysis involved a number of steps including:

- Review of Pacific Island Countries' National HIV Situation Analyses and rapid in-country assessments conducted by the HIV/AIDS & STI Advisor and also the Suva-based PRHP team
- Review of documentation of existing projects/activities/responses to HIV in Pacific Island Countries (including review of AIDSTOK archives)
- Development of key questions for the data collection and implementation of a Training Needs Assessment (TNA) questionnaire (*appendix 1: TNA Questionnaire*). The TNA questionnaire was also sent out to key contacts and also incorporated into the Information, Education and Communication (IEC) review (survey and focus groups) which is also being undertaken by the HIV/AIDS project.
- Participation in the regional meeting sponsored by UNAIDS and Fiji Great Council of Chiefs held in March at Vuda, Fiji (representatives from 14 PICTs attended). Needs assessments in BCC commenced with some workshop participants using the TNA questionnaire and informal interviews
- Email discussion with Pacific Island experts working in response to HIV, particularly in the area of education and prevention
- Consultative missions were undertaken to Fiji, Vanuatu, Solomon Islands, Kiribati and Samoa over the period late April to early July. Missions to countries yielded useful information regarding BCC training needs (as well IEC) through meetings and contact with key stakeholders/ educators and agencies (both government and civil society). (*Appendix 2: list of focus groups, interviews and meetings*)
- Meetings with regional stakeholders based in Fiji, for example representatives from UN agencies, Red Cross, Maire Stopes International Fiji, AIDS Task Force of Fiji
- Participation in the Regional Strategy reference group meetings
- Draft findings of the Training Needs Assessment were presented to the first PRHP Orientation workshop for National AIDS Councils (or equivalent) in order to obtain feedback on the draft TNA report document
- Review of material presented by national HIV/AIDS program managers at WHO Western Pacific Region Program Managers Meeting of the Pacific Island Countries Nadi, Fiji, August 2004

Key stakeholders and agencies were targeted for data collection (through survey and focus groups/ interviews) including:

- HIV/AIDS program managers
- Staff members of implementing agencies
- Staff with a "hands on" role in implementing HIV/AIDS & STI strategies
- Peer educators, outreach workers, counsellors and community workers whose primary responsibility is communicating with target populations.

2. FINDINGS

2.1 Experience in HIV/AIDS & STI education and prevention activities

All countries in the region embarked on awareness and education on HIV/AIDS and STIs as the main strategy in response to the threat of the HIV/AIDS epidemic⁴. Raising awareness of the virus, risks and impact is the key feature of most prevention efforts in the Pacific. Some countries describe their commitment to tackle HIV/AIDS *“by conducting awareness programmes”* MoH worker, Cook Islands. In some instances this wholly describes their approach to prevention, for example a stated goal of the Nuie National Program on HIV/AIDS/STI is *“to increase and strengthen the awareness programs”*, National Strategic Plan for HIV/AIDS. This indicates a commonly held belief that greater awareness will lead to people reducing their risk or changing their behaviour. This raises concerns about the limitations of a solely awareness-raising approach with a lack of consideration or understanding of the necessary factors for facilitating behavioural change.

Participants in the training needs assessment were asked about their experience in education and prevention activities. They described a range of levels of experience in designing, implementing and evaluating HIV/AIDS & STI education and prevention activities, with strong evidence of a predominant focus on implementation.

Designing activities

Seventy-six percent of study participants stated that they had experience in designing HIV/AIDS & STI education and prevention activities:

“Have designed education programs for women’s group, for health workers, and provincial HIV/STI coordinators. Implementing through provincial coordinators” HIV/AIDS program, MoH, Solomon Is.

“Designing program activities for youth outreach activities to the provinces” CBO worker, Solomon Is.

Implementing activities

This was the area where the majority of participants in the study had the most experience and expressed most confidence. Ninety percent of participants indicated that they had experience in implementing HIV/AIDS & STI education and prevention activities. Workshops and information sessions were the most common activities implemented.

A number of the program/activity implementers also acknowledged that they had experience in the area of implementation only- *“I have experience for HIV/AIDS programs but I have little knowledge and skill for designing”* CBO Youth Coordinator, Samoa.

Evaluating activities

Evaluation is an area where many study participants expressed a need for skills. Many workers described the lack of monitoring and evaluation within their settings. This was consistent across both government agencies and community-based organisations:

“No formalised systems for feedback/ evaluation are in place” NGO worker, Vanuatu

“There is no evaluation of the effectiveness of STI/HIV/AIDS education materials” MoH, Palau.

⁴ Dennie Iniakwala, Situational and response analyses report for HIV/AIDS & STI, March 2004, SPC Training Needs Assessment Report

Only 52% of participants stated that they had experience in evaluating HIV/AIDS & STI education and prevention activities. When asked to describe their experience, it became clear that this experience is mostly limited to short term evaluation of workshops, as described by a HIV program worker, Vanuatu MoH *“evaluation is only at each workshop”*.

