

THE FOUNDATION FOR THE PEOPLE OF THE SOUTH PACIFIC
(A Division of Counterpart, Inc.)
PO Box 43, Tarawa,
South Pacific

Kiribati

DETAILED IMPLEMENTATION PLAN, CS IX, KIRIBATI
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SECTION A:

1. BUDGET SUMMARY IN U.S. DOLLARS

Place dollar amounts in shaded areas only

(a)	(b)	(c)	(d)
a. By year of project	A.I.D. Contribution (held + HQ)	PVD Contribution (held + HQ)	Total Contribution (held + HQ)
Year 1	\$93,311	\$95,624	\$195,139
Year 2	\$123,766	\$76,848	\$200,413
Year 3	\$129,420	\$45,486	\$174,915
Country project total	\$358,496	\$211,971	\$570,467

b. Percent of PVO Match	37%
(PVO Contribution divided by Total Contribution: sum of column "c" divided by the sum of column "d")	

3. PERCENT OF TOTAL A.I.D. CONTRIBUTION by INTERVENTION

Place percentages in shaded areas only, percentages in unshaded areas only

INTERVENTION	Percent of Project Effort (%)	Percent of A.I.D. Funds in US \$
a. Immunization	10	\$35,850
b. Control of Diarrheal Diseases	25	\$89,624
c. Nutrition		\$0
d. Vitamin A	20	\$71,699
e. Iodine		\$0
f. Control of Pneumonia	20	\$71,699
g. Maternal Care/Family Planning	25	\$89,624
h. Malaria Prevention & Management		\$0
i. HIV/AIDs		\$0
j. Other (specify)		\$0
k. Other (specify)		\$0
l. Other (specify)		\$0
m. Other (specify)		\$0
TOTAL	100%	\$358,496

2. SIZE OF 1KT POTENTIAL BENEFICIARY POPULATION

Note: POTENTIAL BENEFICIARIES are defined as those in the project area who are eligible to receive services for a given intervention, not the percent you expect to provide services to - which may be smaller than the eligible population.

(e)	(f)
a. Current population within each age group'	Number of Potential Benefic.
infants, 0-11 months	2,548
children, 12-23 months	2,772
children, 24-59 months	1,295
children, 60-71 months (If Vitamin A component)	2,291
females, 15-19 years (high risk pregnancy)	3,442
females, 20-34 years	10,543
females, 35-49 years (high risk pregnancy)	5,479
Other (specify)	
Other (specify)	
b. Additional births	
Total estimated live births, years 2 and 3	4,774
c. Total Potential Beneficiaries	39,144

* Note: Females (ages 15 - 49) should only be included as potential beneficiaries where they are direct beneficiaries of services (for example, TT immunizations, or family planning services), and not for educational interventions (for example, education on proper use of ORT).

4. CALCULATION OF A.I.D. DOLLARS per BENEFICIARY per YEAR

a. Total A.I.D. Contribution to Country Project (sum of column "b" in table 1, this page)	\$358,496
b. Total Potential Beneficiaries (sum of column "f" in table 2, this page)	39,144
c. A.I.D. Funding per Beneficiary for Project (line a. divided by line b. in table 4, this page)	\$9.16
d. A.I.D. Funding per Beneficiary per year (line c. above divided by 3 years)	\$3.05

5. ACTIVITIES: Circle all activity codes that apply for each intervention

a. Immunization

- 1 = Distribute vaccines
- 2 = Immunize mother/children
- 3 = Promote immunization
- 4 = Surveillance for vaccine preventable diseases
- 5 = Training in immunization
- Other _____ (specify)

d. Vitamin A

- 1 = Vitamin A deficiency treatment
- 2 = Vitamin A supplementation
- 3 = Vitamin A fortification
- 4 = Vitamin A education
- 5 = Vitamin A food production
- Other _____ (specify)

h. Malaria Prevention and Management N/A

- 1 = Residual insecticides
- 2 = Larviciding
- 3 = Provision of bednets
- 4 = Provision of commodities
- 5 = Treatment
- 6 = Health education
- 7 = Training
- Other _____ (specify)

b. Control of Diarrheal Diseases

- 1 = Distribute ORS packets
- 2 = Promote use of ORS packets
- 3 = Promote home-mix
- 4 = Promote SSS home-available fluids
- 5 = Dietary management of diarrhea
- 6 = ORT training
- 7 = Hand washing
- Other _____ (specify)

a. Iodine N/A

- 1 = Iodine deficiency treatment
- 2 = Iodine supplementation
- 3 = Iodine fortification
- 4 = Iodine education
- 5 = Iodine food production
- Other _____ (specify)

i. HIV/AIDS Prevention N/A

- 1 = Distribution of Condoms
- 2 = AIDS education
- 3 = X-3' testing and counseling
- Other _____ (specify)

j. Other Specify:

c. Nutrition

- 1 = Distribute food
- 2 = Provide iron, folic acid, vitamins
- 3 = Provide scales and growth charts
- 4 = Sponsor mother-to-mother breastfeeding/promotion support groups
- 5 = Conduct food demonstrations
- 6 = Counsel mothers on breastfeeding and weaning practices
- 7 = Conduct group sessions
- 8 = Training in breastfeeding and weaning
- 9 = Training in maternal nutrition
- 10 = Training in growth monitoring
- Other _____ (specify)

c. Control of Pneumonia

- 1 = Promote antibiotics
- 2 = Health education
- 3 = Improve referral sites
- 4 = Training
- Other _____ (specify)

k. Other Specify:

g. Maternal Care/Family Planning

- 1 = Distribute contraceptives
- 2 = Promote exclusive breastfeeding to delay conception
- 3 = Promote child spacing or family planning
- 4 = Antenatal care
- 5 = Promote malaria prophylaxis
- 6 = Train TBAs in improved birth practices
- 7 = Family planning counseling
- 8 = Improve Referral Sites
- Other _____ (specify)

l. Other Specify:

SECTION B: LOCATION AND FORMAL AGREEMENTS

B.1 LOCATION DESCRIPTION

The Republic of Kiribati (pronounced “**kíh - rih** - boss”, a local spelling of the British colonial name for the group, the “Gilberts”) covers a vast stretch of the central Pacific Ocean and contains 33 coral atolls in three main island groups - the Gilberts, the Line Islands, and the southern or phoenix group. The capital is on the atoll of Tarawa, located about at the intersection of the Equator and the International Dateline. More than one third of the country’s 72,335 people live on Tarawa. The total land area of Kiribati is tiny - a mere 310 square miles. However, the total sea area between and around all the islands is approximately 1.4 million square miles.

Summary descriptions of the national population are given below.

Table B.1 Summary Statistics, Kiribati	1985	1990
Total Population	63,883	72,335
Annual Growth Rate	2.1%	2.24%
Infant Mortality Rate (IMR)/1,000	82	65
Maternal Mortality Rate (MMR)/ 10,000	2	1
Life Expectancy (? + ♂)	55.6	60.2
Economic Activity: % of active population		
Cash Economy	26.5%	34.2%
Village Economy	71.1%	63.0%
Unemployed	2.4%	2.8%
Per Capita Health Spending	US\$ 21.19	US\$ 35.81
% of Government Expenditures		
On Education	-	14.0%
On Health	6.5%	10.3%
Sources:	1990 Census of Population 7th National Development Plan	

Several of the Child Survival project activities are targeted toward national (based in the capital) or district levels (on outer atolls) for strengthening institutional capacity and in improving the delivery of child survival health services. Four islands, all in the Gilberts group, have been identified for broader-based community involvement and health education training. The Gilberts group contains 91% of the country’s population.

Maps of the Republic of Kiribati and the four specific project locations of Betio (an urbanized islet of Tarawa), Butaritari, Maiana, and Onotoa are provided in Appendix A.

Constraints have already been encountered during the baseline survey and participatory planning processes. It can be expected that the following areas will continue to present challenges:

B.1.a Geographic Constraints-Transport and Communications

Local flights are available, but are unpredictable. Several atolls are served only twice monthly; competition for seats is considerable. There are no flight alternatives, and Bonriki airport in the capital of Tarawa has just closed for six months (except for 2 hours per week) while the runway is extended. Sea transport is more costly, time-consuming and subject to capricious weather. Land transportation on all atolls other than Tarawa is limited and is generally in poor repair. The most consistently available land transportation is walking. There is no telephone or fax service on outer islands. The need to continually revise travel schedules, the unreliability of mechanical devices (vehicles, boats, planes, computer hardware, photocopier, etc.) and the difficulty of replacing or repairing non-working equipment are all problems faced by anyone trying to do business in the country, and add extra time and money to the costs of doing a development project.

B.1.b Economic Constraints

Because of the geographic isolation and the nature of the islands-a series of tiny coral atolls-making a living is not easy. The atolls of Kiribati are seldom higher than 16 feet above sea level, and are often a thin broken strip of sandy islets surrounding a central lagoon.

The population is large relative to land area; the land itself, being mostly alkaline coral sand, is of poor quality; and rainfall is scarce. These factors make it difficult to grow the range of foods necessary for good health. Traditional food is only a few items; fish, coconut in its many forms, breadfruit, pandanus, and babai, a form of taro. Imported food items such as flour, rice and canned meat or vegetables have become important in recent times but are expensive. The sea offers a great variety of fish which is the staple of the Kiribati diet, but these too are under pressure from environmental factors such as pollution and man's habit of catching more fish than the resource can support.

In recent years, people from the outer atolls have flocked to South Tarawa for the usual reasons of opportunity and employment possibilities, which has created the current crowded living conditions in the capital. Typically, 8 to 20 people will live in a single family dwelling. Often, a majority of family members have arrived from outer islands to live with relatives on Tarawa and have no income earning skills. This situation has contributed to a great deal of poverty, poor health, and malnutrition on the islands of South Tarawa, including Betio, one of the four islands chosen for this project. Population densities on the islands in the Gilberts group range from a low of 236 people per square mile (on Kuria Atoll) to over 3,500 per square mile on South Tarawa. This extremely high density has had its usual effects on the quality of sanitation, water, and life in general. Vitamin A deficiency in South Tarawa, for example, is about four times as high as on other atolls of the Gilberts group.

Finally, the Government is poor and largely dependent on external aid. Health spending, while taking up about 10% of the annual budget, is only \$36 per person per year. The total

health budget is about US\$ 2.5 million per year, which would be the yearly budget for one very small hospital in the US . . .

B.1.c Education and the Status of Women

The general level of education of the people of Kiribati has not kept pace with the need to provide support for modern systems of technology - computers for example. There is virtually no service available locally for repairs or purchases of computer equipment. Kiribati is in the position of needing to provide education for its young people and needing to provide opportunities for employment at the conclusion of that education.

Considerable effort is currently going into educating women, which will hopefully give them the skills and the confidence needed to contribute to modern Kiribati. The traditional low status of women, however, still prevails. The more modern I-Kiribati woman working an office job to provide money for food for her family may find difficulty solving family problems because traditionally, I-Kiribati men take very little interest in day-to-day happenings within the family. The wife is still commonly expected to cook all family meals and look after the children as well as work at a job that pays money for living expenses. Especially in urban Tarawa, there may little family support from grandparents, who often are still living in the outer islands.

FSP CS project planning has been delayed by the scarcity of I-Kiribati people with the education credentials needed for project personnel slots. We have elected to revise job descriptions and increase the number of positions rather than recruit additional expatriate staff.

B.1.d Cultural and Community Organization

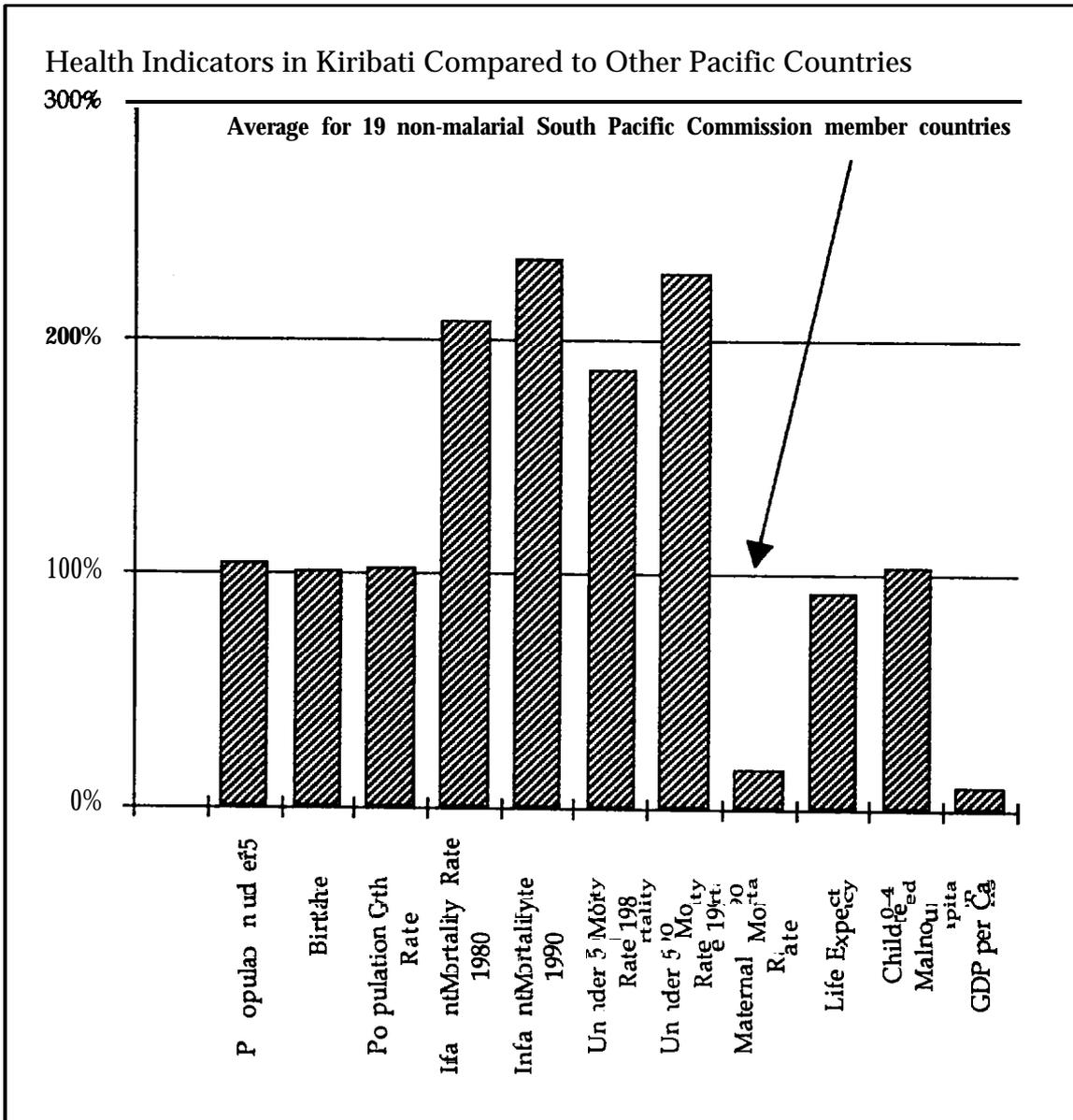
The Micronesian people of Kiribati are a strongly community oriented group. Traditionally, elder men made up Island Councils for making all important community decisions. Wives of the elders attended community meetings and were not allowed to speak. The women sat behind the men and whispered what they thought. This system is still intact today.

Because of the size of the islets, villages tend to be small, close knit groups extensively tied together by blood and marriage. Economic independence is encouraged, and being dependent on others carries great shame. This is balanced by a social system of mutual aid, called bubuti, which takes the form of an irrefusable assistance. Abuse of the system is prevented by the shame associated with being seen to be dependent on others.

On most atolls, foreign NGOs are required to register with the Island Council and pay an annual fee to them. Not all NGOs are willing or able to comply, creating difficulties in contacting some community groups and enrolling their membership. In recent history, most organizations and Government Ministries have taken on a pattern of making money payments or gifts of tobacco to Island Councils and community groups to cover the opportunity cost of time such individuals devote to collective gatherings. FSI? has explained that such "sitting fees" or monetary compensation will not be provided. FSP has also substituted vegetable seeds for tobacco as a custom gift. This departure from customary practices has been greeted with varying levels of enthusiasm.

B.2 LOCATION JUSTIFICATION

Kiribati has been designated a least-developed country by the European Community (1979) and the United Nations (1987). As can be seen in the following chart, child health statistics in Kiribati are bad even when compared to its neighbors. Infant Mortality and Under 5 Mortality rates are among the highest in the non-malarial countries of the Pacific, while GDP per capita is among the lowest. In addition, although the IMR and U5MR have improved, they have not kept pace with the average decrease in their neighbor's rates.



FSP is well positioned to augment Child Survival initiatives on the strength of its long standing regional and in-country presence. The Ministry of Health, Family Planning and Social

FSP

Welfare (MHFPSW) has worked closely with FSP on previous health projects, most notably in Vitamin A activities,

The Ministry was restructured in July 1991 to be responsible for (a) community development (b) population and family planning (c) public health and hospital services (d) traditional medicine (e) sports and physical fitness and (f) social welfare and extension services.

All public health services are provided by the MHFPSW. There are 24 Health Centers and 48 Dispensaries in the country. We will call them "clinics" in this DIP. There is one hospital, Tungaru Central Hospital, located on the capitol atoll of Tarawa. In 1988, there was one doctor for every 1,967 people. However, with the exception of one doctor on Christmas Island, *all* of the doctors were located in Tarawa. The Health Centers are supervised by the District Principle Nursing Officers (DPNOs). There was one Public Health Nurse (PHN) for every 550 people, with PHNs located on almost all of the islands, and one Health Center or Dispensary for every 1,750 people. There is also one Medical Assistant (MA) on almost every island, and a Nurses Aide (NA) for every 970 people. Facilities and personnel are inadequate to meet the medical needs of the people.

The four project areas selected for in-depth community training are the three outer atolls of Butaritari, Maiana and Onotoa, and the populous islet of Betio. They were chosen according to two criteria: health status or need, and community support. Health status was derived from MHFPSW statistics on diarrheal disease, malnutrition, vaccine preventable diseases and family planning coverage. The 19 potential project areas were ranked by severity of health problems.

For each island, a point score was calculated by using 1992 data on diarrheal disease, nutrition, family planning and immunization. Higher scores indicate more widespread health problems. Another score was added for resources that the community agreed to provide.

Community organization for these islands is typical of Kiribati as a whole, with the running of the island's affairs being the responsibility of the elected Island Council. Each Island Council (with one exception) was visited by FSP staff to explain the project and explore community support. The level of commitment was measured both by the island visits and by written agreement to provide local resources such as transport, meeting facilities and accommodations for project staff. A shortlist of 9 islands was presented to representatives from MHFPSW and the **Ministry** of Home Affairs and Rural Development (MHARD), from which the 4 were selected.

All islands that had a combined score of ninety (90) or higher received careful examination. That list included:

Beru	94
Butaritari	152
Maiana	92
Makin	112
Nounouti	118
Onotoa	140
Tarawa N.	123

In addition to the point scores, the issue of fairness and balanced distribution was discussed, so that no district would be over-represented or under-represented. The final decision was reached with the assistance of representatives from both **MHFPSW** and **MHARD**.

B.3 FORMAL AGREEMENTS

FSP has maintained an office in Kiribati since 1982. From the earliest stages of developing the proposal for the Child Survival Program, **MHFPSW** has been an active participant in planning project goals, activities and locations. Primary cooperation has come from the **MHFPSW** Secretary, the Chief of Preventative Care, and Health Education Unit (**HEU**) which has provided the facilities for a weekly meeting with FSP staff and **HEU** representatives. Formal agreement is being developed with **HEU**. The **Ministry** of Home Affairs and Rural Development (**MHARD**) has also been an active partner in project planning, selection of project locations and assisting with outer-island communications via radiophone.

A written project agreement is being created for signing by FSP and the Island Councils of the four project locations. This will formalize the responsibilities of FSP and the provision of community resources, which vary slightly by atoll.

SECTION C: PROJECT DESIGN

C.1 BASELINE SURVEY

Please note that, due to the constraints on travel mentioned earlier, we were not able to complete the baseline survey for all four of the target islands. However, the survey currently contains 77% of the projected number of respondents, and will be completed as soon as airline schedules permit. Based on our previous visits to the rest of the areas, we feel that the addition of the **final** data will not materially change our conclusions or our objectives.

A summary of the baseline survey results is given in the Appendix. The survey was used in the design of the project to:

- 1) Assess the relative importance of the 5 intervention areas.
- 2) Verify that the disease incidence in the project areas matched that reported in other national surveys.
- 3) Quantify the numerical objectives for the various interventions.
- 4) Assess the level of knowledge about various diseases and preventions for use in the design of the trainings and educational materials.

Survey Population Demography

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A) Population Age 0-24 Months (Note: Used Annual Increase Of 1.023%)

Island	1990 Census		Estimate	Estimate	Estimate
	<12 mo.	12-24 mo.	1994	1995	1996
Betio	302	306	666	681	697
Butari	143	165	337	345	353
Maiana	54	67	133	136	139
Onotoa	56	55	122	125	128
	Totals		1,258	1,207	1,317

B) Population By Island As % Of Total

Betio	52.9%
Butari	26.8%
Maiana	10.6%
Onotoa	9.7%

C) Population By Village

	1990 Census	Estimate	Estimate	Estimate
		1994	1995	1996
Betio				
Tokoronga	298	326	334	342
Temakin	310	340	347	355
Total	608	666	681	697
Butaritari				
Kuma	29	32	32	33
Keuea	19	21	21	22
Tanimainuku	17	19	19	19
Tanimaiaka	22	24	25	25
Tabonuea	27	30	30	31
Butaritari	129	141	145	148
ukiangang	50	55	56	57
Bikoti	15	16	17	17
Total	308	337	345	353
Maiana				
Tebikerai	5	5	6	6
Tekaranga	13	14	15	15
Temanta	12	13	13	14
Aobike	5	5	6	6
Natareta	2	2	2	2
Tebwanga	15	16	17	17
Tebwangaua	10	11	11	11
Toora	10	11	11	11
Tebwangetua	3	3	3	3

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	Teitai	3	3	3	3
	Tebiauea	13	14	15	15
	Raweai	14	15	16	16
	Bubutei	16	18	18	18
	Total 129	121	133	136	139
Onotoa					
	Tekawa	13	14	15	15
	Tanaeang	15	16	17	17
	Buariki	25	27	28	29
	Temao	8	9	9	9
	Otoa	12	13	13	14
	Aiki	17	19	19	19
	Tabuarorae	21	23	24	24
	Total	111	122	124	127

C.2 GOALS AND **OBJECTIVES**

DIP TABLE B: PROJECT GOALS AND OBJECTIVES

FSP KIRIBATI PROJECT GOALS: 1. To decrease the morbidity and mortality of children under 5 years of age.

2. To improve the training of the rural and national medical personnel.

(1) Project Objectives by Intervention	(2) Measurement Method How /When	(3) Major Planned Inputs and Activities	(4) outputs	(5) Measurement Method & Data Source - How /When
Increase from 72% to 90% the number of infants receiving DPT3.	KAP survey - Baseline & End of Project Monthly MHPPSW Coverage Statistics	1. DPNO Training Course 2. MA/PHN Training 3. NGO Training #4	1. Improved mgmt / communication of EPI program 2. Improved Time Mgmt /Record Keeping 3. Increased community knowledge/support for immunization 4. Motivation of mothers to take children to Immunization Clinic	1. MHFPSW C 2. Monthly check Cold Chain Log 3. Outer island MA/PI-IN followup 4. Community verbalization of learned principles 5. KAP survey - Baseline & End of Project
Inaease from 78% to 90% the number of infants receiving Polio3.	KAP survey - Baseline & End of Project Monthly MHPPSW Coverage Statistics	1. DPNO Training Course 2. MA/PHN Training 3. NGO Training #4	1. Improved mgmt/communication of EPI program 2. Improved Time Mgmt /Record Keeping 3. Increased community knowledge/support for immunization 4. Motivation of mothers to take children to Immunization Clinic	1. MHFPSW C 2. Monthly check Cold Chain Log 3. Outer island MA/PI-IN followup 4. Community verbalization of learned principles 5. KAP survey - Baseline & End of Project
Increase from 38% to 70% the number of mothers able to produce immunization card.	KAP survey - Baseline & End of Project	1. NGO Training #4	1. Greater number of mothers carrying Immunization Card	1. KAP survey - Baseline & End of Project

Increase from 69% to 90% the number of cases of diarrhea treated with packaged ORS.	KAP survey - Baseline & End of Project	1. NGO Training X3 2. MA/PHN Training	1. Increased number of mothers giving their children ORS. 2. Enhanced community education skills 3. Improved case mgmt.	1. KAP survey - Baseline & End of Project 2. Monitoring communities progress in Training W4. 3. MHPPSW Stats.
Increase from 52% to 88% the number of breastfeeding mothers who continue or increase the amount of breastmilk given children during diarrhea.	KAP survey - Baseline & End of Project	1. NGO Training #3 2. EIC / Teachers / Religious/ TBA/ TH Workshops	1. Increased number of mothers breastfeeding during diarrhea. 2. Message to continue breastfeeding spread through community.	1. KAP survey - Baseline & End of Project 2. Verbalization of message by community members. 3. community followup visits.
Increase from 35% to 60% the number of mothers who continue or increase the amount of food given children during diarrhea.	KAP survey - Baseline & End of Project	1. NGO Training #3 2. EIC / Teachers / Religious/ TBA/ TH Workshops	1. Increased number of mothers continuing or increasing food during diarrhea. 2. Increased community awareness and action of correct diarrheal case mgmt.	1. KAP survey - Baseline & End of Project 2. Verbalization of message at end of workshop Trainings. 3. Assessment of learned messages and correct action during Trainine #4.
Increase from 63% to 90% the number of mothers who continue or increase the amount of liquid given children during diarrhea.	KAP survey - Baseline & End of Project	1. NGO Training #3 2. EIC/ Teachers/ Religious/ TBA/ TH Workshops	1. Increased number of mothers continuing or increasing liquids during diarrhea. 2. Increased community awareness and action of correct diarrheal case mgmt.	1. KAP survey - Baseline & End of Project 2. Verbalization of message at end of workshop Trainings. 3. Assessment of learned messages and correct action during Training #4.
Increase to 95% the number of mothers providing Vitamin A foods to their children.	KAP survey - Baseline & End of Project	1. NGO Training X3 2. EIC I Teachers / Religious/ TBA/ TH Workshops	1. Increased number of mothers providing Vitamin A foods to their children. 2. Increased community skills in growing Vitamin A rich foods.	1. KAP survey - Baseline & End of Project 2. community followup visits (Trainings #3 & #4).

Maintain at 95% the number of children receiving Vitamin A capsules on schedule.	MHFPSW Coverage Records	1. DPNO Training 2. MA/PHN Training 3. NGO Training #2	1. Improved clinic mgmt of Vitamin A campaigns & records 2. Increased community awareness of Vitamin A Campaigns.	1. Increased attendance of Vitamin A Campaigns (March/July/November)
Increase to 50% the number of mothers introducing weaning foods between 4-6 months of age.	KAP survey - Baseline & End of Project	1. NGO Training #2 2. EIC /Community Leaders Workshop	1. Enhanced knowledge of correct weaning age/weaning foods.	1. KAP survey - Baseline & End of Project
Increase to 70% the number of couples in union, not planning a pregnancy in the next two years, who use a contraceptive method.	KAP survey - Baseline & End of Project	1. NGO Training X4 2. MA/PHN Training	1. Increased number of FP acceptors. 2. Increased awareness of the types of PP methods available in the clinic.	1. KAP survey - Baseline & End of Project 2. MHFPSW FP acceptor statistics
Increase from 69% to 90% the number of mothers who know the danger signs of ALRI and when it is appropriate to seek treatment.	KAP survey - Baseline & End of Project	1. NGO Training #3 2. MA/PHN Training	1. Increased maternal knowledge of signs/symptoms of and treatment for ALRI. 2. Inueased number of community health talks on ALRI.	1. KAP survey - Baseline & End of Project



C.3 PROJECT DESIGN

The project is designed to support **MHFPSW** in improving the provision of public health services, and in promoting community education and local action to support both the prevention and proper treatment of illnesses

Activities at the national level will consist of training aimed at augmenting institutional capacity and at upgrading the skills of current health care providers. Efforts at the local level will be concentrated on community-based workshops which will take place on the four chosen islands for the project.

