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COUNTERPART/

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

Report submitted to:

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

December, 1996

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FOUNDATION FOR THE PEOPLES OF THE SOUTH PACIFIC

DIVING THE COOLIDGE:

A final evaluation of the Santo Family Health Project,
Child Survival IX, Sanma Province, 1993- 1996.

Report Submitted to:
Department of Health, Vanuatu
Overseas Development Administration
US AID

December, 1996

Acknowledgments

The external evaluators would like to acknowledge all the assistance and support they received during the three weeks of the evaluation visit. The FSP staff in Port Vila, particularly Alison Sese Bovu, Karen Preston, Kathy Fry, Lisa Mauro-Bracken and Selena Haggai facilitated the work of the team and provided a congenial and efficient atmosphere in which to work. The FSP project staff in Santo, Augustine Bule and Jolyon Rose, made every effort to provide us with information, organize interviews and gave us their honest opinions of the project. We would particularly commend FSP for the openness with which they have provided access to all the documentation that we have requested and the honesty of their responses. For FSP, this project has been a particularly difficult one to implement and despite our criticisms within the evaluation, we would like to reassure FSP staff that we consider they have tried extremely hard to make the project work under very difficult circumstances. We hope that this evaluation will both mark and help FPS in the move into new areas and programs.

We would like to thank all DoH staff at national, provincial and clinic level whom we interviewed and who came to the presentations in Santo and Port Vila. This evaluation reveals some serious problems in the health services in Sanma Province which need urgent attention and which the project could not significantly improve. The politicization of the health services in the country, from the national strike in 1993 and resonating throughout the life of the project, have seriously impacted not only on the project but health services in general. What constructive criticism we make in this evaluation is in the hope that the divisions and the wounds of the last three years can be put aside in the best interests of the health services, the children of Vanuatu and their parents.

Our gratitude is likewise extended to the ODA aid attaches, Alex Harper and David Fidler, for their openness and insights into the project. Despite the fact that ODA will no longer provide funding in the health sector, we nevertheless hope that this evaluation will spark some measure of debate within ODA about the appropriateness of aid project framework design and management.

Our thanks to the members of NGOs , community health educators and community members who agreed to be interviewed and gave us important insights into the impact of the program. Alex Collingwood provided valuable help and saved much time in analyzing the results of the KPC survey. Finally, our sincerest thanks go to Leo Rihu and Alison Sese, our evaluation colleagues, for all their information, kindness and gracious guidance throughout the evaluation.

Chris Chevalier & Will Parks
Port Vila, 14th December 1996

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List of acronyms used

ARI	Acute Respiratory Infection
CDD	Control of Diarrhoeal Diseases
CHE	Community Health Educator
c s	Child Survival
cs IX	Child Survival Project “Improving the Quality of Child Survival Services in the South Pacific.”
DIP	Detailed Implementation Plan
DoH	Department of Health
EPI	Expanded Program on Immunization
FHU	Family Health Unit, Department of Health
FP	Family Planning
FSP	Foundation for the Peoples of the South Pacific
HC	Health Centre
HIS	Health Information System
IEC	Information, Education, Communication
KPC	Knowledge, Practices and Coverage (questionnaire survey)
MCH	Maternal and Child Health
NGO	Non Government Organization
OBM	Outboard Motor
ODA	Overseas Development Administration (UK)
PHS	Provincial Health Supervisor
RHO	Rural Health Office
TBA	Traditional Birth Attendant
TOT	Training of Trainers
USAID	United States Agency for International Development
VHWs	Village Health Workers
VRDTCA	Vanuatu Rural Development Training Centre Association

EXECUTIVE SUMMARY

In January 1994, the Santo Family Health Project was officially launched with the goal of improving the health of women and children in Sanma Province. The project was organized and implemented by FSP in conjunction with the Republic of Vanuatu National Department of Health. The project was jointly funded by United States Agency for International Development and the Overseas Development Administration of the United Kingdom, with funds also contributed by the Scraggs Grant and support given in kind by the Department of Health and Northern District Health Service.

According to quantitative indicators, there have been two measurable changes in the three years of the project implementation. In growth monitoring, a KPC survey in 1996 found that the percentage of children **weighed in the 4 months prior to the survey had increased when compared to 1994 baseline data** (collected during a public service strike). In EPI, while there has been no significant change in the percentage of Fully Immunized Children, **there has been a significant drop in the coverage of children under 2 years with 8 out of 11 antigens**. Other objective indicators such as levels of breastfeeding, family planning users, and improvements in treatments of ARI and diarrhoeal diseases, have showed no significant changes. Further qualitative investigation into the process indicators reveals underlying constraints to project implementation. The political arena within which the project had to operate was a major factor.

Although developed for the specific physical, economic, cultural and social settings of the Northern District, the project included a combination of primary health care approaches that had been implemented in previous Vanuatu-based FSP health projects on Ambrym Island and Tafea Province. The Santo project's two main strategies to improve the quality of health services in Sanma Province were: health education training and management training. This "dual strategy" approach was believed to be entirely sustainable because no direct services whatsoever were provided by the project itself. Instead, the project was confined to equipping health staff and members of local organizations and communities with adult education techniques and specific health information and to training government staff in management and supervisory skills.

Among the project's achievements, the production of FP posters, counselling guidelines and a field tested flipchart will hopefully be widely used throughout Vanuatu in years to come. It is not possible to measure the increase in health education sessions conducted by nurses. Health campaigns, on AIDS in 1994 and Breastfeeding in 1995 were conducted and also used theater, T shirts and radio promotion in Luganville. These social marketing approaches are relatively new to provincial services but should be expanded upon in the future.

A cadre of 72 Community Health Educators has been trained and a further 21 Village Health Workers and Nurses attended one week training. This is an impressive achievement particularly given training did not start until May 1995. One-to-one follow

up of CHEs was conducted and health talks given by them under supervision. However, without further training and follow-up, which was difficult to accomplish in the remaining part of the project except for the Luganville CHEs, it appears that subsequent activity by CHEs was not high. Personal and cultural barriers to public health talks need to be considered very carefully in future.

“Management training” was poorly conceived in terms of identifying staff needs, defining objectives, and organizing an informative monitoring or assessment system. Implementing such an unfocused training regime could only be accomplished on an “ad hoc”, informal, and therefore, untargeted and perhaps unachievable basis. FSP installed radios, instituted staff meetings, and gave monthly written feedback to counterparts. Despite these efforts, FSP staff often failed to motivate RHO staff to take action if problems arose in their respective Sections. Little progress was made towards improving health management.

Any outputs and impacts the project managed to achieve were remarkable given the difficult circumstances in which the project was launched and subsequently had to operate. The project was implemented at a time when the health service was in crisis. The national strike removed many of the well-qualified staff whose positions were not to be filled until late 1994 (in some cases well into 1995). A few posts still remain vacant. As a result, weak management links existed between the Department of Health in Port Vila and the Rural Health Office in Luganville (the Municipality of Sanma Province).

Weak supervisory links were further exacerbated by a lack of transport which, when finally addressed, only aggravated staff/counterpart relationships. Outreach services were limited by the lack of support from district level and the lack of available staff to assist over-burdened sub-centre nurses. Lack of regular follow-up and support of the cadre community health workers left many floundering within communities reluctant to heed the advice of CHEs especially those who were young, unmarried school leavers.

Achieving direct impact using two indirect strategies such as health education training and management training relied upon close collaboration between project staff and counterparts. In just a few, critical positions within the Rural Health Office, this collaboration was not forthcoming.

The lack of qualitative research further hindered the ability of project health education outputs and activities to target audiences with culturally meaningful messages. What research was conducted was innovative but limited in scope. Important baseline data on nurses’ needs and counterpart management skills was either not collected or not systematically recorded, which left the assessment and monitoring of progress against baseline information almost impossible.

Many lessons have been learnt from this project. Constraints have rarely been overcome because circumstances beyond the control of the project staff have limited their abilities

to change or adapt to difficult situations. This evaluation pinpoints areas of weakness in both the management of health services (which the project intended to improve) and the design features of the project itself. Recommendations are made that might improve both these important areas and may assist future health activities in Sanma Province, future health projects organized by FSP, and for future assessments and evaluations used in the development of Vanuatu health services and policies.

The following recommendations are seen as very high priorities that should be addressed within the next 6 months:

- Restore EPI coverage with a catch-up campaign
- Address staffing needs in Sanma: PHC coordinator & qualified nurses
- Address transport needs in Sanma (DoH truck to Sanma dedicated to MCH)
- Use social marketing to mobilize the EPI campaign (drama, churches, Community Health Educators, Family Planning Agents, mass media)
- Monthly and quarterly review of diseases, health service activities, and coverage (including Family Planning)
- Move duplicated radios in Sanma to areas of greatest need (Provincial Government should assist with access).

A question that arose in the minds of the evaluators was whether history repeats itself? On October 26th 1942, the SS President Coolidge, an American luxury liner converted for wartime operations, was approaching the harbor of Luganville, Sanma Province. She was carrying 5000 American troops and much needed military hardware and supplies. Traveling too fast to pick up a local pilot to guide her through the minefield protecting Luganville's waters, the Coolidge struck two mines, ran aground upon a reef and sank within 1 hour. Fortunately, many of the ships anchored in the harbor that day rushed out to help the 5000 troops disembark and remarkably only 2 men lost their lives. The Coolidge now lies on her side in 50 meters of water off the shore near Luganville.

The Coolidge provides a useful analogy for the Santo Health Project. Here was an overseas funded project entering Sanma Province. The project needed to be implemented and donors forced the pace throughout the project's life. The project failed to collect enough reliable baseline data to pilot the initial stages of planning and implementation. Two major crises affected the implementation of the project: the national strike and the lack of transport. In combination, these made the project's original plans almost null and void. Sanma Province now requires a major EPI catch-up campaign involving many organizations and groups to mobilize and rescue the services and, more importantly, increase the survival chances of the 5000 under 5 year olds in Sanma Province, probably half of whom are not immunized against measles. If history does repeat itself, do we learn from our mistakes?

1. INTRODUCTION

1.1 Project Background

The island of Espiritu Santo in Sanma Province, Vanuatu, was one of the two main locations for the 1993-1996 Child Survival IX (CSIX) Program aiming to improve the quality of child survival services in the South Pacific (Vanuatu and Kiribati). The Foundation for the Peoples of the South Pacific (FSP) were responsible for the organization and implementation of a 3 year Family Health Project (FHP) in Sanma Province. The, project was jointly funded by United States Agency for International Development (USAID) and the Overseas Development Administration (ODA) of the United Kingdom, with funds also contributed by the Scraggs Grant and support given in kind by the Republic of Vanuatu National Department of Health (DoH) and Northern District Health Service (NDHS).

The selection of Sanma Province, one of the six provincial zones within the country, was decided upon by the DoH in consultation with FSP. The selection was based upon several criteria, including:

- the need to improve certain child survival indicators (e.g. to reduce the prevalence of malaria, pneumonia, and diarrhea, and to increase EPI coverage that had recently declined);
- the Province's high population growth rate;
- the staff capacity to conduct a Provincial-level health project; and
- the need for improvements in the Northern District's communication infrastructure.

The Santo Family Health Project was officially launched in January 1994 with the goal of improving the health of women and children in rural villages and Luganville. Although developed for the specific constraints and situation of the Northern District, the project included a combination of primary health care approaches that had been implemented in previous Vanuatu-based FSP health projects on Ambrym Island and Tafea Province. The Santo project's two main strategies to improve the quality of health services in Sanma Province were: health education training and management training.

Health Education Training

At the start of the project, it was envisaged that the knowledge of appropriate health practices within communities would be increased by training a cadre of adult educators in basic participatory techniques on health topics such as family planning, nutrition, breastfeeding, and personal and village hygiene. This cadre was to consist of District health staff (Section Heads, Nurses, and Aid Post workers), representatives of NGOs and other local organizations (e.g. church groups), and selected community members.

Management Training

The purpose of the project was also to assist the Northern District Health Service enhance the quality of women's and children's health services by improving the management and

supervision of the Rural Health Office Sections, Health Sub-centres, and Clinic Dispensaries, and the recording, reporting, analysis and use of health information statistics. The project aimed to help government health staff set up a new EPI program and a decentralized system with local clinics giving comprehensive outreach services to sites no more than 1 hour's walk from any village.

This “dual strategy” approach was believed to be entirely sustainable because no direct services whatsoever were provided by the project itself. Instead, the project was confined to training government staff in management and supervisory skills as well as equipping health staff and members of local organizations and communities with adult education techniques and specific health information. By the end of the project it was hoped that project and government counterparts would have achieved the following:

- produced high quality information, education and communication (IEC) materials for health;
- increased the amount of health education work conducted by both health staff and trained community members and improved the quality of health education;
- improved health system management.

In addition, the project was to purchase and eventually hand-over equipment necessary to sustain these three hopeful achievements to the District Health Services. The equipment was to include a boat for transport in Big Bay, 4 radios, a computer, a printer, a fax machine (and telephone line), together with a building extension to the Rural Health Office in Luganville. The project has now reached its conclusion after 3 years and in December 1996, all activities and most of the resources were handed over to the Northern District Health Service.

From the project's inception, effective and sustained implementation of these strategies had to overcome the difficult topography of Sanma Province. Mountain ranges sharply divide Espiritu Santo so that one sub-district, Nokuku, is only accessible by sea or air. In 1995, roads finally connected the other 5 sub-districts although in some areas (e.g. South Santo) road transport is restricted during the cyclone season (December to April). The Northern District Health Service is also responsible for the Banks/Torres region of Torba Province, for which the only access is by sea or air. Many in-land areas on Espiritu Santo, known as the “Middle Bush”, can only be accessed on foot or horse. No children on one isolated island in Torres (Mere Lava) are immunized as the 500 strong population has not been visited by Rural Health Office staff in over 4 years.

In addition to pre-existing physical limitations and other economic, cultural and social constraints, November 1993 saw a national public service strike remove 80% of the Provincial Health Service staff, including all but one of the District level Rural Health Section Heads who were to have been the project's principle counterparts. It was not until September 1994 that the Provincial Health Services returned to the minimal levels of staff

numbers. Project and DoH staff quantity and quality and insufficient transport resources were critical issues that influenced the project's implementation and sustainability.

1.2 Purpose of Final Evaluation

The purpose of this final evaluation is to assess the impact of the project on the health status of the project beneficiaries and the management and training processes of the Northern District Health Services. This impact evaluation is made against the Project Framework Objectives and Verifiable Indicators established in consultation with the ODA and finalized in September 1995. The evaluation does not assess the impact against the original objectives outlined in the USAID Detailed Implementation Plan drafted in April 1994. The evaluation also critically appraises the future sustainability of health education activities and management regimes established during the project's life and highlights some of the key lessons of project implementation learned over the last 3 years. The evaluation concludes by making specific recommendations for future health activities in Sanma Province, any subsequent FSP health projects, and for future baseline assessments and project evaluations to be employed in the development of Vanuatu health services and policies.

This evaluation was carried out by a four person team consisting of the Shefa Provincial District Health Supervisor (DoH representative), the Family Health Program Adviser (FSP representative) and two external consultants, one an Epidemiologist and the other a Medical Anthropologist (see Appendix 1). The methodology adopted by the team combined quantitative and qualitative techniques. Quantitative methods permitted selected indicators to be measured for any impact against pre-project baseline data. Any available process indicators were also quantified to measure output of the project's activities (e.g. number of workshop participants). Qualitative methods allowed the team to learn about selected issues, cases and events and to describe participants' experiences and impressions of project inputs, activities and outcomes.

This evaluation was made possible with the support of the ODA under cooperative agreement number FAO-0500-A-00-3027-00.

2. METHODOLOGY OF THE EVALUATION

Pre and post intervention data are only as good as the data collection methods used. Rapid quantitative methods, such as Knowledge, Practices and Coverage Surveys (KPCs), are often favoured by agencies but the reliability of data is often poor. Increasingly, international and national agencies are being encouraged to seek combined qualitative and quantitative approaches so that the weaknesses in one method can be compensated for by the strengths of another method.

2.1 Qualitative and Quantitative Methods

The team believes that qualitative data provide depth and detail through direct quotation and careful description of project situations, events, people, interactions, and observed behaviors. Qualitative data e.g. content analysis of in-depth interviews and personal communications, revealed people's experiences with project activities and their perspectives on project impacts. The quantitative data collected and analyzed by the team e.g. KPC survey and HIS data, gave broad, generalizable sets of measurements that were systematic and easily presented in a short space. Statistics from standardized items made summaries and generalizations quite easy and precise whereas qualitative responses were longer, more detailed and variable in content so that analysis was difficult because data were neither systematic nor standardized. Quantitative data, however, did not permit the evaluation team to understand and capture the settings or perspectives of project participants nor provided a framework within which people could respond in a way that represented accurately and thoroughly their point of view about the project. Multiple methods and a variety of data sources contributed to the methodological rigor and ensured the project's processes and impacts were audited from different vantage points.

