HEALTHY ISLANDS
TECHNICAL REPORT

Phase1-2 (2010-2012)

Ministry of Health

Healthy Islands Initiative, Vanuatu

Technical Report (Phase 1-2/2010-2012)

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List of Acronyms and Abbreviations

HI	Healthy Islands	**VHWP**	Village Health Worker Programme
PHC	Primary Health Care	**S&C**	Supervision and Coaching
HSS	Health Sector Strategy	**CN**	Community Nurse
HP	Health Promotion	**HC**	Health Centre
HPU	Health Promotion Unit	**NGO**	Non-Government Organization
HPO	Health Promotion Officer	**UN**	United Nations
PHT	Provincial Health Team	**IGO**	International Government Organisation
TOR	Term of Reference	**GO**	Government Organisation
WHO	World Health Organization	**MoH**	Ministry of Health
UNICEF	United Nation Children's Fund	**IEC**	Information Education Communication
GF	Global Fund	**HIP**	Healthy Islands Package
SCA	Save the Children Australia	**HIS**	Health Information System
SC	Steering Committee	**HPG**	Health Partners Group
MOU	Memorandum of Understanding	**CBO**	Community Based Organization
MOU	Memorandum of Understanding	**HFA**	Health for All
NCD	Non-Communicable Disease	**PEN**	Package of Essential NCDs
JICA	Japan International Cooperation Agency	**VSO**	Voluntary Service Overseas

1. Background

The birth of Primary Health Care

At the Alma Ata Declaration in 1978, Primary Health Care (PHC) was articulated as a set of guiding values for health development, a set of principles for the organization of health services to reach all communities, and a range of approaches for addressing priority health needs and social determinants of health. Vanuatu adopted the PHC Strategy following the Alma Ata Declaration. A PHC policy was developed in 1984, its intention was to provide direction for promoting health and prevention of diseases. A number of best practices based on the values of primary health care were implemented and some still have their mark today; for example, development of the public health unit, establishment of new rural health facilities such as dispensaries and aid posts, and the village health worker programme. [1)]

A PHC module was developed and taught in the nursing school to ensure that graduating nurses apply the PHC philosophy in the field. For doctors' training, the Fiji Medical School was also teaching a PHC-oriented training programme. In response to the apparent need to decentralize services, new categories of health workers were trained including nurse practitioners and nurse aids. More community-based midwives and public health nurses were trained, also taking advantage of PHC-oriented training courses made available at the Fiji School of Nursing. [1)]

The next few years saw PHC thrive in many provinces and communities in Vanuatu as approaches of community participation, health promotion and multi-sectoral partnership became part of community health. Village health committees were established to coordinate and lead community involvement in health initiatives. The main entry points for PHC to reach communities revolved around the malaria programme, environmental health, and water and sanitation programmes. Early community priorities included clean water supply, toilets and preventive measures against malaria. Community-based initiatives included income-generation projects such as cash crop farming, piggery, poultry and cattle farming to support basic family needs. This participatory approach attracted communities to buy-in to the PHC model. The impacts of PHC were beginning to surface – such as reduction in deaths from malaria and TB, improvement in infant and child mortality, and improved maternity care.[1)]

However, the enthusiastic early phase of PHC was short-lived. Within 10 years (mid 1980s to mid 1990s), it started to lose focus and lost its vigour. It almost disappeared unnoticed although its values and principles stood strong. A number of circumstances would have contributed to this. Firstly, the noble vision encapsulated in the PHC policy was not adequately translated into operational plans for implementation, resourcing, continuous support and monitoring. Secondly, there were inadequate long-term plans for continuity of initial investment in PHC staffing and facilities. Thirdly, there was insufficient

dialogue among planners and implementers at every level of the health delivery system on the application of PHC. This affected the effectiveness of the referral system to link primary and secondary care. In addition, the 1990s saw a shift of global and regional focus to disease-oriented interventions (such as HIV, malaria, TB) which somewhat diverted health resources to particular areas and left PHC poorly funded. This formed part of the explanation in the decline of attention for PHC. [1)]

In the 2000s, the Ministry of Health (MoH) put great effort into health sector reform and policy integration, however it has not yet been paid off. "Ministry of Health Policies 2002" was the first major national policy document for the MoH, addressing 15 priority areas. [2)]"Master Health Services Plan 2004-2009" provided the overall direction for all health services in Vanuatu, reflecting overall policy of the Vanuatu government at the time. The plan also tried to reform health sectors based on PHC philosophy, however it was not well translated into practical work of the MoH. [3)]The basic concept of the plan is handed-over to "Health Sector Strategy 2010-2016", which is a principle reference for all actors working in the health sector. The document provides the vision, mission and values for the development and overall objectives of the health sectors and indicators aiming to achieve these objectives. [4)]

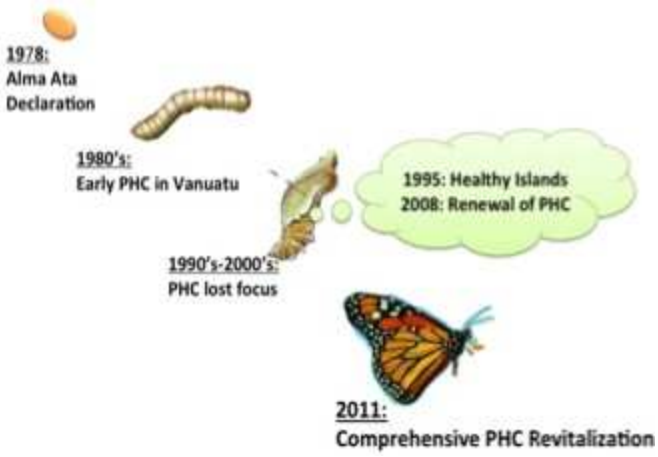
The emergence of Healthy Islands concept

The concept of Healthy Islands unifies efforts for health promotion and health protection in island settings based on the principles of the healthy settings promoted in the Ottawa Charter. It provides a framework within which health issues are analysed, prioritised, and implemented in island settings. The success of Healthy Islands initiatives, as reflected in improved health status, is strongly linked to community commitment and buy-in from other sectors. The concept, endorsed at the Health Ministers' meeting in 1995 in Yanuca Island in Fiji was an attempt by Pacific health leaders to revive the PHC using the healthy settings approach to improve health outcomes among island countries.[5)]

The goal of Healthy Islands is to improve the health and quality of people's lives in island settings. Application of the healthy settings approach aims to establish more effective working relationships between the health sector and other sectors with participation of people to address health problems. This involves strengthening community education, health promotion and stakeholder mobilization. [5)]

Following the Yanuca Declaration in 1995, the 1997 Rarotonga Agreement reinforced the Healthy Islands concept to address priority health issues in partnerships with communities, organizations and agencies at local, national and regional levels. The health ministers' meeting proposed that donors and development partners support and revive PHC applying the vision of Healthy Islands. However, the application process did not adequately materialize as envisioned. Nevertheless, Vanuatu continued to adopt the PHC approach despite low resources allocated for PHC. [5)]

The beginning of Primary Health Care revitalisation in Vanuatu



The PHC Revitalisation agenda was the focus of the 2008 World Health Report, 30 years after Alma Ata. The report highlighted unacceptable levels of disparity in health status between rich and poor countries and within countries – an indicator of unequal distribution of resources and access to health services. [6)] Since health is a fundamental human right, WHO called on global action to address unequal access to health services and to reduce health inequity. The report called for *a* "return to primary health

care" and to note the importance of addressing social, economic, and political determinants of ill health which contribute to inequity. The report also highlighted that primary health care was a model for strengthening health systems.

Vanuatu responded positively to the call for PHC Revitalisation and embraced a redirection for the way forward. Since 2010, a series of PHC workshop were conducted as first steps in the revitalisation process. Vanuatu also benefited from a number of regional meetings to help shape the revitalisation process. In April 2010, a PHC seminar was conducted jointly by the MoH and WHO country office in Vanuatu. In October, MoH fully endorsed the concept of PHC Revitalisation and conducted a national workshop on PHC Revitalisation to discuss the PHC philosophy and the rationale for revitalisation. In response to this workshop, a national Primary Health Care team responsible for leading the PHC revitalisation was formed in the Health Promotion unit at the beginning of 2011. Representatives from SHEFA Provincial Health Office, the Village Healthcare Worker Programme, WHO and JICA were recruited as initial team members.

National Primary Health Care team (1st phase): left1; Akihito M. Watabe: Public Health Physician/JICA, left2; Myriam Abel: Local Technical Advisor for PHC, WHO/former DG of Health, right1; Asha Shine: National Coordinator for VHWP, right2; John Tasserei: PHC National Officer/former NCD coordinator SHEFA

2. Policy and situation analysis

Policy analysis (National Level)

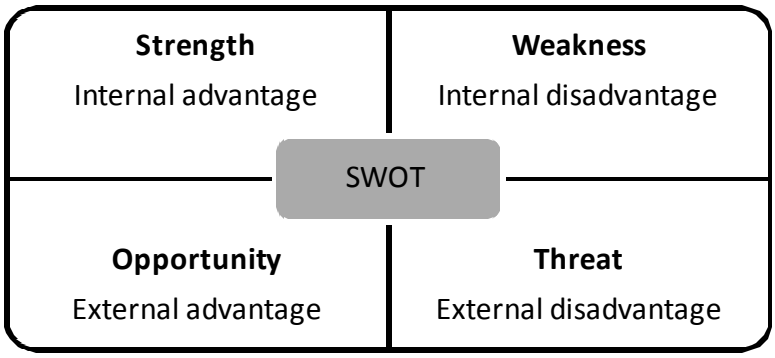
The national PHC team analysed the current situations surrounding PHC programmes at the national level. The team reviewed government documents, such as policy papers in priority areas, MoH's annual business plan, annual budget and human resource for PHC. The team also consulted preliminary findings to executive officers and provincial health promotion officers to collect additional information. There were three key findings by this analysis as below.