Health content areas at both levels will be:

- Control Of Diarrheal Diseases
- Childhood Immunizations
- Family Planning
- Improved Nutrition (Including Vitamin A)

The baseline survey has also indicated a need to incorporate a project element for education regarding respiratory infections. The project does not include technical interventions for acute lower respiratory infections, but will develop appropriate health education messages in response to the need indicated. The project as a whole is an integrated, comprehensive approach involving multi-level training, education, and impetus to further community and personal action.

As all of these areas are not of equal importance, the relative amounts of time which will be allocated to the areas during the trainings are:

- Control Of Diarrheal Diseases.....25%
- Family Planning25%
- ALRI20%
- Improved Nutrition (Including Vitamin A)20%
- Childhood **Immunizations**10%

We are aware that the scope of the areas of training is perhaps somewhat broad. However, the training content has been developed with close contact and extensive input from **MHFPSW**, who feel very strongly that once the money has been spent to train the trainers, transport them out to the outer islands, house them, feed them, develop training materials, and generally put the project in place, they (**MHFPSW**) would like to use the trainers to deliver all of what they see as the most important health messages.

because of this, we have designed the trainings to be long enough (1 week for the medical personnel, four 1 week trainings for each of the villages) to allow us to completely cover what is admittedly a fairly broad range of topics.

Eligible women, children, and newborns will enter the project by visiting their local Health Center, as their Community Health Worker (CHW), Medical Assistant (MA) or Village Welfare

Group (VWG) will have been trained by the project. Also, their participation will be encouraged and expanded by the community based workshops, where community leaders will receive information about the specific signs of dangerous illness, home treatments, prevention, and other health issues which will be dealt with by the project. See Section C.5.d for more information on these community level workshops.

This project design was chosen for reasons of sustainability and cost-effectiveness. It is sustainable because it consists of the education of the various health personnel, village and community leaders, and families. This education will remain long after the **project** is gone.

It is cost-effective for the same reasons, and also because it is the easiest way to reach the scattered population of Kiribati. Educating the health personnel will reach the entire country, not just four islands, and will affect the lives and welfare of the entire nation.

C.4 PROJECT EVALUATION

Several types of monitoring and evaluation will go on, each dealing with a different aspect of the project.

C.4.a Training Evaluation

Each category of training and workshop activities has associated follow-up visits. These are designed to evaluate the effectiveness of project elements and levels of learning achieved. This information will be of crucial importance in continuous improvement of training materials, delivery, and content. Monitoring and evaluation will be done by means of:

Monitoring

- 1) Training feed back by trainees
- 2) Trainer evaluation (of workshops run by Health Educators) by the Trainer of Trainers.
- 3) Followup visits to MAs, PI-Ins, and DPNOs
- 4) Follow-up visits to Island Councils, NGOs, and community leaders
- 5) Monthly island public health statistics.

Evaluation

- 1) Trainee evaluation forms (self evaluation & training evaluation)
- 2) Trainer evaluation reports
- 3) Follow up visit reports
- 4) Health statistics forms (MS1) in Appendix

TRAINEE JOB TITLE	COURSE TITLE	NO. OF HOURS PER MONTH		SUPERVISOR	CONTACTS PER MONTH	INTERVENTION(S)
		INITIAL	SERVICE			
MHFPSW Senior Official, DPNO for District, Cathy Emery FSP TOT	DPNO Clinic Management Assessment	40 hours k # districts = 200hrs		Unknown Clinic Management Assessment Consultant	Several, minimum of 2, often more	Overall improvement of clinic /management, therefore, all C. S. areas.11
Sean Kennedy FSP HPC, Cathy Emery FSP TOT, Fenua Tamuera FSP HE	DPNO Workshop		80	Mary McMurtry, FSP CR	Several, minimum of 2, often more	All.
DPNO, MHFPSW official, Sean Kennedy FSP HPC, Cathy Emery FSP TOT	MAPHN Workshop		40	Mary McMurtry, FSP CR	Several, minimum of 3, often more	Impact on all project areas: Time Management Community Education, Record Keeping.
Sean Kennedy FSP HPC, Fenua Tamuera FSP HE	Extended Island Council Workshops		30	Sean Kennedy FSP HPC	Several, minimum of 2, often more	All, through focus on community motivation & action skills.
Fenua Tamuera FSP HE, Unknown FSP Junior HE, Island MAPHN	NGO/Community Worker Training - Series 1		30	Sean Kennedy FSP HPC	Several, minimum of 2, often more	Introduction to child survival issues.
Fenua Tamuera FSP HE, Unknown FSP Junior HE, Island MAPHN	NGO/Community Worker Training - Series 2		30	Sean Kennedy FSP HPC	Several, minimum of 2, often more	Nutrition/Vitamin A.
Fenua Tamuera FSP HE, Unknown FSP Junior HE, Island MAPHN	NGO/Community Worker Training - Series 3		30	Sean Kennedy FSP HPC	Several, minimum of 2, often more	CDD/ALRI.
Fenua Tamuera FSP HE, Unknown FSP Junior HE, Island MAPHN	NGO/Community Worker Training - Series 4		30	Sean Kennedy FSP HPC	Several, minimum of 2, often more	Family Planning/EPI.
Sean Kennedy FSP HPC, Cathy Emery FSP TOT, Fenua Tamuera FSP HE	Island Teachers Child Survival Workshop		30	Sean Kennedy FSP HPC	Several, minimum of 2, often more	All.
Sean Kennedy FSP HPC, Cathy Emery FSP TOT, Fenua Tamuera FSP HE	Island Religious Leaders Child Survival Workshop		30	Sean Kennedy FSP HPC	Several, minimum of 2, often more	All.
Sean Kennedy FSP HPC, Cathy Emery FSP TOT, Fenua Tamuera FSP HE	Island TBATH Child Survival Workshop		30	Sean Kennedy FSP HPC	Several, minimum of 2, often more	All.
TOTAL		200	360		min 22	

C.4.b Timing and Budgeting

Completion of individual project components will be compared against the training schedule. Budgets will be reviewed monthly, to ensure that the project stays within budget.

c 4. c Health Status

The Health Statistics Unit of MHFPSW will provide the data on health status. These statistics are collected from all outer islands and processed by MHFPSW staff. This data is regularly made available to FSP.

C.4.d Overall Project Performance

Midterm and final evaluations will be carried out by an independent evaluator, along with the FSP Regional Health Coordinators. The midterm evaluation is scheduled for 18 months into the program.

C.5 TRAINING/ SUPERVISION PLAN

These activities represent the main **body** of the program. Project elements are summarized here in general order of their occurrence.

The personnel involved in doing the trainings (supervisors) will be the Health Programs Coordinator, the Trainer of Trainers, and two Health Educators. The resumes of the HPC and the TOT are in the appendix; the Health Educators have not yet been hired. A total of 556 people, made up of 5 DPNOs, 19 MAs, 42 PHNs, 100 extended Island Council leaders/members, 180 NGO leaders /members, and 210 other island leaders will be trained. There will be no field work. See Section C.4.a for the monitoring and evaluation plan.

C.5.a Training of Trainers (TOT) for FSP Staff.

This is listed as part of the training plan, although it will be done in-house and no AID funding is requested. FSP has an experienced Trainer of Trainers on staff, who **will** give primary attention to the training of FSP Health Educators. **This** is listed as a scheduled event; however, the Trainer of Trainers will continue to be on staff into the 2nd Year, as a continuous resource person.

C.5.b Clinic Management Assessment

This is a one-time activity designed to serve as both a training needs analysis for the training of health care providers, and as an exercise in self assessment techniques. A team comprised of an FSP consultant (with background in participatory self assessment techniques), the District Principal Nursing Officer (DPNO), and a Senior MHFPSW Officer will conduct assessments on three islands.

The assessment will look at the current level of knowledge of the people who are actually staffing the Health Center(s) on each of the islands. Particular attention will be paid to their knowledge of currently recommended practice regarding diarrheal diseases, childhood

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immunizations, family planning, ALRI, and nutrition. In addition, non-technical areas such as Health Center management, sanitation, and patient waiting time will be assessed.

c.5.c Training for Health Personnel

C.5.c.1 District Principal Nursine Officers (DPNOs).

A two week workshop for the 5 DPNOs will build on the lessons of the clinic management assessments. Institutional capacity building is to be addressed through training aimed at improving such areas as communications with **health** services staff, supervision, planning, and monitoring. The training will be provided by FSP in-country staff.

C.5.c.2 Medical Assistants (MAs) and Public Health Nurses (PHNs).

Five one week sessions are to be held at the district level to accommodate 19 **MAs** and 42 **PHNs**. Training components are to be refined from the DPNO workshop. The **training** team will include the responsible DPNO from each district and an FSP Health Educator.

Monitoring for both types of workshops will be provided through follow-up visits and technical assistance visits within **12** months of training by the FSP TOT or Health Programs Coordinator (**HPC**).

C.5.d Community-Level Training

C.5.d.1 Extended Island Councils Training

For each of the four island areas, a one-week workshop will be held for an average of 25 participants. They will include the Island Council members, representatives of the **unimane** (translated as “old men”, who play a central role in village decision making), the MA, and other relevant local officials.

C.5.d.2 NGO Training

Participation in local **NGOs** (youth groups, women’s groups, religious groups, etc.) is a large part of life in Kiribati, as these groups play a large role in the island community life. This project activity will be delivered as a series of four one week workshops. Each group of 12-15 participants will receive each of the four workshops. The number of groups scheduled for the course of four workshops varies by project location. The content areas are: an introductory unit, **diarrheal** diseases, childhood immunizations, family planning, nutrition and respiratory infections. The workshops are spread over the life of the project, so that each session will reinforce and follow-up on the previous session.

C.5.d.3 Other Island Leaders Training

This activity will reach three categories of community leaders: teachers, religious leaders, and Traditional Healers / Traditional Birth Attendants (**TH /TBA**). Each of these groups will receive a one week workshop. All Island Leader workshops will address basic child survival concepts (enumerated in **NGO** training plan) with further training tailored to each specific audience. The teachers workshop will address issues of community education and reinforcement of

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health messages in the classroom. For religious leaders, community motivation strategies and the church's role in health will be discussed. The Traditional Healers/TBA workshop will have more of a technical medical focus on child survival issues and incorporate ideas which can integrate the practice of traditional skills with modern medical child survival techniques.

C.6 DETAILED PLANS BY INTERVENTION

C.6.a

C.6.a.1 Coverage Estimates

Available coverage estimates were reported for the national population in 1991, expressed as a percentage of infants/children immunized *according to schedule*. 1991 was:

BCG	at birth.....	96%
DPT3	at 14 weeks	72%
Polio3	at 14 weeks	77%
Measles	at 9 months	63%
Source: MHFPSW, 1991		

Immunization statistics are also available (from 1990) regarding the percentage of children immunized by one year of age.

BCG	at one year	83%
DPT3	at one year	87%
Polio3	at one year	87%
Measles	at one year	67%
Source: MHFPSW, 1991		

This shows that immunizations are often given later in the child's life than is recommended by the MHFPSW.

In 1989, 37% of pregnant mothers had received 2 tetanus toxoid injections, up from only 5% reported for 1987. In 1993, MHFPSW began a new protocol to immunize girls in secondary school; there are no coverage statistics available yet. There are also no statistics on the dropout rates for DPT3.

C.6.a.2 Knowledge and Practice

Overall, mothers' understanding of immunization is limited. MHFPSW policy is to issue an Immunization/Growth Monitoring Card (IGM Card) to the mother at the birth of every child. During the baseline survey, 38% of the mothers interviewed were able to produce this card for inspection. Many of those cards are in fair to poor condition, as they are typically stored in palm-thatched roofs and are subjected to the elements. At present, the cards have no protective coating or jacket.

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In response to questioning on Vitamin A, some mothers answered that their child had received a capsule at birth, indicating that they may be confusing OPV with the oral **Vitamin A** capsule, which is not given at birth.

C.6.a.3 Immunization Objectives

- To increase from 72% to 90% infants receiving DPT3 on schedule.
- To increase from 77% to 90% infants receiving Polio3 on schedule.
- To increase from 38% to 70% mothers able to produce IGM Card.

C.6.a.4 Approach

The official MHFPSW immunization policy, as stated in the 1992-1995 Kiribati National Health Plan is as follows:

“All newborn children should be fully immunized; a child must have 3 doses of DPT, 4 doses of Polio, one dose of BCG, one dose of measles, and 3 doses of Hepatitis B before the age of 1.” (3rd National Health, Family Planning & Social Welfare Plan 1992-1995, p. 13)

In keeping with this broad goal, FSP will implement a series of trainings designed to augment the current workings of the EPI project.

On the national level, the 5 DPNOs will be given training in clinical management assessment techniques and HIS. This will influence the EPI project by enhancing DPNO management skills and facilitating monitoring of MA/PHN record keeping and dropout followup.

The MAs/PHNs will be given technical training in case management and followup of immunization dropout cases. Additional training in time management skills and enhanced record keeping will be provided.

These two sets of workshops are designed to achieve country-wide impact by improving overall immunization coverage and tracking.

Further efforts will be undertaken on the community level designed to educate, motivate, and activate **village** leaders and mothers through intensified community efforts. Village level workshops will focus on the importance of timely childhood immunizations, education on vaccine preventable diseases, and the importance of IGM Cards.

Immunizations can be obtained year round, and are delivered from both fixed and mobile facilities. All immunization activities will be delivered as part of the specified national/regional and community level workshops.

C.6.a.5 Population

Through the national and regional workshops the project will benefit 5,320 children of immunizable age (0-23 months). 1,254 children will be the target population for the intensive

community level training in the four selected project areas. Estimated births in the country during years 2 & 3 of the project will be 4,774; on the four selected islands, 1,171 births. 5 clinic visits are required for full immunization. The “high risk” group for immunization are those children living on the populous island of Betio.

C.6.a.6 Individual Documentation

The current MHFPSW IGM Card **will** be used by the Child Survival Program. (See Appendix C.6.a for Card.) All PHNs are required to conduct a yearly census of **infants** eligible for immunizations. From this census an immunization ledger is drawn up detailing each eligible child and recording a schedule for immunizations still required. Every month the ledger is to be updated with new births/eligible children moving into the clinic jurisdiction, and a total of all vaccines administered in the month is to be given to the DPNO. This ledger is also used in case a child’s card is lost. No money will be provided by the project for the cards or ledgers.

C.6.a.7 Dropouts—Children

The ledger is designed to act as a monitoring tool to enable nurses to catch any children not being immunized at the appropriate age. The MA/PHN is then required to follow up each case of missed immunization (on a monthly basis) by making a home visit. The child is to be immunized at that time, and the mother encouraged to bring the child to the growth monitoring/immunization clinic for future required immunizations.

C.6.a.8 Dropout-Women

The new tetanus toxoid protocol described above is designed to broaden national coverage and reduce the incidence of dropout. It includes home visits for young women not reached at school.

C.6.a.9 Cold Chain Support

MHFPSW is currently receiving assistance from UNICEF in the areas of cold chain support and vaccine supply. FSP will not be involved in cold chain support.

C.6.a.10 Surveillance

Not applicable to this project.

C.6.b DIP for Diarrheal Disease Control

C.6.b.1 Baseline

The Health Statistics unit calculated diarrheal diseases to be the cause of 31% of deaths in children aged 12-60 months (1991-1992). Morbidity figures from the same source for the selected project islands, identify a total of 5,476 cases of diarrhea and 127 cases of dysentery in children 0-4 years. Data on the attack rate or duration of **illness** are not available. However, in the baseline survey 65% of mothers interviewed responded that their child had experienced an episode of diarrhea during the past month.

C.6.b.2 Knowledge & Practice

Baseline survey data show that of the women who reported their child had experienced diarrhea:

- 53% who were breastfeeding provided the same or increased amount of breastmilk
- 63% of women provided the same or increased amounts of other liquids
- 35% of women with children on solid food provided the same or increased amounts of food.
- 69% of the women reported that they had given ORS, although there are no statistics on whether it was prepared correctly or given in appropriate amounts.

27% of all women were unable to describe any dangerous symptoms of diarrhea, and 17% answered that they did not know what to do when their child had diarrhea.

The use of antibiotics is officially discouraged by **MHFPSW** for all cases other than dysentery. Use of other medications has been difficult to quantify at this point, as I-Kiribati mothers report an extensive assortment of local remedies, with individuals using various types of local vegetation (pandanus, saltbush, and coconut) in combinations of rook, leaves, and fruits.

C.6.b.3 MHFPSW Protocol and Practices

The current **MHFPSW** therapy regime for children is ORS packets, which are provided by UNICEF. The Ministry does not have a written protocol for case management of diarrheal diseases. The only written policy on diarrheal disease states:

“In Kiribati, diarrheal diseases are among the major causes of morbidity and mortality especially in **infants** and children. Proper sanitation, potable water supply and good food hygiene are the most cost effective and cost beneficial ways of combatting these diseases.” (3rd National Health, Family Planning, & Social Welfare Plan 1992-1995, p.17)

Appropriate case management will be pursued in discussions with the Ministry doctors as both a policy and a practical issue. In the course of planned project activities, FSP staff will be able to determine to what extent the absence of a written protocol is a function of gaps in public health knowledge, or of administration and policy making.

C.6.b.4 Objectives

- To increase from 69% to 90% the cases of diarrhea treated with packaged ORS.
- To increase from 53% to 80% breastfeeding mothers who continue or increase the amount of breast milk given children during diarrhea.

- To increase from 35% to 60% the mothers who continue or increase the amount of food given children during diarrhea.
- To increase from 63% to 90% the mothers who continue or increase the amount of liquids given children during diarrhea.

C.6.b.5 Approach

Activities at the National/District level will focus on the training of the country's public health staff in correct case management of diarrhea³ diseases. This will be addressed as an area for policy development as well as in a health education context. We will focus on the health education content areas, and build on the existing MHFPSW policy of motivating the community to take actions regarding water supply and sanitation. Specific health messages will relate to early treatment, increased liquids, continued feeding (including breastfeeding), correct preparation and administration of ORS, and handwashing.

The CDD activities are to be phased in according to the outlined training activities schedule. A protocol for use by FSP educators will be developed in conjunction with MHFPSW staff, including input from the DPNOs and the support of Health Education Unit. If feasible, this protocol will be used as the basis for official MHFPSW policy.

C.6.b.6 Population

The total population of project beneficiaries is the estimated 14,906 children aged 0-5 years. The population which will receive more intensive project attention is the estimated 3,580 children aged 0-5 years living on the four selected islands. See the Demography table and the Baseline Survey for more details on the population age groups. As case management is not covered by this project, we have not defined "high risk".

Community based NGOs in Betio will be covered by three one-week workshops, with four workshops in Butaritari, three workshops in Maiana, and two workshops in Onotoa. The number of workshops was determined by the number of active groups, population, and geography.

C.6.b.7 ORS

ORS packets are supplied to MHFPSW by UNICEF. ORS is available without charge from the Health Centres /Dispensaries on all islands. ORS availability has not been reported to be a problem to MHFPSW, and shortages have not been encountered at any of the facilities visited by FSP staff. Monitoring of correct ORS preparation and use will be developed as a regular activity of MAs and PHNs.

C.6.b.8 Home Fluids

Given the array of local remedies involving various plant-based beverages, FSP will promote the use of coconut water alone as a home available fluid (HAF). No other local remedy fluids will be either encouraged or discouraged. Not enough is known about the benefits or harms of

these alternatives. Coconuts are available throughout Kiribati, and coconut water is regularly consumed by persons of all ages.

C.6.b.9 Health Education

As the health education messages and materials will be developed in cooperation with the Health Education Unit, their exact form is not yet known. The specific content areas will include early treatment, increased liquids, continued feeding, correct preparation of ORS, handwashing, and water and sanitation.

The community CDD workshops are designed to equip the participants with health knowledge and, more importantly, to encourage them to adopt beneficial health behaviours and practices. The participants will be prepared to share what they learn with the villages and organizations they represent. Emphasis will be given to motivating the communities to take positive actions on their own behalf.

C.6.b.10 Other Strategies

Community initiatives in preventing diarrhea disease through improved water and sanitation will be supported by assisting the community's communications with responsible agencies (such as UNDP) or in seeking material support. FSP does not provide funding for construction projects

C.6.c DIP for Nutritional Improvement

C.6.c.1 Baseline

The Government of Kiribati conducted a National Nutrition Survey in 1988. The survey found 10% of children 0-5 years of age were undernourished, using weight for height criteria. When using weight for age, 2-39 of children under 6 months were undernourished, with 18% of children 2-3 years considered undernourished. The results by sex are not available. (Source: "The Situation of Women and Children in Kiribati", GOK & UNICEF, 1991. Undernourished means over 2SD below WHO standards.)

Results from the 1989 Vitamin A study showed 77% of all children surveyed were Vitamin A deficient. Because the nutrition aspect of this project is concentrated on Vitamin A, the **project** will not do any anthropometric assessments.

.6.c.2 Current Practices

Baseline survey results report that 93% of the mothers had breastfed their **infants** at some time, with 79% currently breastfeeding. 82% initiated breastfeeding within 8 hours of giving **birth**.

Breastfeeding is culturally accepted, even in public places. Potential constraints to breastfeeding in Kiribati include mothers entering the workforce, the care of children by grandmothers so the mother can resume household duties, and the adoption of children who have not yet been weaned.

Weaning foods were introduced by 61% of mothers before the infant was four months of age, 26% between 4-6 months, and 12% after 6 months. The most common supplementary liquid is fresh toddy, which is a product of the coconut tree, often mixed with sweetened condensed milk. The first weaning foods are rice, bananas, taro, and breadfruit.

Daily food supply on the atolls of Kiribati consists of coconut, rice, fish, breadfruit, and taro. While there is generally sufficient food available to prevent widespread conditions of protein-energy **malnutrition**, there is often not enough variety to prevent micronutrient deficiencies.

N.6.c.3 Nutrition Objectives

- To increase to 50% the number of mothers first introducing weaning foods to their **infants** between 4-6 months of age.

C.6.c.4 Approach

Most of FSP's planned nutrition project objectives are aimed directly at Vitamin A interventions.

General strategies for improving the overall nutritional status of infants and children are to be implemented through the series of training workshops.

The village level workshops will augment the efforts of PHNs/MAs in nutrition education. Community level training will include a series of workshops for both village leaders and community members, the focus of which will be weighted toward, but not limited to, Vitamin A education. Constraints to Vitamin A education are covered in that section.

C.6.c.5 Low Birth Weight Babies

Tungaru Central Hospital is the only health facility currently registering birth weights for infants. 1990 reports from MHFPSW indicate only 6% of all recorded births fall into the WHO Standard for low birth weight. This figure is considered low on a global scale. The project does not plan interventions in this area.

C.6.c.6—C.6.c.13 Growth Monitoring

The project will not include a specific growth monitoring component, but rather will provide general information on nutritional improvement.

C.6.c.1A.C.6.c.19 Nutritional Improvement for **Pregnant/Lactating** Mothers

The project will not include a specific component for pregnant/lactating mothers, but rather will involve them in the "Prevention of Vitamin A Deficiency" and the "Maternal Care" aspects of the project.

Prevention of Vitamin A Deficiency

C.6.c.20 Baseline

Data on Vitamin A deficiency are of excellent quality. The rates for total active xerophthalmia in Kiribati are some of the highest on record for the world. This has attracted international research.

<u>Type of Xeronthalmia</u>	<u>WHO Criteria for Pub. Hlth. Problem</u>	<u>Prevalence in Kiribati</u>
Night Blindness	1.00%	3.52%
Bitot's Spots	.50%	10.85%
Corneal Xerosis	.01%	.32%
Corneal Ulceration	.01%	.04%
Total Active Xerophthalmia	1.52%	14.74%
Comeal Scar	.05%	1.08%
Source: MHFPSW		

.6.c.21 Knowledge and Practice

The baseline survey showed that 74% of mothers did not know which vitamin prevents night blindness. Less than half the mothers (44%) were able to name any foods that are rich in Vitamin A. In actual feeding practices, 88% of the mothers reported feeding their children at least one food source of Vitamin A (pawpaw, pumpkin or green leaves). Unfortunately, these data provide no information on frequency of use of these food sources, which in casual observations appears to be low. Cultural impediments include the attitude that green leaves are food for pigs.

C.6.c.22 MHEPSW Protocol

An new Vitamin A Deficiency Prevention and Treatment Protocol has been issued by MHFPSW (February, 1994), with technical assistance from a VITAL consultant working in conjunction with FSP. That protocol is appended to this document.

.6.c.23 Population

Vitamin A capsule distribution is not incorporated into the Child Survival Project. FSP continues to assist MHFPSW in ik current procedures. The beneficiary population, as reported in Country Table A, is defined there as the number of children aged 61-70 months, or 2,291 children in Kiribati.

C.6.c.24 Vitamin A Objectives

- To increase to 95% the number of mothers providing Vitamin A foods to their children.
- To maintain at 95% coverage the proportion of children under 6 years of age receiving Vitamin A capsules three times/year.

C.6.c.25 Approach

FSP has developed a comprehensive plan for prevention of Vitamin A deficiency, which includes activities funded by other donors. The elements directly supported by USAID are the community based training and MHFPSW system enhancements.

Island level workshops will provide health education on causes of Vitamin A deficiency and local solutions. Food sources to be promoted are pumpkin (which in Kiribati is used to **describe** several varieties of squash), pawpaw (papaya), green leaves (te buka, nambere, and drumstick), and home gardens.

Project interventions at the national/district level will concentrate on two issues: implementation of the new Vitamin A protocol, and improved record keeping.

C.6.c.26 Individual Documentation

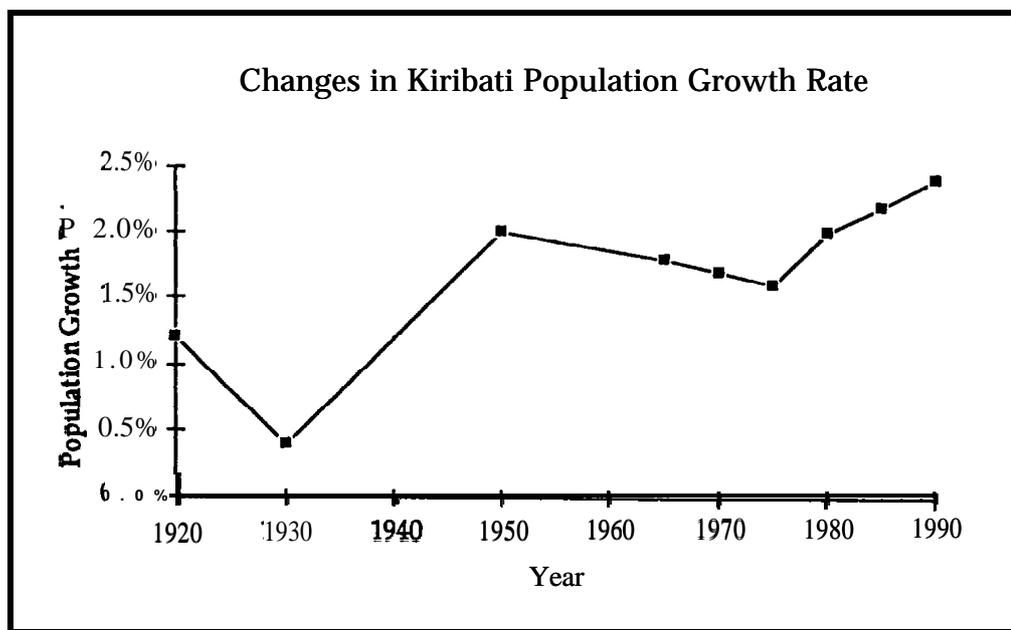
Records of Vitamin A capsule distribution are written on the IGM Card, which is appended. The cards presently in circulation do not have a printed section for Vitamin A capsules; the PHNs write this information in the upper right hand margin of the card, above the immunizations. Appropriate design changes have been suggested for the next printing. All PHNs are required to conduct a census of their clinic areas and make patient ledgers accordingly. Vitamin A capsule distribution information is to be recorded in the ledger, used during mass campaigns.

