# Final report: Highlands Sexual, Reproductive and Maternal Health Project

CARE International in Papua New Guinea: January 2018

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## Acknowledgements

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Cover page photo: An outreach patrol visit for immunisations in Siaka supported by CARE staff.

Image: Patrick McCloskey

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# Contents

Project Overview ..... 1

Assessment of project outcomes ..... 3

Outcome 1: Increased community support for gender equality in sexual, reproductive and maternal health decision-making (Key Result Areas 4, 5, 7) ..... 3

Outcome 2: Women, girls and their communities have the knowledge and tools they need to create healthy living environments (Key Result Area 4, 5, 7) ..... 8

Outcome 3: Health systems are supported to ensure high-quality services – particularly sexual, reproductive and maternal health services – are available, accessible and acceptable to local communities (Key Result Area 1, 2, 3, 4, 5, 7) ..... 11

Beneficiary numbers ..... 16

Challenges ..... 17

Lessons learned and reflections ..... 18

Sustainability ..... 19

Annex 1 – Alignment with *Pacific Women Shaping Pacific Development* indicators ..... 21

Annex 2 – Alignment with Papua New Guinea Government Key Result Areas ..... 23

# Project Overview

In rural Papua New Guinea, where over 80 per cent of the population live, nearly 50 per cent of women birth outside of a health centre. One out of 25 women dies of pregnancy related causes and 52 babies out of every 1000 born die before their first birthday.[1] For every woman who dies in childbirth or pregnancy, another 30 will suffer lifelong pain or disability from pregnancy-related complications.[2]

These alarmingly high death rates are partly the result of structural problems within the health system. Health centres can be many hours walk away from remote communities and are often rundown and lacking in basic drugs, supplies and suitably trained staff. There is little outreach supervisory and clinical support provided to staff working in remote health centres from district and provincial health services, and health centre staff are often poorly connected to the communities they serve.

But these high rates are also the result of communities not understanding sexual, reproductive and maternal health issues, not using existing health services and not demanding better service. Ingrained cultural norms that support 'big man' male dominance and restrict women's autonomy lead to delays, or even prevent, women seeking health care. Women in rural Papua New Guinea have little control over their own sexual, reproductive and maternal health and face high levels of family violence, which can stop them seeking healthcare. Discussion of women's health needs remains taboo in communities and within families, meaning knowledge of sexual, reproductive and maternal health issues is very low. These cultural taboos and lack of knowledge mean that women and their families can be unaware of available health services, or unable or unwilling to access these services because they do not have the support of their husband. This dynamic is especially problematic during pregnancy when life-threatening complications can arise and early intervention is essential.

CARE International in Papua New Guinea began the Highlands Sexual, Reproductive and Maternal Health project in 2015, with AUD$1.4 million funding provided jointly by the Department of Foreign Affairs and Trade's *Australian NGO Cooperation Program*, and *Pacific Women Shaping Pacific Development.* The project built on the successes and learnings of the previous Maternal and Infant Health project implemented in the Highlands region from 2012 – 2015 and was strongly aligned to six Key Result Areas within the Papua New Guinea National Health Plan 2011-2020[3], the Community Health Post Policy[4] and the 2014 Papua New Guinea National Department of Health Sector Gender Policy.[5] CARE's rights-based approach particularly aligns with the National Department of Health sector gender policy to enhance women's decision-making in relation to health seeking practices; educating women and men about their right to health and supporting their family and spouses to seek care; and improving gender integration into health services so that women, men, boys and girls can access gender-sensitive care.

CARE delivered this project with key partners including the Morobe Provincial Department of Health, Church healthcare providers, and local non-government organisation Barola Haus Mama.

