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THE FOUNDATION FOR THE PEOPLES OF THE SOUTH PACIFIC

Child Survival V Project:

**Maternal and Child Health Extension Program
in
Vanuatu**

January 1, 1992 - December 31, 1992

**ANNUAL REPORT
SUBMITTED TO
THE UNITED STATES AGENCY FOR INTERNATIONAL DEVELOPMENT
BUREAU FOR FOOD AND HUMANITARIAN ASSISTANCE
OFFICE OF PRIVATE AND VOLUNTARY COOPERATION**

March, 1993

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I. PROJECT DESIGN SUMMARY

A. Country Project Objectives

Project objectives have been revised as follows since the first annual report.

1. To increase the percent of fully immunized children under 12 months of age to the following:

<u>Region</u>	<u>Target Coverage</u>
Ambrym	85%
Tanna	85%

2. To increase the percent of women who deliver protected with two doses of tetanus toxoid to the following:

<u>Region</u>	<u>Target Coverage</u>
Ambrym	90%
Tanna	90%

3. To increase the percent of caretakers of children who correctly manage episodes of diarrhea among their children under two years of age to the following:

<u>Region</u>	<u>Target Coverage</u>
Ambrym	60%
Tanna	50%

4. To decrease the percentage of children in the 0-2 year age group whose weight for age is below the 80th percentile to the following yearly average:

<u>Region</u>	<u>Target Figure</u>
Ambrym	<15%
Tanna	<20%

5. To increase the percent of caretakers who seek referral at a health facility for their 0-24 month old children with moderate ARI to the following:

<u>Region</u>	<u>Target Figure</u>
Ambrym	80%
Tanna	90%

6. To increase the acceptance of modern family planning methods among women in union as follows:

<u>Region</u>	<u>Target Figure</u>
Ambrym	15%
Tanna	20% over baseline

B. Location and Size of Population

FSP's Child Survival project in Vanuatu instituted a procedure to generate population figures for catchment areas of every health facility in Vanuatu. Until 1992, the Health Department provided figures only for district catchment areas. The district officers had difficulties estimating figures for specific catchment areas and thus problems calculating coverage. Once the procedure was followed, district supervisors found it easy to calculate targets and to estimate coverage.

This update of the population figures in Ambrym and Tanna is adjusted for population growth in the last three years. It is calculated from the 1989 census figures with 2.5% growth. The demographic breakdowns from the 1989 census came out only this year. In Vanuatu average percent of population for rural areas are as follows: under 12 months, 3.4%; under 60 months, 17%; women 15-49 years, 22% (times 0.67 for "in union" figure); and, pregnant women, 3.7%.

The population FSP covers has expanded to include the outer islands around Tanna as we will extend Primary Health Care projects to these areas in 1993.

Table 1:
Child Survival Population in Project Sites

	<u>Children</u> <u>0-4 years</u>	<u>Women</u> <u>15-49 years</u>	<u>All Persons</u>
Ambrym	1,349	1,746	7,935
TAFEA*	4,206	5,579	24,741
TOTAL	5,555	7,325	32,870

*includes Tanna, Aniwa, Futuna, Erromango, and Aneiytum.

Source: Department of Health

C. Health Problems

There are no changes in the focus of this project since the DIP was written.

D. Child Survival Interventions

A family planning intervention was added in September 1991. Women are classified as low risk/high risk on the occasion of childbirth. Risk status is noted on a birth register. The register includes home births. Every postpartum woman with a high risk factor is visited at home within three months after discharge and is given private counselling on family planning, together with her partner.

E. Linkages to other Health and Development Activities

A sub-project has been added to USAID-funded Child Survival project in order to forge links between women's organizations in Vanuatu and the Department of Health (DOH). It is called "Women's Primary Health Care/Income Generating Project. FSP trains the women's clubs officers to integrate health education into their income generating workshops. This is important for two reasons. First, it provides more manpower for health education. Second, it serves as a model of cooperation, at the local level, for organizations that find it difficult to cooperate at the national level because of political differences.

F. Strategies to Identify and Follow-up People at High Risk

The criteria for high risk have been expanded this year to include others for postpartum women. They are: parity >4, child spacing <24 months, age <18 or >35 years, i.e. "too many, too close, too young or too old." Posters with this information are displayed in every health facility and also public meeting places. The definition of high risk child, for the purpose of follow-up, remains the same as stated in the 1990 Annual Report. However, the figures given for high risk children on quarterly reports do not include children who have defaulted on growth monitoring, so long as their immunizations are up to date.

II. HUMAN RESOURCES

Staffing has changed significantly from the time the DIP was written. While developing the DIP, the consultant negotiated a agreement with the Health Department to second key staff to the Child Survival project. The consultant, a former DOH official, was held in such high esteem that everyone agreed to what he asked, though they knew it was not feasible. To second staff to the project, the

DOH ran the risk of losing a portion of their recurrent budget. Therefore we negotiated revised agreement: FSP hired two supervisor nurses of proven ability who had been given early retirement from the DOH for purely political reasons and agreed to pay a subsistence fee to any DOH staff who assisted the project. This arrangement was ideal because it fulfilled the purpose intended originally to integrate the Child Survival project activities with the DOH and provide technical support. It had the added benefit of stretching DOH funds for supervisory touring travelling, allowing them to do more supervision nationwide. It was an excellent compromise to seconding staff.

Table 2:
Human Resources for the FSP Project

<u>Position*</u>	<u>Salary paid by</u>	<u>Contribution to Project</u>	<u>How Compensated</u>
Assistant manager operations for Ambrym	CS Project	full time	FSP
Project Assistant for Tanna	"	"	"
Project manager	"	"	"
Administrative Support Staff(3)	FSP	1/4 time	match grant
Fiscal Support Staff (2)	"	"	"
Family Health Unit staff (EPI, MCH, FP, NUTR = 4)	Dept. of Health (DOH) national level	varies, approx. 1/10 time	Project pays only subsistence fee for project site visits
District Health Officers (MCH & PHC X 2 areas = 4)	DOH, District level	varies, approx. 1/7 time	"
Local staff	DOH, local	1/5 time	Project pays only subsistence fee for trng. sessions on other sites

Village health workers (aid posts & sanitarians X 2 areas = 12)

Local gov't Council 1/3 time

Women's club officers as health educators

VNCW or WA 1/10 time

Canada Fund

* Note that only two positions are full time. The others will remain in place after the project is closed in March 1994.

III. IMPROVEMENTS IN PROGRAM QUALITY

It must be repeated that the Child Survival project moves slowly from area to area, following the national PHC program openings. It is simply too expensive to start up all sites at once and then progress to a close in four years. So the Child Survival project is always "starting up" and "handing over." This project should be seen as a pilot project dealing with the problems of starting up PHC and preventive health in a country which has only been independent for ten years and never before exposed to the concept of PHC. Therefore, program quality depends heavily on community participation and health education.

The most important changes in the Child Survival project are its integration into the district management team and into the national PHC program. During implementation in Ambrym in 1990 and 1991 neither was possible because the national PHC Coordinator was out of the country at school and because access to the district management staff was extremely limited. (Formerly, the communication from Ambrym to its district headquarters was nigh impossible, simply because of inadequate communications hardware and postal system. Ambrym remains very isolated.) The planning and implementation of the project in Tanna has enjoyed excellent participation of the district supervisory staff. Hand over will be greatly simplified.

This year saw further improvements in two areas; in the information system and in new linkages with other development organizations. These changes have resulted in increased community participation, improved quality of high risk follow through, improved management at the national level, and in increased health education.

Community participation improved in 1992 as village assessments were carried out by a team of local leaders and their health workers. Previously, assessment tended to be dominated by nurses rather than community members because the procedure and forms were too complicated.

The village assessment procedure and forms have been revised twice: first to convert from pictorial to written records, and to fit them to national PHC and MCH program indicators as well as FSP's project indicators, and second to simplify them. Though we began with pictorial records, we have changed to written records because the villages tend to choose committee secretaries from the body of primary and trade school graduates. Secretaries tally results and prepare the village presentation and they are more comfortable with written records than with pictures. Simplification of registers for birth, death and child health status has improved high risk detection and follow-up. Nurses resisted hand over of work to target high risks until the registers and review procedures were simplified. Hand over is in progress now.