There is evidence of a degree of process evaluation being undertaken for programs/ activities such as peer education and outreach activities but little in other IEC programs: *“Evaluation of community workshops and using the feedback to modify the material”* NGO worker, Vanuatu. Where monitoring and evaluation does take place, it is often at a very basic level - one worker described the evaluation of peer education strategies as *“peers fill in forms; peer educators assess the forms to check that they are reaching both males and females in the target group”* NGO worker, Vanuatu.

Many participants identified that although they had been implementing a number of IEC activities, they were uncertain what impact - if any – these were having. As described by a FBO worker in Fiji, *“we need to know whether the message is received or not”*. There are few feedback and evaluation systems in place. There was recognition by many participants of the difficulty of assessing impact and also an impression that this evaluation, particularly in terms of impact on behaviour was in the ‘too hard basket’. One focus group participant explained their difficulty in assessing behavioural change *“this cannot be specifically measured as there are different types of IEC materials and as to which materials changes behaviour...?”* NGO worker, Fiji.

When asked if there was any indication of change in behaviour from the target audience as a result of receiving the information disseminated, many participants were unable to answer this question or mentioned increases in knowledge (although not how they had measured this) - *“their knowledge has been greatly increased”* MoH worker, Fiji. Therefore, many participants were anecdotally reporting an improvement in knowledge, but not actually trying to measure anything. Sometimes following implementation of awareness-raising, there was evidence of an increase in HIV testing for a time. For example, in the period following the Youth Summit in Vanuatu, the KPH clinic (located at Wan Smolbag) saw an increase of young people seeking HIV tests. Where achieved, these increases do not appear to have been sustained, however.

There is a strong need throughout the region for specific skills in monitoring and evaluation and particularly how to incorporate these areas into program/ project design.

RANGE OF ACTIVITIES

There are currently a range of education and prevention activities being implemented in the region. For example, the situational analysis report of the Cook Islands notes that prevention efforts have consisted of *“a variety of community health education and awareness-raising programmes targeting all age groups at all levels within the community”* MoH, Cook Islands.

The types of activities being implemented as indicated by survey respondents:

- 71% Information, Education & Communication (IEC) programs
- 66% Peer education strategies
- 43% Strategic planning and policy development
- 42% Providing counselling services
- 33% Research activities

It is clear that many NGOs are working across diverse areas of HIV/AIDS. In detailing their experience many staff mentioned prevention, treatment, support as well as involvement in the country's NAC (or equivalent): *"We started a peer education program; are involved in the development of the HIV/AIDS Strategic Plan; attend STI clients and provide treatment and counselling for them"* Executive Director of a CBO, Tonga.

Although there is much evidence of a range of activities and programs being implemented in the region, there was a strong acknowledgement from study participants (and this is supported by country situational analyses) of their limitations and that much more needs to be done: *"Prevention and educational programs are highly limited"* Youth program worker, Marshall Islands; *"Implementation of programs and IEC materials is seriously needed"* CBO worker, Kiribati.

A lack of skills or capacity, limited resources, and a lack of collaboration and coordination were cited as key obstacles to expanding the implementation of activities and programs.

Peer education strategies

Peer education and youth outreach programs are a feature of the education and prevention activities implemented by NGOs. These strategies are implemented in a range of settings in/out of school and have the scope of specific HIV awareness training to inclusion within broader programs such as Life Skills training:

"We implement 3 day community workshops on ARH, including HIV/AIDS awareness; HIV/AIDS awareness for Grade 6 students, out of school youth and church group youth." NGO worker, Vanuatu

"We conduct skills & knowledge training on HIV/AIDS & STIs for young people" CBO worker, Solomon Islands

In particular, using peer educators has been very effective in some countries. The youth-to-youth program in Marshall Islands has been very successful in reaching the hard to reach young people. A recent review of vulnerable groups in the region⁵, noted that the youth sector has been one of the most active in the HIV response regionally. Many of these activities are part of initiatives such as: UNICEF's Pacific Life Skills program; Adolescent Reproductive Health program (UNFPA/SPC); ATFF's regional peer education training; and Red Cross Societies' peer education and community theatre programs (particularly Fiji, Cook Islands, Kiribati & FSM).

The awareness-raising, peer education and activities of a number of a number of national youth congresses (e.g. Tonga NYC), church youth organisations (e.g. Sautiamai in Samoa) and local NGOs (eg. Wan Smolbag in Vanuatu) also significantly contribute to HIV/AIDS and STI education and prevention activities being undertaken in the region.

Information, education & communication (IEC) programs

One of the most widespread approaches to behaviour change used in the battle against HIV/AIDS has been information, education and communication (IEC) campaigns focused on raising awareness about the virus and avoiding behaviours associated with increased risk. IEC programs have been a focus of prevention initiatives in the Pacific - *"we are implementing IEC to all groups we target"* CBO worker, Samoa.