CARE's health project aimed to meaningfully and sustainably improve the health and wellbeing of women, their families and communities in targeted rural areas of Papua New Guinea. The project used an integrated, three-pronged approach; it supported attitudinal and behavioural change to drive community demand for health services, developed the health workforce through village health volunteer and health

[1] Papua New Guinea Demographics Health Survey, 2006.
[2] *Ibid*
[3] Papua New Guinea National Health Plan 2011-2020 <http://hiip.wpro.who.int/portal/Countryprofiles/Vanuatu/HealthProfiles/TabId/204/ArtMID/1064/ArticleID/155/National-Health-Plan-2011-2020.aspx>
[4] PNG Community Health Post Policy February 2013 <http://www.health.gov.pg/publications/Community%20Health%20Post%20Policy.pdf>
[5] National Department of Health Gender Policy 2014

worker training, and strengthened health systems through infrastructural support and outreach sexual, reproductive and maternal health clinic visits.

To achieve this the project worked towards the following three outcomes:

1. Increase community support for gender equality in sexual, reproductive and maternal health decision making and demand for health services through the Community Workshop Series model[6] (**Key Result Area 4,5,7)**
2. Give women, girls and communities the health information, knowledge and tools to improve health seeking behaviour, access health services and create healthier living environments through supporting village health volunteers (**Key Result Area 4,5,7)**
3. Support health systems and staff to ensure they have the skills and infrastructure needed to deliver high quality and equitable sexual, reproductive and maternal health services that are accessible and acceptable to the community. **(Key Result Area 1, 2 3, 4 5, 7)**

Outcomes 1 and 3 were funded by *Pacific Women Shaping Pacific Development*. Outcome 2 was funded by the Department of Foreign Affairs and Trade. A fourth outcome addressing governance and enabling environments was included at the outset of the project but was cut in 2016 following budget cuts. These cuts also substantially shortened the span of the project to conclude in June 2017 rather than June 2019. The El Niño emergency drought response in 2015/16, which resulted in the secondment of CARE's health project staff, further disrupted planned activities with implementation time cut from two years to ten months for all activities. A no-cost extension until December 2017 enabled the project team to complete most activities although follow-up timeframes were shortened and long-term mentoring and follow-up was no longer possible.

CARE's health project worked in three sites – Siaka, Yamaya and Umba/Hengiapa – in Menyamya and Markham Districts of Morobe Province with an estimated population of 20,000. All three sites are extremely remote and mountainous with limited health services. In these areas, health indicators are some of the worst in the world. In PNG, the maternal mortality rate is high, estimated at 594 maternal deaths per 100,000 live births,[7] with the rate higher in these remote regions. Across CARE's three sites, baseline data revealed that 24 per cent of households had suffered at least one maternal death and 21 per cent a neonatal death. Only 11 per cent of respondents at baseline had given birth in a health facility, the rest gave birth at home, in a birthing house, or in the bush. Access to and knowledge of family planning is low across these three sites – more than a third of respondents at baseline claimed to have never received education or information about family planning and only 29 per cent of couples were using a modern form of contraception. Gender and power issues in the household and community, such as negative masculinities that make acceptable men's domination of women, the conception of masculine sexuality as an uncontrollable force, and high acceptance of violence against women are major underlying factors leading to poor sexual, reproductive and maternal health outcomes.

Activities and outputs for this project were delivered through CARE's comprehensive and integrated outreach model, which addresses interrelated challenges to health in the highlands. CARE's outreach model includes a mixture of health facility supervision, improving partnerships and coordination, health staff training and mentoring, infrastructure support, health promotion, community engagement as well as facilitating delivery of key sexual, reproductive and maternal health services including immunisations and family planning.

Over the course of two years, CARE's health project has reached nearly 30,000 men, women and children by driving community demand for services, extending community-based healthcare through village health volunteers, strengthening health system infrastructure, and building the capacity of health staff. The project has produced promising results that contribute to Key Result Areas prioritised by the Papua New Guinea

[6] The Community Workshop Series is a participatory, human rights-based community mobilisation tool that helps communities challenge negative gender norms and behaviours related to poor health and take ownership of their own healthcare (Key Result Area 7).

[7] Kassebaum, Nicholas J et al. "Global, Regional, and National Levels and Causes of Maternal Mortality during 1990–2013: A Systematic Analysis for the Global Burden of Disease Study 2013." Lancet 384.9947 (2014): 980–1004. PMC. Web. 22 May 2017.

Government. A table highlighting how the project has contributed to the Key Result Areas in contained in Annex 1.