Revision of the registers has improved the quality of data so that national and district staff began to use information for management. For example, the 1992 EPI statistics were nearly meaningless (see Appendix C) because of poor reporting, using the DOH system. Institution of the FSP project system - quarterly reviews of the simplified DOH child health register - provided data that was easily graphed monthly and yearly (see Appendix D).

The latest two steps taken to improve program quality were to plan training of local women's clubs' officers in health education and to conduct yearly health education conferences for all local development workers. The former improves the program because it expands manpower for health education and involves local leaders. The latter is important because it promotes the PHC multi-disciplinary approach and rationalizes all expenditures for training of trainers in health education. Up to 1992 each sort of health worker and development worker was trained separately, sometimes with different messages, and each had his own work plan to implement in isolation. Now all health workers receive refresher training jointly and make their work plans jointly, drawing on each others knowledge and skills. [There are 4 different types of development workers with responsibility for health education including 1) village sanitarians, 2) aid post orderlies, 3) nurses, and 4) Rural Women's Officers. Each receives separate refresher workshops run by different DOH sections, either annually or bi-annually.]

IV. PROJECT HEALTH INFORMATION SYSTEM

A. Baseline Survey

As noted above, the Child Survival project is involved every year in community assessments as the project moves from area to area. However, the baseline which will be used for evaluation purposes is for Ambrym alone, the first site.

The methodology for village assessment has changed to make it suitable for local leaders and health workers to use without FSP staff supervision so it may be done in new areas beyond the life of the project.

KAP survey questions on EPI, and ARI did not change in the Tanna assessment. Nutrition KAP questions concerning the introduction of food types were abandoned in favor of a 24-hour diet recall. Management of diarrheal disease questions were re-worded. These changes cut interview time from 1 hour to 10 minutes! More prenatal questions were added in order to assess compliance with anemia and malaria prophylaxis. New questions were pre-tested in the same fashion used for the original baseline survey which the Johns Hopkins PVO Child Survival Support Program designed. A report on village assessment written in basic English was prepared for the district management team (Appendix E).

B. Monitoring System

The project staff reports on several indicators every quarter. These reports have not changed since 1991. Appendix F contains copies of the 1992 statistical reports. Other project indicators were reported on an annual basis, in the USAID Child Survival and Health Questionnaire.

V. WORK PLAN

Although not a change it bears repeating that the Child Survival project did not start up as soon as it was funded, in October 1989, nor was it funded for the time period requested, five years. The project was initiated in Vanuatu in Jan. 1990 and, with the requested 6 month no-cost extension, intends to close in March 1994. Our project years correspond to calendar years and are thus not synchronized with USAID fiscal years.

The project work plan originally called for start up on Tanna in January 1992. This was not possible because of the extra work imposed in order to deal with Hurricane Betsy which devastated parts of Ambrym. In addition, the work plan for Tanna has been changed to fit into the implementation of the national PHC program. Appendix B contains the new work plan for 1993.

Though all of the proposed activities will be implemented by the close of the project in Tanna, local health workers will continue to need extra training in health education for another year. After closure of the Child Survival project we hope to extend the MCH Extension Program in Tanna for a year, through the whole of 1994. The present Child Survival Assistant Manager will run the program using funds raised locally.

Another sub-project has been designed to answer the need for more safe drinking water in Ambrym. A proposal has been submitted which requests \$15,000 to build nine ferro-cement water tanks under the direction of DOH Environment Section Head, Ellison Sese. The project is in the National Development Committee now. If it is approved, FSP will incorporate this activity into the 1993 Child Survival work plan.

An impact evaluation will not be attempted in Tanna, because the project closes only 12 months after the initiation of project implementation.

The portion of the KAP survey dealing with nutrition questions may not be repeated in Ambrym at the final evaluation because FSP did not find that the baseline provided useful indicators. Instead, data from the project H.I.S. will be analyzed.

VI. PROJECT EXPENDITURES AND BUDGET REVISION

A pipeline analysis was submitted in October, 1992. No significant budget revisions have been made since the submission of the Detailed Implementation Plan.

VII. SUSTAINABILITY

A. Estimates of Recurrent Costs and Potential for Recovery

This Child Survival project is a pilot in nature and therefore nearly all costs are considered "start up." All operational costs for salaries, supplies, and yearly training courses for health workers are covered by the government.

There is one crucial activity the project has introduced and funded without handing over responsibility to the government. That is yearly conferences for all local development workers. FSP is working now to promote the inclusion of this activity in the national PHC program.

A major change in national health policy occurred with the change of government in January, 1992. Health care is provided free of charge nationwide. There is no possibility of cost recovery through fees for service at present.

B. Strategies for Reducing Sustainability Concerns

The potential for sustainability is the project's greatest strength. A glance at the human resources section shows that FSP has worked to develop the skills of management and line staff of the DOH. The project has used local transport and joined government supervisory tours whenever possible. No Child Survival service is dependant on FSP vehicles (2 motorbikes), and the DOH has provided motorbikes for areas where we demonstrated the improved quality of services achieved through improved transport for nurses.

The ability to sustain project achievements was enhanced this year through the planning of a program to train women's club officers in health education and through their inclusion in PHC workshops as consultant trainers. Sustainability was also improved through the attachment of FSP project staff to the district management team of the DOH as technical advisors. And, as stated above, after the completion of the Child Survival project, the MCH Extension Program in Tanna may be extended for one year administered by the ni-Vanuatu Child Survival Assistant Manager using locally raised funds.

Costs of continued training of the volunteer CHWs and meetings to make yearly PHC work plans for each small PHC area has now been assured through the national PHC program. The program is committed to provide review workshops for all CHWs trained by the project every six months for at least the next five years.

The FSP project trained not only nurses, but also all the different health workers and local development workers in order to assure sustainability. The more trainers trained, the more likely training will continue. FSP has served as a coordinating influence for the different health and development workers in isolated areas. For instance, through the influence of the Child Survival program, the Local Government Officers and the MCH/PHC nurse began planning their monitoring and assessment tours together. All development workers participated in yearly workshops to develop health education lessons and to form joint work plans.

Sustainability was served at the national level as well. Though the project activities fall under the section of Maternal and Child Health within the DOH, the project has worked with several other sections including: Environment, Malaria, and Family Health. The latter is a consolidation of MCH, EPI, Nutrition, ARI, and CDD. FSP has fed information, especially the lessons learned at the local level, across all of these sections. FSP has also had input into the training of all the different local health workers which each section fields.

The one activity for which we have not assured continuation beyond the life of the project is yearly conferences for all local health workers.

There are two possible organizations that might take over these conferences, either the Local Government Planning Section or the national PHC program. The latter would be preferable because they have the expertise to give technical assistance to participants for the further development of health education lessons. FSP project staff are working on this.

VIII. PROJECT ACCOMPLISHMENTS TO DATE

The 1992 Child Survival Questionnaire was submitted to the Child Survival Office at PVC in October. Copies of the quarterly statistical report are appended to this report (Appendices F1-F4). ARI curriculum and messages were also submitted in September, but are appended here as well (Appendix A). The following is a brief review of achievements:

- FSP has established a program of mobile MCH outreach clinics to villages with limited access to services in Ambrym. (This involved expanding the national cold chain throughout the island; social mobilization of the communities; and training nurses)
- Within the EPI activities, FSP has defined calculations for ordering vaccines by doses to save waste. This strategy was later adopted by national EPI program.
- The project established a Health Information System which is simple to use, and is effectively employed for project management.
- Project staff have been consulted by national health officers on H.I.S. (the forms which FSP developed are used nationally).
- FSP has developed a procedure for village assessment by the local people which has been subsequently adopted by the Tafea Primary Health Care program.
- FSP has developed the first non-formal training curriculum for health education in rural Vanuatu, and trained non-health workers to deliver health education
- The project has consistently helped local organizations to link up in order to make the best use of time, human and money resources

FSP intends to continue the implementation of Child Survival interventions on other islands of Vanuatu, instituting improved HIS, health management system, and health education through technical assistance for the DOH District Management Teams and improvements in the communication network.

Appendix A.1.

