Independent Evaluation of the Village Health Worker Program, Vanuatu

Final report

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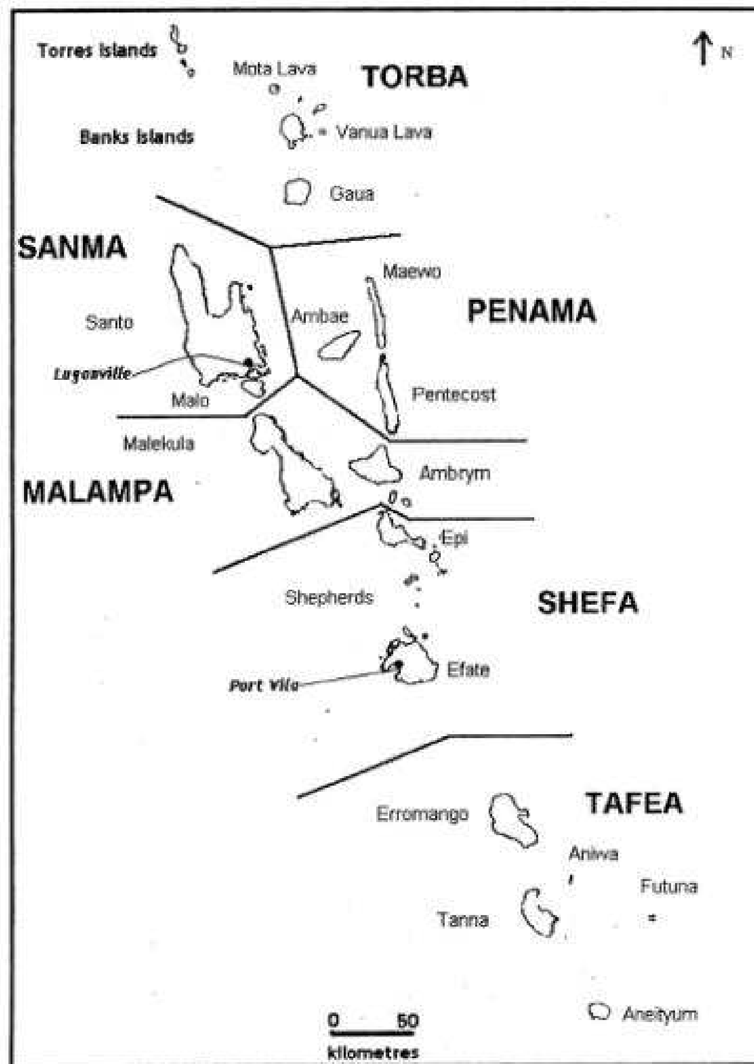
Acronyms

APC	Aid Post Committee
AUD	Australian dollar
AusAID	Australian Agency for International Development
AYAD	Australian Youth Ambassador for Development
DAC	Development Assistance Committee
GoV	Government of Vanuatu
HIS	Health information system
HIV	Human immunodeficiency virus
HPO	Health promotion officer
HPU	Health Promotion Unit
IEC	Information, education and communication
ISP	Implementation Service Provider
M&E	Monitoring and evaluation
MOH	Ministry of Health
MOU	Memorandum of understanding
NGO	Non-government organisation
OECD	Organisation for Economic Co-operation and Development
PCC	Project coordinating committee
PHC	Primary health care
PIF	Pacific Island Forum
PLAS	Planning long, acting short
RDT	Rapid diagnostic tool
SCA	Save the Children Australia
VHW	Village health worker
VNSO	Vanuatu National Statistics Office
VNTE	Vanuatu School of Nursing
VUV	Vanuatu vatu
WHO	World Health Organization

Reference map of Vanuatu



Executive summary

The Village Health Worker (VHW) Program in Vanuatu has been active since the 1970s. Since 1998 Save the Children Australia (SCA) has supported the Ministry of Health (MOH) to implement the program with funding from AusAID totalling approximately AUD $3.7 million. Phase II of the Strengthening Village Health Worker and Community Based Health Management Project (2006-2012) aimed to improve health in rural communities by improving the performance of VHWs and strengthening program management.

This independent evaluation was conducted between October 2012 and March 2013. There was an in-country visit in October 2012 which included site visits to ten Aid Posts and communities in two provinces, as well as interviews with key stakeholders at national and provincial level. A second visit to Port Vila for further interviews was undertaken in February 2013. The purpose of the evaluation was to review the performance of the VHW program over the last decade with a focus on Phase II, based on the OECD Development Assistance Committee (DAC) criteria of effectiveness, efficiency and sustainability, and to provide recommendations on how the program can best focus its efforts to contribute to primary health care (PHC) in Vanuatu and specifically the MOH's National Policy and Strategy for Healthy Islands, going forward.

Reviewing the performance of the VHW program proved challenging due to limitations in the monitoring and reporting systems, resulting in limited data available to assess the outcomes of the program. However, sufficient information was collected to enable an assessment of the relevance, effectiveness, efficiency and sustainability of the program and provide recommendations for the future of the program.

Findings

Relevance

The MOH has a decentralised health care delivery model which is supported by the Healthy Islands Policy (2011-2016). Primary health care is delivered at the village level by VHWs operating from community-run Aid Posts. While there is conflicting evidence on the effectiveness and appropriateness of community health workers in the geographical and institutional context of Vanuatu, where access to formal health care is limited due to dispersed islands, rugged terrain, long distances to remote and rural areas, limited transport and transport costs, the use of VHWs to deliver primary health care services, including basic curative and preventive services, surveillance, referrals and health education, appears appropriate. [1] It can reasonably be concluded that without VHWs, communities in some areas of Vanuatu would not have access to any health services at all.

Effectiveness

The evaluation found that while the strategy of using VHWs and Aid Posts to provide decentralised health services to the Vanuatu population is sound, the design and implementation of the strategy needs refining. A significant number of program activities have been carried out at provincial and area levels aimed at improving the

[1] See for example Lewin et al. 2010

management of Aid Posts, the knowledge, confidence and skills of VHWs, and the management of the project, and these have been accelerated in recent years. However, it does not appear that the progress has been in line with the expansion in resources allocated to the program, and some activities, such as VHW training and supervision, remains insufficient for the 212 VHWs and 188 Aid Posts that now operate across Vanuatu's six provinces. This is due in large part to the lack of capacity and resources at the provincial level. In addition, there is little evidence that the capacity of the MOH to take over responsibility for the program has been strengthened, despite this being a priority throughout the last ten years of the program.

The evaluation also found that the bulk of VHW and Aid Post activities appear to be focused on the delivery of curative services. While these services may be more highly valued by communities than prevention and promotion activities, it does mean that the program is not fully aligned with a primary health care approach and the Healthy Islands Policy. A stronger focus on prevention and health promotion will need to be incorporated in the future. Insufficient attention is currently paid to ensuring that VHWs have both the capacity and incentives to refer patients to higher levels of care, and that these higher levels have the capacity to deliver the needed services.

Efficiency

The evaluation found that the implementation of the VHW program strategy is not as efficient as it could be. Despite most project activities being implemented at the district and village level, a large proportion of funding remains at the national level. Over 50 per cent of funds have been allocated to management, staffing and support costs over the last ten years. The division of responsibilities between the MOH and SCA affects the efficiency. Closer attention therefore needs to be paid to the distribution of the limited financial and human resources available to the program to ensure resources are used in the most cost effective way to deliver the required services to the Aid Posts, VHWs and health promotion officers (HPOs) most in need, so that the quality and reach of service delivery improves at the village and provincial levels.

Monitoring and evaluation

It is widely acknowledged that despite its 30 year history, there has been no effective monitoring and evaluation (M&E) framework in place for the VHW program, and the collection of data has been sporadic. In the absence of a sound results framework and evidence base, it is only possible to draw some tentative conclusions about the extent to which the program has contributed to achieving health outcomes; whether it has alleviated pressures on the formal health system; or whether it has been effective and delivered value for money. A continuation of the program will only be justified if a robust monitoring and evaluation framework is in place which collects, analyses, reports and uses information to support decision making and review resource allocations to Aid Posts, VHWs and HPOs.

Sustainability

The evaluation found that there is limited capacity in the MOH to absorb managerial and financial responsibility for the program, but that there appears to be commitment within the MOH to the program. There is insufficient ownership of the program at the national, provincial and community level to ensure sustainability.

Conclusions

The VHW Program delivers important basic services to a large proportion of Vanuatu's population, and is a key to Vanuatu's Healthy Islands Policy. Significant efforts and resources have been invested in the program, and it is clear that there are good intentions of all partners to positively influence the health of communities across Vanuatu. However, design, management and funding allocation issues have constrained the program's effectiveness, and certainly the extent to which it can prove the effectiveness of the VHW and Aid Post primary health care model. There is also a substantial gap in capacity at provincial level which weakens provincial health workers' role as an important link between strategy development and management at national level and the service delivery and program beneficiaries at community level.

Upcoming processes and decisions within the MOH provide an excellent opportunity to build on lessons learned throughout this program and improve the services delivered, the management of the program and the ownership and capacity of the MOH to oversee it.

Recommendations

Based on the findings and conclusions, the following recommendations are made in order to develop the next phase of the program:

1. Develop a phased, realistic transition plan, with clear steps and milestones towards integration of the program into MOH, while being aware of capacity constraints. Strategies for strengthening management systems and leadership of the program should be specified, with explicit milestones for gradual transition, for example the integration of key program management roles into the MOH after the first two years.
2. Review the allocation of existing recurrent budget resources to increase the proportion allocated to Aid Posts, VHWs and HPOs to improve service delivery at the provincial and village levels.
3. Better align the program with the Healthy Islands Policy, increasing the attention paid to health education and promotion and community mobilisation and aligning program activities with those of the Revitalisation of Primary Health Care initiative.
4. Prepare and implement a systematic approach to monitoring progress (against annual MOH plans) and performance (towards Government of Vanuatu and program outcomes) using existing systems wherever possible. The monitoring system should collect, analyse, report and use information to support monthly management meetings where decisions are made and resource allocation to Aid Posts, VHWs and HPOs are reviewed.
5. Increase focus on community mobilisation and community support for VHWs. Specifically:
    a. Revitalise Aid Post Committees and broaden their remit to health education and promotion (suggestions for revisions for the 2003 Health Committees Act, which forms the legal foundation for Aid Post Committees (APCs), are outlined in Annex 8).

b. Explore options for making small grants available for community level activities.
c. Explore the potential integration of more Aid Posts with strong existing organisations in communities, such as schools and churches, to encourage and mobilise further community support for VHWs.

6. Provide VHWs with quality assured and effective training and materials to enable them to effectively do their work, and explore options for developing more extensive training for VHWs working in remote Aid Posts. This will require expert review of existing curricula and training materials, as well as development and/or adaptation of more appropriate information, education and communication (IEC) materials, in coordination with the MOH's Health Promotion Unit.
7. Develop clear job descriptions defining the roles and responsibilities of VHWs and communicate these to VHWs and their communities. Consider differentiation of roles of VHWs to reflect the varying contexts and circumstances faced by different VHWs across Vanuatu. (Suggestions for roles and responsibilities can be found in Annex 7.)
8. Develop a new model for good quality and regular supportive supervision as soon as feasible to strengthen support to VHWs, including peer support and learning exchange.
9. Conduct a baseline survey and mapping activity to take stock of the number and activities of VHWs and Aid Posts to allow for evidence-based support in the next phase.
10. Carry out an independent assessment to investigate the motivation of VHWs and identify appropriate incentives.

1. Background

Vanuatu is a lower middle-income country with a total estimated population of 234 000 in 2009, of which 75 per cent live in rural areas spread over 69 inhabited islands. The terrain is mountainous with narrow coastal plains, contributing to transport difficulties on the main islands. GDP per capita was US$2500 per annum in 2011.[2]

The Ministry of Health (MOH) has identified the provision of efficient, equitable and effective health services as a priority, with a particular focus on community health.[3,4] However, the country faces constraints imposed by geography and inadequate resources, which have resulted in poor performance in health. While key health indicators have improved over the last few decades, Vanuatu still faces a significant health burden, including high rates of child and maternal mortality and persistence of malaria, as well as emerging issues related to non-communicable diseases (see Table 1).[5]

Table 1: Key health indicators in Vanuatu

	Health indicator	Earliest 1990 (unless specified)	Latest 2009 (^2007)
Child health	Under 5 mortality (per 1000 live births)	40.1	16.3
	Infant mortality (per 1000 live births)	33.0	14.0
	Measles immunisation of 1 year olds (%)	66.0	80.0
Maternal health	Maternal mortality (per 100,000 live births)	96.0 (1998)	86.0^
	Skilled birth attendance (%)	79.0 (1990-1995)	74.0^
	Contraceptive prevalence rate (%)	15.0 (1991)	38.0^
	Adolescent birth rate (per 1,000 females)	92.0 (1999)	64.0
Malaria	Malaria incidence rate (per 100,000)	19800.0	1600.0
	Malaria death rate (per 100,000)	22.0	0.9
	Under 5 sleeping under bed-nets (%)	13.0 (2002)	81.0
TB	TB prevalence rates (per 100,000)	176.0	110.0
	TB death rates (per 100,000)	11.0	10.0
Water & Sanitation	% of population using an improved drinking water source	68.0 (1989)	81.0
	% of population using an improved sanitation facility	28.0 (1989)	64.0

Source: 2011 Pacific Regional MDGs Tracking Report

Vanuatu has one of the lowest ratios of health workers per head of population in the Pacific. For example, in 2012 there were an estimated 1.77 health workers per 1,000 people, compared with ratios of 2.67 in Fiji and 2.27 in the Solomon Islands.[6,7] This is exacerbated by inequalities in the distribution of the health workforce, for example in 2010 there were 0.8 doctors per 1000 population in urban areas compared with 0.016 per 1000 in rural areas, where 75 per cent of the Vanuatu population live.[8] Access to health services are hampered by transport costs and geography. Lack of basic health services has been identified as a major cause of poverty in the country, and in response, the MOH launched the "Healthy Islands" initiative in 2011, which

[2] VNSO 2012
[3] MOH 2010
[4] GoV 2009; MOH 2010
[5] PIF Secretariat 2011
[6] WHO & MOH 2012
[7] WHO 2012
[8] WHO & MOH 2012

advocates for revitalisation of primary health care (PHC) at community level throughout Vanuatu.

The Village Health Worker (VHW) program in Vanuatu began in the 1970s, and Save the Children Australia (SCA) has worked with the MOH to implement the program since 1998. AusAID has supported the program since then, providing over AUD$3.7 million, of which approximately AUD$800 000 was spent in 2011. At national level, the VHW program is part of the Department of Public Health, where the national VHW coordinator is based.[9] In addition, the contract manager, SCA, has three fulltime project staff. At provincial level, VHWs are managed by provincial health promotion officers (HPOs), who provide technical assistance to community level health workers particularly through supervisory visits and training. At local level, there are health centres, dispensaries and aid posts. The first two are staffed by professional health workers, such as nurses, while aid posts are generally staffed by VHWs, often with some support from an area nurse. In addition to technical support from health staff, VHWs and Aid Posts are supported by Aid Post Committees, which consist of elected community members.

The MOH has identified the VHW program as a key program for delivering components of primary health care in rural and remote areas. VHWs operate in Aid Posts, the most basic level of health care in the Vanuatu referral system. For rural and remote populations, the VHW program is a key component of service delivery, as they often work in communities which have no or limited access to formal health care i.e. dispensaries, health centres and hospitals.[10] There are currently an estimated 230 VHWs working across 212 Aid Posts in Vanuatu's six provinces. They typically provide simple curative health treatments, first aid and community health education. Table 2 summarises the health facility and village health worker numbers in each province in 2011.

Table 2: Village Health Workers and health facilities by province, 2011

Province	No of VHWs			No. of Aid Posts	No. of Dispensaries	No. of Health Centres	No. of Hospitals
	Male	Female	Total				
Tafea	28	6	34	30	6	5	1
Malampa	18	20	38	41	14	7	1
Sanma	25	11	36	39	6	7	1
Penama	9	22	31	38/	8	6	1
Torba	13	6	19	19	6	2	1
Shefa	17	28	45	44	7	3	1
Total	**110**	**93**	**203**	**211**	**47**	**30**	**6**

Source: SCA 2011b

The VHW Program in Vanuatu has undergone a series of transformations over the last decade, with a number of different phases and stages. Phase I covers 2003-2006 (including the one year transition phase 2005-2006) and Phase II covers 2006-2012 (including the subsidiary arrangement from 2008 through January 2012). The current stage of the program is covered by a MOU between SCA and the MOH from

[9] Since1998. Prior to 1998, the VHW program was housed by the Vanuatu College of Nursing.
[10] Interviews in Vanuatu highlighted difficulties in conveniently gaining access to a health centre for an injection, to deliver a child or to have an injury treated.

2012 to 2014, however it has recently come to light that this MOU has not been cleared according to GoV legal requirements, and the MOH has decided to put the program out to open tender during 2013. As such, SCA will be implementing a reduced workplan until the contract has been awarded in order to ensure continuous service provision. While the goal of the program has remained largely unchanged – to contribute to improved health of people in Vanuatu - the focus of the program has expanded from narrowly focusing on training of VHWs to a broader set of activities. Successive stages have shifted priorities and outputs from local community support in Phase I to management of the program and Aid Posts in Phase 2. Table 3 outlines the purposes, objectives and outputs of Phase I and II.

Table 3: Goals, purposes and objectives/outputs of successive phases and stages of the VHW program

Phase	Goal	Purpose	Objectives/Outputs
Phase I (2003-2006)	Contribute to improved health of Vanuatu people, in particular rural populations and women and children through effective management of PHC principles.	Develop and support improvements in effective community based health management at provincial and community levels	– Strengthened MOH ability to support VHW program – Increased skills and knowledge of VHWs – Strengthened local community support for VHW program – Effective and efficient coordination and management of the project
Phase II (2006-2011)	Improved health among project communities	Improved performance of VHWs	– Transition of VHW Program from SCA to MOH management is well managed. – Improved management and support of VHW Program at provincial and area levels. – Improved management of Aid Posts. – Improved knowledge, confidence and skills of VHWs. – Project is well managed.
Revised Phase II (2011-2012)	Improving the health of rural communities in Vanuatu through access to primary health care services	Strengthen management of VHW program in collaboration with MOH at the national, provincial, area and community levels. This will be conductive to improving the hygiene provision of primary health care services in rural communities throughout the six provinces of Vanuatu	– Build capacity of VHWs in terms of knowledge, confidence and skills to ensure children and their families have access to basic health, treatment of common illnesses and family planning advice. – Strengthen capacity of management of the Aid Posts at the community level by Aid Post Committees throughout the 6 provinces. – Facilitate increased community awareness, health education and behavioural change in relation to health rights, hygiene, HIV, safe sex and clean environment. – Ensure equal access to health services through advocating to government and local partners for improved support – Ensure efficient and effective management of the VHW program

2. Purpose of the evaluation

The purpose of the independent evaluation is to review the performance of the VHW program over the last decade, with particular focus on Phase II, and provide recommendations on how the program can best focus its efforts to contribute to primary health care in Vanuatu and specifically the MOH's Healthy Islands Policy. The evaluation was commissioned at the request of both AusAID and MOH following the end of Phase II. The evaluation focuses primarily on the OECD Development Assistance Committee (DAC) criteria of effectiveness, efficiency and sustainability, as well as relevance and monitoring and evaluation, and presents recommendations for improvement, based upon evidence collected.[11] These findings and

[11] See Annex 1 for further details on DAC criteria.

recommendations will feed into on-going discussions on the role of VHWs in the delivery of primary health care across Vanuatu.

3. Evaluation methodology

The evaluation plan identified i) the stakeholders to meet during the review; ii) the forum for the meetings; iii) precautions to ensure ethical and efficient data collection; and iv) methodological considerations to minimise bias and normative responses (see Annex 2). Data collection is summarised below and the process was in practice iterative and collaborative. Triangulation using multiple sources of data was used as far as possible to cross-check information to ensure a more robust and credible analysis. Two consultants were used to analyse data in two stages. The independent evaluation report has been prepared in accordance with the 'Evaluation capacity building program monitoring and evaluation standards' (AusAID 2012).

1. **Review of literature, and program documents and reports, as well as country and MOH documentation**: Secondary sources of information were reviewed and analysed at the beginning and during the independent evaluation. Program documentation was identified and obtained through agencies in Vanuatu, in particular AusAID, MOH and SCA. In addition, a literature review was carried out to identify relevant evidence and international best practice on community-based health care. . See Annex 9 for a list of documents reviewed.

2. **Stakeholder interviews in Vanuatu**: During the first in-country mission, semi-structured one to one and group interviews were held with key stakeholders and site visits were carried out to observe the activities of the VHWs. Key stakeholders included program management and AusAID staff in country; relevant government and other partners (MOH, SCA, Peace Corps) and civil society organisations; HPOs and VHWs. Visits were made to 10 Aid Posts and 3 health centres in two provinces: Shefa (October 11-12) and Malampa (October 16-17). See Table 4 for a summary of individuals interviewed and Annex 3 for the complete list of persons consulted and sites visited.

3. **Feedback and reflection meetings**: discussions were held with AusAID representatives and the Director of Public Health, who accompanied the consultant during field visits to discuss emerging themes and cross-check information to ensure consistency and accuracy. A formal feedback session was held in Port Vila on 19th October 2012 with AusAID, SCA, MOH and other partners at which the Aid Memoire recommendations were presented.