The following combination of methods were employed during this final evaluation:

Review & Analysis of KPC Survey Data (1994 Baseline & 1996 Endline):

Alex Collingwood kindly assisted FSP with analysis of the Endline KPC survey data and drafted a short report comparing 1996 results with the 1994 Baseline (see Annex 1). Summary data for 1994 indicators and 1996 KPC survey data were double-checked and confidence intervals were calculated for both 1994 and 1996 data by Chris Chevalier. Precision of summary sample statistics for key indicators in the baseline and endline surveys was estimated. The statistical significance of results between the two surveys was assessed by comparison of the 95% confidence intervals of the sample statistics to determine whether the project had had any measurable impact on the stated objectives.

Focus Group Discussions:

- Four open-ended group discussions with selected informants were moderated by two of the evaluation team. The four groups consisted of: 3 CHEs; 5 members of a clinic health committee; 6 village women; and 3 mothers at an MCH clinic. These discussions focused on specific issues of concern to the informants e.g.

- with the 6 village women: knowledge of children’s ‘Blue Card’ (child health card);
- with the 3 CHEs: personal experiences of giving community health education talks,
- with the 3 mothers: personal experiences of attending an MCH clinic; and
- with the village health committee: the problems of implementing health promotive activities in rural communities.

In-depth, semi-structured interviews:

Open-ended interviews were conducted with project staff, project counterparts, beneficiaries, other interested parties, and National DoH staff. These interviews provided data on personal experiences, impressions, and opinions of the project. For key issues e.g. effects of the strike and lack of transport, this verbal information was triangulated with evidence from documents. A list of interviewees is presented in Appendix 2.

Group meetings:

Five group meetings were organized. These discussions allowed open-ended review and comment on the project and were held with: the ODA Aid Attache and representatives of FSP (twice); one with just FSP Head Office Staff; one with RHO Section Heads; one with the Executive Director of VHFA; and lastly, with an invited audience who attended the final presentation of the Evaluation Team’s findings and recommendations. Appendix 3 provides a list of those who attended this final presentation.

Observations:

Unstructured observations of project staff-counterpart interactions during formal and informal activities provided the Team with an insight into the social setting of the project. Close attention was paid to verbal and non-verbal communication amongst individuals and gave the Team insights into patterns of decision-making and the organization of social relationships (including the internal politics of the Rural Health Office) e.g. those staff members who could have but did not attend scheduled meetings. Unstructured observations of practitioner-client interaction were also made at two MCH clinics. Unobtrusive measures were used to gather information on project activities and outputs e.g. examination of project materials such as the positioning of posters on clinic walls and the wear and tear of flip-charts, and inspection of clinic HIS returns (previous 3 months), outpatient registers, EPI graphs, refrigerators and vaccines (at clinic and provincial store).

Document Analysis:

A detailed review of the following documents was conducted by the medical anthropologist: project proposal and project profiles; monthly, quarterly and annual reports; trip reports, workshop reports; minutes of staff management and project management meetings; personal communications; and other associated manuscripts, papers, letters and faxes. These issues are described in more detail in Sections 4, 5 and 6. Appendix 4 provides a complete list of documents and communications reviewed in-depth and content analyzed.

3. PROJECT FRAMEWORK EVALUATION SUMMARY

Narrative summary	Verifiable indicators	Means of verification and references within report	Results and impact	Key issues and comments
<p>GOAL:</p> <p>To reduce morbidity and mortality among children under 5 and improve reproductive health of women in Sanma Province.</p>	<p>Indicators were not thought to be verifiable and valid within the time period of this project.</p>		<p>Not assessed during evaluation</p>	<p>HIS data of insufficient completeness and timeliness to measure morbidity and mortality accurately</p>
<p>PURPOSE:</p> <p>To improve health seeking practices in Sanma Province and improve the quality of health care services provided there.</p>	<p>Decrease the % of urban children who were either never breast fed or were weaned before 12 months from 33 to 16%.</p> <p>Increase the % of infants put to the breast within 1 hour after delivery from 75 to 100%.</p> <p>Decrease the number of pediatric tetanus cases away and in 1993 to 0.</p>	<p>Knowledge, Practice and Coverage (KPC) 1994 baseline survey and 1996 end of project survey, plus DoH HIS data.</p> <p>KPC survey.</p> <p>DoH HIS data</p>	<p>1994 - 33% 1996 - 23.4%</p> <p>1994: 74.8% 1996: 75.3%</p> <p>1 case in 1998</p>	<p>NO significant change</p> <p>NO significant change.</p> <p>Not a sensitive indicator since NNT likely to be unreported or undiagnosed</p>

Narrative summary	Verifiable indicators	Means of verification	Results and impact	Key issues and comments
Purpose (continued)	Increase contraceptive use rates among couples who wish to delay pregnancy from 27% to 50%.	KPC surveys	1994: 33% 1996: 37%	All methods of contraceptive compared. No significant change.
Increase the % of diarrhea cases among children under 2 that are treated with rehydration therapy from 55- 80%.	KPC surveys	Continued breast feeding: 1994: 52.8%, 1996: 52.3% ORS: 1994: 38.1%, 1996: 43.1% Coconut water: 1994: 16.7%, 1996: 33.8%	Construction of rehydration indicator from 1994 results is not evident and cannot be replicated. No significant change.	
Increase children 0-2 years weighed within the last 4 months from 36% -60%	KPC surveys	1994: 36% 1996: 72%	Original indicator (7-60%) applies to children over 1 year. Significant increase.	
Increase the % of fully immunized children aged 12-23 months from 44 to 65%.	KPC surveys	1994: 44.4%; 1996: 34.8%	Statistically significant drop in 8/11 antigens (BCG, DPT/OPV 1 & 2, and all HEP B doses).	
Reduce the % of ARI cases (excluding mild ARI) which present at severe level from 16-80% in some centres to 4% in all.	ARI baseline study (SCFA) HIS data	Data not available at provincial or national statistics at time of final evaluation. 1994 data shows 11.6% of cases were severe ARI. 3 clinics showed no reported cases of severe ARI in past 3 months.	Not a sensitive or valid indicator of causal change. Assumes diagnosis and treatment records are accurate.	
All health centre nurses achieve at least 80% of the standard set for family planning counselling.	Staff evaluation reports from supervision reports. Final evaluation	Not possible to measure	Counselling checklists were field tested in one workshop and sent out to some nurses for comment but were not systematically implemented or monitored.	

Narrative summary	Verifiable indicators	Means of verification	Results and impact	Key issues and comments
<p>Outputs: <u>Planning and evaluation</u></p> <p>Reports from start and end of project KPC surveys.</p>	<p>Reports produced and presented to relevant DoH and NGOs.</p>	<p>FSP quarterly reports Annual reports</p>	<p>Baseline KPC reported completed. Endline survey report to be finalized. Local personnel trained in KPC survey techniques. External analysis required.</p>	<p>Very thorough baseline report but external analytical skills required for endline survey. EPI coverage survey did not use standard methods of analysis reasons for failure to immunize.</p>
<p><u>Health education</u></p> <p>High quality IEC materials produced</p>	<p>Materials produced and used by DoH and other NGOs.</p> <p>Materials meet objective criteria for quality.</p> <p>Focus groups understand the intended messages from IEC materials.</p> <p>Health curriculum developed and health lessons used by VRDTCA.</p> <p>Home observation record for TBAs produced in use.</p>	<p>Flipchart mail survey in '96 to NGOs and 5 rural health offices.</p> <p>Visual inspection.</p> <p>Health education for FP report Feb 1995.</p> <p>Workshop report</p> <p>Draft version seen</p>	<p>15 copies of flip chart developed and field tested.</p> <p>6 FP posters developed, printed and distributed in 96</p> <p>Existing FP posters studied and tested in 7 communities and with 60 people prior to development of new posters</p> <p>Training workshop held in Vila, January 1995.</p> <p>Produced by DoH with limited field testing and no follow up of TBAs.</p>	<p>Not used in field test as much as expected, except in Tanna and Malekula.</p> <p>Posters meet all quality indicators</p> <p>Individual interviews not focus groups were used for testing.</p> <p>Impact not verified</p> <p>Use not verified.</p>

Narrative summary	Verifiable indicators	Means of verification	Results and impact	Key issues and comments
<p>Outputs: Increased quantity and improved quality of community level health education.</p>	<p>Doubled volume of health education sessions and campaigns from] 994 -96.</p> <p>Counterparts meet objectives of Health Education skills development.</p>	<p>Baseline data was not collected in 1995 of nurses.</p> <p>Interviews with Community Health Educators.</p> <p>Summary of activities report</p>	<p>Impact not verifiable. 90 Community health educators trained May 95 - September 96. 9 CHEs visited had given 1-3 health talk since training (see table).</p> <p>3 Nutrition Fare Staff 8 nurses. Objectives not assessed by project of final evaluation.</p>	<p>Follow up of CHEs by project staff, by nurses and RHO. Selection and age of CHEs. Cultural and personal barriers to health education.</p> <p>Definition of counterpart too broad. Objectives unrealistic for assessment.</p>
<p>Health Program Management</p> <p>Improved health system management</p>	<p>Monthly staff meetings section heads.</p> <p>Supervision checklists for FP, EPI and nutrition developed and used by section heads and health centre nurses.</p> <p>All monthly HIS returns received from each of the 5 health centres and 80% received from dispensaries.</p> <p>All centres keep EPI graphs</p>	<p>Minutes of project meetings with RHO staff.</p> <p>Draft checklists seen during final evaluation.</p> <p>Health facilities statistics report form (monthly), Jan-Oct 1996,</p> <p>Project manager's reports</p>	<p>1994-5 1995-6 1996 - 1 (planning w/shop)</p> <p>Checklists field tested but no evidence of use in touring or in clinics.</p> <p>Health Centre reports: 84% Dispensary reports: 78%</p> <p>z/s Health Centres + MCH 3/11 dispensaries.</p>	<p>Monthly staff meetings scheduled but often cancelled by PHS.</p> <p>Good reporting returns.</p> <p>1/3 clinics visited had properly kept graph.</p>

Narrative summary	Verifiable indicators	Means of verification	Results and impacts	Key issues and comments
<p>Health Program Management (cont)</p>	<p>2 month supply of oral contraceptives, condoms, chloroquine, iron and folic acid, cotrimoxazole and in 1996, depo-provera in centres.</p> <p>5 or more clinics conducted annually in 80% of designated mobile clinics.</p> <p>For any facility with cold storage, the stock of each vaccine to be on hand at all times.</p>	<p>Quarterly review by FSP staff (semi-annual report 1996, last quarter 1995),</p> <p>List of dispensaries doing immunization (RHO).</p> <p>Interview with MCH supervisor.</p> <p>Weekly radio checks on vaccine supply and temperature by MCH supervisor or MCH staff.</p> <p>Interviews with MCH staff and Project Manager.</p> <p>Assessment of EPI at provincial and clinic level.</p>	<p>75% stock levels in 6 clinics and 12 dispensaries in 1995. 100% stock levels in 1996. Uncertain levels of depo-provera with no users in many clinics.</p> <p>1996: Immunization conducted on average in 5/10 months in Health Centres and 2.2/10 months in dispensaries. MCH unit conducted 5 tours in 9 months.</p> <p>Radio checks not done. Vaccine stocks only available every 2 months with intermittent vaccination strategy.</p> <p>Unused vaccines returned to provincial store.</p> <p>Temperature charts kept at Tasmalum, Port Orly and Malau.</p> <p>NO improvement in EPI management except for EPI graphing in some clinics.</p>	<p>Reliability of indicator is doubtful and probably unrelated to project.</p> <p>Mobile program severely affected by lack of transport and staff at clinics. Project vehicle only used for a few MCH outreach clinics. Decentralized mobile program by each sub-centre was very inconsistent.</p> <p>Cold chain management at provincial store inadequate (no temperature charts, broken thermometers). Potency of vaccines uncertain. Cold box strategy poorly executed.</p> <p>Detailed Implementation Plan objectives for immunization were not carried out apart from purchase of boat and OBM for Malau. Motorbikes not purchased for transport of cold boxes.</p>

Narrative summary	Verifiable indicators	Means of verification	Results and impacts	Key issues comments
<p>ACTIVITIES: Planning and evaluation</p> <p>1. Conduct baseline knowledge, practices and coverage (KPC) survey on: immunization, reproductive health, ARI/CDD management, and nutrition.</p> <p>2. Produce detailed implementation plan.</p> <p>3. Conduct midterm evaluation (external evaluator, FSP, reps from PHU and NGO's).</p> <p>4. Conduct end of project evaluation including KPC survey.</p>	<p>Baseline assessment report</p> <p>DIP report</p> <p>Midterm evaluation report</p> <p>Final evaluation report</p>	<p>Report read and key 1994 results recalculated with estimates of precision</p> <p>Detailed Implementation Plan CSIX, Vanuatu produced 11/4/94, reviewed 9/1994 but no final version seen.</p> <p>Recommendations included: . Planning day within 8 wks . Further workshops for nurses and community health educators . Project vehicle required. . Replace boat at Malau Key lesson: ownership of project by counterparts.</p> <p>This document</p>	<p>Well conducted survey and comprehensive display of results. EPI component not standardized. Reasons for failure, plus TT protection at birth were not established.</p> <p>DIP appears not to have been used as the main reference for implementing the project. 80% of objectives were dropped or revised for the ODA framework.</p> <p>. Planning workshop took place 6 months later (1996) 6 CHE courses held . 3 courses for nurses . FSPI vehicle leased for project and boat replaced. Ownership did not occur and relationship with PHS worsened.</p> <p>KPC survey well conducted and provisional results calculated. Data analysis derived from summary statistics.</p>	<p>Use surveys for immunization and objectively verifiable data. K&P surveys not sufficiently valid, reliable or provide proper detail for health behavioral issues. Plans for focus group discussions in project proposal (12/92) were ignored in favor of KPC. Reporting against DIP objectives not required by USAID after 1/95. ODA Framework appears to be the main implementing and monitoring tool used.</p> <p>Focus of program activities moved to clinic and community level, particularly after the provision of a project vehicle. Financial imperatives a strong motivational factor. Problems of management non-cooperation not resolved.</p> <p>Data entry in a non statistical package has limited the analysis. Further analysis and full report would be worthwhile.</p>

Narrative summary	Verifiable indicators	Means of verification	Results and impacts	Key issues and comments
<p>Health Education</p> <p>Provide technical assistance to local organizations: to FHU on TBA training; to VRDTCA on health curriculum development.</p> <p>Form, train and support a team to field test current IEC materials and any new materials produced during the life of the project. (2 week long workshop, then touring 2 times/year).</p> <p>Produce revised nutrition, FP, child care and breast feeding materials, plus FP materials for men.</p>	<p>Training report</p> <p>Workshop report and results</p> <p>Materials produced</p>	<p>Report read</p> <p>Health Education of Family Planning Report.</p> <p>Report of field testing of Health Education Flip Chart.</p> <p>IEC committee minutes not read.</p> <p>Health education lessons plans for use of posters.</p> <p>Posters reviewed and discussed.</p>	<p>3 day workshop on h.ed. for VRDTCA. Vila 1/95 National TBA training 6/95. No. trained and impact not measured</p> <p>Workshop to train team to find out attitudes and test existing FP posters 2/95. FP poster series developed and distributed. .FP guidelines test 3/95 with 5 nurses. . Field testing of flip chart in H.Cs and elsewhere. 5 tours of CHE courses (including FU sessions and immunization tour).</p> <p>6 Family Planning posters and lessons plans for use produced and distributed.</p> <p>Flip chart on VIP latrines, nutrition, immunization, breast feeding, care of child with ARI.</p> <p>FP materials for men</p>	<p>Good liaison with other projects.</p> <p>Follow up of trainees necessary</p> <p>Sound basis of development of new posters. Not able to measure impact but posters widely displayed. in Sanma.</p> <p>Infrequent use of flipchart. Needs to be taken up by Health promotion Unit and passed by CHEs</p> <p>Good quality posters. Flipchart requires final changes and widespread distribution.</p> <p>FP flipchart based on posters may be produced.</p> <p>Not specifically produced.</p>

Narrative summary	Verifiable indicators	Means of verification	Results and impacts	Key issues and comments
<p>Activities: H.Ed. (cont) Send nutrition fare coordinator, MCH health education nurse and FHU section based to ToT courses in Tafea district (2 workshops /year).</p> <p>Conduct training workshops in adult education skills development (2/yr),</p> <p>Conduct refresher workshops (4/yr) on: FP counselling and FP education (2), ARI/CDD education (1) and nutrition counselling for all counterparts, also village sanitarians.</p> <p>Evaluate training during follow up (ouf) to each health centre, twice a year. Community health education workshops will be conducted once at each of d rural centres.</p>	<p>Quarterly reports</p> <p>Training reports</p>	<p>Training reports</p> <p>Monthly reports (fell out in 1996),</p> <p>Quarterly reports</p> <p>Summary of activities - Santo Family Health Project - CS IX Project document</p> <p>Tour reports</p> <p>Many tours and 1:1 visits of h.workers to FSP office not recorded.</p>	<p>ToT of nurses Tanna (8/94) and FU 4/95 - no counterparts went.</p> <ul style="list-style-type: none"> · H.Ed of section based 10/11/12 9LI (d days) · H, Ed. of nurses 2/94 · H.Ed. of nurses Tanna 6/95. · VRDTCA curriculum 1/95 · H.Ed.. nutrition fare staff 3/95. · 6 CHE training courses (5/95 - 9/96). · ARI/EPI /HIS of nurses 3/95. · PP workshop, Vila 4/95 · FP counselling of VHWs · TBA training 6/95 · HIV / AIDS training and campaign 1 1/95. · 7 follow up tours of CHES after training. · 22 recorded tours and visits. 	<p>Not possible to measure qualitatively or quantitatively health talks</p> <p>NO talks given by MCH nurses at hospital clinic in 1996,</p> <p>East coast cancelled due to ODA budget decision.</p> <p>Final evaluation found little activity of CHES after follow up. Selection (%v) and sustainability many CHES in doubt.</p>

Narrative summary	Verifiable indicators	Means of verification	Results and impacts	Key issues and comments
<p>Health Program Management</p> <p>Provide training in health management for counterparts including 4-day workshops for EPI (2) HIS (2) and Planning retreats (2).</p> <p>Develop tool for clinic supervision of EPI, FP maternity and nutrition services.</p> <p>Support DoH counterparts in program management and monitoring (2 tours per year)</p>		<p>Workshop report</p> <p>Workshop report</p> <p>Health Centre and EPI supervisory checklist</p> <p>Trip reports given to RHO</p> <p>Quarterly reports</p>	<p>. 1 week HIS /EPI /ARI for section heads with nurses 5/95</p> <p>. 1 week Planning retreat 2/96</p> <p>Draft ready by July 1995 but never properly field tested or used by project staff or counterparts.</p> <p>. 2 tours with PHS to Big Bay and Port Orly.</p> <p>. 3 tours with MCH team.</p> <p>Considerable independent touring by project manager once project vehicle available.</p>	<p>Underachievement of counterpart training activities - 1:1 training and workshops (33%)</p> <p>Workshop too rushed and tried to do too much.</p> <p>Delayed by 28 weeks</p> <p>Needed to be developed and implemented much earlier in project.</p> <p>. New RHO staff following national strike.</p> <p>. No baseline information for management.</p> <p>. No systematic monitoring of HIS data.</p> <p>. Unclear training objectives</p> <p>. Frequently cancelled staff meetings</p> <p>. Counterproductive relationships with PHS</p> <p>. Insufficient cooperation between project and RHO.</p>

4. OBJECTIVES OF THE PROJECT

This evaluation is measured against the objectives described in the ODA Framework Project Profile. The final version of the profile was not established until September 1995. The original project documents followed USAID Child Survival document procedures, culminating in a Detailed Implementation Plan (DIP), CSIX in April 1994. The goal of the project was not changed in the metamorphosis from USAID to ODA format.