HOME MANAGEMENT OF ACUTE RESPIRATORY INFECTIONS

The few child deaths we have had can all - but one - be attributed to late treatment of ARI or non-compliance with medical treatment. We have learned that all ARI cases are treated with safe traditional cures in addition to patent medicines and that caretakers do generally go to a clinic first, before traditional healers, if a child presents with labored breathing and the clinic is less than one and a half hours away. We have also learned that nurses do not often teach mothers the danger signs that indicate a need to return to clinic. This is important because, according to verbal autopsies, families do not return to clinic if the patent medicine (Cotrimoxazole) fails to achieve results within 24 hours. The latter has been the focus of nursing inservice education this year.

I wrote in 1991 that our ARI intervention was an important though small part of the project. This year I have increased the estimated percentage of funds we spend on ARI strategies because the problem has become more important as we entered the island of Tanna. Tanna is further south and therefore much cooler. The project site is under an almost permanent rain cloud. People here do not yet wear clothes. Most houses here do not have separate kitchens and a fire burns in the sleeping house half the night. We have not completed the baseline survey here yet, nevertheless I can see that now --in the "spring"-- the prevalence of mild ARI is greater than 50% in children under two years of age. The main strategies of the ARI intervention are to:

- correct over treatment by nurses
- teach nurses to give the first dose of medicine in clinic and to teach the caretaker when to return (i.e., danger signs)
- develop songs and skits to teach communities about danger signs and environmental hazards
- develop cooking demonstration lessons and songs that teach home care to grandmothers as well as mothers (i.e., give medicine, keep warm, give fluids and food, stay away from smoke, etc.)
- begin project to build kitchens or cheap smokeless stoves in Tanna

Appendix A.2.
TRAINING CURRICULUM AND MESSAGES

N.B. The Curriculum was written in Bislama. The following is an outline prepared for this report.

ARI Lesson for Nursing Inservice Training Workshop

Total hours: four

1 hour: Pre-test followed by discussion on diagnosis, treatment, and advice given to parents.

3/4 hour: Review Assessment: Lecture. Handout.

Nurse should perform:

- a. History (age, from volcano area - asthma?, duration of cough, breast feeding since cough, fever and duration fever, convulsions),
- b. Physical Exam (count resp. rate, look for chest indrawing, listen for stridor and wheeze, lethargy or sleepiness, body temperature, nutritional status).

Danger signs given for nurse to refer to hospital: chest indrawing, unable to drink, very lethargic or sleepy, stridor in quite child, convulsions.

Signs to rule out pneumonia given to encourage nurses to prescribe home treatment (they tend to over-treat): Resp. rate less than 40/min. in child 1-4 year or less than 50 for child under 1 year.

3/4 hour: Review Treatment: Lecture. Handout.

Mild ARI (cough, no pneumonia) treated at home with extra fluids, warm clothes, vapor treatment, breastfeeding, and small feedings of soft food, may give cough syrup, must give mother advice about danger signs.

Moderate ARI (pneumonia) treat with Cotrimoxazole bid according to weight (we have a good manual with charts of doses that fits int the pocket). Severe ARI (severe pneumonia), refer to hospital if one on island otherwise to a health centre, give proper injection stat, treat wheezing of present, keep hydrated and feed if possible (some health centre have nurse practitioners who can handle tube feeds).

Vanuatu has no designated Very Severe ARI.

1 hour: Practice Teaching Action Messages for n.others: Role play.

DANGER SIGNS SHOWING MOTHER SHE MUST RETURN TO CLINIC QUICK:

Labored breathing. Breathing speeds up. Child won't breast feed or drink. Child develops fever. Child seems worse.

HOME TREATMENT OF MILD ARI

Feed small soft meals with vitamin foods. Give extra fluids. Stay at home with child to breastfeed frequently. Give vapor and/or cough remedy as needed but not before time changes (from early morning to middle morning, etc).

HOME TREATMENT OF MODERATE ARI

As above. Also give the medicine morning and night. Give it very slowly to avoid vomiting or aspiration. Do not give any medicine away. Finish all the medicine.

Appendix B

1993 WORK PLAN FOR FSP/CS PROJECT

ACTIVITY	1ST QUARTER	2ND QUARTER	3RD QUARTER	4TH QUARTER
Village Assessments in five new sites on Tanna	4-29/1, Green Hill; 1-19/3, White Sands	1-19/6, Aniwa	27/7-12/8, Green Point	1-15/10, Futuna
HIS start-up 5 new sites	as above, the latest date	as above, the latest date	as above, the latest date	as above, the latest date
Program Implementation 5 new sites	Green Hill	White Sands	Aniwa	Green Point & Futuna
Local Health Workers' Conference		Tanna, north		Ambrym
Training of women's clubs' officers		Tanna, Ambrym		
Combine health/income workshops	1, West Tanna	2, Ambrym 3, Tanna	1, Ambrym	2, Tanna
Retraining of health education trainers	8/2 - 5/3, Port Vila and Ambrym			
Baby Contest in Ambrym		28/4		
School visits to give Child to Child health lessons during National Health Week		12-18/4, South east, North, & West		
Build 9 ferro-cement water tanks	29-31/3, Feli	13/5, P. Vato 17/5 Meitungan 7-8/6, Barress	August, one; September, two	Oct., two; Nov., one
Final Evaluation				1-19/11, Ambrym; 22-26/11, Tanna

TAUX DE PROTECTION DES VACCINATIONS D'ENFANTS MOINS D'1AN

YEAR 1992

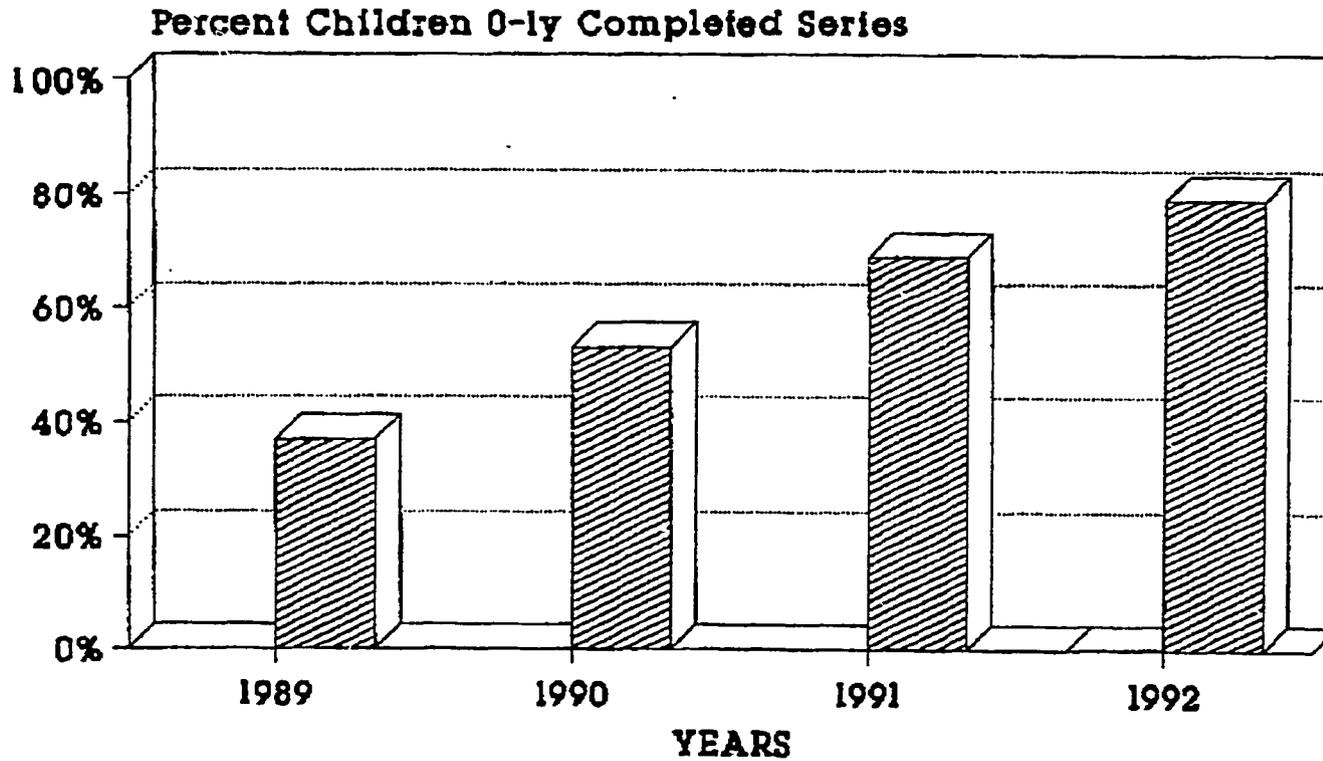
GOUVERNEMENT	POPULATION	B.C.G.		HEPATITIS B, 31ans		D.T.COQ, 31ans		POLIO, 31ans		MEASLES	
		N	%	N	%	N	%	N	%	N	%
BANKS & TORRES	208	129	69.1%	109	49.5%	55	26.4%	82	39.4%	87	41.8%
SANTO & MALO	887	1028	115.9%	804	90.6%	729	82.2%	742	83.7%	601	67.6%
AMBAE & MAEWO	385	251	65.2%	283	73.5%	264	68.6%	274	71.2%	206	53.5%
PENTECOST	393	172	43.5%	162	41.2%	1733	44.1%	161	41.0%	126	32.1%
MALEKULA	673	599	89.0%	681	101.2%	696	103.4%	670	99.6%	579	86.0%
AMBRYM	246	117	47.5%	164	66.9%	172	70.2%	179	73.1%	163	66.5%
PAAMA	58	21	36.2%	9	15.5%	8	13.8%	8	15.8%		0.0%
EPI	129	117	90.7%	258	20.0%	186	144.2%	189	146.5%	164	127.1%
SHEPHERDS/TONGOA	139	88	48.9%	95	68.3%	88	63.3%	88	63.3%	49	35.3%
EFATE	1085	1299	12.0%	1238	114.1%	1217	112.2%	1226	113.0%	1054	97.1%
TAFEA	785	871	11.1%	759	96.7%	689	87.8%	723	92.1%	647	82.4%
TOTAL VAKUATU	4902	4586	49.5%	4558	61.4%	5807	117.0%	4942	87.1%	3576	73.7%