4. **Consolidation of data**: Following limitations identified in the first draft of the report, a new consultant was introduced to consolidate the in-country data collected by the initial evaluator as well as review data from academic and grey literature and program documents.

5. **Further consultations in Vanuatu**: A second in-country mission was conducted February 4-8, 2013. Interviews were held with key stakeholders, including SCA, MOH and AusAID to discuss findings, ask further questions and fill remaining data gaps.

Table 4: Individuals interviewed

	AusAID	SCA	Other agencies/ NGOs	MOH National	MOH Provincial	Aid Post & Community	Total
Individuals interviewed	2	4	4	7	10	22	**49**

(Note: Table includes interviews from both country visits. Some individuals were interviewed on more than one occasion but are recorded once)

Key evaluation questions:

Relevance

1. To what extent has the VHW Program contributed to health promotion and primary health care in Vanuatu and specifically to the Healthy Islands Policy?

Effectiveness

2. How effective has the VHW program been in meeting its objectives particularly against the program purpose stated in Phase II and its associated outputs and indicators?
3. How far is the VHW program consistent with Gender, Equity and Social Inclusion, including access to health promotional materials and increasing equitable access to other (referred) services?

Efficiency

4. What has been the efficiency with which SCA has delivered the program in terms of value for money and any other comparative advantages in its delivery?

Sustainability

5. What are the implications for future support to the VHW intervention and more broadly for community level service delivery?
6. How has the capacity of the MOH and the SCA been developed to sustain program management arrangements with and without future funding from AusAID?

Monitoring and Evaluation

7. To what extent has the delivery of the program been consistent with best practice in terms of management systems, the strategic approach and monitoring and evaluation?
8. To what extent has SCA allowed the learning and experiences from the program to be fed back to the different program stakeholders and partners, including marginalised groups, in the on-going program cycle?

3.1 Limitations of the methodology

There were a number of limitations of this independent evaluation.

- The data and information collected during the first in-country visit was incomplete. This was in part due to the fact that the assignment was conducted by one rather than two consultants as originally planned, after the team leader, an M&E specialist, pulled out at the last minute. Additional inputs were needed after this visit to compile and analyse field information, collect additional data where there were gaps, and to complete the reporting. There are risks of involving additional expertise following the initial visit however these were mitigated through detailed debriefings with the consultant who

carried out the initial fieldwork, open communication with stakeholders and a second visit to conduct further interviews with key stakeholders in Port Vila.

- The geography of Vanuatu and the spread of the VHW program required substantial travel for field visits, which reduced the amount of time available for consultations and observations.
- The lack of program baseline data and the irregular collection and reporting on monitoring data collected and activities conducted constrained the ability of the reviewer to make a fully informed judgement of program effectiveness. While anecdotal accounts and observations in the field as well as reviews of previous reports were used to make some assessment, this was limited and cannot replace a robust monitoring and evaluation (M&E) framework and data collection system.
- The VHW program is large, with many stakeholders and locations. The evaluation has been constrained to some extent by having to generalise the findings from ten Aid Posts and three health centres across the entire program.

4. Findings

4.1 Relevance

The criterion of relevance assesses the extent to which the services being delivered are appropriate for the needs and particular context of the program. A review of international literature suggests that the use of lay health workers is common in countries where access to formal health care is difficult, whether due to geographical, financial or other obstacles. Where programs with variations of the VHW model have been implemented, impact on health outcomes has been difficult to measure and systematic studies have shown mixed findings and inconclusive evidence of their effectiveness.

For example, VHW programs have been implemented with some success in a number of countries (Mozambique, Cambodia), and with mixed results in others (Vietnam, Papua New Guinea). A Cochrane Review of the impact of lay health workers in primary and community health care for maternal and child health found that lay health worker interventions, compared to usual health care services, may reduce neonatal and under 5 mortality and morbidity for common illnesses in children under five years, and may increase the number of parents who seek help for their sick child. However, the quality of the evidence for all these studies was found to be low.[12] A review carried out by World Health Organization (WHO) in 2007 found that there is consensus in the literature that community health workers "*can improve access to and coverage of communities with basic health services, especially… in the field of child health*."[13] However, they also point out that the services that these workers provide do not consistently have a substantial health impact, and that the quality of the services is questionable. **Hence while VHWs can be part of an effective strategy to make basic health interventions more accessible for rural communities, they are not a panacea for weak health systems, and require**

[12] Lewin et al. 2010
[13] Lehman & Sanders 2007:v

investment in the form of training and support, management and community ownership to be effective.[14]

A review of Vanuatu's geographical and institutional context suggests that - given the difficulties of accessibility of care for the largely rural population and the decentralised nature of the health system - strong primary health care delivered at community level is a sound approach.

Access to formal health care is limited in Vanuatu due to dispersed islands, rugged terrain, long distances to remote and rural areas, limited transport and high transport costs.[15] Vanuatu's population suffers from preventable illness, including malaria, diarrhoea, and respiratory infections, all of which can be treated with simple interventions.[16] Community Aid Posts tend to be located where communities have limited or no access to dispensaries, health clinics or hospitals and they provide basic essential primary health care services to the majority of rural and remote populations in Vanuatu. In addition, expenditure on health is low and the government is reliant on donor funding for 40 per cent of its health expenditure, making a system of voluntary health workers attractive.

Therefore, while the VHW program is not without its challenges, **the approach appears relevant for Vanuatu's health status and context.** The push to continue the use of community health care mirrors that called for in Papua New Guinea, which also faces difficulties of geography, coupled with a weak health system, thus demonstrating a continued strong belief in the potential of VHWs.[17] However, while the VHW model appears appropriate for the health system context of Vanuatu, this does not imply that the *design* of the Vanuatu VHW program has been entirely relevant. This is discussed in subsequent sections.

Vanuatu's Healthy Islands Policy seeks to revitalise primary health care, focusing on the role of prevention and promotion activities and community ownership, support and mobilisation.[18] The success of healthy islands initiatives, demonstrated by improved health outcomes, are strongly linked to community involvement, relationships between the health sector and other sectors, and peoples' participation in addressing health problems. VHWs are mentioned explicitly in this policy as having the potential to play a key role in strengthening community education and mobilization.[19]

The evaluation found that while **the VHW program in Vanuatu is relevant to the overarching Healthy Islands Strategy and Policy**, **the two approaches are not yet aligned**. It should be noted that this strategy was only launched in early 2011, so there has been limited time for the program to align itself with the strategy. This said, health promotion and community engagement were identified program activities before the launch of the 2011 strategy. Observations and conversations held during field visits suggest that the main focus of VHW's is on providing basic **curative** services. There could be a number of reasons for this – for example curative services are easier to charge for and their impact is more noticeable.[20] VHWs do receive training on community engagement and mobilisation, and some information, education and communication (IEC) materials are available (for example posters on

[14] Lehman & Sanders 2007
[15] SCA 2012a
[16] MOH 2010
[17] Byrne & Morgan 2011
[18] MOH 2011
[19] ibid
[20] Tien, LeBan & Winch, 2000

oral rehydration, hygiene and breast feeding), the level of dialogue and interactivity of the materials appear to present constraints to effective prevention and community education, which in turn limits alignment with the Healthy Islands Policy. The active involvement of communities should enable them to take the lead in prioritising their needs and working together with other stakeholders to find solutions to health problems that they can afford and sustain.

4.2 Effectiveness

The effectiveness of a project relies on the causal link between outputs and outcomes. Evaluation of effectiveness looks for evidence that the program theory is valid and that progression towards expected end-of-program outcomes has occurred and that these will contribute to impact. As outlined in Section 4.4 on M&E, evaluating the effectiveness of the VHW program is difficult. SCA reported in their 2012 Completion Report that changes to the program logframe have posed "*challenges to reporting against specific, identified program outputs/objectives*" and attempts had to be made to match outputs from the original program logframe with objectives in the revised version.[21] Table 5 below outlines how these two logframes are matched for the purposes of this report, but also illustrates the inconsistencies in language and reporting and the complexities involved in assessing whether project objectives have been achieved. The following sections will evaluate to what extent the outputs and objectives identified in Table 5 have been achieved. Table 6 provides an overview of key Phase II indicators reported by SCA, which in general demonstrates a steady increase in activities since 2003. While this evaluation focuses on Phase II, which ended in February 2012, figures from 2012 are included to demonstrate the continued development of the program, including improvements that have been implemented by SCA.

Table 5: Key for reporting on effectiveness, outlining where each output and objective is addressed

Sub-section heading	Original Program Logframe (2008-2011)	Revised Program Logframe (2011-2012)
Improved access to VHW services		Objective 3: To facilitate increased community awareness, health education and behavioural change in relation to health rights, hygiene, HIV, safe sex and clean environment
		Objective 4: To ensure equal access to health services through advocating to government and local partners for improved support
Performance of VHWs	Output 4: Improved knowledge, confidence and skills of VHWs	Objective 1: Build capacity of VHWs in terms of knowledge, confidence and skills to ensure children and their families have access to basic health, treatment of common illnesses and family planning advice
Support for Aid Posts and VHWs	Output 3: Improved management of Aid Posts	Objective 2: Strengthen capacity of management of the Aid Posts at the community level by Aid Post Committees
Management of the VHW program	Output 5: The VHW project is well managed	Objective 5: Ensure efficient and effective management of the VHW program
	Output 1: Transition of VHW Program from SCA to MOH management is well managed	
	Output 2: Improved management of VHW Program at provincial and area level	

[21] SCA 2012a p. 10

The program has carried out the activities in accordance with its workplan and associated logframes, although these plans and logframes have been of variable quality. A number of key activities, such as in-service training and supervisory visits, the responsibility for which is shared between SCA and the MOH, have been regularly undertaken, though not sufficiently to meet the needs and stated requirements of the program. There is anecdotal evidence that VHWs provide valuable services to parts of the population in Vanuatu, particularly those in remote areas where, without the VHW, they would not have access to any health services at all, through the delivery of basic curative treatments and diagnosis. However, without a more detailed stocktake of VHWs and their activities, it is difficult to assess to what extent they are an effective complement to the Vanuatu health system.

The findings suggest that while VHWs have an important role to play, they are not currently operating as effectively as they could, due largely to inadequate support. There are a number of challenges to providing sufficient support to the VHWs, primarily difficult terrain making many communities hard to reach, and limited financial and human resources. In addition, responsibilities within the VHW service delivery system are divided between the MOH and SCA – for example, all program workers at the provincial level, including Health Promotion Officers (HPOs) and Area Nurses, who are responsible for supporting VHWs, are MOH staff and are therefore not the responsibility of the SCA managed component of the program. Given these limitations, it would be beneficial for the program to invest more to these support activities.

Overall, despite the absence of a systematic collection of field-based data, interviews during site visits suggest that VHWs are often effective in delivering basic curative services (objective 1), however they are less effective in delivering more holistic primary health care services, including health promotion (objective 3). In the sites visited, management capacity of Aid Posts remains in need of strengthening (objective 2). Local government support has improved (objective 4), but the program could be managed more efficiently and effectively if more emphasis was placed on provincial level (objective 5).

VHWs deliver important services, and the program is necessary to support them. The findings of this section point to the need for improvements in effectiveness in future phases.

Table 6: Summary of Phase II indicators

Indicator	2003-2005	2005-2006	2006-2008	2008	2009	2010	2011	2012
New Aid Posts opened		4		0	2	3	9	10
No. of VHWs trained through pre-service training	20			21	32	44	18	21
No. of in-service trainings held (number of participants)	6 (88)	4 (47)	6 (86)	3	2	3	2 (23)	7 (102)
No. of Aid Posts who received supervisory visits	169^			29	39	30	77	78
No. of APC trainings delivered	100	61	4	3	6	36	48	
No. of Community awareness activities	106	40[22]		6	3	23	44	

Compiled from SCA 2013; 2012a; 2012b; 2008; 2006; 2005
^ Number of visits, so the number of Aid Posts receiving supervisory visits may be lower, if some received more than one visit.

[22] In Sanma Province. There were also community-awareness-raising training for 275 participants, but it is unclear how many activities/trainings were carried out.

4.2.1 Improved access to health services

The primary purpose of VHWs is to improve access to health services and thereby the health of community members. They do this through providing basic primary health care, referring cases to higher levels of the health system, and conducting health education and promotion activities. SCA estimate that the total direct reach of the program in 2011 was 26 320 people, or roughly 11 per cent of Vanuatu's population, and that since 1999 the program has enabled more than 97 000 people to have direct access to basic health care services.[23,24] SCA have separately calculated that in 2010 and 2011, up to 55 per cent of the Vanuatu population has benefitted from improved access to basic health care services or education delivered through the program.[25] SCA report that the VHW program benefits mainly women and children, as these groups are more likely to use their services.[26] According to SCAs total reach figures for 2011, the VHW program directly reached 13 163 girls and women compared to 13 157 boys and men. These figures are based on models, rather than attendance data collected at Aid Posts, so it would be important going forward to report accurate attendance figures, including disaggregated data on age and gender, to provide concrete evidence on who is benefitting from the services being provided under the program.

While it is difficult to assess the level of satisfaction of users of the VHW program since no systematic study of utilisation or satisfaction has been carried out, informal feedback obtained during the field visits was largely positive. Anecdotally, there are examples of how the curative services provided by VHWs have made a difference to the health of individuals. Tools such as rapid diagnostic tests (RDTs), which enable community-based diagnosis of malaria, appear to have been particularly helpful at community level. For example, a young child with fever was able to be diagnosed and treated in the middle of the night by a VHW in Shefa province, without having to travel to a health centre.

a) Provide basic primary health care

As previously mentioned, the evaluation found that VHWs are primarily engaged in the provision of mainly curative basic health services, and some surveillance (for example, diagnosing malaria). In most Aid Posts, VHWs treat minor injuries, diagnose malaria using RDTs, and provide medication for headaches and fevers. Cases requiring more specialised medical knowledge or those presenting with particularly severe or acute symptoms should be referred on to the nearest dispensary or health centre.

There are variable circumstances in different regions of Vanuatu and in different locations of the Aid Posts and it appears that some VHWs carry out activities and deliver services which stretch beyond the basic list for which they are trained. In effect, there appear to be different tiers of VHWs; some, mostly those in less remote areas where formal health services such as dispensaries and health centres are more accessible, deliver the basic services outlined above. Other VHWs, often those based in more remote areas where access to formal health care is extremely limited, also deliver additional services beyond their initial training, such as giving injections, suturing and assisting deliveries. At times these activities were found to be carried out with the support of, or following on-the-job training from, health centre staff such

[23] SCA 2012a
[24] Ibid.
[25] ibid
[26] See for example SCA 2008

as a nurse. However at times VHWs also carry out these activities by themselves, if support is not available. While this is likely the best health care that community members will receive in the circumstances, particularly in urgent circumstances, it may be problematic as VHW's are providing care beyond their training and capacity. There is a risk that inappropriate care is provided and this may damage the communities' views of VHWs, or lead to unrealistic expectations of what health issues VHWs are able to help with. While most stakeholders appear to be aware of this situation, and some efforts have been made to address it through on-the-job training, it has not yet been systematically addressed.

b) Refer cases through the health system

A key function of community based health care is to treat minor health issues and refer any more complex cases to the formal health care system, thereby assisting the connection of patients to the formal health system while also alleviating pressure on the lower levels of the formal health system, such as dispensaries and health centres. Effective referral relies both on awareness of the severity of a case and overcoming obstacles to access formal health care when necessary (e.g. geographical or financial). SCA provided an example of a health centre where the number of out-patients (and therefore waiting times) decreased substantially when the four surrounding VHWs were working in their respective Aid Posts. The health centre was therefore able to focus more on in-patients and patient referrals. However, while VHWs are trained to write referral letters (and guidance is also provided in the Aid Post Manual), and they report on the number of referrals they make per month in the health information system (HIS) form, there is no program level reporting on whether the referral system is effective or whether the links between the Aid Post and the formal health system are functioning well.

c) Health promotion and education and community mobilisation

A comprehensive primary health care approach, as outlined in the Healthy Islands Policy, entails a strong focus on preventative care including community education, as well as community mobilisation to involve people in the community's wellbeing. These should be key functions of VHWs and interviews suggest that the VHW program is perceived to place emphasis on increasing community awareness in relation to health and hygiene. Successive stages of the program have carried out community awareness activities, and between 2008 and 2012, 76 community awareness activities were carried out, increasing from six in 2008 to 44 in 2011.[27] These are often carried out by program staff or HPOs, and it is unclear to what extent VHWs are provided support to enable them to conduct such activities themselves.

As outlined above, the evaluation found that the primary focus of VHWs appears to be on basic curative services and some surveillance, with much less attention to **health promotion and education**. The reasons for this have not been robustly investigated in this evaluation, however international evidence suggests that community members often more easily understand and appreciate curative services, rather than community education, particularly when paying for services, this means that both demand and supply may be skewed in favour of curative care.[28] This, however, will need to be further investigated in the specifics of the Vanuatu context

[27] SCA 2012a
[28] The USAID review on incentives for community health workers found that in instances where voluntary health workers receive fees for services, it is common for them to prioritise curative services rather than community education, since these are more easily understood and appreciated by community members, and payment can therefore be expected.

and this program. Certainly the training that VHWs receive has been largely focused on basic curative care, and while increased focus has been placed on training for community engagement and education towards the end of Phase II, it does not yet appear to have as yet significantly changed what VHWs actually do. Further, VHWs may lack confidence and support to effectively engage in broader community activities, and there may be limited awareness of the role of the VHW and Aid Post in carrying out such activities. Finally, limited support from APCs and health workers limits the effectiveness of VHWs.

One significant limitation of the **community mobilisation** component of the VHW program appears to be the low level of awareness of the program in some areas. A number of interviews during the site visits, for example, at the provincial level in Sanma and at the community level in Malampa, revealed that the level of awareness about the purpose and responsibilities of VHWs was low among community members, APC members and even health staff. This may limit utilisation, accountability and the level of support provided to VHWs, APCs and the Aid Posts themselves. It appears that a key component of a successful community based health program relies on the community seeing value in the program and the VHW, which would both encourage them to support the VHW and their activities, and likely provide better recognition and status for the VHW, which may contribute to their motivation. Community awareness of the program and the role and value of the VHW is therefore of paramount importance.

In addition, while VHWs currently have access to a limited range of **health education materials** to support their promotion roles, these are largely limited to posters on health issues such as oral rehydration, hygiene and breast feeding. However, the evaluator suggests that these materials may not be ideal for their purpose, as behaviour change is best facilitated through dialogue and interaction between the VHW and community participants. More interactive materials would facilitate such engagement – for example, flash cards and flip charts. There are a number of existing materials, developed specifically for use in Vanuatu, which could be used, such as the IEC healthy islands package and 'hands up for hygiene'.[29,30] In addition, the Health Promotion Unit (HPU) at the MOH also develops and prints community education materials as part of the revitalisation of primary health care initiative; however, these different contributions to health promotion have not yet been streamlined for community level primary health care.

The legal basis for APCs, the Health Committees Act of 2003, defines a narrow set of functions which seem to be interpreted as limited to the maintenance of the Aid Post, charging and collecting fees, and ensuring primary health care services are provided to the community.[31] It does not address how these primary health care services are delivered, how health problems can be avoided or a broader role of community mobilisation to identify and address local problems.

4.2.2 Improved performance of VHWs

The exact number of active VHWs in Vanuatu is unknown. The Aid Post list provided by SCA, which was accurate at the middle of 2011, estimated 203 VHWs (see Table 2), however SCA estimate that as of January 2013 there are approximately 230

[29] WHO 2011
[30] Live and Learn 2011a
[31] GoV 2003

VHWs.[32] In several remote areas, it is unknown whether VHWs continue to operate, as no contact has been made in a number of years. The number of active Aid Posts also fluctuates as buildings fall into disrepair, and others are repaired.

The **gender of VHWs** is important as an equal opportunities issue, but also in relation to how the gender of service providers may influence men and women's willingness to access VHW services. While there was previously a majority of male VHWs (63 per cent in 2004), with female participation ranging from 11 per cent in Tafea to 40 per cent in Malampa, the gender balance has significantly improved with 54 per cent of VHWs male in 2011.[33,34] However, it should be noted that the proportion of female VHWs in 2011 ranged from 18 per cent in Tafea to 71 per cent in Penama (see Table 2). In Sanma and Torba provinces there seems to be a reluctance towards female VHWs.

Cultural explanations given include the view that an unmarried female is unlike to remain in her village and would therefore be ineligible for the program, or that a remote Aid Post requires a 'strong man.' Previous reports suggested that even where female VHWs are present, they may not be able to control their Aid Posts. For example, SCA reported in the 2006 completion report that there had been an incident involving an over-powering husband in Malampa taking over the Aid Post and administering drugs to clients on behalf of his VHW wife.

Discussions during field visits suggest that women may be reluctant to visit a male VHW, particularly if it means being alone with him, or if it involves a physical examination (even though SCA highlight that VHWs are unlikely to need to undertake a physical examination, and if required, they should request the presence of a woman's husband). This suggests that utilisation of VHW services might increase if there were more female VHWs, since women and girls may feel more comfortable seeking their assistance – particularly in areas such as family planning. These findings and suggestions indicate that a systematic gender analysis of the program is required to inform the program strategy in the next phase.