Goal: to reduce the morbidity and mortality among children under 5 and improve reproductive health of women in Sanma Province.

The **purpose** of the project was twofold:

- to improve health seeking practices in Sanma Province
- to improve the quality of health care services provided there.

The beneficiaries were identified as women and children. Two basic strategies were used to achieve the purpose of the project:

- Health education
- Health management training.

4.1 Objectives and indicators

The objectives of the program were being refined and redefined in response to donor requests throughout the first half of the project. The objectives chosen were based on a DIP which had been described by external reviewers as “only fair” . The 10 objectives in the DIP plan were revised and refined in 4 successive versions of the ODA framework. Some 60% of the objectives (relating to nutrition, prenatal care, ARI, diarrhea) were dropped and the remainder adjusted to become 9 verifiable indicators (see Project Framework - Purpose).

The objectives/indicators are quantitative measures by which the program can be assessed through KPC surveys and HIS data. From an epidemiological perspective, the validity of some of the indicators are doubtful. For example, when disease incidence is considered (e.g. Neonatal tetanus, Acute Respiratory Infection), disease patterns are likely to account for changes in indicators. The reliability (repeatability) and bias involved in measuring behavioral changes (e.g. breast feeding, self reported contraceptive use) are also questionable. Probably the only reliable indicators chosen were fully immunized status of children and growth monitoring in the previous 4 months, because both could be objectively verified from a child health card. The size of change sought in the indicators was quite arbitrary (from minus 50% to plus 850% changes in indicators). For some indicators (e.g. EPI) the targeted change lay within the expected confidence intervals given the size of the sample surveys which would make it difficult to detect significant changes . Even if a significant change were to be found, ascribing a casual relationship to the project might not be justifiable. Thus indicators based on quantitative indicators measurements in questionnaire surveys are of doubtful validity and may have unnecessarily narrowed the focus of the program . It

certainly biased the information gathering away from the type of qualitative inquiry which was vitally necessary in a program aiming to change the behavior of both health seekers and providers.

The final framework was produced in September 1995 late in the project lifetime. It becomes clear from the documentation that even FSP staff only became conversant with the project's objectives and strategies towards the end of 1995. The degree of understanding and ownership that could have been expected from counterparts, struggling to come to terms with their own work, was always in doubt given the ambiguity of local FSP staff towards the documentation, strategies and indicators. Critical assumptions were placed into the framework well into the project lifetime: e.g. "Indicators would not be verifiable and valid in the time period of this project" and "Changes in the political arena do not impact on the capacity of DoH to deliver services" appear for the first time in March 1995. Other assumptions were imprecise and ill-defined: such as "Constraints to adopting healthy practices are well understood and incorporated into health education" (which could not occur as only a KPC survey was used to collect data and no anthropological work carried out despite being recommended in Ambrym's final evaluation and in the country submission in 1992).

4.2 Intended inputs

The main intended inputs (Project Framework 9/95) were:

ODA	UKf	Vatu	US \$
100% funding of:			
VSO Health Educator	25,000	4,375,000	40,000
Training activities	12,000	2,100,000	19,000
Health education materials	6,000	1,050,000	9,500
Radio equipment	10,825	1,894,000	17,200
Computer / printer	2,250	393,750	3,500
Part funding of:			
Project adviser	54,200	9,485,000	86,000
Midterm & final evaluation	8,600	1,500,000	13,700
15% FSP costs	16,400	2,870,000	26,000
10% contingency plans	13,275	2,323,125	2 1,000
Total UK input	148,800	26,040,000	236,900
Total USAID funding	131,800	23,065,000	211,655
Scaggs grant (boat)	1,700	297,500	2,700
Total financial inputs	282,300	49,402,500	451,255

The actual contributions from each of the main two donors has not necessarily followed the above budgets. The accounting procedures of FSP and the two donors make it impossible to determine budget line expenditure during the project. USAID funding was completed by September 1996 and ODA funded the project completely in the last quarter of 1996. There was an underspend of approximately £25,000 by the end of the project in December 1996. There has been considerable confusion in the

accounting methods used and the Team recommend that in future projects, an external financial audit be conducted prior to final project evaluation to determine areas of over spending, underspending and the proportional budget expenditures.

4.3 Intended outputs of the project

The main intended outputs were:

- High quality IEC materials.
- Increased quantity and quality of community level health education.
- Improved health system management.

The relationship of the outputs to the objectives of the program appear logical but are very indirect interventions. No direct services were to be provided by the project and all change was to be mediated through counterparts. Given the general environmental health conditions in Vanuatu, the difficulty of affecting health behaviors in the short term and the state of health services management during and following the strike, the intended outputs were always unlikely to result in achievement of the ultimate objective of the program.

4.4 Implementation plan

The detailed implementation plan appears to have ceased to be used for implementation at some point before the mid-term evaluation. The DIP (April 1994) does not appear to have been produced in a final version despite considerable criticism by external reviewers of the DIP 2 draft. Some of their suggestions were incorporated in the first versions of the ODA framework document. By January 1995, USAID were not requiring reporting on the program except for financial accounts. The framework project profile became the implementation plan, although it is not usually designed for this purpose. The framework is short of detail on process and strategies and in itself is not a sufficient guide for program implementation. This may help to explain why, for example, almost none of the immunization strategies in DIP were implemented. The tighter focus of the project reflects the increasing role that ODA came to play as principal donor in the latter half of the project.

4.5 Alternative methods of achieving the objectives

It appears that the project encompassed many similar design features to previous CS programs in Ambrym and Tanna but inputs were primarily aimed through counterparts at the provincial level. Counterparting and “cascade” effects of management training were supposed to lead to changes in the quality of health systems and health education training to behavioral changes in families. External reviewers of the DIP pointed out the lack of contingency plans if there was insufficient manpower in the rural areas to do outreach work. However, no contingency plans appear in subsequent documents.

EDUCATION CONSTRAINTS	ISSUES ARISING	LESSONS LEARNT
<p>The problem of measuring the impact of health education training: quantity and/or quality of health educators?</p>	<ul style="list-style-type: none"> • Activities may have become more important than outputs i.e. number of workshops and number of participants became more important than quality of workshops and post-workshop activities. No recording system was set up to provide details of health education activities done by counterparts to monitor the development of health educator skills amongst counterparts who have undertaken H/Ed skills trainings. • Lack of regular follow-up of CHEs by either FSP or local nurses reduced any chances of gathering information on the quality of community-based health education. The issue of “quality education” was never adequately addressed. Measuring the adoption of healthy practices by target groups was only attempted in the final KPC survey with doubtful validity and reliability of data. 	<ul style="list-style-type: none"> • The number of health staff trained is probably less relevant to objectives than the number of trained health staff active and competent in health education. Clear indicators to monitor would be: <ul style="list-style-type: none"> - the number of trainees who went through health education skills training (both counterparts and community representatives); - how many have on-going health education plan - what health education has been done and on what health subject. • The most meaningful assessment of health education impact should be changes in target group behaviors i.e. the sustained adoption of healthy practices as a result of health education. This is a long-term process, difficult to measure without detailed, qualitative baseline data and ongoing qualitative investigation, and difficult to isolate from potential confounding variables e.g. changes in domestic income generation.

EDUCATION CONSTRAINTS	ISSUES ARISING	LESSONS LEARNT
<p>Feasibility of expecting nurses to “go out to communities” to give health talks ●</p>	<ul style="list-style-type: none"> ● Health talks given by nurses are mostly held at health centres and very little is done in communities due to the common problems: lack of travel budget and lack of staff to run clinics while the nurse is away giving health talks. Some nurses show no interest in doing health education in their communities. 	<ul style="list-style-type: none"> ● Motivating nurses to visit communities to share community health information continues to be a problem. Closer collaboration between CHEs and nurses or between church groups and nurses may motivate health staff to pass on health information outside the confines of clinics.
<p>The voluntary status of CHEs.</p>	<ul style="list-style-type: none"> ● CHEs may face political resistance from village leaders and receive little back-up from local or district level staff. Without any form of incentive and support from local health staff, the active community education/social mobilizer role of CHEs is unsustainable and therefore short-lived. 	<ul style="list-style-type: none"> ● Involving local health staff during CHE training workshops and when CHEs actually organize health-related discussions with community groups (e.g. women’s groups) may provide CHEs with greater assurance that they are being supported and valued for their unpaid efforts ● ● Community mobilization for health may be better achieved with a social marketing/health promotion approach which utilizes touring drama groups, mass media, and other channels of communication e.g. church groups.

EDUCATION CONSTRAINTS	ISSUES ARISING	LESSONS LEARNT
<p>Inappropriateness of a newly created “social mobilizer” role functioning within the context of pre-existing, stable social organizations and cultural beliefs guiding community life: e.g. established rules determining when, why, how, on what, by whom and with whom group meetings should take place.</p>	<ul style="list-style-type: none"> • Within communities, strict channels of decision-making, gender issues, and patterns of resource distribution (including information) limit the “mobilizing role” of many nurses and CHEs (especially those who are young and single). Topics such as Family Planning address issues that may be culturally inappropriate to discuss in the context of certain kinship ties, social positions, age differences, and gender relations between nurses/CHEs and their “target groups”. • Interviews with CHEs suggested some would like to be trained as Village Health Workers (increasing their status through the ability to treat disease) and many of the younger CHEs had not been able/allowed to talk during village meetings. Only those older, female CHEs with support from their church, seemed to have had any success in organizing talks with a defined audience (i.e. their own women’s group). 	<ul style="list-style-type: none"> • Greater attention must be given to the social and cultural context within which “social mobilizers” are expected to act. The cultural appropriateness of young, single men and women talking to audiences of mature and respected kin relations with established lines of decision-making must be questioned. • Social status determines ability to pass on information and make decisions, not workshop training. Qualitative research should have been conducted to examine the feasibility of creating a new social role for usually low status community members (e.g. school leavers). • Selection criteria for such mobilizers must be based upon socially realistic, culturally appropriate characteristics such as age, gender, marital status, and political position within the community.
<p>Feasibility of expecting nurses to increase their workloads and go beyond their health practitioner role to become health promoters</p>	<ul style="list-style-type: none"> • Most nurses (and CHEs) do not make plans for health sessions. Nurses talk on an ad hoc basis at the health facility and only when time allows after or during consultation with mothers at MCH clinics and/or with patients. 	<ul style="list-style-type: none"> • The health educator role of nurses needs to be addressed in nurse training with practical sessions and follow-up to encourage nurses to move beyond the role of treating disease

EDUCATION CONSTRAINTS	ISSUES ARISING	LESSONS LEARNT
<p>Cultural inappropriateness of training to “give health talks” instead of training to “share health stories”.</p>	<ul style="list-style-type: none"> Health knowledge and communication skills of some nurses and CHEs is reported to have improved (ane to tal evidence only) but these skills are mostly used in one-to-one situations rather than group sessions. Nurses rarely give health “talks” outside the confines of their clinic. CHEs rarely give health “talks” outside the confines of their immediate family. Language is a factor for nurses giving health talks at MCH clinics for mothers who do not speak Bislama (the national language). Some CHEs are asked by their church group to give talks at specified times. Others rarely arrange specific dates in advance. IEC materials such as flipcharts, booklets and posters were not used much by nurses but were often requested by CHEs and put to use when made available. 	<ul style="list-style-type: none"> Health education “stories” on a one-to-one basis may be more effective and less daunting to educators than having to “talk” to community groups. Custom and/or biblical stories with traditional narrative styles may be more appropriate forms of communication by which health messages can be transferred to people than health “lectures”. In some cases health messages must be communicated through local interpreters. IEC materials should be designed for CHEs (if found to be an appropriate channel for communication) or for touring drama groups and church groups and not just for nurses, many of whom do not appear to put such materials to regular or worthwhile use.

MANAGEMENT CONSTRAINTS	ISSUES ARISING	LESSONS LEARNT
<p>In November 1993, a nationwide public service strike removed many of the country's medical and health planning personnel at all levels of the health service. In Santo itself, 80% of the provincial hospital and RHO staff were sacked. At the same time, administrative and technical support from the Health Department decreased so that there were drug shortages and a shortage of funds for routine service delivery.</p>	<ul style="list-style-type: none"> • This had a devastating impact on the Family Health Project, and served to re-emphasize the absence of any form of contingency plans (despite previous warnings from USAID) and over-reliance on the presence of key individuals within the RHO. With the removal of all but one of the Section Heads, (the remaining staff member was promoted to DHS), the project's management training component for District level staff became virtually redundant until intended counterparts could be replaced. In the words of the former Project Manager, the project plan agreed to by the former staff was "void now that they are gone." • To the project staff's credit they persevered, re-defining the project's purpose, approach and expected outputs to fit the radically changed post-strike situation. But the project became unfocused: "Do we train as health education trainers the Nutrition Fare staff, or APOs, or nurses, or hospital staff, or village sanitarians, or all of them? WHO ARE THE TRAINERS WE ARE MEANT TO TRAIN?" the former project manager asked in a fax to FSP's Regional Adviser in March 1994. 	<ul style="list-style-type: none"> • Future projects using such indirect strategies to improve children's survival must develop realistic contingency plans including the option of delaying or terminating the project if circumstances dictate. • Keen involvement from several rural nurses especially Jean Rapti, Isaac Avok, Peter Yanik, Philip Tanake, and Zepulon Moipitwen, local interest from hospital staff including Dr. Timothy Viktor, Rachel Kalmas, Margeret Lui, and Mary Bebe, and financial support from USAID and ODA kept the project going. FSP staff were extremely adept at persevering with an otherwise unpromising project implemented in a period of national crisis and political upheaval. Project Manager Augustine Bule and VSO Health Educator Jolyon Rose deserve special mention. FSP head office managerial staff, Elison Sese, Kathy Fry, and Lisa Mauro-Bracken, also gave the project with much needed technical support and <i>onidance</i>