The first finding was lack of operational plans for implementation. Disease focused vertical programmes driven by the global trend, were too powerful to promote a horizontal approach. Managers and programme coordinators in the public health department were working separately since a coordination mechanism was not functioning well among the departments. Although there is a health sector policy paper based on PHC, this document does not include clear work plans enabling its link with the government's annual business plan. Health Promotion unit was assigned to lead the departments to harmonise their programmes, however their passive work style, assisting activities upon request of other units, made it difficult for the unit to take leadership in MoH.

The team also identified budget shortage as another major problem. Village Healthcare Worker Programme (VHWP), a PHC oriented government programme aiming to improve access to first aid through Aid Posts and Village Healthcare Workers, consumes considerably a huge budget of the annual programme budget funded by AusAID. Moreover, this programme is outsourced to an Australian NGO and does not link well to other health programmes due to poor communication between the programme coordinator and responsible managers in the MoH. Except for this, no government budget was allocated to activities adopting the PHC concept at the beginning of 2011.

In addition, lack of manpower was a significant problem to maintain PHC activities. During the declining period of PHC, government positions related to PHC had been removed from their structure, thus acute shortage of human resources resulted in limited implementation of comprehensive activities. Although six provincial health promotion officers were appointed six years ago, their responsibilities were not clear, mainly because of working for other public health programmes or assisting VHWP upon request. Lack of communication between provincial health promotion officers and the national health promotion office was also cause of an inadequate annual plan which ignored provincial and community needs.

SWOT analysis (Provincial Level)

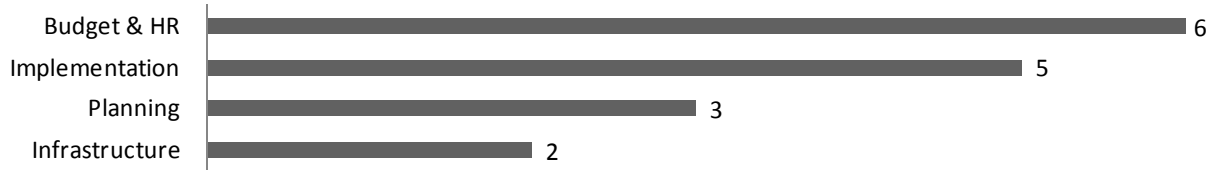


In collaboration with VHWP, which was managed by Save the Children Australia, the national PHC team visited six provinces and held provincial PHC revitalisation workshops. Target groups of the workshops were decision-maker and key actors at provincial level (total of about 150 participants for six workshops), such as Provincial Health Officers, Provincial Government and other head office representatives, local NGO partners, chiefs, priests, youth groups, and women's group representatives. During the workshops, participants experienced several group works, which included vision making, SWOT analysis, prioritization with objective scoring, and provincial action plan as well as series of lectures. At the beginning, 20-30

participants were divided into 4-5 small groups for situation analysis using SWOT (Strength, Weakness, Opportunity, and Threat). Following this, all information was merged into one mind-map and reviewed by all participants. After clarification and consensus building, they identified a few core problems which would affect other problems. In addition to this, recommendations to the national government and/or donor partners were made regarding the opportunities and threats of the provinces.

Overall, all provinces did understand that management of the provincial health offices were problematic. As shown in the chart below, all provinces identified lack of budget and human resources as major problems. This included delay and/or restricted funding to specific public health programmes and a lot of acting-position and/or double responsibilities assigned to one officer. Five out of six provinces and three out of six provinces realised their weak implementation capacity and inadequate planning skills as serious issues, respectively. Participants complained that most of the public health programmes were planned at national level, making the main responsibility of provinces as being implementation without a proper planning process. In some provinces, there were no coordination mechanisms in their offices with the provincial health manager not having substantial authority due to the acting-position and vertical programmes with direct grants by donor partners. Under the situation, some units flourished, while others ceased implementation even though community needs were relatively high. Only two provinces mentioned that absence of basic infrastructure, such as transportation and water sources, is a critical issue in their region.

Following the findings, provincial stakeholders made recommendations to the national government: first, current health programmes must be delivered horizontally while mobilising resources; second, the national government should provide provincial governments and community leaders with continuous management and financial support, in order to achieve decentralization of the health system. In addition, shortage of human resources is a critical problem needed to be resolved promptly, including clearing out acting-positions and a succession plan for retirement-age personnel and vacant positions.



Top 4 problems in provinces: N=6 (province) and 150 (participants)

Provincial Action Plan 2011-2015

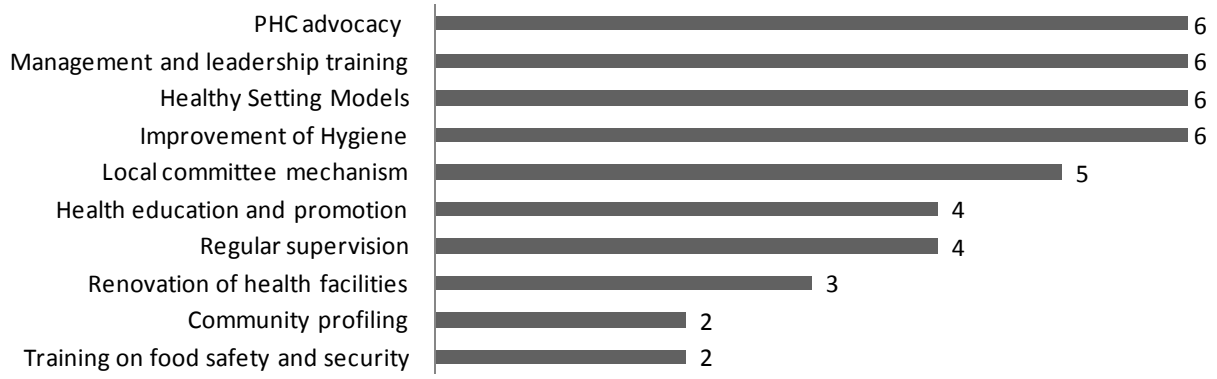
After analysing the situation, provincial stakeholders were divided into five working groups that were in charge of; overall provincial management, health facilities, schools, markets, and villages. They brainstormed preliminary activities based on the previous analysis, prioritised them considering five key factors; community needs, urgency, feasibility, efficiency, and sustainability. Each participant had one scoring right for each factor per activity, ranging from 1 (low) to 5 (high). Based on the total sum of five factors and/or multiplication of five factors, all activities were prioritised objectively.

Activity	Needs	Urgency	Feasibility	Efficiency	Sustainability	Sum	Multiply	Priority
Activity1	4	3	4	1	5	17	240	2
Activity2	3	1	1	3	4	12	36	3
Activity3	2	2	2	1	1	8	8	4
Activity4	4	4	5	5	1	18	400	1

Example of prioritization with five key factors: Community Needs, Urgency, Feasibility, Efficiency, and Sustainability

According to the provincial action plans, provincial stakeholders nominated the following 10 activities as a higher priority for upcoming years. First and foremost, all provinces agreed that further advocacy of PHC to community leaders were crucial for its revitalisation. Although the philosophy of PHC had been introduced to the communities in the 1980s, community participation and ownership was lost over the next few decades. Management and leadership capacity building that contributes to decentralised health systems also needs to be a primary activity. They also wished to launch good models of a "Healthy Setting" which meant improved hygiene at schools, clinics, villages and markets. Most of the provinces also pointed out that it is important to initiate or strengthen local committee mechanisms, enabling community leaders to be part of a health activity in their village. The Health Committee Act 2003, a law giving community representatives an authority to maintain their local health facilities, is crucial to community mobilisation. However, this mechanism is not used adequately at this moment.

Four out of six provinces claimed that comprehensive health education and promotion, and regular supervision of health facilities by provincial health managers or zone supervisors are necessary. It is true that some public health programmes have already started community based education and frequent supervision, however other diseases are ignored. Half of the provinces suffer from old health facilities that need to be renovated. Some provinces requested standardised community profiling tools which is applicable to the communities in Vanuatu. Responding to current food shortage, foodborne illness and eating habit risking to NCDs, skills training on food safety and security would be considerable activities as well.



Top 10 activities in 6 provinces prioritised by 5 key implementation factors: N=6 (province) and 150 (participants)

Analysis and costing of Health-Related MDGs in Vanuatu

At the same time the PHC team were finalizing the analysis in the middle of 2011, UNICEF had conducted a health system analysis and costing of Health-Related MDGs. The purpose of the analysis was to provide evidence to make available critical resources to accelerate action towards (a) reduction of child deaths and pregnancy-related deaths and (b) uninterrupted delivery of quality and equitable health services to all people of Vanuatu. Key findings and recommendations are as below [8)];

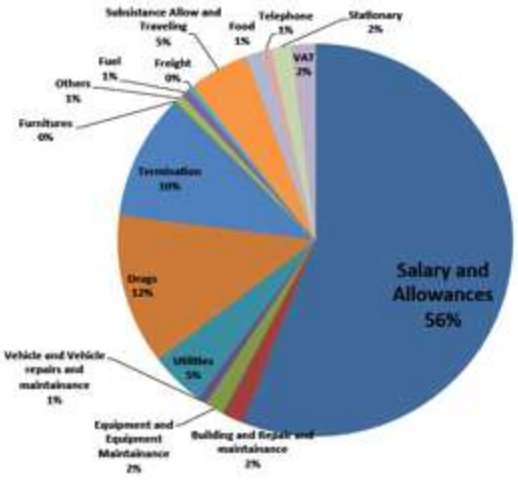
1. **Severe and near catastrophic shortage of nurses and doctors**: 94% (34/36) Nurse Practitioners; 66% (21/32) Doctors; 52% (25/48) Midwives; 52% (77/147) Nurse Aids and 25% (74/291) Registered Nurses. 44 Health facilities are not functioning due to staff shortages and quality of health care is compromised because Nurse Practitioners who would assist doctors virtually do not exist. [8)]