VHWs are volunteers nominated by their communities and final selection is done by the HPOs. Basic selection criteria were refined in 2009 to reduce gender bias towards the selection of male VHWs. Communities are asked to consider some of the following attributes when nominating VHWs: honesty and trustworthiness, wiliness to sacrifice their time, living in the community, literacy in Bislama, education standard equivalent to Year 10, and demonstrated respect for the community. HPOs are responsible for reviewing and approving nominations and selecting the preferred candidates. However, given the importance of the role of VHWs in many communities, the program may want to explore whether a more rigorous selection process is required.

There are no formal **job descriptions for VHWs**, although there is a section in the Aid Post Manual entitled 'Wok blo wan VHW' which outlines their roles and responsibilities. The activities carried out by VHWs across Vanuatu are not uniform – each Aid Post is unique as it serves the particular needs of a specific population and context, and VHWs often have differing levels of educations and expertise. Although most should have received the same pre-service and in-service training, some VHWs

[32] It is unclear why there is such a discrepancy in figures. The list from 2011 includes 11 vacant VHW positions and four unnamed positions. If these were filled, it would bring the total to 218. To ensure comparability, the figures provided in the 2011 table are used for Table 2.

[33] SCA 2004

[34] SCA 2011b

may only be educated to Year 6 level (particularly if recruited prior to revised selection criteria in 2009), and may be without any pre-service training or knowledge of the health system. In general, VHWs are trained and encouraged to carry out basic surveillance and diagnosis (to be able to identify e.g. suspected malaria), deliver basic health care services (including preventative and curative care), refer cases through the formal health system, and conduct health promotion and education activities in the community. Given the heterogeneity of the Aid Posts and their circumstances, it is challenging to provide a general overview. While some appear to be well staffed and resourced, others have been neglected. To highlight some of the difficulties faced in more remote areas, and to illustrate the continued need for efforts to improve the performance of VHWs, an example of the circumstances faced by one particular VHW and Aid Post is outlined in Box 1 below

Box 1: Galleli VHW case study

Galleli village, Malampa province

Galleli village is a 3- 4 hour drive from the Provincial Hospital in Norsup on rough roads. The village Aid Post is officially supported by an Area Nurse at the Atchin Health Centre, which is situated along a very rough track with no public transport and is a difficult walk of 3-4 hours from Galleli. The Aid Post provides services to approximately 200 people in the area.

The attached VHW completed pre-service training in 2008 and in-service training in 2010. The VHW had never received a supervisory visit. The VHW receives no allowances but retains the consultation fees from the 5-10 people treated each month, providing between 100-400 vatu. Some people cannot afford to pay for the curative services.

In 2008, the VHW received a one-off payment of 5000 vatu for the maintenance of the Aid Post from the provincial government office. The Aid Post is a basic one room design made of bamboo and coconut leaves and does not have a secure place to store medicines. The VHW collects medical supplies from the Atchin Health Centre, but at the time of visit the Aid Post had been unable to obtain pain killers and antibiotics for a number of months.

The Aid Post is quite isolated but the VHW does not perform any additional services such as injections and refers problems such as deep cuts, dental and pregnancy complications to the Health Centre. The VHW cannot report on the curative services provided because he has run out of HIS forms, although he does keep a rudimentary outpatient record book.

The Aid Post Committee is not active and has not met for the past three years. Although the VHW feels isolated he showed a real commitment to his work and a desire to continue to provide a service to the community.

a) Training

Training is the longest established aspect of the VHW program, and VHW skills development accounts for 12 per cent of total expenditure between April 2008 and February 2012.[35] This allocation has fluctuated over the last ten years, ranging from 5.4 per cent in 2005-2006 at the lower end, to 20 per cent in 2010 at the higher end. However, the relative allocation does not appear to consistently correlate with training outputs (see Figure 1). The pre-service and in-service training curriculum, the clinical placement, the Aid Post manual and the supervisory visit handbook have all been developed by SCA to help develop the skills of VHWs. However, their quality has not been assessed, and it is unclear whether they have been developed in line with international benchmarks. The mid-term review and some reports by SCA have indicated that the knowledge, confidence and skills of VHWs have improved over the years; for example, in 2005, SCA reported that VHW pre-service and in-service training led to a 19 per cent improvement in test results. Interviews during field visits

[35] SCA 2012a

found that VHWs are often confident in their skills and are able to deliver basic services; however, the baseline survey conducted in 2006, which included indicators on the level of confidence of VHWs, has not been repeated; hence any such evidence is largely anecdotal. Interviews and review of program reports suggest that a clear effort has been made to improve the knowledge, confidence and skills of VHWs, however, the quality of the training curricula and Aid Post manual has not been assessed and the effect of the training has not been well documented.

Pre-service training

All new VHWs are supposed to undergo ten weeks of residential, pre-service training before commencing their work. This training consists of eight weeks of intensive theory, comprising twenty-four technical modules which focus on body systems, disease theory, management and prevention of specific health issues such as malaria, acute respiratory infection, non-communicable diseases and diarrhoea. There is also a module on health promotion.[36] This training is followed by a two week practical attachment to a Health Centre or Dispensary. Pre-service training is predominantly organised and delivered by the national VHW Program team with technical expertise sourced mostly from different sections within the MOH. Since 2008, HPOs have been increasingly encouraged and supported to deliver technical training modules in order to bring the value of their field level knowledge and experience to the VHW training.[37] The number of VHWs participating in pre-service training has increased since Phase I. Between April 2008 and February 2012, 115 VHWs were trained through pre-service training, ranging from 21 in 2008 and 2012, to 44 in 2010.[38] In comparison, 20 VHWs were trained in the two years between May 2003 and June 2005.[39] However, there are indications that a number of VHWs have never attended pre-service training, a fact which is often discovered during subsequent in-service training. The midterm review identified that there were 35 VHWs in 2010 who had not undergone pre-service training; in 2011, 30 out of 203 VHWs (15 per cent) had never attended pre-service training.[40,41]

In-service training

All VHWs are supposed to attend a two week in-service training held at the provincial level every two years, which serves to refresh and reinforce information learned during the pre-service training, to update them on emerging technical issues or practices, to train them in any new program processes or protocols and to give them an opportunity to meet and share experiences relating to the delivery of health care and engagement with their communities.[42] Continuous, regular 'refresher' training is key for improving the skills of VHWs and therefore the quality of the services they deliver. It has also been identified as an important factor in retaining the motivation of community health workers and peer support and VHW networks have been found to

[36] However, given the importance of confidence and engagement of VHWs, it is unclear whether this module is sufficient for effective community engagement. Consistent support and encouragement are likely also important.
[37] Interviews with SCA; SCA 2012a.
[38] SCA 2012a.
[39] SCA 2005.
[40] Chevalier 2010
[41] SCA 2011
[42] The strengthening of VHW networks can be an important way to develop professional support and improve performance, for example through the regular meeting of members or through electronic links such as SMS. A USAID review of CHWs highlighted that several NGO programs have successfully paired CHWs so that they can work together and support each other, while others bring CHWs together in monthly meetings to help bonding, as well as contribute to in-service training and supervision. Development of such networks can help motivate VHWs and include them as a part of the health team in their area, involving them in on-going programs with health professionals (Tien, LeBan & Winch 2000).

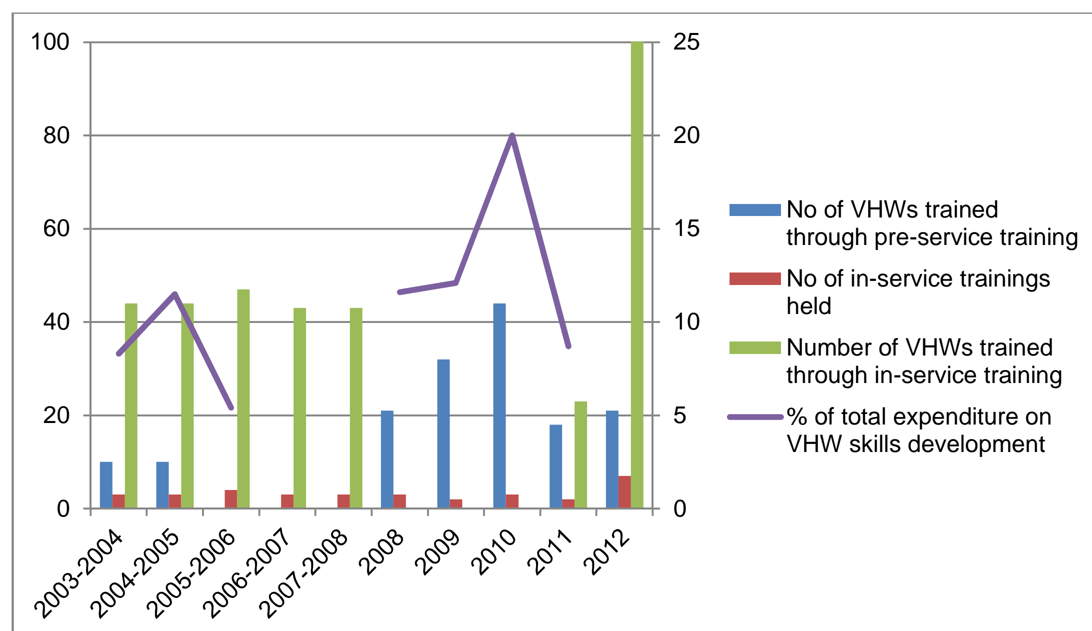
strengthen motivation and lead to ownership and creativity.[43] The effectiveness of in-service training depends on their regularity.[44] The number of in-service training sessions has been relatively constant since 2003, averaging around three per year, except for a spike in 2012 when there were seven. There is incomplete data available on the number of VHWs attending these training sessions, but between 2003 and 2008, 221 VHWs attended in-service training (124 men and 97 women) – an average of 44 per year. In comparison, in 2011, there were two training activities with a total of 23 (6 male and 17 female) VHWs participating. In 2012 this increased substantially to 7 activities with 102 attendants (49 male and 53 female) (see figure 1). In 2011, 73 per cent of VHWs had attended at least one in-service training session, while 24 per cent had never attended an in-service training.[45] It is also unclear whether VHWs are attending one training every two years as required. To provide regular in-service training to the over 200 VHWs, the frequency of these training activities would need to be maintained at a level similar to 2012.

Other training

The program has also delivered some additional training, such as how to fill in HIS forms and in 2008-2009, 77 VHWs attended special training in Rapid Diagnostic Testing for malaria.[46] Increased emphasis has reportedly been placed on strengthening VHW's community engagement skills. For example, in 2011, the Program team worked with Peace Corps Volunteers to design and deliver a community mobilisation workshop to VHW – Primary Health Care Revitalisation Training for Community Leaders. Training of trainer workshops for this approach have been conducted for 24 participants in Shefa and Tafea Provinces.[47] However, this occurred at the provincial level, and it is unclear whether subsequent training took place at the community level with VHWs, where it is likely most needed.

[43] Tien, LeBan & Winch 2000
[44] Ibid.
[45] The remainder are retired nurses who are not seen to need in-service training.
[46] SCA 2012a
[47] SCA 2012a

Figure 1: In-service and pre-service trainings conducted between 2003 and 2012



Source: compiled from SCA 2013; 2012a; 2012b; 2008; 2006; 2005

4.2.3 Support for VHWs & Aid Posts

There were 211 operating Aid Posts across Vanuatu in 2011, and SCA estimate that as of January 2013, there are 212. At the end of 2012, there were approximately 230 VHWs, which means that most Aid Posts are staffed by one, and in some places two, VHWs (some VHWs work in dispensaries). However, the estimated number of VHWs in 2011 was only 203, hence it is unclear whether all Aid Posts counted were active, or whether the VHW count was accurate. Aid Posts were previously mainly constructed using traditional methods and materials, and should contain a basic set of furniture, including tables and chairs, and equipment, such as a medicine cupboard. Drugs and medicine are provided free of charge by the Government, based on stocktakes and information contained in the HIS form completed monthly.

SCA reported that in 2008, many of the country's Aid Posts were in a poor state of repair, and that this contributed to deflated morale of VHWs, APCs and communities.[48] Since then, efforts have been focused on constructing new Aid Posts and revitalising existing buildings, with 3 million vatu worth of materials committed in July 2010 to support community-led construction of twelve semi-permanent or permanent Aid Post buildings (two per province), and the establishment and expansion of a small grants scheme which allocated about VUV100 000 per year to each province. This is divided amongst communities identified by the HPO or who request assistance.[49] A 'Safe Model Aid Post' has also been designed; the first was constructed in 2011 in Shefa Province, and similar Aid Posts are in construction or have been completed in the remaining five provinces in 2012.[50]

[48] SCA 2012a

[49] SCA report that this was done because supervisory visits conducted in 2008 and 2009 found that 75% of Aid Posts building were built from locally-available materials, which only remain effective for up to 3-5 years (SCA 2012). However, the evaluator has some concerns that the construction of permanent buildings may not be efficient, as communities often lack resources and skills to complete construction or maintain these buildings.

[50] By Jan 2013, model aid posts had been constructed in three more provinces, and construction had commenced in the remaining two in Tafea and Torba provinces.

While the structure of the budget makes it difficult to ascertain the exact amount allocated to construction of Aid Posts over time, in the first six months of 2012, about VUV2.5 million, or 15 per cent of total expenditure, was allocated to construction and renovations of Aid Posts, and SCA report that this has been a key expenditure over the last few years. This focus has meant that 16 new Aid Posts were opened between April 2008 and February 2012, increasing the total number of Aid Posts staffed by VHWs at that stage from 172 to 188.[51]

While expanding the reach of the program is commendable, given the difficulties in keeping VHWs trained, supported and engaged, it would be useful to conduct a current mapping or audit of Aid Posts across Vanuatu, particularly in relation to the location of dispensaries and health centres. This would determine whether, and where, new Aid Posts need to be constructed or renovated. It could also help identify whether there would be benefits of limiting the number of Aid Posts that the program supports, thereby consolidating investments. In addition, it should also determine how important a permanent structure is to the effective functioning of a VHW.[52]

a) Management of Aid Posts & support for VHWs

Aid Posts across Vanuatu are managed by Aid Post Committees (APCs). The functions of APCs are defined by the 2003 Health Committees Act, and include maintaining health facilities, charging and collecting health fees, overseeing the sanitation of communities, using or spending money received for the overall maintenance of health facilities and sanitation of the communities and ensuring that primary health care services are provided to the community. The APC should be a source of support and oversight for the VHW, and should help facilitate community engagement activities. However, although there are many active groups and committees in Vanuatu, such as churches, women's groups and village councils, the field visits found that many APCs appear to be inactive, which leaves the VHW to manage the Aid Post by him/herself and limits community involvement, as well as the accountability of the VHW to the community.

Observations during the evaluation field visits suggest that the inactivity of many APCs may contribute to the poor management of funds, as without it, there is limited accountability and oversight for the VHW. In addition, an inactive APC would leave the VHW isolated and with little support, which may affect his/her motivation and ability to carry out their functions, in particular those related to health promotion and community mobilisation. Strengthening the support available for VHWs from the community and APCs is important to encourage and promote health promotion and community mobilisation. Strategies for this need to be explored, but one option discussed during one interview was to make grants available to fund small scale initiatives at the community level, which could potentially be a powerful way of expanding the reach of the program. Communities would need to work together to identify priorities and prepare proposals, together with the VHW and with the support of the HPO, and could be asked to match the requested funds with labour or resources. The availability of such a small grants scheme could contribute to increased engagement of community members in development issues that affect their communities.[53] This seed funding would be different from the current small grant scheme, which is focused on construction, repairs and equipment. Such a scheme

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[51] ibid
[52] For example, one of the most effective strategies of community health workers in Bangladesh for health promotion and education was door-to-door visits to families (http://www.unicef.org/infobycountry/bangladesh_66012.html)
[53] See for example Wharf-Higgins, Naylor, & Day 2007.

would require resources (either additional or reallocated) to cover the grants, and would also have implications for management.[54] The grant scheme would need to be carefully managed and monitored, introduced in a phased manner in manageable numbers, and be contingent on upon satisfactory submission of a project proposal and with the assistance of the HPOs.

APCs are appointed and approved by the HPO, and usually consists of both the VHW and the local area nurse, who acts as committee secretary. In addition, there should be a treasurer to manage funds. There is limited information available on membership of APCs, but a gender baseline study of APC membership and VHW participation, carried out in 2004, revealed that the number of women who were members of the APCs was as low as 20 per cent across the program.[55] However, there has not been a repeat of this survey. The APC should decide how to spend the funds collected at the Aid Post, mainly through VHW consultations, as well as through community fund raising initiatives. In different Aid Posts funds were variously found to be divided between the VHW and APC, held fully by the APC, or used personally by the VHW. As outlined above, observations and discussions during the first field visit suggested that an inactive APC may contribute to the poor management of an Aid Post, including of funds. The program has provided training for APC members – 93 training activities were delivered between 2008 and 2012 (of which 48 were conducted in 2011, increasing from 3 in 2008).[56] These are generally conducted by HPOs, at times with support from program staff, and include training on basic book keeping. These training sessions provide useful opportunities for encouragement and awareness raising on the roles and responsibilities of the APC.

To address some of these issues, some Aid Posts have been moved into school grounds. Schools have budgets for ancillary staff, which means that VHWs can receive an allowance or salary. The school is then responsible for the Aid Post, and replaces the need for a separate APC. This location of the Aid Post facilitates access for families and taps into existing committee structures. Currently, 96 Aid Posts are located within school boundaries. Initial feedback suggests that this model has been effective, but a more detailed assessment is necessary prior to expanding this model.

b) Supervisory visits

Supervisory visits, which are conducted by MOH HPOs or Area Nurses, are key to ensuring upkeep of Aid Posts, appropriate conduct of VHWs, receiving and communicating feedback, supporting VHWs, and providing on-the-job training. They also serve to boost the morale of VHWs, and demonstrate their value to the rest of the community, including leaders. The program recommends a supervisory visit to each VHW or Aid Post every six months. Presently, supervisory visits represent the only interaction of VHWs with the formal health system, and other than in-service training, the only opportunity they have to renew and check their skills, request support and obtain mentoring and encouragement. These visits are particularly important since there is limited communication between VHWs and other actors, due in part to lack of communication technology at Aid Posts.

Since 2008, efforts have been made to increase the number of supervisory visits, including through support by the VHW program (for example increased funding for travel costs of HPOs), however, the target of one visit per six months has never been achieved. While the data currently collected on these visits is limited, SCA report that

[54] The evaluator suggested Aud 150-500 per Aid Post Committee as a guide.
[55] SCA 2004
[56] SCA 2012a

175 supervisory visits were conducted between April 2008 and February 2012, ranging from 29 in 2008 to 30 in 2010, and 77 in 2011.[57] While the increase is positive, if the objective of two supervisory visits per year were to be reached, the 188 Aid Posts needed to receive two visits in 2011, a total of 376. There is anecdotal evidence that some Aid Posts have never received any supervisory visits (see Box I for the case study of the Aid Post in Galleli which was established in 2008 and has never received a supervisory visit).

Supervisory visits are challenging because although the Program monitors the number of visits and provides resources to facilitate them, they are under the responsibility of MOH, through HPOs and Area Nurses. As outlined in section 4.2.4. below, there is insufficient capacity at the provincial and local level to undertake the required quantity and quality of supervisory visits. Two main resource limitations which limit the number of supervisory visits were identified by the review:

- **Human resources**

  The responsibility of conducting supervisory visits falls on provincial HPOs, sometimes with the support of area nurses. There are supposed to be six HPOs across Vanuatu – one for each province, but one of these positions is currently vacant (in Torba), leaving only five HPOs (and the Penama HPO position was inactive and then vacant from late 2011 until late 2012). HPOs work for the MOH, and not solely for the VHW program, and their availability to support the VHW program depends on the MOH provincial workplan. In general, HPOs may only be able to dedicate about half of their time to the VHW program. There are presently 212 Aid Posts in Vanuatu, and most HPOs would be responsible for 30-50 each. Many of the Aid Posts are difficult to reach, and even if visits are combined, interviews suggest that it may take anywhere between one and four weeks for an HPO to visit five Aid Posts, depending on the province. It therefore appears unrealistic that one HPO would be able to conduct the required 60-100 visits per year, and it is difficult to envisage how VHWs could receive the support they require without additional human resources.[58]

- **Financial resources**

  Travel and logistics in Vanuatu are expensive, due to its geography and high cost of travel. The funds made available to HPOs for supervisory visits have increased over time. It ranged from VUV80 000 and 105 000 per province per year between 2008 and 2011. SCA report that following the Project Coordinating Committee (PCC) meeting in 2011, it was agreed that more funding should be made available, and in 2012 SCA report that between VUV100 000 and VUV400 000 was made available for each HPO based on a workplan and budget approved by SCA. SCA report that they have at times responded to submissions of high activity budgets from HPOs in the field with guidance to encourage efforts which look at delivering fewer outputs with improved quality, rather than trying to over-extend human resource capacity

[57] SCA 2012a. This report counts 55 Aid Posts which received supervisory visits in 2011; however, reporting in the beginning of 2013 updates this figure of 77. At the guidance of SCA, this updated figure has been used.
[58] In 2012 an agreement was made to create a new formal health worker role – the assistant health promotion officer, to help address the shortage of human resources at the provincial level. These were to be hired by SCA, and would support the HPO with conducting supervisory visits. However, issues identified relating to reporting lines, salaries and responsibilities were identified, and these positions are now on hold. The issues identified are serious, and need to be resolved; however, it is important that options for strengthening capacity at the provincial level continue to be explored

and deliver activities, such as supervisory visits of reduced quality. The financial allocation for supervisory visits is important, because in many parts of Vanuatu, it seems that the amount made available between 2008 and 2011 was often insufficient to cover both travel and basic accommodation for many visits. For comparison, the evaluation team hired a vehicle to visit a remote Aid Post for half a day, which cost VUV150 000. Boat travel between islands is also costly – often VUV15 000 for a short trip, which leaves insufficient funds for subsequent road travel and overnight stays. HPOs interviewed during the evaluation field visits indicated that they would conduct more supervisory visits and would stay for longer in communities to increase the value and utility of the visits - if they had access to sufficient funds for these activities.[59]

In addition, the Program needs to ensure that the supervisory visits are of sufficiently high quality. Supervisory visits are guided by the supervisory visit handbook, which was produced for provincial HPOs. After a trial in thirteen communities, the final handbook was prepared and HPOs trained in its use during the mid-year planning and reflection meeting in 2011. Examination of the handbook and discussions with HPOs revealed that the handbook is largely focused on a narrow supervisory checklist, such as checking medicines, ensuring these are stored correctly, checking that VHWs fill out the HIS forms correctly and examining Aid Post cleanliness and upkeep. While they do pose some questions relating to the activities of the VHW, supervisory visits do not necessarily assess the work of the VHW, how and to what extent they engage with the community, and their leadership skills. Some positive steps have been taken to strengthen supervision within the VHW program. For example, in 2012 one of the supervisory visits in Torba was expanded to include a TB and Leprosy program officer to conduct screening of suspected TB cases and a Maternal and Child Health nurse to follow up on overdue child immunisations in the far islands of Tekua, Toka, and Hiu.[60] Since supervisory visits are essentially the only time that the VHW is able to access support, it is important that the visits are detailed, comprehensive and high quality.