IEC is commonly seen in the Pacific as *"providing information and communication materials to raise awareness"* MoH worker, Solomon Is. There is also great deal of awareness-raising activities being implemented within communities. These are commonly

⁵ Cathy Vaughan, Youth, Gender and Vulnerable Groups Strategy, 2004 PRHP, Suva Office Training Needs Assessment Report

implemented through schools, church groups and community workshops: *“Awareness-raising in schools; teachers and schools trained”* MoH worker, Cook Islands.

Many of these activities are of a fairly short duration and have similar content, as described by a HIV program worker, Vanuatu *“mainly 1-2 hr information sessions on HIV/AIDS including, what is HIV/AIDS, transmission, risks, prevention of STI & HIV (with condom demonstration)”*.

Most countries produce and distribute some forms of print-based IEC materials - *“We produce IEC including pamphlets. Also translate IEC materials from other organisations”* NGO worker, Vanuatu. In viewing the range (often fairly limited) of print-based IEC materials available, there were a number of instances of outdated and even inaccurate information in these materials⁶.

Video material is another popular medium for IEC, with quality education materials being produced by organisations such as Wan Smolbag in Vanuatu and Nei Tabera Ni Kai Video Resource unit, Kiribati. Drama, theatre and puppetry are also popular and culturally appropriate mediums used in many countries (particularly Fiji, Tonga, Vanuatu, Samoa, Kiribati).

Mass media is also used for communication and awareness-raising for a few Pacific Island countries - *“Utilisation of the media services such as radio, television and the newspaper”* MoH, Cook Is. *“Radio and TV spots used for education and prevention”* MoH staff, Fiji. In some instances the use of mass media is a key component of responses, particularly for NGOs. Successful ongoing examples include: Radio dramas such as Famili Blong Serah (Wan Smolbag, Vanuatu); and Weekly radio programs eg. Solomon Islands Planned Parenthood, Radio Kiribati ARH program (KIFHA).

Apart from these ongoing programs, in many instances within the Pacific these mass media strategies feature around specific events or times of the year, with World AIDS day being a common time for focused activities- *“TV and radio spots around world AIDS day”* MoH worker, Samoa. This appears to be largely dependant on funding with many participants expressing that this is an expensive medium, particularly the CBOs. Mass media is an important but currently under-utilised medium. There is also a need for it to be utilised regularly, not just once a year, as HIV/AIDS is an issue for the whole community, year round.

Research

Few research activities were described by study participants, but there was some evidence of varying forms of needs assessments being undertaken prior to activity/ program design - *“We do a survey then implement activities to meet the problems seen in the survey”* CBO worker, Tuvalu.

Research was at times directed at appropriate materials for use or adaptation within the local context - *“We research different materials/ sources for development of IEC”* CBO worker, Solomon Islands. When describing their sources for information (particularly for brochures/ pamphlets), many workers described downloading information from a range of internet sites and essentially ‘cutting & pasting’ into fact sheets.

There are instances of small scale research activities being done; particularly by NGOs e.g. knowledge, attitudes, practice (KAP) surveys, and condom use surveys, both implemented by Foundation of the South Pacific (FSP) in Vanuatu. Overall, few organizations dedicate staff time and resources to research.

⁶ more detail and data available in the Review of HIV/AIDS & STI materials report
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2.2 Experience in Behaviour Change Communication (BCC) activities

Overall, few participants in the study acknowledged experience in behaviour change communication (BCC). Many respondents to the survey and participants in the focus groups/ interviews indicated they did not have experience in BCC but a number were however aware of BCC approaches and theory. The HIV Program Manager in Kiribati described his experience of BCC as *“only through reading and just enough to know how important it is”*. Others expressed some generalized understanding - *“I have some knowledge in behaviour change approaches in general but not specific to HIV”* CBO worker, Fiji.

Study participants were asked to describe their experience (if any) in BCC. For those who had some level of experience the following were indicated:

- 32% Designing BCC activities
- 43% Implementing BCC activities
- 24% Evaluating BCC activities

Although some participants indicated a level of experience with BCC activities, particularly in implementation, their actual description of these would indicate that they did not in fact have a clear understanding of BCC activities. In describing the implementation, a CBO worker in Fiji stated *“this was basically the IEC materials”*, whilst BCC activities conducted by a FBO in PNG involved *“workshops with youth and other groups, women”*. In Tuvalu *“we do advocacy workshops with the community & see what the barriers are”* CBO worker.

Evidence from descriptions of activities which participants described under ‘behaviour change strategies’ indicates that these would be more accurately classified as awareness-raising activities.