2. **Limited availability and access to community-based health care (prevention and promotion)**: Current Village Health Worker programme covers only 35% of people of Vanuatu. Almost all villages within the catchment areas of HCs and Hospitals are not covered by face-to-face health promotion activities. Average straight-line distance from Aid Post to Dispensary/ Health Centre is 10.1 km, ranging from 14.1 km in TORBA, 12.3 km in TAFEA to 6.7 km in PENAMA. [8)]

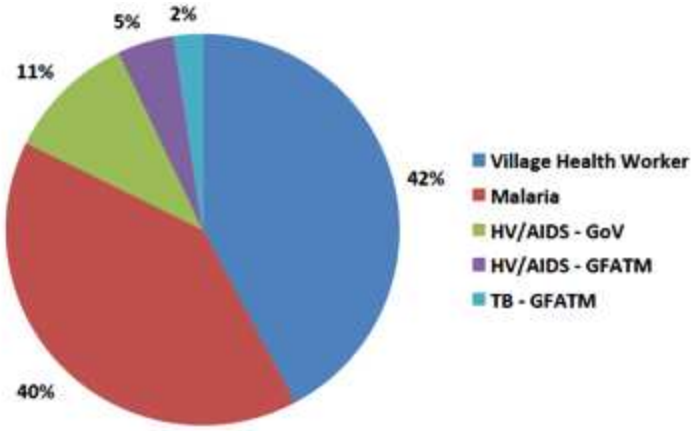
3. **Very narrow fiscal space and chronic inadequate government and donor funding**: In 2010, MoH had a fiscal space of USD25 million with Government of Vanuatu contributing 87% and health development partners 13%. Government of Vanuatu funds (2-3% of GDP for the last 5 years) goes to fixed and impossible to cut items: e.g. in 2010: 56% salaries and allowances; 12% drugs; 10% termination (all together approximately 80%), leaving MoH with narrow fiscal space for other 14 budget line items, including repairs and maintenance and travelling. 80% of donor funds in 2010 were on Village Health Worker (42%) and Malaria (40%) programmes, leaving other public health programmes virtually grounded. [8)]

4. **Proven and efficacious interventions are available in Vanuatu, but not at scale and far from those who need them the most**: Killers of women and children in Vanuatu are related to childbirth and the first week of life (mothers and new-borns) and pneumonia and diarrhea (infanthood to five-years): Children: 37.05% neonatal conditions; 23.35% pneumonia; diarrhea 6.61%; (all together approximately 70%); Mothers: 57% bleeding after delivery (post-partum haemorrhage). Low coverage of known and cheap high impact interventions: For neonatal conditions: - NONE or low at family/community level; mainly in hospital-based and low coverage; for maternal: NONE at family/community; mainly in hospital, low coverage and far. Limited availability and access to community-based health care (prevention and promotion). [8)]

Distribution of Health Budget, 2010:



Distribution of Grants Actual Expenditure, 2010:

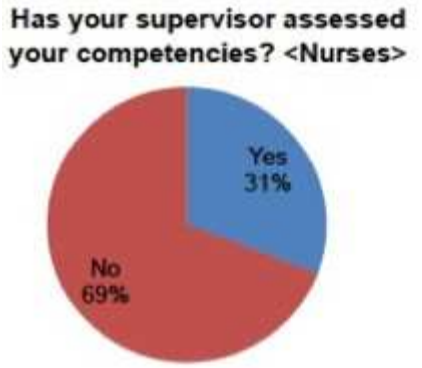


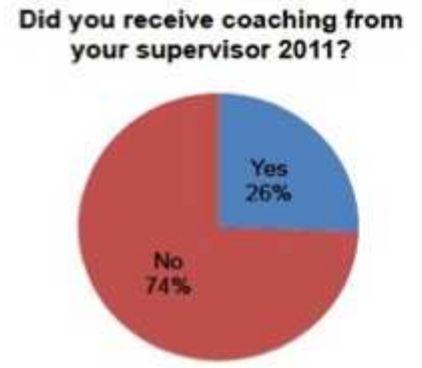
Key recommendations: 1. Government should provide adequate funding for drugs, maintenance and operation of health facilities. 2. Development partners should double or match government funding to the health sector (health system strengthening). 3. Government and development partners should invest additional resources in the highest causes of maternal, newborn and child illnesses and deaths. [8)]

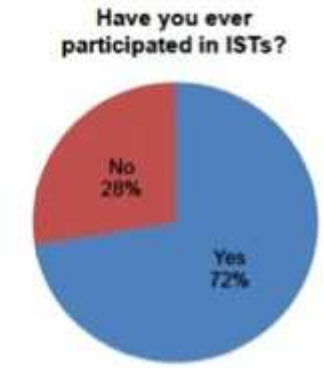
Supervising and coaching for Community Health Nurses

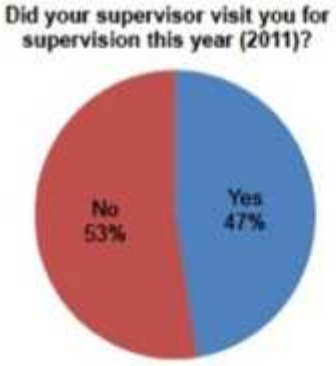
Supported by Japan International Cooperation Agency, a survey on supervision and coaching was conducted in SHEFA province in 2011. According to the survey, the percentage of community nurses who were assessed their competencies and received coaching by their supervisor was 31% and 26%, respectively. On the other hand, half of supervisors replied that they had conducted supervisory visit in 2011. Although 72 % of interviewees have ever participated In-service trainings, it seems that most of the trainings were taken place in Prot-Vila, the capital city of Vanuatu. Some of them argued that it would disturb their regular service deliveries at health facilities. The survey also identified several issues

that included a lot of nurses suffered from low morale caused by shortage or human resource and fragile infrastructure, lack of appropriate policies on HRD and infrastructure maintenance, scarcity of fund, uneven provision of training opportunities and supervising and coaching (S&C), competency standard assessment, and post-training supervision are not in place. The report concluded that the government should support supervisors, develop a field-adjusted model of S&C and cooperate with various health personnel. [9)]

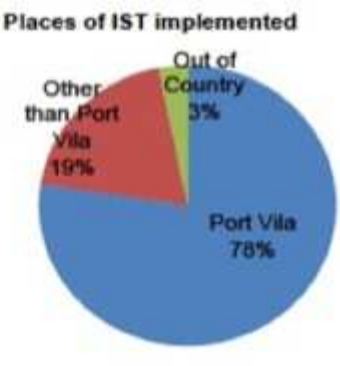








Major Topics of Training (more than 50% of respondents have participated)		Least Topics of Training (less than 20% of respondents have participated)	
Topic name	Percentage of attendance	Topic name	Percentage of attendance
HIV/AIDS, STI	82.8	risk management	3.4
NCD	65.5	proposal writing	3.4
EPI	62.1	IMCI	6.9
reproductive health	58.6	nursing competencies	6.9
family planning	51.7	nursing standards	10.3
		M&E	13.8
		data analysis	17.2



JICA NB-IST Baseline Survey in SHEFA Province, 2011: N=CHNs(48)+Nursing Supervisors (15)

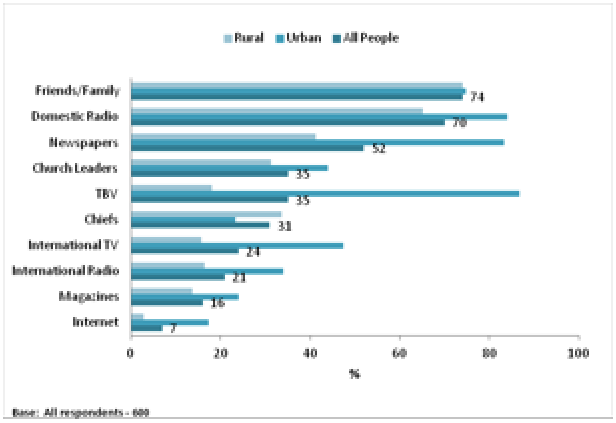
Vanuatu Media Usage Study 2010

The Vanuatu Media Usage Study 2010 is a media audience survey conducted by Australian Broadcasting Corporation as a part of the Australian government supports to Vanuatu. According to the survey, the MoH should consider application of public media more efficiently. [11)]

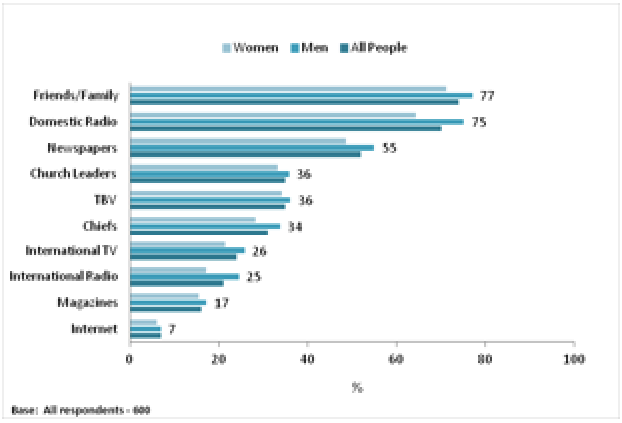
Source of news in urban/rural: According to the survey, 72% of respondents reported that radio was the highest 'ever used' media. This was followed by newspapers (52%), television (46%) and Internet (9%). In case of newspapers 'ever used', there was a higher percentage of urban (77%) than rural respondents (43%). Television was much higher in urban areas (88%) when compared to rural (43%). The survey highlighted disparities between the sources of media used by urban and rural locations. In addition to the public media, friends and family were considerably high information source at 74% in both urban and rural. Church leaders and chiefs were also possible information sources at 35% and 31%, respectively. Church leaders seemed to have more influence in urban areas than chiefs; on the other hand, chiefs influenced community people stronger in rural areas. [11)]