Overall, the Program's support in this area has not led to a sufficient improvement in the support provided to VHWs, so alternative arrangements need to be explored.

c) Incentives

Incentives have been raised as an important issue for VHWs throughout the international literature, and was raised as a key issue and concern in a number of interviews in Vanuatu. Particular focus was paid to financial incentives, but issues of community support for VHWs were also raised as key. As lay health workers tend to be community volunteers, traditional monetary incentives (i.e. salaries) are not in place, but strong incentives are nonetheless important. There have been international reviews on this subject which can inform an analysis of incentives in Vanuatu. For example, a draft USAID review of incentives and disincentives for community health workers found that specific and relevant incentives – both monetary and non-monetary – are necessary for VHWs to maintain the motivation and enthusiasm. Community recognition and support appear to be key factors in all successful CHW programs, while personal development and growth through training, mentoring and supervision appear to be a major element in community health worker

[59] It is unclear whether these HPOs were aware of the increase in budget which was apparently made available in 2012.
[60] SCA 2012b

motivation and retention. The impact of monetary incentives appears to be mixed – while it can help VHWs feel acknowledged and approved (provided they are compensated in an appropriate, respectful and regularised manner), it can also act as a disincentive. For example, money can undermine VHWs commitment or undermine their relationship with his/her community. The source of the monetary incentive is also important – for example, fee for service can help provide motivation for VHWs, but equally, it can decrease the incentive for provision of preventative care and community education by VHWs, increasing curative activities and risking over-prescription of medication.[61] Fees can also limit access by those most in need of services but unable to pay a fee.

Throughout the field visit, incentives and payments to VHWs were issues that were consistently raised. Financial incentives appear to be important motivation for VHWs, as a number of interviews suggested that many use their VHW role to supplement their incomes. The VHW program has a standard set of fees – VUV50 for a child and VUV100 for an adult. These are generally charged, although some exceptions were reported, for example in poorer areas VHWs do not always charge families for services. However, due to the variation in use of Aid Posts and VHWs, and the different sizes of the populations that they serve, the monthly income for VHWs can range from a few hundred to a few thousand vatu. In addition to fees, some provincial governments have begun to financially support their VHWs. The Program mid-term review found that in 2010, five out of six provinces were providing some sort of financial support to VHWs, but the extent of the support varies, and it often does not cover all VHWs.[62] While provincial support for the program is positive, it has resulted in inequity across the VHW program.[63] For example, all 35 VHWs in Shefa province now receive some payment from the provincial government (VUV7000 per month each), while many VHWs in other provinces receive no payment.

Interviews suggest that VHWs are aware of this imbalance and those not receiving payments are dissatisfied, and that the continuation of the current provincial inequity could influence the motivation for those receiving little financial rewards. It is important that the calls for financial incentives do not overshadow other needs of the program, and non-financial incentives, including increased community and program support, recognition and status of VHW, should be equally considered.

d) Community support

Community support has been identified in the international literature as key for effective community health care, and appreciation, recognition and status have been found to be important drivers for community health workers.[64] In the Vanuatu context, it is important that community members identify and recognise the value of having a VHW and an Aid Post – recognising the value will likely contribute both to a more supportive environment for VHWs and a more receptive audience for health promotion and education activities. As outlined earlier, interviews conducted in Sanma and Malampa revealed that awareness of the purpose and responsibilities of VHWs was low among community members, APC members and even health staff, suggesting that continuous efforts are needed to engage communities. There are close links between community support for VHWs and health promotion and education and community mobilisation activities driven by VHWs and APC members,

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[61] Tien, LeBan, & Winch 2000
[62] Chevalier 2010.
[63] According to the mid-term review, Penama was the only province where the government provided no financial allowance or support to their VHWs (Chevalier 2010).
[64] Tien, LeBan, & Winch 2000

as they are likely to positively (or negatively) reinforce each other. Stakeholders interviewed in Vanuatu are aware that community support and engagement with VHWs is a key issue.

Examination of the activity list and expenditure suggests that most activities are carried out at the provincial level (e.g. VHW training), and a significant proportion of activities at the community level are focused on Aid Post construction and repairs. The reasons for focusing on Aid Post buildings are understandable, and the motivation of VHWs may indeed be linked to improved working conditions. Most stakeholders acknowledge that the construction process, including engaging community members and promoting ownership, are just as, if not more, important as the building itself. However, it is unclear whether the focus on Aid Post construction and repairs adequately addresses the issue of inadequate community support, and care should be taken that other, perhaps less tangible, elements are not neglected.

As outlined above, community awareness activities have been undertaken throughout phase II of the program, however, to ensure continuous support and engagement, it is likely that more activities will need to be moved from the provincial to the community level to improve this aspect.

e) Support/training at the provincial level

The program also delivers training to area nurses to promote their support role for VHWs. From 2006 to 2008, 103 nurses participated in HIS training (including preparing them to train VHWs), 60 nurses attended nurses forums where they are made aware of their roles as community health managers at the area level, and 36 nurses attended training of trainers training and supervision and community mobilisation training, where they were introduced to the supervision checklist and the methods of conducting coaching supervision to VHWs and communities.[65] Such activities were not reported on in the period of 2008 to 2012 so it is unclear whether they continue and how the roles of area nurses are currently defined.

4.2.4 Management of the program

The VHW program is part of the Health Promotion Unit within the MOH, and the national coordinator is a HPU staff member. In addition, the provincial HPOs are MOH staff, working for the provincial health office, under the supervision of provincial health managers. The rest of the program is outsourced to SCA, who manage all activities, including providing funds for activities carried out by relevant MOH staff, such as the national coordinator and the HPOs.

The bulk of program management is undertaken at the national level. The national coordinator sits in the HPU within the MOH. At the national level there are also three paid SCA staff managing the program, including the program manager and the Southern Coordinator (both based in Port Vila), as well as a Northern Coordinator (based in Luganville). In addition, there are two volunteers supporting implementation – a Peace Corps volunteer based in Port Vila and an Australian Youth Ambassador for Development (AYAD) volunteer based in Luganville. SCA also have management and program support staff at the national level who support the program, including senior management, finance and construction. At the provincial level, there are only MOH staff – the health promotion officers. There is one HPO per province (although currently only five as the post is vacant in Torba). HPOs are not dedicated solely to

[65] SCA 2008

the VHW program – they have other functions as well, primarily related to other activities for the revitalisation of primary health care. Their availability to support the VHW program therefore depends on the workplan of the MOH.

SCA provides funds for the HPO to carry out VHW program related activities, such as supervisory visits and trainings, and the program also provides some office support at the provincial level. The HPO is supervised by the Provincial Health Manager, and SCA have little influence over their activities and are not able to address issues such as underperformance. Interviews suggest that awareness of the particular roles and responsibilities of HPOs among Provincial Health Managers is sometimes low, hence the HPO may not receive much support within his or her office. In effect, all activities related to VHWs and the delivery of their services should be carried out at the provincial level – HPOs conduct supervisory visits, organise and deliver training for VHWs, area nurses and APCs, coordinate with provincial health officials, thereby linking VHWs to the formal health system, and participate in management meetings. The responsibilities of HPOs are substantial, and their performance will directly impact the quality and reliability of the program. This role appears too important to be a subset of the responsibilities of five or six individuals. Dedicated, experienced and qualified staff at the provincial level, who are provided with appropriate support and capacity building, are essential to the effective delivery of this program.[66]

Efforts have been made throughout the program to allow for sharing of experiences, learning and feedback, and there are a number of committees and management processes in place for this purpose. At the national level, there are program reflection and planning meetings, project coordinating committee meetings and national stakeholders meetings. The reflection and planning meetings are held annually or biannually with program staff (there was one in 2011 but two in 2012). They include program staff, HPOs, and recently, provincial health managers (in December 2011, provincial health managers were also invited to accompany their HPOs to strengthen provincial-level management and dissemination of project funds, and ownership of program activities). The purpose is to reflect on highlights, achievements and challenges, and to contribute detailed, coordinated activity planning and budgeting. HPOs report back on gaps or issues that they identify at the community level through their visits. It allows for issues to be raised – for example, in 2011, the issues and challenges of supervisory visits were raised, and it was agreed that the budget allocation for supervisory visits would be increased.

The Program Coordinating Committee (PCC) meets every six months. It is chaired by the Director of Public Health at the MOH, and participants include the National Coordinator and other key representatives of the MOH, the Department of Strategic Policy, Planning and Aid Coordination and the Ministry of Internal Affairs, the SCA Country Director and VHW Program Manager, representatives of AusAID, Peace Corps and other key technical agencies. In this setting, SCA presents its six month reports, and the purpose is to review progress and to discuss and address key issues

[66] A plan to recruit and support a new set of provincial level workers – assistant HPOs, was devised for 2012. While there is support from a range of stakeholders that such support is important, there were disagreements regarding the division of responsibility and access to funds between the AHPO, who would have worked for SCA, and the HPO, who works for the MoH. There is currently no plan to implement this plan. Further thinking will be needed to devise a plan to provide additional support at the provincial level which is compatible with government structures.

relating to both the technical delivery of activities and the relationship and collaboration between MOH and SCA.

In addition, there are national stakeholders meetings once every two years, which includes the participants of the previous two meetings, as well as additional PHC actors and other non-government organisations (NGOs). These are also used to feedback experiences and learning, and reflect on progress.

At the provincial level, there are mini-stakeholder meetings, which are facilitated by the provincial governments, and involve reflection on primary health care activities. There was one meeting held in each province in 2011. Some, but not all, VHWs attend these meetings. Their purpose appears to be both to pass on resolutions from national stakeholder meetings and update provincial level actors, and to feed information up to national-level planning.

Table 7: Regular meetings and feedback sessions in VHW program

Meeting	Level	Participants
Program reflection and planning	National	Health Promotion Officers, VHW Program staff, Provincial Health Managers
Project Coordinating Committee	National	Director of Public Health, National Coordinator and other key representatives of the MOH, the Department of Strategic Policy, Planning and Aid Coordination and the Ministry of Internal Affairs, the SCA Country Director and VHW Program Manager, representatives of AusAID, Peace Corps and other key technical agencies
National stakeholders meeting	National	VHW Program staff, MOH, Provincial governments, AusAID, Peace Corps, other NGOs
Mini-stakeholder meetings	Provincial	Provincial government, HPOs, Provincial Health Managers, VHW Program staff, some VHWs.

The current working arrangement between MOH and SCA requires close collaboration and communication, to ensure streamlined activities and avoid duplication, as lines of responsibility can be difficult to differentiate. Collaboration between MOH and SCA appears to have been inconsistent in the past, with some complaints of lack of commitment by the MOH. However, SCA reports that cooperation has improved markedly since 2011 but that challenges remain due to delays of the delivery of program funds from MOH to SCA, which has at times delayed implementation of provincial activities such as supervisory visits.[67] Having parallel management and reporting structures inevitably causes difficulties, as the program managers in fact have no authority over key implementation staff (HPOs), and are not able to deal with issues such as underperformance. In addition, the VHW program does not appear to be sufficiently integrated within the MOH, but rather remains perceived as a separate activity (and as a source of additional funds for some). To improve efficiency, the VHW program should be firmly integrated with other primary health care activities to ensure that for example, community visits and activities as well as educational materials are coordinated and streamlined. Strengthening the MOH's capacity and transitioning the management of the program from SCA to MOH has been a priority for the program since 2003, although the focus on this objective was reduced in 2011. While it should be recognised that outsourcing service delivery is an acceptable strategy, given restrictions in the MOH's capacity to absorb funds and manage the program, ownership and engagement by the MOH is

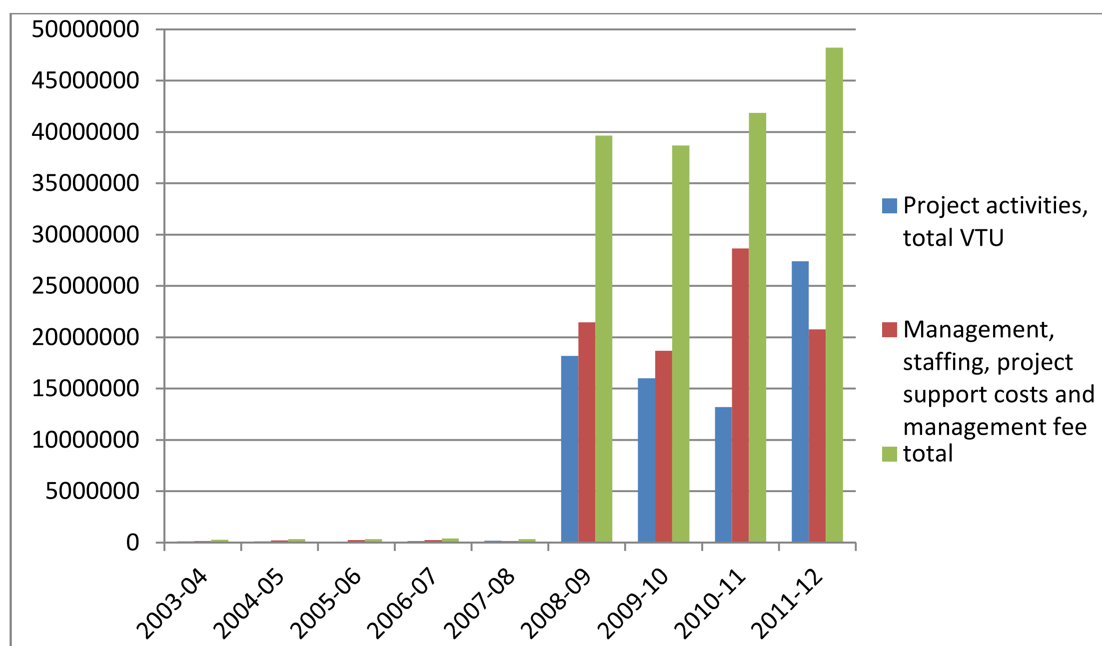
[67] SCA 2012b

vital for the sustainability of the program. There appears to be general agreement that MOH will eventually need to take over the program but concrete steps need to be taken to ensure that this will be possible, which will require commitment from both SCA and MOH. (This is discussed in more detail in Section 4.5 on sustainability).

4.3 Efficiency

The criterion of efficiency requires an analysis of the inputs and outputs of the project, to see if more outputs could be delivered with the same inputs or whether the same outputs could be delivered with fewer inputs. Efficiency is challenging to assess: firstly, the cost effectiveness of program delivery has not been systematically reviewed; secondly, there is a lack of unified evidence on the effectiveness of community based interventions; and thirdly, limited reporting on outputs makes a comparison of inputs and outputs difficult. However, by assessing the levels of inputs, in particular expenditure and adviser inputs, and comparing these to the outputs outlined in the previous section on effectiveness, some analysis of the program's efficiency can be made.[68] It is clear that in absolute terms, the expenditure for the VHW program has increased substantially over the last decade; annual program expenditure increased from VUV284 000 in 2003-2004, to VUV48.2 million in 2011-2012, with the biggest increase occurring in 2008. Total expenditure for phase 2 (2006-2012) was approximately VUV169 million (see Figure 2 and Figure 3).

Figure 2: **Trends in absolute expenditure from 2003 to 2012**[69]



Source: Calculations based on SCA 2005; 2006; 2008; 2012.

Expenditure for the program includes project activities, program management and staffing and project support costs, as well as the management fee. In addition, since 2008 there is a separate budget line for monitoring and evaluation. During phase 2 (2006-2012) 44 per cent of total expenditure was spent on project activities, while the

[68] The details of the inputs for this project have been obtained and compiled from project completion reports. Reporting on both inputs and outputs has been inconsistent over the last ten years, making this assessment difficult. Compiling the data involved considerable effort and suggests that in future reporting, key data should be clearly presented.

[69] Management, staffing and support are assumed to include: management and staffing, project support costs and management fees.

remaining 56 per cent was allocated to management, staffing and support costs.[70] To examine inputs in more detail, the expenditure data from 2008 to 2012 provides a useful snapshot.[71] Between April 2008 and February 2012, the total budget was VUV168.4 million, or AUD$1.7 million (see Table 8). During this period, project activities constituted 44 per cent of total expenditure (VUV12.7 million, significantly less than the budget of 52 per cent). Program management and staffing constituted 33 per cent of total expenditure, while project support costs were 11 per cent and the project management fee was 10 per cent; a combined total of 55 per cent.

Table 8: VHW program expenditure - 1 April 2008 to 29 February 2012 (in Vanuatu vatu)

Budget Line Items	Total Expenditure (VUV)	% of total expenditure
1. Program Management & Staffing	54,757,822	33
2. Project activities		
Project extension sites	12,778,996	8
VHW program management strengthening	16,478,979	10
Provincial Level strengthening	13,992,490	8
VHW skills development	20,725,058	12
Community management strengthening	10,826,520	6
Sub-total: Project Activities	74,802,043	44
3. Monitoring and Evaluation	4,015,983	2
4. Project support costs	18,576,625	11
Total: Direct Costs	**152,152,473**	**90**
5. Project management fee	16,250,065	10
Grand Total	**168,402,538**	**100**

Adapted and calculated from VHW Completion report 2008-2012: Annex 2

Out of the VUV12.7 million expenditure on project activities from 2008 to 2012, the largest proportion, 28 per cent, was spent on VHW skills development. The proportion of funding allocated to VHW skills development as a proportion of project activities has fluctuated over the last decade, going from 32 per cent in 2004-2005, 20 per cent in 2005-2006, 16 per cent in 2008, and 43 per cent in 2010. It was down to 18 per cent in 2011. On average, the proportion has increased, which appears to reflect the finding that there has been a steady increase in training activities for VHW over the last four years (as illustrated in Table 6). The lowest proportion, 14 per cent (or 6 per cent of total expenditure), was allocated to community management strengthening (see Table 9), which appears to reflect the finding that community engagement has not been prioritised (as discussed in effectiveness section).