C.6.d DIP for Maternal Care

C.6.d.1 Coverage Estimates

The current estimate of maternal mortality in Kiribati is **1/10,000** live births in **1990**, and **2/10,000** in 1985 (Source: MHFPSW). Causes of maternal morbidity cited in the **1990** MHFPSW statistics are vaginal bleeding, ante-partum bleeding, and offensive vaginal discharge. In the baseline survey population, 84% of mothers reported that they went to the clinic for checkups when they were pregnant.

As can be seen in the following chart, however, the population growth rate is both high and rising.



Source 'The Situation of Women and Children in Kiribati', GOK & UNICEF, 1991

because of this clear need to reduce the population growth rate, our interventions will focus on family planning.

C.6.d.2 Maternal Care Objectives

- To increase to 70% the number of couples in union, not planning a pregnancy in the next two years, who use a contraceptive method.

C.6.d.3 Approach

In the process of data collection and community level participatory planning, village participants (both male and female) expressed great interest in increasing their knowledge of family planning methods. This expressed need is to receive direct response through the three types of island workshops for the Extended Island Council, local NGOs, and Other Island Leaders.

Project activities will not include the distribution of contraceptives. The supply of contraceptive materials at MHFPSW facilities has not been problematic. The project will promote the desirability and advantages of conscientious birth spacing and educate participants regarding methods available at local Health Centres and Dispensaries. The approach is characterized by providing appropriate health information, motivating female and male individuals to adopt beneficial practices and preparing these individuals to take what they have learned back to their communities.

.6.d.4 Population

There are an estimated 19,464 women of child bearing age in Kiribati for whom education at the national and regional level will have the greatest impact. 4,677 women of childbearing age will benefit from in depth community education and training.

C.6.d.5 Current Ante-natal Care Practices

Not applicable to **this** project.

C.6.d.6 Current Birthing Practices

Not applicable to this project.

C.6.d.7 Current Postnatal Care Practices

Not applicable to this project.

.6.d.8 Current Contraceptive Practices and Estimates

National figures report family planning acceptors at 28% in 1990 (Health Statistics Unit). The statistics appear to fluctuate over time. In the baseline survey population, 56% of women not pregnant, or planning a pregnancy in the next two years, responded that they were using a family planning method. Of these women:

- 47% were using Depo-Provera.
- 27% reported using either the rhythm or Billings method.
- 25% reported using various other modern methods (surgical sterilization, IUD, Pill, Condom).
- <1% were using a local method.

The 1990 census data show that 53% of the population are Roman Catholic and 39% belong to the Kiribati Protestant Church (KPC). In the four selected islands, the overall pattern is roughly similar, although Onotoa and Betio have somewhat larger KPC populations while Butaritari and Maiana have somewhat larger Catholic populations. Religious faith is of central importance in the I-Kiribati daily life, and church organizations and leadership are valuable resources in reaching the communities. Project activities **will** be respectful of all religious beliefs regarding birth spacing and family planning. In FSP project reporting the Billings method will be recognized to be a modern family planning method.

.6.d.9 Health Education Messages

Both men and women are involved in all island level and national level health education activities. Health Education messages and materials will be in accordance with MHFPSW stated goals (see Appendix) emphasizing the health benefits of birth spacing and promoting the range of services locally available.

C.6.d.10—C.6.d.11

Not applicable to the project.

C.6.e DIP for Case Management of Childhood ALRI

C.6.e.1 Baseline

Figures provided by the Health Statistics Unit for 1991-1992 estimate pneumonia to be the cause of 22% of the deaths of infants aged 0-11 months and 6% of the deaths of children aged 12—60 months. The average number of episodes of pneumonia are not available. The percent of episodes treated with antibiotics is not known.

During the baseline survey, 51% of mothers responded that their child had been sick with cough and rapid breathing during the past two weeks. The quantity of technical information on ALRI is sparse. Until a better research base can be established, FSP project interventions in this area will be limited to community level education regarding prevention activities and recognizing the danger symptoms of ALRI.

C.6.e.2 Knowledge and Practice

In the baseline survey population, 31% of the mothers were not able to list any of the danger signs of ALRI which would cause them to seek treatment for their children. Casual observations by FSP staff in the course of data collection indicate a high prevalence of respiratory infections. The general response of mothers was that this was not serious and was a common situation.

C.6.e.3 MHFPSW Policies and Protocols

MHFPSW has no official written policy for **MAs/PHNs** regarding the case management for ALRI. The **Ministry** has supplied posters depicting WHO **Guidelines/Flowchart** to the various Health Centres and Dispensaries. These facilities and the **MAs/PHNs** which staff them are the sole providers of professional health care services in the project locations. There is virtually no over the counter sale of medications in Kiribati. Health care is provided free of charge to all citizens. The antibiotics recommended by MHFPSW for the treatment of childhood ALRI follow the WHO guidelines.

C.6.e.4 Current Infrastructure

Each of the project islands has one Health Centre. **Butaritari** atoll has four Dispensaries, while Betio, Maiana and Onotoa have two each. The Health Centres are staffed by one MA per island, and each Dispensary is staffed by a PHN or Nursing Assistant (NA). There are occasional shortages of drug supplies in the outer islands due to the large distances involved and limited transportation. The estimated traveling time for an individual seeking health care services varies greatly. MHFPSW has established **clinics** where they are accessible to the majority of the population. Atoll geography is such that smaller populations living on separated islets can reach clinics only with some difficulty.

C.6.e.5 Current Costs

All medical coverage is provided to the I-Kiribati people free of charge.

.6.e.6 Population

Total project beneficiaries equal 14,906 children 0-5 years. For the community level interventions beneficiaries total 3,580 children 0-5 years.

C.6.e.7 Current Barriers

The constraint to be addressed by the project is parental knowledge of the signs and symptoms of ALRI. FSP does not plan to be directly involved in the procurement or supply of antibiotics.

C.6.e.8 ALRI Objectives

- To increase from 69% to 90% the percentage of mothers who know the danger signs of ALRI and when it is appropriate to seek treatment.

C.6.e.9 Approach

Workshops with the **MAs/PHNs/DPNOs** will address the difficulties encountered in diagnosing and providing treatment for ALRI. If appropriate, this forum can be used to initialize the process of developing an official protocol. Lessons learned from the CDD component will be applied.

Community activities are to be incorporated into the series of planned workshops. Specific training **will** include the danger signs of serious ALFU and the encouraging of mothers to seek appropriate treatment. Prevention of respiratory infections at the village level will be the theme for community action.

C.6.e.10 ALRI Training

FSP Health Educators will receive ALRI training during the in-house Training of Trainers. Existing WHO training materials will be used until such time as locally tailored materials can be developed. ALRI project objectives have deliberately been limited, to prevent overburdening the FSP Health Educators.

C.6.e.11 Case Management

All training for health care practitioners in ALRI case management is provided by MHFPSW. The project is not supporting health workers other than those currently responsible for **ALRI** diagnosis and treatment. Any additional training contributed by the project in the area of case management will conform to the WHO ALRI guidelines.

C.6.e.1.2 Parent/Caregivers Education

The **MAs/PHNs** are the official source of education for the community in the area of ALRI. FSP project staff will assist these practitioners through the island level training in educating

community members on the importance of seeking treatment when serious symptoms of ALRI are manifested, and in motivating local NGOs to take action in preventing respiratory infections. Materials and messages available from the WHO office in Kiribati will constitute short term resources until local resources have been developed by the project.

C.6.e.13 Drug Availability

Not applicable to this project.

SECTION D: SUSTAINABILITY

D.1 SUSTAINABILITY PLAN.

Unlike projects that provide services or materials, this is a training program. Because of this, sustainability is not as difficult an issue.

Our training of the DPNOs, MAs, and PHNs is planned to be done in conjunction with the regular annual inservice training which is done by the MHFPSW. We are working closely with the Ministry, and they have expressed interest in permanently incorporating our training into this training. In this way, it will become a regular part of the training which is received by all of the front-line health care professionals in the entire country.

The project design emphasizes the enhancement of existing MHFPSW plans for child survival rather than the pioneering of unfamiliar approaches or the introduction of new technologies. It is true that new assessment techniques, updated public health knowledge and tailored health education messages are to be developed. Ministry staff are involved in each of these steps, as is feedback from the community, so the knowledge will be widely disseminated.

FSP continues to search for qualified I-Kiribati candidates to fill increasingly responsible project management positions. Funding will not be an impediment to sustainability, as FSP has a diversified base of donors with support from ODA, GTZ, Misereor and Jersey Aid.

D.2 COMMUNITY INVOLVEMENT.

The communities, as represented by the Island Councils, were required to demonstrate local initiative prior to being considered for inclusion in the community-level aspects of the project. The commitment of local resources is compelling evidence of interest and demand for child survival services. Significantly more than the four islands selected have demonstrated willingness to participate. The project atolls can be viewed as demonstration areas for future expanded project activities.

Ownership of and active support for the health activities will be maintained by spacing the four 1-week workshops over the life of the project, and by involving all of the key community figures (teachers, leaders, NGOs, religious leaders, unimane, and others) in the trainings. The members of the Island Councils of Betio and Butaritari were involved with us in the development of this DIP

D.3 COLLABORATION.

Essential collaboration has been established with top officials of MHFPSW and its various sub **units**. These include the Health Education Unit in the development of health education messages and materials, and the Health Statistics Unit in monitoring and reporting health status indicators. As mentioned above, MHFPSW is interested in incorporating the successful aspects of the trainings into their curriculum.

MHARD has played an important role in the planning of community development **aspects** of the project, selecting project locations, and in maintaining communications between project staff and the outlying atolls. Additional collaboration has come from the Kiribati extension of the University of the South Pacific (USP) by assisting project research such as the baseline survey.

D.4 PHASE-OVER PLAN.

Given the overall design of the project, phase-over is best understood as the eventual replacement of expatriate staff. Constraints have prevented this element from being contained in the early stages of the project. Hiring of counterpart personnel is anticipated for the second and third years of the project cycle.

D.5 COST RECOVERY.

Cost recovery has been built into planning in the form of written commitment by the Island Councils to share the **costs** of transportation, meeting facilities, and project staff accommodations. The cost recovery arrangements will be further detailed in formal agreements. User fees are not appropriate for this project. The HPC will be responsible for overseeing the cost recovery agreements.

SECTION E: PROJECT HEALTH INFORMATION SYSTEM

E.1 HIS PLAN.

The project has designated approximately 7% of the budget for surveys, monitoring and evaluation. The project will depend heavily on the current HIS **administered** by the MHFPSW, which works well. The HIS policies of MHFPSW are reproduced in Appendix E (See National Plan, pages 113-115). Responsibility for the surveys and communication with MHFPSW is assigned to the FSP Health Programs Coordinator.

E.2 CENSUS INFORMATION.

A national census was conducted by the Government of Kiribati in 1990. Coverage was complete, including coverage of the four project atolls. Another national census will be done in 1995, and the preliminary data will be available for use before the end of the project.

E.3 DATA COLLECTION AND USE.

Data on health status indicators are collected, analyzed and reported by MHFPSW. Supplemental data are drawn from the baseline survey for information regarding maternal

knowledge of health education messages and maternal practices/behaviors. FSP project staff will monitor all training sessions, community workshops and follow-up visits. This information will be reported quarterly. Copies of the relevant sections of all reporting submitted to AID will also be submitted to MHFPSW.

E.4 HIS TRAINING FOR STAFF.

Potential refinements in HIS will be identified during the first project year as part of the clinic management assessments and DPNO/MA/PHN workshops. FSP staff will provide the training for these improvements.

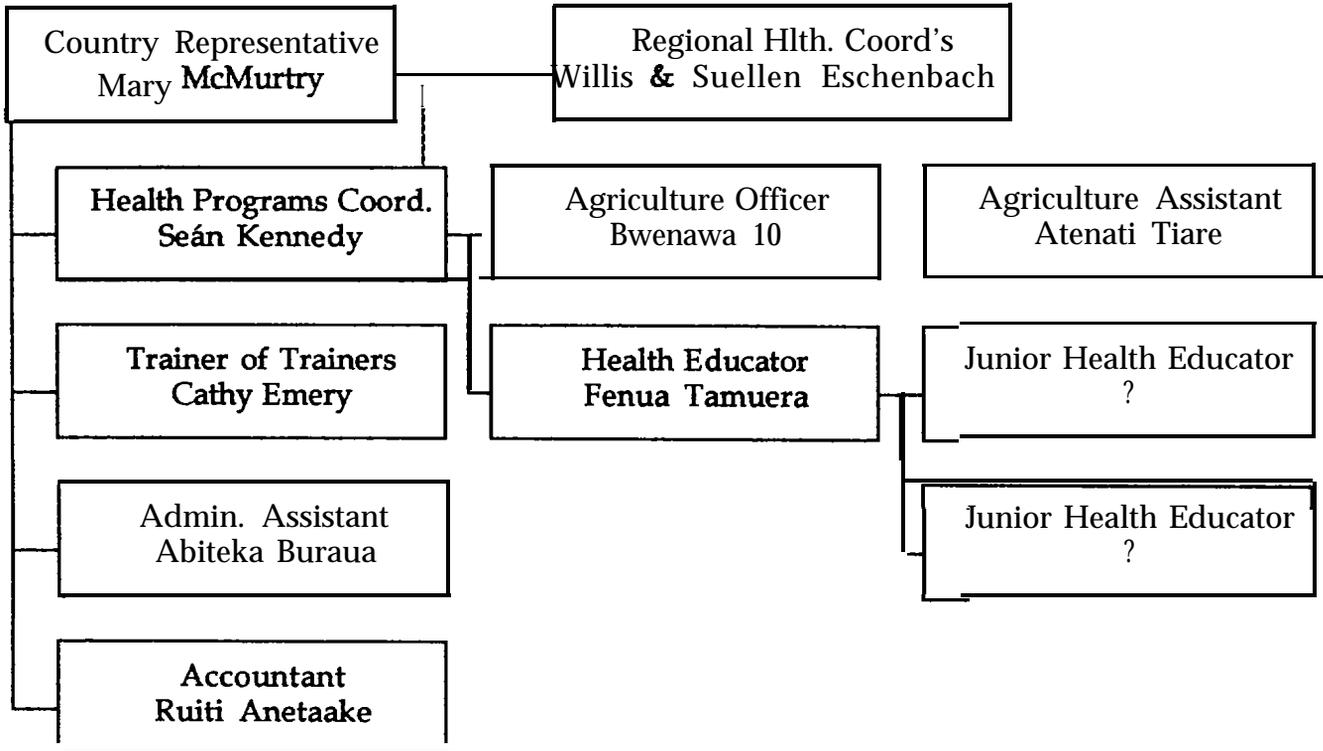
E.5 BASELINE SURVEY INPUTS.

Health Education Unit participated in the design and translation of the survey questionnaire. They assisted in the preparation of a sampling frame and accompanied FSP staff during data collection. Due to the small population and isolation of Kiribati, a large sample size was not required. There are an estimated 1,258 children aged 24 months and under distributed unevenly between the four project islands. The total number of observations to be collected is N=303 interviews, 233 of which are reported in this document. Interviewer training, pre-testing and data collection were carried out during 2-28 March. Four interviewers were recruited and trained with the assistance of USP. Supervision was provided by FSP staff and HEU. The final resdk of the baseline survey **will** be submitted to AJD in the 3rd Quarterly report, along with explanation of any significant changes in the findings.

SECTION F: HUMAN RESOURCES

FSP

F.1 ORGANIZATIONAL CHART



NOTE: All positions are full-time, salaried positions. The Country Representative, TOT, and HPC are expatriates, all others are I-Kiribati. The Junior Health Educators have not been hired yet.

Responsibilities:

- Project Administrative ManagementCR
- Oversight of technical health content.....I-PC, RHC
- MonitoringHPC
- Training of health workersHealth Educators, TOT
-

F.2 COMMUNITY GROUPS

FSP will train approximately 180 village representatives of local NGOs. Assistance in identifying active NGOs and in quantifying their memberships is being received from MHARD and the individual Island Councils. FSP is also pursuing independent identification of unregistered NGOs to promote full community participation. Two groups, the **unimane** and the **VWGs**, will be represented in both the NGO and the Other Island Leaders workshops.

The groups we will be working with are:

- I. Butaritari Membership

FSP

1.	Unimane	50
2.	Women's Groups	
	a. ABAB (Unified Island Group)	150
	b. RAK (Protestant, KPC)	58
	c. Te itoiningaiana (Catholic)	280
3.	IYA (Island Youth Association)	280
4.	Religious Groups	
	a. ICC (KPC)	22
	b. Antibani Iesu (RC)	60
5.	BAPO (Butaritari Ag. Plantation Assoc.)	45
6.	BRWCEL (Butaritari Rural Workers Union)	?
7.	Teachers Union	?
8.	WBBA (Parents of Schoolchildren)	48
9.	VWGS	?
II.	Onotoa	
1.	Unimane	50
2.	Women's Groups	
	a. RAK (Protestant, KPC)	90
	b. Te itoiningaiana (Catholic)	30
	c. Village Women's Groups	47
3.	Youth Groups	
	a. Rikiraken Tabutuia	30
	b. Rikiraken Buamao	45
	c. Rikiraken Tabuarorae	12
	d. Others	20
4.	VWGS	3
Group lists and numbers for the following 2 islands are not yet complete.		
III.	Betio	
1.	Unimane	
2.	Women's Groups	
	a. AMAK (National)	
	b. Teiario (Catholic)	
	c. Marewan Betio (KPC)	
3.	Youth Groups	
	a. St. Kabiriera (RC)	
	b. Teiario (KPC)	
	c. Nanomatoa (KPC)	
	d. SDA	
	e. Church of God	
	f. Assembly of God	
4.	VWGs	
IV.	Maiana	
1.	Unimane	
2.	Women's Groups	
	a. AMAK (National)	
	b. Teiario (Catholic)	
	c. Marewan Betio (KPC)	

3. Youth Groups
4. **VWGS**
5. School committee

F.3 COMMUNITY HEALTH WORKERS (CHW)

On the outer islands all formal health services are provided by the MAs and PHNs. The Kiribati equivalent of a CHW could be considered the Village Welfare Groups (VWG). VWGs are members of the community who have not generally received **health** training, therefore differing from some countries which have trained CHWs. For this reason the **VHWs** will participate in the workshops as NGO members, not specially trained community health workers. Although the number **will** vary by village, we expect that about 5-10 members of the **VWGs will** attend the training per island, for a total of ~~20—40~~ VHW members trained. Typically, a **village** will have four or five people in a VWG.

F.4 VOLUNTEER TURNOVER

Figures estimating turnover of trained health volunteers (VWG members) are not available. However, as they are members of the local community rather than people who have come in from the outside, we expect the turnover to be reasonably low.

F.5 STAFF EDUCATION

The most important staff education planned is the training of trainers for FSP health educators. Additional plans are being developed to upgrade the skills of administrative support personnel through the introduction of computer training. FSP has the in-house capability to provide these services.

F.6 ROLE OF COUNTRY NATIONALS

All project positions other than **Country** Director, HPC and TOT are currently filled by I-Kiribati. Long range planning is addressed in section D.4.

F.7 ROLE OF HEADQUARTERS STAFF

Technical assistance to the field is provided by the FSP Regional Health Coordinators (**RHCs**), Willis and Suellen Eschenbach, who are responsible for supporting the Child **Survival** Programs in Vanuatu, Solomon Islands, and Kiribati. The **RHC's** are based in Suva, Fiji, and have fax, phone, and computer links to the rest of the world. They provide technical information, arrange for the luring of consultants, oversee and assist in the preparation of reports and plans, check for compliance with the USAID "Substantial Involvement" policy for Cooperative Agreements, arrange for technical assistance through Johns Hopkins University, and generally ensure the quality of the work being done.

Headquarters staff in Washington handle **all** of the financial records, making sure that **USAID** fiscal reporting requirements are met, and preparing quarterly reports, pipeline analyses, and

FSP

other reports as necessary. They also provide general office support (copying, binding, etc.), and perform other tasks in Washington as well (liaison with USAID and other agencies, etc.).

SECTION G: TRANSPORT AND LOGISTICS

G.1 TRANSPORT

FSP currently has sufficient vehicles for project operations on Tarawa. Travel to all outer islands is by local airline or boat. Ground transportation on the outer atolls of Butaritari, Maiana, and Onotoa has been arranged through the various Island Councils. In general, the Councils will provide a vehicle for the use of project staff, and the project will pay the cost of the fuel.

G.2 PROCUREMENT

No supplies and equipment still need to be obtained for this project.

SECTION H: DIP SCHEDULE OF ACTIVITIES

DIP TABLE D: HEADQUARTERS SCHEDULE OF ACTIVITIES

PVO: _____ FSP

	Year 1				Year 2				Year 3			
	1	2	3	4	1	2	3	4	1	2	3	4
6. REGIONAL Technical Staff Visits												
a. Country 1 (AS NECESSARY) 5 max												
b. Country 2 (AS NECESSARY) 5 max												
7. Health Info. System Functioning												
a. Country 1	X											
b. Country 2	X											
8. Mid-Term/Final Evaluation						X	X				X	X
9. A.I.D. Reports Prepared												
a. Country 1		X	X	X	X	X	X	X	X	X	X	X
b. Country 2		X	X	X	X	X	X	X	X	X	X	X

WORDPERFECT TABLE-D.WP

DIP TABLE D: COUNTRY PROJECT SCHEDULE OF ACTIVITIES

PVO: _____ FSP

Country: _____ KIRIBATI

	Year 1				Year 2				Year 3			
	1	2	3	4	1	2	3	4	1	2	3	4
1. Personnel in Position												
a. Project Manager		X										
b. Technical Coordinator		X										
c. Health Information System Manager		X										
d. Community/Village health workers												
e. Other Support Jr. Health Educator			X									
2. Health Information System												
a. Baseline Survey												
- Design/preparation		X										
- Data collection and analysis		X	X									
- Dissemination and feedback to community and project management			X									
b. Consultants/contract to design HIS												
c. Develop and test HIS												
- Implementation			X	X	X	X	X	X	X	X	X	X
- Development and feed back to community and project management				X				X				X

WORDPERPERFECT TABLE-D.WP

DIP TABLE D: COUNTRY PROJECT SCHEDULE OF ACTIVITIES

PVO: <u>FSP</u> Country: <u>KIRIBATI</u>	Year 1				Year 2				Year 3			
	1	2	3	4	1	2	3	4	1	2	3	4
3. Training												
a. Design			X	X	X	X	X					
b. Training of trainers			X	X	X	X	X	X				
c. Training sessions			X	X	X	X	X	X	X	X	X	X
d. Evaluation of knowledge of skills												
<u>4. Procurement of Supplies</u>	X	X	X	X	X	X	X	X	X	X	X	X
5. Service Delivery to be initiated												
a. Area I— National/District Level												
- Control of Diarrheal Diseases			X									
- Immunization			X									
- Nutrition:			X									
Breastfeeding												
Growth Monitoring/Promotion												
- Micronutrients (Vitamin A)			X									
- HIV												
- Control of Pneumonia			X									
- Maternal Care/Family Planning			X									
- Other												

WORDPERFECT TABLE-D.WP

DIP TABLE D: COUNTRY PROJECT SCHEDULE OF ACTIVITIES

PVO: <u>FSP</u> Country: <u>KIRIBATI</u>	Year 1				Year 2				Year 3			
	1	2	3	4	1	2	3	4	1	2	3	4
b. Area 2 — Community Level												
- Control of Diarrheal Diseases					X							
- Immunization				X								
- Nutrition:					X							
Breastfeeding												
Growth Monitoring/Promotion												
- Micronutrients					X							
- HIV												
- Control of Pneumonia					X							
- Maternal Care/Family Planning				X								
- Other												
6. Technical Assistance												
a. HQ/HO/Regional office visits	X											X
b. Local Consultants	X			X		X	X		X		X	X
c. External technical assistance			X	X	X	X	X					X
7. Progress Reports												
a. Annual project reviews				X				X				
b. Annual reports					X				X			X
c. Mid-term evaluation						X	X					
d. Final evaluation											X	X

WORDPERFECT TABLE-D.WP

FSP Regional Health Office
Kiribati Baseline Survey

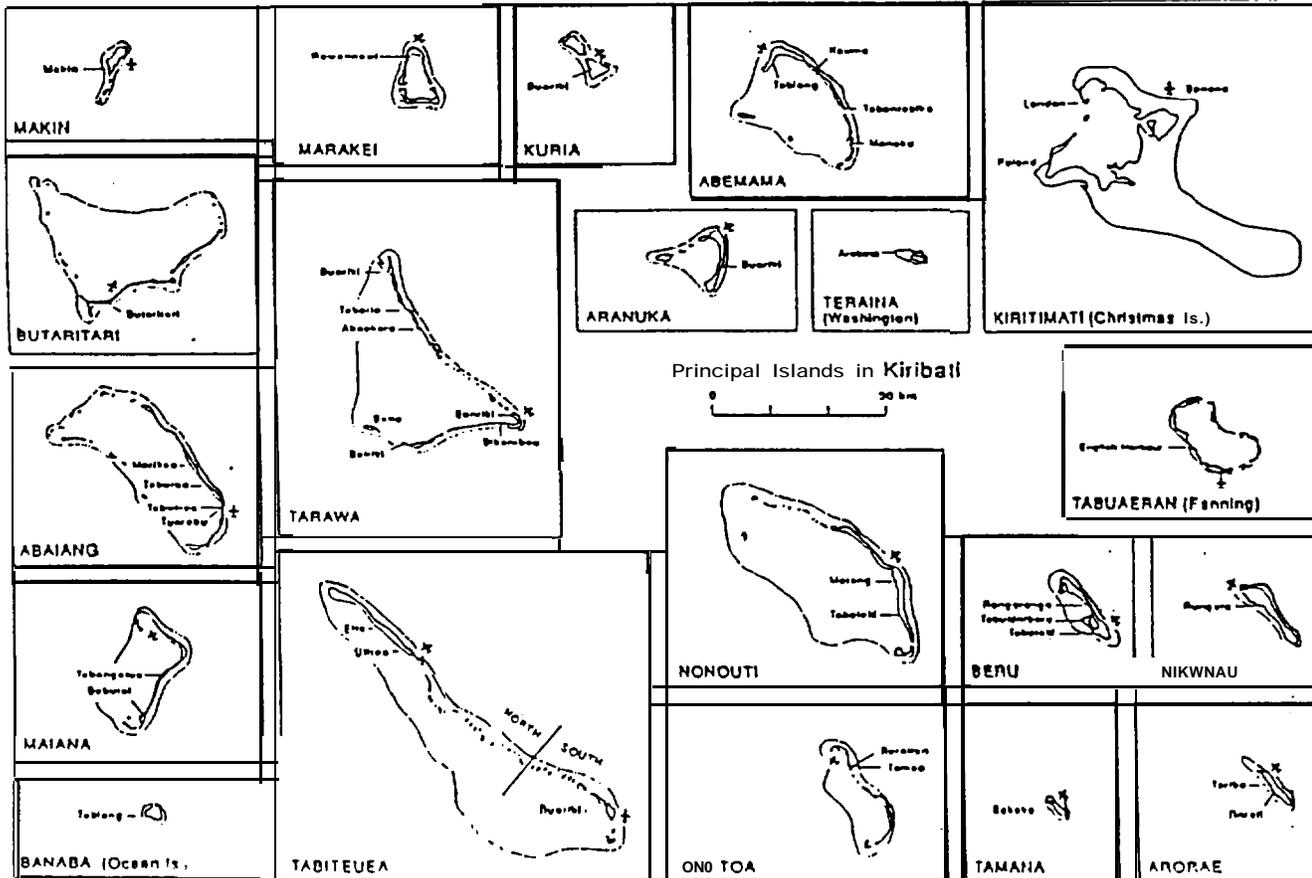
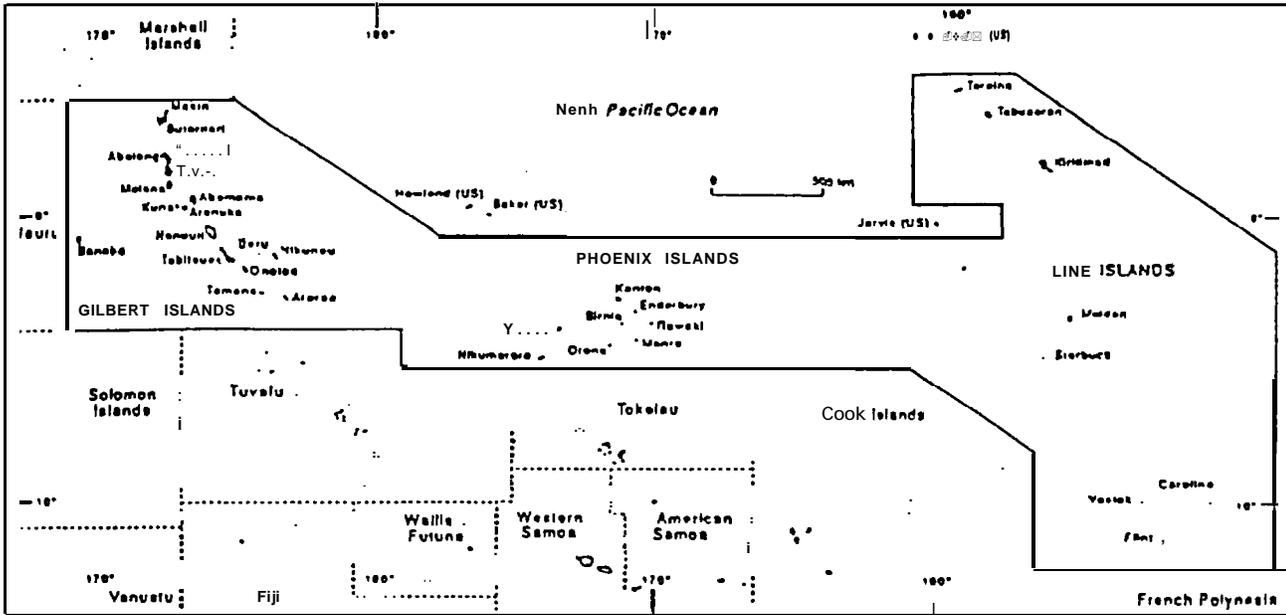
NOTE: not all questions in the survey related to the CS Program.
Only CS related-questions are reported.