MANAGEMENT CONSTRAINTS	ISSUES ARISING	LESSONS LEARNT
<p>Provincial staffing numbers were always insufficient to achieve the project's objectives ● The project depended critically upon the quantity of staff being adequate to facilitate decentralization and community outreach.</p>	<ul style="list-style-type: none"> · From the project's inception, the low levels of manpower within the rural services was a major constraint on the ability of existing staff to carry out additional supervisory, outreach and community health activities. While (before pre-strike RHO had six well-staffed sections and 4 trucks, (before situation in (before rural areas of Santo was not promising. A USAID DIP review pointed out this potential weakness and suggested a contingency plan be put in place if staffing levels proved too low. No contingency was made. · Without contingencies plans, both the project's activities and the province's decentralization could not succeed if the DoH did not provide additional staff. What alternatives were suggested e.g. asking neighboring nurse aides (to come (to look after sub-centres on clinic days while (before nurses conducted outreach and supervised (before health staff (e.g. dispensary nurses) were not sufficient (to allow sub-centre staff (before time nor (before confidence (to leave their clinics. Lack of travel funds and transport further reduced their inclination (to conduct outreach. ● The District Health Supervisor was interested in decentralization and made requests to the Department of Health for more staff. Despite (before project's aim to equip RHO staff and sub-centre nurses with (before sufficient managerial skills to support decentralization, inadequate human resources limited (before efficiency of rural health services. Official policy says each sub-centre must have three staff: nurse practitioner, midwife, and nurse. A survey of Santo's health facilities carried by National staff in June 1996 revealed that of 16 health facilities, only 3 did not require extra staff, and 4 required some form of transport to increase the staff mobility. 	<ul style="list-style-type: none"> ● Over-reliance on a few district level individuals, reduces the channels through which projects such as this can influence the health of families. The implementation of two indirect strategies (health education and management training) through a small, under-resourced, poorly supervised and inexperienced district team is unlikely to improve the quality of health services unless staffing levels, finance, and administrative abilities are sufficient. ● Realistic contingency plans must become a basic feature of NGO project proposals. Without such alternatives, projects can quickly stagnate or falter i.e. <u>Child Survival Projects</u> become <u>Project Survival Projects</u>. ● Staffing levels need to be addressed in Sanma Province (as in most of Vanuatu), especially for rural postings which are notoriously difficult to fill ●

MANAGEMENT CONSTRAINTS	ISSUES ARISING	LESSONS LEARNT
<p>Staffing needs within the project were also</p>	<ul style="list-style-type: none"> ● In November 1995, the project staff 	<ul style="list-style-type: none"> ● From the beginning of the project

<p>insufficient: there was no direct counterpart to the Project Health educator ●</p>	<p>identified that an on-the-job health educator trainer should be made a counterpart to the FSP Health educator ●</p> <p>The most appropriate position within the RHO would have been the District PHC Coordinator. This post remained vacant throughout the life of the project.</p> <ul style="list-style-type: none"> ● Those counterparts who began training as health educator trainers were not in ideal positions. The Nutrition Fare coordinator dropped out because he became too busy with his own work. An MCH nurse who showed an interest in health education was later transferred to the hospital maternity ward, and one of the sub-centre nurses the project had trained informally as a health education trainer, could not leave his sub-centre post through lack of a suitable replacement. ● In January 1996, the matter of a direct health educator counterpart was discussed further with the DHS but no obvious action was taken. The DHS in a letter to the National Health Educator, remarked: <i>“FSP have worked hard because they have budget and manpower available to maintain the program continuously but my province doesn't have a full time PHC or Educator... I have this post vacant but approved (for financing)”</i> (DHS I/V/0/96). 	<p>there should have been a direct counterpart for the Health Educator and a clear replacement when the project finished. “Counterparting” may need to be redefined as “one-for-one” not “one-for-all”.</p> <ul style="list-style-type: none"> ● It is essential to fill the vacant post of District PHC Coordinator if there is to be any further community outreach and follow-up of Community Health Educators.
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MANAGEMENT CONSTRAINTS	ISSUES ARISING	LESSONS LEARNT
<p>There was a lack of transport for RHO to maintain adequate links with nurses and conduct outreach. ●</p>	<ul style="list-style-type: none"> ● A pre-existing lack of transport throughout Sanma Province was a major constraint to the successful implementation of the project. The increased frequency and number of supervisory visits that the project had to implement were not feasible until the delivery of an additional truck in August 1995. ● Lack of transport did not just affect RHO work schedules. In November 1995, the Project Manager reported that nurses at sub-centres and dispensaries had transport difficulties and budget constraints and could not do outreach: <i>"This has an effect on a lack of proper maintenance and efficient use of equipment such as fridges, gas supply, etc. supplied to rural health facilities. The vaccination coverage for the whole of Santo and Torbais very low. Only a few centres were up to date in EPI activities in the areas"</i> (Santo Health Tour Report 11/1995, pp.2-3). ● The RHO in Santo was reduced to one truck to be shared between the outreach programs of six different sections (malaria, environmental health, TB/leprosy, nutrition, and MCH). A similar FSP project in Tanna, Tafea Province, had several trucks on hand for the work of RHO Sections. At the end of the first year, the Project Adviser commented upon the differences between the two projects. In Tafea: <i>"...the local FHP manager enjoys excellent support from the health department staff in the RHO. In this district the effects of the public health department strike are significant but much less severe than in Sanma because the DHS and MCH supervisor remain at their posts. The Northern District has a new vehicle provided by WHO which they allow us to use on rare occasions"</i> (FSP Quarterly Report Oct -Dec 1994, pp.4-8). 	<ul style="list-style-type: none"> ● Decentralization increases the need for effective communication, regular touring, and efficient supply lines. Adequate transport is fundamental to the success of decentralized services.

MANAGEMENT CONSTRAINTS	ISSUES ARISING	LESSONS LEARNT
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<p>Donors were unconvinced that a project vehicle was an economical or worthwhile input.</p>	<ul style="list-style-type: none"> • Even with the level of cooperation evident in Tanna, an evaluation of the work in Tafea Province recommended that such projects should acquire a vehicle. Despite an initial transport budget-line of 2.8 million vatu to be spent on hiring or purchasing a truck, funding agencies involved in the Santo project still remained unconvinced that a truck should be donated. • The project's original MOU stated that the Department of Health would allow project staff to share government vehicles. FSP made a contribution to RHO transport costs when tours and outreach programs were conducted. This offer was perceived by FSP to be one of assistance in line with the need to transfer managerial skills to project counterparts. • At first, this sharing of transport was welcomed, but as workloads increased and relationships deteriorated, the need for additional transport became obvious. Not until September 1995, was a separate truck leased to allow project staff to carry out their follow-up and supervisory visits. • The eventual arrival of the truck further revealed the pre-existing constraints that had been placed on project activities. From August 1995 onwards, supervisory visits to clinics: "...<i>would not have been possible without the generous agreement between FSP Regional and FSP/Vanuatu in agreeing to Family Health Program hiring of the Regional vehicle for project use</i>" (Quarterly Report 1 995 Jul 1 -Sep 31, p.5); "<i>The vehicle to implement the various components of the health activities especially in follow up program requiring transport would not have met without having this vehicle</i>" (Quarterly Report Oct 2-Dec 31 1995 p.11). 	<ul style="list-style-type: none"> • Transport issues quickly become political issues which can rapidly undermine counterpart relationships to the point of resentment. The feasibility of "sharing" limited resources must be addressed before assuming long-term cooperation. • Donors supporting projects such as this should give much more serious consideration to the purchase and handing-over of a project truck that can then be dedicated to counterpart activities e.g. MCH/PHC outreach. Donor reluctance is only justifiable if existing transport resources are already sufficient but simply mismanaged. In Santo, existing resources were insufficient and mismanaged. Separate MOUs may have to be established to reduce the risk of vehicle misuse. • A DoH truck in Vila is to be sent to Santo and this may help to overcome transport constraints, but only if one of the two trucks becomes dedicated to MCH/PHC outreach.
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MANAGEMENT CONSTRAINTS	ISSUES ARISING	LESSONS LEARNT
<p>Project staff (including head office management) remained indecisive as to</p>	<ul style="list-style-type: none"> • The project had originally planned to buy motorbikes to help with EPI and MCH 	<ul style="list-style-type: none"> • Project's attempting to increase outreach and management support

<p>how to solve the problem of transport .</p>	<p>services in Tasmalum and Port Orly on the basis that a truck would quickly succumb to the wear and tear of poorly maintained roads. This opinion was later reversed. In a memorandum from the Project Manager to the Project Adviser, the manager suggested: <i>"...getting rid of the idea of supplying 2 motorbikes to Port Orly and Tasmalum. 1 bike went down to South Santo but due to bad management and the rivers it keeps breaking down "</i> (Project Memorandum 20/12/94).</p> <ul style="list-style-type: none"> • Funds that had been available to purchase these bikes was diverted to the purchase of a boat for the Big Bay area. It is still unclear how funds originally set aside in the DIP for both bikes and a boat were eventually spent 	<p>must themselves address transport requirements and assess the feasibility of different options</p> <ul style="list-style-type: none"> • Making adjustments late in the project's lifetime (in response to pre-project problems) is not an efficient method of budgeting or planning. Realistic modes of transport in relation to the activities required must be determined before the project commences.
<p>The delivery of a hired truck (for use by FSP staff only) late into the project further unsettled relationships between project staff and the RHO.</p>	<ul style="list-style-type: none"> • When FSP received a truck in August 1995, project staff started to take over the supervisory role of the DHS. The direct duplication of RHO activities by project staff was poorly received by the RHO. This led to a further deterioration in project/counterpart relationships. 	<ul style="list-style-type: none"> • The lack of transport created a need for cooperation. As a scarce resource, vehicles become political pawns and status symbols. With available funds to purchase rather than hire a truck, the donors and project staff made a decision based on economic criteria that placed the project in a virtually irreconcilable position with counterparts. Direct duplication of RHO activities by project staff added further insult to the contentious issue of vehicle access.

MANAGEMENT CONSTRAINTS	ISSUES ARISING	LESSONS LEARNT
<p>Establishing meaningful training objectives and monitoring improvements in managerial skills.</p>	<ul style="list-style-type: none"> • No formalized monitoring system to gauge progress in management skills (e.g. effective and systematic use of HIS data, checklists, drug ordering, etc.) was • What management needs were identified amongst clinic nurses were usually gathered in a non-systematic fashion and without detailed regard to what and how subsequent changes, if any, could be measured. 	<ul style="list-style-type: none"> • “Management training” was poorly conceived in terms of identifying staff needs, defining objectives, and organizing an informative monitoring or assessment system. Implementing such an unfocused training regime could only be accomplished on an “ad hoc”, informal, and therefore, untargeted and perhaps unachievable basis. • The collection and analysis of detailed baseline data on the managerial skills and needs of all district staff (RHO and nurses) could have been a useful management training guideline and vital monitoring tool.
<p>The informal approach adopted described as being “flexible” and “problem solving”, taking advantage of opportunities for management training as they arise.</p>	<ul style="list-style-type: none"> • The training needs and major management problems of Section heads were informally assessed. <u>These assessments were not recorded.</u> • Some district level management training needs were still being identified as late as November 1995. These included: (1) planning of outreach activities; (2) costing for outreach activities; (3) budgeting for supplies/repairs support staff/assistance; (4) channel of request/needs to appropriate bodies; (5) identifying needs for training subordinate workers; (6) planning and organizing a workshop at the facility level. 	<ul style="list-style-type: none"> • More attention must be paid to identifying training needs of counterparts and creating baseline database with which to monitor progress e.g. number of tours, management meetings attended, number of nurses visited, etc..

MANAGEMENT CONSTRAINTS	ISSUES ARISING	LESSONS LEARNT
<p>Δ formal management training course for new RHO staff was perceived as a threat to their autonomy and dignity.</p>	<ul style="list-style-type: none"> • Only three formal management training courses for RHO staff (and nurses) took place during the project: March 1995 on ARI/EPI/HIS organized by FSP, February 1996 on action planning organized by FSP, and November 1996 on EPI organized by the Department of Health. • Some participants at these courses described them as too short and intensive with too many topics, too rushed and not well explained. • The District Supervisor and Maternal Child Health Supervisor both attended a 6 month Management Training Course in Fiji. 	<ul style="list-style-type: none"> • Workshops organized by National representatives with NGO inputs may be perceived as or less a threat to dignity than workshops organized entirely by NGOs.
<p>Abilities to solve management problems.</p>	<ul style="list-style-type: none"> • The Mid-Term Evaluation in July 1995 did not attempt an in-depth examination of the sensitive issues of project staff/district staff relationships. The close reciprocal link that had to be forged between personnel in the RHO was a prerequisite for the success of the project and impinged directly upon the sustainability of activities after the project withdrew its support. The public service strike created an even more pressing need to develop congenial and productive partnerships with new colleagues. • Towards solving management problems, FSP installed radios, instituted staff meetings, and gave monthly written feedback to counterparts. Despite these efforts, FSP staff often failed to motivate RHO staff to take action if problems arose in their respective Sections. Little progress was made towards improving health management, primarily because health management problems were not appreciated by the highest level managers who showed little interest and had scarce resources. 	<ul style="list-style-type: none"> • Uncooperative relationships leads to counter-productivity. Problem solving approaches must also apply when dealing with inter-staff relationship problems. More direct assistance and support from both the Department of Health and FSP Head Office in Vila might have prevented further decline in the level of collaboration between Project Staff and RHO staff. • Well-planned agendas for provincial management meetings plus increased radio communication could have some impact on management of rural health services. Drug ordering may also improve because of use of radios. More radios should be used (including redistributing existing radios where they are duplicated e.g. Tasmalum, Nokuku, and Mota Lava).

MANAGEMENT CONSTRAINTS	ISSUES ARISING	LESSONS LEARNT
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5.2. HEALTH MANAGEMENT AND TRAINING

<p>At the start of the project, two "steering" committees were formed. One would be an advisory committee consisting of local government, health, nutrition, and women's council. The other would be a steering committee consisting of health, nutrition, and women's council. The steering committee would be responsible for the project-related policy decisions and planning sustainability.</p> <p>In February 1995, a third, originally unnamed "management committee" was established.</p>	<ul style="list-style-type: none"> • Advisory committee was unworkable due to the large number of members and organizations and thus who needed to be contacted and coordinated if any meetings were to occur. Sanma Provincial representatives in the district were not kept well informed on the project's activities despite being responsible for the future development of Sanma Province's health services. • This committee met twice in 1995 but not once in 1996. The first meeting included Section Heads and District Health Officers. They were invited to attend the last meeting in September 1995. Their initial objectives and activities. This Executive Committee had no impact. • Section Head to take place on a monthly basis, his name at committee" was perceived as: "...an experience for us for tackling management problems. The first meeting was to raise various issues and discuss them following a problem-solving approach". Despite its worthy agenda only 3 meetings took place over the next 23 months. The work was cancelled and the staff were laid off. The staff were laid off and RHC staff were laid off. The staff were laid off and RHC staff were laid off. 	<ul style="list-style-type: none"> • Committees involving many different organizations are rarely workable and rarely convene. What direct and meaningful contributions into individual projects such committees can make is uncertain. It may be better to create network of interested organizations and maintain contact through a project newsletter. • Small "Executive Sub-Committees" can have direct inputs into projects but must have a regular timetable and contributions from FSP's head office. Section Heads at District level should have been included in this committee from the start instead of attending separate staff meetings (see below). • The Team believe that attempts to establish district-level action planning could not be achieved through one-to-one consultation. The concept of forming a "District Team" was abandoned with the demise of staff management meetings. As the initial need for such meetings was instigated by FSP, the project staff might have taken more responsibility to arrange such meetings or to rearrange the schedule to bimonthly or quarterly meetings to better suit the work commitments of RHO staff. • This committee may have been more effective if its primary role had been the management of the project (i.e. it was combined with the Executive Sub-Committee).
<p>MANAGEMENT CONSTRAINTS</p> <p>Feasibility of staff cross-training.</p>	<p>ISSUES ARISING</p> <ul style="list-style-type: none"> • One hope of the project was that each 	<p>LESSONS LEARNT</p> <ul style="list-style-type: none"> • The cross-training of Section

	<p>Section Head would learn the main health issues in the other sections and that s/he would be able to complete supervisory checklists for any section ● This was to be accomplished by cross-training staff in technical skills of other sections. This “cross-training” rarely occurred. The lack of regular management meetings also reduced the opportunities for cross-training to take place.</p> <ul style="list-style-type: none"> • One to one follow ups and supervisory visits were conducted by the Project Manager but <u>all too frequently in (be absence of the DHS and Section Heads (reducing the transfer of supervisory and cross-sectional skills).</u> Likewise Section Heads often conducted outreach work in the <u>absence of the Project Manager</u>. Busy schedules, other work commitments, and non-cooperative relationships led to such disjointed activities. 	<p>Heads, while theoretically impressive and economically rationale, must be considered in relation to the practicalities of expecting existing roles and responsibilities of Section Heads to increase ● It would appear transport limitations restricted Section Heads from carrying out regular outreach and supervision of rural staff. Rather than overload supervisors with new monitoring tasks (unrelated to their Section), it might be more practical to increase the limited opportunities supervisors have to carry out their existing roles i.e. provide more transport.</p> <ul style="list-style-type: none"> • Quarterly provincial management meetings might be a better forum in which Section Heads initially learn about the activities of other Sections rather than “on-the-job” when they have their own specific tasks already assigned.
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MANAGEMENT CONSTRAINTS	ISSUES ARISING	LESSONS LEARNED
<p>Reliance on counterparting: strike-related problems resulted in total change of RHO staff. New staff had to rapidly learn new responsibilities as well as extra activities imposed upon them by the project's management strategy (such as having to train their own staff).</p>	<ul style="list-style-type: none"> ● Declining levels of cooperation which began at the start of the project and gradually worsened to the point of non-cooperation resulted in counterparts becoming counter-productive. ● The concept of "Counterparting" needs in-depth evaluation. The idea of working closely with counterparts relies on the quality of individuals. For example, the Nutrition Fare Coordinator was identified as "the principal project counterpart for health education as his remit is expressly for health education" (Quarterly Report Oct 1-Dec 31 1994, p.4). The Coordinator, despite attending initial health education training and accompanying project staff on early tours, appeared to distance himself from the project from around October 1994. The project staff had little further input into his health education training from this point forward. 	<ul style="list-style-type: none"> ● Over-reliance on counterparting, particularly with only a few district level individuals, reduces the channels through which projects such as this can influence the health of families. The implementation of two indirect strategies (health education and management training) through a small, under-resourced, poorly supervised district team is unlikely to improve the quality of health services unless staffing levels, finance, and administrative abilities are sufficient. ● District level staff must be involved in project design and hold positions within any project management committees. ● Future projects must have contingencies in place if project success depends upon the managerial abilities of individual people. Because FSP has no clear liaison relationship with the DoH to address issues of uncooperative district staff, this liaison must be established before project begins