[70] This includes only those expenditure lines classified by SCA as 'project activities.'
[71] SCA 2012a

Table 9: Budget and expenditure on project activities, April 2008-Feb 2012

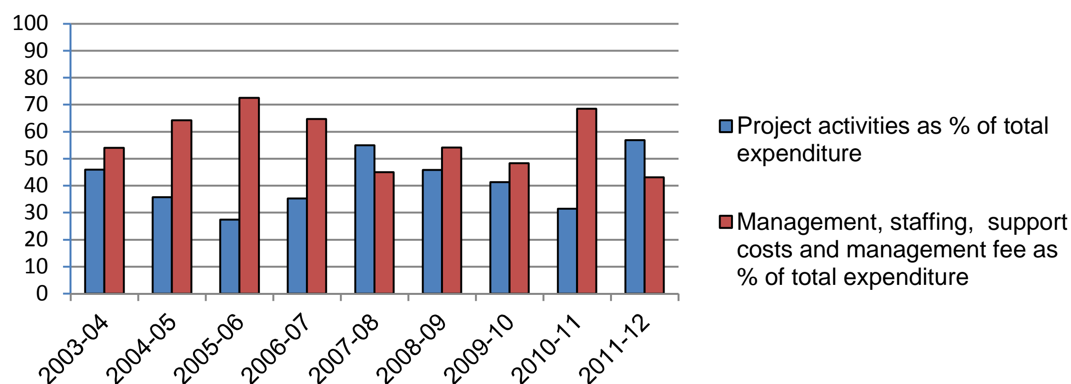
Budget line	Activities	Expenditure (VUV)	% of expenditure
Project extension sites	Support to the provincial health offices (where HPOs are based)	12,778,996	17
VHW program management strengthening	Planning and reflection meetings, project coordination committee meetings, national stakeholder meetings, VHW small grants scheme (for Aid Post construction & repairs)	16,478,979	22
Provincial level strengthening	Training of nurses, supervisory visits	13,992,490	19
VHW skills development	In-service training, pre-service trainings, mini-stakeholder meetings	20,725,058	28
Community management strengthening	APC training, VHW community awareness, promotional and IEC materials	10,826,520	14
Sub-total: Project Activities		**74,802,043**	**100**

Adapted and calculated from VHW Completion report 2008-2012: Annex 2

However caution must be exercised when comparing inputs, because the structure of budgets, and the classification of budget lines, can be varied. The three full time VHW program staff members from SCA, for example, are classified under program management and staffing, while it could be argued that incorporating a percentage of their costs under project activities could be appropriate, since they provide some support to HPOs, and some deliver pre-service training. It must also be recognised that expenditure depends on timely disbursement of funds from the MOH, which has at times been challenging. This likely goes some way to explain why there are significant differences between budget and expenditure during this timeframe. Nevertheless, even when allowing for some flexibility in budget lines, the relative expenditure on project activities appears to be quite low. In phase 2, this expenditure ranged from 32 per cent in 2010-2011 at the low end, to 57 per cent in 2011-2012 and the high end, with an average of 44 per cent (see figure 3). Relative expenditure on project activities has remained relatively constant over the last ten years, suggesting that the management costs are stable, rather than due to one-off or short term set up costs. In the first half of 2012, the allocation for project activities dropped to 33 per cent. This means that the proportion of expenditure allocated to management, staffing and support has averaged more than 50 per cent.[72] For a system with the bulk of its activities performed at the provincial or community level – by HPOs, Aid Posts and VHWs, the budget allocation for the program appears to be imbalanced towards the national level (where most program management and staffing and project support costs are incurred) – although a shift in focus from training at the national level to the provincial level has gradually occurred in Phase II. In addition, the increase in activities (for example pre-service and in-service training and supervisory visits) over the last four years is less significant than the very significant increase in expenditure. This suggests that the efficiency of the program could be substantially improved.

[72] Management, staffing and support are assumed to include: management and staffing, project support costs and management fees.

Figure 3: **Trends in relative expenditure from 2003 to 2012**



Source: Calculations based on SCA 2005; 2006; 2008; 2012.

4.4 Monitoring and evaluation

An strong M&E system supports effective management of implementation and monitoring and reporting progress against agreed indicators, milestones and targets. Without a robust framework in place, there is little evidence upon which to base decisions regarding the continuation or focus of a particular program or to know whether or not the intended results have been achieved or are on target to being achieved. It is widely acknowledged that despite its 30 year history, there has been limited M&E of the VHW program. For Phase II of the program, there was a logframe for the period 2008 to 2011 with five outputs, each with between 9 and 15 associated activities (see Annex 5). The program logframe was reviewed in 2011, to incorporate a goal and purpose, as well as five objectives, with associated outputs (see Annex 6). While the revised logframe significantly improved on the earlier one, several limitations remain and it has never been comprehensively reported against.

While reporting at the program level is limited, there are existing systems which are used to collect data, which could be used by the program, although they would likely need to be strengthened. For example, VHWs complete an outpatient logbook and a malaria reporting sheet, as well as a HIS form which summarises this data, including details of the patient, the illness, medication given and the fee charged. These HIS forms are standard across Vanuatu, and VHWs are required to submit completed HIS forms monthly in order to obtain their allocation of essential medicines. These forms are sent to the HPO and area nurse at provincial level, and to the HIS department of MOH. It appears that this data is not regularly collated, and is not obtained by SCA and used to inform program management decisions or as key monitoring data. Table 10 below outlines the data collected on a regular basis, as part of the VHW program, which should be adapted, integrated into and streamlined with a comprehensive M&E framework.

Table 10: Data collected through the VHW program

Level	Monitoring and evaluation method
VHW	Details from the out-patient book (such as age and gender of patient, treatment given), and malaria reporting sheet are recorded in the HIS form and copies sent to the Provincial Health Office, HIS MOH, the Area Nurse and a copy retained at the Aid Post.
Provincial SCA	Activity reports are submitted to the SCA national office. Information is also collected at the mini-stakeholder meetings held annually and fed into the reflection and planning meetings.
Provincial Health Promotion Officer	Information in regard to the Aid Post and VHW activity is collected during the supervisory visits. A monthly activity report is also submitted to the SCA national office by the HPO.
National SCA	External reporting is 6 monthly from SCA to the MOH and AusAID.

The program also has a number of processes to facilitate **learning and sharing of program experience** with the different program stakeholders as an integral part of the program cycle (as outlined in Section 4.2.3). These include national stakeholders reflection and planning and Project Coordinating Committee meetings. However, most of the meetings, discussions and reflections are occurring at the national level, far away from the realities of community level service delivery. The experience and lessons learned at the community level should be fed up to the national level through HPOs, who engage both with VHWs and national level program management. However, as explored in the section on supervisory visits, these interactions may be minimal, hence opportunities for integrating lessons from the community level are limited. There is a lack of consultation with beneficiaries of the program, including communities, and there is limited consultation with targeted or marginalised groups such as women or youth.

There are a number of limitations of the current program M&E:

- There is confusion around activities, outputs, outcomes and purpose make logical results chains difficult to establish.
- The original outputs are poorly defined and measured
- The logic chain is therefore weak between activities, outputs and outcomes.
- It is not clear that either the original or revised output indicators are being used for monitoring purposes by SCA or the MOH; SCAs reporting has been of variable quality, and inconsistent with the program's logframes.
- Data collected at the implementation level is not analysed or incorporated into program processes.

As a result of these limitations, M&E is not used as a program management tool and importantly for this review, it was difficult for the reviewer to judge whether the program has achieved the stated outputs and outcomes.

4.5 Sustainability

Throughout both phase I and II of the VHW program, the need to hand over the program to the MOH to ensure sustainability was consistently identified as a priority. However, it was dropped from the revised logframe in 2011, reportedly due to a

change in MOH policy towards out-sourcing.[73] Prior to 2011, building the capacity and ownership of MOH to enable them to take on the program was identified as a key activity, but a clear plan or set of priorities was not identified. The long term sustainability of the program is dependent on ownership of the program by local actors and their capacity to manage it, at the national, provincial and community level as well as continued funding.

a) Ownership

Although the process for transitioning management of the program from SCA to MOH has not yet been fully addressed, and while there appears to be agreement that at this point in time, the MOH does not have the capacity to take over managerial and financial responsibility for the program, some progress has been made over the last decade. In 2008 the program was moved from Vanuatu College of Nursing to the MOH Directorate for Public Health, demonstrating a degree of ownership and commitment by the MOH. A National VHW Coordinator has been appointed at the MOH, who since 2011 appears to have worked closely with SCA program staff. At provincial level, the fact that Letters of Agreements have been signed between provincial government councils and provincial health offices and that several governments have made efforts to provide some financial support to VHWs and Aid Posts is a promising sign for longer term sustainability of the program. However, despite these improvements, the current program arrangement where the program sits in the MOH but its management is outsourced to SCA, was viewed by some people interviewed as ‘an out-sourced initiative with little ownership within the MOH’. Interviews revealed that levels of awareness of the program within the MOH, for example, at the provincial level with provincial health managers, is at times low, and there appears to be a tendency to view the program as a set of activities external to the MOH, rather than as a key component of its revitalisation of primary health care initiative.

b) Capacity

Coupled with ownership at the national and provincial level, management and financial capacity is a key issue for sustainability. The MOH is not seen to have the necessary capacity to absorb, manage and continue funding the delivery of the program, presently at approximately AUD$650 000 per annum. Vanuatu is dependent on external support for its health budget, with external partners responsible for almost 40 per cent of health sector expenditure (recurrent and investment).[74] While health expenditure as a proportion of Gross Domestic Product (GDP) in Vanuatu has recently increased, just passing the recommended minimum of 5 per cent (5.2 per cent), it is still behind other Pacific countries such as Samoa (6.5 per cent) and Solomon Islands (8.6 per cent).[75] The budget for the VHW program is relatively small, however it appears unlikely that the Government of Vanuatu would be able to continue the program by themselves if AusAID funding were to be discontinued.

Management skills and systems and structures within the MOH at the national level will need to be strengthened. At national level, appropriate systems, structures, resources and skills will need to be established. At the same time, it must be acknowledged that strengthening the MOH’s capacity and preparing for a handover

[73] SCA 2012a
[74] MOH 2010
[75] World Bank (2013), Health expenditure data.

of the project was a key objective of the project until 2011. As outlined above, progress has been made, but it is difficult to say whether these changes are proportional to the investment and focus that has been placed on this area. Candid discussions will need to be had to assess why previous attempts at capacity building and handing over responsibility have not been effective, and how these short-comings can be avoided in the future as this issue is returned to the agenda. A detailed capacity development plan will need to be designed to enable the MOH to absorb the program.

Addressing the issue of MOH capacity will require a detailed, long term approach. For the next phase, a detailed phased transition plan should be developed with key stakeholders which is aimed at strengthening management systems and leadership of the program during hand-over from SCA to the MOH. The plan should include clear transition stages over a 5-10 year period, with a clear explanation of how responsibility will be handed over to the MOH, with specific milestones identified, for example the integration of certain roles or positions into the MOH at one or two year intervals. The implementing agency will have a key role to play as capacity builders, rather than just implementers. Ownership and leadership of the program also need to be encouraged and stimulated, to reduce the perception of it as an outsourced program. This transition period will also require clear delineation and differentiation of the roles and responsibilities of the implementing agency and the MOH.

Beyond the capacity building of a team in the MOH to gradually take on, the VHW program, there are broader, more **systemic issues faced by the MOH that will need to be addressed.** Many of the difficulties faced are not unique to this program, and it will continue to be affected by more systemic issues in the Ministry. AusAID has a key role to play through the capacity development and training provided as part of their health sector budget support, to help create an enabling environment for primary health care and the VHW program. AusAID can also use its influence and leverage to encourage reforms, promote the program as a priority and encourage its continuation and improvement.

c) Other issues related to sustainability

While ownership and capacity at the MOH is key to sustainability of the program as a whole, it is important to recognise that other aspects will be equally influential in the sustaining the program’s impact. While there are layers of management and activities at the national level, the majority of activities which are visible and tangible to beneficiaries, are those at the community and area levels: the activities carried out and services delivered by the VHWs. The sustainability of the program relies on the continued motivation and drive of VHWs to deliver basic health care services in their communities and regularly update their knowledge and skills, which will require supportive supervision and appropriate incentives. The effective performance of VHW also relies on awareness, appreciation and support from the communities . As highlighted elsewhere, there appears to be insufficient support and ownership of the program at provincial and community levels, both by government staff and by the beneficiaries of the program. These shortcomings will need to be addressed to assure the continued relevance and sustainability of the program.

5. Conclusion and recommendations

Within the specifics of the Vanuatu context and the constraints of the Government health care system VHWs play an important role in meeting basic health care needs

at community level, both curative and increasingly preventive. VHWs are often the only source of services to a significant number of people in hard to reach areas who would otherwise have very limited and in some places no access to formal health services. While the impact of the program has not been evaluated, the findings from this evaluation overall suggest that community based health care, to which VHWs contribute, is important in Vanuatu. The idea of VHWs and Aid Posts providing decentralised health services to the Vanuatu population remains relevant. In addition, significant efforts and resources have been invested in the program, and it is clear that there is demonstrated considerable commitment of all partners to contribute to improve the health of communities across Vanuatu.

There is therefore **sound rationale to continue the VHW program** to contribute to the Government of Vanuatu's goal of improving the health of its citizens – with the important caveat that this conclusion is **conditional on key weaknesses being addressed.** The evaluation has identified a number of weaknesses in the design, management, implementation and monitoring of the program, which will need to be addressed in order to make it an effective and efficient investment that delivers measurable results. These have been well documented in the previous section on the evaluation findings. The fact that it is not entirely clear how many VHWs there are, what activities they carry out, and to what extent their services are utilised is an indication of broader weaknesses of the program. The theory of change is poorly defined, with unclear links between activities, outputs and outcomes. Combined with ineffective M&E, it is in fact unclear what the program's achievements and outcomes have been. The weakness of these design aspects are likely to have contributed to inefficiencies within the program.

Both design and management issues have contributed to some of the efforts and resources dedicated to the program being misplaced, with a disproportionate amount focused at national level. As a result, there is a substantial gap in capacity at the provincial level. This is caused at least in part by budget allocations by both the MOH and the program, breaking the link between the strategy development and management and the national level and the beneficiaries of the program and the community level. It also reflects the mixture of responsibilities between program staff and MOH personnel (which program staff have limited ability to influence). Despite this, VHWs continue to work to the best to their abilities, which provides an indication of what the impact of the program might be if regular and engaged support were provided at community and provincial levels.

Due in large part to the restrictions in capacity and resources at the provincial level, there has been limited engagement at the community level. There have been community awareness raising sessions and some support provided to APCs, but these have been insufficient, and the findings suggest that VHWs are not provided sufficient support or motivation to more substantially engage in health education and promotion, and community mobilisation activities. VHWs deliver the services that this program is built around, so the logic of the program falls apart if they are under-resourced and isolated in ways which affect their capacity to deliver the services which are expected of them. Substantial effort needs to be directed at generating the value that communities place on VHWs to enable them to do their work more effectively. There has been insufficient engagement with VHWs, not just in terms of capacity development and supervision, but in terms of collecting data, involving them in the planning of training and other program activities, which limits the program's

ability to adapt and respond to the health needs of communities and the particular needs of VHWs.

The program operates under significant constraints, with limited resources, complex management structures and difficult geography, all of which must be recognised. There may therefore be need for prioritisation of program activities. There appears to be a paradox in which the more accessible VHWs and Aid Posts, which are near formal health providers such as dispensaries and health centres, are more effectively resourced and supported, while the more remote VHWs and Aid Posts, which often provide the only source of health services to the surrounding population, and which, it could be argued, represent the most vulnerable communities, receive little or no support. Consideration should be given to the relative importance of the services provided by these two groups of VHWs, the circumstances under which they operate and the level of support needed in order to ensure that all in Vanuatu have access to basic health care.

Based on the findings and conclusions the reviewer makes the following recommendations for program improvement to be taken into the next phase of the program.

	Recommendation	Responsible agency
1	Develop a phased, realistic transition plan, with clear steps and milestones towards integration of the program into MOH, while being aware of capacity constraints. Strategies for strengthening management systems and leadership of the program should be specified, with explicit milestones for gradual transition, for example the integration of key program management roles into the MOH after the first two years.	AusAID MOH Implementation Services Provider (ISP)
2	Review the allocation of existing budget resources to increase the proportion allocated to Aid Posts, VHWs and HPOs to improve service delivery at the village and district levels.	MOH
3	Better align the program with the Healthy Islands Policy, increasing the attention paid to health education and promotion and community mobilisation and aligning program activities with those of the Revitalisation of Primary Health Care initiative.	MOH ISP
4	Prepare and implement a systematic approach to monitoring progress (against annual MOH plans) and performance (towards GoV and program outcomes) using existing systems wherever possible. The monitoring system should collect, analyse, report and use information to support monthly management meetings where decisions are made and resource allocation to Aid Posts, VHWs and HPOs are reviewed.	MOH ISP
5	Increase focus on community mobilisation and community support for VHWs. Specifically:	
	a. Revitalise Aid Post Committees and broaden their remit to health education and promotion (suggestions for revisions for the 2003 Health Committees Act, which forms the legal foundation for APCs, are outlined in Annex 8.)	MOH

	Recommendation	Responsible agency
	b. Explore options for making small grants available for community level activities.	ISP
	c. Explore the potential integration of more Aid Posts with strong existing organisations in communities, such as schools and churches, to encourage and mobilise further community support for VHWs.	MOH
6	Provide VHWs with quality assured and effective training and materials to enable them to effectively do their work, and explore options for developing more extensive training for VHWs working in remote Aid Posts. This will require expert review of existing curricula and training materials, as well as development and/or adaptation of more appropriate IEC materials, in coordination with the MOHs Health Promotion Unit.	ISP
7	Develop clear job descriptions defining the roles and responsibilities of VHWs and communicate these to VHWs and their communities. Consider differentiation of roles of VHWs to reflect the varying contexts and circumstances faced by different VHWs across Vanuatu. (Suggestions for roles and responsibilities can be found in Annex 7.)	MOH
8	Develop a new model for good quality and regular supportive supervision as soon as feasible to strengthen support to VHWs, including peer support and learning exchange.	MOH ISP
9	Conduct a baseline survey and mapping activity to take stock of the number and activities of VHWs and Aid Posts to allow for evidence-based support in the next phase.	ISP with MOH input
10	Carry out an independent assessment to investigate the motivation of VHWs and identify appropriate incentives.	AusAID ISP

Annex 1: Terms of reference

1.1 Country Context

Vanuatu is a lower middle-income country with a total estimated population of 240,000, of which 70% live in rural areas spread over 69 inhabited islands. The Vanuatu Ministry of Health (MOH) has identified the provision of an efficient, equitable and effective health service as a priority,[76] with a particular focus on Community Health[77]. However, constraints imposed by geography, limited fiscal space and inadequate human resources have resulted in chronic underperformance, particularly in terms of community health.

Vanuatu has one of the lowest ratios of health workers per head of population in the Pacific, exacerbated by significant inequalities in distribution of workforce; it is likely that only 30% of the health workforce is targeted at community health. Access to these services is further hampered by transport costs and geography. At the national government level a lack of basic health services has been identified as a "major cause of hardship and poverty in the country". For this reason, MoH launched the "Healthy Islands" initiative[78] which advocates for revitalisation of primary healthcare at the community level throughout Vanuatu.

1.2 Background

AusAID is committed to helping improve the health status of the people of Vanuatu with accelerated progress by Vanuatu towards the health MDGs, namely reducing child mortality, improving maternal health, controlling and progressively eliminating malaria and combating HIV/AIDS and other diseases. These shared development outcomes, jointly agreed between the Government of Vanuatu and the Government of Australia through the Partnership for Development Process, aims to steadily and significantly assist in the progress towards reaching these MDG targets. The development outcomes also extend to include enhanced access to and quality of health care services, particularly for the rural communities for whom the Village Health Worker Program is a key component of rural service delivery.

The Village Health Worker program has been identified by MoH as a key program for delivering components of primary healthcare in rural and remote areas. Village Health Workers (VHWs) operate in Aid Posts and provide simple treatments, first aid and community health education. They generally work where communities have no or limited access to dispensaries, health centres and hospitals. Village Health Workers have operated in Vanuatu since the 1970s and were initially trained by practical attachment at clinics. There are approximately 183 Aid Posts staffed by a total 207 VHWs.

Save the Children (SCA) has worked with the Ministry of Health (MOH) to implement the Village Health Worker Program since 1998 and has supported the VHW Program since then, mainly with funding totalling approximately AUD3,719,000 from AusAID of which approximately AUD800,000 was spent in 2011. From 1993 to 2002, the VHW Program, supported by SCA, focused on both pre-service (basic) and in-service training of VHWs, plus community awareness and education delivered through on-going community meetings and outreach by the VHW's. From 2003-2005, the Project broadened the focus to improving the support and management of VHWs and Aid Posts by elected community Aid Post Committees in four provinces. Area nurses (ANs) and provincial health staff also began to be trained in supporting and

[76] Health Sector Strategy 2010-2016
[77] PLAS Agenda 2011 and MoH Health Sector Strategy 2010 – 2016
[78] Healthy Islands Policy, 2011

managing VHWs. Provincial responsibility for VHWs was formally taken up by Health Promotion Officers (HPOs) in 2005-6. Since this time, the Project has continued the broader focus of Community Based Health Management, while expanding to cover all six provinces of Vanuatu.

Save the Children are currently contracted by the Ministry of Health to implement the Village Health Worker Program. AusAID provides funding directly to the Ministry of Health which then is disbursed to SCA based on agreed annual work plans. During the course of the implementation of the contract between MoH and SCA, any significant changes are negotiated and agreed by the two parties. AusAID is consulted by MoH and indirectly by SCA as a courtesy.

1.3 Key Issues

The most recent phase of the VHW Program (Phase II Stage II – 4/2/08 to 30/04/12) has come to an end and future funding for the program will be subject to approval by MoH as it is now channelled by AusAID into sector budget support. SCA will need to continually demonstrate their ability to effectively manage the program while contributing to MoH's Healthy Islands policy outcomes in order to justify receipt of funding.

This Independent Evaluation is being commissioned at the request of both AusAID and Ministry of Health following the end of Phase II. It is timely because MoH has renewed its push for Primary Healthcare and its interest in the VHW program to deliver services at the community level. Village Health Workers are key for the delivery of primary health care across Vanuatu. In addition, the CAPF and a number of recent aid reviews have significant implications on targeting AusAID funding to reach the poor, including the Aid Effectiveness Review (2011).

<u>The primary purpose of the evaluation is to provide recommendations on how the VHW Program can best focus its efforts to contribute to primary healthcare in Vanuatu and specifically MoH's Healthy Islands Policy.</u> AusAID, SCA and MoH will use this information to make key management decisions including the definition of a renewed program focus, development of a monitoring and evaluation framework, an implementation schedule and appropriate funding levels.