Facilitating behaviour change

When asked about whether they felt confident in their knowledge/ understanding of approaches, strategies and activities that best help facilitate behaviour change, 47% of survey respondents indicated that they felt confident; 37% were unsure and 16% did not feel confident.

Although 47% of survey respondents indicated they had this knowledge, on further description or discussion it became clear that this understanding was based on a very simplistic framework for thinking about behaviour change i.e. based on the assumption that once a program ‘intervenes’ directly with an individual who has been practicing unsafe behaviour, that individual will then move to practice only safe behaviour - *“the training workshops are for behaviour change for our target groups”* FBO worker, PNG.

There was considerable evidence that most participants did not have a clear understanding of BCC activities or what was required to facilitate behaviour change. There was a general lack of certainty about what best facilitates sustainable behavioural change i.e. stages of change, an enabling environment etc., which was clearly evidenced in the focus groups and individual interviews.

Ability to implement behaviour change interventions

When asked about their ability to implement behaviour change interventions (BCI) 53% of survey respondents indicated they felt confident; 37% were unsure and 10% did not feel confident in their ability. Although over half of the survey respondents said they were able to implement BCI, as mentioned above there was much evidence to suggest that these 'interventions' are based on very simplistic notions of changing people's behaviour.

It was widely acknowledged that it is important to implement programs that encourage and support behavioural change (in fact this was the goal of many activities/ programs). This being the case, however, there is little evidence of a thorough understanding of the kinds of programs that best facilitate behaviour change and in particular what is needed for individuals and communities to change their behaviours (or reduce their risk).

A number of participants drew attention to some of the obstacles in implementing BCI within their communities - *"Religious beliefs & taboos are obstacles to implementing"* CBO worker, Vanuatu; *"I usually get allotted 1-2 hours for sessions which is not adequate time to implement high quality behaviour change training"* MoH worker, Vanuatu.

Few National Strategic Plans for HIV/AIDS mention behaviour change strategies (only Kiribati, Palau, Samoa and Solomon Islands), and where they are mentioned, it is not clear how implementation will be achieved. There is little evidence to suggest BCI are being implemented within countries.

The needs assessment provides evidence of low levels of knowledge and understanding of BCC as well as lack of skills for implementation of BCI within the Pacific. This was reinforced at a recent training workshop for National AIDS Councils/ Capacity Developing Organisations⁷ at which of 8 Pacific Island Countries were represented. Following the presentation of the training needs assessment data, participants confirmed the accuracy of the 'picture' for their own countries and the region:

"We need to urgently make the shift toward a BCC approach to our work, rather than just 'awareness raising' as knowledge alone does not change behaviour" NAC representative, Tonga.

⁷ Orientation Workshop for NACs & CDOs 2-11 August, 2004 (PRHP – Suva based team)
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2.3 Training needs for behaviour change communication in HIV/AIDS & STIs

“We really need to accelerate our activities because the virus is spreading fast.....we are way behind” FBO worker, PNG

Changing behaviour to reduce risk or minimize infection is emerging as a key element of prevention goals in the Pacific. Many participants in the study identified behaviour change as a goal of activities and this is also reflected in country strategic plans, for example *“Changing behaviors to promote responsible sexual expression”* is identified by MoH, Palau as one of the top 5 priorities for the country. The Kiribati National Plan names *“Appropriate Behaviour Change Communications”* as an objective. In order to fulfill these priorities and objectives it will be necessary to significantly increase knowledge and skill levels in BCC across the region.

All participants in the survey and focus groups/ interviews expressed strong interest in attending training on behaviour change communication in HIV/AIDS & STI. This reflects both a desire to scale up behavioural prevention and harm reduction, a need for improved understanding on facilitating behavioural change and also the enormous need in the region for training generally.

Particular topics or issues for inclusion in BCC training workshops nominated by participants:

- 89% evaluating activities or strategies
- 84% creating enabling environments
- 79% capacity development for behaviour change
- 73% stages of behaviour change
- 68% designing strategies/ activities

Other additional areas nominated by study participants:

- Developing a BCC strategy
- Training others in BCC
- Modifying BC approaches to suit target group
- Culturally effective BC models

Evidence from the study data would suggest that all areas of behaviour change need to be addressed as current levels of knowledge/understanding and skills for implementation are very low.

OTHER TRAINING NEEDS

There is a huge need for education and training generally and particularly to update workers' knowledge and skills - *“The problem is the knowledge and skills need more training to update”* FBO worker, Samoa.

Many staff members and workers (in both Government & CSOs) had had limited opportunities to participate in formalised training, describing 'learning on the job' as the most common knowledge and skills acquisition method- *“On the job experience, learn through doing it”* NGO worker, Tonga.