Source of news by male/female: The rate of media usage in Vanuatu varies across gender and age. Male respondents were also more likely to consume various types of media when compared to females. 83% of the respondents aged between 15 and 24 have listened to the radio compared with only 65% of respondent's aged 35 and over. The survey highlighted greater media consumption by males and those aged between 15 and 24. [11)]

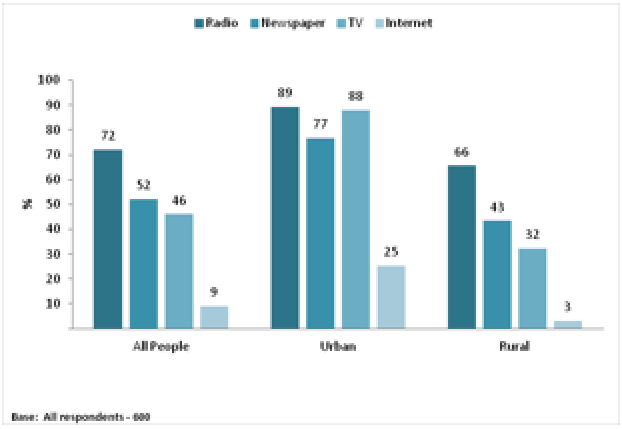
Media equipment ownership: Another finding is that ownership of mobile phone is quite high at 88%. Since recent mobile phones equip radio tuner, the radio accessibility would be considerably high in the whole Vanuatu. (Short radio wave coverage is 100% in Vanuatu) DVD player coverage is also relatively high with 51% and it looks like one community has at least one DVD player even in rural area of Vanuatu. Radio, mobile phone and DVD could be useful information channel especially to remote area. [11)]



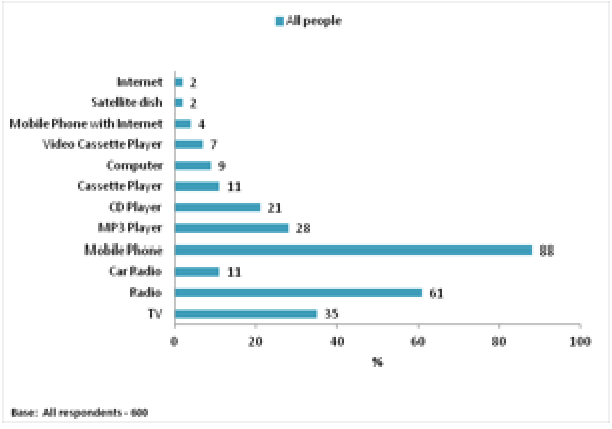
Source of news in urban/rural: N=600



Source of news by male/female: N=600



"Ever used" media in urban/rural: N=600



Media equipment ownership: N=600

3. Implementation

Revitalisation process in Vanuatu (Planning and roll out phase)

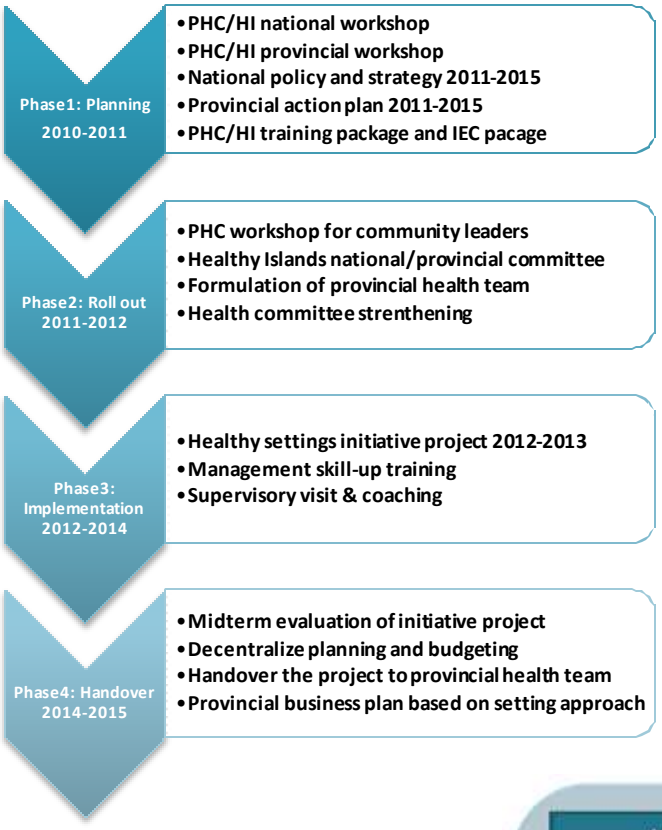
1st National Meeting on Healthy Islands, July 2011: Left; Director General of Health, Middle; Minister of Health, Right 1; JICA Country Representative, Right 2; WHO Country Liaison Officer

Major programme documents and materials are available on
http://healthyislandsvanuatu.wordpress.com

Apr 2010	PHC seminar
Oct 2010	National PHC Revitalisation workshop with national health partners
Feb 2011	Launched National PHC team in Health Promotion unit
Mar 2011	1st National Health Promotion workshop with provincial health promotion officers
Apr-Jun 2011	Provincial PHC Revitalisation workshop with provincial partners
Jul 2011	1st National Meeting on Healthy Islands with national health partners
Jul 2011	Launched Healthy Islands IEC Package and Education DVD in Bislama
Jul 2011	Launched Policy Paper and National Steering Committee
Aug 2011	Launched 6 Provincial Steering Committees
May 2011	Final version of Policy paper submitted to Executive Committee
Sep 2011	Launched community mobilization training manual in Bislama
Sep-Nov 2011	Training of trainers on community mobilization
Nov 2011	Launched provincial health teams
Jan-May 2012	Workshop on community profiling and PHC advocacy for community leaders
May 2012	Launched Healthy Settings Initiative Project 2012-2013
Jun 2012	Baseline survey for the initiative project

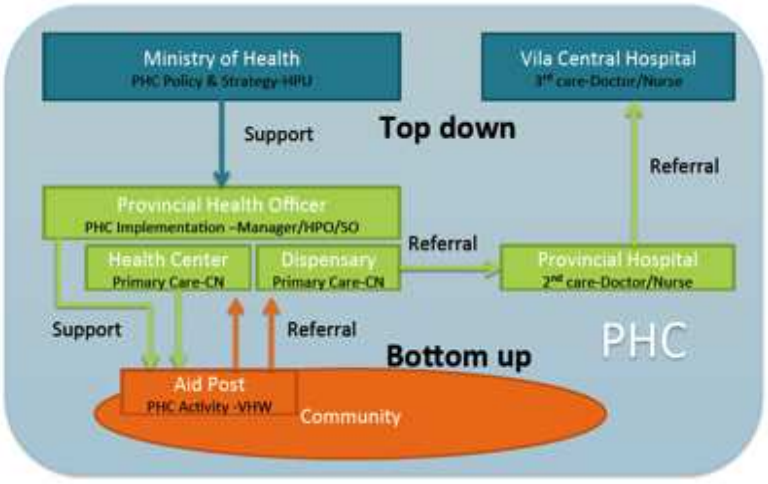
Healthy Islands Initiative 2011-2015

Following the results of PHC workshops, the PHC team wrote a policy paper. The document aims to provide strategic direction to operationalize the Healthy Islands vision, applying the PHC approach as a tool to realise this vision, and health promotion functions as the driving vehicle behind the agenda. The implementation of the policy is expected to assist the Health Sector Strategy 2010-2016 to accomplish its goals and objectives to bring about improved availability and accessibility of health services, attain its mission to protect and promote the health of all people in Vanuatu, and achieve its vision for an effective and efficient integrated and decentralized health system that promotes equitable health services. [7)]



Key concepts of this policy are applying the Healthy Promotion concept, multi-sectoral approach, multi-layer and top-down/bottom-up combination approach, and linking national and provincial body tightly to drive decentralisation of health systems of Vanuatu. This initiative is composed of four phases: 1. Planning phase; 2. Rollout phase; 3. Implementation phase; and 4. Handover phase. The first phase mainly focused on planning, advocacy, and development of educational materials. In the second phase, series of capacity building trainings to different target groups were conducted with a new framework development, such as provincial health teams and steering committees in three layers. After the second phase of spreading it to the whole country, model cases of applying the policy will be launched at over 40 project sites during the third phase. Through supervision and coaching for the initiative project, provinces will be trained by national government and health partners to improve management of their office. In the final phase, the policy expects the ownership of the initiative will be handed over from national government to provinces and communities fully under the normal government planning and financing procedure. [7)]

[Electronic copy of the policy paper]
http://healthyislandsvanuatu.wordpress.com/policy



Multi-layer & Top-down/Bottom up combination approach:
1st layer: National level, 2nd layer: Provincial level, and 3rd layer: Community level

Series of advocacy and capacity building trainings

Variety of advocacy and capacity building trainings to different target groups took place during 2011-2012. The whole list of workshops and its target groups are shown below;

[Electronic copy of workshop materials] http://healthyislandsvanuatu.wordpress.com/workshop