1.4 Scope

The evaluation team will develop an evaluation plan aligning as closely as possible to the AusAID Evaluation Capacity Building Program (ECBP) standard 5 on Evaluation Plans. This will be submitted to AusAID for approval prior to the in-country mission.
A collaborative approach to the evaluation will be used, which will include methods such as a document review, semi-structured interviews and field observations. A (non-exhaustive) list of reference documents can be found in Annex A.
As part of the evaluation plan, the evaluation team will prepare a list of primary and secondary evaluation questions and data collection methodologies informed by the DAC criteria (Annex B) and best practice in the evaluation of community health worker interventions; to be submitted to AusAID for approval.

The methodology should identify: i) the stakeholders to meet during the design; ii) the forum for the meetings (one-to-one; small group; workshop; field visit etc. iii) any additional issues (other than those outlined below) to be explored during the design. iv) precautions to ensure ethical and safe conduct, v) methodological considerations

to minimise bias and normative[79] responses and ensure inclusion of marginalised groups.

The evaluation team will focus on effectiveness, efficiency and sustainability criteria. Primary evaluation questions should focus on the following issues:

- Assessment of the efficiency with which SCA has delivered the project.
- Assessment of the effectiveness of the VHW program as it has been implemented during the past decade (since 2003) reviewing achievements against the project purpose stated in Phase II and associated outputs and indicators.
- Assessment MoH and SCA capacity to sustain current program management arrangements with and without future funding from AusAID.

In addition, the evaluation team will evaluate:

- Current program Monitoring and Evaluation practices
- Program alignment with MoH Healthy Islands Policy
- What can stakeholders learn more broadly from the ways in which it is working and not working; what are the implications for future support to the VHW intervention, and more broadly for community level service delivery.
- How far is the VHW program consistent with Gender, Equity and Social Inclusion, including access to health promotional materials (BCC) and increasing equitable access to higher level services.

Based upon evidence collected from the evaluation fieldwork, the evaluation team will provide recommendations for improvement against each evaluation criterion. These recommendations will feed into the Ministry of Health's 'Healthy Islands Policy', particularly on the role of village health workers for the delivery of primary health care across Vanuatu.

1.5 Team Composition

The evaluation team will consist of:

- Team leader/ public health specialist – responsible for coordinating team inputs and finalising written reports
- Ministry of Health representative

1.6 Person Specifications

The **team leader/ public health specialist** will have the following skills and experience:

- Strong methodological monitoring and evaluation expertise
- A proven track record of design, management or evaluation of community level interventions on the supply and demand side.
- Experience in public health, preferably a tertiary degree in public health with at least ten years work experience
- Experience of health provision at primary /community level
- Proven competencies in Gender, Equity and Social Inclusion and a familiarity on the literature related to the evaluation of community health worker interventions.
- Extensive experience in the Pacific region, specifically Melanesia would be desirable

[79] Responses that conform to the respondent's expectation of what the questioner is expecting, or a shared cultural narrative. Careful triangulation, and exploration of stories (examples) and community 'gossip' can assist here.

- A thorough understanding of Australia's Aid program, or similar bilateral programs
- High level analysis and writing skills
- Excellent interpersonal and communication skills, including a proven ability to liaise and communicate effectively with multi-cultural colleagues

1.7 Team Responsibilities

The **team leader/public health specialist** will:

- Plan, guide and develop the overall approach and methodology for the evaluation;
- Manage and direct the evaluation's activities, representing the evaluation team and lead consultations with government officials and other donor agencies;
- Produce technical inputs (from a PHC / PH perspective) to and provide comments on the evaluation plan, the aide memoire, the draft and final reports;
- Manage, compile and edit inputs from other team members to ensure quality of outputs;
- Produce an aide memoire, synthesise evaluation material into a clear draft and final evaluation report;
- Provide timely delivery of high-quality written reports; and
- Represent the team in peer reviews.

The **Ministry of Health** representative will:

- Work under the overall direction of the team leader;
- Provide advice, context and an understanding of GoV processes and MoH management of the program
- Provide guidance for and contribute to the organisation of field visits for the team.

An **SCA VHW program representative** will provide advice and relevant documentation from SCA, and logistical support for field visits. The representative may accompany the team during field visits if requested by the team leader.

The **AusAID representative** will observe a number of interviews as selected by the team leader during the evaluation, provide relevant documentation and logistical support. The team leader should assure that AusAID and SCA participation does not compromise the capacity of the evaluation team to maintain independence in conducting the evaluation.

Timing and Duration

The Independent Evaluation will commence from 1 October 2012 and be completed no later than 30 November 2012. An indicative timing and duration for the scope of services is as follows (final dates and inputs will be negotiated with the Team Leader following the presentation of the evaluation plans):

TASK	PERIOD	LOCATION	INPUT (days)
Document review	1-2 October	Home Office	3
AusAID briefings	3 October	Home Office /communication with Vanuatu post	0.5
Evaluation Plan (as per Standard 5)	4 – 5 October	Home Office	4
Evaluation mission	8– 22 October	Vanuatu	14
Preparation of aide memoire	19 October	Port Vila	1

TASK	PERIOD	LOCATION	INPUT (days)
(during mission) and stakeholder workshops to present initial findings (final day)			
Draft Evaluation Report	Due 12 November	Home Office	8
Peer Review of Draft Evaluation Report	TBD	Canberra / Home office	0.5
Redrafting report after feedback from AusAID and other stakeholders	TBD according to Peer Review date	Home Office	3
TOTAL			**34**

OUTPUTS

The following reports are to be provided:

a) *Evaluation Plan* consistent with Evaluation Capacity Building Program (ECBP) Monitoring Standard 5: Independent Evaluation Plans (Methodology). The plan, including relevant evaluation questions, will be submitted for agreement with AusAID and GoV prior to mission. GoV, AusAID and SCA should be consulted prior to finalisation of the evaluation plan.

b) *Evaluation Mission Aide Memoire* – initial findings to be presented at workshop with key stakeholders in Port Vila, including Vanuatu and Australian Government agencies and Save the Children Australia. The format for the Aide Memoire will follow AusAID's template (to be provided). Consultants should be prepared to submit data collection and analysis upon request.

c) *Final Draft Independent Evaluation Report* consistent with Evaluation Capacity Building Program Monitoring Standard 6: Independent Evaluation Reports. The draft should be a final draft and include all necessary annexes. This will be provided to the evaluation manager, AusAID Port Vila, within 15 working days of completion of the field study to Vanuatu. Feedback from AusAID and other stakeholders will be provided within three weeks of receiving the draft report, and following a peer review.

d) *Independent Evaluation Report* - final document within 10 working days of receiving the feedback, incorporating feedback from stakeholders and the evaluation peer review. The report will be no more than 25 pages including a 2 page executive summary (plus annexes). Findings, ratings, lessons, and recommendations should be clearly documented in the report. The final evaluation report will be published on AusAID's website.

Annex A - Documents for Review

AusAID will provide hyperlinks/electronic copies of documents prior to the evaluation commencing. AusAID appreciates the documentation is extensive although not exhaustive.

Program documents:

2008 MOU between AusAID and MoH for VHW Program
2012 MOU amendment
VHW Program Logframe 2008 – 2011
Relevant training materials

Reports:

VHW Baseline Survey 2006
VHW Progress Reports – 2008 through January 2012
VHW Mid-Term Review 2009

VHW Completion report 2012-06-26
Healthy Islands Initiative, Vanuatu Technical Report (Phase 1-2/2010-2012)
Government of Vanuatu documents:

a) Vanuatu Priority Action Agenda
b) Thinking Long Acting Short 2009-2012
c) MoH Health Sector Strategy 2010 – 2016
d) MoH Healthy Islands Policy

AusAID documents:

a) Evaluation Capacity Building Program Monitoring Standards
    - Standard 5: Independent Evaluation Plans (Methodology)
    - Standard 6: Independent Evaluation Reports
b) Templates
    - Template: Independent Progress Report Aide Memoire
    - Template: Independent Progress Report
c) Policy documents and delivery strategies
    - Independent Review of Aid Effectiveness 2011 <http://www.aidreview.gov.au/publications/aidreview.pdf>
    - Australian Government response to the Independent Review of Aid Effectiveness <http://www.ausaid.gov.au/publications/pubout.cfm?ID=5621_9774_1073_3040_2380&Type>
    - ODE: Discussion Paper: Emerging findings from the ODE Law and Justice Evaluation August 2011

HRF Help Desk Request:

- *The 'Right' Clinical and Public Health Interventions in the Pacific - Lucy Palmer and Dr Ken Grant - June 2012 – This will be available in late June.*
- *The unfinished state Drivers of change in Vanuatu April 2007*

Other key literature on the efficacy of community level interventions in health, such as:

- *Azad, K., S. Barnett, et al. (2010). "Effect of scaling up women's groups on birth outcomes in three rural districts in Bangladesh: a cluster-randomised controlled trial." Lancet 375(9721): 1193-1202.*

Annex B – DAC Criteria

Effectiveness

A measure of the extent to which an aid activity attains its objectives. In evaluating the effectiveness of a program or a project, it is useful to consider the following questions:

- To what extent were the objectives achieved / are likely to be achieved?
- What were the major factors influencing the achievement or non-achievement of the objectives?

Efficiency

Efficiency measures the outputs -- qualitative and quantitative -- in relation to the inputs. It is an economic term which signifies that the aid uses the least costly resources possible in order to achieve the desired results. This generally requires comparing alternative approaches to achieving the same outputs, to see whether the most efficient process has been adopted.

When evaluating the efficiency of a program or a project, it is useful to consider the following questions:

- Were activities cost-efficient?
- Were objectives achieved on time?
- Was the program or project implemented in the most efficient way compared to alternatives?

Sustainability

Sustainability is concerned with measuring whether the benefits of an activity are likely to continue after donor funding has been withdrawn. Projects need to be environmentally as well as financially sustainable.

When evaluating the sustainability of a program or a project, it is useful to consider the following questions:

- To what extent did the benefits of a program or project continue after donor funding ceased?
- What were the major factors which influenced the achievement or non-achievement of sustainability of the program or project?

Annex 2: Independent Evaluation Plan: VHW Program, Vanuatu

1. Introduction

The Australian Agency for International Development (AusAID) is committed to helping improve the health status of the people of Vanuatu with accelerated progress by Vanuatu towards the health millennium development goals (MDGs), namely reducing child mortality, improving maternal health, controlling and progressively eliminating malaria and combating HIV/AIDS and other diseases. These shared development outcomes, jointly agreed between the Government of Vanuatu and the Government of Australia through the Partnership for Development Process, aims to steadily and significantly assist in the progress towards reaching these MDG targets. The development outcomes also extend to include enhanced access to and quality of health care services, particularly for the rural communities for whom the Village Health Worker Program is a key component of rural service delivery.

The Village Health Worker program has been identified by the Ministry of Health (MoH) as a key program for delivering components of primary healthcare in rural and remote areas. Village Health Workers (VHWs) operate in Aid Posts and provide simple treatments, first aid and community health education. They generally work where communities have no or limited access to dispensaries, health centres and hospitals. Village Health Workers have operated in Vanuatu since the 1970s and were initially trained by practical attachment at clinics. There are approximately 183 Aid Posts staffed by 207 volunteers who have now received a 10 week pre-service and a 2 week in-service training.

Save the Children (SCA) has worked with the MoH to implement the Village Health Worker Program since 1998. From 1993 to 2002, the VHW Program focused on training, plus community awareness and education delivered through on-going community meetings and outreach by the VHW's. From 2003-2005, the Project broadened the focus to improving the support and management of VHWs and Aid Posts by elected community Aid Post Committees in four provinces. Area nurses and provincial health staff also began to be trained in supporting and managing VHWs. Provincial responsibility for VHWs was formally taken up by Health Promotion Officers (HPOs) in 2005-6. Since this time, the Project has continued the broader focus of Community Based Health Management, while expanding to cover all six provinces of Vanuatu.

SCA are currently contracted by the Ministry of Health to implement the Village Health Worker Program. AusAID provides funding directly to the Ministry of Health which then is disbursed to SCA based on agreed annual work plans. During the course of the implementation of the contract between MoH and SCA, any significant changes are negotiated and agreed by the two parties. AusAID is consulted by MoH and indirectly by SCA as a courtesy.

The most recent phase of the VHW Program (Phase II Stage II – 4/2/08 to 30/04/12) has come to an end and future funding for the program will be subject to approval by MoH as it is now channelled by AusAID into sector budget support.

2. Purpose of the independent evaluation

The primary purpose for the independent evaluation is to provide recommendations on how the VHW Program can best focus its efforts to continue to contribute to primary healthcare in Vanuatu and specifically MoH's Healthy Islands Policy. AusAID, SCA and MoH will use this information to make key management decisions including the definition of a renewed program focus, development of a monitoring and evaluation framework, an implementation schedule and appropriate funding levels.

The independent evaluation will, as instructed by the terms of reference, focus mainly on the effectiveness; efficiency; and sustainability of the program. However, the methodology will also address relevance, gender equality and monitoring and evaluation, through the following areas of inquiry

Effectiveness

Effectiveness takes into consideration the measurement of the extent to which the program has achieved, or is likely to achieve, its objectives.

1. How effective has the VHW program been in meeting its objectives particularly against the program purpose stated in Phase II and its associated outputs and indicators?
2. To what extent has the VHW Program contributed to health promotion and primary healthcare in Vanuatu and specifically to the Healthy Islands Policy?
3. To what extent has the delivery of the program been consistent with best practice in terms of management systems, the strategic approach and monitoring and evaluation?
4. To what extent has SCA allowed the learning and experiences from the program to be fed back to the different program stakeholders and partners, including marginalised groups, in the on-going program cycle?

Efficiency

Efficiency measures the outputs (qualitative and quantitative) in relation to the inputs. It is concerned with the efficient use of resources and this generally requires comparing alternative approaches to achieving the same outputs, to see whether the most efficient process has been adopted, what activities were cost-efficient and if the program was implemented in the most efficient way.

1. What has been the efficiency with which SCA has delivered the program in terms of value for money and any other comparative advantages in its delivery?
2. What are the implications for future support to the VHW intervention and more broadly for community level service delivery?
3. How far is the VHW program consistent with Gender, Equity and Social Inclusion, including access to health promotional materials and increasing equitable access to other (referred) services?

Sustainability

Sustainability is concerned with measuring whether the benefits of an activity are likely to continue after funding has been withdrawn including if the program is environmentally as well as financially sustainable.

1. How has the capacity of the MoH and the SCA been developed to sustain program management arrangements with and without future funding from AusAID?

3. Summary of the evaluation

The evaluation plan is aligned as closely as possible with the AusAID Evaluation Capacity Building Program (ECBP) standard 5. The Independent Evaluation Report will also align as closely as possible to the AusAID ECBP standard 6 and incorporate feedback on the initial draft report from stakeholders and the evaluation peer review.
A collaborative approach with the key stakeholders groups (SCA, the MoH, AusAID and other implementation partners) and a mixed-methods methodology will be used including a document review, semi-structured (one to one and focus group) interviews and field observations. A key part of the methodology will be site visits to observe and inquire, first hand, the activities of the VHWs.
The methodology identifies i) the stakeholders to meet during the design; ii) the forum for the meetings (one-to-one; small group; workshop; field visit etc iii) precautions to ensure ethical and efficient data collection iv) methodological considerations to minimise bias and normative responses and ensure inclusion of marginalised groups.

4. Data collection methodology

The data collection methodology is given below. This will be refined in consultation with the partners as the evaluation develops using an iterative approach in which each step of the process builds upon and informs the next.

1. **Review of background literature, documents and reports.** A 'systematic' (chronological and issues based) review of secondary sources of information provided to the TL at the beginning and during the course of the independent evaluation (see annex 1).
2. **Quantitative data**: An initial process of collating secondary sources of quantitative data, for example, in regard to the activities of the VHWs, coverage, numbers of beneficiaries of the program, outreach etc. This would also include data in regard to budget allocation to the activities and other resources used in association with the program.
3. **Initial consultations with AusAID stakeholders.** Prior to the evaluation activities in-country the TL will engage in telephone discussions with relevant AusAID staff both in Australia and in Vanuatu.
4. **Country visit to Vanuatu**. During the in-country mission one to one and some focus group discussions (the data collection will have to be flexible when in country depending on availability or opportunity to source information) will be held with key stakeholders. See annex 2 for the list of the key informants and site visits and includes the following:
    - Program Management and AusAID staff in country: to analyse policy, strategy, financial management, efficiency etc.
    - Relevant Government Partners Ministries (MOH, SCA) and Civil Society Organizations to assess sustainability, harmonization, capacity building, alignment, ownership, program outcomes & impact.
    - Two site visits to Shefa (11-12 November) and Malampa (16-18 November) will be carried out to ascertain the role and activities of VHWs, the level of operation and mechanisms in place to ensure an efficient and accountable service. A meeting in Santo/Luganville (15 November) will also be carried out, requiring air travel.
5. **Feedback discussion with AusAID, SCA and other partners.** Evaluation Mission Aide Memoire – initial findings will be presented at a meeting with key

stakeholders in Port Vila, including Vanuatu and Australian Government agencies and Save the Children Australia.

5. Key evaluation questions

The following matrix outlines the key questions and the process by which the TL will address the key criteria during the evaluation. Priority questions are in bold and will be given particular attention including cross-cutting themes such as gender equity and disability inclusiveness. Triangulation using multiple sources of data will enable the cross-checking of information ensuring a more robust and credible analysis. The interviews will be carried out on a face to face basis by the TL, self-assessment instruments will not be used, nor will the interviews be audio-recorded. Instead the TL will take field notes which will be reviewed at the end of each day. The TL will ensure that each person being interviewed gives verbal consent to take part and a record of the field notes will be retained for later review by an independent source, if necessary.

Criteria	Key Questions	Sources of data collection and methods
Effectiveness	**How effective has the VHW program been in meeting its objectives particularly against the program purpose stated in Phase II and its associated outputs and indicators?** What have been the expectations of the delivery of the program against its originally intended design features? What is the evidence that the program delivery has reached the intended beneficiaries- as the preferred service in comparison to alternatives?	Review of relevant documentation provided for the evaluation (see annex 1). Key informant interviews.
	To what extent has the VHW Program contributed to health promotion and primary healthcare in Vanuatu and specifically to the Healthy Islands Policy? What is the most effective role (JD) for the future of the VHWs? What is the actual range of activities carried out by the VHWs? What is the evidence of recipient satisfaction of the services provided? To what extent has the VHW training and supervisory handbooks improved the delivery of the program? What is the most effective relationship between the VHWs, dispensaries and Aid posts in regard to program function?	In-country site visits (Shefa and Malampa) and observation of program activities. Quantitative data sources and records regarding referrals, use of resources, materials etc.
	To what extent has the delivery of the program been consistent with best practice in terms of management systems, the strategic approach and monitoring and evaluation? What has been the level of cooperation and collaboration for the delivery of the program by the different stakeholders? In terms of program delivery-what has been the most effective relationship between PHC and health promotion functions?	Review of relevant documentation provided for the evaluation. Key informant interviews with SCA/MoH.
	To what extent has SCA allowed the learning and experiences from the program to be fed back to the different program stakeholders and partners, including marginalised groups, in the on-going program cycle? What has been the level of cooperation and collaboration for the monitoring of the program between SCA and the different stakeholders?	Key informant interviews (one to one and focus groups) with SCA/MoH/AusAID staff.

Criteria	Key Questions	Sources of data collection and methods
Efficiency	**What has been the efficiency with which SCA has delivered the program in terms of value for money and any other comparative advantages in its delivery?** What consideration/review has been paid to the cost effectiveness of the program delivery? What records are kept and analysis carried out by SCA to monitor the efficient delivery of the program? **What are the implications for future support to the VHW intervention and more broadly for community level service delivery?** What consideration has been given by SCA and the MoH for the future delivery of the program? What efforts have been made to strengthen community engagement, capacity building and support to the work of the VHWs? **How far is the VHW program consistent with Gender, Equity and Social Inclusion, including access to health promotional materials and increasing equitable access to other (referred) services?** Are women and youth increasingly using the program services? What resources are available to and are being used by the VHWs? What records are kept by the VHWs and how are these analysed?	Review of relevant documentation provided for the evaluation. Key informant interviews with SCA/MoH. Key informant interviews (one to one and focus groups) with SCA/MoH/AusAID staff. Key informant interviews (one to one and focus groups) with SCA/MoH/AusAID staff. In-country site visits and observation of program activities. Quantitative data sources and records regarding referrals, use of resources, materials etc.
Sustainability	**How has the capacity of the MoH and the SCA been developed to sustain program management arrangements with and without future funding from AusAID?** What capacity does the MoH have to absorb the program? What capacity does SCA have to continue supporting the efficient and effective delivery of the program? What will need to change in the program to ensure that community service delivery can continue to be supported?	Review of relevant documentation provided for the evaluation. Key informant interviews with SCA/MoH.