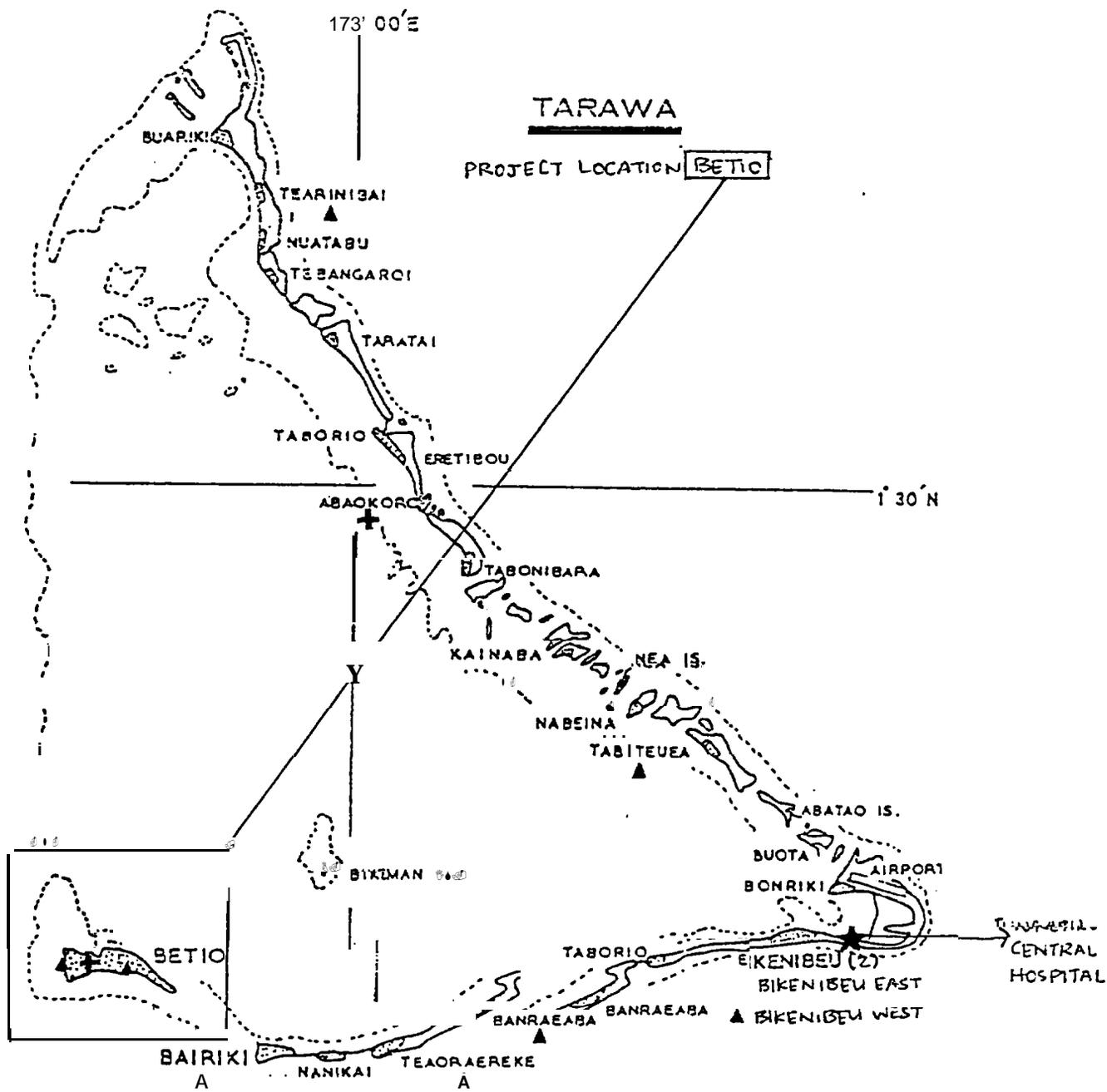
N ^o	Question	Betio		Butaritari		Average Yes	195% Conf. Interval
		Yes	No	Yes	No		
2B1	Is the mother a Roman Catholic?	89	61	62	21	64.8%	±13.3%
2B2	Is the mother a Kiribati Protestant Church member?	51	99	18	65	29.6%	±10.6%
2B3	Is the mother a member of some other organized religion?	10	140	3	80	5.6%	±2.6%
7	Do you currently breastfeed your baby	110	40	73	10	78.5%	±12.6%
8	Did you breastfeed your baby before?	28	12	9	1	74.0%	±10.8%
9	Did you breastfeed your baby within 8 hours of birth?	110	29	72	10	82.4%	±7.7%
10	Do you feed your baby Vitamin A foods	133	17	71	12	87.6%	±2.7%
11a	Did you start giving other foods before 4 months?	92	52	45	36	60.9%	±7.2%
11b	Did you start giving other foods at 4-6 months?	32	112	26	55	25.8%	±8.6%
11c	Did you start giving other foods after 6 months?	18	126	10	71	12.4%	±0.1%
11d	Do you NOT know when you started giving other foods?	2	142	0	81	0.9%	±1.2%
12	Do you know what vitamin prevents night blindness?	53	97	8	75	26.2%	±22.2%
13a	Are green leaves rich in Vitamin A?	56	74	56	8	57.7%	±36.4%
13b	Are yellow fruit rich in Vitamin A?	63	67	63	1	64.9%	±41.0%
13c	Are fish/meats leaves rich in Vitamin A?	17	113	17	47	17.5%	±11.1%
13d	Is breastmilk rich in Vitamin A?	0	130	0	64	0.0%	±0.0%
13e	Is egg yolk rich in Vitamin A?	1	129	1	63	1.0%	±0.7%
14	Do you have an immunization card for your baby?	50	100	38	44	37.9%	±11.2%
15	Has your baby had diarrhea in the past 4 weeks?	103	47	49	34	65.2%	±8.3%
16	Do you breastfeed when your baby has diarrhea?	48	46	25	20	52.5%	±3.6%
17	Do you give other liquids?	59	42	36	13	63.3%	±12.3%
18	Do you give as much or more food as usual?	38	64	15	33	35.3%	±4.8%
19	Do you give ORS packets?	105	44	56	27	69.4%	±2.6%
20	Do you NOT know symptoms of dangerous diarrhea?	31	119	32	49	27.3%	±16.1%
21	Do you NOT what to do when your baby has diarrhea?	16	134	25	58	17.6%	±16.8%
22	Has your baby had fast breathing and cough / difficult breathing?	91	59	29	54	51.5%	±22.2%
29	Do you NOT know symptoms of dangerous ARI?	35	113	39	51	31.1%	±17.6%
33a	Have any of your children died?	15	135	19	64	14.6%	±11.1%
33b	Was the child under 1 year old?	9	9	11	10	62.7%	±16.9%
33c	Was the child 1-5 years old?	6	12	9	24	29.4%	±5.2%
33d	Was the child over 5 years old?	3	15	1	32	7.8%	±11.7%
36	Do you practice family planning?	64	53	37	28	55.5%	±1.9%
37a	Do you practice ... tubal ligation?	2	65	2	38	3.7%	±1.8%
37b	Do you practice ... Dep Provera?	24	43	26	14	46.7%	±26.0%
37c	Do you practice ... Pill?	4	63	2	38	5.6%	±0.9%
37d	Do you practice ... IUD?	5	62	0	40	4.7%	±6.6%
37e	Do you practice ... Rhythm Method?	12	55	4	36	15.0%	±7.0%
37f	Do you practice ... Abstinence?	3	64	3	37	5.6%	±2.7%
37g	Do you practice ... Billings Method?	13	54	0	40	12.1%	±17.3%
37h	(Do you practice ... any other method?)	4	63	3	37	6.5%	±1.4%
41	When pregnant, did you go to the clinic for checkups?	114	34	79	3	83.9%	±16.7%
43	Did you smoke when you were pregnant?	56	92	38	45	40.5%	±7.1%
44	Did you drink when you were pregnant?	2	146	0	83	0.9%	±1.2%
46a	Does your water come from ... rain water tanks?	74	92	21	70	37.0%	±57.7%
46b	Does your water come from ... a piped system?	74	92	0	91	28.8%	±77.1%
46c	Does your water come from ... a protected well?	16	150	67	24	32.3%	±65.4%
46d	Does your water come from ... an unprotected well?	2	164	3	88	1.9%	±2.1%
47a	Do you have ... a communal toilet?	56	94	0	85	23.8%	±32.6%
47b	Do you have ... a house flush toilet?	49	101	4	81	22.6%	±24.4%
47c	Do you have ... a water seal latrine?	20	130	8	77	11.9%	±3.4%
47d	Do you have ... a beach/beach latrine?	25	125	73	12	41.7%	±60.4%

VOTE:

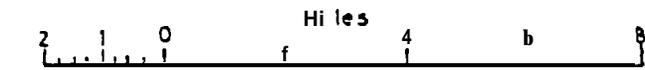
Final results of the survey will be reported with statistical analysis in the next quarterly report.

THE REPUBLIC OF KIRIBATI

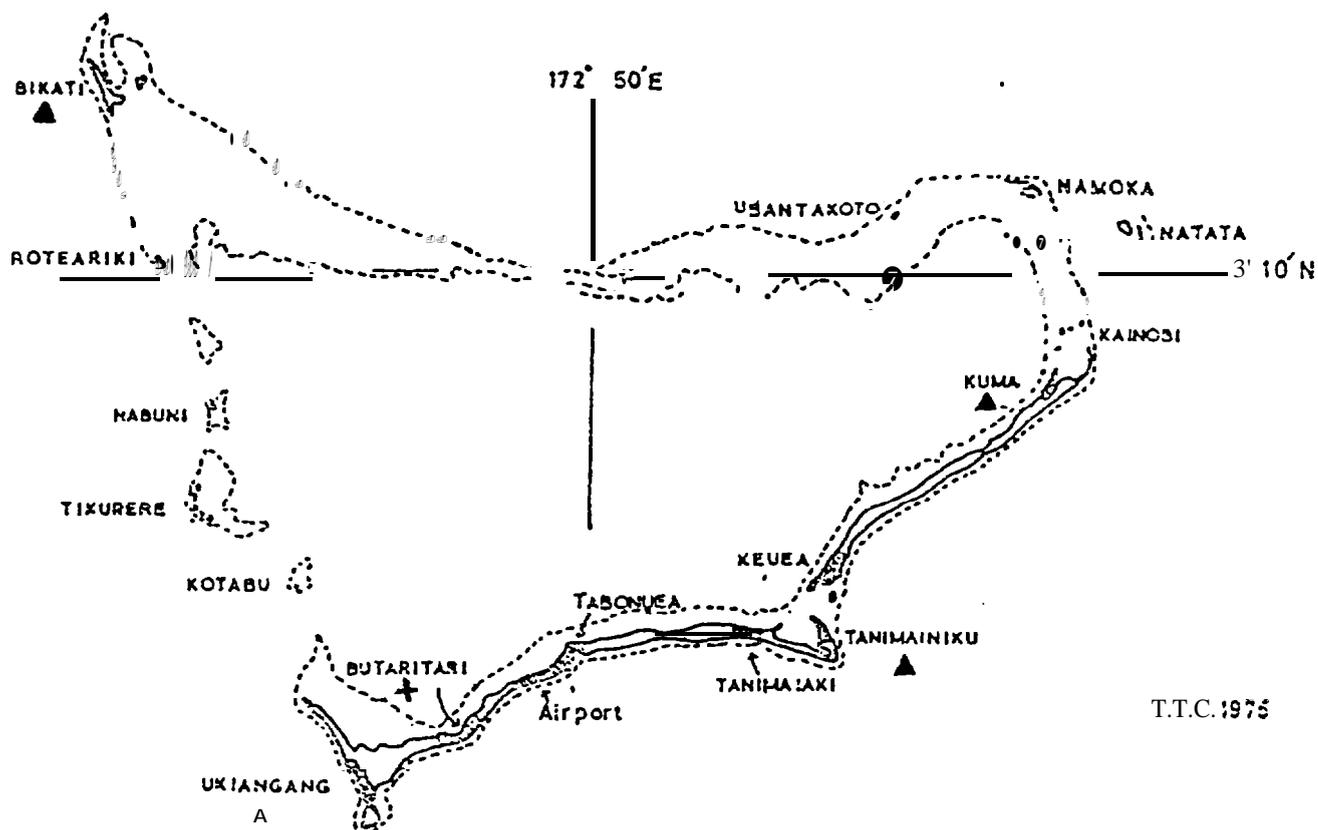




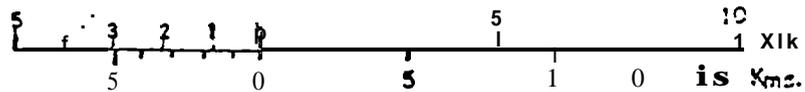
- IN BETIO:**
- + (1) HEALTH CENTRE
 - ▲ (2) DISPENSARIES



BUTARITARI



on Admiralty Chart No. 326.9, and
Lands and Surveys 1:50,000 Butaritari map.

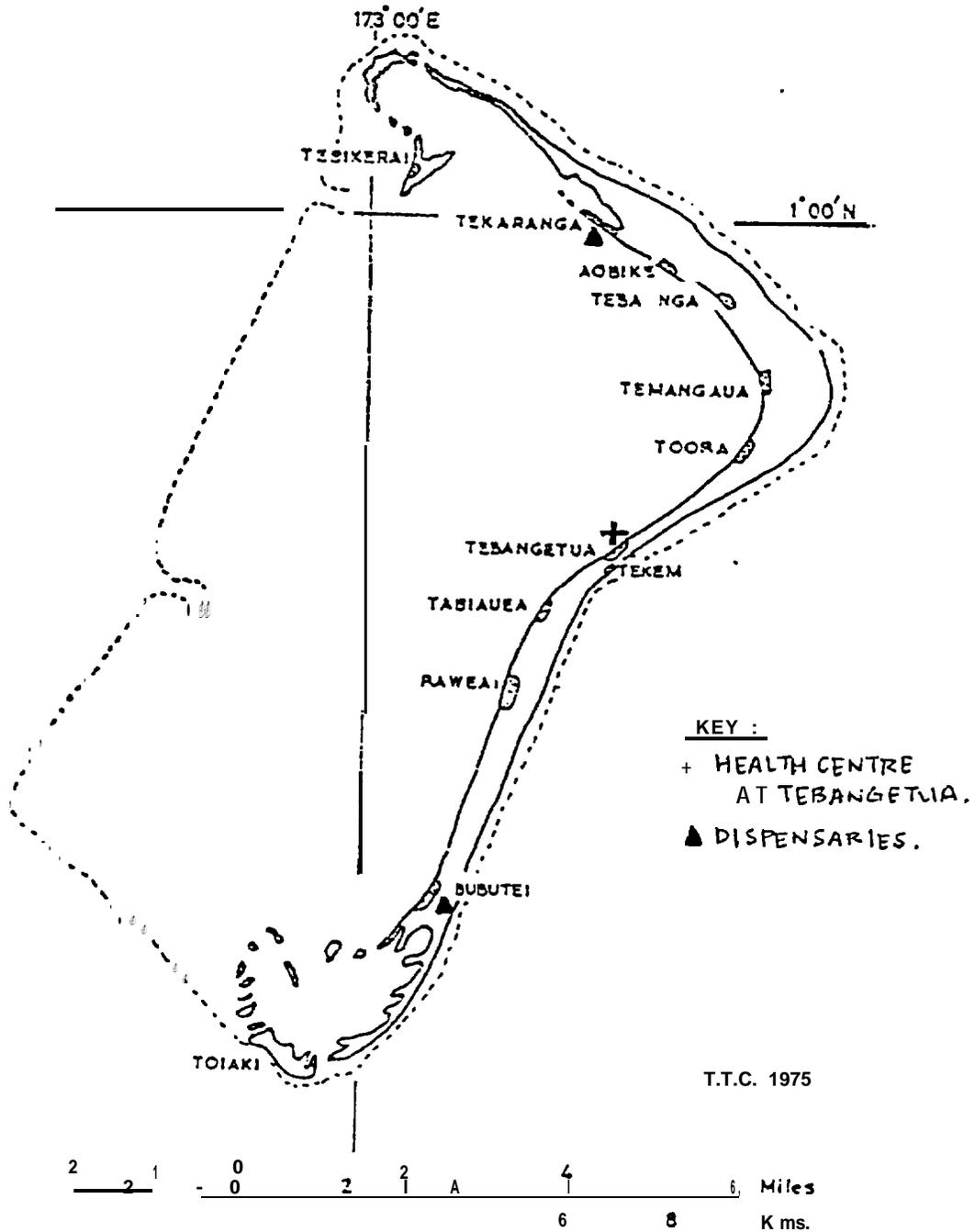


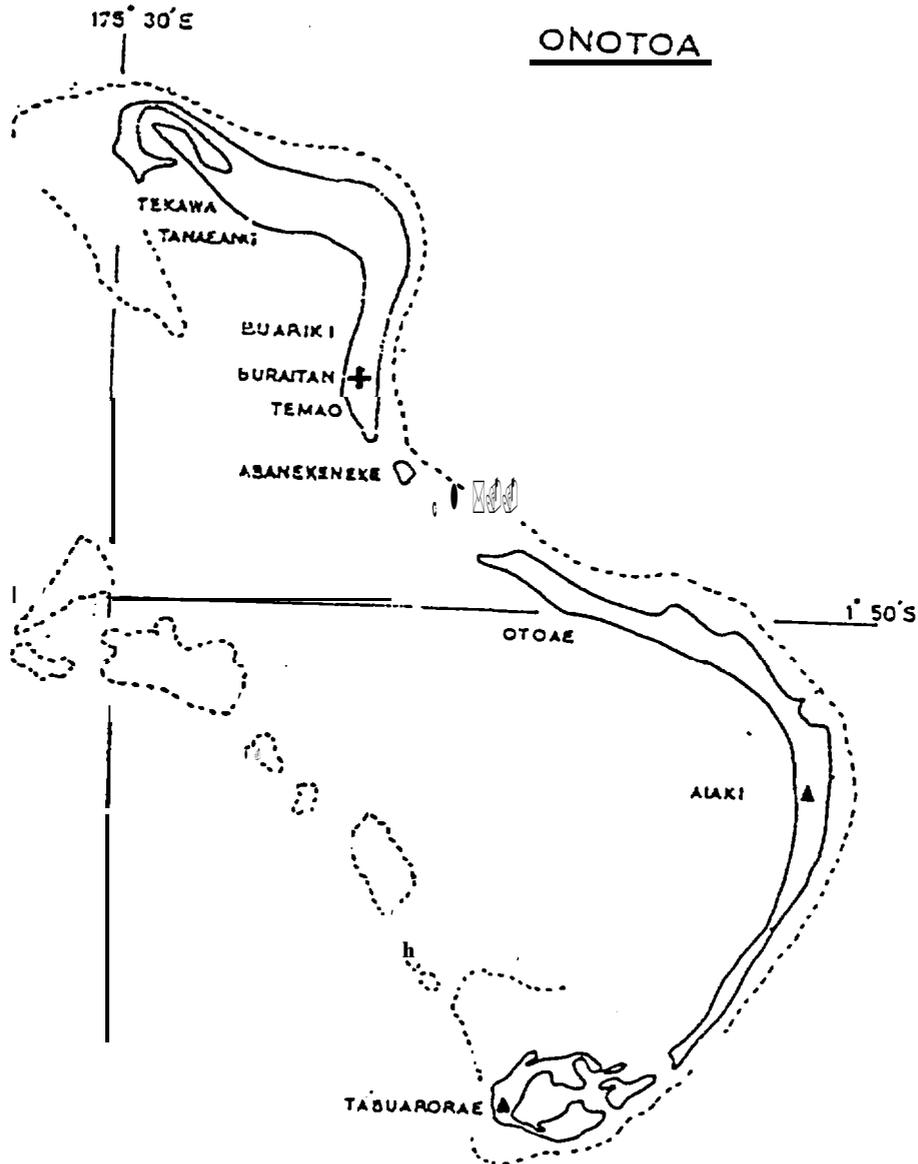
KEY:

+ HEALTH CENTRE AT BUTARITARI.

▲ DISPENSARIES.

MAIANA





T.T. c. 1975

Based on Admiralty Chart No. 3269 and Atoll Research Bulletin No. 47

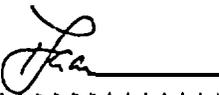
KEY:

- + HEALTH CENTRE AT BURAITAN.
- ▲ DISPENSARIES AT ALAKI, TABUARORAE.

REVISED IMMUNIZATION SCHEDULE

AGE	VACCINE	DOSE	ROUTE
At Birth	1. BCG	0.1 ml	Intradermal (L)Deltoid
	2. Polio 0	2-3 drops	Orally
	3. Hepatitis B 1	10	Intramuscular
6 weeks	1. DPT 1	0.5 mls	Intramuscular
	2. Polio 1	2-3 drops	Orally
	3. Hepatitis B 2	10	Intramuscular
10 weeks	1. DPT 2	0.5 mls	Intramuscular
	2. Polio 2	2-3 drops	Orally
14 weeks	1. DPT 3	0.5 mls	Intramuscular
	2. Polio 3	2-3 drops	orally
	3. Hepatitis B 3	10	Intramuscular
9 months	Measles	0.5 mls	Subcutaneous, Deltoid
All Girls in Cl. 7, 1st T*	Tet. toxoid 1	0.5 mls	Intramuscular
6/52 after 1st dose	Tet. toxoid 2	0.5 mls	Intramuscular
6/12 after 2nd dose	Tet. toxoid 3	0.5 mls	Intramuscular
All Girls in Cl. 8, 2nd T*	Tet. toxoid 4	0.5 mls	Intramuscular
All Girls in Cl. 9 or at Secondary Sch.	Tet. Toxoid 5	0.5 mls	Intramuscular

Key: T* = Term
Cl = Class



 Dr. Tere Taaram
 C P P H S

PUBLIC HEALTH CIRCULAR, PEC1

TO : DPNOS
M.&S
PENS

CC: ALL DOCTORS
HOST ITAL NURSES
PHARMACIST

FROM : CHIEF OF PREVENTIVE AND PUBLIC HEALTH SERVICES

DATE: FEBRUARY 4, 1994

SUBJECT: VITAMIN A DEFICIENCY PREVENTION AND TREATMENT PROTOCOL CHANGE

1. TREATMENT SCHEDULE

Serious Vitamin A deficiency is an emergency. The revised Vitamin A treatment schedule is called a 1-2-3 step as follows:

**NEW
VITAMIN A PROTOCOL
TREATMENT**

- 1 capsule: Acute lower respiratory infection,
severe diarrhoea ,
malnutrition.
One capsule on diagnosis.
- 2 capsules: Measles .
One dose on diagnosis
Second dose next day:
- 3 capsules: Night blindness "
Bitot's spots . .
Xerophthalmia'
One-dose-on-diagnosis ,
Second dose next day, . .
Third dose two -weeks later. . .

Dosage:

Infants under 12 months: 100,000 IU
Children 13 months and older: 200,000 IU

PLEASE NOTE: This DOSE SCHEDULE SHOULD NOT be given if a child has already received a dose of Vitamin A within the preceding month

2. PROPYLAXIS:

The Vitamin A campaign in **March, July** and November will continue. The targeted age group are ~~from 6 months to 6 years~~ of age (instead of 6 months to 10 years).

**NEW
VITAMIN A PROTOCOL'
PROPYLAXIS**

Infants aged 6 months to 12 months Three times yearly March, July, November	100,000 IU
Children 13 months to 6 years Three times yearly March, July, November	200,000 14
Women at birth Within one week of parturition	200,000 IU

For convenience sake and to have the Vitamin A campaign under one **campaign**, the infants-, 6 months to 12 months will **receive** a Vitamin A dose, 100,000 IU during the major **campaigns**. This will take the place of -giving it during the **immunization** clinics.

The older children aged **7-10** years need **NOT receive Vitamin A for prevention**. However, any child who suffers and shows signs of Vitamin A deficiency **SHOULD** be treated **accordingly**.

The woman-at-birth will **still** receive a-single- dose Vitamin A 200,000 IU within one **week of parturition**.

3. RECORDING THE DOSAGE

Vitamin A is stored in the body, in the liver. It is safe, but large doses should not be taken too often (not to exceed every 3-6 months, **EXCEPT IN MEDICAL TREATMENT**). Program monitoring is important to be sure that the child DOES NOT receive too many Vitamin A capsules.

3.1 Register

A Vitamin A register must be in place and the dosage should be recorded in this register during the campaign distribution. This will enable follow-up of those who missed the distribution.