Date	Name of training	Target group
Feb 2011	National Health Promotion meeting	Health Promotion Officers
Apr-Jun 2011	Provincial PHC revitalisation workshop	Provincial stakeholders
Jul 2011	National meeting on Healthy Islands	National stakeholders
Sep-Nov 2011	Training of trainers on Community Mobilisation	Provincial Health Teams
Sep 2011 -May 2012	PHC revitalisation workshop for CL	Community leaders
Oct 2011	Nursing education based on PHC concept	VCNE tutors
Oct 2011	Clinical practice based on PHC concept	VCH clinical staff
Nov 2011	Northern & Sothern Health Care Group meeting	Provincial Health Teams
Nov 2011	Clinical practice based on PHC concept	NPH clinical staff
Dec 2011	PHC advocacy workshop	NGO partners
Jan 2011	Nursing education based on PHC concept	ANP students and tutors
Feb 2012	1st Public Health management meeting	Public Health staff

Healthy Setting Initiative Project 2012-2013

In order to establish a good model of integrated and horizontal service delivery to different target groups, a total of 42 two-year-long initiative projects have been launched. This project mainly targets people around four settings; schools, health facilities, markets and communities. It also encourages community participation and ownership in public health activities. [12)]

The national team expects provinces to launch seven initiative projects per province, applying a health promotion approach for specific settings. Depending on the community needs and socio-geological traits of provinces, provincial teams can combine several different types of projects into one and launch it in a certain area. The national team is responsible for overseeing the quality of projects, overall time management, fundraising, and providing technical assistance. On the other hand, provincial health teams and its provincial partners are in charge of project coordination and part of its implementation. People living in the project sites are expected to implement the initiative by themselves with regular support by the provinces. [12)]

At the start of the project in 2011-2012, facility survey and community profiling are scheduled in about 120 communities. At the end of the project in 2013-2014, a mid-term evaluation of the initiative will be

conducted. Based on the results, the national team will consider whether a specific project can be applicable to all provinces in Vanuatu. Good performance of project implementation with achievement of criteria below could be a considerable aspect to apply the model to formal government service delivery. [12)]

[Electronic copy of the project implementation guideline] http://healthyislandsvanuatu.wordpress.com/project

Minimum end-point criteria for both cross-cutting approaches at each setting (detail output and outcome indicators are in Annexes):

Cross-cutting criteria
1. Engage community participation and active community committees, where relevant 2. Apply an integrated approach 3. If investing in equipment or refurbishment, include community education as well 4. Set up a Health Promotion notice board, where relevant 5. Conduct a PHC WS for CL and a project facility survey, where relevant
Healthy Market criteria
1. Access to clean water & improved sanitation 2. Standard food safety measures & healthy food 3. Restrict sales of unhealthy products
Healthy School criteria
1. Access to clean water & improved sanitation 2. Health education in curriculum 3. Healthy food for school children 4. Physical education in curriculum 5. School security & safety 6. School health focal point
Healthy Clinic criteria
1. Access to clean water & improved sanitation 2. Trained & competent health worker with right attitudes and professionalism 3. Essential primary health care package & referral system
Healthy Community criteria
1. Access to clean water, improved sanitation & environmental health 2. Community-based healthy lifestyle programme 3. Access to PHC facility 4. Reliable source of food supply

Name and zone number of project sites in six provinces:

Province	Clinic 1 + reform		Clinic 2 + reform		School 1	School 2	Community1	Community2	Market 1
TORBA	Hanigton (3)		Sola PH (3)	+	Arep (3)	Sanlang (3)	Avar (2)	Vatrata (3)	Motalava (2)
SANMA	Fanafo HC (4)		Vulesepe HC (4)		Banban (9)	Hogharbour (9)	Rastron (2)	Nil	Tangara (1)
PENAMA	Kerepei HC (2)	+	Mann Disp (2)		Ambaebulu (1)	Gamalmaua (7)	Lavoda (1)	Wanur (10)	Saratamata (1)
MALAMPA	Lehil dis (12)		Nil		Tautu (1)	Nil	Uripiv Island (1)	Nil	Nil
SHEFA	Vaemauri HC (3)		Mele HC (1)		Akama (4)	Manua (2)	Bongovio (4)	Tongamea (3)	Morua (3)
TAFEA	Launanen (4)		Nil		ICPS (1)	Nil	Ipai (1)	Nil	Lenakel (1)

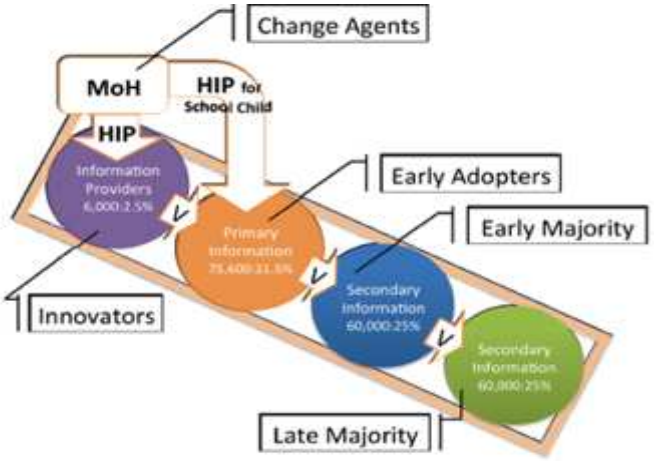
Advocacy tools

A variety of advocacy tools have been produced for stakeholder capacity building at each layer.

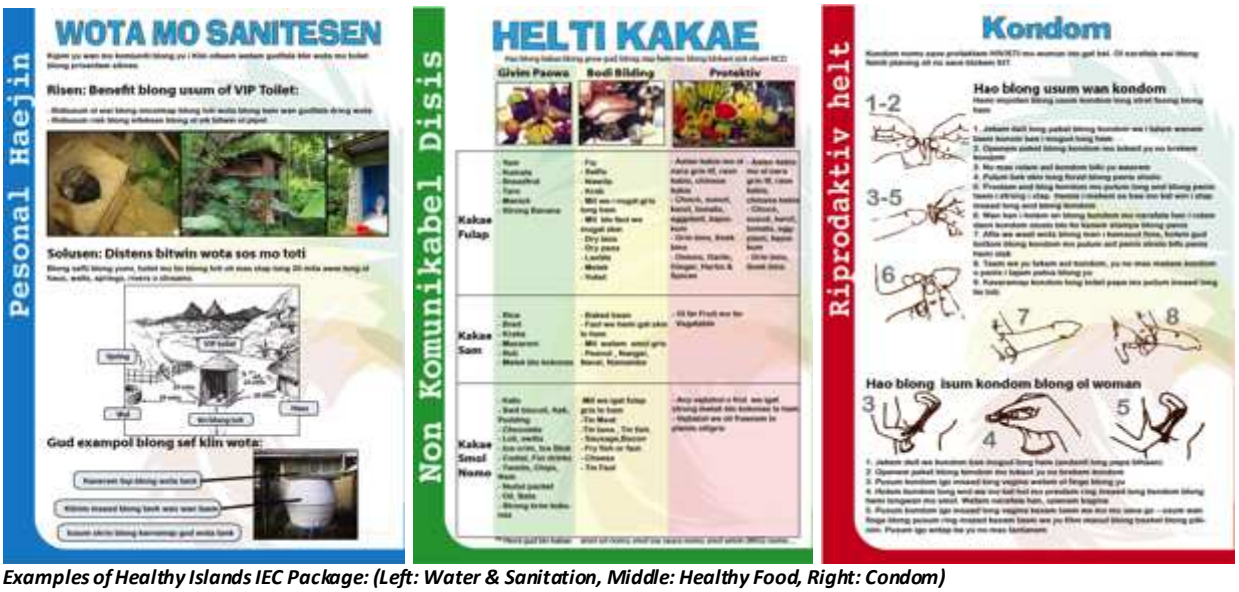
[Electronic copy of advocacy tools] http://healthyislandsvanuatu.wordpress.com/iec

Healthy Islands IEC Package is an archive file with simple and essential information covering major health issues that community people are suffering from. The package allows MoH to reduce shipping costs, confusion by nonstandard information and overlaps among vertical programmes. The distribution plan is based on "Innovation theory" targeting "Innovators" and "Early adopters" as information providers. According to the Innovation theory, 2.5% of the population (6,000) is categorized as "Innovator" and provincial health officers, community nurses, village health workers, priests, chiefs, and volunteers (Peace Corps, VSO, JICA, AusAID and other NGOs) are identified as the category group. The

theory states that 31.5% of the population (75,000) is "Early adopters" having higher compatibility to new information. The team regards teachers and school children at primary and secondary schools as the category group. The package will be distributed to the two category groups by the end of 2012 step-by-step with communication trainings and supplementary materials, such as education DVDs, advocacy T-shirts and logo stickers. They are expected to share information orally with at least a few family or friends. The information recipients will be 50% of the population (120,000), which are "Early Majority" and "Late majority". [13)]



Topics included in the 2nd edition of the package are the followings; definition of health, HI/PHC concept in Vanuatu, communication technique, personal hygiene: teeth brushing, hand washing, water sanitation, waste management, diarrhea, malaria, dengue, warms, skin disease, respiratory disease among children, TB, vaccination, nutrition, STIs, HIV/AIDS, Healthy life style, drugs, tobacco, alcohol, kava and mental health. [13)]