As a result of this project, CARE has learnt a great deal about implementing a rights-based health program in remote regions of Papua New Guinea. The project team has navigated tensions between government policy and reality when it comes to supervised births, realising that in remote areas even when women are encouraged to birth at a health facility, they still often turn to a village health volunteer given prevailing accessibility and cultural issues. So it makes sense to provide village health volunteers with some basic training.

The team has also improved their understanding of key aspects of CARE's behaviour change model and why this works. Engaging families and communities to challenge gender norms is essential to achieve health outcomes in these remote regions where these traditional gender norms are strongly ingrained. This gender-informed and rights-based approach enables communities to take charge of their own health and shift harmful norms that prevent women and men seeking care, aligning with wider goals outlined in multiple Papua New Guinea Government health policies.

In addition to mobilising community support for sexual, reproductive and maternal healthcare, the project team also realised the invaluable role health workers play sitting at the nexus of bottom up community mobilisation and top down work with government and health systems. In order for health outcomes to improve, these health workers must be trained to provide quality services, and supervised by relevant Provincial Health Department staff to ensure continual professional development and support.

# Assessment of project outcomes

## Outcome 1: Increased community support for gender equality in sexual, reproductive and maternal health decision-making (Key Result Areas 4, 5, 7)

**Key achievements:**

- **427 community members** completed at least one session of the Community Workshop Series with 53 per cent completing all three sessions.
- **The Community Workshop Series review showed positive evidence of behaviour change** – over half of the most significant changes reported indicated partners were sharing household workloads more equitably, almost half indicated that families were discussing family planning and a quarter indicated that instances of forced sex were declining.
- Rates of modern contraceptive use following the Community Workshop Series are estimated to have **increased by 3-9 per cent**
- In Siaka, **24 supervised deliveries have occurred at the health facility** as of November 2017 from a base of zero. The community attribute this to changing birthing norms following the Community Workshop Series.
- **4131 people** have benefitted from community health promotion events
- The Community Workshop Series has **supported the formation of community-led groups** focused on improving sexual, reproductive and maternal health.
- **8819** people reached through community and village health volunteer health awareness and promotion during El Nino

**Community leaders are changing behaviour and modelling positive gender norms that support women's autonomy and decision-making on their own sexual, reproductive and maternal health issues**

Participation in the Community Workshop Series

The Community Workshop Series is a participatory, human rights-based community mobilisation tool developed by this project to help communities challenge negative gender norms and behaviours related to poor health and take ownership of their own healthcare. The rights-based and gender-focused approach of the Community Workshop Series fulfils key strategies contained within the 2014 National Department of Health Sector Gender Policy namely increasing awareness of the links between human rights, health and gender, enhancing women's decision-making in relation to health practices, and encouraging women and men to support each other to seek care.

To participate, communities select men and women participants for the workshop based on their roles as local leaders. CARE encourages the partner or spouse of those selected to attend. Participants attend three workshops over an 8-12 month period.

The Community Workshop Series has three teaching pillars taught over the course of three days each:

- **Leadership** – topics include being a good leader, governance, transparency, accountability, conflict resolution.
- **Sexual, reproductive and maternal health** – topics include underlying determinants of health, sex and reproduction, gender, culture and belief, policy and laws.
- **Action** – includes topics on behaviour change process, influencing attitudes, identification and solving problems, prioritising actions.

Through these pillars, participants explore how local customs and gender norms can be harmful to women's health, and identify norms and practices they can change within their communities. Participants learn key leadership, conflict resolution, communication and organisational skills that help them to convert these ideas into collective action plans at the end of each of the three workshop pillars. CARE's health project team follow up with communities three weeks after each workshop to track the progress of their action plans since their last visit and offer guidance.

At the end of the workshop, Community Workshop Series participants draw up a collective role model agreement that outlines how they will take ownership of their own healthcare and increase sexual, reproductive and maternal health knowledge and outcomes within their community going forward. Actions can include encouraging use of family planning, walking their wife to the health centre or sharing household workload more. CARE awards participants who complete all three Community Workshop Series sessions and role model agreements with certificates of completion. Those who complete two sessions earn a certificate of participation.