3.2 MS 1 Form

Instead of recording by the number of campaign (Vita-1, Vita-2, Vita-3), the recording should be in the same place for PROPHYLAXIS and TREATMENT thus:

Vitamin A Prophylaxis: These cases will be marked by age group as before. There will be only one line for Prophylaxis (which take place during the 'three campaigns'). As well, the dosing to the woman-at-birth will continue to be marked in the appropriate age box, the month when it is administered.

Vitamin A Treatment: Below the line for Prophylaxis, Vitamin A deficiency cases treated will be marked by age group (i.e.; -for night blindness, bitot's spots, measles, severe diarrhoea). Only mark once per case (not the number of capsules given per case). This will allow us to monitor the number of Vitamin A deficiency cases in the country.

3.3 Child Growth Card and Under-5 Clinic Record Card.

Vitamin A is stored, in the body. Therefore, we have to monitor carefully the amount of Vitamin A that each child receives. The special large dose capsule (200,000 IU) should normally NOT be given more than 3-6 months. If the child is seriously ill, it can be given if the child has not received it in the previous month.' To track the individual's receipt of Vitamin A capsule, please record on both the Child's Growth Card (as instructed earlier) and on the Under-5 Clinic Record Card.

* Children under one should be given treatment.

3.4 Medical Record Card and Labour and Puerperium Card.

All those over five years of age who receive the large dose Vitamin A should have it recorded on their individual medical card. This includes the woman-at-birth, whose dosing will also stay recorded on the Labour/Puerperium Card.

TABLE II

VITAMIN A CAPSULE COVERAGE BY ISLAND
PRELIMINARY 1993 FIGURES

ISLAND	TOTAL VAC CHILDREN 1-10 YEARS	POPULATION 1-10 YEARS	CAPSULE PER CHILD
1. Makin	1767	531	3.33
2. Butaritari	3395	1138	2.98
3. Marakei	2106	863	2.44
4. Abaiang	4318	1573	2.75
5. Tarawa North	1383	1095	1.263
6. Tarawa South	12154	7558	2.72
7. Betio	8414	(combined with #6)	
8. Banaba	449	86	5.22
9. Maiana	1563	657	2.38
10. Kuria	957	298	3.21
11. Aranuka	456	302	1.51
12. Abemama	1356	967	1.40
13. Nonouti	1780	848	2.10
14. Tabiteuea North	1879	964	1.95
15. Tabiteuea South	1047	401	2.61
16. Onotoa	1479	633	2.34
17. Beru	1365	876	1.56
18. Nikunau	1357	601	2.26
19. Tamana	223	418	0.53
20. Arorae	413	434	0.95
21. Christmas	1847	759	2.43
22. Fanning	708	394	1.80
23. Washington	354	282	1.255
24. Canton	Nd data	14	--

National mean: 2.23 capsules per child
*National median: 2, 3 0 capsules per child

Top five:

1. Banaba
2. Makin
3. Kuria
4. Butaritari
5. Abaiang

Lower five:

1. Tamana
2. Arorae
3. Washington
4. Tarawa North
5. Abemama

Assumptions:

- a) 1990 census data extrapolated at annual 2.02% growth rate for 1993.
- b) Percentage population used from 1990 census.
- c) Capsule distribution as marked in respective age boxes on MS1 forms in 1993.

Sectoral Chapter 2.1

FAMILY PLANNING & POPULATION POLICY

1. Introduction:

1.1. The national census (1990) showed a population growth rate of 2.24% between 1985 and 1990 - an increase in rate of 0.14% from 1985. This implies that the Policy target of 1.4% growth rate by 1991 will not be achieved.

1.2. The Health Information Centre (HIC) showed a very steady rising trend (23% in 1987 to 27.63% in 1990) in the number of the eligible population practising some form of conception control; however such increase has not been reflected in a reduction of the population growth rate.

1.3. Although the population growth rate has been fairly constant just above 2%, there is a need to increase the Family Planning practice from 27% to over 50% of the eligible population by the year 1995 and to 85-90% of the eligible population by year 2,000. This is important in order to slow down the population growth, parallel to keep pace with economic growth. Clearly there is a need for a more cohesive Policy to integrate the Family Planning programmes,

2. Policy:

2.1. The Family Planning Services should aim to reduce the population growth rate from 2.24% to zero growth by the year 2,000 through comprehensive programmes dealing with; community motivation to accept the "2 child per couple" norm; programme intensification and expansion to make the services readily available, and manpower upgrading to make the delivery of the services effective. By these means the population growth will be comparable with economic and social development by 1995.

2.2. A firm Population Policy should consider seriously other fertility interventions such as Intermediate and Indirect Interventions.

3. Objective:

3.1. To increase the number of FP acceptors to 12,000 by 1995.

3.2. To make all forms of FP methods readily available nationwide by 1995.

3.3. To maintain and upgrade the efficiency of all health and allied personnel on the techniques of FP delivery.,

3.4. To monitor constantly the progress of FP programmes in each island for immediate improvement and/or adjustment.

3.5. To formulate a more Cohesive Population Policy.

4. Strategy:

4.1. Couples and the community should be motivated to plan

their families to 2 children per couple through intensive Publicity delivered by radio, group discussions, posters, and other audio-visual methods.

- 4.2. Every health clinic in Kiribati should be able to offer FP service requested by immediate delivery of the service or immediate referral to appropriate clinics.
- 4.3. The knowledge and skills of health staff and other related staff on FP services should be constantly updated and upgraded through courses, workshops, on the job training and seminars.
- 4.4. The progress of FP programmes should be reviewed and evaluated constantly through proper recording and reporting.
- 4.5. The initiation of a cohesive Population Policy should be done through wide collaboration and research.

Activities:

5.1. Health Education:

5.1.1. The Health Education Unit prepares and programmes 4 radio talks on FP/yr.

5.1.2. The Health Education Unit prepares and programmes 52 radio spots on FP/yr.

5.1.3. The Health Education Unit prepares and distributes 1,000 posters initially.

5.1.4. The Public Health Staff conduct 300 community discussions per year including 1 talk per school per year.

5.1.5. The Ministry organises competitions on FP acceptance every year.

5.1.6. VWGs discuss Population problems with the Community and motivate them to use FP services.

5.2. Delivery of Services: (Cafeteria System)

5.2.1: PHNs/MAS and Catholic workers offer advice on Ovulation method.

5.2.2. PHNs/MAS organise pill distributions.

5.2.3. Touring DPNOs/MAS insert loops.

5.2.4. Doctors conduct vasectomies at home.

5.2.5. Doctors conduct tubectomies at TCH.

5.2.6. Dispensaries/Clinics supply condoms to the community.

5.2.7. PHNs/MAS conduct home visit follow ups for defaulters.

5.3. Resource Development:

- 5.3.1. The Ministry sends 4 PHNs per year to study IUD insertion techniques.
- 5.3.2. DPNOs organise training of 50 TBAS/Nurse AIDES/per year (also covered under MCH).
- 5.3.3. The Ministry organises 3 workshops per year.
- 5.3.4. The Ministry purchases 120 IUD insertion/kits.
- 5.3.5. The Ministry purchases 12 vasectomy kits.

5.4. Evaluation:

- 5.4.1. PHNs/MAs record the names of FP clients in a special record,
- 5.4.2. PHNs/MAs compile and submit regularly each month relevant information on FP practices to HIC via DPNOs.
- 5.4.3. HIC stores information submits relevant information monthly to CPMEB for monitoring.

5.5. Population Policy Formulation:

- 5.5.1. The Minister, MHFP&SW submits Cabinet Paper on the Proposed Population Policy.
- 5.5.2. The Ministry requests a short term consultant for 'Research on Behavioural Attitudes towards F.P.'

6. Schedules:

<u>Activities</u>	<u>1992</u>	<u>1993</u>	<u>1994</u>	<u>"199s</u>
Pill distribution	-----	-----	-----	-----
IUD insertions	-----	-----	-----	-----
Vasectomies	-----	-----	-----	-----
Tubectomies	-----	-----	-----	-----
Condoms	-----	-----	-----	-----
Home visits	-----	-----	-----	-----
Courses	-----	-----	-----	-----
Local training	-----	-----	-----	-----
Workshops	-----	-----	-----	-----
Kits Procurement	-----	-----	-----	-----
Evaluation	*	*	*	*
Health education	(See chapter on Health Education)			

7. Budget:

- 7.1. Personnel emolument = \$512,350/yr (part of Recurrent Budget)
- 7.2. Programme tours = 144,452/
- 7.3. Radio spots (52) = 728.00
- 7.4. Radio talks (7) = 105.00
- 7.5. Posters (1,000) = 250.00

- 7.6. Depo provera - 500 (10ml.) vials =)
- 7.7. Eugynon ED - 8,000 =)
- 7.8. flicrogynon 30 ED-600 vials =) \$10,000 annually supplied as aid in kind by INPA
- 7.9. Condoms - 200 gross =)
- 7.10 Lippes A-200 =)
- 7.11 Lippes B-100 =)
- 7.12 Lippes C-200 =)
- 7.13 Lippes D-300 =)
- 7.14 Copper TOU - 200 =)

Other Needs:

- 1. Syringes 5ml. 500 x 3.00 = \$1,500.00
 - 2. Needles 25" 500 x .80 = 400.00
 - 3. Suture with needles 500 x 4.00 = 2,000.00
 - 4. Lignocaine 100 x 5.00 = 500.00
 - 5. Iodine solu. 500mls. cont. = 100.00
 - 6. Surgical knife 500 x 1.50 = 750.00
 - 7. Swab (gauze) 2 carton = 80.00
- \$5,330.00**

Project:

- 8.1. Vasectomy sets (12) = \$3,600.00
- 8.2. Fellowships IUD (4) = 19,200.00
- 8.3. Workshops (3) = 24,000.00
- 8.4. Island training of TBAs (12) = 9,000.00
- 8.5. STC (3 mth). = 21,000.00



C FOLLOW UP

Information to be recorded:

1. Complaints
2. Observations - including number of days bleeding, how often, any pain, any discharge, threads felt; PV result.
3. Supplies given - how much.
4. Change of method.
5. Date of discontinuation, with reason.
6. If preganant, state length and result of pregnancy.

Date	L.M.P.	B.P.	WT	METHOD	REMARKS	T.C.A.

If this page is finished, please pin an additional sheet to the top of this page. Please remember to send all duplicate copies of case cards to C.C.H., Bikenibeu, each month with the MCH Monthly Return.

THANK YOU.

Secretoral Chapter 6.2

HEALTH INFORMATION CENTRE

1. INTRODUCTION:

1.1. This chapter will describe the functions of the Health Information Centre in support of the implementation of the National Health, Family Planning and Social Welfare Programme Plan and the roles of the health staff in this function.

1.2. The purpose of the Health Information Centre is to support the other units of the Ministry of Health, Family Planning and Social Welfare in implementing the National Health, Family Planning and Social Welfare Programme Plan.

2. POLICY:

As policy the Health Information Centre will work as much as possible in a reliable and effective way to provide valid information relating to disease incidence, prevalence, and programme coverage.

3. OBJECTIVE:

The objective of the Health Information Centre is to provide valid, reliable and appropriate information about health services and their infrastructure. It is the aim of the Health Information Centre to ensure that all relevant bodies within and outwith the Ministry have access to accurate and appropriate data. This data will be in a form which will facilitate planning, monitoring, evaluation and review of the National, Health, Family Planning and Social Welfare Programme Plan.

4. STRATEGIES:

4.1. Through regular recording of events in registers by the MAs and in Log Books by Health Aides.

4.2. By regularly sending report forms to the Health Information Centre.

4.3. Disseminating Health Information to all relevant bodies approved by the Secretary for Health, Family Planning and Social Welfare.

4.4. Cooperating with other information units in the country or abroad as an independent unit for the purpose of facilitating work and preventing duplication.

5. ACTIVITIES:

5.1. H.I.C. will collect relevant reliable and valid data on the health situation, health services provisions and operations for planning, monitoring, evaluation.

5.2. H.I.C. will gather and store the results of special studies conducted in cooperation with the R & D Section of the Ministry through Medical Assistants, Public Health Nurses and community self help bodies (VWGs).

5.3. H.I.C. will handle and store these data, classify, tabulate and present them (using informatics) to health units as and when required.

5.4. H.I.C. will record and permit access to essential information on health related situations in Kiribati only on official requests- from health units and with approval from the Secretary of the Ministry for parties outside the Ministry of Health, Family Planning and Social Welfare.

5.5. It will tentatively receive data as follows:

Flow of Information from Health Centre and Dispensaries Basic Record

- .. Medical Record Card/Register ---
- . ANC Cards
- . Child Health Card
- . Under five clinic record Cards
- . Notification of Births and Deaths
- . School Health Cards

- . Home visiting Register

- . In patient Register
- . Family Planning Cards
- . TB & Leprosy Cards
- . Referral Forms

Work sheets

monthly consolidated statistical record

Work sheets

Flow of Information from Health Centre and Dispensary to HIC

- . Monthly consolidated statistical report
- . TB & Leprosy review forms
- . Mental patients Informations management
- . Notification of Special Disease
- . TB treatment card
- . Field activities monitoring report

Health Information Centre

All forms must reach the Health Centre before the 15th day of the succeeding month.

5.5.6. Activities related to MAs and PHNs

5.6.1. Daily recording of information related to Family Planning and priority diseases to pinpoint areas of need. Information is to be recorded in registers and specific forms by the MAs and PHNs, and MCH Log books by the Health Aides.

5.6.2. Monthly reporting of this information to the Health Information Centre especially in relation to Family Planning and priority diseases. This will serve to highlight problem areas.

5.7. Activities related to the DPNOs

5.7.1. DPNO's should supervise and train M.A.'s and PHNs in their areas to ensure that accurate and correct reporting procedures are applied. Stress should be placed on provision of good quality information, especially on Family Planning and priority diseases. Instruction should be given on maintaining registers and completing forms.

Vertical text on the left margin.

5.712. DPNO's must ensure that workers under their control adhere to daily recording and monthly submission of information rules.

SUMMARY BUDGET

HEALTH INFORMATION SYSTEM COST

	1992..	1993	1994	1995	REMARKS
SUPPLIES	\$8771	\$9209	\$9669	\$10152	ref. attached annual require-ment
EQUIPMENT	23000.	13000	-	-	Compute model 386(1992), Copyprinter (1993)
SHORT TERM CONSULTANT	-	-	9000	-	(1X1MTH) on informatics
TOTAL	31771	22209	18669	10152	

	Copies	Sheet	Reams	cost	Total cost &
<u>Rota Printer Machine:</u>					
Child Health Card (Under Five)	3000	200			
Child Health Graph	3000	375			
Medical Record Card	24000	2000			
Antenatal Card	2000	250			
TB Treatment Card	1000	125			
Leprosy Treatment Card	1000	125			
Patient Index	1998	37			
Patient Confidential Cover	4000	2000	26 x 200	267	6942
MSI	3000	750			
Admission Folder	4000	2000	6 x 500	170	1620

Duplicating Machine:

Special Disease Notification	1000	1000			
TB Review	250	250			
Mental Patient Inf. & Management	250	250			
School Medical Record	1000	1000			
Referral Form	2000	2000			
Treatment Work Sheet	3000	3000			
Annual Census Form	250	250			
Requirement Form	250	250			
Field Activity Monitoring	500	500			
Health Staff Evaluation Form	250	250			
Summary Ward Census	500	500			
Special Clinic	500	500			
Hospital Discharge Record	2500	1200	22	9.5	209

MCH log books and PHNs register included under HQ provision. TOTAL=-.8771

KIRIBATI MINISTRY OF HEALTH AND FAMILY PLANNING
AND
THE FOUNDATION FOR THE PEOPLES OF THE SOUTH PACIFIC

Child Survival IX:
IMPROVING THE QUALITY OF CHILD SURVIVAL SERVICES
IN
THE SOUTH PACIFIC
(VANUATU AND KIRIBATI)

October 1, 1993 - September 30, 1996

MID-TERM EVALUATION

Child Survival Project
KIRIBATI

Report submitted to:

Overseas Development Administration
Pacific Regional Advisory Group

The United States Agency for International Development
Bureau for Food and Humanitarian Assistance
Office of Private and Voluntary Cooperation

Ministry of Health and Family Planning
and
Ministry of Home Affairs and Rural Development
Republic of Kiribati

FSP Kiribati

September 26, 1995

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Abbreviations

ARI	Acute Respiratory Infection
CDD	Control of Diarrhoeal Diseases
CMA	Clinic Management Assessment and Training Component of the CSP
CPPHS	Chief of the Preventive and Public Health Services, MHFP
c s	Child Survival
CSP	Child Survival Project
DIP	Detailed Implementation Plan
DPNO	District Principal Nursing Officer
EHU	Environmental Health Unit
EPI	Expanded Program of Immunization
EU	European Union
FAO	United Nations Food and Agriculture Organization
FP	Family Planning
FSP	Foundation For The Peoples Of The South Pacific
HC	Health Center
HE	Health Education
HEU	Health Education Unit
HIS	Health Information System
HIV	Human Immunodeficiency Virus
IEC	Information, Education and Communication Materials
KAP	Knowledge, Attitudes and Practices
KPC	Knowledge, Practice and Coverage
MA	Medical Assistant
MCH	Maternal and Child Health
MHARD	Ministry of Home Affairs and Rural Development
MHFP	Ministry of Health and Family Planning
NGO	Non-Government Organization
PHC	Primary Health Care
PHN	Public Health Nurse
PVO	Private Voluntary Organization
SCF	Save The Children Fund
SPAFH	South Pacific Alliance For Family Health
STD	Sexually Transmitted Disease
UNDP	United Nations Development Program
UNICEF	United Nations Childrens Fund
VHW	Village Health Worker
WHO	World Health Organization

Introduction

The Kiribati Child Survival Project was implemented in October 1993 in order to promote improvements in the health of children and women in 4 islands of Kiribati with the worst Child Survival Indicators (Betio, Butaritari, Maiana and Onotoa). The term of the project is 3 years. USAID funds will close on September 30, 1996. Support from the ODA will continue until at least March 31, 1997.

The purpose of this evaluation is to review project implementation and generate recommendations for any mid-course corrections necessary to meet the project objectives during the second half of the project. The evaluation consisted mainly of interviews with the project counterparts and beneficiaries. Appendix 'A' is a list of people interviewed.

The Project focus is on improving Child Survival Indicators in the target groups by improved Clinic Management (CMA) and also Health Education of community members with Community Health Education Workshops for NGO representatives (womens, youth and church groups) on immunization, nutrition, ARI/CDD and reproductive health. The Project is not involved in service delivery of any sort.

The Project has achieved its Mid-Term Targets in CMA and the first round of Community NGO Representative Workshops. This has happened despite considerable constraints with transport and the departure of key Project staff. There should be no changes to Project Goals, Objectives or Target Population. However, these are significant constraints and the Project will not reach its End of Project Targets unless there is a reduction in the number of Community Health Education Workshops in the remaining 18 months of the Project. This is spelt out clearly in the Report and its Recommendations.

This Mid-Term Evaluation was carried out by a three person team consisting of MHFP and FSP staff and an external consultant (see Appendix B).

This evaluation was made with the support of the Overseas Development Administration of the government of the United Kingdom and the support of the United States Agency for International Development under cooperative agreement number FAO-0500-A-00-3027-00.

1. Accomplishments

The Kiribati Child Survival project has officially been going since 1 October 1993. The major Inputs and Outputs have been:

A. Project Establishment - Inputs/Outputs

Island Selection Process

Input

At the commencement of the Child Survival Project (CSP) criteria were developed to determine which Kiribati islands became CSP project sites.

Two main criteria were used:

- (1) health status of the 19 islands (based on EPI coverage data, ARI/CDD morbidity/mortality data and Family Planning (FP) user rates)
- (2) community support - measured by written responses from the 19 Councils.

output

All 19 Island Councils, for the first time in Kiribati, were prepared to commitment their own resources to a development project in their communities by waiving “sitting fees”, and also providing transport and accommodation for CSP staff and participants in CSP Workshops. Four Island Council areas were chosen using these criteria (Butaritari, Maiana, Onotoa and Betio). The decision making process, because it was widely consultative and selected those islands with the worst morbidity/mortality data, was seen to be fair. The number of Councils was limited to 4 because of the number of Workshops to be carried out and also the absorptive capacity of the communities on the Project sites.

Baseline Survey and Participatory Planning

Input

All villages in each of the 4 project locations were visited. A baseline survey of child health indicators and mothers of children < 24 months was carried out. All village elders were met and representatives of won-tens, youth, church etc groups were interviewed.

output

As a result, some 300 mothers were interviewed (20% of mothers in the f sites). These results provided the basis for the interventions outlined in the DIP. ARI and CDD were

shown to be the most significant causes of morbidity. As a result, AR1 was added to the Project Intervention area. Supplementary Questions also showed that most families lack access to basic sanitation or safe water supply.

Project Staff Hired and Training of Trainers Workshops

Input

Training of Trainers Workshop

A CSP Training Of Trainers Workshop was conducted over 2 weeks for the FSP CSP Staff (Senior Health Educator, 2 Health Educators, Agriculture Officer), DPNOs, 2 staff each from the Health Education Unit and the Department of Agriculture, and one representative each from the preschool association and the Ministry of Education. Additional training in health topics to FSP staff was organised by the Health Programs Coordinator, with the assistance of the Senior Health Educator.

Training of Trainers Extension Workshop

On Mondays and Wednesdays for half a day for 4 weeks, a TOT Extension Workshop was conducted providing practice exercises for the participant of the above Workshop.

output

The result was 15 people trained in Trainer skills (planning, methods, etc.) which were appropriate to Child Survival and as well as other training programs prioritized by the Government of Kiribati.

Island Council Workshops

Input

In each of the 4 Project Sites, a CSP Information Workshop of 5 days duration was conducted to provide the Councilors with background information on the goals and objectives of Child Survival, the main causes of illness and death on their own island and actions they could take, as a Local Council, to address these problems.

Output

As a result the Island Councils in each of the 4 Project Sites have provided formal written agreement to support and assist the Project in their respective Council areas. In their area they now provide transport and accommodation for activities which relate to the CSP. All Councils prepared action plans related to Child Survival activities. Also, at least two of the Councils have established CSP Sub-committees:

B. Clinic Manawment - Inputs/Outputs

Clinic Management Assessment Consultancy

Input

An external consultant, with the assistance of the Chief of Preventive and Public Health Services, the FSP Health Programs Coordinator, and 2 DPNOs reviewed the various aspects of the management of clinics in 3 sites (Betio, Abaiang and Tabiteuea North) to see what improvements could be made in optimising services, including follow-up of Family Planning and EPI clients and increasing preventive health outreach .

output

A clinic Management Assessment Report outlining the findings and presenting forms for: Self Assessment, Facilities Maintenance Checklist, Supervisory Checklist, and Tickler File System (a patient follow-up system). (See Appendix F).

Clinic Management Training Workshou for DPNOs

Input

This one week Workshop for all 5 DPNOs (the supervisors of all non-hospital services) reviewed the power and role of the DPNO and the importance of effective clinic management. The participants then refined, as a group, the various forms developed during the Clinic Management Consultancy (see above).

output

Five DPNOs trained in Clinic Management and the purpose and use of the Clinic Management Forms with a work-plan for three visits a year for each outer Island Clinic to implement this new Clinic Management Strategy.

Clinic Management Training: for Medical Assistants

Input

This one week Workshop brought the 19 MAs together on Tarawa to undertake the 4 areas of Clinic Management training that the Clinic Management Consultancy had developed.

output

Nineteen MAs trained in Clinic Management including Supervisory Checklists. Facilities Maintenance Checklist, Self Assessment Forms and the Tickler File System.

Clinic Management Training for PHNs

Input

Training of the PHNs on the outer Islands in Clinic Management has been carried out by the DPNOs and MAs with the PHNs in their respective clinics.

output

To date, the PHNs on 4 Islands have been trained in Clinic Management and the use of the Forms used to improve Clinic Management.

C. Community Health Education - Inputs/Outputs

KAP Nutrition

Input

An external consultant, a medical sociologist, with the assistance of a member of the HEU, the Ministry of Health Nutritionist and the FSP Nutritionist undertook a survey of Knowledge, Attitude and Practice on Nutrition on Butaritari, Betio and Maiana.

output

A Draft Report is available with the findings and recommendations for Health Education messages and Strategies for the Community NGO Nutrition Workshops. The Final Report is completed, but has evidently been delayed in the international mail.

[Note: The KAP Nutrition Final Report was received 4/10/95 during the final printing and distribution of this Mid-Term Evaluation Report]

KAP Control of Diarrhoeal Diseases

Input

A second external consultant with the assistance of the same member of the Health Education Unit, a member of the Environmental Health Unit and one FSP Staff member are undertaking a survey of Knowledge, Attitude and Practice of Care givers in CDD on Onotoa, Butaritari and Betio at the time this Mid-Term Evaluation is being conducted.

Output

Report to be submitted in October of 1995.

Church Leaders Workshop, Betio

Input

A CSP Information Workshop was held for 15 Church leaders at the Betio Project Site. Betio had the worst Child Survival Indicators in Kiribati in the Baseline Survey. The Workshop aimed to inform religious leaders about the major health problems and their causes in Betio and to motivate them to take action in line with their roles in community life.

output

As a result there are Church leaders now trained and committed to Child Survival, meeting regularly and who have registered as an NGO concerned with Child Survival (the first time there has been any such inter-church group in Kiribati) to undertake Child Survival activities in Betio.

Community NGO Level Workshops

Input

With between 12 and 15 participants at each Workshop representatives from various community NGOs (Womens, Youth and Church groups) have attended the first round of Workshops. The theme of this first round has been an Introduction to Child Survival and Immunization. Each has been conducted over 5 days and have used participatory Health Education techniques, ie. role plays, songs, small group discussions, etc.

output

A total of 10 Workshops has been included in this first round of Community Workshops: 3 in Betio, 3 in Butaritari, 2 in Maiana, and 2 in Onotoa. The 2 Workshops for Onotoa are yet to be completed. There are now approximately 130 people from various NGOs in the Project Locations trained in Child Survival and Immunization and who have an Action Plan to convey this information to the other members of the NGOs and the community at large.

2. Effectiveness

The Project has reached its stated Mid-Term Targets as can be seen in the previous section. The targeted high - risk groups in the 4 Project sites i.e. women and children of less than 5 years are being reached. The initial 18 months of the Project has been particularly effective in providing high quality baseline KPC and also KAP data which has provided the best possible information for both the Clinic Management and Community NGO Representative Workshops.

There are, however, constraints which have made the achievement of Mid-Term Targets difficult and which mean that End of Project Targets, in their present form, cannot be achieved. These constraints are:

Transport

The three outer island Project sites (Butaritari, Maiana and Onotoa) are isolated and the air and boat links are increasingly irregular and unreliable with frequent changes of time table and cancellation of services.

Project Staff Changes

In the 18 months of the Project, 2 of the 3 FSP Health Educators have left the Project. One of these was the Senior Health Educator who left the Project during the course of this Mid-Term Evaluation. These are crucial positions in achieving Project Targets, as these 3 people deliver all Project training Workshops. They were the main recipients of the TOT Workshops on Child Survival Interventions and were the only FSP Project staff with this training as well as the required local language skills to conduct the Community NGO Representative Workshops which account for the majority of Project activities for the remaining 18 months.

Major difficulties are being encountered in recruiting replacement H.E. staff, as people with the required educational background and experience are not common and extremely difficult to recruit. Once recruited, a period of orientation and training in Project Goals, Objectives and Workshop methodology will be required. This will essentially put the Community NGO Workshops “on hold” for the next 4 months.

It should be noted that the reason for the departure of these 2 crucial Health Educators was that they were offered Government jobs which provided higher salaries with housing.