There was a therefore a broad range of additional training needs identified through the survey, the focus groups and individual interviews. These are listed in priority order as nominated by participants:

1. Skills in monitoring and evaluation of programs
2. Counselling skills (see note below)
3. Designing IEC materials
4. Treatment and management
5. Training techniques
6. HIV/AIDS & STI Knowledge update
7. Sex & Sexuality

Other additional areas nominated:

- Communication
- Media training
- Empowering family support networks
- HIV program management

Counselling

Skills in HIV/AIDS & STI counselling for general counsellors, NGO workers, health and community workers was identified as an enormous area of training need by all participants in all countries:

“We need serious help on counselling, prevention and treatment. There is little to no counselling for those living with STIs & HIV as well as those at risk of transmitting STIs & HIV” Youth Worker, Kiribati

This is also supported by data from situational analyses and from reports from national HIV program managers. Currently there are few trained counsellors in countries and very limited (if any) access to counselling for STIs and HIV/AIDS. Study participants also stressed the need for counsellors to be available in the community outside the formal health system for reasons of access but also privacy: *“Counsellors at the hospital are not trusted by the community”* NGO program director, Samoa.

One of the critical and related issues to counselling is confidentiality. Those undertaking counselling roles or access to confidential information need to be trained on how to protect confidentiality and why it's important. As emphasised by a CBO worker in Kiribati *“the right to privacy needs to be stressed and understood”*. There is evidence of many breaches of confidentiality within countries and this has had a serious impact on people accessing the health system:

“The announcement of the HIV positive status of the adult PLWHA in 2002 severely challenged patient confidentiality mechanisms within the health system” Aide Memoire to MoH, Vanuatu⁸

These areas of need for training and capacity building support those identified in the Situational and Response Analyses Report and the Youth, Gender and Vulnerable Groups Strategy prepared earlier this year.

⁸ Rob Condon, UNICEF Review and Development of Policy and Practices for the Prevention of Mother-to-Child Transmission of HIV in Pacific Island Countries 30 July 2004
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3. SUMMARY

“For many of us in the Micronesian sub-region, it is evident that prevention, screening and treatment of HIV/AIDS are still in the very early developmental stages. These must be expanded if we are to be adequately and appropriately prepared for the inevitable.” Youth Health Adviser, Marshall Islands

Increases in reported cases of STIs (and of HIV/AIDS) indicates that despite awareness and preventative education programmes, unsafe sex continues to be practiced and the risk of HIV continues to increase in most countries⁹. To date in the Pacific region there has been only limited development of interventions that support sustained sexual and attitudinal behaviour change as distinct from providing information about HIV/AIDS and STIs.

The vast majority of HIV/AIDS and STI education and prevention activities within the region are still focused on ‘awareness-raising’ and are short-term; most activities/programs being implemented are workshops and information sessions of varying lengths and formats. These focus on intervening with individuals for behaviour change, without consideration of environmental factors which enable (or provide barriers for) change.

There is strong evidence that IEC campaigns which have been implemented have been imparting knowledge and information rather than inspiring behaviour change. There is a need for clear targeting of interventions for preventive activities, and extending prevention beyond simple information, education and communication to programs actually aimed at producing sustained behavioural change, particularly in vulnerable groups.

Regional training needs in behaviour change communication therefore encompass all areas of BCC, particularly starting with increasing knowledge and understanding of approaches, strategies and activities that best facilitate behavioural change and more specifically training in skills for implementing behaviour change interventions. The need for community participation and collaboration is central to BCC therefore training needs to strengthen skills in this area to enable a community-based focus and ownership.

RECOMMENDATIONS

Based on the findings of the Training Needs Analysis, the following recommendations are made:

1. General awareness on behaviour change approaches

Increase levels of knowledge/ understanding of approaches, strategies and activities that best help facilitate behaviour change amongst a range of key stakeholders including, but not limited to, the National AIDS Councils or equivalent and country HIV program managers (‘Behaviour Change 101’ or similar).

Recommended approaches:

- i. Integrate BC component into regional HIV/AIDS training programs facilitated by PRHP and other key agencies eg. Orientation Workshops for NACs & CDOs; HIV/AIDS courses; ARH training programs (UNFPA/SPC)

⁹ Dennie Iniakwala, Situational and response analyses report for HIV/AIDS & STI, March 2004, SPC

- ii. Advocate/ collaborate with PRHP – Suva-based team for incorporation into National Strategic Plan reviews or development including clear implementation plans.
- iii. Advocate with other key agencies in region for inclusion of information on Behaviour Change strategies in their programs/ training eg. UN agencies, IPPF, WHO, Red Cross
- iv. Advocate with NACs & CDOs for consideration of Grant Scheme applications for Behaviour Change Interventions ensuring proposals have described the BC approach, and how the project will facilitate BC.
- v. Provide training to CDOs on BCC, and identify strategies for this to be followed by ongoing mentoring and skill development in-country.