SOURCE: Department de Sante Publique, au 8.2.93

Progress of Ambrym EPI Program 1989-92

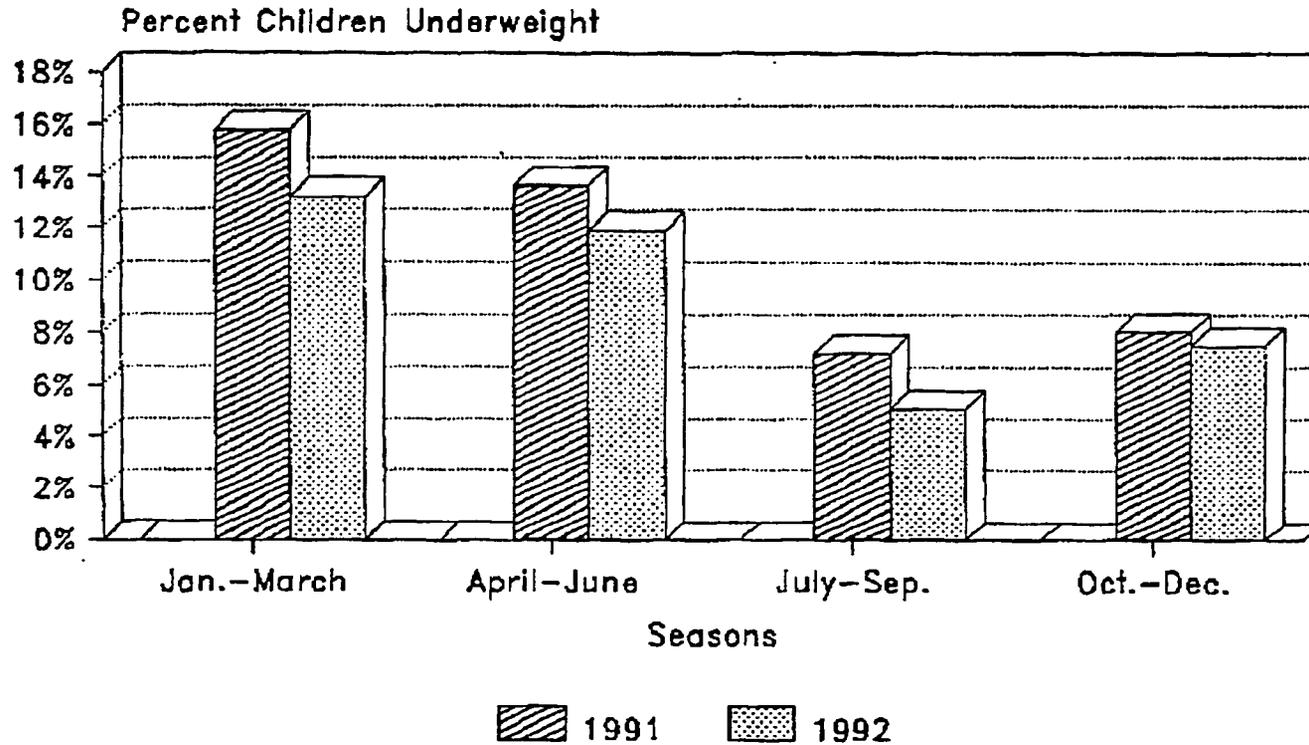
Complete Series Coverage

Children 0-1 Years



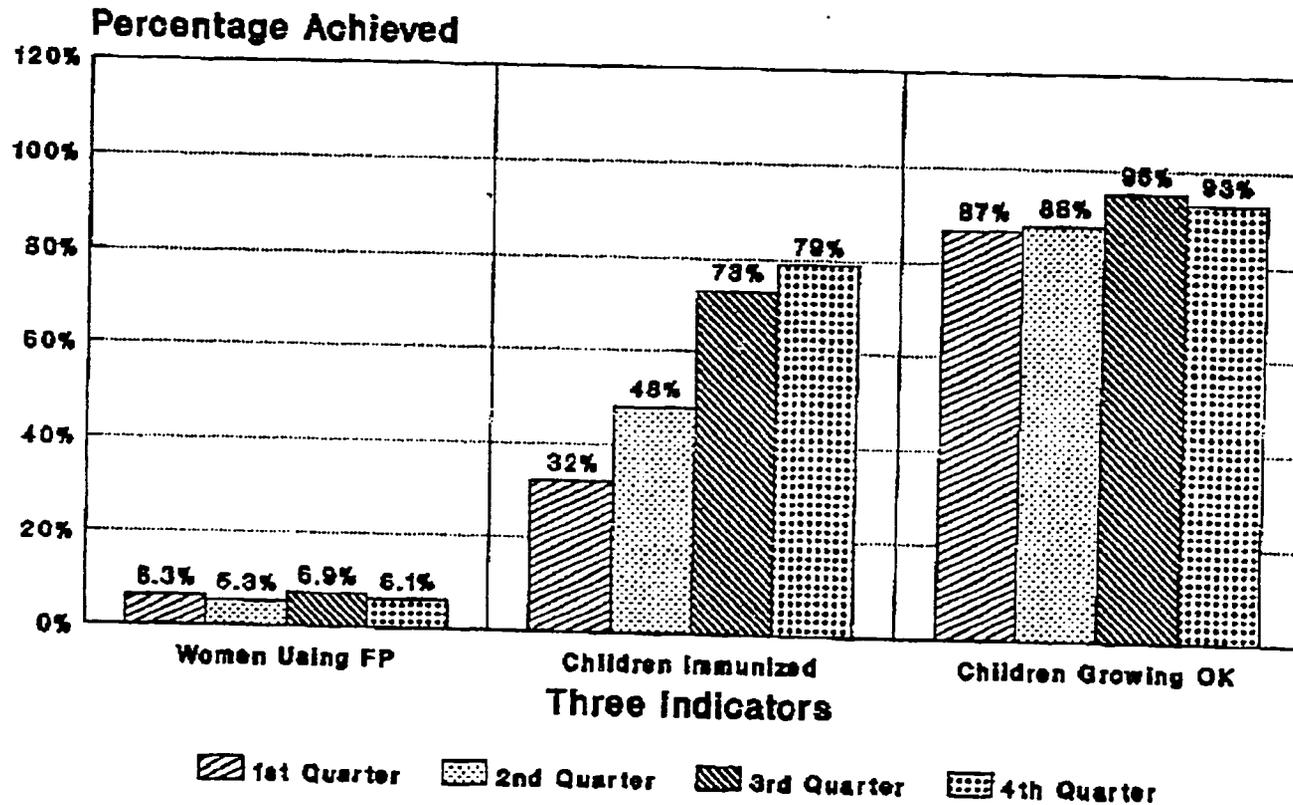
Data from quarterly reviews of the MCH
Registers in Ambrym
by the Child Survival Project