There have also been several MHFP staff changes in the Project locations, such as MAs and PHNs who were involved with the Project being transferred to other islands. Several of the Clerks to the Island Councils (the Senior Local Government Officials) have been transferred as well. Periodic re-introductions to Project activities have been necessary.

MHFP Staff participation in Outer Island activities

A further constraint to the Projects outer islands (Butaritari, Maiana and Onotoa) activities has been the difference in payment of per diem for nights spent on the Outer Islands. The Kiribati Government per diem is \$45 per night spent away from home for accommodation and meals. The CS Project rate is \$15 per night which is in keeping with FSPs agreement with island councils who provide accommodation free of charge and FSP provides only for meals and incidentals. This has caused some MHFP staff concern and an apparent unwillingness to participate in CS Project Outer Island activities. This does not apply in Betio which is on South Tarawa where no per diem is necessary and where participation by the MHFP staff has been most effective. At the time of this Mid-Term Evaluation the MHFP and FSP seem to have resolved this issue with FSP continuing to adhere to its agreement with the island councils (and in keeping with USAID guidelines), the MHFP contributing to make up any shortfall in MHFP staff per diem.

The I-Kiribati cultural trait of not sharing Information

There is a trait within Kiribati culture of not sharing information with other people. Information is power and is not to be shared with others. This is seen in all walks of life in Kiribati. Even some Nurses in Dispensaries are known to not tell everything to the care givers of sick children for this reason. It will be clear only when the final evaluation of this Project takes place how much of a constraint to the Projects goal this cultural characteristic has been, and how effectively the Community NGO Representatives have shared the information they have learned from the Community Workshops with their NGOs members.

3. Relevance to Development

The Project has increased the ability of families to participate in and benefit from child survival activities by:

- i. Improved clinic management and monitoring skills of DPNOs, MAs and PHNs through management training and supervisory checklists has improved the delivery of child survival interventions at the Dispensary level.
- ii. By the use of Health Education themes, thoroughly researched and developed through KAPs, Community NGO Representative Health Education Workshops provide child survival interventions directly to Community members and their representatives.
- iii. Families will have access to IEC materials which will have been tested and found to be relevant to the target group.

4. Design and Implementation

4.1 Design

The original discussions between FSP and MHFP were for a Child Survival Project encompassing: (a) strengthening of Clinic Management and (b) Community Health Education on Immunization, CDD, Nutrition and Reproductive Health on a maximum of 6 Islands. After preliminary investigations, this would have meant approximately 200 Workshops over a 36 month period; Given the transport constraints, this was considered an impossible task, so the Project design was changed to 4 islands or Project sites. The DIP was written accordingly.

Since the actual commencement of the Project, the Project area and size of impact population have not altered. Likewise the Project strategies have remained the same.

The Project Management has been willing to make changes when appropriate. At the request of the DPNOs, Clinic Management training for the PHNs was changed from a National Workshop to local “on the job training” of the PHNs by the DPNOs. This was felt necessary because all PHNs would have been away from their posts at the same time leaving the outer islands without medical services. Also, the unpredictable transport situation would have made central Workshops almost impossible to coordinate.

With the present design of the Project, it will not be possible, given the constraints as outlined in Section 2 (Effectiveness), to carry out all of the Project activities for the second half of the Project. In light of the constraints, and especially with the departure of the Senior Health Educator, some Project activities will be put “on hold” until a new Senior Health Educator is found and trained. This will mean that there will not be any further Community NGO Workshops for possibly the next four months. Clinic Management Training for PHNs will continue.

A close examination of what is achievable, if the Project is not extended beyond March 1997, shows that it will only be possible to undertake 22 Community NGO Workshops between now and the end of the Project. Of the four topics for the Workshops (Immunization, Nutrition, ARI/CDD and Reproductive Health), the Immunization Workshops are almost completed. Of the three remaining Workshop topics, Nutrition and ARI/CDD are the major causes of morbidity and mortality in Kiribati. Already, substantial UNFPA and SPAFH funds are being expended in Reproductive Health including training, supplies and equipment for all levels of the MHFP services (see Section 4.12). It is, therefore, recommended that the Community NGO Reproductive Health Workshops be dropped from this Project and be considered as part of a possible second Child Survival Project commencing in 1997. The Reproductive Health KAP should proceed, as this will contribute valuable information on Reproductive Health for planning as well as Health Education interventions. For the same reasons, the remaining Church Leaders Workshops, of which only one has been completed at this Mid-Term stage, should not be carried out in the remaining time for this Project. Given the difficulty in finding a replacement for the Project Senior Health Educator, the

option of increasing the number of Project staff (either I-Kiribati or expatriate) to carry out the presently planned Workshop load is not, at this stage, realistic.

With these changes to the number of Workshops, the Project goal of improving the Child Survival indicators of the target group will be achieved with a greater degree of certainty about the quality of the training in those Workshops.

4.2 Management and Use of Data

Project Quarterly Reports, prepared by the FSP Health Programs Coordinator in Tarawa, include statistics on the Project Inputs/Outputs ie number of Health Education sessions number of people, involved and post Workshop Questionnaires results etc. These have been submitted on time and meet the requirements of the DIP.

The Project also has generated qualitative data of the highest quality in the baseline KPC and Nutrition KAP. The CDD KAP which is being conducted at the time of this Mid-Term Evaluation and the planned Reproductive Health KAP should provide equally as good data. This information has provided most worthwhile information not just for the Project but also for the MHFP and other donor agencies in planning other Programs and Health Education themes.

All Project data is made available to the MHFP, Ministry of Home Affairs, local Councils and other interested agencies. Feedback is provided to Local Councils and also to the DPNOs, MAs and PHNs in the Project Locations.

4.3 Community Education and Social Promotion

This Project is devoted to Community Health Education and improved Clinic Management. There is no service provision. Section 1 (Accomplishments) gives a detailed outline of the number of Health Education Workshops. These Workshops do make extensive use of messages developed through the baseline and KAP studies outlined above (see Section 1 - Accomplishments). These messages have been field tested and refined. The messages are consistent because the Project has had only one Health Education Team working during the Project. This means that the team members are constantly reviewing and comparing their individual inputs.

The Project distributes MHFP HEU printed materials which are appropriate to Child Survival Interventions. Workshop handouts have been developed by the Project which have been field tested before being used in the Workshops and the members of the community do regard these as simple and useful.

One of the two components of the Project is taken up with Community Health Education Workshops. These Workshops use adult participatory learning techniques - role plays, small group discussion, games, videos, and have also made use of the local drama group (Te

Itibwerere). The Project has a Post-Workshop Questionnaire (see Appendix D), and also has developed a Follow-up Guideline for each Workshop participant to be applied 3 months after the Workshop (see Appendix E).

4.4 Human Resources for Child Survival

The Project activities in the first half of the Project has led to the creation of a large group of people both within the MHFP at the national and outer island levels, and also at the community level. 'with Child Survival skills appropriate to their level of training and education.

FSP Project Staff

The CS Project provides partial funding for 5 FSP positions. All positions are based in Tarawa. The FSP Country Representative has administrative responsibility for the Project. The FSP Health Programs Coordinator has responsibility for the Child Survival Intervention Program components of the Project. There is one FSP Senior Health Educator position, which has recently become vacant, and two Junior Health Educators positions, only one of which is filled at present. This is the right balance of positions within the Project. There are only two concerns. The first is being able to find local staff who have the qualifications and experience to fill the Health Educators positions. The second is that the FSP Health Programs Coordinator will complete his 2 year contract in the next 5 months, and an extension until the end of the Project has not yet been negotiated. This provides another potential constraint to the achievement of End of Project Targets.

Within FSP, it has always been the intention that both the Country Representative and the Health Programs Coordinator would have counterparts. At the time of this Mid-Term Evaluation, neither of these official counterpart positions had been filled. In practice the CPPHS has acted as the Project Manager for Child Survival from the MHFP. It is recommended that the CPPHS be recognized in his role as CS Project Manager. This is both an acknowledgement of the work and support already provided and a positive step in increasing the sense of ownership on the part of the MHFP.

MHFP Staff

All DPNOs and MAs as well as all PHNs on 4 out of the 16 islands in Kiribati, have received training in the Clinic Management component of the Child Survival Project. This means they are trained in the use of the Supervisory Checklist (DPNOs only), the Self Assessment Forms, the Clinic Maintenance Form, and the use of the patient recall system (Tickler File System). For the DPNOs and MAs, this was done through two separate Workshops held in Tarawa. For the PHNs, it has been by "on the job" training in their Dispensaries in Clinic hlanagement by the DPNOs and MAs.

Training of Trainers National Workshop on Child Survival Interventions

The 2 week Training of Trainers Workshop provided training in adult training skills to FSP Staff (Senior Health Educator, 2 Health Educators and Agriculture Educator), MHFP Staff (5 DPNOs and 2 Health Education Unit staff) and one representative each from the preschool association and the Ministry of Education.

Local Council

These Workshops provided training to all members of the Local Councils in the 4 Project locations. This training gave an introduction to the Project with an overview of the CS Indicators in each of the Council areas and the topics and methodology for the Community NGO Workshops. There was 100% (25 Councilors x 4) attendance by each Council and has resulted in major local support for the Project.

Community NGO Volunteers

Community Volunteers are crucial to this Project. The Community NGO Representative Workshops are conducted for representatives elected by Community NGOs (womens, youth and church groups). These representatives then attend the Projects Community NGO Representative Workshops which run for 5 days each. The 4 themes for these Workshops are Immunization, Nutrition, ARI/CDD and, possibly, Reproductive Health. The Workshops are conducted 3 to 4 months apart and the same NGO representative attends each of the Workshops. At the end of each of the Workshops, the NGO Representative develops, with the assistance of the Health Educator, an Action Plan for her/his Community NGO and through talks, song, plays, etc convey to the NGO they represent the Workshop themes. It is important to note that these Community Volunteers are not VHWs.

The first round of these Community NGO Representative Workshops is almost completed. The topic of this first round has been Introduction to Child Survival and Immunization. So far, there have been 10 Workshops in the 4 Project locations, with 2 more to be done to complete this initial round. Each workshop has had 10 to 15 representatives. There are now approximately 130 Community NGO Volunteers in the 4 Project locations who are trained in and are a resource to their Community NGO on Child Survival and Immunization. The post-training assessment of these Workshops will take place over the next 3 months, and the methodology used in the next round of Workshops will be adjusted accordingly.

4.5 Supplies and Materials

This Project has no service provision. The only Project supplies have been Workshop materials such as note-pads, pencils etc. Supplies are being appropriately used e.g. tickler file system. Also staff and participants do improvise e.g. making own their patient followup system when appropriate etc.

4.6 Quality

The Baseline Survey carried out in early 1994 thoroughly evaluated the KPC (knowledge practices and coverage) of care-givers at the commencement of the project. Since then, further qualitative data has been collected on child survival indicators on Nutrition. The CDD KAP survey is under way and the Reproductive Health KAP is being planned.

There is a True/False questionnaire applied at the end of each Workshop to each participant (Appendix D). Within 3 months of each community NGO Workshop there is an interview guideline applied to each Workshop participant (Appendix E).

The Clinic Management Training has been carried out for all DPNOs and MAs, and this has improved communication re clinic supervision, self assessment and clinic maintenance.

4.7 Supervision and Monitoring

FSP Project Supervision

The FSP line of supervision is the FSP Country Representative to the Health Programs Coordinator to Senior Health Educator to Junior Health Educators. All positions are based in same office, so supervision is on a continual and daily basis. When Health Educators travel to outer island for workshops, they do so as a team of 2 to 3 persons. Upon return, a written report is prepared for the Health Programs Coordinator on each training activity.

Ministry of Health and Family Planning Supervision

Within MHFP, supervision is from the Secretary of Health and Family Planning to the Chief of Preventive and Public Services to the Chief Nursing Officer to the DPNOs, then to MAs who are responsible for the PHNs. The supervisory checklists, clinic maintenance checklist and the self assessment form developed during the Clinic Management Consultancy and later refined by the DPNOs have become the basis for supervision and monitoring from the DPNO down (see Appendix F).

Each DPNO has 4 islands in his/her District. Their goal is to make 3 visits each year to each island. In practice, some islands do not receive even annual visits. Now the DPNOs have a more realistic goal of one trip per island/year. If this level of visits and supervision was achieved, then there would be an adequate though not ideal level of supervision for each intervention. By the end of the Project, the goal is to have each DPNO carrying out this level of supervision in each of their districts. It is also a goal to have the clinic management activities included in the School of Nursing Curriculum by the end of the Project.

4.8 Regional and Headquarters Support

There was an FSP Regional Health Coordinator based in Suva until May 1995 when the two people sharing this position resigned. The position was vacant for 4 months. It has now been relocated to Port Vila Vanuatu and reclassified as Regional Health Assistant. However, the amount of assistance required and asked for has not been significant.

4.9 PVOs Use of Technical Support

Outside consultants were brought in for KAP nutrition, KAP CDD, Clinic Management Assessment and this Mid-Term Evaluation. Outside assistance was not used for the Baseline KPC Survey or DIP. The only other outside technical assistance will be for the KAP Reproductive Health. In-country FSP staff and the FSP Regional Health Assistant will carry out the Final Project Evaluation.

4.10 Assessment of Counterpart Relationships

The principal counterpart in this Project is the Kiribati Ministry of Health and Family Planning (MHFP).

The CS Project has five FSP positions funded in Tarawa. The FSP Country Representative, FSP Health Programs Coordinator, one Project Senior Health Educators position (which has recently become vacant) and two Junior Health Educators positions (only one of which is filled at present).

The Secretary of the MHFP and Chief of Preventive and Public Health Services were involved in all phases of the Project beginning with the development of the Project proposal. MHFP staff have been involved in the Island selection process, the baseline survey, and also six MHFP staff were involved in the TOT Workshops. Staff from the HEU have been involved in the planning and delivery of community level health education workshops. A staff person from HEU has been a primary counterpart for the KAP studies and there has been additional support from the MHFP Nutrition Unit for the nutrition KAP and the EHU for the CDD KAP.

In addition to this counterpart staff support, there have been exchanges of funding most frequently in the form of travel and subsistence allowance payments. Exchanges of materials has been most commonly in the form of Workshop supplies.

There is to be a restructuring and expansion of positions within the next 6 months which will enable the MHFP to eventually take on the functions necessary to operate effective child survival activities. Until now and until these changes have taken place within MHFP, the CPPHS is and has been carrying out the functions of CSP Project Manager Counterpart. There is an open and free dialogue between the MHFP and the Project which is a result of the full support given to the Project by the Secretary for Health and the Chief of Preventive and Public Health Services. This has not been the case with the HEU who are the group within the MHFP who would naturally eventually assume responsibility for many of the

Projects functions. It is not clear why the HEU has not seen the CSP Project as a priority area for its activities as the Project does have the full support of the MHFP and is entirely consistent with the Kiribati Five Year Health Plan. This relationship with the HEU is crucial to the Project achieving its goals and objectives and also becoming integrated into MHFP routine activities. It is the area which requires maximum effort on the part of MHFP, HEU and FSP staff in the remaining 18 months of the Project.

At the community level the counterpart relationships are with the 4 Local Councils and the various community NGOs (womens youth and church groups). Because of the ongoing support and commitment of the MHFP and Ministry of Home Affairs these community counterpart relationships have been and continue to be very good during the time of the Project.

The DPNOs are the Project Counterpart Staff for the Clinic Management Training. This has been a good relationship and has provided the DPNOs with a series of checklists and a program for supervision. However, due to difficulties encountered with inter-Island travel some of the earlier momentum in implementing and carrying out these activities has been lost. As soon as these transport problems can be overcome this momentum needs to be regained.

4.11 Referral Relationships

The referral relationship in the Project area is from the community to the PHNs in Dispensaries to MAs in Health Centers who then refer to Tungaru Central Hospital in Tarawa. There are no medical doctors on the outer islands.

The goals of this Project have been to strengthen the capacity of PHNs, MAs and DPNOs in Clinic Management and also to promote community awareness and action in child survival interventions. There is a good ongoing relationship between the project and the referral sites. The services of the referral system from the community to DPNO level have been strengthened at each level of the referral system by Project Inputs in Clinic Management and Community Health Education.

4.12 PVO/NGO Networking

The only other PVO working in Kiribati has been Save the Children Fund (KMK) which was working with housing improvements in the outer Islands.

NGOs working in Kiribati in the health sector during the lifetime of the Project include UNICEF, WHO, SPAFH, SPC, UNDP, UNFPA, FAO and EU.

The strongest evidence of effective networking up to this point in the Project has been with UNICEF and WHO. The Clinic Management Training for MAs was in the form of a Workshop on Tarawa. The Project funded Clinic Management took up one week of this

Workshop. Besides this, UNICEF funded three days of training on ARI/CDD and Vitamin A deficiency. WHO funded a week of training for the same Workshop on HIV/STD.

UNICEF is continuing to fund refresher training in ARI/CDD and Vitamin A deficiency for all PHNs which is being carried out at the same time as the DPNOs carry out their Clinic Management training. Also UNICEF has been successful in negotiating the Kiribati Governments' ratification of the Convention on the Rights of the Child and therefore creating advocacy at the highest level of government on the rights of children. UNICEF has also sponsored a UNV, Community Education Specialist to work as part of the HEU for a 2 year period. UNICEF' intends to continue this support after the present HE Specialist's term expires at the end of this year.

UNFPA through WHO is funding several activities in Family Planning and Reproductive Health including In-services training, equipment purchases and Health Education material production. At the time of this Mid-Term Evaluation UNFPA was funding a series of workshops for Nursing Aids on each of the outer Islands which were focusing on ante- and post-natal care, Family Planning, ARI/CDD, EPI and Nutrition. The EU has completed a series of training Workshops for TBAs on Tarawa and the outer Islands. The EU is also funding 3 MAs currently doing a midwifery course in Fiji.

FAO supports the Pacific Regional Agriculture Program which has cooperated closely with FSP in promoting local vegetable production for nutrition improvement. UNDP has focused on water supply improvement for the outer islands and is currently seeking permission for improved latrine design, also for the outer islands.

SPAFH has assisted Kiribati in the production of Health Education materials about Reproductive Health including a family planning manual.

There is no apparent duplication of effort between the various PVO/NGO's and resources are willingly shared when opportunities arise, e.g. Workshops.

4.13 Budget Management

The rate of expenditure of project funds to date is on target and in keeping with the DIP projections. There has been no shifts of money from one category to another in the project budget. The combined USAID and ODA grants appear to be adequate to achieve project objectives. It is not anticipated, at this point that the budget will be underspent at the end of the Project.

The Project Pipeline Analysis (Vanuatu and Kiribati) is attached as Appendix C.

5 . Sustainability

Table 1 - Sustainability Goals, Objectives, Mid-Term Evaluation Measures & Steps Taken/Needed

Goal	End of Project Objective	Steps taken to date	Mid-Term Measure	Steps Needed
A) MHFP will tie on clinic management activities of CS Project.	<p>1) Assessment of clinic management practices. development of appropriate clinic management tools</p> <p>2) All DPNOs. MAs & PHNs are used in clinic management using forms & checklists</p> <p>3) Clinic management tools & training process become part of Kiribati nursing school curriculum</p>	<p>1) External consultant has completed CMA & developed prototype forms & checklists</p> <p>2) All DPNOs & MAs trained. PHNs on 4 out of 16 Islands trained.</p> <p>3) Initial discussions held with MHFP Staff.</p>	<p>1) MHFP have refined the CMA tools. See Appendix E</p> <p>2) Training of DPNOs & MAs completed. Training of PHNs in progress.</p> <p>3) Little progress beyond initial discussions</p>	<p>1) Objective accomplished</p> <p>2) Deliver training of PHNs to remaining Islands</p> <p>3) Final commitment to adopt & actual adoption of Chl into Nursing School curriculum.</p>

<p>B)MHFP will continue to promote community awareness & action in child survival interventions.</p>	<p><u>Qualitative Research</u></p> <p>1) Nutrition KAP data for H.E. and Community Workshop themes.</p> <p>3) CDD KAP data for H. E. and Community Workshop themes.</p> <p>3) Reproductive health KAP data for H.E. and Community Workshop themes.</p> <p><u>Community Level Workshops</u></p> <p>4) To conduct Workshops with the Island Councils in the 4 Project locations.</p> <p>5) To conduct Workshops with Church leaders in the 4 Project locations.</p> <p>6) To conduct 10 Workshops for Community NGO representatives on Immunization in the 4 Project locations.</p> <p>7) To conduct 10 Workshops for Community representatives on Nutrition in the 4 Project locations.</p> <p>8) To conduct 10 Workshops for Community NGO representatives on ARYCDD in the 4 Project locations.</p> <p>9) To conduct 10 Workshops for Community NGO representatives on Reproductive Health in the 4 Project locations.</p>	<p>1) KAP completed, Draft Report to hand.</p> <p>2) Consultant employed & field research currently underway.</p> <p>3) Process of finding & employing consultant has commenced.</p> <p>4) All four Workshops completed.</p> <p>5) One Workshop completed at Betio, South Tarawa.</p> <p>6) 8 of the 10 Immunization Workshops have been completed.</p> <p>7) 10 Nutrition Workshops will be the next round of Project activity.</p> <p>8) CDD KAP in progress which will provide themes for ARYCDD Workshops.</p> <p>9) Nil</p>	<p>1) Awaiting Final Report.</p> <p>2) Awaiting completion of KAP & submission of report.</p> <p>3) Field work yet to be carried out.</p> <p>4) 100% of Councilors in the 4 Project locations understand & support CS Project goals & objectives.</p> <p>5) Only 25% of Workshops completed due to constraints (See Section 2). Not possible to undertake any more of these Workshops.</p> <p>6) 80% of Immunization Workshops completed.</p> <p>7) Pending</p> <p>8) Workshop ARI/CDD themes to be developed based on CDD KAP.</p> <p>9) Due to constraints (Section D) it will not be possible to carry out these Workshops before the end of this Project (see Recommendations).</p>	<p>1) Wait for Report.</p> <p>2) Continuing facilitation of field research.</p> <p>3) Facilitation of employing consultant.</p> <p>4) ongoing liaison with the 4 local councils.</p> <p>5) No further church leaders Workshops to be carried out in this CS Project.</p> <p>6) 2 further Immunization Workshops to be completed once H.E. staff tied.</p> <p>8) Await CDD KAP Report.</p> <p>9) Inform MHFP and Donor Agencies of reasons.</p>
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6. Recommendations

Recommendation 1

With the present design of the Project it will not be possible, given the constraints as outlined in Section 2 (Effectiveness), to carry out all of the Project activities for the second half of the Project. In light of the constraints and especially with the departure of the Senior Health Educator some Project activities will be put “on hold” until a new Senior Health Educator is found and trained. This will mean that there will not be any further Community NGO Workshops for possibly the next four months. Clinic Management Training for PHNs will continue.

A close examination of what is achievable shows that it will only be possible to undertake 22 Community NGO Workshops **between** now and the end of the Project. If the present workload of Workshops is reduced the quality of the community level training **will** be strengthened, and the impact at the community level of the Project will be increased.

On examining the four topics for the Workshops (Immunization, Nutrition, ARI/CDD and Reproductive Health) the Immunization Workshops are almost completed. Of the three remaining Workshop topics Nutrition and ARI/CDD are the major causes of morbidity and mortality in Kiribati. Also, UNFPA and SPAFH are undertaking a wide range of activities in the Reproductive Health area. It is one of the best funded areas at present in Kiribati.

It is, therefore, recommended that the Community NGO Reproductive Health Workshops be deleted from this Project and be considered as part of a possible second Child Survival Project commencing in 1997. The Reproductive Health KAP should proceed as this will contribute valuable information on Reproductive Health for planning as well as Health Education interventions.

Because of the same constraints the remaining Church Leaders Workshops, of which only one has been completed at this Mid-Term stage, should not be carried out in the remaining time for this Project. Given the difficulty being encountered in finding a replacement for the Project Senior Health Educator the option of increasing the number of Project staff (either I-Kiribati or expatriate) to carry out the presently planned Workshop load is not, at this stage, realistic.

Even with these changes to the number of Workshops the Project goal of improving the Child Survival indicators of the target group will be achieved and with a greater degree of certainty about the quality of the training in those Workshops.

Recommendation 2

There has been a marked improvement, especially since early this year, in the ownership of the CS Project as a MHFP activity and not just an FSP activity completely separate from the MHFP. However, **this** fact could be strengthened further by the following recommendations:

- i. That the Chief of Preventive and Public Health Services officially take on the title of Child Survival Project Manager.
- ii. That MAs and PHNs on the outer Islands be encouraged to maximize their participation, as resource people and participants, in the Community Health Education Workshops.
- iii. That FSP Child Survival Project staff be encouraged to spend more time at the MHFP and that the possibility of CSP staff being based at the MHFP be investigated.
- iv. That the MHFP needs to develop a 12 Month Workplan for the HEU which clearly spells out the HEUs responsibilities for IEC production, KAP research and actual Community Health Education activities. This not only for CS Project activities but all HEU activities. The HEU to report monthly to the Chief of Preventive and Public Health Services as to progress with this Workplan.
- v. That training in the purpose and use of the various Clinic Management tools, which have been developed and so successfully implemented, be made a formal part of the Kiribati Nursing School Curriculum.

7. Summary

The Child Survival Project in Kiribati is being implemented by the MHFP and FSP from October 1993 until March 1997 in the 4 Islands which had the worst child survival indicators in the baseline survey (Betio, Butaritari, Maiana and Onotoa). The goal of the Project is to bring about an improvement in the Child Survival Indicators in the target population (mothers and children under 5) of the 4 Islands. The two components of the Project are: (1) capacity building in Clinic Management and (2) Community Health Education Workshops on Immunization, Nutrition, ARI/CDD and Reproductive Health.

This Mid-Term Evaluation was carried out between September 9 and 23, 1995 with a 3 person team with representatives from MHFP and FSP and an External Consultant (see Appendix B). Interviews were conducted with appropriate MHFP staff, the Ministry of Home Affairs, the ODA Aid Attache, FSP Staff and many Local Government and Community Representatives (see Appendix A). Three of the 4 Project sites were visited - Butaritari, Maiana and Betio. All project Quarterly Reports and Documentation were reviewed.

The Project has accomplished all of its Mid-Term Targets with Clinic Management Assessment and Training, the collection of excellent quantitative and qualitative data and with the almost completed first round of Community NGO Representative Workshops on Introduction to Child Survival and Immunization. These Mid-Term targets have been achieved despite major constraints with transport and the departure of key Project Health Education staff. The important contribution of the MHFP and MHARD in achieving these Targets needs to be acknowledged.

Several of the Project activities/methods constitute ground-breaking progress for child survival efforts in Kiribati. Highlights include the attention paid to participatory planning, innovations in Clinic Management techniques, extension of community health education and carrying out formative research.

The constraints, as outlined, combined with an ambitious target of a further three rounds of Community NGO Workshops makes the successful completion of all of these Community Workshops unlikely. Whilst the goals, objectives and target population of the Project should remain the same the number of planned Community Workshops needs to be reduced ie one round of Workshops needs to be deleted at this stage. This will also ensure that the quality of the Health Education presented in the remaining Workshops will continue to be to the high standard already achieved in the Project.

The other Project area which needs to be addressed in the remaining 18 months is to increase to an even greater extent the ownership of the Project by some key MHFP staff. Strategies to try to change this perception are outlined in the recommendations.

These results have been presented to the MHFP and MHARD in a formal presentation and will be conveyed to the Local Council and Community NCO Representatives at the next round of Community NGO Representative Workshops.

The author of this Mid-Term Evaluation is Dr John Hall, Team Leader and External Consultant who took into consideration the input of the other team members. Section 4.13 was supplied by the FSP Health Programs Coordinator.