2. Behaviour change training at a national level

National approach vs. regional approach to training

Based on the findings of the study and also feedback from consultative missions and presentations at the PRHP Orientation Workshops for NACs & CDOs, the recommendation is to approach training at a national rather than regional level. The following issues and problems with regional training programs were identified: lack of follow on and follow up within countries; lack of control of who is selected to attend the training (therefore not always the most appropriate individuals selected), and; lots of changes in roles/ positions within countries means that when those trained move on, the knowledge and skills go with them.

Recommended approaches:

- i. The BCC training program be developed with national partners and be responsive to localised issues and needs but also incorporate the foundation areas (where levels of knowledge and skills are low) of:
 - Stages of behaviour change
 - Creating enabling environments
 - Capacity development for behaviour change
 - Developing BCC strategies/ activities
 - Evaluating activities or strategies
- ii. BCC specialist to facilitate training at a national level in collaboration with CDO staff.
- iii. Training to take a train the trainer approach to enable and empower participants in training others in BCC. It should also cover modifying BC approaches to suit target group (in particular vulnerable groups) and acknowledge specific cultural issues.

The needs assessment has also identified other areas of need for training and technical support. This information will be passed on to other members of the PRHP team for consideration in terms of capacity development activities, as well as regional organizations who may also be able to assist (eg. UN partners, Marie Stopes International, WHO). In particular, it is recommended:

- iv. At regional level donors and regional agencies collaboratively address the critical need across the region for a) Skills in monitoring and evaluation of programs; and b) Counselling.

3. Develop specific behaviour change initiatives

“At risk populations esp. youth and sex workers are very much overlooked. More needs to be done” CBO worker, Kiribati

Populations most vulnerable to HIV infection within the Pacific (youth, sex workers, seafarers, MSM, mobile populations) have not received their share of the attention and resources for prevention activities

In keeping with the recommendations of the YGVG strategy and the Situational and Response Analyses Report there is a need for a particular focus on supporting behaviour change among young people and vulnerable groups.

As behaviour change interventions targeting populations vulnerable to HIV infection are more effective where there is strong participation by members of the target populations it will be necessary to work with young people and vulnerable groups from around the region to develop specific behaviour change initiatives including, but not limited to, IEC development and social marketing of condoms.

Recommended approaches:

- i. Encourage countries to identify vulnerable populations and prioritise current risk settings and behaviours in their particular communities
- ii. Encourage countries to conduct behavioural surveillance surveys, where possible, among selected vulnerable groups to support and monitor BCC activities
- iii. Support training for CDOs and others wanting to work with groups particularly hard to reach effectively (eg. sex workers or men who have sex with men).
- iv. Incorporate representatives of vulnerable groups in National level BCC training
- v. Build on current activities and strategies of those who are currently working with vulnerable populations (mostly CBOs) eg. ATFF sex worker outreach activities, peer education strategies etc.
- vi. Develop specific behaviour change initiatives including IEC with identified populations and those who work with them
- vii. Consult with SPC Youth bureau, ARH project, Women’s bureau and Fisheries program (Seafarers) on the integration of behaviour change approaches through regional programs.

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TRAINING NEEDS ASSESSMENT QUESTIONNAIRE Pacific Regional HIV/AIDS Project

Behaviour Change Communication in HIV/AIDS & STI Prevention

An analysis of training needs in Behaviour Change Communication (BCC) among government and community based organisations involved in HIV prevention programs is being undertaken by the Pacific Regional HIV/AIDS Project to guide the development of a training program on **Behaviour Change Communication and Behaviour Change Intervention Strategies**.

***Behaviour Change Communication** is an interactive process with communities (as integrated with an overall program) to develop tailored messages and approaches using a variety of communication channels to develop positive behaviours; promote and sustain individual, community and societal behaviour change; and maintain appropriate behaviours.*

***Behaviour Change Intervention** is a combination of activities/interventions tailored to the needs of a specific group and developed with that group to help reduce risk behaviours and vulnerability to HIV by creating an enabling environment for individual and collective change.*

Your name:

Your position:

Your agency/ organisation:

Mail address:

Email address:

Fax:

Best way to contact you? (please tick)

Mail

Email

Fax

Please indicate your YES or NO answer to each question by circling the appropriate response, or respond with a few words/ sentences, as appropriate.

Q1. Do you have experience in	<i>(circle "Yes" or "No")</i>
i) Designing HIV/AIDS & STI education and prevention activities	YES / NO
ii) Implementing HIV/AIDS & STI education and prevention activities	YES / NO
iii) Evaluating HIV/AIDS & STI education and prevention activities	YES / NO

If yes to any of these, please describe briefly.

Q2. Do you have experience in	(circle "Yes" or "No")
i) Peer education strategies in HIV/AIDS & STI	YES / NO
ii) Information, Education & Communication (IEC) programs in HIV/AIDS & STI	YES / NO
iii) HIV/AIDS & STI research activities	YES / NO
iv) HIV/AIDS & STI Strategic planning and policy development	YES / NO
v) Providing HIV/AIDS & STI counselling services	YES / NO

If yes to any of these, please describe briefly.