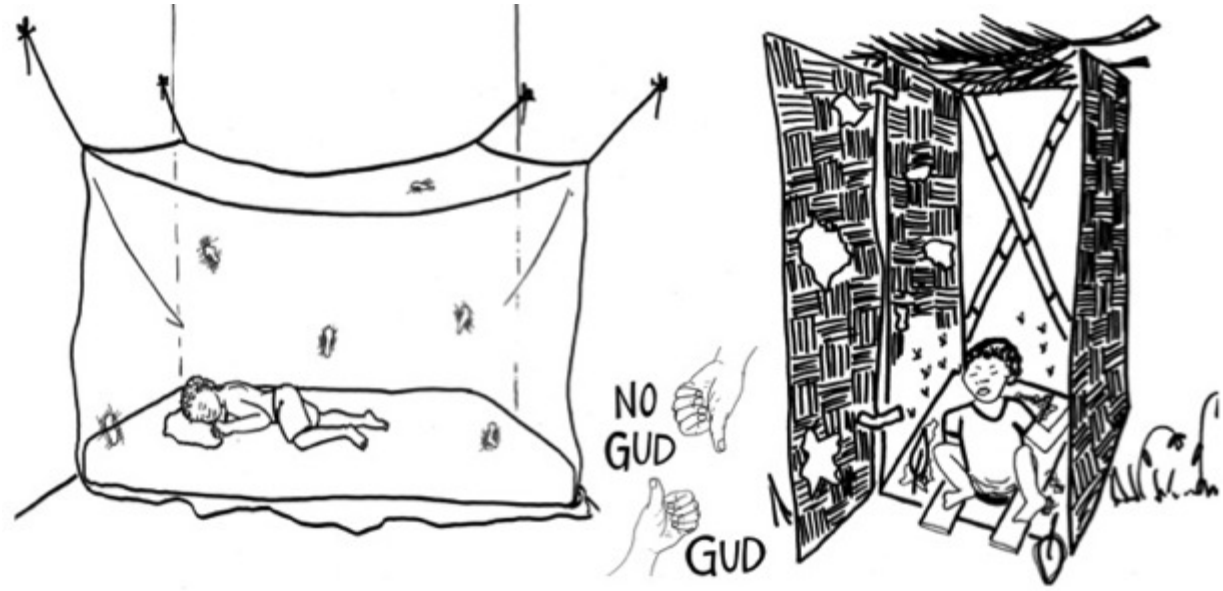


Examples of Healthy Islands IEC Package: (Left: Water & Sanitation, Middle: Healthy Food, Right: Condom)

Healthy Islands Education DVD & Media Programme are supplementary educational materials for the Healthy Islands IEC Package mentioned above. Some practices are difficult to follow appropriately, thus these movies assist information providers to understand the techniques and explain it to the audience properly. Available topics by 2012 will be; community mobilisation, hand washing, ORS, condom, food safety, healthy lifestyle, tobacco, marijuana, alcohol, healthy food, malaria, dengue and water & sanitation. The movie and audio will be disseminated through DVD, radio and TV. [14)]

Example of Healthy Islands Education DVD: (Hand Washing)

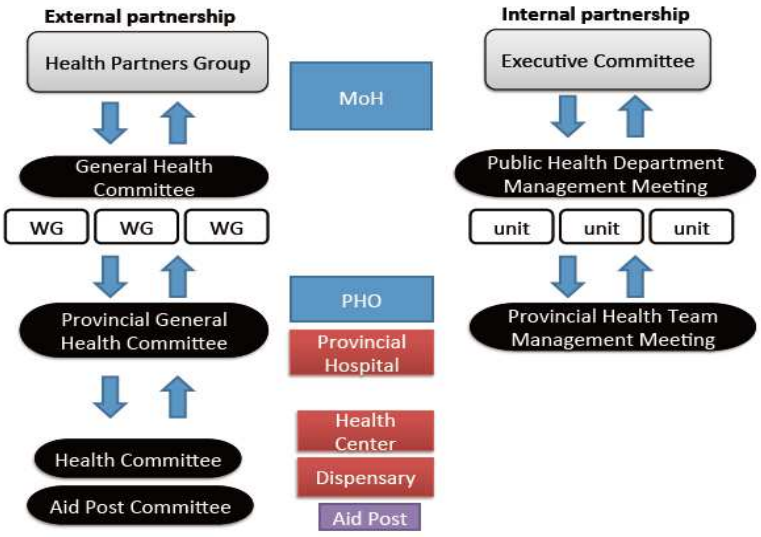
Community Mobilisation Training Booklet is a trainers' manual in Bislama, targeting community leaders. In collaboration with Peace Corps volunteers, the "SARAR" method is translated into the local context. In 2011-2012, seven training of trainers and community mobilisation workshops for about 600 community leaders at 120 communities have been carried out. Contents of the training are; concept of PHC and community mobilisation, communication skills using HI IEC Package, community mapping, problem identification, prioritization, community action plan, M&E plan and Health Committee revitalisation. [15)]



Example of group work pictures for the community mobilisation workshop: (I Gud or I no Gud?)

Change agents

General Health Committee (Healthy Islands Steering Committee) was launched in July 2011 at the national level and in August 2011 at the provincial level. The purpose of the national committee is to allow dialogue among health and non-health stakeholders to explore innovative ways of implementing healthy islands initiatives. It is well documented that the health of individuals and communities is affected by social determinants that exist outside the health sector. Therefore, responses to health problems must address these social factors. The main functions of the committee are to oversee the implementation of the National Healthy Islands Policy, provide guidance to implementation issues,



and advise on appropriate multi-sectoral interventions that are cost-effective and sustainable in improving health outcomes. Under the national committee, two working groups were set up, aiming to assist function of the committee regular bases and expand membership of the national PHC team. One is Planning M&E working group and the other is Healthy Community working group. [16)]
[Electronic copy of the ToR] http://healthyislandsvanuatu.wordpress.com/committee

Provincial Health teams were established in November 2011 after the Northern and Sothern Health Care Group meeting. The provincial health manager is the team leader of the team. The manager leads, directs and takes overall responsibility for managing the services and programmes at provincial level. The list of members of each provincial health team is attached. Terms of Reference of the team are [17)];

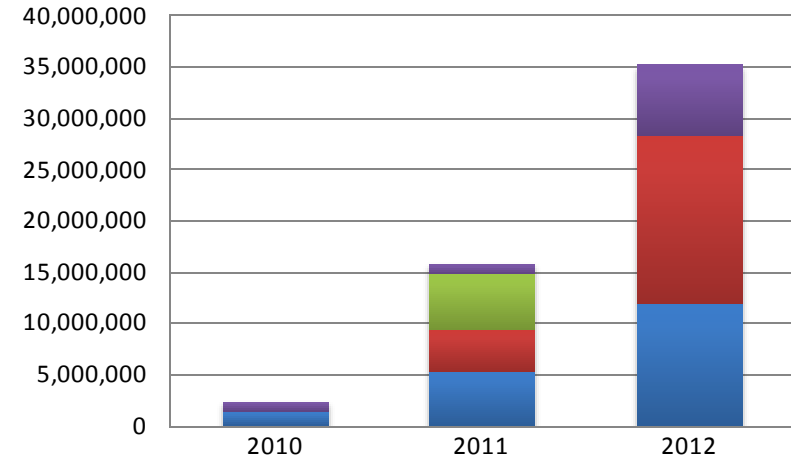
1. Plan and coordinate all health programmes and services in province
2. Share information and resources
3. Meet regularly to review progress, address issues
4. Coordinator plans agenda with the provincial health manager & calls the meeting
5. Minutes of meeting are recorded and distributed and a copy sent to Director Southern & Chair of Provincial PHC steering committee
6. Regularly update core PHC indicators
7. Provide briefing to visiting external missions & obtain debriefing from them
8. Review and strengthen NGO partnership at provincial level

Frequency and average number of participants:

	TORBA	SANMA	PENAMA	MALAMPA	SHEFA	TAFEA
Provincial Health Team						
Frequency of PHT Meeting	1/week	1/quarter	Nil	1/month	1/week	1/month
Average # of participants	10	7	Nil	13	8	11
Unit participated	6	5	Nil	9	10	11
General Health Committee						
Frequency of meeting	1/y	1/quarter	1/y	1/quarter	1/half year	1/quarter
Average # of participants	20	Nil	12	9	7	15

Financing PHC activities

Annual budget for PHC has been considerably increased after launching the Healthy Islands policy and strategy 2011-2015. In 2011, the MoH applied the New Policy Programme, a government scheme to support new policy financially, however the application was declined by the Ministry of Finance. The initial idea of the MoH was to launch the Health Promotion Fund, a financial scheme using objective taxes to sustain essential health promotion programmes; such as tobacco, alcohol and sugar. Current major funding sources to the programme are AusAID, WHO and UNICEF in 2011-2012. [18)]



Annual Budget for PHC in 2010-2012 (Vatu):

4. Conclusion

Major achievements in Phase 1 and 2

There have been considerably rapid and visible changes surrounding PHC in 2010-2012. Especially, following five achievements would be major shifts during the first two phases.

First and foremost, detail roadmap for PHC revitalisation has been made based on provincial and community needs with wide range of consultation to stakeholders. The roadmap is truly a operational plan for Health System Strengthening of Vanuatu absorbing PHC and Health Promotion principles.

Secondly, through the planning and rollout activities, the national and provincial team have strengthened partnership with stakeholders in all level. Particularly, communication with VHWP (Save the Children Australia) is notable in terms of planning and programme implementation. Regular interactions with provinces and among provincial health team also have progress.

It is also important to mention that variety of comprehensive advocacy tools have been produced in different format; paper, movie and sound. Number of these materials are still increasing day by day, thus more tools will be available in phase three.

42 model projects launched at the end of the second phase would be a good opportunity for both the MoH and provincial governments to integrate and harmonise existing programmes. Throughout the project management, the provincial health team can improve their own management capacity.

Finally, although it is still challenging to sustain budget for PHC programmes, the programme budget has increased 14 times, relative to 2010 level. It is clear to see that the initiative is matched with government needs and attracts donor partners.

Recommendations to phase 3

After showing positive aspects of the initiative, there are several drawbacks moving forward to third phase. Recommendations to remove them are listed as bellow;

National and provincial committee reform: There are too many committees and taskforces in national and provincial level, primarily aiming for partnership with external partners. Membership of some committees is overlapped and narrow focus. Committee reform would be necessary to reduce duplication and improve participation of committee members. Additionally, expansion of Joint Partners' Group could be another considerable option.