AMBRYM % CHILDREN UNDERWEIGHT FOR AGE COMPARISON OF 1991 AND 1992 Children 0-2 Years of Age



Data from a quarterly reviews of the
MCH Registers
Underweight = under 80th percentile

HEALTH STATUS ON AMBRYM ISLAND 1992 PROGRESS MADE IN CHILD SURVIVAL



% 0-2yrs. old w/ weight >80th percentile
 % 0-1mos. w/ BCG, DPT3, OPV3, MEASLES
 % women in union using contraception

Appendix E

**CHILD SURVIVAL V. PROJECT
F.S.P./U.S.A.I.D./D.O.H.
Vanuatu**

ACTIVITY REPORT

**North Tanna Village Assessment for the Opening of the
Primary Health Care Program by D.O.H. & C.S. in December 1992**

**Prepared by A.C.Devine
Program Manager
24 Feb. 1993**

**Copies Distributed to Department of Health Staff:
PHC Section
Family Health Unit
Tafea Rural Health Office**

**Copies Also Distributed to:
Child Survival Project of World Vision**

1.0 BACKGROUND

The Child Survival Project of the Foundation for the Peoples of the South Pacific (CS) carried out health Registration and Knowledge & Practice (KAP) Surveys in Ambrym in 1991 to provide baseline information not only to assess the needs of villages but also to use as a comparison for looking at progress made by the end of the project. Reports are on file in the FSP office.

Household registration and surveys in Ambrym were expensive and required a high standard of professional expertise. Large sample sizes were needed to make statistically significant observations so that the information could be used for evaluation as well as assessment. Outside consultants ensured that highest quality data was collected and then analyzed rapidly.

The CS project manager and the Rural Health Office (RHO) of Tafea District decided not to conduct baseline studies as described above, but to perform a village assessment of good quality using only local manpower so that we may find a model for village assessment anyone can use in Vanuatu.

An important criticism of the Ambrym project during the mid term evaluation was that local health workers did not collect and use health information, to guide them in decision making. All the different health workers including Village Sanitarians, Aid Post Orderlies, and Staff Nurses do collect information but they do not often share the information among themselves or with the community to help them make decisions.

The RHO & CS started village assessment as a part of opening a new PHC project area with these ideas:

Health information is more likely to be used if it is simple to collect and analyze.

Health information is more likely to be used if it collected and analyzed by the local health workers and Village Development Committee members.

Health information can help communities decide what health problems are most important.

The information collected should help nurses to identify high risk women and children in their communities and to update their records.

2.0 OBJECTIVES OF VILLAGE ASSESSMENT

- 2.1 Encourage community participation in primary health care.
- 2.2 Identify the resources of communities.
- 2.3 Identify the health needs of communities.
- 2.4 Identify high risk women and children in communities.
- 2.5 Teach health workers and community leaders how to use health information.
- 2.6 Promote good cooperation between the local nurse, the village sanitarian, the aid post orderlies, the Village Development Committee members, the chiefs, and the RHO supervisors.

3.0 ACTIVITIES OF VILLAGE ASSESSMENT

3.1 Conduct a House Hold Registration

Make a record book of all families and family members for each village or group of villages who have a Village Development Committee (VDC);

List names and ages of the people with notes about special problems, toilets, and kitchens.

3.2 Update all Clinic Records

Make sure every child has a "Blue Card."

Make sure every CBA has a "Pink Card.:

Update the Child Health Register.

Make a list of women and children who are high risk and schedule home visits.

Update population figures on the monthly report.

3.3 Make a Village Tour

Win the community leaders, especially the chief, to participate in PHC by helping them notice health needs and problems;

Teach PHC by giving local leaders experience in assessing the health of their people and their environment;

Make a one page long report of village resources (including the leaders, community buildings, water source, and a summary of population figures from the VDC book).

3.4 Survey Mothers

Ask mothers about their knowledge and practices for:

- feeding children under two years old
- danger signs of ARI and diarrhoea
- home management of ARI and diarrhoea
- pregnancy and childbirth practices

3.5 Prepare a Report for the 1st PHC Workshop

Give feedback to the community on the assessment of the village.

Provide information for VDCs to use when they request projects from the Local Government Council such as population, resources, & infrastructure;

Provide information on cases of illness nurses see in clinics to use in deciding main health problems.

4.0 METHODS OF VILLAGE ASSESSMENT

4.1 Registration

The CS assistant, members of the RHO Team, and the village sanitarian held a meeting with all the chiefs and introduced the idea of PHC. They asked chiefs to suggest people for VDCs. This took two whole days. Next a meeting was held in North Tanna for new VDC members sent by the chiefs, together with chiefs. They were all shown how to do a registration. They made appointments for a village assessment in each village. This took one full day.

The RHO supervisors and CS assistant used the Population Atlas from the 1989 census to find out how many house holds there might be in each village. They bought large exercise books and ruled one page for each family, with some extras. In some villages they used copies of a form (See Appendix A) instead of an exercise book. Later they clipped the copies together and made a book.

Two or three local health workers walked to each village to help do the assessment. The village sanitarian or one of the RHO supervisors did a tour of the village with the VDC members and the chief. They wrote a book telling every family in the village, with everyone's birth dates, and notes about toilets or kitchens. This book is called the VDC book. (See Appendix A) They added up figures in the VDC book and wrote a summary. (See Appendix B)

This took one day for each village. It can be done slowly, going to one or two villages each day. The local nurse went out to do village assessment on days scheduled for home visits or PHC visits. In North Tanna it took one month (8 days). The VDCs gave the nurse food and accommodation. The RHO or CS paid for subsistence.

4.2 Update clinic records

The nurse looked after blue cards and other health records. He or she weighed the children too. The CS assistant helped the nurse. This took one day, the same day as the VDCs made their book.

4.3 Village Tour

Some nurses and village sanitarians went walking around the village with the chief and VDCs. Some simply talked with the chief and the VDCs, asking questions. Others helped the local people to draw a map of their village on the ground. They made a list of village resources (See Appendix B). This took one or two hours. It was done the same day they made the VDC book.

4.4 Survey Mothers

Before training, the CS Manager worked out a questionnaire that only took five minutes to ask. The questionnaire was adapted from the one used in Ambrym, with changes suggested by Votausi Mackenzie, the Nutrition Coordinator. The questionnaire is in both Bislama and in English. This took three weeks.

The CS Manager and the assistant trained two women VDCs to interview all mothers with children under 2 years. The training took one week. The most difficult part of the training was getting the Bislama meanings right and learning to translate into the local language. The MCH Supervisor, Nancy Miake did a good job with this. The local nurse, Andre Nounamu, helped VDC women who don't read and write to plan the schedule for interviews and make ready for touring.

Each mother was asked to come have her child weighed and to "storion" with the woman VDC. It took 5-10 minutes for each interview. It took 20 days for all the interviews in North Tanna. If more than a week went by between village visits, the CS assistant reviewed training again with the VDCs.

In North Tanna almost all mothers (175 out of 179) attended from every village, because the local nurse did an excellent job passing the message. Six mothers came who had never brought

their children, over a year after the children were born. Three mothers didn't come because they went fishing with their children. One mother ran away from fright. In one village, half the mothers didn't come the first time because of a misunderstanding. The local nurse met the chief and the people in a special meeting to clear up the misunderstanding and a new date was set. The mothers came on the second date.

The questions asked were on the topics of nutrition, childbirth, immunisation, and care of the sick child. We asked mothers to tell us every food she gave the child the day before, from early morning to bedtime. (See Appendix C).