Behaviour Change Communication is an interactive process with communities (as integrated with an overall program) to develop tailored messages and approaches using a variety of communication channels to develop positive behaviours; promote and sustain individual, community and societal behaviour change; and maintain appropriate behaviours.

Q3. Do you have experience in	(circle "Yes" or "No")
ii) Designing Behaviour Change Communication (BCC) activities	YES / NO
iii) Implementing BCC activities	YES / NO
iv) Evaluating BCC activities	YES / NO

If yes to any of these, please describe briefly.

Behaviour Change Intervention is a combination of activities/interventions tailored to the needs of a specific group and developed with that group to help reduce risk behaviours and vulnerability to HIV by creating an enabling environment for individual and collective change.

Q4. Do you feel confident in the following:	(circle "Yes" "No" or Unsure)
i) Your <u>knowledge/ understanding</u> of approaches, strategies and activities that best help facilitate Behaviour Change?	YES / NO / UNSURE
ii) Your <u>ability to implement</u> Behaviour Change Interventions?	YES / NO / UNSURE

If yes, please describe briefly.

Q5. Please list any particular topics or issues that you wish to find out more about during training workshops on Behaviour Change Communication in HIV/AIDS & STI

- stages of behaviour change
- creating enabling environments
- capacity development for behaviour change
- designing strategies/ activities
- evaluating activities or strategies
- Other – specify

Q6. Do you have any other training needs in HIV/AIDS & STI? (tick all that are relevant)

- HIV/AIDS & STI Knowledge update
- Sex & Sexuality
- Risk, risk settings and risk behaviours
- Designing IEC materials
- Training techniques
- Basic counselling skills
- Treatment and management
- Surveillance
- Evaluation of prevention programmes/ activities
- Working with vulnerable at-risk groups (e.g. youth, sex workers, military etc.)
- Other – specify

SPC is planning a training workshop on Behaviour Change Communication to be held later this year. The workshop will train people how to design and implement HIV/AIDS & STI strategies that best help facilitate behaviour change. Staff with a “hands on” role in implementing HIV/AIDS & STI strategies will be attending.

Q8. Would your agency/ organisation be interested in sending a representative to attend a regional training workshop on Behaviour Change Communication Strategies? (circle “Yes” or “No”)

YES / NO

If YES, please provide a contact name:

Q9. Any other comments you would like to make regarding the setting you work in or HIV/AIDS prevention and awareness raising?

Thank you for your participation.

Please return to:
 Robyn Drysdale
 Behaviour Change Communication Specialist (HIV/AIDS & STI)
 Public Health Programme
 Secretariat of the Pacific Community (SPC)
 Fax: + 687 26.38.18
 Email: robynd@spc.int

LIST OF MEETINGS HELD DURING THE REVIEW**Focus groups and individual interviews during consultative missions:**

Both focus groups and individual interviews during agency visits were audio recorded and transcribed.

Fiji:**Focus group attendees (20th April 2004)**

Fiji Red Cross	Lavenia Rasanivatu, Health and Care Director Temu Sausau, Information Officer
Marie Stopes International, Fiji	Caroline Mohammad
MoH Fiji	Dr Jiko Luveni, HIV/AIDS Program Officer
National Centre for Health Promotion	Philip Komai Sera Waqa Premila Deo
Seventh Day Adventist Church Megalife Ministeries	Simione Nauluvula
SPC ARH Programme	Dr Rufina Latu
Pacific Regional HIV/AIDS Project	Jerry Cole, Grants Manager

Agency visits

AIDS Task Force of Fiji

Vanuatu: (14- 17 May)**Focus group**

Wan Smolbag	Alison Moore
MoH - Public Health	Diana Sant Angelo (VSO) Jean Jacques Rory
Vanuatu Family Health Association	Blandine Baulekome
Foundation of the South Pacific Vanuatu Odina Lala	

Agency visits

Wan Smolbag (Peter Walker & Jo Dorras), FSP Vanuatu (Amon Gwero E.D. & Morgan Armstrong- Technical Adviser), MoH, Vanuatu FHA.