Public Health Department Management Meeting: The 1st meeting started at the beginning of 2012 with initiative of Director of Public Health. Such a kind of regular meeting might be helpful for all public health staff to harmonise public health programme within the department.

Planning M&E Working Group/National PHC team: Although JICA and WHO provided on-the-job training to national officers improving ownership of the initiative, their capacity is still insufficient to lead the initiative and required continuous assistance to them, specifically in programme management and M&E.

Provincial Health Team: Six teams were formed in 2011 and they are receiving on-going capacity building by the national team and health partners through the Healthy Setting Initiative Project 2012-

2013. Their capacity is also low, especially TORBA, PENAMA and MALAMPA province, and continuous support will be crucial at least until the hand over phase. Continuous administration assistance to the provincial health team through volunteer schemes could be more beneficial to provinces rather than occasional capacity building workshops.

New partnership: In order to support the provincial health team regularly, new partnership with NGOs working in provincial level could be applicable. There are some strong NGOs targeting a specific province, hence their regular assistance might be helpful for the provincial team. Additionally, following four projects could be collaborators of the initiative project; WHO Package of Essential NCDs (PEN) programme, VHWP, JICA NB-IST and Malaria community mobilisation programme.

Programme integration: In 2011-2012, there have been too many national meetings and trainings, targeting provincial health managers and health promotion officers. Most of the cases, they came to Port-Vila, the capital city of Vanuatu, due to the logistics of organising meetings/trainings. Although their primarily roles were different from the issues of the meetings/trainings, the meeting organisers invited them to the meetings, expecting them to supervise and/or assist other provincial offers. Normally schedule of the meetings/trainings was not adjusted well among national programmes, thus they had to be out of office for long time and that interfered with their primary responsibilities seriously. Targeting of participants considering primary role of officers and adjustment of schedules must be a priority issue to be solved.

Public Media and audio & visual materials: The Ministry of Health used to produce mainly paper based publication, however such “traditional” education materials have not reached target groups in many cases and get stacked at provincial health offices. Community health providers also complain that poster format is not appropriate for community because normally they do not have stationary to put it on the wall and people do not pay attention to it carefully. Considering the media survey, public media and audio & visual materials should be applied more for health promotion and education.

Health Promotion Fund: One of the reasons why PHC declined in the past few decades was insufficient budget supporting PHC oriented activities, which was driven by global trend. The policy analysis conducted by UNICEF shows that grants are mainly awarded to three major diseases in MDGs 6. However, since the Global Fund has postponed round 11 grant application due to the global financial crisis, TB, HIV/AIDS and Malaria programmes could suffer a sharp setback. In terms of the annual health budget, service deliveries are severely squeezed by salary and allowances. Hence, establishment of the Health Promotion Fund, making good use of a few percentages of tobacco and alcohol taxes, would be one of the solutions for a sustainable health promotion and prevention in Vanuatu, independent from global trend and donor money.

5. Reference

1) History of Primary Health Care in Vanuatu, WHO-MoH document 2010
2) Ministry of Health Policies 2002, Ministry of Health, Vanuatu
3) Master Health Service Plan 2004-2009, Ministry of Health, Vanuatu
4) Health Sector Strategy 2010-2016, Ministry of Health, Vanuatu
5) Framework for Action for Revitalisation of Healthy Islands in Pacific Island Countries and Territories, World Health Organization
6) World Health Report 2008, World Health Organization
7) National Policy and Strategy for Healthy Islands 2011-2015, Ministry of Health, Vanuatu
8) Analysis and costing of Health-Related MDGs in Vanuatu 2011, UNICEF
9) NB-IST impact survey 2011, JICA
10) APW technical report in PHC revitalisation 2011, WHO Vanuatu Country Office
11) Vanuatu Media Usage Study 2010, Australian Broadcasting Cooperation
12) Healthy Settings Initiative Project 2012-2013 Implementation Guideline, Ministry of Health
13) Healthy Islands IEC Package 2nd edition, Ministry of Health
14) Healthy Islands Education DVD, Ministry of Health
15) PHC Workshop for Community Leaders Training Booklet, Ministry of Health
16) ToR of National Healthy Islands Steering Committee, Ministry of Health
17) ToR of TAFEA Provincial Healthy Islands Steering Committee, Ministry of Health
18) MoH annual report 2011, Vanuatu

6. Annexes

National Strategy and Activities for Healthy Islands 2011-2015

STRATEGY 1: National Leadership & Governance in PHC

A1.1: Establish regular public health meetings to dialogue on PHC implementation, monitoring and Support, and discuss ways for reducing vertical programmes
A1.2: Train and capacity build all programme managers at national and provincial levels
A1.3: Develop advocacy and educational tools for HI/PHC in Bislama
A1.4: Establish national PHC steering committee
A1.5: Establish appropriate healthy settings for creating supportive environments

STRATEGY 2: Provincial Leadership/Governance in PHC

A2.1: Hold PHC biannual meetings for working towards programme harmonisation
A2.2: Organise provincial workshops in each province to translate policy into action plan
A2.3: Launch provincial Action Plans in six provinces
A2.4: Establish provincial HI steering committee and formulate it

STRATEGY 3: Access to PHC services

A3.1: Develop and distribute PHC Package to all information providers
A3.2: Train service provides in adequate numbers and competency to deliver PHC services
A3.3: Upgrade facilities and supplies to enable health facilities deliver prescribed PHC functions
A3.4: Develop effective mechanisms for referral within the existing health care levels
A3.5: Establish standard procedures for IEC development, pre-test and distribution
A3.6: Develop communication channels with media
A3.7: Develop communication channels with CBO

STRATEGY 4: PHC Financing

A4.1: Develop annual PHC costing plan to be incorporated into MOH annual business plan
A4.2: Establish Health Promotion Fund for financial sustainability
A4.3: Develop resource mobilization to support implementation of strategy on an on-going basis

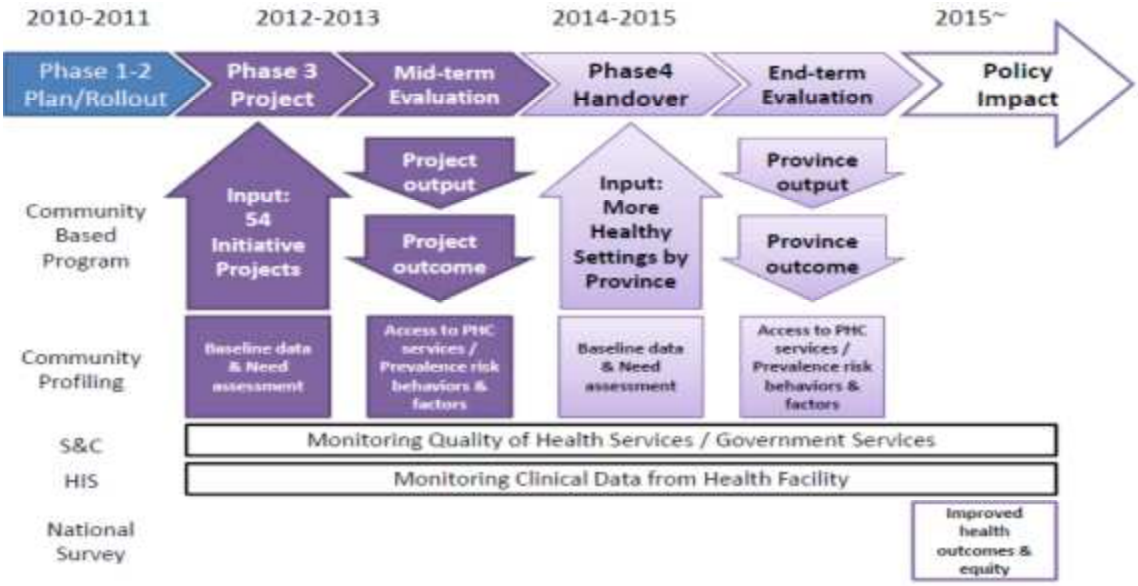
STRATEGY 5: Health workforce for PHC

A5.1: Recruit national staffs for HI/PHC and Health Promotion
A5.2: Recruit provincial staffs for HI/PHC
A5.3: Develop HI/PHC resource package for training and capacity building
A5.4: Arrange national and provincial staffs to undertake short term PHC training or online courses
A5.5: Conduct on-going capacity building in-country training for PHC staff

STRATEGY 6: Health Information

A6.1: Support Health Workers to understand data collection, analysis, reporting and use of data
A6.2: Conduct supportive and supervisory activities to monitor province and community
A6.3: Undertake timely collection of M& E indicators, analysis and use of information
A6.4: Conduct evaluation activities to assess results

Monitoring and Evaluation Plan



Policy outcome indicators

Outcome	Overall Outcome Indicator	2016 Target	HSS
Reduce child mortality (MDG4)	Under-five mortality rate	25/1,000	5.1.1
	Infant mortality rate	20/1,000	5.1.1
Improve maternal health (MDG5)	Maternal mortality rate	50/100,000	5.1.2
	Ration of maternal deaths to population by province	9/100,000	5.1.2
Access to safe water and improved sanitation (MDG7)	Proportion of people with access to safe water	90%	5.2.3
	Proportion of people with access to improved sanitation	80%	5.2.3
Promote better health for all people though healthy settings	Percentage of persons per population who use support groups and facilities to promote healthy lifestyles and healthy settings	50% / setting	