MANAGEMENT CONSTRAINTS	ISSUES ARISING	LESSONS LEARNT
<p>The concept of “Supervision” and “Decentralization” of supervisory roles placed time-consuming and socially unfamiliar burdens on some sub-centre nurses.</p>	<ul style="list-style-type: none"> Decentralization placed the onus to supervise dispensaries and Aid Post Workers on sub-centre nurses. For some sub-centre nurses, such supervision became a major problem. A visit to a sub-centre by the FSP Health Educator in November 1994 reveals: <p><i>“[The sub-centre nurse] has to some extent been involved in supervising dispensary staff in the [local] area. He does see this as part of his work, but encounters some resistance from dispensary nurses to take his advice seriously. There could be a number of possible reasons for this: dispensary staff are set in their ways, there is inadequate support from District staff for the [sub-centre nurse’s] supervisory activities, the [sub-centre nurse’s] supervisory skills need updating. Clearly, the fact that this [nurse] is alone at the health centre is a major block to him developing his work and skills in supervision... He has tried discussing [clinical issues] with [one dispensary nurse] but the nurse showed little interest in his advice”</i> (Report Of a Health Centre visit 04/11/94).</p> 	<ul style="list-style-type: none"> In general, the concept of “supervision” may be culturally inappropriate. Formal supervision in a socially hierarchical system such as Vanuatu requires diplomacy and appreciation of social status rather than acknowledgment of public service position. In some instances, the strike has placed young, relatively inexperienced staff in positions of authority requiring them to supervise older, more experienced colleagues. In such circumstances, the role of “supervisor” becomes socially unacceptable and administratively untenable. “Support” and “motivation” may be better terms to use than “supervision”.
<p>The non-use of Checklists.</p>	<ul style="list-style-type: none"> The checklists developed by FSP in this project were viewed positively by some health staff, but confusion was created with the production of too many checklists alongside pre-existing national checklist guidelines and the Northern District Hospital’s own checklists. Added to this perception is the stark reality that very few supervisory tours or rural nurses were conducted by the RHO. A Family Planning counselling checklist was also developed in response to the lack of a standardized guideline within the health service. The development of the checklist appeared to be rushed and ad hoc. Before assessing the impact of counselling training the project needed to find out what pre-training counselling skills nurses had. 	<ul style="list-style-type: none"> The results of checklists were not used for follow-up. Many recommendations simply remained written observations rather than priority needs that had to be addressed. The use of regimented checklists has become a much favoured supervisory tool because it conveniently bypasses the inefficiencies of human communication. However, one-to-one follow-up and discussion appear to be the more favoured form of staff interaction in Sanma. Combining such an approach on a monthly basis with quarterly monitoring using one clear, simple checklist may be more productive than simply relying on a standardized, written supervisory system.

MANAGEMENT CONSTRAINTS

ISSUES ARISING

LESSONS LEARNT

<p>Unproductive use of H forms.</p>	<ul style="list-style-type: none"> Over the project's lifetime completion and returns of H forms to the RHQ has improved. At S's HIS data led the forms were not returned. This first fuel camp, in the Annual Report of 1994, progress in the utilization of forms was set for the year. "Monthly returns are critical data and HIS were few with less than 30% of the forms being returned. The health facility as a whole, with the implementation of the camp, the use of forms was improved from the New Year and the information was in circulation and they were the exercise was poorly planned. Of six health centres in Tiamalun - is performance an acceptable standard." With the introduction of radios, but, around a project vehicle enabled one of the follow-up to be commenced towards the end of 1995. The increased frequency of contact between Lugayville and rural centres was the responsible for increasing the number of returns. The total number of clinics, however, remained below 10. 	<ul style="list-style-type: none"> Improved radio communication and the vital provision of transport to allow more regular supervision was increased the return of HIS for IS but the application of such information still remains weak. HIS should be perceived as "information for Action!" rather than information for information's sake.
<p>Levels of EPI monitoring and management.</p>	<ul style="list-style-type: none"> The EPI graph is useful for the monitoring of the progress of the various components of the program. The graph shows that the team has been able to maintain a high level of coverage and that the number of children were fully immunized. 	<ul style="list-style-type: none"> Further training and on-the-job instruction is required if the PI gap is to be useful as a decision-making tool at the clinic level.

MANAGEMENT CONSTRAINTS	ISSUES ARISING	LESSONS LEARNT
<p>The three Child Survival Projects in Vanuatu overtopped ● The second and third projects began before final evaluations had been conducted on the first project ●</p>	<ul style="list-style-type: none"> • There was no clear period of time after one project ended and another one began to allow thorough evaluation and review of the sustainability and impact of inputs and outputs. There was thus no comprehensive follow-through on recommendations made during evaluations of previous projects. • Objectives for the Santo project were only finalized two thirds of the way through the project. Project staff remained unclear as to what priority areas they should address and what targets had been achieved. 	<ul style="list-style-type: none"> • Sufficient “lead-in time” for projects (how much time is required for examining the feasibility and budgeting of the project proposal before the project actually begins) needs to be given careful consideration. NGOs, donors and government departments must agree to a formal timetable that allows results from current projects with similar inputs and outputs to be examined before commencing with “more of the same”. • With the benefit of hindsight, it appears recommendations from evaluations were often too little, too indirect, and too late.
<p>Two major donors with 50% matched funding.</p>	<ul style="list-style-type: none"> • Funding by two donors caused budgetary difficulties and delays: 3 separate budget forms were required (one for FSP, one for USAID, and one for ODA). Both donors had different end-points to financial years. The overall budget-line was unclear (the spread-sheet format of budget record forms changed 5 times during project). 	<ul style="list-style-type: none"> • If a project has multiple donors, the budgeting system must use easily transferable and transparent accounting methods ●

5.2. HEALTH MANAGMENT AND TRAINING

MANAGEMENT CONCEPTS • INTS	ISSUES ARISING	LESSONS LEARNED
<p>Donor driven imperatives to commence project on time despite national strike.</p>	<ul style="list-style-type: none"> • Often pushed the project into almost irreconcilable positions with the government e.g. baseline KPC survey employed strikers. • Efficient planning and monitoring systems were not established due to the need to speed up implementation. Important baseline data was not collected (e.g. survey of nurses' needs and current levels of knowledge). 	<ul style="list-style-type: none"> • The project should have been delayed or even transferred to another province. Donors were too insistent on the completion of DIPs and Project Profiles and evidence that work was underway. The Profile had to be changed during the project as a result (creating more confusion). It was the wrong project, in the wrong place, at the wrong time.
<p>Donor specified which inputs and project activities they would fund.</p>	<ul style="list-style-type: none"> • Project activities scheduled to take place at specific times during the project rarely did so. Activities were either brought forward, delayed or cancelled according to which donor was supporting which activity. • Monitoring of the project's progress became complicated and imprecise. 	<ul style="list-style-type: none"> • Some activities were rushed, others postponed, and a few were cancelled in order to fit within the budget-time requirements of donors who had specified what they would and would not fund. There was a 4,500,000 vatu (£25,000) underspent by the end of the project. Projects with multiple donors must have realistic timetables (including contingencies) so that money is spent correctly. Donors could afford to be more flexible with the transfer of funds. Field activities cannot always be carried out according to ideal timelines: cyclones, strikes, and non-cooperative staff, for example, undermine these schedules.

MANAGEMENT CONSTRAINTS	ISSUES ARISING	LESSONS LEARNT
<p>There were weak management links between DoH (Vila) and RHO (bu%&nde) ●</p>	<ul style="list-style-type: none"> • The DoH Preventive Officer post has remained vacant since the strike ● This has meant that no supervisory link exists between the DoH and RHO in Luganville. 	<ul style="list-style-type: none"> • District Supervisors must be guided by the DoH Preventive Officer (this position must be filled) and would benefit from meeting annually with other District Supervisors.
<p>There were weak management links between FSP (Vila) and FSP (Luganville).</p>	<ul style="list-style-type: none"> • Funding requests from the field staff in Luganville were not always responded to promptly and records were not explained fully adding to their confusion. • Almost constant staff changes at all levels may have weakened the management of the project. At government level, the Director of Health post (left vacant after the strike) was at last filled in June 1994 (yet another Director of Health was appointed in October 1996). A new Project Manager arrived on site in July 1994 when the previous manager moved to FSP head office to become FSP/Vanuatu's Health Project Adviser. Towards the end of November 1994 changes also occurred in the staffing of the USAID and ODA regional aid offices (in charge of funding and monitoring the project) resulting in new advisers with different perspectives taking over from their predecessors and altering the objectives of the project. In March 1995 a new FSP Project Adviser was appointed requiring him to become quickly acquainted with the project's aims and strategies. In August 1995, a new FSP/Regional Health Coordinator was appointed and she too had to undergo a rapid process of project familiarization. 	<ul style="list-style-type: none"> • It cannot be confirmed that various staff changes at project, national, regional and international levels had a negative influence on the project's implementation. However, the need for new personnel to quickly familiarize themselves with the project's objectives (which were not finalized until September 1995) may have led to some of the fundamental problems confronting the project (e.g. lack of counterpart cooperation) to be overlooked. The fact that the objectives were changed 5 times after the original proposal was submitted to Vanuatu in 1992, might also suggest that such adjustments, while contributing to the theoretical refinement of the project's profile, did not address the basic logistical and cultural constraints the project was facing. Many of these constraints and the lessons that have been learnt during the three years of the project have been outlined in this evaluation.

6. ACHIEVEMENTS OF THE PROJECT

6.1 Summary of health education project achievements

- **High quality IEC materials:** the production of FP posters, counselling guidelines and a field tested flipchart are concrete achievements which hopefully will be widely used throughout Vanuatu in years to come. The materials meet objective criteria for quality as defined in the project proposal. Field testing of new materials and evaluation of existing materials should be integral and mandatory parts of IEC materials production. Sustainability of this project achievement depends on linkages with the Health Promotion Unit (DoH), other NGOs and continuation of the National IEC Committee.
- **Health education sessions and campaigns:** it is not possible to measure the increase in health education sessions conducted by nurses. Limited interviews suggest that nurses and CHEs feel more comfortable with counselling and 1: 1 health education. Group talks confront more personal and cultural barriers and there is little evidence of their being independently practised after training courses. Health campaigns, on AIDS in 1994 and Breastfeeding in 1995 were conducted and also used theater, T shirts and radio promotion in Luganville. These social marketing approaches are relatively new to provincial services but should be expanded upon in the future.
- **Counterparts health education skills:** a cadre of 72 Community Health Educators has been trained and a further 21 Village Health Workers and Nurses attended one week training. This is an impressive achievement particularly given training did not start until May 1995. One-to-one follow up of CHEs was conducted and health talks given by them under supervision. However, without further training and follow-up, which was difficult to accomplish in the remaining part of the project except for the Luganville CHEs, it appears that subsequent activity by CHEs was not high. Personal and cultural barriers to public health talks need to be considered very carefully in future. Regular follow up and involvement of CHEs by Provincial Health Services staff will be required if they are to remain active in the future. It is not possible to draw conclusions about changes in nurses' and VHWs' health education skills since no monitoring was done and no health talks were witnessed. The limited staff-client interchange observed during an MCH clinic and two immunization procedures, were characterized by "rituals of silence" with little verbal interchange between practitioner and clients.
- **Links between other projects:** there has been an active effort to link the health education training component to other projects (in Tanna), NGOs (SCFA and VRDTCA) and DoH (Health promotion Unit). Sustainability of training activities was thus enhanced but active steps need to be taken to ensure that materials developed by the project are widely available and used by other NGOs and DoH.

The Health Education component was the most dynamic and successful part of the project. This was in due part to the excellent personal and communication skills of the VSO Educator, Jolyon Rose, who like the Project Manager, Augustine Bule, must be commended for completing a project under extraordinarily difficult circumstances. However, the absence of a Primary Health Coordinator (in common with other provinces) weakened the sustainability of the HE component since there is no identifiable counterpart responsible for sustaining training activities and follow up of CHEs and health staff.

6.2 Summary of quantitative indicator achievements

- Urban breastfeeding: no significant change detected.
- Breastfeeding after birth: no significant change detected.
- Neonatal tetanus: not achieved.
- Contraceptive use: no significant change detected.
- Diarrhoeal disease: no significant change detected.
- Growth monitoring: **weighing of children in the previous 4 months increased.**
- Fully immunized children: **no significant change in FIC but significant drop in 8/11 antigens.**
- Acute Respiratory Infection: data not available for 1995/6.
- Family planning counselling: not possible to observe FP counselling and no monitoring measurements are available.

As outlined in the Project Framework summary (see Section 3. - Purpose) and discussed in 4.1, only growth monitoring and fully immunized children in the list of quantitative indicators of achievements are considered by the team to be reasonably valid and reliable indicators.

6.3 Summary of health program management achievements (see also Annex 1 for details of time-line)

- **Staff and management meetings:** 33% achievement, dogged by cancellation and non cooperation by the PHS. There were no meetings in 1996.
- **Supervision checklists:** there is no evidence of their systematic use.
- **HIS returns from clinics and dispensaries:** the 80% target was achieved in 1996. However there is no evidence to indicate critical monitoring of programs, particularly EPI and FP, either by project staff or DoH counterparts. Added to the weakness and delays in feedback from the national level, the provincial health services operate without essential data for action.
- **EPI graphs:** 5/11 clinics keep graphs and only 1/3 graphs were properly kept. The project manager has tried very hard to teach and reinforce this but there are formidable problems in teaching graphing and arithmetical skills to older staff or those with lower levels of education.

- **Drug supplies:** stock level targets appear from reports to be have been achieved but it is not clear what the objective levels were. Shortages of contraceptives and depo-provera in particular are reported to have been common during the project.
- **Mobile clinics:** the mobile program was severely affected by lack of transport and staff in rural clinics. The project vehicle was not used with counterparts and a decentralized mobile program by each sub-centre was very inconsistent. The provision of a canoe and OBM to Malau H.C. has enabled mobile work in Big Bay to go ahead but this is limited by lack of caretaker staff for the nurse practitioner.
- **Cold chain stock for outreach:** the intermittent immunization strategy means that vaccine stocks for outreach were only available every two months. Immunization is in general only carried out in the vicinity of the sub-centre. Almost none of the DIP objectives for immunization were carried out.
- **Health management training:** there was considerable under-achievement (33%) of counterpart training workshops and 1: 1 training of RHO counterparts due to lack of contact.
- **Provision of radios:** the provision of radios was a much heralded part of the program and provided much needed help in a critical area of communication and support of some clinics. However the effect was sadly diluted by the duplication of radio installations at Tasmalum, Motalava, and Nokuku by other radios - further evidence of the degree of mismanagement of scarce resources within the province.
- **Conduct of KPC surveys:** Despite the Teams' reservations about both the validity of such surveys and utility in providing baseline data on health beliefs and behaviors, FSP is to be commended for both the training and conduct of the 1994 and 1996 surveys. Analysis of data still requires assistance from outside of FSP. In future, if Coverage surveys are to be used to measure such indicators as EPI coverage or to collect growth monitoring data, assistance on sample design and analysis can be sought in-country from the Department of Health Statistics Unit. Combined with qualitative techniques such as Focus Group Discussions and In-depth Interviews, Coverage surveys will strengthen FSP's (and other NGOs and government departments) abilities to create baseline data upon which more culturally appropriate health interventions can be designed and against which more reliable post-intervention impact assessments can be made.

In summary, in spite of the best efforts of individuals and some promising developments (e.g. survey training), the management training component of the project has met with very limited success, particularly at provincial level.

6.4 Quality of health services viewed through EPI

The Expanded Program of Immunization (EPI) is a major component of child survival and provides objective insight into health management capacities such as logistics, organization, training, and monitoring. These aspects are critical elements of other child survival strategies (e.g. family planning). EPI has more objective indicators than other health programs and was used as the focus of inquiry to assess the quality of health services. The drop in immunization coverage between the baseline and endline surveys (see reflect significant problems in EPI in Sanma and Torba provinces.

Serious deficits were detected which have not been resolved by the project or provincial health services with which the project was supposed to interface. Problems include:

- **Poor immunization coverage**
- **Inappropriate immunization strategies, including outreach**
- **Unsafe vaccine cold chain management and practices**
- **Insufficient staff and knowledge of basic EPI good practice**

More details on quality of EPI are shown in Annex 2.