Over the course of this project, nine cohorts across three sites completed the Community Workshop Series. Four hundred and twenty-seven participants (272 men, 155 women) enrolled in the Community Workshop Series and completed at least one session. The average age of these participants was 36 years old. Three hundred and thirty-three women and men earned a certificate by completing two or more sessions. One hundred and thirty-four men and 94 women completed all three workshop sessions (surpassing the project target of 60 for each gender) to earn a certificate of completion with a further 71 men and 34 women completing two of three sessions, earning a certificate of participation. Of those who earned a certificate, 38 per cent were women and 62 per cent were men.

The retention rate for participants completing the entire course was 53 per cent (61 per cent for women, 49 per cent for men). This was depressed by lower completion levels in Umba/Hengiapa due to tribal violence and community deaths. Completion of two or more of workshops was 78 per cent. For women this was higher at 83 per cent and for men lower at 75 per cent.

Action plans

Action plans are part of the collective action pillar of the Community Workshop Series that encourage community ownership of their own healthcare. In this session community leaders identify and prioritise issues they would like to work on within their community. The nine Community Workshop Series cohorts operating across the three sites developed 25 action plans (three not appropriate). The most common action plan issues included: raising awareness and uptake of family planning (nine actions); supporting pregnant women (six actions); sharing workloads (four actions); raising awareness and practicing consensual sex (four actions); and other miscellaneous topics.

Actions plans were graded using the following scale:

| **Ratings:** | **Definition** | **Per cent of completion** |
|---|---|---|
| Very Good (4) | Significant number of participants have completed more than 76 per cent of the action plans | 76-100 per cent completed |
| Good (3) | Significant number of participants have completed more than 51 per cent of the action plans | 51-75 per cent completed |
| Fair (2), | Attempts made with some success | 26-50 per cent completed |
| Poor (1) | Nil to some attempts made, with no success | 0-25 per cent completed |

A majority of action plans (72 per cent) have been implemented to some degree. Thirty-two per cent of plans have been implemented by a significant number of participants with over half of the plans completed. Siaka is the only site where some plans were deemed inappropriate. These action plans were:

1. Building of birthing houses which is against the Papua New Guinea National Department of Health policy.

2. Training for maternal health volunteers to assist women during labour. Since 2013, village health volunteers are not expected to supervise deliveries in the communities. They are meant to facilitate referrals to health facilities.

3. Have a female health worker to assist women in delivery. This would be a decision that is taken by the Evangelical Brotherhood Church who own and manage the health facility.

While these ambitions are positive and important, they are not achievable in the short term or without significant external support and resources. During a follow up visit, the community leaders came together and combined these three action plans into one action plan that resulted in the public denouncement of cultural taboos that prevented women from delivering babies in places where a man might go such as the health centre in case he became sick. They agreed publicly to do away with this custom and to allow their wives and daughters to deliver at the health facility. Although the aid post has been in operation since 1982 and a maternity wing built and opened in 2014, women did not deliver their babies there due to this taboo. The first baby was delivered at this aid post a few weeks after this denouncement in February 2017. As of November 2017, 24 babies were delivered at the aid post from a base of zero – a very significant achievement.

Results from the Community Workshop Series

In May/June 2017, CARE International in Papua New Guinea and CARE Australia commissioned an internal end of project desk review of the Highlands Sexual, Reproductive, Maternal Health project. The review focused on how effective the Community Workshop Series was in contributing to positive change in community and individual sexual, reproductive and maternal health related attitudes and behaviours as well as contributing to Papua New Guinea National Department of Health Key Result Areas. The review

analysed existing qualitative data (Most Significant Change stories[8], focus group discussions, informal guided discussions, action plans, and staff interviews) through participatory discussions and thematic analysis, and generated basic statistical analysis of quantitative pre/post Community Workshop Series test data from Siaka.