Policy output indicators

Strategy	Overall Output Indicator	2016 Target	HSS
S1: National Leadership / Governance	Healthy Islands National Committee	Biannual Meeting	5.3.2
	Hold public health regular meeting	Every month	5.3.2
	Number of healthy promoting school projects	50%	
	Number of healthy market projects	50%	
	Number of healthy village / community projects	30%	
	Number of healthy Aid Post projects	50%	
S2: Provincial Leadership / Governa	Provincial roles and mechanisms defined	6 Action Plans	5.3.1
	6 Healthy Islands Provincial Committees	Biannual Meeting	5.3.1
S3: Access to services	IEC Package distribution ratio/population	13.5%	
	Number of referrals from primary care to hospital	300	5.2.1
S4: Health Financing	Health Promotion Fund supports activities	13 million VT/year	
S5: Health workforce	Public health officers / 1000 population	1/20,000	5.2.2
	Health workers (including volunteers) trained to provide Primary Health Care	70%	
	Health care facilities that received supervision in the past six months	70%	
S6: Health Information	Health staffs trained in M&E	90%	
	VHW trained in M&E	70%	
	Province submitting timely, complete and accurate reports to the national level	90%	
	VHW using standard data collection formats according to national guidelines	70%	

Healthy Settings Initiative Project output and outcome indicators

Health Promoting Schools

Standard Criteria	Process/Output Indicators	Contribution to Outcome & Impact Indicators
1. Water, sanitation, hygiene	Each school has: • Source of safe clean water • Toilets for students and teachers – male and female • Good waste management – eg. garbage dumping area • Student health check by zone nurse 2 times a year • Regular clean-up every week	Teachers and students acquire clean and hygienic practices. These contribute to: • Reduce illness (morbidity) due to common illnesses – skin infections, pneumonia, diarrhea , etc
2. Health education in	• School curriculum incorporates health	• Increased knowledge of health which

curriculum	education from class 1 to all levels • Teachers actively teach health education evidenced by number of classes per week • PHC/IEC package in schools.	contributes to healthy behaviour and practices. • Contributes to reduced illness (as stated above).
3. Healthy foods for children	A service for making healthy foods available for students is established (this will differ in different settings) PTAs is involved in every school	Contributes to: • Reduced NCD risk factors leading to reduced disease burden due to NCD • Reduced malnutrition • Reduced obesity
4. Physical education	Physical education takes place regularly at least 3 times/wk to engage all classes.	Increased physical activity contributes to reduction in NCD, which then contributes to reduced early morbidity/mortality.
5. School security & safety	Each school has security plans in place – including gate and fencing, road safety measures, and disaster precautions.	Contributes to reduction in morbidity due to accidents and trauma
6. School health focal point	• Each school has a teacher or staff assigned as "health focal point" to assist students needing health care or referral. She/he links the school with the health system. • First Aid taught in schools. • The "health focal point" is able to provide basic interventions to students exhibiting signs of mental illness and/or substance abuse	Early management of ill health thus contributing to reduced disease burden.

Healthy Clinic

Standard Criteria	Process/Output Indicators	Contribution to Outcome & Impact Indicators
1. Water & sanitation and hygienic	Clinic fulfils 6 minimum requirements for W & S standards • Water source • Toilet • Effective hand-washing with soap and towel • Garbage disposal area • Regular clean-up each week • Clean facility – inside & outside	Contributes to reduction in disease transmission and therefore contributes to reduction in disease burden. Improved MDG 4,5,6,7
2. Competent Health Provider (VHW, nurse, doctor) - Technical competency - Managerial competency	Each clinic must: • Have a well trained and competent health provider with ability to handle patients • Positive attitudes and exercise professionalism • Be available in clinic during govt working hours and be able to attend to sick people during off hours • Be able to initiate effective referral of patients • Able to manage a health facility (AP, dispensary, H/C) with leadership and management skills appropriate at respective levels • A functional health committee	Contributes to effective management of patients which then contributes to reduction of morbidity and mortality Improved MDG 4,5,6,7
3. Essential primary health care package & referral system	Each clinic must be able to facilitate the delivery of essential package of PHC services comprising of: 1) Health promotion 2) Food supply and nutrition 3) Water and basic sanitation 4) MCH & Family Planning 5) Immunization 6) Environmental health 7) Treatment of endemic diseases - *malaria, TB, NCDs, mental health* 8) Essential drugs	Contributes to early and timely management of patients, increased awareness of disease prevention, healthy environment and safe health seeking behaviours. As a result the conditions contribute to healthy populations, reduced disease burden and ultimately to reduced morbidity and mortality. Improved MDG 4,5,6,7

	Each clinic must have a clear referral system in place.	

Healthy Community

Standard Criteria	Process/Output Indicators	Contribution to Outcome & Impact Indicators
1. Environment health, water and sanitation	Each community fulfils 5 minimum requirements for environmental health standards: • Water source • Clean toilet – ideally VIP • Garbage disposal area • Regular clean-up each week • Use of bed-net • Clean houses	Contributes to reducing chances for disease transmission; this will contribute to reduced disease burden, and eventually lowers morbidity and mortality.
2. Community-based healthy lifestyle programme	Each community develops a community-based healthy lifestyle programme to include: • physical activity schedule for all ages, men and women • regular community education for all ages, men and women • risk minimizing interventions for targeted groups to address specific issues, eg: reduce kava, prohibit marijuana, safe sex practices, family planning, mental health • Social inclusion in health promotion activities	Contributes to healthy behaviours and practices which in turn contributes t: • risk reduction in NCD • risk reduction related to drugs, alcohol, smoking and kava • risk reduction related to unsafe sex • improved family planning use Eventually contributing to reduced burden of disease, morbidity and mortality.
3. Access to PHC facility	• Each community has easy access to a health facility – aid post, dispensary or health centre within one hour walking distance. • Functional health committees • Participate in supporting patient referral, if needed	Access to health primary care services which contributes to early management and/or referral of patients; thus contributing to reduced mortality and morbidity.
4. Reliable source of food supply	Each community has a reliable source of locally available sources of three types of food types to enhance healthy nutrition of families. • Adequate food supply • Breastfeeding for all infants to at least 12months	Contributes to healthy nutrition as measured by: • Reduced child malnutrition which contributes to reduced childhood illnesses; • Adult obesity which contributes to reduced NCD.

Healthy Market criteria

Standard Criteria	Process/Output Indicators	Contribution to Outcome & Impact Indicators
1. Water and sanitation and cleanliness	Each market fulfils 5 minimum requirements for W & S standards • Water source • Toilet • Garbage disposal area • Regular clean-up each day • Clean facility – inside & outside	Contributes to clean and healthy environment, reduction in disease transmission, reduction in disease burden and eventually to healthy populations.
2. Standard food safety measures	Each market fulfils these minimum requirements for food safety standards: • Tables to display ready to eat foods & perishable foods (vegetables & fruits)	Contributes to healthy food and nutrition which reduces food-related NCD risks; which eventually contributes to disease burden due to NCD.

	• Food handlers must display hygienic practices • Utensils for food preparation are kept hygienically clean	
3. Restrict sale of unhealthy products	• Promotion of healthy local foods and restrict unsafe items • Market board to establish a regulation to restrict sale of unhealthy products (as listed). ✓ Tobacco raw leaves ✓ Cigarettes ✓ Betelnuts. ✓ Liquid kava	Contributes to healthy eating habits; prevents onset of addiction and mental health disorder, and therefore contributes to reduction of burden due to NCDs.

Cross-cutting approaches in all 4 healthy settings

In addition to settings-specific standard criteria, each setting will adopt these common cross-cutting approaches:

1. Conduct a community profiling
2. Engage community participation and active community committees
3. Set up a Health Promotion notice board, where relevant
4. Apply integrated approach
5. If investing in equipment or refurbishment, include community education as well.

List of Change Agents

Member of the national Primary Health Care team (1st Phase: Planning phase)

- Akihito Watabe: Public Health Physician/JICA Volunteer
- Asha Shine: National Village Healthcare Worker Programme
- Jean Jacques Rory: Manager, Health Promotion
- John Tasserei: PHC National Officer, Health Promotion/former NCD coordinator SHEFA Health
- Myriam Abel: Local Technical Advisor for PHC, WHO/former Director General of Health

Member of the national steering committee

- Ministry of Health
- Ministry of Education
- Ministry of Agriculture
- Ministry of Internal Affairs
- National Council of Chiefs
- Ministry of Ni-Vanuatu Business
- Ministry of Finance
- Ministry of Justice and Community Services

- Department of Aid Coordination –PM's office
- CSOs and NGOs
- IGOs, CROP
- UN agencies: WHO, UNICEF, ILO, UN Women

Member of the Planning M&E Working Group (2nd Phase: Roll out)

- Akihito Watabe: Public Health Physician/JICA Volunteer
- Jean Jacques Rory: Manager, Health Promotion
- John Tasserei: PHC National Officer, Health Promotion/former NCD coordinator SHEFA Health
- Myriam Abel: Local Technical Advisor for PHC, WHO/former Director General of Health
- Rose Bahor: Project Coordination Officer
- Viran Tavu: Senior Health Planner
- WHO Country Office representative
- JICA NB-IST technical project representative
- Save the Children Australia representative

Member of the national IEC development team

- Akihito Watabe: Public Health Physician/JICA Volunteer
- Hillary Garae: Communication Officer
- Ionnie Alwyn: Graphic Artist
- Jean Jacques Rory: Manager, Health Promotion
- Maki Ogushi: Audio & Visual technician/JICA Volunteer

Member of the Provincial Steering Committee (example: TAFEA province)

- Tafea Provincial Government
- Tanna Municipality
- Public Works Provincial Office
- Police Provincial Office
- Agriculture Provincial Office
- Water Supply
- Provincial Education Office
- Provincial Health Office
- Non Government Organizations
- Chiefs
- Church Leaders
- Youth Leaders
- Women's Representatives
- Private Sector
- Tourism Operators

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Ministry of Health

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