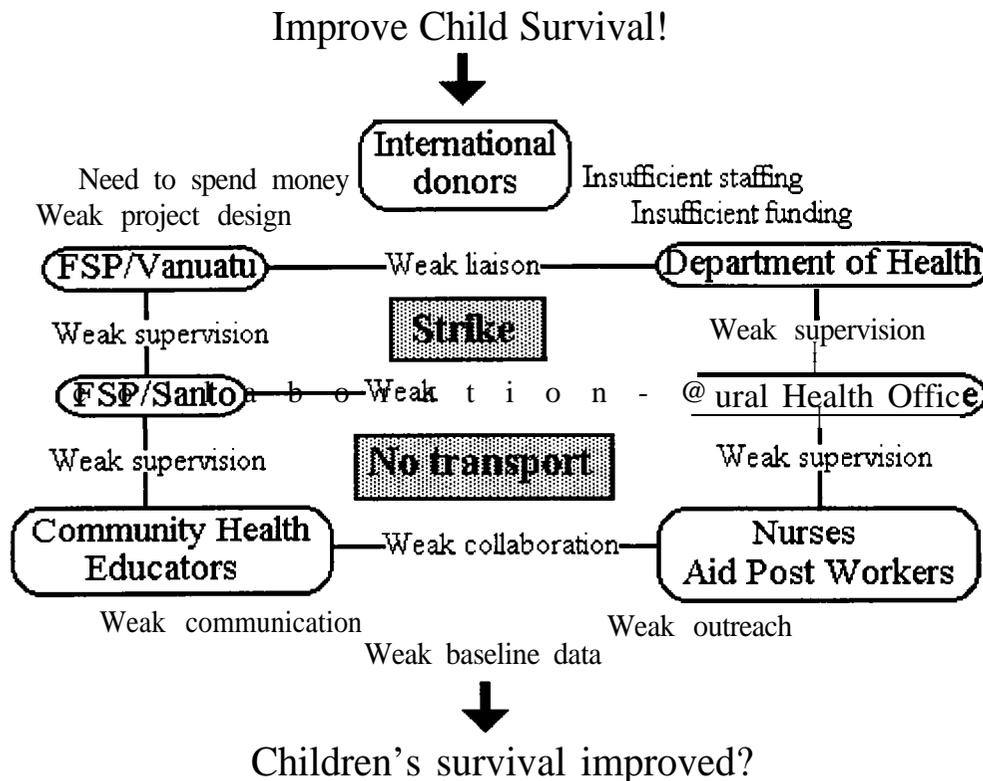
Other health service programs are more difficult to measure objectively and were not examined in depth but it is probable that a similar lack of progress in quality of health services would be revealed. The Family Health Project was never able to achieve the degree of counterpart cooperation to effect change in the operations of the Rural Health Office. The standard of provincial staff brought into the RHO after the strike was probably not of equivalent calibre to the staff involved in the original project design. Most of the new staff had much less experience and training to perform their duties. The picture which emerges from the evaluation is one of a decline in quality of health services in Sanma Province which the project was unable to arrest. At clinic level, one-to-one training during supervisory visits by project staff was generally conducted in isolation from counterparts. There is no evidence of systematic training which might improve quality of services but the visits of project staff, contacts at office level and radio communication probably had a positive effect in terms of staff motivation and performance. However without a similar degree of support by counterparts, the motivational effects were diluted and inherently unsustainable.

6.5 Project Achievements in relation to constraints

- Figure 1 is a diagrammatic representation of the connections between some of the main issues and determinants of Child Survival IX (Vanuatu). Any outputs and impacts the project managed to achieve were remarkable given the difficult circumstances in which the project was launched and subsequently had to operate.
- The international agenda to “Improve Child Survival!” in developing nations of the Pacific has created interdependent linkages between donors, governments, and NGOs.
- Insufficient staffing and funding within the Department of Health has meant that the government must turn to NGOs for extra human resources and international agencies for financial support.
- Donor imperatives to spend funding dictated the pace of activities throughout this project’s lifetime.
- Achieving direct impact using the two indirect strategies of health education training and management training relied upon close collaboration between project staff and counterparts. In just a few, critical positions with the Rural Health Office, this collaboration was not forthcoming. As a result, a major weakness in the project

design was revealed by a major weakness in the relationships between project and district teams.

Figure 1: The main issues and determinants of Child Survival IX (Vanuatu)



- The project was implemented at a time when the health service was in crisis. The national strike removed many of the well-qualified staff whose positions were not to be filled until late 1994 (in some cases well into 1995). A few posts still remain vacant. As a result, weak management links existed between the Department and Rural Health Office. These weaknesses were mirrored within the management of FSP caused by regular staff changes that required new personnel to become quickly acquainted with the project profile, which itself changed in composition 5 times over 3 years after the initial concept paper.
- Weak supervisory links were further exacerbated by a lack of transport which, when finally addressed, only aggravated staff/counterpart relationships. Outreach services were limited by the lack of support from district level and the lack of available staff to assist over-burdened sub-centre nurses. Lack of regular follow-up and support of the cadre community health workers (over 70) left many floundering within communities reluctant to heed the advice of CHEs especially those who were young, unmarried school leavers.
- A major part of the project's baseline data to improve health education was to be collected by a consultant anthropologist. While the corresponding Child Survival project in Kiribati usefully deployed anthropological expertise in the design of IEC, the Vanuatu project did not make use of extensive qualitative research. The lack of

qualitative research further hindered the ability of project health education outputs and activities to target audiences with culturally meaningful messages. What research was conducted was innovative but limited in scope (6 family planning posters were produced; no work on nutrition was redesigned on the basis of qualitative data). Important baseline data on nurses' needs and counterpart management skills was either not collected or not systematically recorded, which left the assessment and monitoring of progress against baseline information almost impossible.

- Many lessons have been learnt from this project (see Section 5). Constraints have rarely been overcome because circumstances beyond the control of the project staff have limited their abilities to change or adapt to difficult situations. This evaluation has pinpointed areas of weakness in both the management of health services (which the project intended to improve) and the design features of the project itself. The following section outlines recommendations that may improve both of these important areas and may assist future health activities in Sanma Province, future health projects organized by FSP, and for future assessments and evaluations used in the development of Vanuatu health services and policies.

7.1 RECOMMENDATIONS FOR HEALTH MANAGEMENT AND EDUCATION

PRIORITY RANKING	TIME FRAME: SHORT-TERM (within 6 months)	MEDIUM TERM (within 1 year)	LONG-TERM (within 3 years)
VERY HIGH PRIORITY	<ul style="list-style-type: none"> • Collaboration essential for effective provincial health services • Restore EPI with catch-up campaign (contingency plans in place) • Address staffing needs in Sanma: PHC coordinator & qualified nurses • Address transport needs in Sanma (DOH truck to Sanma dedicated to MCH) • Use social marketing to mobilize EPI (drama, churches, Community Health Educators, Family Planning Agents, mass media) • Monthly and quarterly review of diseases, health service activities and coverage (including FP) • Move duplicated radios in Sanma to areas of greatest need (Provincial Government to assist with access) 	<ul style="list-style-type: none"> • Effective District management especially MCH Program • EPI recovery (80% coverage) • Increase quantity and quality of Northern District staff • Dedicated MCH/PHC truck in Sanma Link EPI into other Child Survival strategies • "Supervision" needs to be redefined: support/motivation • Training must have regular follow-up • HIS becomes "information for action" • Clinics linked by radio network 	<ul style="list-style-type: none"> • Regular in-service management refreshers and DHS meetings • EPI sustained at 80% • In-service refreshers for all nurses • Transport budgets maintained and misuse of vehicles addressed • Comprehensive CS strategy in place • Professional social marketing/health promotion approach to health
HIGH PRIORITY	<ul style="list-style-type: none"> • Address supervision needs: NGO to project managers, DOH to District level staff • Use CHEs within campaign • HIS information training • Planning for more radio linkages 	<ul style="list-style-type: none"> • Donors reconsider their role in micromanagement of projects • FSP creates clear lines of liaison with DOH • Flip chart on family planning is designed and used to community groups 	<ul style="list-style-type: none"> • All IEC design and messages become uniformed - be consistent
MEDIUM PRIORITY	<ul style="list-style-type: none"> • FSP improves links with DOH • IEC material provided to CHEs • Flip-chart on family planning designed 	<ul style="list-style-type: none"> • IEC review committee continues but links with drama, mass media, schools 	

7.2 RECOMMENDATIONS FOR PROJECT DESIGN AND IMPLEMENTATION

PRIORITY RANKING	TIME FRAME: SHORT-TERM (within 6 months)	MEDIUM TERM (within 1 year)	LONG-TERM (within 3 years)
VERY HIGH PRIORITY	<ul style="list-style-type: none"> Address problem of lead-in times for projects (project overlap, final recommendations come too late) Discontinue KP methodology Qualitative information gathering and analysis training for FSP staff and trialed in Tanna 	<ul style="list-style-type: none"> Use combination of qualitative and quantitative approaches to gather baseline, midline and endline data, e.g. Coverage surveys and Focus Group Discussions FSP improves project design NGOs estimate budgetary requirements of post-project activities Review feasibility of Community Health Educator approach FSP reviews its main strategies: Training of Trainers, Cascading, Counterparting 	<ul style="list-style-type: none"> DOH requests projects that fit within development plans and budgetary capacities
HIGH PRIORITY	<ul style="list-style-type: none"> Review project design and evaluation (FSP) Review project screening (DOH) Review project consultation and MOUs (DOH/FSP) 	<ul style="list-style-type: none"> Regular (every 6 months) review of projects by DOH/NGOs Donors reconsider their frameworks DOH begins budgeting for post project activities 	<ul style="list-style-type: none"> Donors/NGOs coordinate 5 year funding cycles: <ul style="list-style-type: none"> 1st year "listening year" to gather baseline data and plan activities 2nd-4th years "implementation of activities" 5th year "handing over" activities Projects receive final evaluation 1 or 2 years after funding finishes (external financial auditing included) i.e. 7th year.

Appendix 1. Evaluation team members

Name	Title	Organization
Elison Sese Bovu	Health Adviser	FSP
Christopher Chevalier	Project Manager	Choiseul Community Health Project, Solomon Islands
Will Parks	Medical anthropologist	Tropical Health Doctoral Fellow, University of Queensland
Leo Rihu	SEPHA Provincial Health Supervisor	Department of Health

Appendix 2 : List of persons interviewed during final evaluation

Name	Title	Organization
Karen Preston	Country Director	FSP
Selena Haggai	Family Health Educator	FSP
Elison Sese Bovu	Health Adviser	FSP
Lisa Mauro-Bracken	Regional Advisor	FSP
Jean Jacques Rory	Health Education Officer	DoH
Valentine Ronalea	National FP Coodinator	DoH
Aniset Male	National EPI Coordinator	DoH
Gabre Haile Kenso	UN Volunteer	DoH
Gideon Mae1	Principal Health Planner	DoH
Winnie Yakam	Former EPI Coordinator	telephone contact
M. Blondine Bulekon	Executive Director	Vanuatu Family Health A.
Rod Menere	Program Manager	Save the Children Fund
Stephanie Grivell	Reproductive Health Adv.	Save the Children Fund
Alex Harper	ODA Aid Attach&	Aid Management Office
David Fidler	ODA Aid Attache	Aid Management Office
Yoan Bororoa	Prov. Health Supervisor	Northern District
Dr Timothy Vikor	Medical Superintendent	Northern District Hospital
Rachel Kalmos	Matron	Northern District Hospital
Margaret Lui	Pharmacist	Northern District Hospital
Leone Boe	Nutrition Fare Educator	Northern District Hospital
Kasimir Liwuslili	MCH Coordinator	RHO, Northern District
Cherry	Nutrition Fare	RHO, Northern District
Keith Kasi	Environmental Health	RHO, Northern District
Vira Mele	Provincial Planner	Sanma Provincial Govt.
Andrew Ala	Health Inspector	Municipal Council
Augustine Bule	Project Manager	FSP, Santo FH Project
Jolyon Rose	VSO Health Educator	FSP, Santo FH Project
Isak Avok	Nurse Practitioner	Malau Health Centre
Mary Sur	Nurse	Municipal Dispensary
Jean Rapti	Nurse	Tasmalum Health Centre
Vululu Lesley	Nurse	Vules Epe
Polycarp Tapi	Nurse	Fanafo Dispensary
William	Chairman	Fanafo Dispensary Cttee
Janet Fred	Nurse	KPC Interviewer
Pilau Ates	Nurse	KPC Interviewer
Russell Olue	Dental Assistant	KPC Interviewer
6 women	Community members	Nasulesule village
2 women	MCH clients	Tasmalum H. Centre
3 women	MCH clients	Hospital MCH Clinic
3 CHEs	Community Health	Luganville
6 CHEs	Educators	Big Bay, Araki, S.Santo, Fanafo

Appendix 3: List of participants at the presentation of the findings of the final evaluation of the Santo Family Health Project, 12/12/96

Name	Title	Organization
Selina Haggai	Family Health Educator	FSP
Karen Preston	Director	FSP
Lisa Mauro-Bracken	Regional Health	FSPI
Melody Avok	Coordinator	World Vision
Haile G. Kenso	Secretary	EPI Unit, DoH
Maleb Anicet	United Nations Volunteer	EPI Unit, DoH
Myriam Abel	National EPI Coordinator	Community Health, DoH
Theto Winnie Moses	Principal Officer	DoH
Adeline Wilin	Nat. Nutrition Coordinator	VCNE, DoH
Neil S Nefoy	Principal Nurse Educator	VANGO
Jean Jacques Rory	Coordinator	DoH
LeonardsTiabilip	Health Education Officer	DoH
David J Fidler	MCH Coordinator	ODA
Nick Duggin	Aid Management Attache	ODA
Stanley Womack	Administrative Assistant	FSP
Daniel Kalorib	Environment Coordinator	DoH
Jameson Mokoroe	Director of Health	DoH
Helsie Timatso	Senior Accountant	DoH
Elison Sese Bovu	Principal Nursing Officer	FSP
Will Parks	Evaluation team member	University of Queensland
Leo Rihu	Evaluation team member	SHEFA Province
Chris Chevalier	Evaluation team member	Choiseul Community Health Project, Solomon Islands

Appendix 4: List of documents reviewed during evaluation.

Development Planning Procedures 1982 (National Planning and Statistic: Min.H)
First National Health Development Plan 1992-1996 (Health Planning Unit: Min.H)
Child Survival IX Country Submission Proposal 1992
Mid-term Evaluation Child Survival V 1992
Annual Report Child Survival V 1993
Final Evaluation Child Survival V 1993
Rapport Statistique Statistical Report 1993
Detailed Implementation Plan 1994
Technical Reviews of Child Survival IX 1994 (n=2)
USAID Project Child Survival Questionnaire 1994
Baseline Assessment Report Child Survival IX 1994
A Review of the VHW Program 1995 (SCFA: Port Vila)
Project Profiles 1994-1995 (n=5)
Monthly Reports, FSP Project Office 1994-1996 (n=16) (not all Reports were written)
Quarterly Reports 1994-1996 (n=6 some reports not written)
Annual Report 1994 (no Annual Report for 1995)
Progress Report for Sanma, Ambrym and Tafea 1994
Mid-Term Evaluation Child Survival IX 1995 (Vanuatu)
Mid-Term Report of Progress against ODA Project Profile 1995
Report of Field Testing of Health Education Flip-Chart 1996
Semi-Annual Report 1996
Final Evaluation Child Survival IX 1996 (Kiribati)
Minutes of Executive Committee Meetings (n=6)
Minutes of Staff Meetings (n=3)
Trip Reports to Sub-Centres and Dispensaries (n=1 1)
FSP Head Office Trip Reports to Santo (n=2)
Trip Report to Solomon Islands 1994
Tour Report of Sanma Province by National Staff 1996
Child Survival IX Workshop Reports (n=1 1)
Review of IEC materials produced: posters, flip-charts, “Kof” Booklet, Health Education Lesson Guideline, Family Planning Counselling Guideline, booklets (produced by the National Health Education Unit and SCFA)
Faxes, memorandums, letters, manuscripts (various)

Time-Line of Main Activities and Outputs of Santo Family Health Project December 1992 - September 1994

ACTIVITY/ OUTPUT	Dec/92	Sep/93	Oct/93	Nov/93	Dec/93	Jan/94	Feb/94	Mar/94	Apr/94	May/94	Jun/ 94	Jul/94	Aug/94	Sep/94
Workshops													Santo/ Tanna DH Staff TOT	
Follow-Ups/ Hours*										EP/Dental tour with NZ army Malaio/Port Only Visit				
Santo-based Meetings												1st Ex Com meeting		2nd Ex Com meeting
Vila-based Meetings														
Project Reports & other documents	Country Submission by FSP	Original project profile submitted to RHO					1st and 2nd ¼ Reports	ODA FRWK 1 Minutes of DoH/ FSP meeting	ODA FRWK 2 DIP to USAID	EP/Dental Tour Report Hand-written report of Malaio and Port Only visit		Minutes of 1st Ex Com	TOT Report	Minutes of 2nd Ex Com
Other events		MOU draft	FSP PM on site	NS National Strike PM on leave	PM on leave	PM on leave		VSO Health Educator on site	DIP NEEDED BY USAID	MOU draft	New DIR DOH	New PM	NT No transport MOU draft	USAID Review of DIP RHO staff in place

*Many hours and one-to-one supervisions with rural nursing staff visiting the FSP office in Lijapaville are not accounted for.