4.5 Prepare a Report

The local nurse, the village sanitarian and CS assistant counted up all the figures in the VDC book and in clinic registers. They looked at these figures:

- how many families have toilets and/or kitchens outside
- how many high risk children, according to the blue card
- how many high risk women, according to the posters
- population figures for 0-1, 1-4, CBAs, and total
- how many cases of ARI or malaria or diarrhoea last year divided by how many children 0-5 last year times (x) 100
- how many cases of malaria or scabies or other skin disease divided by the total population times (x) 100
- how many cases of important illness each month

Then the local nurse and CS assistant made graphs to show their figures. This took an hour or so each day for a week. The graphs were ready in time for the 1st PHC Workshop.

The VDCs helped make some of the graphs and pictures. No one knew how to draw so we used pencil first and copied off posters and books.

5.0 FINDINGS

So far we have studied the information from Green Hill only, not yet in other areas. A village assessment has begun in White Sands and the RHO & CS plan to assess each new PHC area.

General

Different health situations occur in each of the three zones of North Tanna. First, "Zone A" or Salt Water Side where the villages are very isolated and have problems with food in the dry season. Second, Green Hill or "Zone B" where there is plenty of food and a clinic nearby and many people still follow tradition fashion. Third, South East or "Zone C" where there is also plenty of food but no aid post and where most people follow the traditional way of life.

To make it easy for local people to understand we presented most of the findings using pictures or graphs. We cannot attach these to the report because they are large and they belong to the VDCs. For instance, the number of toilets was reported on a poster showing a toilet. For your information, the figures are reported in tables (See Appendix D).

This report is accurate in reporting the knowledge of mothers because we asked a lot of mothers, in fact all the mothers who had children under two years old.

This report may not be accurate in reporting mothers' practices because there were too few mothers who were actually doing home management for diarrhoea or ARI at the time we asked. There were 22 mothers whose children had diarrhoea and 44 mothers whose children had a cough during the two weeks before the survey.

Danger Signs of ARI

Women do not know important danger signs of ARI like fever (26%) or not eating (14%). Too few worry about "pulum win" or labored breathing (59%) and say they would take their children to the hospital for this. See Graph 1.

Even though most women would go to the clinic if their child coughs too much (89%), they might not return to the clinic later on if the child got into danger after the visit.

The main season for ARI is June through October, but there are many cases every month. About two thirds of all children will get ARI every year.

Home Management of ARI

Too few mothers know how to manage ARI at home with fluids (54%), warm covers (6%), and no smoke (0%). Although they don't say they know to keep on giving food and fluids, most do so (91% & 73%). A small number of women (7%) said they would give custom medicine to children for ARI. In actual practice, a third (30%) of the women whose children were sick did give the child custom medicine. See Graph 2.

Danger Signs of Diarrhoea

Mothers do not know important danger signs of diarrhoea. Many know the late signs which may not give them enough time to get to the clinic. Two children died of dehydration soon after the survey. Women say they worry when a child has increased diarrhoea (63%) and they would take the child to the clinic. Only half the mothers (54%) know even one sign of dehydration. Most mothers do not know the danger signs of vomiting (40%) or fever (31%). See Graph 3.

The main season for diarrhoea is November through March but there are a few cases all the time. Only 10% of children under five are taken to the clinic for treatment of diarrhoea. We don't know how many children get diarrhoea every year, because many of them are not taken to clinic. We do know two children died of diarrhoea lately partly because they got to the hospital too late.

Home Management of Diarrhoea

Mothers prefer to take their children to clinic for diarrhoea (90%) but are not always able to do so (50%). The clinics have been giving ORS and the mothers know about ORS (91%). Too few mothers know they should give extra fluids for diarrhoea (57%). Although many mothers don't say they know to continue giving breast milk and food (39%), in fact most of them do so in practice (73%). See Graph 4.

Sanitation

Most large households do have pit latrines, some smaller households do not. In all, about half the population have some sort of toilet (46%) but many toilets need repair. (See Appendix E.)

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One area, Laobulbul to Lapngnuo in Zone C, has no toilets at all for 70 households. On the other side of Zone C, Imaen to Lounapina, there are only 11 toilets for 27 families. In Zone B, half the people do not have latrines. In Zone A, on third of the people do not have latrines. Many villages have pigs and other animals running about, even inside the houses.

Ten villages out of 25 villages do not have any water close by. Only nine villages have water that is safe to drink.

There are not many cases of diarrhoea or worms seen in the clinic probably because people do not come for these problems.

Birth Practices & Antenatal Care

Most women in North Tanna have their babies at home (78%). Some get help from a woman in the family (18%), most go out on their own (44%). There are at least two traditional midwives working in North Tanna, one in Zone C, one in Zone B. Women who have enough vatu and women who are having their first child go to the hospital (22%) in Lenakel. No one comes to the clinic to have their babies.

Most women (78%) attend the antenatal clinic at least once before they deliver. They all receive Chloroquine but 1 out of every ten women do not take the chloroquine.

Nutrition Practices

Though there are very few underweight children under two years old in North Tanna (4%), hardly any compared to Ambrym (11%), this does not mean there is no nutrition problem. We do not know how many children were born and died this year before the survey. See Graph 5.

We do know there is good food available in Tanna and nearly all mothers are breast feeding their children (96%). Most children (89%) are getting a balanced diet.

The problem in North Tanna is that too many children don't get fed five times a day. Only 58% of the children were given five meals the day before the interview. We asked mothers about snacks and counted any snack as a meal. None of the very young children are underweight, it is the older children, 9 months and up who are

underweight, perhaps because they need more food than they are getting. (See Graph 6.)

A second problem is that a few mothers start giving food to their children far too late. Seven (7) out of the 60 children between the ages of 4 to 12 months were not eating yet. (See Graph 7.)

Immunisation

Immunisation coverage is better in the areas served by MCH Mobile Team than in the areas served by the Green Hill Clinic. Even in villages close to Green Hill, some one year old children have come to MCH only once or twice in a whole year.

Mothers do not know much about immunisations. Less than half of the mothers (41%) know that the purpose is to prevent serious illness. None of the mothers knows the right time to come for measles immunisation.

Too few children (54%) are being brought to MCH clinic at the right time and enough times to get their immunisations before they are 1 months old.

Mothers may have had tetanus toxoid immunisation before childbirth but it is difficult to know. Half of the mothers (52%) reported that they did not get 2 or more doses before the birth of their last child. The trouble is, they had a hard time remembering doses given long ago and they had lost their pink immunisation cards.

6.0 COMMENTS ON THE VILLAGE ASSESSMENT & RECOMMENDATIONS

We met most of the objectives set for village assessment. In some villages the VDCs did not participate much in the first assessment because the health workers were doing it all themselves, to get the job done quickly. Village leaders did get good feedback from the assessment.

The village assessment helped health workers to identify health problems and to make a list of high risk women and children. The work of doing an assessment forced them to learn how to use the health information system. The communities got the information they

needed to make PHC plans and to make proper requests to the Local Government Council.

Nurses worked together with aid post orderlies and village sanitarians and VDCs. They met all the chiefs and helped straighten out some missed understanding between health workers and village people. Some people were glad to see health workers visit their village, a few were afraid.

The VDCs haven't given us much feedback on how they liked the village assessment. They had to learn a lot in a short time to start the PHC projects. There will be a final CS project evaluation in November 1993 to get more feedback from them after they have had more time to think about PHC and village assessment.

We recommend that mothers' surveys be done in group discussions any time women are waiting for MCH or some other meeting or after church. CS has a pamphlet written in Bislama on how to do this. The RHO and CS will try this group interview survey method for the assessment of Aniwa. We will not continue to do more Mothers Survey by questionnaire because it is too expensive and takes too much time. See the notes below on "Costs."

Village mapping and village graphing should be added to the village assessment plan in the new PHC project areas this year. A report from the Family Health Education course from 8th Feb. to 26 Feb. 1993 explains how village mapping is done. It is written in English.

7.0 COSTS OF THE VILLAGE ASSESSMENT

The time cost was 3-6 weeks to work village assessments. The assessments for Green Hill areas took more time because of the mothers' survey. In White Sands the assessment took only 3 weeks because we did not include mothers' survey. Work goes more quickly when the RHO supervisors gave a hand. The least number of people needed is four, the nurse, the village sanitarian, and the VDCs.