The review found evidence that gender roles, norms and behaviours are changing following Community Workshop Series:

- There is evidence that household workloads are being shared more equally by partners. **Over half the Most Significant Change stories thematically analysed mentioned sharing household workloads as a key change**, with gardening, household chores, and childcare most frequently mentioned. Women most often commented on men helping with childcare and household chores.
- Partners and families are overcoming long-held taboos around talking about sex and family planning. **Twelve per cent more people are now receiving sexual health information from family members than at baseline indicating a willingness to talk within families about these culturally taboo issues.** Women are initiating these conversations, with 24 per cent more women more confident to speak to their husband about family planning. This aligns with the National Department of Health sector gender policy aimed at enhancing women's decision-making and encouraging men and women to support their spouses seeking healthcare.
- **A quarter of all Most Significant Change stories mentioned engaging in consensual sex as a key change**, with both men and women reporting more respectful relations and nearly half the group Community Workshop Series action plans aiming to reduce forced sex.

*I am seeing myself to be gradually changing in terms of cleaning around my house, helping my wife with gardening activities, doing wife's activity when she is pregnant, cooking for the family'* – Man, 31, Umba/Hengiapa

*"This is very significant to me; the respect I am experiencing in the bedroom, my husband's respect for me when I refuse sex.* – Woman, 50, Yamaya

The Community Workshop Series has improved sexual, reproductive and maternal health outcomes including uptake of family planning, supervised deliveries and improved maternal health as highlighted in Key Result Areas 4 and 5:

- Almost **half of Most Significant Change stories mentioned uptake of family planning as a key change** with over 1600 people reached across project sites through family planning advocacy activities. Estimate figures indicate that reported uptake of contraception following the Community Workshop Series **increased across the three project sites by 3-9 per cent**.[9] **Ninety-five per**

[8] Most Significant Change stories were collected from 84 men and women participants across the three project sites. Within these stories participants narrated the most significant change(s) they had experienced as part of the project. These stories were then thematically analysed to draw out trends across sites, genders, age groups and other useful categories.

[9] The increase of 3-9% was found through the Community Workshop Series as of June 2017. This only considers direct participants of the Community Workshop Series compared to a broader population surveyed in the baseline. As a comprehensive endline survey was not completed by the project, a final per cent increase uptake of modern contraceptives cannot be established. However, reports from aid posts, Marie Stopes and Lutheran Health Services following patrols facilitated by CARE, indicate that the overall percentage increase is much higher than this, especially when considering the number of first time recipients of modern contraceptives.

**cent of post-test respondents could name a modern contraceptive compared with 59 per cent at baseline**.

- Most Significant Change stories and action plans indicate that men are challenging traditional norms around not assisting pregnant women and are walking their wives to the health centre for antenatal check-ups since the Community Workshop Series. **Ninety-five per cent of respondents affirmed that pregnant women need to go to the health centre, compared to 51 per cent at baseline.**
- **In Siaka, 24 supervised deliveries have occurred at the health facility as of November from a base of zero.** At baseline over 90 per cent of births in Siaka occurred outside a health facilities. The community attribute this to the norm changes around birthing as a result of the Community Workshop Series.

*"When I went into labour he took me to Okinawa Health Centre for me to deliver and he was there to support me through my labour to delivery. It was something he never had done before.'* Woman, 38, Yamaya.

*'I never allowed my wife to go on family planning before but after this training, I have agreed for her to access family planning health services… I don't want my wife to face difficulties during childbirth after giving birth close together.'* Man, 33, Yamaya

The Community Workshop Series had a number of positive yet unexpected outcomes:

- **Improvements in shared household financial management.** Across the three sites, some men and women have reported that following Community Workshop Series they have begun to share financial and budget decisions more within their household despite this not being specifically addressed in the training.
- **Improvements in community governance.** Leadership training has improved the transparency and inclusivity of existing community leaders and helped community members take on diverse leadership roles outside of sexual, reproductive and maternal health in institutions such as Law and Order Committees, Youth Groups and Elementary School Boards.
- **Communities are organising local governance structures for sexual, reproductive and maternal health.** Participants are forming their own community groups dedicated to sexual, reproductive and maternal health awareness and advocacy. In Siaka there is the 'CARE Training Group' and 'Komuniti Change Group,' in Umba/Hengiapa the 'Awareness Committee', and in Yamaya the 'Sexual, Reproductive and Maternal Health Support Group.' These groups are establishing roles and responsibilities so they can effectively work with non-government organisations and government in the future.
- **Community Workshop Series is promoting sustainable community governance structures.** One sexual, reproductive and maternal health community group in Umba/Hengiapa has reportedly addressed youth drug and alcohol issues upon request from the community.