Abbreviations: **LY:** ¼ Quarterly; **Ann Rep:** Annual Report; **AP:** Aid Post; **BE:** Breastfeeding; **CHES:** Community Health Educators; **DE:** District Health; **DHS:** District Health Supervisor; **DIE:** Detailed Implementation Plan; **DIR:** Dir. Director of Department of Health; **DofH:** Department of Health; **EWK:**

name work;

SPE: FSP Implementation; **HE:** Health Education; **KPC:** Knowledge, Practices and Coverage; **MCHS:** Maternal/Child Health Supervisor; **MOU:** Memorandum of Understanding; **NS:** National Strike; **NT:** no transport first mentioned in reports as creating problems; **PA:** Project Advisor; **PM:** Project

Manager;

RE: Report; **RHA:** Regional Health Advisor; **RHO:** Rural Health Officer; **SHS:** Section Head; **TOT:** Training of Trainers; **VRDICA:** Vanuatu Rural Development Training Centres Association

Time-Line of Main Activities and Outputs of Santo Family Health Project October 1994 - October 1995

ACTIVITY/ OUTPUT	Oct/94	Nov/94	Dec/94	Jan/95	Feb/95	Mar/95	Apr/95	May/95	Jun/95	Jul/95	Aug/95	Sep/95	Oct/95
Workshops	1 day HE for S Heads	1 day HE for S Heads	2 days HE for S Heads	VRDTCA Curriculum	Field-test FP posters	ARI/EPI/ HIS Santo & Torba HE for Nut.Fare	Vila-based FP workshop		CHE urban TBA national	Breastfeedin g Promotion Campaign Mid-Term Evaluation			CHE South Santo
Follow-Ups/ Hours*	Port Orly	Tasarik i/Malao		Sulemauri West Coast (W.Coast)	Fanafo West Coast MCH			SEA Middle Bush 6PI		Follow-up of CHES urban	South Santo Waiapa Port Orly	Malao with PA	Follow-up of CHES South Santo
Santo-based meetings	3rd Ex Com meeting	4th Ex Com meeting			RHO/ FSP	RHO/ FSP		RHO/ FSP				5th Ex Com meeting	6th Ex Com meeting
Vila-based Meetings		FP meetin g										PA to MAL	
Project Reports & other documents	Monthly Report O B A FRWK 3	Monthly Report Ann Rep 1994 Trip Rep Malao Minutes of 3rd Ex Com Solomon Islands Report	Monthly Report S Heads HE Rep	Monthly Report VRDTCA Report Trip Rep W.Coast	Monthly Report O B A FRWK 4 Trip Rep W.Coast Minutes of RHO/ FSP meeting FP Field- test Rep	Monthly Report O B A FRWK 5 ARI/EPI/ HIS Report Minutes of RHO/ FSP meeting	Monthly Report		Monthly Report (May & June)	Mid-Term Evaluation Report BF Campaign Report	1/4 Report Apr-Jun 95 Trip Rep South Santo Waiapa Port Orly	Monthly Report O B A FRWK 6 Trip Rep Malao Minutes of 5th Ex Com Tour Report of Vila Staff	Monthly Report Minutes of 6th Ex Com CHE Report & Follow-Up Report South Santo
Other events	Visit by PA to Solomon Islands		Office opened			New PA	FSP staff computer training All d radios now installed		DHS & MCHS away	Independenc e Day Celebrations (BF Campaign)	Project Truck on site New IHA	New boat in Malao	

* In-v tours and one-to-one supervisions with rural nursing staff visiting the FSP office in Luganville are not accounted for.

Annex 1

Time-Line of Main Activities and Outputs of Santo Family Health Project November 1995 - December 1996

ACTIVITY/ OUTPUT	Nov/95	Dec/95	Jan/96	Feb/96	Mar/96	Apr/96	May/96	Jun/96	Jul/96	Aug/96	Sep/96	Oct/96	Nov/96	Dec/96
Workshops	AIDS awareness Luganville			1996 <i>Action Planning</i>	FP guide test FP training			CHEs W.Coast FP training	CHEs Big Bay	CHEs Malo/Aore KPC Training	CHEs MotaLava (Torba) KPC Training & Survey	CANCELLED CHEs Port Orly	CANCELLED CHEs Fanafo EPI (National) Workshop	Final Evaluatio n
Follow-Ups/ Tours*	2nd Follow- up of CHEs South Santo Avunatari Atariboe	Follow-up of urban CHEs	Fanafo Kona AP	Tasariki Sulemuari			Vules Epe Fanafo Port Orly Tasmalum		Follow-up of W.Coast & Big Bay CHEs		Follow-up of Malo CHEs No. Follow- up or MotaLava CHEs	Middle busb MCH	Vules Epe Tasmalum Fanafo MCH	
Santo-based Meetings	Vila staff tour Santo (2 days)						RHO/NGO on VHW Review							
Vila-based Meetings			FSP staff meeting											
Project Reports & other Documents	Monthly Report ¼ Rep Jul- Sep 95 Trip Rep Avunatari Atariboe MBS Workshop Report	Monthly Report	Monthly Report ¼ Report Oct-Dec 95 Trip Rep Fanafo Kona AP Field-tests for Flip- Chart begin	Action Planning Report Trip Rep Tasariki Sulemuari	FP guide test Report FP workshop Report Urban CHEs review		Monthly Report Trip Rep Vules Epe Fanafo Port Orly Tasmalum Minutes or RHO/NGO VHW review	Report on National Tour FP Workshop Report FSP Health Education Guide Book	Semi- Annual Report CHE Rep & Follow-Up Report W Coast & Big Bay	Monthly Report CHE Rep & Follow-Up Report Malo/Aore	Monthly Report CHE Report Malo/Aore KPC Training Report		EPI (National) Workshop Report Trip Rep Middle Bush & Vules Epe Tasmalum Fanafo MCH	Final Evaluation Report KPC Survey Report
Other events	MBS awareness week		DHS & MCHS return			FSP staff on leave		National Tour of Service Needs <i>ODA NEED BUDGET- LINE</i>	FSPI localization underway			New Acting Dir of DoH		HAND OVER

*Many tours and one-to-one supervisions with rural nursing staff visiting the FSP office in Luganville are not counted for

Annex 2. EPI problems identified in Sanma Province

● Immunization coverage

- the proportion of children immunized has been poor since 1993, before the project started (see below) and has not recovered since the strike.
- approximately 40-50% of children under 5 are not immunized against measles,
- hepatitis B coverage is extremely low (1996: 10-20%) due to vaccine shortages.
- graphs which monitor coverage levels are used in a minority of clinics and are not used for taking action.

● Strategies

- intermittent vaccination at health centres means that sub-centre areas are without vaccines for 50% of the time. Intermittent vaccination should not reduce the possibility of outreach work at dispensary level and below.
- the cold box strategy requires close monitoring of vaccines with monitor card and temperature charts, plus training of nurses in handling vaccines.
- communities in the middle bush are reached once or twice a year. There have been no immunizations in the middle bush above Tasmalum in 1996.
- catch up campaigns are urgently needed in Sanma and Torba Province. The last epidemic of measles was in 1984 which means a large cohort of susceptibles is now vulnerable to an outbreak.
- transport is a major deficit and handicaps reliable EPI delivery. The FSP project vehicle has not been used significantly for EPI. There is not a shortage of vehicles at Northern District Hospital but these do not seem to be considered available for rural outreach work.
- the MCH mobile team manages to find transport to go out 2-3 times a month, rather 2-3 times per week. Failure to conduct clinics and late arrival of the outreach team in villages reduce attendance by mothers. MCH and EPI mobile work needs to be given the highest priority in vehicle allocation.

● Vaccine cold chain

- evidence of improper storage and handling of live (BCG, measles and polio) and dead vaccines (DPT, Hep B, Tetanus Toxoid) at provincial and clinic level. Improper packing of cold box prior to one observation clinic visit possibly destroyed half the vaccines in the consignment.

- the cold box strategy to deliver vaccines to clinics and dispensaries without fridges is not properly monitored. Unmonitored and unmarked vaccines are returned to the provincial store. This is a potentially disastrous practice that will lead to failure of confidence in immunization in the event of an outbreak in immunized children.

- temperature monitoring at the provincial level and with cold boxes was not in evidence. Potency of vaccines cannot be assured.

- vaccine deliveries are sometimes not collected from the airport by MCH staff but rely on other individuals such as the Northern District Pharmacist..

• **Staff**

- Health management skills for EPI (monitoring coverage, strategic planning, cold chain management, ordering vaccines) at provincial level appear insufficient.

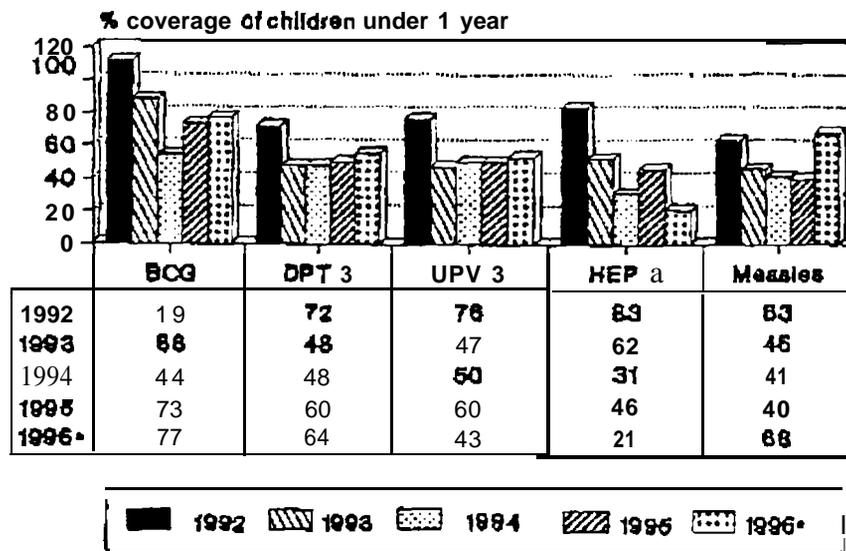
- some older nurses are reportedly untrained or unable to give immunizations.

- nurses are reluctant to leave their clinics to do outreach.

- despite on the job training, nurses show limited ability to use immunization coverage charts.

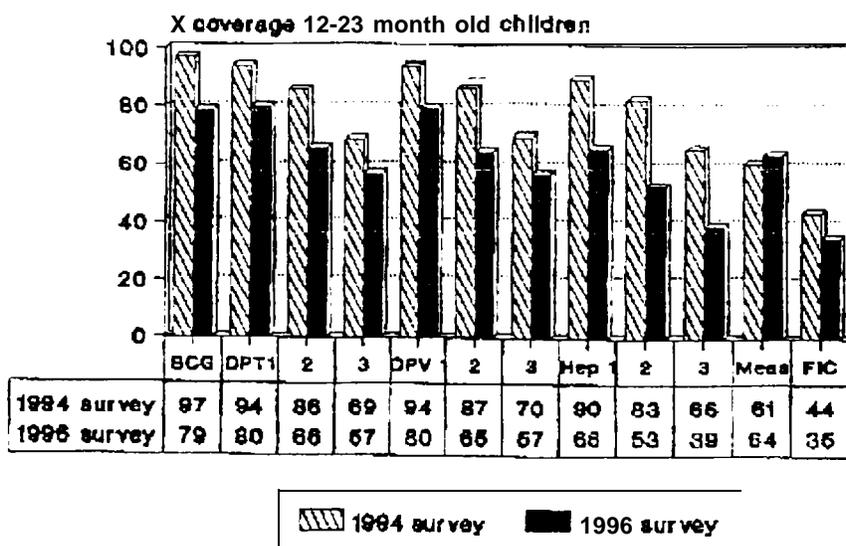
- knowledge of vaccine properties and handling requirements appears weak

**Fig.1 Reported EPI coverage 1992-96
Sanma and Torba Provinces**



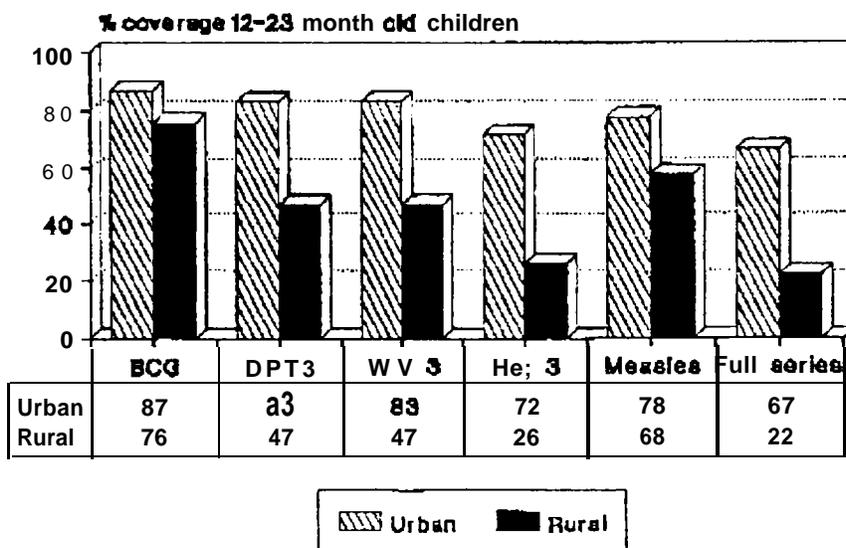
* Projected figure. HIS data, DaH

**Fig.2 Immunization coverage, Sanma
1994 & 1996 KPC surveys**



1994 n = 90; 1996 n = 151

**Fig 3. Immunization coverage. Sanma
Urban and rural, 1996 KPC survey**



Urban n = 40; rural n = 115

ANNEX 3: Community Health Education Workers Training participants 1995-6

CHEW Luganville

Date: May 1995.

Topics: family planning, nutrition, breastfeeding.

Trainers: Jo1 Rose, Marie Michelle Tsiabon, Jennifer Timothy.

Refresher workshops: July 1995 - one day - breastfeeding;

Nov 1995 - 2 days - Aids*.

One-to-one follow up: Nov\Dec 1995.

Name	Church	Lives
*Elizabeth Tavo	Anglican	Haos blong Bishop, kolosap long Abraham Gau kamuni
Helivson Tabi	Anglican	Tankara
*Nancy Kalran	Presbyterian	Saed river, kolosap long Bon Marche
*Angela Avia	Presbyterian	Sarakata, stret long Primary School
Paul Solomon	Seventh Day Adventist	Toman Island, Malecula
David Avoc	S.D.A.	Pepsi, kolosap long SDA ofis, mo Malo tu
Henry Boal	Catholic	Pump Station
Sondrine Sawan	Catholic	Solwei
Koilo Pisouvoke	Protestant	Natchara, South Santo
Kaleb Seth	Holiness Fellowship	Port Vila
*Glenis Wilkins	Assemblies of God	Mango Station
*Iris Hugai	Assemblies of God	Sarakata, klosap long AoG church
Lettine Ismael	S.D.A.	Malecula
Lilly Kaku	S.D.A.	Ambrym
Andre Paul	Protestant	
Elise Leo	Christian Outreach Centre	Port Vila

* Others who attended Aids workshop: Katleen Timothy (Maternity Ward), Jerry (Nutrition Fare), Helen Dempsey (NDH), Dominique Edmund (Outpatient Dept, NDH), Jonas (Natawa communtiy, Fanafo), Annie (Luganville Womens' Centre).

CHEW South Santo

Date: October 1995

Topics: nutrition, breastfeeding, hygiene, immunization, diarrhea and home treatment, worms, family planning, Aids.

Trainers: Jo1 Rose, Jean Rapti.

Follow up: One week after workshop. Rapti has some regular contact with these people.

Name	Village	Comments
Rose Veret	Tanovusvus	
Femele	Bakataura	Aid nurse at Tasmalum HC
Jonas	Bakataura	
Loli	Tanovusvus	
Andre	Ipayato	Aid nurse; now works at laboratory at hospital
Jules	Namoru	Aid nurse in aid post
Lolomar	Sarete	Not active
Wilson	Vimele	
Vevinano	Araki	Now works in kindergarten at Kamewa school, Luganville
Rose	Nasulesule	Active
Jorolyn	Vimele	
Jake	Araki	
Vevotsi	Tasiriki	
Koilo	Natchara	
Roselyn	Puama	
Jenis	Tasmalum	Aid nurse at Tasmalum HC

CHEW West Coast

Date: June 1996

Topics: family planning, malaria, cleanliness, nutrition, breastfeeding.

Trainers: Jo1 Rose, Jean Rapti, Peter Yunak.