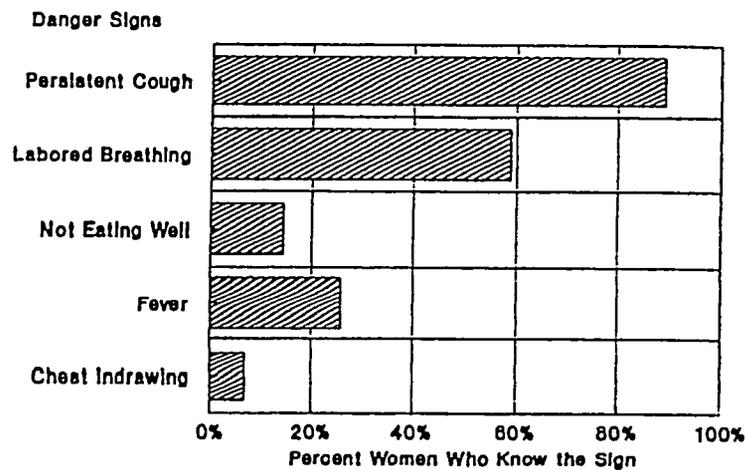
The materials cost for North Tanna was high (40,000vt) because we bought expensive VDC books and flash materials. It was lower for White Sands (14,000vt) where we used forms not books and basic materials. See the table below.

Costs estimates for Village Assessment

ACTIVITY	MANPOWER	TIME	MATERIALS	VATU
Meeting with chiefs	RHO, Nurse, Village Sanitarian	one day	Examples of forms	free
Registration	Village Sanitarian VDC Nurse Chief	One day per village	Large exercise book or copies of a form clipped together Pencils, etc.	VDC Book: 2,000/village or 1,600/village 800
Update Clinic Records	Nurse	One day for each village	Blue cards, Pink cards, exercise book, Child Register	500vt
Make a Village Tour	Nurse, RHO, Village Sanitarian, VDC, chief	same day as registration	one form, one report on "Village Mapping" from Family Health Unit	200vt
Survey Mothers	Nurse, woman VDC, RHO	one week training, one day for every 2 villages	forms, exercise books, pencils, rubbers, clip board, scales, backpack	forms 1,600 supplies 4,500 30,000vt for subsistence
Prepare Report	Nurse, VDCs	7 hours work	poster paper, calculator, markers, posters, graph paper, colored pencils, glue	400vt 1,000vt 220vt free ask FHU 120vt 230vt
TOTAL (without Survey Mothers)	TEAM OF 4-6	3-6 WEEKS		19,470vt FOR 10 BIG VILLAGES

GRAPH 1.

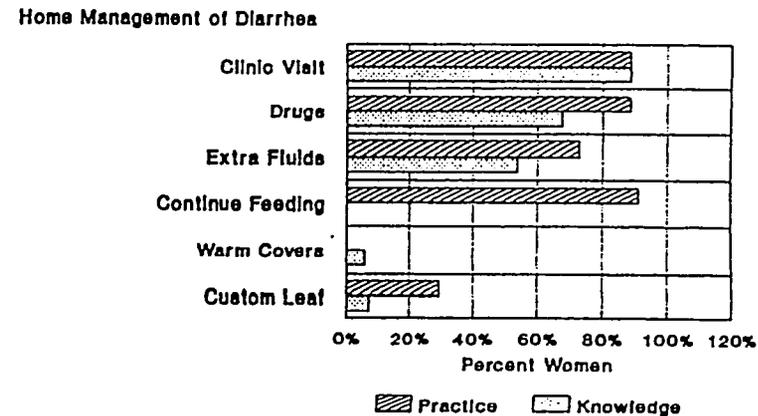
KNOWLEDGE OF MOTHERS IN NORTH TANNA Recognized Danger Signs of A.R.I.



From a Child Survival Survey 12/92
Survey of knowledge of 175 women.

GRAPH 2.

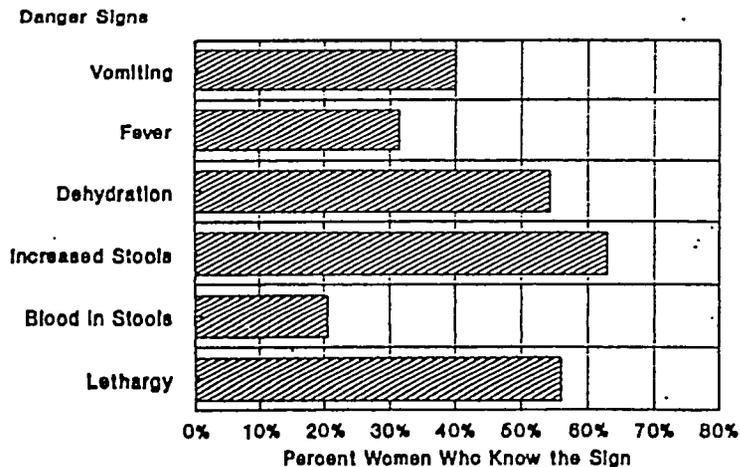
KNOWLEDGE AND PRACTICES OF MOTHERS Management of A.R.I. in North Tanna



From a Child Survival Survey 12/92
Survey of knowledge of 175 women.
Survey of real practice of 22 women.

GRAPH 3.

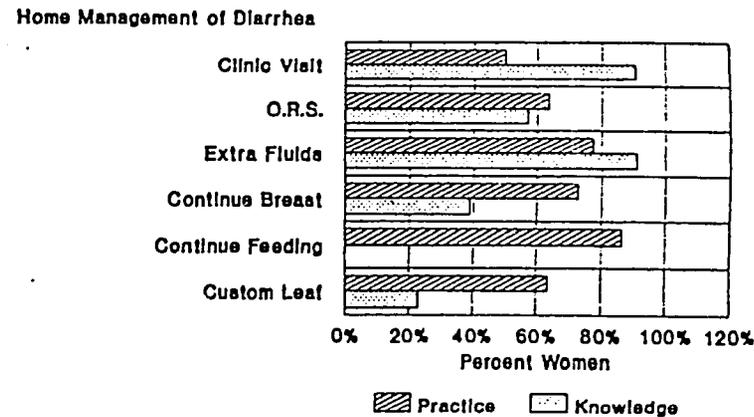
KNOWLEDGE OF MOTHERS IN NORTH TANNA Recognized Danger Signs of Dehydration



From a Child Survival Survey 12/92
Survey of knowledge of 175 women.

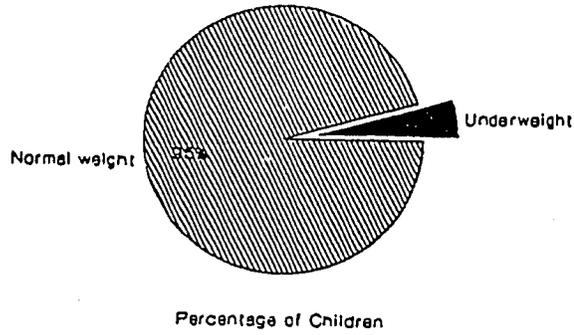
GRAPH 4.

KNOWLEDGE AND PRACTICES OF MOTHERS Management of Diarrhoea in North Tanna



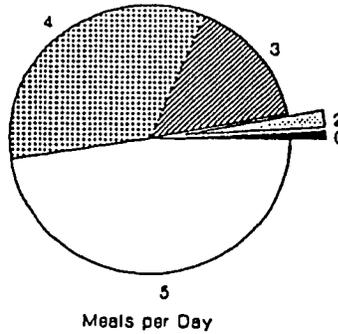
From a Child Survival Survey 12/92
Survey of knowledge of 175 women.
Survey of real practice of 22 women.

Graph 5. NUTRITION PRACTICES IN N. TANNA
Weight for Age
Children Under 2 Years



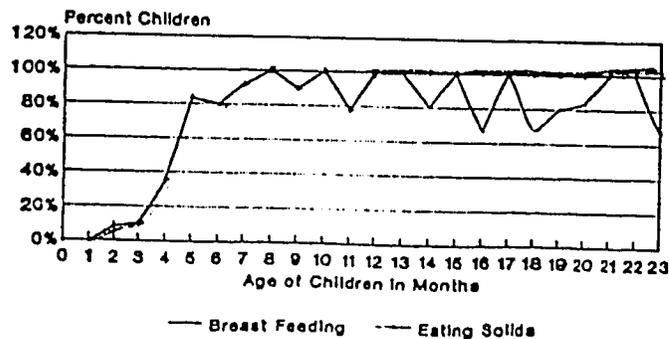
From a Child Survival Survey 12/92
Survey of 177 children under 2 years old

Graph 6. NUTRITION PRACTICES IN N. TANNA
Frequency of Feeding
Children Under 2 Years



From a Child Survival Survey 12/92
Survey of 177 children under 2 years old

Graph 7. Nutrition Practices in North Tanna
Weaning Practices
Children Under 2 Years



From Child Survival Survey, 12/92
177 children weighed.
176 Mothers interviewed. (2 sets twins.)