6. Data analysis

Following the collection and collating of the collected data it will be analysed in a number of ways:

1. Documentary Review: Key data will be extracted and used in text /tables, as appropriate from the documents provided for the evaluation.
2. A concept-mapping involving a textual analysis of the interview transcripts. The content of interview transcripts will be reviewed by thematic areas. Key themes and points will be categorized and coloured coded for extraction, aggregation and analysis using a simple ‘cut and paste’ technique.
3. The analysis of the data will be an on-going process by the TL during the evaluation, for example, an overall review at the mid-point of the independent evaluation will be carried out to ensure consistency. This will allow any emerging themes/issues to be identified and to make modifications to the questioning where appropriate or necessary. For quality control purposes the AusAID representative will also observe a number of interviews as selected by the TL. However, the TL will ensure at all times that other stakeholder participation does not compromise the quality of the data collection and that independence is maintained during the evaluation.
4. The information collected will also be cross-checked to maintain consistency and accuracy, for example, the key issues emerging from the interview transcripts will be cross-checked with the government counterpart accompanying the review. This will be done using a simple inter-observer agreement matrix with a selection of the key themes and issues from randomly selected interviews.

7. Limitations and constraints of the evaluation

The terms and reference and the AusAID monitoring and evaluation standards provide the basis on which the TL has planned and designed the Evaluation Plan.

Ordinarily, the time available for the evaluation mission in Vanuatu would be sufficient if data collection were to proceed without delay or were to be based in the centre. However, the Village Health Worker program is designed to deliver components of primary healthcare in 183 Aid posts in rural and remote areas covering all six provinces. VHWs generally work where communities have no or limited access to dispensaries, health centres and hospitals. The evaluation of the program will require extensive travel, over a relatively short period for the whole mission, to two sites in Shefa and Malampa. Given the time available and the possibility for delays this could create a constraint in the collection of the necessary data and preparation of the aide memoire.

Other potential limitations of the evaluation include:

- The lack of a baseline description of the effectiveness of the VHW activities as they were implemented prior to the program will constrain any judgement about the overall effectiveness. Without any real baseline data other sources of data will have to be used to make judgements such as from anecdotal accounts and original program design documentation in a comparative context.
- The evaluation will also depend on the availability and quality of data and information, and the quality of the systems which provide these. The TL will

have a limited timeframe to collect primary data and will therefore depend on the availability of quality primary and secondary sources of information.

- This is a large program with many stakeholders and technical aspects and it will not be possible to visit all project sites, and indeed not to interview all people, so the evaluation will be constrained to some extent by having to generalise the findings in some areas across the entire program.
- There will be a large amount of documentation, reports, previous evaluations, technical data and other sources of information. The time available may not be sufficient to thoroughly review all this data and therefore some points may not be included in the final analysis and judgements.

In spite of the above potential limitations and constrains for the evaluation the TL will make every effort to deliver a credible, defensible evaluation product. This will include ensuring that the work is carried out in an efficient and professional manner, with a flexible design to accommodate unexpected issues that emerge, and use methods to minimise bias and normative responses and onerous conclusions.

8. The evaluation team

The evaluation team will consist of:

A Team leader/public health specialist. The Team Leader will be responsible for providing recommendations for the improvement of the program and the completion of the Terms of Reference.

The team leader/public health specialist will also:

- Plan, guide and develop the overall approach and methodology for the evaluation;
- Manage and direct the evaluation's activities, representing the evaluation team and lead consultations with government officials and other donor agencies;
- Produce technical inputs (from a PHC / PH perspective) to and provide comments on the evaluation plan, the aide memoire, the draft and final reports;
- Manage, compile and edit inputs from other team members to ensure quality of outputs;
- Produce an aide memoire, synthesise evaluation material into a clear draft and final evaluation report;
- Provide timely delivery of high-quality written reports.

A Ministry of Health representative who will:

- Work under the overall direction of the team leader;
- Provide advice, context and an understanding of GoV processes and MoH management of the program and contribute to the organisation of field visits for the team.

Annex 3: Interviews and site visits

Individuals interviewed

First visit

	Date	Name	Position	Organisation
1	08.10.2012	Kendra Derousseau	Senior program manager, health	AusAID
2	08.10.2012	Elena Haines	Program officer	AusAID
3	08.10.2012	Len Tarivonda	Director of Public Health	MOH
4	08.10.2012	Morris Amos	Director	Southern Health Care
5	08.10.2012	Asha Sine	VHW National Coordinator	Health Promotion Unit, MOH
6	08.10.2012	John Tasserei	Primary Health Care Coordinator	Health Promotion Unit, MOH
7	09.10.2012	Chris Hagarty	Senior health program manager	SCA
8	09.10.2012	Nichola Krey	Country Director	SCA
9	09.10.2012	Sara Lightner	Country Director	Peace Corps
10	10.10.2012	Ben Taura	Acting Provincial Health Manager	Shefa Provincial Government
11	10.10.2012	Rufina Latu	Technical advisor	WHO
12	10.10.2012	Michel Kalworai	Secretary General	Shefa Provincial Government
13	10.10.2012	Tracy Robinson	Acting Country Director	Live & Learn
14	10.10.2012	Maturine Tary	Director General	MOH
15	11.10.2012	Rinna Jimmy	VHW	Malafau Aid Post
16	11.10.2012	Meriam George	VHW	Siviri Aid Post
17	11.10.2012	Leinamos Bule	VHW	Saama Aid Post
18	11.10.2012	Pauline Shem	VHW	Epule Aid Post
19	11.10.2012	Kalwat Poilapa	Zone Supervisor	Saupia Health Centre (Paunangisu)
20	11.10.2012	Espel Kalpeau	VHW	Epau Aid Post
21	11.10.2012	Ben Kai	Village Chief	Epau Village
22	11.10.2012	Kalpeau Joseph	Area Secretary	East Efate
23	11.10.2012	Jeffrey Tila Langati	HIS Coordinator	Health Information System Unit, MOH
24	11.10.2012	Bindu Varghese	Volunteer	Health Information System Unit, MOH
25	12.10.2012	Louis Morrison	VHW	Lamen Bay Aid Post, Epi
26	12.10.2012	Tony Daniel	VHW	Esake Aid Post, Epi
27	12.10.2012	Tangat John Keke	VHW	Bonkovio Aid Post, Epi

	Date	Name	Position	Organisation
28	12.10.2012	Jimmy Paul	APC Chairman	Bonkovio Aid Post, Epi
29	12.10.2012	Baie Taun	Village Chief	Bonkovio Village
30	12.10.2012	Morten Jerome	Area Nurse	Burumba Dispensary Post, Epi
31	12.10.2012	Lui Korah	Administration Officer	Epi District
32	12.10.2012	Martha Kolen	Area Nurse	Vaemali Health Centre, Epi
33	15.10.2012	Joel Path	Secretary General	Sanma Provincial government
34	15.10.2012	Casimir Liwuslili	Provincial Health Promotion Officer	Santo Provincial Government
35	15.10.2012	Jivi Mele	Acting Provincial Health Manager	Sanma Provincial Government
36	15.10.2012	Johnson Vutinamoli	Acting Provincial Health Manager	Torba Provincial Government
37	15.10.2012	Polycarpe Terviri	VHWP Southern Coordinator	SCA Santo
38	16.10.2012	Rene Tamat	Nurse Practitioner	Atchin Health Centre
39	16.10.2012	Moise Leles	VHW	Gallili Aid Post, North West Malekula
40	16.10.2012	Rene Tamat	Area Nurse	Gallili Aid Post, North West Malekula
41	16.10.2012	Name could not be confirmed	Community Chief	Gallili Village
42	16.10.2012	Name could not be confirmed	APC chairman	Gallili Aid Post
43	17.10.2012	Eric Tulmal	Secretary General	Malampa Acting Provincial Government
44	17.10.2012	Eliane Maleb	VHW	Lakatoro Aid Post
45	17.10.2012	Grennethy Tavunwo	Health Promotion Officer	Malampa provincial government
46	17.10.2012	Rosie Silas	Provincial Health Manager	Malampa provincial government
47	17.10.2012	Noeline Teilemb	Acting Nursing Manager	Norsup Hospital

Second visit

	Date	Name	Position	Organisation
1	05.02.2013	Chris Hagarty	Senior health program manager	SCA
2	08.10.2012	Caroline Hilton	Program manager	SCA
3	08.10.2012	Asha Sine	VHW National Coordinator	Health Promotion Unit, MOH
4	08.10.2012	Jean Jaques Rory	Manager	Health Promotion Unit, MOH
5	08.10.2012	Kendra Derousseau	Senior program manager, health	AusAID

Site Visits

	Date	Site	Province
		Aid Posts	
1	11.10.2012	Malafau Aid Post	Shefa
2	11.10.2012	Siviri Aid Post	Shefa
3	11.10.2012	Saama Aid Post	Shefa
4	11.10.2012	Epule Aid Post	Shefa
5	11.10.2012	Epau Aid Post	Shefa
6	12.10.2012	Lamen Bay Aid Post, Epi	Shefa
7	12.10.2012	Esake Aid Post, Epi	Shefa
8	12.10.2012	Bonkovio Aid Post, Epi	Shefa
9	16.10.2012	Gallili Aid Post, North West Malekula	Malampa
10	17.10.2012	Lakatoro Aid Post	Malampa
		Health Centres	
11	11.10.2012	Saupia Health Centre (Paunangisu)	Shefa
12	12.10.2012	Vaemali Health Centre, Epi	Shefa
13	16.10.2012	Atchin Health Centre	Malampa
		Hospitals	
14	17.10.2012	Norsup Hospital	Malampa

Annex 4: Aid memoire recommendations

Effectiveness	
1. How effective has the VHW program been in meeting its objectives particularly against the program purpose stated in Phase II and its associated outputs and indicators?	
1.1 It is recommended the activity plan in annex 3 of the MOU between the MoH and SCA (2012-2014) be revised to include a comprehensive component on PHC and community mobilisation.	SCA/MoH **BY JAN 2013**
1.2 It is recommended that guidelines for community mobilization be developed for use with the VHWs and VHCs, for example, based on approaches already used in the region such as the RAP or the 'domains' approach.	SCA/MoH **BY MARCH 2013**
2. To what extent has the VHW Program contributed to health promotion and primary healthcare in Vanuatu and specifically to the Healthy Islands Policy?	
2.1 It is recommended that the revised pre-service and in-service training curriculum, the aid post manual, the supervisory visit handbook and all other materials are reviewed by an expert prior to finalization.	SCA/MoH contracted **BY DECEMBER 2012 TO COMPLETE BY JUNE 2013**
2.2 It is recommended that further health education materials be provided to the VHWs to support a PHC approach. These could be developed from existing in-country materials, for example, the WHO IEC healthy islands package.	SCA/MoH **BY END 2013-2014**
3. To what extent has the delivery of the program been consistent with best practice in terms of management systems, the strategic approach and monitoring and evaluation?	
3.1 It is recommended that a M&E system for the VHW program is developed to allow information to be collected on a regular basis in regard to its goal, objectives, indicators and outcomes.	SCA/MoH contracted **BY JAN 2013 FOR JUNE 2013.**
4. To what extent has SCA allowed the learning and experiences from the program to be fed back to the different program stakeholders and partners, including marginalised groups, in the on-going program cycle?	
Full discussion provided in the report	

Efficiency	
5. What has been the efficiency with which SCA has delivered the program in terms of value for money and any other comparative advantages in its delivery?	
Full discussion provided in the report	
6. What are the implications for future support to the VHW intervention and more broadly for community level service delivery?	
6.1 It is recommended that the role and responsibilities of Provincial Primary Health Care Officers and VHWs be clearly stated, for example, in agreed MOUs.	SCA/MoH **BY JAN 2013 FOR MARCH 2013**
6.2 It is recommended that the Health Committees Act (2003) is revised to include a broader interpretation for the community mobilization and PHC function of the VHCs.	
6.3 It is recommended that an independent report be prepared to investigate the incentives, motivation and sustainability for VHWs and VHCs including the implications of these options.	AusAID COMPLETE **BY END 2013**
7. How far is the VHW program consistent with Gender, Equity and Social Inclusion, including access to health promotional materials and increasing equitable access to other (referred) services?	
7.1 It is recommended that an independent report be prepared to determine how far the VHW program is consistent with Gender, Equity and Social Inclusion.	AusAID **BY END 2013**
Sustainability	
8. How has the capacity of the MoH and the SCA been developed to sustain program management arrangements with and without future funding from AusAID?	
8.2 It is recommended that a phased plan be developed with key stakeholders to detail the strengthening of management systems and leadership of the program during hand-over from SCA to the MoH with clear transition stages over 10 years or less.	AusAID/SCA/MoH **BY JUNE 2013**

Annex 5: Phase II logframe matrix

Project Summary	Identification No. of Indicators	Verifiable Indicators	Means and Source of Verification	Sampling	Risks & Assumptions
Goal					
Improved health among project communities	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable
Purpose					
Improved performance of VHWs	1	Average 'satisfaction-rating' in survey of *community-satisfaction with VHW performance* increases between baseline and endline in at least 50% of sampled aid-post areas. [Idea: 0M and 10F interviewed in the 14 baseline-annual-endline villages.]	Structured interviews (questionnaires) with the eight most recent aid-post clients (counting from the end of an agreed date) (tool 3).	Stratified random sample of 10% of aid-post communities in each province.	
	2	VHWs assessed as performing at a satisfactory standard in terms of internal or Aid Post 'housekeeping' functions increases by 10% between baseline and endline surveys (assessed by project staff using quality checklist).	Combined observation and interview guide used for VHW interview and Aid Post inspection (tool 1).	Stratified random sample of 10% of VHWs (and their Aid Posts: see indicators 8 and 9) in each province.	
	3	Average hours per week worked by VHWs 'in past three months' in sample Aid Post sites increases between baseline and endline surveys. [This is a 'system' indicator, not indicator of individual VHW performance, e.g. common reason why some VHWs weekly-hours are low is drug-supply shortages, not always due to VHWs not placing new drug orders in time.]	Structured interviews (questionnaires) with VHWs (tool 1).	Stratified random sample of 10% of VHWs in each province. Use the sampling strategy for baseline, midline and endline surveys (same 'cohort' of VHWs and Aid Posts).	
Output 1					

Project Summary	Identification No. of Indicators	Verifiable Indicators	Means and Source of Verification	Sampling	Risks & Assumptions
Transition of VHW Program is well managed	4	By the end of the eighteen months period, NC is performing at least 50 % of identified VHW Program management functions (transferred from SCA VHW project Manager)	Observation by project manager of NC's performance of specified management functions (listed in checklist) and document analysis (i.e. read project six-monthly reports on progress of transition).	Not relevant.	MoH Executive Committee agrees with proposal to transfer NC position from VCNE to Directorate of Public Health
	5	By the end of the eighteen months period, NC position is transferred from VCNE to Directorate of Public Health.	Document analysis of MoH Executive Committee minutes.	Not relevant.	
Output 2					
Improved management and support of VHW Program at provincial and area levels	6	By the end of the project 100% of HPOs assisted by area nurses in the project area provide at least two in-service training for VHWs.	Document analysis of training reports and table of completed activities of MoH partners.	Not relevant.	Key provincial and area staff do not change and can absorb responsibilities under the VHW project (i.e. risk that HPOs and area nurses cannot absorb all project responsibilities as they are already overwhelmed). Area Focal Point Committees operate well
	7	By the end of the project, 90% of provincial and area FPCs have met at least once "in the past 12 months" prior to the endline survey (project ideal standard is six-monthly FPC meetings).	Document analysis		
	8	Number of provinces providing financial support to VHWs increases from baseline figure of 1 to at least 2 by the end of the project.	Semi-structured interviews with HPOs.	Not Applicable.	

Project Summary	Identification No. of Indicators	Verifiable Indicators	Means and Source of Verification	Sampling	Risks & Assumptions
					(despite geographical distance between members and fluidity of membership).
Output 3					
Improved management of Aid Posts and support for VHWs by communities	9	Aid Posts assessed as operating to satisfactory standard between baseline and endline increases by 10% using a quality-checklist.	Fully structured interview with APC chair (tool 2).	Stratified random sample of 10% of Aid Posts (and VHWs in those Aid Posts, as per indicators 1, 2 and 3 and indicators 11 and 12) in each province.	
	10	Percentage of VHWs in sample who receives at least 2 types of support from community increases between baseline and endline.	Fully structured interview with VHW (Tool 1).		
Output 4					
Improved knowledge, confidence and skills of VHWs	11	For each VHW training, the average post-test score increases by at least 10% compared to pre-test average score. For each VHW training, the average post-test score is at least 65%.	Self-administered questionnaire filled out by training participants.	Census (i.e. sample of all training events)	Community activities in support of Aid Posts (e.g. cleaning Aid Post and fund-raising) may be crowded out by other community priorities. Trained VHWs continue to function as
	12	50% of VHWs' list of 'I'm confident doing this' increases between baseline and endline (using matched sample of VHWs). 50% of VHWs' list of 'I'm not confident doing this' reduces between baseline and endline (using matched sample of VHWs).	Fully structured interview (that is done at same time as semi-structured interview) with sample of VHWs (using tool 1).	Stratified random sample of 10% of VHWs. Use the sample of VHWs and Aid Posts for baseline, midline and endline surveys.	

Project Summary	Identification No. of Indicators	Verifiable Indicators	Means and Source of Verification	Sampling	Risks & Assumptions
	13	Average score of VHWs in test of knowledge of how to respond to outbreaks increases by at least 10% between baseline and endline.	Fully structured interview (that is done at same time as semi-structured interview) with sample of VHWs (Q 15 in tool 1 on outbreaks).	Stratified random sample of 10% of VHWs. Use the sample of VHWs and Aid Posts for baseline, midline and endline surveys.	VHWs.
	14	Other evidence of improved knowledge, confidence and skills of VHW.	Analysis of data from area nurse supervision checklist.	Purposive sample.	
Output 5					
Project is well managed	15	Project completely achieves 70% of its output 1-4 indicators (indicators 4-15 in this table) by the end of the project.	Analysis of data in indicator tables.	Not relevant.	Skilled project staff remain with project. Political changes at national, provincial and area levels do not adversely affect implementation of project.
	16	Project completely achieves three of its four purpose indicators by the end of the project.	Analysis of data in indicator tables.	Not relevant.	
	17	Project at least 'mostly' achieves 70% of its activity targets annually (mostly = 80%-99% of target).	Analysis of data in activity-target tables.	Not relevant.	

Logframe Activities

Outputs	Activities
Output 1 **Transition of VHW Program from SCA to MoH management is well managed**	1.1 Develop Terms of Reference for National Focal Point Committee and submit to MoH and MoIA for approval. 1.2 Provide on-the-job training and advice on national program management for MoH, MoIA and National Focal Point Committee. 1.3 Revise job description of National Coordinator, Village Health Worker Program and submit to MoH for approval. 1.4 Conduct advocacy towards transfer of NC position from current umbrella of VCNE (that has training focus) to

Outputs	Activities
	the Directorate of Public Health. 1.5 Identify key VHW 'program' management functions currently performed by SCA VHW Project Manager that should be handed over to the VHW National Coordinator (MoH position) and develop management-transfer checklist. 1.6 Develop timetable for handover. 1.7 Develop monitoring checklist for MoH NC (e.g. each year, NC conducts supervision visits to all provinces, sample of areas, sample of Aid Posts; visits include checking how well MoH VHW forms are filled in, sent to right people, data entered, analysed and used. During supervision visits, NC should check that FPCs are meeting according to national schedule (at least twice a year); NC should also check how many communications occur from Area FPCs to Provincial FPCs. 1.8 Conduct on-the-job training for NC to facilitate the handover of specified functions 1.9 Advocate to MoH that job description for HPOs include specific responsibilities relating to VHW Program. 1.10 Develop and use national VHW Program database (with selected fields from VHW Profile Form and from VHW monthly statistical form) 1.11 Conduct six-monthly field visits to provincial, area and community Focal Point Committees. 1.12 Organise annual national stakeholder meetings (including stakeholders from national and provincial levels) 1.13 Produce promotional material about the VHW program (including calendar, update of VHW brochure, newsletter, script for VHW-promotional spot on Radio Vanuatu on weekly public-health segment) 1.14 Organise national workshop (involving both national- and provincial-level health staff) to revise the VHW monthly statistical form (including avoidance of information being collecting in VHW monthly form that is collected in dispensary or health centre forms). 1.15 Conduct a field test of revised form and finalise form. 1.16 Conduct training for HPOs and area nurses on completion of agreed, finalised form (for them to train and advise VHWs on completion of form). 1.17 Work with the VCNE to develop new module on VHW Program. 1.18 Conduct advocacy for VCNE to include the new module in the basic nursing curriculum. 1.19 Conduct advocacy activities for VCNE to develop and support national system of training for new and current HPOs and area nurses in ToT skills (both 'basic' and 'refresher' training). 1.20 Provide funding for NC to conduct three-monthly supervision visits to provinces, areas and Aid Posts. 1.21 Provide technical advice to NC on improvement of forms for planning (e.g. workplans for HPOs and Area Nurses), supervision (e.g. supervision guides for NC, HPOs and ANs) and reporting (e.g. format for three-monthly reports of NC, HPOs, ANs)