Follow up: June 1996 - the week after the workshop. No follow up reported since then,

Name	Village	Comments
Samson Reken	Lajmole	
I Saniel Wola	Valpei	
Dickson John	Wunavai	Aid post worker
Matthew Jimmy	Penoru	
Buha Lanan	Wusi	active
Raoul Pakoa	Molboe	
Tony Boe	Rableba	
Matias Bal	Hokua	
Esrom Louis	Nogugu	1
Louise Obas	Wunpuku	
Ven Bulu	Vunon	
Peter Bosa	Oluoi	
Daniel Saul	Vaseleia	
Sirus Reken	Nogugu	
Ben Frank	Tasmate	

CHEW Big Bay

Dates: July 1996

Trainers: Jo1 Rose, Isac Avoc, Peter Yunak.

Topics: family planning, nutrition, breastfeeding, clean village, malaria.

Follow up: July 1996 - the week after the workshop. No follow up reported since then.

Name	Village	Comments
Nicole Ravoupey	Vusiroro	Aid post worker
Helen Mark	Winsau	
I S a m u e l	Malau	
Anna Aru	Malau	
Nicholas Pecharu	Perau	
Lele	Peavot	
Roman Luc	Lolomatalo, Pelvus	Aid post worker
Nixon Kath	Matantas	Aid post worker
Thomas Balo	Jereviu	Aid post worker
John Ravo	Mataloi	
William Raf	Tombet	Aid post worker
David Nago	Malovuku	
Jimmy Malon	Pesena	Staff nurse, Pesena dispensary

CHEW Malo

Date: August 1996

Trainers: Jo1 Rose, Jean Marie Vira, Nora Aka, Loline Tari.

Topics: family planning, malaria, clean village, cough, diarrhea, nutrition.

Follow up: Jean Marie and Loline did follow up the week after the course in August 1996, report of one follow up only received from Loline.

Name	Village	Comments
Vira Leo Bani	Avunatari	active, started program with other CHES in Malo
Carol Teening	Ataraboe	
Rita Vatar	Bueli, Tutuba	
Hem-v Vanua	Genesis Misen, Malo	Aid uost worker?
Jerry Lakao Bani	Randel, Malo	Aid post worker?
Roselyn Jacob	Siro Plantesen, Aore	
Adelina Pakoro	Ambilage, Malo	
James Surai	Bueli, Tutuba	
Silas Tamata	Avunatari	
Charley Mark	Aore	
Favlin Sammv	Amabelau. Malo	
Frank Alfred	Avunatari	
Meriam Simon	Naviaru, Malo	
Laisa Huri	Rata. Aore	

CHEW Torba

Date: October 1996

Trainers: Jean Rapti, Zebulon Moipitven

Topics: malaria, diarrhea, ARI, nutrition, family planning, breastfeeding.

Follow up: Ott' 1996 - the week after the workshop with communities in Mota Lava

Name	Village/Island	Comments
Aldrin Moltag	Mere Lava	
Grace Yowok	Totolag, Mota Lava	
Robert Pele	Loh, Torres	
Wendv Moinitven	Pemisas. Mota Lava	
Hamson Jeffrey	Toka, Torres	Aid post worker
Paul Lazarus	Gaua	
Daniel Tavoia	Rah Island	
Amstrone Singer	Telvet. Mota Lava	
Renold Dinilen	Ureparapara	
Alban Sakias	Vatrat, Vanua Lava	Aid post worker
Elizabeth Jack	Tasmate. Mere Lava	
Cevenaia Malvanavan	Vanua Lava	
Joseph Tamanwos	I Jreparapara	

ANNEX 4. 1996 KPC Survey Results and Report

INTRODUCTION

The KAP survey on family health was carried out in Santo as a follow up to the baseline survey conducted in 1994. Training for the survey was completed in a week (September 16-20, 1996), and the interviewing took place in the last week of September and the first week of October 1996.

The purpose of the survey was to collect information from mothers about various health topics including, reproductive health, breast feeding, nutrition, care for the sick child and immunization. The survey also aimed to look at the present health of KAP mothers and to see if it had improved. All these topics were covered in the baseline survey of 1994 and project objectives had been devised from the results. The questionnaire used in the follow up survey was an exact duplicate of the one used previously to allow the results to be easily compared and to see if the objectives had been met.

SURVEY METHODOLOGY

Sample Selection

Clusters were randomly selected by the National Statistics Office. Results of the baseline survey were used to calculate how many overall clusters were needed, how many were to be rural and urban, and how many households within each cluster should be interviewed. As the survey was interested in the information from mothers only, the selection made by the Statistics Office was amended slightly to allow only mothers to be interviewed. An average of seven women were interviewed in each cluster. Thirty two clusters were chosen for rural areas, and fourteen for the urban areas. Appendix A lists the clusters.

In selecting the clusters, the total sample size (n) was calculated using the equation:

$$n = \frac{\sum (N_i^2 \times \frac{VAR_i}{W_i})}{N^2 \times D + \sum (N_i \times VAR_i)}$$

Where $D = B^2/4$ and $B =$ bound on error of estimation. Sample size was selected in rural and urban areas based on the total sample size required. Clusters were selected within each stratum according to PSS.

To ensure that the households in each cluster were randomly selected, a random walk technique was used by the interviewers. Unlike the zigzag pattern used in 1994, a slightly different method was used.

Firstly, a community house, (such as a church, nakamal or womens centre) was selected as a starting point, The first survey was carried out at a house immediately in front of the startiws were conducted in Bislama, therefore unlike preparation for the baseline survey carried out previously, no translation exercises were necessary.

The training schedule was as follows:

Monday 16 September

- purpose and rules of the survey
- practical arrangements
- review of pages one and two of the survey

Tuesday 17 September

- review of pages three to six

Wednesday 18 September

- review of pages seven and eight
- role plays carried out in small groups covering the whole survey
- discussing problems with any questions

Thursday 19 September

- Field Outing - practice at carrying out the survey in a small village
- discussing the outcome of the morning activity

Friday 20 September

- confirming survey sites, studying the urban map
- allocating teams for rural and urban areas
- selecting extra villages in each cluster
- discussing the allocation of supplies, transportation and finance
- final summary of training and fieldwork

COST OF THE SURVEY

The survey including the training of interviewers, was funded by USAID. The total cost of the survey including the training was approximately 58 1,965 vatu. Of this amount, subsistence allowance and interview fees came to 266,500 vatu, accommodation costs (for participants and officers) 134,484 vatu, transportation (for participants and officers) 128,630 vatu and training, survey supplies, printing, radio messages and miscellaneous costs amounted to 52,355 vatu.

DATA ENTRY AND PROCESSING

All the data collected was tabulated using LOTUS. Proportions and percentages were calculated using a casio calculator, model fx-82super. To calculate 95% confidence intervals, the following formula was used:

(estimate - 2 SE) to (estimate + 2 SE) where,

$$SE = \left(\frac{p(1-p)}{n} \right)^{1/2} \left(1 + \frac{(b-1)r}{n} \right)^{1/2}$$
 where,

p = the proportion of the population, b = average number of responses per cluster, r = correlation of responses within the cluster compared to the correlation of responses of the population as a whole, and n = total size of the sample population (El Bindari-Hammad and Smith, 1992). As the raw data was not available, the value of r was estimated at r = 0.05.

CHARACTERISTICS OF THE SAMPLE POPULATION

For this survey, the National Statistics Office calculated the number of rural and urban clusters needed based on the results of the 1994 baseline survey results.

In 1994, 30 clusters were used (21 rural, 9 urban), the total number interviewed being 216. In 1996, 46 were used (32 rural, 14 urban) and the total number of mothers included was 302 (see Table I). The rural/urban ratio was slightly lower in 1996 than in 1994 (1996: rural/urban = 2.24: 1, 1994: rural/urban = 2.33: 1).

Table 1. Characteristics of the Sample Population - population and cluster

size (1994 and 1996).

Characteristics 1994-1996 Total number of clusters 3046
Rural clusters 2 132
Urban clusters 9 14
Total number interviewed 216302 Rural/Urban Ratio 2.33: 12.24: 1

The percentage of mothers, who either stay at home with the children or take them to work with them, is 42.2. If they go out to work alone, the infant more often than not is left with a relative other than the father (37.6%). The child is left with the father 15.8% of the time, and with the house girl 8.6% of the time.

Education of Respondents

Three quarters of the mothers (73.0%) have had primary school education, which is slightly lower than the percentage calculated for the baseline survey sample. A quarter attended secondary school. The information as to whether each mother completed either primary or secondary school was not available for analysis.

Over a third of the women (35.3%) had attended a workshop at some point - the most popular being in handicrafts and sewing (24.2%), closely followed by cooking (23.4%). Health workshops were attended by six women, agriculture by four, marketing by three, and the construction of water tanks by three. One woman had attended a workshop on family planning.

Income Generating Activities

Most of the women are involved in selling their garden produce. As shown by the baseline survey, rural women are more likely to have their own source of income. Not far different from the previous results, rural women are 81.1% to have an income of their own, and urban women are 35.4% likely to. One third of all the women interviewed (33.0%) had no source of income.

FINDINGS

Reproductive Health

Most of the mothers had prenatal care during their pregnancy (91.4%). The percentage of women who reported regularly taking chloroquine tablets every week was also high (87.1%). Almost three quarters (73.9%) had a nurse present at the birth.

As the baseline survey carried out in 1994 showed, family planning (FP) is a term familiar with most of the mothers (78.9%). Family planning methods are still much more likely to be discussed with health workers (68.3%), than with women's leaders, teachers, or trained development workers (4.0%).

The use of oral contraceptives was the main family planning method that the women interviewed were aware of (63.7%). The percentage familiar with the use of condoms had risen since 1994 from 20% to 28.4%. The amount of mothers having heard of tubal ligation was still low (28.1%). The statistic to show the proportion of those who recognized the method of using intra-uterine contraceptive devices is not available at present and thus the proportion of mothers using modern methods of contraception cannot be calculated without information on IUD use.

The user rates of family planning methods were low, despite the number of women who Listed various methods of preventing pregnancy. To compare the rates with the results from the 1994 survey, the clusters for the following statistics were split up into %ruralA and %urbanA. There was no statistical significance in the percentage of mothers adopting family planning methods in rural areas of Santo (from 29% down to 23%). The urban rate had slightly increased from 30% to 33.3% (see Table 2).

One third (33%) of women who were not pregnant at the time of the survey, did not want to have another child in the near future. Those who responded saying that they would like to have another child shortly was as low as 7.6%. The remaining 52 women were not sure whether they did or not. Of the 32.7% who said no, less than half (37.1%) were using a family planning method to delay another pregnancy (see Table 2). This is eight percent higher than the result recorded in the baseline survey (33% in 1994).

Table 2. Comparison of family planning variables. 1994 and 1996 coverage surveys, Sanma Province.

Variable	%	95% C.I.	%	95% C.I.	Sig	1994	1994	1996	1996
Mothers adopting FP methods (rural)	29.7	20.7 - 37.3	23.3	16.6 - 29.4	n/s	1994	1994	1996	1996
Mothers adopting FP methods (urban)	30.1	16.8 - 43.2	33.3	22.4 - 44.2	n/s	1994	1994	1996	1996
Not wanting another child in near future	58.8	50.9 - 66.7	33.2	27.2 - 39.4	*	1994	1994	1996	1996
Not wanting/unsure and using family planning methods	32.8	24.8 - 40.9	37.1	26 - 48.2	n/s	1994	1994	1996	1996

* statistically significantly different (p < 0.05)

When asked if the woman and her partner were doing something to prevent pregnancy, only 259 mothers out of 303 answered the question. The remaining 44 women were either pregnant at the time of the survey, or wanted another child in the near future. Out of those who did respond, 30.5% of the mothers were using some method of family planning. This percentage has increased since 1994, but not significantly. The oral contraceptive tablet was still the favored method, at the slightly lower user rate of 51.6%. After this followed abstinence (10.5%), tubal ligation (8.4%), condoms (7.4%) and vasectomy (1.1%). As mentioned earlier, the statistic for IUD use is not available.

Breast Feeding

Table 3. Comparison of feeding methods, 1994 and 1996 coverage surveys, Sanma Province.

Variable	%	95% C.I.	%	95% C.I.	Sig	1994	1994	1996	1996
Bottle feeding - urban	54.4	40 - 68.4	32.6	17.8 - 55	n/s	1994	1994	1996	1996
Bottle feeding - rural	12.6	7.8 - 17.8	17.8	12.5 - 24.5	n/s	1994	1994	1996	1996
Bottle feeding - total	34.3	21.3 - 47.1	27.5	13.3 - 41.5	n/s	1994	1994	1996	1996
Breast feeding - urban	55.5	41 - 70.7	60.5	48.1 - 72.9	n/s	1994	1994	1996	1996
Breast feeding - rural	18.7	10.8 - 26.6	18.8	11.8 - 25.8	n/s	1994	1994	1996	1996
Breast feeding - total	37.1	24.8 - 49.4	39.6	26.6 - 52.6	n/s	1994	1994	1996	1996
Breast fed in 1st hour - with med. attendant	74.8	68.1 - 81.5	81.1	74.8 - 87.4	n/s	1994	1994	1996	1996
Breast fed in 1st hour - without med attendant	15.7	8.6 - 22.8	15.6	8.4 - 22.8	n/s	1994	1994	1996	1996
Never breast fed or weaned under 12 months	3.3	2 - 4.6	3.6	2.4 - 4.8	n/s	1994	1994	1996	1996

The amount of women who are breast feeding their infants still greatly differs depending on whether the mother lives in the town, or in a rural area. The mothers in the urban region of Santo being more likely to bottle feed their children at an earlier age. Although there is no significance, the percentage

After this, the next house to the right was interviewed. This continued until the interviewer reached the end of the village. There is some doubt whether this constitutes a random second stage selection. In homogenous communities, this may not be important.

Interviewing

As in the baseline survey, a supervisor accompanied each single or pair of interviewers every day. Forms were systematically checked for errors after each individual interview had been carried out. If an error was found, either the section with the error was repeated or an entire new interview was scheduled.

Training

The survey training was carried out during a period of five working days, from the 16th to the 20th of September 1996. Eleven interviewers were trained at this time, four of these being supervisors. The purpose of the training was to teach participants to understand the questions, ask the questions, and to correctly record the answers given. Role plays were used to teach interviewing techniques.

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%)

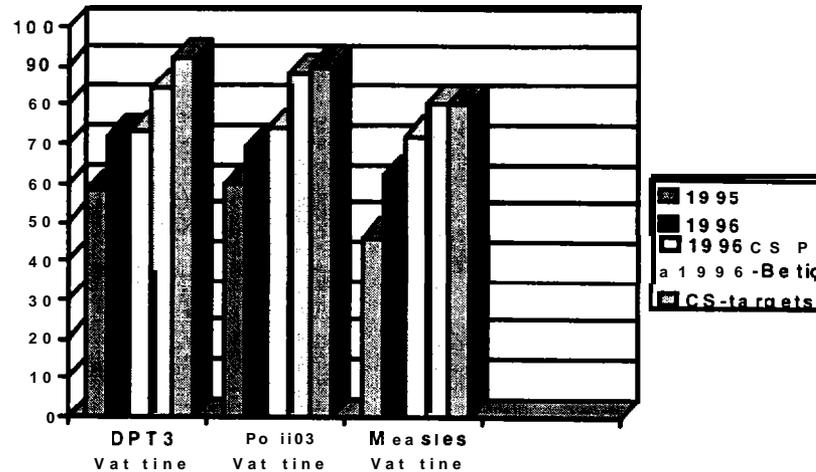
Table I: CS-IX Project Objectives by intervention, target and source of data (from project DIP, 1993) for project sites

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, 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
1) Clinic management improved throughout Kiribati	<p>1) Assessment of clinic management practices, development of appropriate management aids are undertaken.</p> <p>2) Development of appropriate management tools completed.</p> <p>3) all DPNOs, MAs and PHNs trained in management and supervisory techniques and oriented to health education aspects of CS interventions</p> <p>4) Clinic management becomes part of Kiribati nursing school curriculum.</p>	<p>1) External consultant has completed CMA and developed prototype forms and checklists.</p> <p>2) 5 DPNOs, all MAs and supervisory PHNs trained in clinic management on all islands of the Gilbert Group: oriented to CS interventions</p> <p>3) Management aids being used at most clinics in the Gilbert group.</p> <p>4) Discussions continue with nursing school concerning management training.</p>	<p>1) Rural health workers have better management practices</p> <p>2) DPNOs, MAs and PHNs supervise rural clinics more efficiently (19 islands)</p> <p>3) no action taken on incorporating CM into nursing school syllabus; discussion continue</p>
2) MHFP will continue to promote community awareness and action in CS survival	<p>1) island councils and leaders of all islands of the Gilbert chain to be oriented to CS project and health promotion</p> <p>2) KAP studies of CDD, Nutrition and Family Planning will be done</p> <p>3) IO Community Workshop each will be given for CDD/ARI, Nutrition, and EPI on project Islands.</p> <p>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</p> <p>2) KAP studies completed: information used to design community workshops</p> <p>3) 450 representatives of various local NGOs trained in community health aspects of EPI, Nutrition and CDD/ARI</p> <p>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</p> <p>2) 4.50 NGO representatives trained in community health and health promotion aspects of nutrition, ARI/CDD and EPI</p> <p>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 Rereao)
- . 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) <ul style="list-style-type: none"> . 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 <ul style="list-style-type: none"> . 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!**