Appendix A - Persons Interviewed During Evaluation

Name	Position
South Tarawa, 11 September, 1995	
Mr Baraniko Baaro	Secretary, Ministry of Home Affairs
Mr Niall Coffey	Aid Management Attache, ODA, Bairiki
Ms Mary McMurtry	Country Representative, FSP Kiribati
Ms Rita Feinburg	Recently appointed Country Representative, FSP Kiribati
Butaritari Island, September 12 to 15, 1995	
Buretau Mareweata	Clerk to Island Council
Itintamoa Eria	Chief Councillor
Fenua Tamuera	Senior Health Educator, FSP
Workshop Participants, Keuea Village, Butaritari	
Tokanikai Raieta	Te Itoiningaina (Keuea)
Taranibeia Moote	Te Roro-n-Rikirake (Keuea)
Workshop Participants, Temanokunuea, Antekana and Ukiang'ang Villages, Butaritari	
Tanaua Karakaua	Te Itoningaina
Batima Teuea	Toreka, SDA
Taotika I. Kaititi	WIW, BIC
Ioanna Ekeuea	Irekenrao (Temanokunuea)
Maria Titau	RAK (Temanokunuea)
Tion Bauro	Nursing Officer (Antekana)
Bwebwetaake Naariki	Irekenrao, (Onomaru)
Bakate Kaimwata	Itoiningaina (Temanokunuea)
Toakarawa Kourabi	Bouan te Mauri
Tautei Uee	Bouan te Mauri (Ukiang'ang)
Maunana Timwau	Roro-n-Rikirake (Ukiang'ang)
Teruaa Toubiti	Te Itoiningaina (Ukiang'ang)
Kianako Tekiera	Bouan te Mauri (Ukiang'ang)
Teueatake Kian	RAK (Ukiang'ang)
Ruti Teeata	Te Itoiningaina
Rot ia Kakoroa	RAK (Ukiang'ang)

Maiana Island, September 17 to 19, 1995

Tebwebweiti Kabuati Teburea Namoriki	Public Health Nurse, Maiana Kain te Kauntira, Aobike, Maiana
Eman Arerita	RAK Aobike, Maiana
Baabo Maamau Katiua Taniera	Clerk to the Island Council, Maiana Chief Councillor, Maiana

Ministry of Health and Family Planning, September 20, 1995

Health Education Unit

Kotii Torite	Senior Health Education Officer
Kireata Ruteru	Health Education Officer

District Principal Nursing Officers

Tiretaake Titon	DPNO
Tarena Kaitu	DPNO
Veronica Tekiree	DPNO

Betio, South Tarawa, September 21 to 22, 1995

Tokaman Tikataake Tiaon Kairo Tuiata Kamkeiti	Nursing Officer, Takoronga Catechist (Catholic), Takoronga Nursing Officer, Temakin
Tiira Redfern Raion Bataroma	Betio Town Councillor Betio Town Councillor

Appendix B: Mid - Term Evaluation Team Members

The evaluation was conducted from September 9 through September 26, 1995 by the following team:

<u>Name</u>	<u>Title and Organization</u>
Dr. Takeieta Kienene Team Member	Physician, Masters Degree in Public Health, Chief of Preventive and Public Health Services, MHFP, Kiribati
Mr. Sean Kennedy Team Member	Public Health Specialist, Masters Degrees in Economic Development and Public Health, Health Programs Coordinator, FSP, Kiribati.
Dr. John Hall Team Leader	Physician, Masters Degree in Public Health, Consultant in Public Health & Community Development.

KIRIBATI MINISTRY OF HEALTH AND FAMILY PLANNING

AND

FOUNDATION FOR THE PEOPLES OF THE SOUTH PACIFIC

Child Survival IX

IMPROVING THE QUALITY OF CHILD SURVIVAL SERVICES
IN
THE SOUTH PACIFIC
(VANUATU AND KIRIBATI)

October 1, 1993 - September 30, 1996

FINAL EVALUATION

Child Survival Project
KIRIBATI

Report submitted to:

Ministry of Health and Family Planning
and
Ministry of Home Affairs and Rural Development
Republic of Kiribati

The United States Agency for International Development
Bureau for Food and Humanitarian Assistance
Office of Private and Voluntary Cooperation

Foundation for the Peoples of the South Pacific

September 30, 1996

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LIST OF ABBREVIATIONS

ARI	Acute Respiratory Infection
ALRI	Acute Lower Respiratory Infection
c s	Child Survival
c s 1x	Kiribati Child Survival Project “Improving the Quality of Child Survival Services in the South Pacific”; also CS Project
CS Project	Kiribati Child Survival Project “Improving the Quality of Child Survival Services in the South Pacific”; also CS Project
CDD	Control of Diarrheal Diseases
DIP	Detailed Implementation Plan
DPNO(s)	District Principal Nursing Officers
EPI	Expanded Program on Immunizations
FP	Family Planning
FSP	Foundation for the Peoples of the South Pacific
MA(s)	Medical Assistants
MCH	Maternal and Child Health
MHFP	Ministry of Health and Family Planning
MHARD	Ministry of Home Affairs and Rural Development
ODA	British Overseas Development Agency
PHN(s)	Public Health Nurses
USAID	United States Agency for International Development
WRH	Women’s Reproductive Health

EXECUTIVE SUMMARY

Final Evaluation

Child Survival IX Project Improving the Quality of Child Survival Services in the South Pacific (Kiribati)

The project goals are to decrease mortality and morbidity of children under 5 years of age and to improve the training of rural and national medical personnel. These goals were to be reached through community level health education workshops for key members of local NGOs and through improved clinic management. Four child survival interventions were targeted for interventions; nutrition, EPI, and CDD/ARI. A baseline survey was undertaken to determine the status of the four child survival interventions in project sites and based on such baseline data targets were made for the projects. Four islands, one urban and three rural, were chosen as project sites for the interventions. Management interventions were to be given to all district principal nursing supervisors and all nurse supervisors of rural clinics throughout the Gilbert group of islands. The project was to be jointly executed by FSP and the MHFP.

The community workshops were structured so that each participant developed an action plan for follow-on activities after the workshop to disseminate the workshop messages to their organizations and community. Implementation of such follow-on projects were to be aided by oversight visits by project staff. Clinic management was to be improved through an assessment of clinic management problems, development of management aids, and training of clinic supervisors in clinic management.

The community health education workshops were proven to be extremely effective in the Kiribati setting, and should be used by future health promotion projects. Solid steps to improve clinic management were undertaken. The life of the project was not long enough to see real gains made on this topic. The MHFP should continue to build on existing accomplishments to improve management. It could not be determined whether project targets were met, as the end (base)line survey is scheduled for early 1997. The evaluation team believed that the targets were inappropriate for such a short project with such severe transportation and logistics problems.

I. BACKGROUND

The **CHILD SURVIVAL IX / IMPROVING THE QUALITY OF CHILD SURVIVAL SERVICES IN THE SOUTH PACIFIC - Kiribati (CS IX)** Project is jointly supported by the United States Agency for International Development (USAID) and by the Overseas Development Agency of the United Kingdom (ODA). Funds from the two agencies are not co-mingled, but are allocated for specific activities and accounted for separately.

The project commenced October 1, 1993. The project grant from USAID was for 3 years and is to end September 30, 1996, while that from ODA will end March 30, 1997. A no cost grant extension was requested from USAID but could not be obtained. While this report is the final evaluation of the USAID supported child survival activities under CS-IX in the Republic of Kiribati, comparative endline statistics will not be available until the baseline survey is repeated prior to the ODA final evaluation of all completed CS Project interventions in March, 1997. The endline survey and its analysis will be sent upon completion to USAID, as agreed, to complement this evaluation.

The CS Project was designed to support the Ministry of Health and Family Planning (MHFP) in improving the provision of public health services and in promoting community education and local action to support both prevention and proper treatment of illness. Specifically, the goals of the CS-IX project for Kiribati as noted in the Detailed Implementation Plan (DIP) are to 1) decrease mortality **and** morbidity of children under 5 years of age and 2) to improve the training of rural and national medical personnel.

Activities at the national level consist of training aimed at augmenting institutional capacity and upgrading the skills of health care providers. Efforts at the local level concentrated on community-based workshops and follow-on activities. Health content areas at both levels included the following CS indicators: immunizations, improved nutrition (including vitamin A), control of diarrheal diseases (CDD), **and** family planning as well as improved clinic management. An acute respiratory infection (ARI) community education component was added to the interventions following an indicated need identified in the baseline survey. Following the recommendations of the Mid-Term Evaluation, the family planning community workshops component of the project was deleted.

The CS Project is conducted on four islands in the Gilbert Islands group: Butaritari Island (Northern Division), Maiana Island (Central Division), Betio islet (South Tarawa-urban) and Onotoa Island (Southern Division). Island selection was based on health status or need, community support and geo-political considerations. Populous Betio constitutes an urban area (population density is 6,735 /sq. km') and the remaining locations - designated rural - are sparsely populated.

¹ 199.5 census data

The CS Project constitutes an integrated comprehensive approach involving multi-level training and education. It aims to improve clinic management and encourage community understanding, participation and support for child survival interventions. The project does not provide cold chain support, case management or clinical services. It does not support construction activities.

II. PROJECT ACCOMPLISHMENTS AND LESSONS LEARNED

A. Project Accomplishments

A.1. Project Objectives by Intervention: This evaluation covers the life of the USAID Child Survival Grant October 1, 1993 to September 30, 1996. The Child Survival Project objectives as set out in the Detailed Implementation Plan (with modifications as noted in the first annual report and in the recommendations of the Mid-Term Evaluation) use change in various child survival indicators as a means of measuring project success and accomplishments. At the time of the evaluation, change could be measured in three indicators, DPT3, Polio3 and Measles vaccination, using health statistics for the first half of 1996 from the statistics office of the MHFP. Quantitative information concerning change in indicators for other project child survival objectives (CDD/ARI, Nutrition and other EPI) is not available from government statistics; information concerning these indicators must await the end (base)line survey and the terminal final project evaluation scheduled for February and March 1997. Qualitative assessment of progress toward indicator targets is provided as well as of process/activity milestones and delivery of deliverables. Project objectives by interventions and end of project status as of September 30, 1996 are shown in Table I. The end (base)line survey and its analysis will be sent upon completion to USAID to supplement the findings of this report.

Discussion of MHFP DPT3, Polio3 and Measles Immunization Rates in Kiribati:

MHFP DPT3, Polio3 and Measles immunization rates shown in Tables I & II are the latest available data (first 6 months of 1996) and compiled from routine monthly clinic reports from project sites. Conflicting information on population figures exists between the government's official 1990 and 1995 census and the population figures used by the MHFP. The 1995 census is believed to underestimate populations in urban areas and overestimate those in rural areas. The team relied on data from the statistics office, MHFP for information on immunization rates in Kiribati, including population figures.

As can be seen in Table I, the project has not met its overall targets for DPT3, Polio3 and Measles immunization to date. A breakdown of these indicators by the four project sites, as shown in Table II and Graph I, reveals that Betio, the most urban and densely populated of the sites, has met the targets for Measles and Polio3 and has made considerable progress toward DPT3 targets from the baseline. It is anticipated that when immunization information for the entire year, 1996, is collected that some improvement in all three indicators from the other project sites will be noted, as the immunization

programs “catch up” and project interventions are complete for the year, It seems unlikely, given transportation and communications problems and cultural determinates, that measles vaccine will be shown to meet the target **on schedule**, a stipulation of the measles immunization target. The end (base)line survey may yield further information on this subject.

The DPT3, Polio3 and Measles immunization rates all show considerable variation between project sites; the size of the populations vary considerably as well (see Table II, Graph I). The marked variation in immunization rates between the urban and rural CS sites could be convincingly explained by project duration and transportation problems. The project design required extensive start-up activities before implementation could begin, including such things as a baseline survey, site selection and preparation, trainer of trainers, formative research and hiring of personnel. Start-up activities were delayed because of transportation difficulties as well, with project staff barely surviving a harrowing boat wreck at one site during the baseline study. Thus project implementation really began well into year two, except in Betio where activities started earlier.

Delays due to transport problems were so severe by end of year two that the Mid-Term Evaluation recommended dropping one set of objectives (family planning), because it did not believe that the all workshops could realistically be completed before the end of project. The project has continued to suffer many

Table II: DPT3, Polio3 and Measles Immunization Rates for CS-IX Projects Sites in Kiribati

1996	Butaritari	Betio¹	Maiana	Onotoa
Pop. < 1 year of age ²	133	341	62	54
DPT3 Rates ³	80 (60%)	288 (84%)	52 (83%)	12 (22%)
Polio3 ³	39 (59%)	302 (88%)	70 (112%)	4(7%)
Measles ³	41 (63%)	276 (80%)	27 (87%)	18 (33%)

¹ The under one year of age population of Betio could not be desegregated from that of South Tarawa, which may have different health seeking behavior. To calculate the under one year of age population for Betio. the figure for South Tarawa was taken times the total population of Betio divided by the total population of South Tarawa: $930 \times 10,344/28,350 = 341$. The external evaluator believes this yields a conservative or lower rate calculation for the various rates, given Betio’s urban nature, rapid growth and high number of squatters. and dense population.

² Projected no. of infants at project sites for 1996 (as calculated from 1995 census by the Republic Statistics Office, Department of Planning, Ministry of Finance and Economic Planning)

³ No. of infants who have received the child survival interventions in each project site. (No. of infants who have received child survival intervention in all project sites/projected no. of infants in each project site as calculated from 1995 census for 1996 by the Republic Statistics Office, Department of Planning, Ministry of Finance and Economic Planning x 100%)

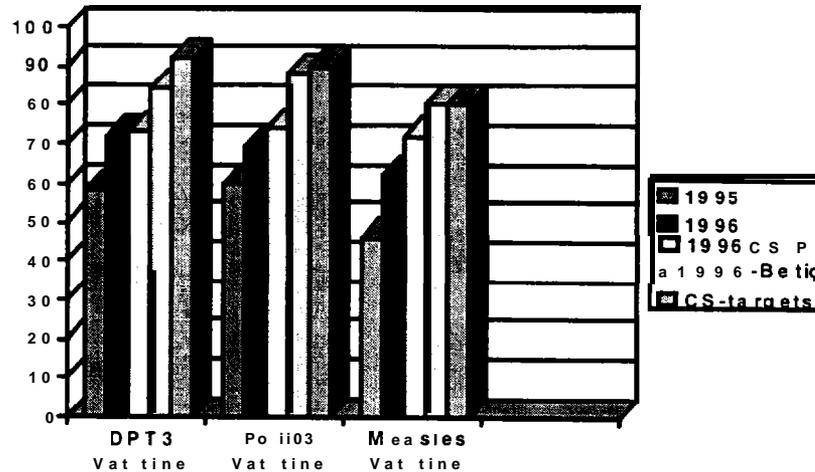
Table I: CS-IX Project Objectives by intervention, target and source of data (from project DIP, 1993) for project sites

Child Survival Objectives by Intervention	Baseline %	Target %	MHFP records¹	EOP Survey
To increase the number of infants receiving DPT3 immunization	72	92	73%	NA
To increase the number of infants receiving Polio3 immunization	78	90	77%	NA
To increase the number of infants receiving measles immunization on schedule (revised-1994)	67	80	72%	NA
To increase the number of mothers able to produce immunization cards for their children	45	70	NA	NA
To increase the number of mothers providing vitamin A foods to their children	NA	95	NA	NA
To maintain the number of children receiving vitamin A capsules on schedule.	NA	95	NA	NA
To increase the number of mothers who first introduce weaning foods between 4-6 months of age (revised-1994).	22	50	NA	NA
To increase the number of mothers who know the danger signs of ALRI and when it is appropriate to seek treatment (added 1994)	49	70	NA	NA
To increase the number of cases of diarrhea being treated with packaged ORS	69	90	NA	NA
To increase the number of breastfeeding mothers who continue or increase the amount of breastmilk given children during diarrhea (revised-1994).	57	80	NA	NA
To increase the number of mothers who continue or increase the amount of food given children during diarrhea (revised-1994).	40	60	NA	NA
To increase the number of mothers who continue or increase the amount of liquid given to children during diarrhea	63	90	NA	NA

¹ No. of infants who have received child survival intervention in all project sites/projected no. of infants in all project sites (as calculated from 1995 census for 1996 by the Republic Statistics Office, Department of Planning, Ministry of Finance and Economic Planning) x 100%

Immunization Coverage

1995, 1996 & 1996 CS Project



Graph I: * Immunization Coverage for DPT3, Polio3 and Measles: Kiribati: 1995, first half of 1996, 4 CS Project sites -first half of 1996 (1996-C S), CS Project- Betio site (CS-Betio), and CS Project targets

* adapted from M HFP health statistics

delays associated with transportation and communication difficulties. Thus where transport is not a problem, urban Betio, the project has made considerable progress; where transport is an issue project activities have languished. Maiana is intermediate between very urban and rural; it is the closest island to Tarawa and quite easy to reach by boat. Its immunization rates reflect the easy access to Tarawa. The team would like to emphasize that transportation is the single most important determinant affecting project implementation; unfortunately in most cases it is beyond the control of the MHFP to affect.

The lower immunization rates in the outer island sites, **as noted** in Table II and Graph I, may also be explained by poor reporting **and** supply problems. Vaccine supplies to outer islands were delayed at the beginning of 1996 due to air-transport problems. These project sites are the most sensitive to air transport problems, and the most likely to be irregularly supplied when there is such problems. It is interesting to note that Onotoa, with the lowest immunization rates of the project sites, is the only project site that has not yet received the community immunization workshop series. Immunization rates for CS project sites as a whole are generally running above the average for the rest of the country, suggesting that the project is having a positive effect on immunization (see Graph I).

The Health Information System, EPI and Cold Chain Issues:

WHO, UNICEF and other donors have worked in the past with the MHFP to improve immunizations in Kiribati. WHO and UNICEF still provide technical assistance and some support for improving EPI. WHO has indicated that a fairly effective EPI/cold chain system is in place in Kiribati, albeit one beset with chronic and recurrent transport and monitoring problems. The system works as follows: MHFP receives a request for vaccines. Pharmacy advises the MA and/or health center personnel on the island via radio telephone **and** or commercial radio broadcast of the **day** and the flight on which the vaccines will arrive. Vaccines are hand carried **by** pharmacy staff from pharmacy to the airport to put on the proper flight. If the flight is delayed or canceled, the vaccines are returned to pharmacy. All vaccines are reported to leave MHFP pharmacy in good condition and in proper transport containers. Vaccines are transported by plane directly to the various islands. Vaccines arrive at the island, and are (hopefully) met by health center personnel who store the vaccine in a working refrigerator (kerosene or solar) at the health center. Immunizations are then carried out either the same day, the following one or as soon as possible in the targeted communities.

Breakdown in the cold chain is most likely to occur when vaccines arrive at their island destination. For instance, if the health center personnel did not receive the advice of arrival, the vaccine is not met, and it deteriorates in the heat and sun. As some health centers do not have working radio-telephones or even commercial broadcast radios, this occurs occasionally. On some islands, the airfield is some distance from the health center with the working refrigerator **and** given frequent flight delays, the health worker may not be at the airport to meet the plane. Likewise, as the health workers in many health centers and dispensaries are alone, an emergency may arise that prevents timely pickup. Similarly, if refrigerators are not working properly or if there is a delay in immunization schedules, vaccines can deteriorate leading to ineffective vaccination. As measles is the most fragile of the vaccines, even mild cold chain problems can **cause the** vaccine to be denatured. If there is no refrigerator, immunizations are scheduled for the same day as the vaccine arrives from Tarawa, if possible.

Solar refrigerators have now **been** installed at most health centers on the outer islands of the Gilbert group. They have notably improved vaccine viability and **cold** chain efficiency where they are working. Such refrigerators are maintained by the Solar Energy Company, an important reason why most in the outer islands are still working successfully. One benefit of the EPI community workshops as reported by project and MHFP staff is that the island councils and the community in most project sites now understand the importance of the cold chain and will notify the health center of vaccine carrier arrival, or bring the carrier to the health center if no one is there to meet the plane. It should be noted that Onotoa, because of air transport difficulties, is the only site which has not yet received the EPI community workshops. It also has the lowest immunization rates of all project sites..

Discussion of the Immunization Card Target

There is no quantitative information available to indicate whether the project will meet this target. The community nutrition and EPI workshops that deal with community understanding and support for this target are complete in all project sites except Onotoa. The card, which contains growth monitoring and health data as well immunization records, was an important topic in both set of workshops. The workshops included education on the importance of the card and suggested to participants that it should be kept in the family bible, often the most secure and safe place in the I Kiribati home. Clinic nurses (Betio) have noted that the care of cards has improved since the workshops were conducted.

Percent of Mothers Providing Vitamin A Rich Food to Their Children

Greater care should have been made in developing this objective, as its parameters and milestones are unclear and ill-defined. In particular, some quantification of the increased amounts of vitamin A enriched foods consumed, and specification of the time period covered should have been specified. Thus this objective may not provide meaningful information even in the final end (base)line survey. Qualitative evidence based on information gathered from the Nutrition KAP study and interviews with workshop participants, community and NGO leaders, members of international agencies and other organizations, and personal observation strongly suggest that consumption of vitamin A rich foods has markedly increased in project sites. The community nutrition workshops, focusing on improved nutrition (especially vitamin A rich foods), cooking demonstrations and the establishment of home gardens have been extremely popular and successful.

It is widely perceived by MHFP, representatives of donor and technical agencies and members of the public that green leaves, a rich source of vitamin A, are now acceptable to the public and are being grown and eaten by young and old alike. The team noticed various varieties of green leaves being grown around many homes during visits to Betio and throughout S. Tarawa, a big change from even 5 years ago when the team leader last visited Kiribati. Virtually all people interviewed by the team confirmed that both adults and children of all ages were seen to be eating vitamin A foods at both family and community gatherings and that such food is now part of the I Kiribati diet.

Several interviewees noted that the supply and transport of such vegetables to the community at a reasonable cost is now the problem in Betio, not the desire to eat such foods. The nutrition KAP study found that even in rural more traditional projects sites, vitamin A foods were frequently consumed and enjoyed and that there was an understanding of its important effect in preventing vitamin A deficiency and blindness. Such foods were reported as consumed slightly less in rural areas than urban, and there were complaints noted **about** the difficulty in gardening in the I Kiribati milieu.

Vitamin A Capsule Distribution

This objective is not relevant to CS Project activities, as the MHFP operates a vitamin A capsule distribution program with support from UNICEF.

Data concerning vitamin A capsule distribution is not available from the MHFP for either 1996 or 1995. An evaluative review of the program is scheduled by the MHFP and UNICEF for 1997.

Percent of Mothers Introducing Weaning Foods Between 4-6 Months of Age

There is no quantitative information available to the evaluation team on whether this target would be met by the end of the project. However, based on the information obtained from the Nutrition and the CDD-KAP studies, knowledge of the timely importance of weaning children at 4-6 months is widely known. Whether practice will reflect knowledge is uncertain. Given the intensity that appropriate weaning is promoted by the CS Project, the MHFP, and by other agencies and organization, it is at least likely that significant progress will be made toward reaching the target.

Percent of Mothers Who Know the Danger Signs of Acute Lower Respiratory Infection (ARLI) and When It is Appropriate to Seek Treatment

It is unlikely that this target will be met. ARLI was identified as a problem in the baseline survey and was included in the project at the time the DIP was prepared. No clinical interventions for ALRI were conducted by the project. Community education was included and combined with the CDD workshops. A drama groups play on AR1 was developed by the project which emphasizes recognition of the danger signs of AR1 and when to seek medical assistance. There has been little emphasis **and** systematic community education on ARLI in the past by other projects and the MHFP. Given the inherent difficulty in promulgating home ALRI assessment techniques, it seems unlikely to the team that this rather ambitious target will be reached.

CDD Objectives:

There is no quantitative information available at this time to the evaluation team on whether these targets will be met by the end of the project. The CDD and Nutrition KAP studies both indicate high levels of knowledge by the community on the use of ORS during episodes of diarrhea and importance of increasing breast feeding, solid food and other liquids during diarrhea. Given the number, quality **and** follow-up of the community nutrition and CDD workshops, it can be expected that real progress in changing practice is likely. The workshops not only provide health education on the **above** topics to the participants, but include and identify the local nurse as a source of information and assistance to the populace of the project site. Additionally, the structure of the workshop

includes each participant developing an action plan in CDD which will be promoted in his or her NGO or organization within an established time frame after the workshop. Scheduled follow-up visits with participants to provide assistance and motivation in their action plans by project staff has been close to 100% in all project sites for other interventions, and has been a **strong** motivation factor in inducing sharing of information among the communities on CDD. It is anticipated that CDD workshops will be equally effective.

Project Deliverables

The accomplishments of the early phases of the project are well documented in the Mid-Term Evaluation. The team noted that project deliverables and other activities noted below seem to be of the highest quality, confirming the finding of the Mid-Term Evaluation. These include to date:

- site selection - all islands but one visited,
- baseline survey,
- local staff hire,
- Training of trainers workshop,
- Orientation workshop for Island Councils and Leaders,
- Clinic Management Assessment Study (and development of clinic management tools for rural clinics and dispensaries),
- Training workshops for District Principal Nursing Officers (DPNOs) in Clinic Management, (and orientation to health education as to chosen child survival technologies),
- Training of Medical Assistants and Public Health Nurses by the DPNOs at not only the 4 project sites but in all islands of the Gilbert chain,
- Nutrition KAP study,
- Women's Reproductive Health/Family Planning KAP study
- CDD KAP study
- 30 Community workshops of 1 week duration each covering EPI, nutrition and CDD topics,
- Action plans developed for each participant; implementation accessed at >95% (see quarterly reports)

The following project activities are scheduled for implementation in the next 4-5 months:

- 10 community workshops on CDD/ARI
- 2 community workshops on EPI
- analysis of clinic management strengths and weakness from management self-assessment, facilities maintenance checklist and supervisory checklistmanagement aids
- end (base)line survey.
- terminal final evaluation

A.2. Highlights of the Project Accomplishments

Several deliverables and activities warrant special mention for the quality of their work.

The **Orientation Workshop for Island Councils** and its follow-up informal meetings generated strong support and interest in the project not only at the project sites, but through-out the islands. The project has received many requests to extend the project to other islands.

The **Training of Trainers Workshop** was acclaimed by all who attended as one of the most useful they had yet received on adult education skills development, how to deal with the community and educational technology. Personnel from several ministries (MHFP, MHARD) and other organizations that attended the workshop have requested additional training for their outreach workers as soon as funds are available.

Both the **Women's Reproductive Health/Family Planning KAP** and the **Diarrhea1 Disease KAP** studies were excellent and were extremely useful to the CS Project in developing the workshop messages: every effort should be made to ensure that these studies are made available to other ministries, agencies and researchers. The team believes that the studies were of sufficient quality that they should be published in book or journal form. The University of the South Pacific has been interested in publishing such high quality research in the past.

The **Community Workshops** design and implementation deserve special mention, as much of the **success** of the project is due to their effectiveness in reaching not only the actual participants but the community. Using a combination of FSP health/nutrition educators, MHFP educators **and** clinic personnel gave the workshop very high credibility to the community: development of an individual **action plan** for each participant at such workshops and then follow-up by the workshop educators to assist and facilitate implementation of the action plan enabled the workshop messages to be widely disseminated throughout the project communities.

The local drama group (**Te Itibwerere**) have been effectively **used** to promote health education messages in the workshops and for the community. Scripts have been written and plays performed on breastfeeding, family planning, CDD and ARI. Plans are underway to video the plays and distribute them to maneabas on all the islands. They have been extremely popular, and assessed as being very effective.