Outputs	Activities
Output 2 **Improved management of VHW Program at provincial and area level**	2.1 Conduct supervision and community-mobilisation training for HPOs and zone-area nurses (for themselves as supervisors and for them to train other zone-area nurses who will train APC and community groups). Note: In this training, area nurses are also trained to complete a *VHW supervision logbook* for area nurses. 2.2 Conduct training for Focal Point Committee members on establishment and operation of Focal Point Committee. 2.3 Conduct advocacy activities toward integration of VHW program into provincial planning, monitoring & reporting cycles (directed towards provincial health office and provincial government) 2.4 Provide on-the-job training and advice to HPO in developing and using VHW Program database (with data from VHW monthly statistical form etc.) 2.5 Conduct training for HPOs and area nurses on use of data from finalised forms (for them to train and advise VHWs on using data from two forms – VHW Profile and monthly statistical form). 2.6 (a) Identify province with the best example of health information system (both good database and good data use) and (b) publicise the good work either through bringing other provinces to the best province or bringing best province to visit and assist and motivate the other provinces. 2.7 Provide on-the-job training and advice to provinces in developing provincial summary databases (e.g. of selected data from VHW Profile forms and VHW monthly statistical forms. 2.8 Revise VHW ToT facilitator's handbook with VCNE. 2.9 Conduct general TOT training (as distinct from supervision training) for HPOs & area nurses. 2.10 Conduct six monthly supervision and coaching of trained ToTs (HPOs and area nurses) 2.11 Reprint the HPO and area-nurse supervisors' handbook. 2.12 Organise *VHW Program Forum for Area Nurses* in each province. 2.13 Inform provincial stakeholders in new provinces of expansion of project into that province. 2.14 Provide essential VHW equipment for new Aid Posts. 2.15 Conduct advocacy activities to Provincial Health Office and area nurses on maintaining adequate level of supplies in Aid Post (e.g. drug supply, VHW monthly statistical forms, Aid Post Drug Order Forms, and Aid Post equipment)
Output 3 **Improved management of Aid Posts**	3.1 Train HPOs and area nurses to train Aid Post Committees on Aid Post management. [see activity 2.1] 3.2 Train HPOs and area nurses to conduct community awareness about VHW Program for youth and women's community groups (in order to increase community use and support of VHW Program). [see activity 2.1] 3.3 Conduct follow-up visits to HPOs and area nurses to monitor quantity and quality of community-level training. 3.4 Develop Terms of Reference for feasibility study for an urban community Aid Post (to include 'next steps' if positive recommendation e.g. link with SCA's young people's project to form youth and women's focus groups). 3.5 Conduct a feasibility study for an urban community Aid Post. 3.6 Conduct orientation for Provincial Focal Point Committees (in pilot provinces – see below) on their roles and

Outputs	Activities
	responsibilities in the operation of the VHW Small Grant Program. 3.7 Develop funding criteria and other guidelines for VHW Small Grant Program (e.g. concerning proposal, reporting and financial acquittal formats). 3.8 Conduct initial pilot of VHW Small Grant Program in one or two provinces. 3.9 Evaluate & expand the pilot.
Output 4 **Improved knowledge, confidence and skills of VHWs**	4.1a Train HPOs and area nurses to conduct in-service training for VHWs. 4.1b Train HPOs and area nurses to conduct pre-service training for VHWs. 4.2 Conduct follow-up supervision and coaching visits to VHWs trained by HPOs and area nurses. 4.3 Provide funding for Area Nurses and HPOs to conduct follow-up training and support to VHWs, APCs, Focal Point Committees and community-awareness of VHW program. 4.4 Reprint the VHW manual. 4.5 Produce, pre-test & distribute new IEC material (flipchart, DVD, T-shirts, bags, posters) for VHW. 4.6 Arrange for provincial health resource people & NGOs to conduct training at each VHW pre- and in- service training in their area of expertise (e.g. drug supply, health information system, communicable and non-communicable diseases, reproductive health etc.) 4.7 Conduct training of HPO in conducting community awareness of gender-sensitive criteria for recruitment of new VHW. [include this activity in activity 2.1] 4.8 Provide funding for publicising the important work done by VHWs in the annual provincial days or the annual national health week in each province. [Connect to local aid-post fund-raising campaigns conducted at same time.] 4.9 Organise a provincial VHW Program forum for VHWs 4.10 Develop a reward-based process for selecting VHW to attend a national forum every two years 4.11 Organise a national VHW forum every two years (whose main purpose is peer learning among VHWs).
Output 5 **The VHW project is well managed**	5.1 Project staff revise Area Nurses Supervision Checklist and pre-test with the other three baseline tools 5.2 Project staff practise interviewing and notetaking with the draft baseline tools among themselves. 5.3 Project staff pilot the tools in two Aid Posts. 5.4 After piloting, project staff revise tools with assistance of STA. 5.5 STA facilitates training of HPOs and project staff as interviewers and notetakers using revised questionnaires. 5.6 STA develops specific indicator databases (2 days). 5.7 Project staff, HPOs and Area Nurses undertake data collection and give feedback on preliminary findings to Aid Post stakeholders (APC, VHW and communities). 5.8 Project staff check completed questionnaires. 5.9 Project staff enter data 5.10 Project staff and STA check that data entered correctly

Outputs	Activities
	5.11 STA and project staff prepare data for analysis, analyse data and prepare baseline report. 5.12 STA provides technical advice on completion of detailed M&E plan esp. feedback on draft checklists (NC supervision checklist; NC management-transfer checklist; Area Nurse Supervision checklist and project staff supervision checklist) and six-monthly report format (2 days) 5.13 STA and project staff conduct one training workshop for HPOs on data analysis relating to general findings across sample Aid Posts and to more detailed findings on specific Aid Posts (the latter to assist HPOs to run feedback workshops for Area Nurses and Aid Post stakeholders.) 5.14 Collect information on project indicators at least three times (baseline, midline and endline) 5.15 Conduct pre- and post- tests at the time of each training and post-training evaluation (i.e. obtain feedback from clients on training quality and possible improvements). 5.16 Prepare brief report on each training. 5.17 Organise external assessment of MOH VHW management capacity towards end of 18 months. 5.17 Organise formal external review of project outcomes towards the end of the third and fifth year. 5.18 Conduct six-monthly meetings of National Focal Point Committee (until handover, the existing project Coordinating Committee functions as the National Focal Point Committee) 5.19 Conduct six-monthly meetings of VHW project staff (including HPOs). 5.20 Prepare six-monthly project reports. 5.21 Prepare Activity Completion Report towards end of fifth year.

Annex 6: Revised phase II logframe

Revised Program Logframe, January 2011 – February 2012.

Strengthening the Village Health Worker Program– Logical Framework Analysis				
Level	**Narrative Description**	**Indicators**	**Means of Verification**	**Assumptions**
Goal	Improving the health of rural communities in Vanuatu through access to primary health care services			
Purpose	To strengthen the management of the Village Health Worker (VHW) Program in collaboration with the Ministry of Health (MoH) at the national, provincial, area and community levels. This will be conducive to improving the provision of primary health care services in rural communities throughout the six provinces of Vanuatu.			
Objective 1	To build the capacity of Village Health Workers in terms of knowledge, confidence and skills to ensure children and their families have access to basic health, treatment of common illnesses and family planning advice	• Increase number of people seeking advice on family planning • Increase number of people accessing the aid post • Decrease number of common illnesses affecting the area	• Aid Post logbook records • Supervisory visit reports • Training reports • Quarterly reports • Total Reach counts • MSC stories reported	Village Health workers are competent and will be eager to participate in the trainings
Output 1	In-Service Trainings for Village Health Workers by province (ISTs)	• Number VHWs recommended by MoH to attend Nursing school for further training • Number of VHWs trained per province • Number of Village Health workers promoted to Aid Nurse	• IST reports • Quarterly reports • Total Reach counts • MSC stories reported	VHWs will excel in their performances after attending the ISTs
Output 2	Pre-Service Training (PST) for	• Number of VHWs trained per province	• PST reports • M&E reports	There will be people available to be trained

Strengthening the Village Health Worker Program– Logical Framework Analysis				
Level	**Narrative Description**	**Indicators**	**Means of Verification**	**Assumptions**
	Village Health workers by Province	• Demonstrated knowledge and confidence of VHWs to operate the aid post	• Supervisory Checklist • Quarterly reports • Total Reach counts	
Output 3	Policy paper developed for direction of VHWP beyond 2011	• Number of recommendations identified to take the program forward • Number of stakeholders consulted to complete the policy paper • Number of meetings held to discuss the policy paper	• Policy paper • Short Term consultant's report • Final Evaluation report • Total Reach counts	The policy paper will be developed within the proposed timeframe
Objective 2	To strengthen the capacity of the management of the Aid Posts at the community level by Aid Post Committees (APCs) throughout the six provinces.	• Number of APC trainings conducted per six months • Number of Aid post with increased community support • Increased community led health initiatives	• Training reports • Supervisory visits report • HPOs reports • Quarterly reports • Total Reach counts	There is need to train existing Aid Post committees
Output 2.1	Six monthly program planning Meetings	• Number of lessons learnt from past plans • Number of additional activities agreed to implement within each province • Number of activities identified needing improvement	• Planning report • Next Six months Plans • Six months progress report • Total Reach counts • MSC stories	Communication between the MoH and Save the Children (SC) will be transparent and supportive of implementing the activities as planned
Output 2.2	Supervisory visits of Aid Posts	• Number of visits	• HPOs reports	The supervisory checklist is

Strengthening the Village Health Worker Program– Logical Framework Analysis				
Level	**Narrative Description**	**Indicators**	**Means of Verification**	**Assumptions**
	and Village Health Workers	conducted by HPOs and Area Nurses per six months • Number of visits conducted by SC per six months • Approaches and activities identified for improvement	• Supervisory Checklist completed • M&E site visit reports • Quarterly reports • Total Reach counts • MSC stories	completed prior to conducting supervisory visits
Output 2.3	Revision of supervisory checklist and coordination of field testing throughout the provinces	• Number of meetings held to discuss the revision of the checklist • Number of additional activities included in the Review	• Revised checklist completed • Field testing reports • Quarterly reports • Total Reach counts	The current supervisory checklist needs to be revised
Output 2.4	Improvements of Aid Post Infrastructure	• Number of Aid Posts per province identified to undergo infrastructure improvement • Increase number of people accessing the Aid Post per month	• Supervisory Visit reports • Activity reports • Aid post records • Quarterly reports • MSC stories • Total Reach counts	More people will access the Aid post after infrastructure improvements Aid post maintained regularly to improve the service delivery
Output 2.5	Aid Post Committee (APC) trainings for committee members throughout the provinces	• Number of people trained per committee • Number of Aid posts Committees established and operational • Increase support provided by the community	• Training reports • HPOs activity reports • Supervisory visit reports • Quarterly reports • MSC stories • Total Reach counts	Communities will respond positively to the trainings and increase their support for their Aid Post

Strengthening the Village Health Worker Program– Logical Framework Analysis				
Level	**Narrative Description**	**Indicators**	**Means of Verification**	**Assumptions**
Output 2.6	New equipment for Aid Posts	• Number of equipment needing replacement • Number of new equipment intended for the aid posts • Increase number of people accessing the Aid Post per Month	• Stock take records • Quarterly report • Supervisory visits reports • Total reach counts • MSC stories	There is an aid post building to house the supplied equipment All Aid posts have the required Aid Post equipment
Output 2.7	Feasibility study on mobile phone use and data collection	• Number of tools developed to be used for feasibility study • Number of people participating in the study	• Feasibility study report • Quarterly report • Total Reach counts	The study will ease communication between HPOs and the VHWs leading to improved data collection
Output 2.8	Study tour to PNG	• Increased knowledge of staff and MoH staff on ways to take the program forward • Number of additional activities adapted from SC PNG program	• Study tour report • Six months planning and reflections report • Quarterly report	Funds will be made available to conduct the study tour as planned
Objective 3	To facilitate increased community awareness, health education, and behavioural change in relation to health rights, hygiene, HIV, safe sex and clean environment	• Decrease number of patients visiting the aid post for common illness treatment • Increase number of people accessing safe sex and family planning methods	• Aid post records • M &E reports • Monthly reports • Quarterly reports	People will respond positively to awareness messages leading to behavioural change in healthy lifestyle practices
Output 3.1	Advocacy/awareness about Village Health Worker	• Number of IECs disseminated on provincial	• Activity reports • Quarterly reports	The provincial day committees will allow the Village Health

Strengthening the Village Health Worker Program– Logical Framework Analysis				
Level	**Narrative Description**	**Indicators**	**Means of Verification**	**Assumptions**
	Program during provincial day Celebrations	days • Increase number of people participating in the VHW program on provincial day	• MSC stories • Total Reach counts	Worker time to implement the plans on provincial day celebrations
Output 3.2	Development, revision, and production of Informational Educational Communication (IEC) materials	• Number of IECs needing review • Number of people participating in the review • Number of new IECs developed	• Developed IECs • Quarterly reports • Review meeting minutes • MSC stories • Total Reach counts	There will be need to develop new IECs or review the existing ones
Output 3.3	Primary Health Care Revitalization	• Number of communities with demonstrated primary health care initiatives • Number of community activities and meetings held to discuss primary healthcare revitalization • Number of Aid post with increased community support recorded every six months	• M&E or supervisory visits • reports • Meeting minutes • Six months reports • Provincial Stakeholders meeting reports and plans • MSC stories • Total Reach counts	Increased community Mobilization and primary health care initiatives
Output 34	HPOs and Area Nurses conduct community awareness about Aid Posts service	• No of Community awareness held every six months by provinces • Increase number of people accessing the aid post	• Quarterly reports • Aid Post logbook records • M&E reports • MSC stories • Total Reach counts	More people will be aware of Aid post's services therefore more people will access the service and the community will be more supportive of the aid post
Objective 4	To ensure equal access to	• Number of aid post with	• Supervisory visits checklists	The government and the local

Strengthening the Village Health Worker Program– Logical Framework Analysis				
Level	**Narrative Description**	**Indicators**	**Means of Verification**	**Assumptions**
	health services through advocating to government and local partners for improved support	increased local support • Number of aid posts with increased government support • Number of VHWs recommended by the provincial health to attend nursing school	• M&E reports • Quarterly reports • MSc stories • Total Reach counts	partners will respond positively to SC and MoH advocacy initiatives
Output 4.1	Mini-Stakeholders Meeting	• Number of stakeholders involved • Number of VHWs attending the meeting • Commitments by provincial stake holders	• Meeting minute • HPOs monthly report • Quarterly report	All stakeholders will be available for the meeting
Output 4.2	Project Coordinating Committee Meetings (PCC)	• Number of people attending the meeting • Number of meetings held annually • Number of additional activities approved	• PCC Meeting Minutes • National Coordinator's report • Quarterly reports • Total Reach counts • MSC stories	The National Coordinator will be able to coordinate and convene all meetings in a timely manner.
Output 4.3	National Health Partners Group meetings	• Number of stakeholders participating at the meetings • Increase number health initiatives by partners	• National Coordinators report • Quarterly report • Total Reach counts	Partners will be enthusiasm to attend the meetings
Output 4.4	Advocacy at the national and provincial levels for support of the Village Health Worker Program.	• Number of VHWs agreed to attend nursing school supported by MoH • Number of aid posts with Increased community	• HPOs report • National Coordinator's report • Quarterly report • Total Reach counts • MSC stories	The government and local partners will respond positively to SC's advocacy initiatives

Strengthening the Village Health Worker Program– Logical Framework Analysis				
Level	**Narrative Description**	**Indicators**	**Means of Verification**	**Assumptions**
		support		
Objective 5	Ensure efficient and effective management of the program	• Timely and effective monitoring, reporting and staff management.	• Project progress, monitoring • and evaluation reports	Stability in VHWs, MoH and SC staffing
Output 5.1	Management, monitoring and evaluation systems of the VHW Program strengthened and operational	• M&E timelines, including roles and responsibilities, established. • Timely and accurate reporting against outputs, objectives and purpose	• M&E reports • Quarterly reports • Site visit reports • MSC stories • Total Reach counts	Staffing Stability Timely support and advice regarding application of M&E functions
Output 5.2	Strengthened reporting mechanisms.	• Timely and effective reporting • Increase knowledge and confidence of data collection and report writing	• M&E reports • Training reports • Quarterly reports • Total Reach counts • MSC stories	Staff will be competent to provide outstanding reports
Output 5.3	Village Health Worker pre-service Training Guide approved by Vanuatu National Training Council.	• Number of meetings held to discuss the training guide • Number of people participating in the meetings	• Meeting minutes • Quarterly reports • Total Reach counts • MSC stories	The Village Health Worker Training guide will meet the National Training Council requirements
Output 5.4	Handover of the VHW Program from Save the Children to the Ministry of Health.	• Number of distinguished staff at MoH planned to work on the VHW Program from December 2011. • Number of trainings conducted for potential candidates beyond	• SCA Final VHW Program Report • MoH VHW Program Planning Documents. • Policy paper developed	The VHW Program will be managed solely by the MoH from December 2011. Risk: The MoH does not have

Strengthening the Village Health Worker Program– Logical Framework Analysis				
Level	**Narrative Description**	**Indicators**	**Means of Verification**	**Assumptions**
		December 2011		capacity to manage the VHW Program from December 2011.

Annex 7: Proposed purposes, roles and responsibilities of VHWs

- The VHW is a bridge between the community and the health system but is not a health professional. Their role is as a volunteer (who may receive some incentives) with an intimate knowledge of their own culture and community. They are expected to live in the community.
- VHWs should be selected by the community, be accountable to the community for their activities and receive support from the community.
- The VHW can expect to receive some basic training which under the program may be delivered at different levels depending on their access to a staffed health centre, dispensary or hospital.
- VHWs are expected to identify people at risk and in need and to take measures to prevent ill-health (for example surveillance), to promote health and well-being (for example health education), improve access to health care (for example delivering basic curative services) and refer cases through the health system.
- VHWs are to help communities (through VHCs or other community based groups) to organise and mobilise themselves to identify their needs and to plan and implement activities to address their needs.
- VHWs should collaborate with other health professionals in the area team including the area nurse, HPO and Provincial PHC officers.
- VHWs should receive and participate in regular supervisory visits and joint activities with other health professionals and community workers in their area such as community organisation, health education and surveillance.

Annex 8: Proposed revisions to Health Committees Act

Recommended changes to this Act are underlined

HEALTH COMMITTEES: An Act to establish health committees throughout Vanuatu and for related purposes.

1. Definitions

In this Act, unless the contrary intention appears:

"health area" means the area served by one or more health facilities;

"**health committee**" means a committee appointed under section 2;

"health facility" means a health centre, dispensary or aid post;

"health fees" means any consultation fee at any health facility;

"Minister" means the Minister responsible for health;

"provincial health supervisor" means a provincial health supervisor appointed by the Ministry of Health to one of the 6 provinces in Vanuatu.

2. Appointment

(1) A **health committee** is to be appointed for each health area by the provincial health supervisor of the province in which the health area is located.

(2) The appointments are to be made in writing.

3. Composition of each committee.

(1) A **health committee** is to consist of a quorum of 4 members.

A quorum should approximate the largest number that can be depended on to attend any meeting except in very bad weather or other extremely unfavorable conditions.

(2) The members of the committee are:

(a) the head health professional or nurse of a health facility such as at health centre; and

(b) a representative of the chiefs of the communities within the relevant health area; and

(c) a representative of the youths of the communities within the relevant health area; and

(d) a representative of the women in the communities within the relevant health area.

(3) No allowances or other form of remuneration is payable to any member of the committee.

(4) A member of the committee is to be appointed for a period of 2 years and can be reappointed.

(5) Other members can be appointed at the discretion of the quorum.

4. Meetings of the committee

(1) A **health committee** is to meet at such times as are necessary for carrying out its functions under this Act.

(2) A health professional is to be the secretary for **health committee**.

(3) The committee is to determine and regulate its own procedures.

(4) A quorum must be present in order to make decisions by the committee.

5. Functions of the committee

A **health committee** has the following functions:

(a) to maintain each health facility within the relevant health area;

(b) to charge and collect health fees;

(c) to identify the general health and well-being needs of the communities within the relevant health area;

(d) to use or spend money received by way of health fees for the overall maintenance of the health facilities within the relevant health area;

(e) to ensure that basic curative primary health care services are provided to the community through the facility.

(f) To mobilise the communities to participate in activities that promote health.

(g) To assist in raising funds to address the general health and well-being needs of the communities.

6. Powers of the committee

A **health committee** has power to do all things that are necessary or convenient to be done for or in connection with the performance of its functions.

7. Health committees not to apply to hospitals

Health committees are not to be appointed for hospitals.

8. Funds of the committee

The funds of a **health committee** consist of:

(a) money received by the committee by way of health fees; and

(b) any other money received by the committee from any other source.

9. Misuse of funds of the committee

A person must not misuse any funds of the committee.

Penalty: a fine not exceeding VT 100,000 or a term of imprisonment of not more than one year, or both.

10. Distribution and accountability of health fees

(1) All health fees charged by a health facility are payable to the **health committee** responsible for that facility.

(2) The provincial health supervisor in consultation with the head nurse of that facility must:

(a) check the receipt books; and

(b) balance the accounts.

(3) The provincial health supervisor may remove a member from a **health committee** if that member misuses the funds of the **health committee**.

(4) In carrying out his or her duties under subsection (2), the provincial health supervisor may seek assistance from the Ministry responsible for Finance.

11. Application of the Public Finance and Economic Management Act

The Public Finance and Economic Management Act [Cap. 244] does not apply to this Act.

12. Regulations

(1) The Minister may by regulation prescribe health fees required under this Act.

(2) The Minister may make regulations necessary or convenient to be prescribed for carrying out or giving effect to this Act.

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