Costs estimates for Village Assessment

ACTIVITY	MANPOWER	TIME	MATERIALS	VATU
Meeting with chiefs	RHO, Nurse, Village Sanitarian	one day	Examples of forms	free
Registration	Village Sanitarian VDC Nurse Chief	One day per village	Large exercise book or copies of a form clipped together Pencils, etc.	VDC Book: 2,000/village or 1,600/village 800
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Prepare Report	Nurse, VDCs	7 hours work	poster paper, calculator, markers, posters, graph paper, colored pencils, glue	400vt 1,000vt 220vt free ask FHU 120vt 230vt
TOTAL (without Survey Mothers)	TEAM OF 4-6	3-6 WEEKS		19,470vt FOR 10 BIG VILLAGES

FSP/CS Village Assessment in Tanna, Vanuatu, 12/1992

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Statistical Report

Quarter 1 Year 93 Date: 30/4/93

DATA	Actual this quarter [a]	Actual year to date [b]	Target year to date [c]	% Target achieved for date [b/c]	* Annual target [e]
Number of women who deliver protected with 2 or more doses of tetanus toxoid.	22	22	16	100%	191
Number of children who complete all immunizations before the age of 1 year.	83	83	13	100%	159
Percent of children under 2 years whose weight is within normal range for age.	87%	N/A	N/A	100%	80%
Percent of women with a high risk birth who receive family planning counselling.	71%	N/A	N/A	95%	75%
Percent of high risk women and children who receive a follow up visit by the nurse or VDC member.	72%	N/A	N/A	96%	75%
Percent of families who adopt the recommended practice.	37%	N/A	N/A	62%	60%
Number of nurses who keep EPI & MCH graphs up to date.	4	4	5	80%	21
Number of VDC members who attend MCH clinics.	21	21	33	64%	134
Number of visits made to VDC members by trainers or nurses.	23	23	63	37%	252

NOTES:

Three child deaths this quarter detailed in report.

Few visits made to VDCs because transport poor and because of general disruption of routine while dealing with the hurricane fall-out and the mid term evaluation.

*191 is 90% of expected births. 159 is 75% of expected births. 21 IS 90% OF the number of nurses multiplied by the numbers of quarters in a year. 134 is the number of visits needed to cover 60% of all the expected MCH clinics. 252 is the number of visits to VDC members necessary to cover 75% of the health catchment areas each month.

Statistical Report

Quarter 2 Year 92 Date: 15/7/92

DATA	Actual this quarter [a]	Actual year to date [b]	Target year to date [c]	% Target achieved for date [b/c]	* Annual target [e]
Number of women who deliver protected with 2 or more doses of tetanus toxoid.	28	50	32	26%	191
Number of children who complete all immunizations before the age of 1 year.	44	127	26	80%	159
Percent of children under 2 years whose weight is within normal range for age.	81%	N/A	N/A	100%	80%
Percent of women with a high risk birth who receive family planning counseling.	81%	N/A	N/A	100%	75%
Percent of high risk women and children who receive a follow up visit by the nurse or VDC member.	84%	N/A	N/A	100%	75%
Percent of families who adopt the recommended practice.	59%	N/A	N/A	98%	60%
Number of nurses who keep EPI & MCH graphs up to date.	4	8	10	38%	21
Number of VDC members who attend MCH clinics.	24	45	66	34%	134
Number of visits made to VDC members by trainers or nurses.	24	47	128	18%	252

NOTES:

There was yet another infant death this quarter in Sameo. A child of 14 months died of ARI complicated by diarrhea. The child was treated appropriately in an aid post and followed up 2 days later. He had recovered then, though not fully. A week later the ARI recurred and the child died.

Trainers visits to VDC members are not satisfactory because manpower is short. Two trainers have resigned and one went off island for a month for a family medical emergency. Slowly we will phase out the trainers and train leaders from local organizations to work on their own without project support. Nurses will be expected to continue the VDC visits. We have not counted the visits made by nurses in this report. Their visits would bring the figure to approx. 35% of the goal.

MCH clinics were not done in half of the southeast area, the nurse has absconded.

**191 is 90% of expected births. 159 is 75% of expected births. 21 is 90% OF the number of nurses multiplied by the numbers of quarters in a year. 134 is the number of visits needed to cover 60% of all the expected MCH clinics. 252 is the number of visits to VDC members necessary to cover 75% of the health catchment areas each month.*

Statistical Report # 11

Quarter 3 Year 92 Date: 22/10/92

DATA	Actual this quarter (a)	Actual year to date (b)	Target year to date (c)	% Target achieved for date (b/c)	* Annual target (e)
Number of women who deliver protected with 2 or more doses of tetanus toxoid.	31	81	143	57%	191
Number of children who complete all immunizations before the age of 1 year.	64	191	119	>100%	159
Percent of children under 2 years whose weight is within normal range for age.	95%	N/A	N/A	>100%	80%
Percent of women with a high risk birth who receive family planning counselling.	80%	N/A	N/A	>100%	75%
Percent of high risk women and children who receive a follow up visit by the nurse or VDC member.	76%	N/A	N/A	>100%	75%
Percent of families who adopt the recommended practice. *	86%	N/A	N/A	>100%	60%
Number of nurses who keep EPI & MCH graphs up to date.	3	11	18	70%	21
Number of VDC members who attend MCH clinics.	26	71	101	71%	134
Number of visits made to VDC members by trainers or nurses.	18	65	189	34%	252

NOTES:

Two children died in Southeast Ambrym, one at 2 weeks with suspected congenital cardiac problem. The other child died at 11 months and was in good health. Police are investigating the case.

*The percent of families adopting recommended practices exceeds the percentage who got home visits because one nurse called all his family planning risk cases into clinic for counselling and 14 women then accepted family planning without ever having had a home visit.

There is still no nurse in Southeast Ambrym, Endu station.

**191 is 90% of expected births. 159 is 75% of expected births. 21 IS 90% OF the number of nurses multiplied by the numbers of quarters in a year. 134 is the number of visits needed to cover 60% of all the expected MCH clinics. 252 is the number of visits to VDC members necessary to cover 75% of the health catchment areas each month.*

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DATA	Actual this quarter (a)	Actual year to date (b)	Target year to date (c)	% Target achieved for date (b/c)	* Annual target (e)
Number of women who deliver protected with 2 or more doses of tetanus toxoid.	33	114	191	60%	191
Number of children who complete all immunizations before the age of 1 year.	19	210	159	>100%	159
Percent of children under 2 years whose weight is within normal range for age.	89%	N/A	80%	>100%	80%
Percent of women with a high risk birth who receive family planning counselling.	100%	N/A	75%	>100%	75%
Percent of high risk women and children who receive a follow up visit by the nurse or VDC member.	94%	N/A	75%	>100%	75%
Percent of families who adopt the recommended practices.	90%	N/A	60%	>100%	60%
Number of nurses who keep EPI & MCH graphs up to date.	27	38	21	>100%	21
Number of VDC members who attend MCH clinics.	27	98	134	73%	134
Number of visits made to VDC members by trainers or nurses.	12	77	252	31%	252

NOTES:

There were no deaths this quarter. The death last quarter in Endu was by drowning by misadventure, according to police reports.

Ola clinic has re-opened this quarter after the nurse had 2 months of traditional medicine treatment in Santo for arthritis.

Two nurses have been reassigned to other posts or sent on a course. One of these has been replaced. There is no MCH/PHC Coordinator for Ambrym at this time.

Separate indicators for Tanna will be added next quarter.

**191 is 80% of expected births. 159 is 75% of expected births. 21 is 90% of the number of nurses multiplied by the numbers of quarters in a year. 134 is the number of visits needed to cover 60% of all the expected MCH clinics. 252 is the number of visits to VDC members necessary to cover 75% of the health catchment areas each month.*