A.3: Project Impact

The CS Project has had a very visible and positive impact on community health promotion and education in Kiribati. In particular, the community health education

workshops are viewed by the NGO community and by many in government and the community to be extremely effective in the I Kiribati milieu in promoting positive knowledge, attitude and behavior changes for the targeted child survival interventions. The workshops are well prepared and well delivered by staff who are culturally adept and excellent communicators. Technical aspects of the workshop messages are based on current World Health Organization materials locally adapted by the project. Presentation, content and focus were guided by the formative research and were based on clear and specific understanding of how people thought about the various interventions. The workshops successfully targeted participants who brought back what they had learned to their organizations and their communities. Health messages appeared widely disseminated in the project sites. The workshops have been well monitored and tracked through solid process indicators; post workshop evaluations have shown that the workshops were both useful and valued by the participants. Requests from non-project islands for the workshops have increased; and, because of local demand, increasing numbers of local NGOs have started shadow workshops on the topics, using MHFP and project personnel as resource persons. The project has worked closely with the Health Education Unit of the MHFP and very much broadened their experience, exposure, and expertise in community health education. All in all the MHFP and FSP is to be commended for the success of this aspect of the project. Community health workshops, using the model developed in this project should be used by the MHFP to continue their health promotion and education efforts in other parts of the country.

A good start has been made to improve clinic management. A technical assessment of the clinic management situation was made by a well-qualified consultant. The findings of the assessment were used to develop training materials, including management aids, and to train DPNOs, MAs and supervisory PHNs in all islands of the Gilbert group. This is a significant milestone and a **good** start. Lack of process indicators has made the success of subsequent activities unclear. Several of management **aids**, including the management self-assessment checklist and facilities maintenance checklist can be used not only by the individual health worker to assess management problems and strengths but also **collected** and analyzed to provide the MHFP with information that would allow targeting of specific areas for further training, research, supervision and problem solving. This is being done, and when complete should provide clear directions for future activities to improve management. Less clear however is the status of ongoing supervision and training activities. No process indicators were developed by the CS Project or by the MHFP to monitor status, content or problems with ongoing training; thus little can be done if difficulties arise. Thus efforts to improve clinic management have proceeded in a steady but slower pace than other project elements. Lack of clear process indicators have hampered monitoring of progress on clinic management. Project expectation that research and training alone would effect management practice without additional inputs and adjustments was clearly unrealistic. Accomplishments in clinic management to date are noteworthy and should be **used** by the MHFP to continue work to improve such management. Management gains require substantive cognitive and behavioral changes **and** can not be effected overnight; the management component of this project should be

continued but within a more realistic time frame and with clearer process indicators and targets.

B. Project Expenditures

Project expenditures will be reported separately from this evaluation.

C. Lessons Learned

c.1. Project Design and Start-up

Extensive and early participation by the MHFP, and other government agencies as appropriate is needed to ensure successful project design and implementation and ensure MHFP/government “ownership” of the project. Such participation should begin early in the design and include all levels of MHFP personnel. In particular, MHFP personnel that will be directly involved in project administration and implementation need to be closely involved in initial planning. It was not clear at start-up to many key MHFP personnel that the CS Project is a MHFP project and not a FSP project. As a result much of the staff viewed project activities as extra work and not part of their primary duties or interests. Although this difficulty was addressed later in the project, some residual resentment remains and continues to negatively affect some aspects of the project, particularly those that involve DPNO cooperation and assistance. **Project participation by the MHFP must begin early and occur often to ensure project success!** FSP health staff should be aware that MHFP personnel are counterparts and co-workers; they must maintain excellent and collegial relationship with relevant MHFP personnel, such as DPNOs and health education unit staff.

Additionally, every effort should be made to hire, keep and promote qualified I Kiribati. Projects such as the CS Project have an obligation to transfer technologies and skills to qualified local personnel, even if at some effort to the organization. Loss of trained personnel adversely affects all projects; in a country such as Kiribati, loss of a talented staff member could cause costly for the project. FSP should review the causes of recent staff turnover noted in the Mid-Term Review and more recently, and take appropriate action.

C.2. Training of Trainers

Training of trainers in communication and non-formal education skills using the principles of adult learning met with remarkable success and was very well accepted. Even health workers with years of community education experience found that the workshop taught them new and important skills that greatly assisted them in the performance of their jobs. Such training should be included in all projects with a

community education component and should target all project and MHFP staff appropriate to project activities.

c.3. Formative Research

The **KAP studies** have proven invaluable for tightly focusing health communication messages and health education activities. Such studies should be used, as in this project, to determine key information about specific child survival problems, and **not** as a means to try to find out everything about everything.

c.4. Clinic Management

The Clinic Management Assessment (CMA) and its consequent management training provided the team with special problems. In particular, the project design did not specify clear objectives or targets that would document development and mastery of management skills by nursing staff, or the possible need for remedial or additional training based on such monitoring. This was also noted in the Mid-Term Evaluation. Subsequent discussions between the project and ODA proposed use of the supervisory checklist, the management self-assessment, and the facility maintenance assessment as indicators for progress in improved clinic management. However, there is no evidence that this was pursued by the CS Project or the MHFP.

The MHFP have distributed the management tools to all supervisory health personnel in the Gilbert group. The DPNOs are providing management training and supervision based on the recommendations of the CM consultant and workshops. This management training and the use of various management checklists have generally been viewed positively by rural health staff. They note, in several cases, that no feed back has occurred yet from the MHFP consequent to collection of these forms. Unfortunately, the data from the management checklists for a!! rural clinics have not yet been processed and little is known about their effectiveness as management or planning tools in the I Kiribati setting. **The team believes that clinic management is of key importance to this and any follow-up health project and that management skill development should be monitored and continuing education provided as needed over the course of such project.**

It was strongly suggested in the Mid-Term Evaluation that clinic management be included in the syllabus of the Kiribati Nursing School. There is little evidence that this has been considered. It might, in fact, be more appropriately given as a briefing course for new graduates prior to departure to their first postings. In any case, developing such a course for newly graduated nurses should probably require specially curriculum development to meet their needs, as opposed to experienced nurses already in the field. The Team agrees with the Mid-Term Evaluation that management training should be provided to new graduates prior to their first posting.

C.5. Mobilizing: the Community

Community workshops in the Kiribati milieu have proven to be an especially effective way of mobilizing and involving the community in health and nutrition education. Additionally, the project further expanded community education and mobilization for child survival interventions by recruiting community leaders and representatives from various NGOs to be workshop participants. The use of an action plan, developed by each workshop participant, to assist in disseminating information and skills learned from the workshop to the members of the participant's NGO also proved very effective, and ensured much wider dissemination of messages than normally obtained from workshops. In the Kiribati environment this strategy has worked exceptionally well and should be used in health and other community education and mobilization projects.

C.6. Project Design and the Use of Child Survival Indicators as Targets for the Project

The team is unconvinced that using targets based on improvement in various child survival indicators are an effective way of illuminating project success or failure in a project of such short duration in a small **and** developing country with so many logistic and communication problems.

The CS Project has accomplished many things including providing improved training of health workers in clinic management and increased understanding of health topics by the community. Such accomplishments should build on the work of the MHFP and other agencies to provide sustainable improvements in health that can be measured and quantified over time. The Kiribati CS Project faced many communications and logistical problems over which it had no control. This combined with the relatively short duration of the project - three years - made it difficult to realistically measure improvement in the designated child survival indicators. This project should have been a four to five year project; that would have given time for interventions to affect behavior, in turn affecting targets.

C.7. Transportation to the outer islands of Kiribati is the single most important but relatively non-controllable factor affecting project implementation in outer island sites. This should be taken into consideration when planning and designing future projects and activities in Kiribati.

III. Project Sustainability

A. Community Participation

It is projected that community interest and support for health services will continue to improve as services and community understanding of health improves. The target communities of this project have been well informed about nutrition, breastfeeding,

vitamin A deficiency prevention and vitamin A rich foods, as well as CDD/ARI and immunizations. This CS Project has effectively built on previous community health education programs stretching back 20 years or more into the past. The CS Project KAP studies have shown positive knowledge, attitude and behavioral changes toward breastfeeding, weaning, feeding and breastfeeding in diarrhea, nutrition, especially growing and consuming of nutritious vitamin A rich foods, such as green leafy vegetables. Sustainable cognitive gains have been made that will lead to improved health in Kiribati and encourage appropriate health seeking behavior and health advocacy. These components are culmination of efforts by many projects, including the CS Project, and many agencies and organizations over the years. Nevertheless, the project has focused and vitalized past training with current concepts and technologies. This in turn is leading to positive cognitive and behavioral changes toward the various child survival interventions of this project.

The island councils have supported the CS Project and contributed in significant ways to its success. Members of the community have contributed time and effort implementing action plans and to spread child survival messages to the communities. Child survival subcommittees as well as nutrition clubs have been formed in many NGOs. Some NGOs have begun running training workshops and other activities on child survival topics. Project staff have reported greater community support for clinics and dispensaries and greater willingness to participate in health related activities and projects. Other island councils have requested child survival workshops and offered concessions to aid in implementation. The team is of the opinion that much of the health education and promotion focus of the project has been absorbed and will be sustained in some degree by the community. Local NGO involvement in the CS project through the community workshops has been both energetic and sustained; follow-on NGO activities, all locally supported, have disseminated the health education messages of the workshops and are effecting health behaviors in project sites.

B. NGOs

This community education component of this project is focused primarily on NGOs. The community workshops on each island site focus on having members of key NGOs in the community participate. The participants subsequently transfer what they have learned to members of their organization and to the community. Follow on action activities to workshops have included among other things development of shadow workshops for the NGO and the community, establishment of child survival and nutrition sub-committees, health promotional talks, gardening contests, cooking demonstrations and advocacy/volunteer work for the health center/dispensary and health services.

Several NGOs, such as the Teitoiningaina Center have taken what they have learned at the CS Project community workshops and started running their own workshops on nutrition and other child survival topics. In these cases, CS-IX and MHFP personnel are often used as resource persons, rather than project organizers. These NGOs have often

sought out other expertise in areas not covered by the project to broaden their workshop repertoire and provide service to the community.

Other NGOs have formed subcommittees on child survival and nutrition whose focus is to alert the community to health problems and to encourage proper nutrition . Nutrition clubs have been formed than encourage growth of vitamin A foods in home gardens, and encourage consumption of such foods by vulnerable groups.

The **use** of action plans developed by each workshop participant to assist in implementing follow-on activities has been extremely effective. Evaluation of the action plans has shown follow-through by participants to be close to 100%. The participants in almost all cases do return to their community and organizations **and** give workshops, talks, arrange contests, give demonstrations on child survival, and their friends and neighbors are listening.

The local NGO community in the project islands of Kiribati have truly taken the “child survival” ball and run with it. Communities NGOs participating in the workshops are shown in Appendix E.

C. Ability and Willingness of Counterpart Organizations to Sustain Activities

Medical assistants and public health nurses, the only providers of non-traditional medical and public health services in rural areas, are better trained today than at any time in Kiribati’s history, although some serious gaps remain in their education and experience that need further attention. The MHFP has invested heavily in developing an effective and efficient Health Education Unit, and it is now in place and performing well. It has both contributed heavily to and learned from the development and implementation of the community workshops and has gained significant capability in community promotion and health education. This unit will continue to be a major resource to health workers and the community in health promotion and education.

The MHFP remains strongly committed to improving clinic management and improving the quality of services throughout Kiribati. It is committing funds to rehabilitate rural health centers and dispensaries and is attempting to maintain proper supervision, support and training to rural health workers despite chronic and re-occurring transport, communication and supply problems. The MHFP is relying heavily on WHO and UNICEF for assistance in management and training for public health services, such as EPI, cold chain, pharmaceutical, CDD and ARI.

Although, support for non-service clinic management and planning skills development for rural health workers and their supervisors will finish at end of this project, the MHFP recognizes that more work is needed to bring about improvement in MHFP management systems. The MHFP will continue to provide such management training and support as they are able through existing supervision and support systems. Transport remains a major obstacle to both health services and health promotion activities on the outer islands

of Kiribati and one without the purview of the MHFP to correct. However, continued efforts are being made to improve rural dispensary and health center conditions by the MHFP, to encourage community support for health centers and to improve supervision of support of these rural health services. Other donors may be interested in providing support for this important area. Clinic management overlaps with public health and clinical management issues such as EPI, cold chain, family planning, pharmaceutical supply and transport, medical evacuations. Thus ongoing programs by WHO, UNICEF, and others in this area will continue to provide input and support.

As noted in the NGO section above, some local NGO's have already started their own workshops on child survival topics, especially on nutrition. These NGOs have demonstrated considerable initiative in trying to disseminate what they have learned to the community and have been judged as doing excellent community education in many cases. They still depend on external organizations and resource people for topical assistance as well as improving educational technology. It is likely in the years to come that these NGOs, as they develop increasing expertise **and** competence, will continue to complement the health education efforts of the MHFP. The MHFP has expressed interest expanding CS interventions to other islands. The team strongly supports such expansion if feasible.

D. Sustainability Plan: Objectives , Steps Taken and Outcomes

Plans for extension of the approaches used in CS Project, community workshops combined with upgrading of local nursing skills, is already under consideration in the MHFP. It is likely that such an extension **would** focus on ARI/CDD as diarrhea and acute lower respiratory infection are the major cause of mortality and morbidity in children under 5 in Kiribati. The Ministry has encouraged FSP to discuss and submit concept proposals for such activities to them for review and discussion. The addition of other CS interventions to existing project sites or as separate projects (family planning, non-communicable diseases and tuberculosis) has received some discussion. However, MHFP priorities, at this time, are to build on the present successes of the project, **and** move community workshops on high priority interventions (CDD/ARI) to other islands.

Collation of the findings of the management tools developed to improve clinic management is underway. MAs and supervisory PHNs have submitted a management self assessment and facilities maintenance assessment. The comments of the various nurses from clinics through Kiribati are expected to **be** very useful in further focusing on improving clinic management skills development. Unfortunately, results of this compilation was not available at the time of this evaluation, but should **be** available at the terminal final evaluation in March of 1997

A review of the sustainability plan, projected process objectives, steps taken and outcomes for the CS Project are shown in Table 3.

Table 3: Sustainability Plan and Outcomes

Goal	End of Project Objectives	Steps taken to date	Outcomes
<p>1) Clinic management improved throughout Kiribati</p>	<p>1) Assessment of clinic management practices, development of appropriate management aids are undertaken. 2) Development of appropriate management tools completed. 3) all DPNOs, MAs and PHNs trained in management and supervisory techniques and oriented to health education aspects of CS interventions 4) Clinic management becomes part of Kiribati nursing school curriculum.</p>	<p>1) External consultant has completed CMA and developed prototype forms and checklists. 2) 5 DPNOs, all MAs and supervisory PHNs trained in clinic management on all islands of the Gilbert Group: oriented to CS interventions 3) Management aids being used at most clinics in the Gilbert group. 4) Discussions continue with nursing school concerning management training.</p>	<p>1) Rural health workers have better management practices 2) DPNOs, MAs and PHNs supervise rural clinics more efficiently (19 islands) 3) no action taken on incorporating CM into nursing school syllabus; discussion continue</p>
<p>2) MHFP will continue to promote community awareness and action in CS survival</p>	<p>1) island councils and leaders of all islands of the Gilbert chain to be oriented to CS project and health promotion 2) KAP studies of CDD, Nutrition and Family Planning will be done 3) IO Community Workshop each will be given for CDD/ARI, Nutrition, and EPI on project Islands. 4) Follow-on activities for participants of each workshop will be monitored and supported by project staff.</p>	<p>1) 19 island councils and approximately 190 island leaders oriented to and support CS interventions 2) KAP studies completed: information used to design community workshops 3) 450 representatives of various local NGOs trained in community health aspects of EPI, Nutrition and CDD/ARI 4) 450 follow-on activities supporting dissemination and promotion of child survival interventions supported and monitored by staff completed</p>	<p>1) Approximately 180 island leaders oriented to importance of child survival interventions and supporting project 2) 4.50 NGO representatives trained in community health and health promotion aspects of nutrition, ARI/CDD and EPI 3) Estimate 4000 members of local NGOs receive training and promotion on child survival interventions through workshop follow-on activities</p>

IV. Evaluation Team

<u>Name</u>	<u>Title, Background and Organization</u>
Booti Nauan Team Member	BS (Health Education) Health Educator, Ministry of Health and Family Planning, Kiribati
Ms. Rita Feinberg Team Member	BS, MA, FSP/Kiribati Country Director
Dr. Patrick C. Lowry Team Leader	Physician, MPH, Board Eligible in Preventive Medicine, Fellow of the American Academy of Family Physicians

Dr. Patrick C. Lowry MD, MPH, FAAFP was the external evaluator and drafted the final evaluation report

Appendix A Scope of Work

SCOPE OF WORK

1.1 Prior to the start of the evaluation, the Consultant shall study the documents which shall be provided by FSP regarding the project. The Consultant shall work with the Regional Health Coordinator and Country Director from Kiribati to design the evaluation. Guidance for the design shall come from the USAID evaluation guidelines and the Consultant's prior experience.

1.2 In-country, the Consultant shall assume the role of Evaluation Team Leader, and shall be responsible for defining specific scopes of work for the individual team members. The Team shall consist of the Consultant as external evaluator, the FSP Kiribati Country Director, Rita Feinberg, and one local staff person from the Ministry of Health in Kiribati or from FSP Kiribati. The Consultant shall be responsible for the quality of the implementation of the evaluation process, investigative activities (survey, interviews, observations, synthesis of information), as well as formally coordinating the input of the other team members and presenting their findings and recommendations.

1.3 The Country Director in Kiribati shall be the Consultant's counterpart in-country. The Country Director shall coordinate the logistics of the evaluation process, make necessary appointments, introductions and travel arrangements for the team. The Country Director shall discuss these plans with the Consultant prior to the start of the evaluation. The Consultant shall have the right to request changes and/or additions to this schedule.

1.4 The Consultant shall evaluate all aspects of the Child Survival IX project, including but not limited to, the administration, personnel, successes, failures, outputs, timeliness, governmental interactions, trainings, training materials and other materials produced, reaction of the participants, and the impact of the project on the proposed beneficiaries.

1.5 Analysis and presentation of the findings is the Consultant's primary responsibility. Analysis shall be based on the USAID guidelines. Analysis of the data must take place in-country and be formally discussed with the team members. The Consultant shall make a presentation of the findings to the Department of Health. A draft report shall be developed and e-mailed or faxed to the FSP Regional office for review by September 30, 1996. If required, two (2) days shall be allocated for revisions with the final report submitted to the Regional Health Coordinator, both as a hard copy and on diskette.

Appendix B

Evaluation Team Itinerary

Child Survival IX Evaluation
Schedule of Activities **and** Appointments
September 15 - October 1, 1996

September 15

1400 Arrive Air Nauru and Transport to Otintai Hotel
1500 Project discussions with FSP country director

- . review of upcoming appointment schedule
- . finalization of evaluation strategy
- . review of reference documents

1600 Meet with Prof. Cliff Welsh, AusAID Aid Review Team

September 16

0800 Travel to FSP office

- . introductions to staff and team members (Bwenawa, Taoniti and Rerea)
- . review day's schedule

0930-1530 Ministry of Health and Family Planning for appointments with

- . Dr. Takieta Kiene, Director, Preventive Health Services
- . Mr. Booti Nauan, Health Education Officer and evaluation team member
- . Ioelu Tatapu, Health Information Officer
- . Health Education Unit (Kotii Torite, Aboro Henry, Kireata Ruteru)
- . Acting Chief Nursing Officer (Ake Rotaria)

1.530 FSP office for debriefing and discussions
1900 Official Reception for AusAID AID Review Team, Prof. Cliff Welsh

September 17

0800 Travel to FSP office
0930 Meeting with Niall Coffey. British Aid Attache. British Aid Office, Bairiki
1100 Meeting with Mikaere Bataniko, Secretary, Ministry of Home Affairs and Rural Development, Bairiki
1400 Meet with NGOs

- .
- .
- .

1600 Meet with Fenua Tamuera, former FSP senior health educator
1800

September 18

0800 Travel to FSP, review upcoming appointments
0900 and Nutrition Education staff.

1000 - 1200 Meeting with District Principal Nursing Officers (DPNOs)
 . Tiretake Maerere
 . Veronica Tekiree
 . Ioanna Tekaa
 1400 - 1600 Meeting with Health Education Unit
 1630 FSP for discussions

September 19

0800 FSP
 0930 - 1200 Attend CDD/ARI workshop in Betio
 1330 Met with clinic nurses in Betio (Taoniti joins team)
 1600 FSP for discussions

September 20

0800 FSP
 0900 Briefing with Dr. Takeieta Kienene to update progress
 1000 Briefing with Dr. TaiTai, Secretary of Health to update on progress
 1100 - 1500 Continuation of meetings in Betio
 1600 FSP for discussions

September 21

0800 - 1600 FSP, compilation of notes, discussions, writing, review of upcoming meetings, evaluate information needs.

September 22

free

September 23

0800 - 1600 FSP. writing, discussions
 continue meetings, MHFP
 1800 Meeting with Mr. Frank Rouser, WHO/South Pacific

September 24

0800 FSP
 0930 Meeting with Dr. Takieta
 1030 Meeting with personnel of health statistics office
 1300-1630 FSP
 1400 Linda Warren, former FSP health educator
 1800 Meeting with Mr. Frank Rouser, WHO/South Pacific and Dr. B.J. Rana. UNICEF/South Pacific

September 25

0800- 1630 Prepare for briefing at MHFP

September 26

0800 FSP
 1000 - 1230 Presentation of Evaluation Report at MHFP
 . Dr. T. TaiTai, Secretary of Health

- Mr. Mikaere Baraniko, Secretary of Home Affairs and Rural Development
- Dt. Takieta Kienene
- UNICEF Representative, Mr. Chandra
- Health Education Unit
 - Kotii Torite,
 - Booti Nauan
- DPNOs
 - Veronica Tekiree
 - Ioanna Takaai
 - Tiretake Maerere
- Tinai Eita, Nutritionist and Nutrition Unit
- Nursing School and supervisory nursing staff

01230

Meeting with Secretary of Health

September 27

0800 - 1600
1700

Write report
MHFP Reception for Child Survival Evaluation Team

September 28

0800 - 1700
1800

Write report
Dinner with Secretary of Health

September 29

free day (write report)

September 30

Final report preparation/ fax report to Vanuatu

October 1

Depart Kribati

Appendix C

Persons Interviewed during Evaluation

September 16-30, 1996

Name	Position
<u>Ministry of Health</u>	
Hon. Kaaotika Tekee	Minister of Health
Dr. Tetaua Taitai	Secretary of Health
	Director Preventive Health Services
	OIC Tuberculosis
	Acting Chief Medical Officer
	Senior Health Education Officer
	Health Education Officer
	Health Education Officer
	Health Education Officer
	Nutritionist
	Nutrition Education Officer
	District Principal Nursing Officer
	District Principal Nursing Officer
	District Principal Nursing Officer
	Senior Nursing Officer-Betio
	Medical Assistant - Bairiki
	Health Information Officer
<hr/>	
Mr. Mikaere Baraniko	Minister of Finance
Reina Timau	Secretary, Ministry of Home Affairs and Rural Development
Fenua Tamuera	Ministry of Foreign Affairs
	Senior Housing Officer
<u>Other Agencies and Organizations</u>	
Niall Coffey	British Aid Attache, British Aid Office
	British High Commission
Mr. Frank Rouser	World Health Organization/South Pacific
Dr. B. J. Rana	UNICEF
Mr. Chandra Sekarei B.D.A	UNICEF
Cliff Welsh	Australian Aid (AusAid) Review Team
<u>FSP</u>	
Rita Feinberg	Country Director (outgoing)
Sylvia Linggi	Country Director (ingoing)

Bwenawa 10
Taoni ti Irata
Rereao Tebau
Manikaoti Timeon
Ruita Aritake
Raoi Bohnet

NGO and Community Leaders

Tini Riiuteti
Teretia Teitia
Tebwa Itinikua

Agricultural Officer
Health/Nutrition Educator
Health Coordinator
Environmental Officer
Accountant
Administrative Assistant

Marewen Betio
Teachers' Cultural Association
Police Women Association

Appendix D

References Consulted

1. Child Survival IX (Improving the Quality of Child Survival Services in the South Pacific/Kiribati) Annual Report, October 1993-November, 1994
2. Child Survival IX (Improving the Quality of Child Survival Services in the South Pacific/Kiribati) Baseline Survey
3. Child Survival IX (Improving the Quality of Child Survival Services in the South Pacific/Kiribati), Detailed Implementation Plan, CS-IX Project - Kiribati, 1993
4. Child Survival IX (Improving the Quality of Child Survival Services in the South Pacific/Kiribati), Mid-Term Evaluation, September 1995
5. Child Survival IX (Improving the Quality of Child Survival Services in the South Pacific/Kiribati) project proposal to USAID
6. Child Survival IX (Improving the Quality of Child Survival Services in the South Pacific) Quarterly Report no. 5, 6, 7, 10, 11
7. Clinic Management Assessment Report (Report of a Consultancy on Clinic Management Assessment - a Component of the Kiribati Child Survival Project), Judy Otto, February, 1995
8. Clinic Management Workshop Report
9. Clinic Management Assessment Checklists
10. Health Statistics on Immunizations from the Statistics Office, MHFP
11. Knowledge Attitudes and Practices Research on Diarrheal Diseases for the Kiribati Child Survival Project
12. Knowledge Attitudes and Practices: a Qualitative Research Study of Child Survival and Nutrition in Kiribati, Daniel Meyer Ph.D., 1995
13. Knowledge Attitudes and Practices Research on Women's Reproductive Health and Family Planning for the Kiribati Child Survival Project
14. ODA Child Survival IX Proposal
15. ODA Evaluation Checklist
16. ODA Project Profile **and** Concept
17. UNICEF: State of the World's Children - South Pacific
18. USAID Final Evaluation Guidelines for Child Survival IX Projects

Appendix E

List of NGOs and Other Organizations Participating in Community Workshops

1. Assemblies of God Women's Association
2. Bah'ai Women's Association
3. Betio Town Council
4. Bokabonnei
5. Bouantermauri
6. Church of God Women's Association
7. The Church of Jesus Christ of the Latter Day Saints
8. Itoiningaina (Roman Catholic Women's Association)
9. Kamwanerai
10. Kiribati Protestant Church
11. Marewen Betio
12. Moroni Relief Society Women's Organization
13. Old Men's Organization
14. Onotoa Island Council
15. Police Women Association (Te Mauri)
16. Pre-School Association
17. Protestant Women Organization
18. RAK
19. Rekeniao
- 20. Red Cross**
21. Scouts Association
22. Seaman's Wife Association
23. Seven Day Adventist Women's Organization
24. Traditional Women Landowner's Association
25. Teachers Cultural Association
26. Te Kaawa
27. Unimwane
28. Youth Organization

Appendix F

Recommendations to the Ministry of Health and Family Planning

1. Community Workshops, as developed by the CS Project, appear to be an effective way of delivering health education in Kiribati. This approach should be incorporated in future health education projects. The Health Education Unit should take an increasing leadership role in such projects in the future.
2. Work should continue to improve clinic management in Kiribati. A systematic review of management issues should be performed once data from the management checklists have been analyzed and approaches to improved management developed. Existing supervisory systems can be used to implement management reforms and training
3. Transport and communication difficulties remain as a constant and recurring problem for effective implementation of essential MHFP activities, much less health projects. While transportation is difficult for the MHFP to influence, improved communications and backup communication to island clinics could be facilitated by requesting the island police to allow health centers to use their radios to facilitate communication and program logistics when their radios are inoperative.
4. The use of drama, video, local arts and other “non” formal educational tools should be continued as a means to disseminate and popularize health messages; this has proven to be remarkably popular in the I Kiribati setting. Drama, when appropriate, should be video taped for use in health education workshops.
5. MHFP should consider extending this project in part or whole to several other islands. The Health Education Unit would benefit from continued involvement and leadership in the community workshops. Clinic management continues to present a challenge to the MHFP and must be followed-up in any case. However, **project participation by the MHFP must begin early, involve all relevant staff at all levels and continue throughout the life of the any health project!**