Solomon Islands: (18 – 20 May)**Focus group**

MoH	Amos Lapo Sarah Ben - Reproductive Health Dept. Alby Lovi- Health Promotion Dept. Ken Konare -ARH Project
Save the Children	Divine Waiti
Family Support Centre	Lovelyn Kwaoga Macson Sake
SI Planned Parenthood Assoc.	Roland Gitto
Training Needs Assessment Report	

Agency visits

Save the Children (Ian Rodgers- Manager), SIPPA (Tasi Meone E.D. & Steven & George- Community & Yth programs)

Kiribati: (22-24 June)**Agency visits**

MoH	Ms. Mamao Robate - HIV/AIDS coordinator Lauren Kendt HIV/AIDS desk & Danielle Bennett – Youth Worker (PCV)
Broadcasting Publishing Assoc. (BPA)	Roz Terubea, Radio Editor (& member of AIDS Task Force)
Nei Tabera Ni Kai Video Resource Unit	Linda Uan, Manager
Kiribati Red Cross Society	Mr. David Teabo, Secretary General
Foundation of South Pacific, Kiribati	Ms. Komera Otea, Social Programs Coordinator
Kiribati Family Health Assoc. (KIFHA)	Katikoua Amon – Executive Director

Samoa: (28 – 30 June)**Focus group**

MoH - ARH Project	Mr Manu Samuelu
MoH - Health Promotion Services	Ms Aaone Tanumafili
Samoa Family Health Association	Ms Faalua Poese Mataaga
Catholic Family Ministries- Sautiamai	Mr Palapoi Sione Pula Mr Faafouina Matua

Agency visits

Samoa Red Cross (Tautala Mauala - Sec. General); Ministry of Woman's Affairs (Palanitina Toelupe-Assistant Sec.); SFHA (Apineru Peniamina – Executive Director); CFM Sautiamai; World Health Organisation (Dr Asaua Faasino).

Other Data collection sources:**2 Regional Strategy Reference Group meetings****Reference group members:**

Dr Kabwea Tiban	HIV/AIDS Program Manager Desk, Kiribati
Ms Maire Bopp Du Pont	Pacific Islands AIDS Foundation
Mr. Joe Kalo	Wan Smol Bag, Vanuatu
Mrs. Margaret P. Sesserson	Community Planning Group, Palau
Dr. Ninkama Moyia	Director, National AIDS Council, PNG
Dr. Nuualofa Tuuau Potoi	Director Preventive Health Services, Samoa
Dr. Stuart Watson	UNAIDS Pacific Program Coordinator
Dr Bernard Rouchon	HIV/AIDS programme Coordinator. MoH New Caledonia
Dr Jiko Luveni	HIV/AIDS Project Officer, Fiji
Dr Juliet Fleischl	HIV / AIDS Focal Point, WR South Pacific Office, WHO
Liz Kennedy	IFRC Australian Red Cross HIV/AIDS Advisor, Suva
Christine Sturrock	AIDS Task Force of Fiji,
Ms. Losevati Naidike	Representative, WCC Office in the Pacific, Fiji
Steven Vete	Executive Liaison Officer, Forum Secretariat
Dr. Helen Tavola	Social Policy Adviser, Forum Secretariat

UNAIDS Workshop – VUDA: Mon 22-Fri 26th March

Approx. 100 delegates from 14 countries across the Pacific

Needs assessments in BCC commenced with some workshop participants using questionnaires and informal interviews

Orientation Workshop for NACs & CDOs (PRHP – Suva based team) 4/8/04 –

Draft results of TNA presented to representatives of 8 PICs.

Attendees:

Cook Islands	Edwina Tangaroa - NAC Julianne Westrupp - Cook Islands Red Cross
Fiji	Jiko Luveni - NAC Ms Ashiana Shah - Fiji Council of Social Services
Kiribati	Batiri Bataua - Kiribati AIDS Task Force Dr Kabwea Tiban - NAC Ms Mamao Robate - NAC
Samoa	Roina Faatauvaava - Samoa Umbrella of NGOs
Solomon Islands	George Malefoasi - NAC Holly Aruwafu - NAC Dolores Elima- Oxfam
Tonga	Betty Blake - NAC Iemaima Havea - Tonga Family Health Association
Tuvalu	Annie Homasi - Tuvalu Association of NGOs
Vanuatu	Dr Timothy Vocor - NAC Siula Bulu - Wan Smol Bag

Desk review

- Trip reports - rapid in-country assessments conducted by the HIV/AIDS & STI Advisor and also the Suva-based PRHP team
- Situational and response analyses report for HIV/AIDS & STI prepared by HIV/AIDS & STI Advisor
- National HIV/AIDS Strategic Plans
- Reports by National HIV/AIDS Program Managers presented at WHO WPRO workshop 16-19 August

Survey:

Total individual surveys completed - 42 surveys from 11 countries:

Cook Islands, Fiji, Kiribati, Marshall Islands, Palau, PNG, Samoa, Solomon Islands, Tuvalu, Tonga, Vanuatu. Plus 2 x Regional Organisations – UNICEF & Australian Red Cross.

NB: Red Cross data compiled (by Mikayla Rose & Liz Kennedy) from the 11 National Societies in the Pacific (Cook Islands, FSM, Fiji, Kiribati, Marshall Islands, PNG, Samoa, Solomon Islands, Tonga, Tuvalu & Vanuatu).