The Community Workshop Series also had some unintended outcomes:

- There is evidence within the Most Significant Change stories analysed that in some instances the teaching of the Community Workshop Series, especially around respect and conflict resolution, is leading to unintended interpretations that reinforce harmful gender norms that women, not men, need to change their behaviour to diffuse couple disputes by being submissive, obedient and silent when they have grievances or want to refuse sex.

- Rates of family violence remain high in project areas and CARE needs to ensure that the Community Workshop Series is not increasing risks to women, especially those who attend the workshop without their husbands.

To address these unintended outcomes, CARE will prioritise incorporating family and sexual violence awareness and prevention into the Community Workshop Series in future projects through staff training, engaging with appropriate stakeholders that work in the area of family and sexual violence, and risk management processes in alignment with the National Department of Health Sector Gender Policy and the Papua New Guinea Gender-Based Violence strategy 2016-2025. It will also investigate the Community Workshop Series model and facilitation to see if any modifications are required to avoid unintended interpretations and to assess if this needs to be tracked as a risk in the future.

**Community groups are increasingly engaged in addressing sexual, reproductive, and maternal health issues**

Fifteen health awareness interventions linked to promoting healthy lifestyles were conducted during the project including 10 video nights. Video nights are part of sexual, reproductive and maternal health resilience activities and reinforce key messages around safe motherhood through locally appropriate films such as 'John and Ellie'. This film depicts a couple who have nine children and still refuse to use contraceptives resulting in the wife dying during labour. Overall, 2109 people (1138 women, 971 men) attended video screenings.

Various health awareness interventions were conducted with Colgate Palmolive including a handwashing day and oral hygiene day. In total 2700 oral hygiene kits were distributed benefitting 2038 students and teachers (1036 women and girls, 1002 men and boys).

Community health promotion and sexual, reproductive and maternal health resilience activities in the first year of the project during the El Niño response reached 8819 people, raising awareness on prevention of negative impacts from drought conditions especially for vulnerable groups like women and children. This included water purification and community health training, village health volunteer refresher training, and water, sanitation and hygiene health education.

As mentioned above, work with communities through the Community Workshop Series has encouraged the formation of local community groups to tackle sexual, reproductive and maternal health issues and other pertinent issues to the communities. These groups are putting into practice some of the organisational and leadership skills they learnt thus increasing the future engagement of community groups in sexual, reproductive and maternal health and health issues.

## Outcome 2: Women, girls and their communities have the knowledge and tools they need to create healthy living environments (Key Result Area 4, 5, 7)

**Sexual, reproductive, and maternal health and knowledge is shared in target areas**

Community-based health systems like the village health volunteer program are fundamental to improving maternal and broader community health. Village health volunteers are part of the national health system and are positioned to facilitate sustainable, long-term improvements to community health. As part of CARE's health project, village health volunteers are selected by their communities and receive National Department of Health training, which includes modules on healthy families, safe motherhood and first aid. After completion of all three modules some village health volunteers undertake a safe motherhood practical training at a district or provincial hospital and are then classified by CARE as maternal health volunteers. Village health volunteers that do not attend safe motherhood training are instead trained in the Healthy

Islands criteria[10] and are classified as village health promoters. These trainings are facilitated over a one-year period, with the modules facilitated over two week slots with an intermittent period of 4 – 6 weeks when participants are expected to carry out their action plans developed during the trainings. CARE staff follow up on these action plans as part of monitoring, support and supervision prior to commencing the next module.

Communities selected 63 individuals to undergo the core National Department of Health mandated village health volunteer training with 44 earning a certificate of completion, 10 a certificate of participation and nine participants dropping out. Of those 44 village health volunteers that completed the training, 30 (21 women, 9 men) attended safe motherhood practical training in March/April and will now continue as maternal health volunteers. Nine men were selected because their villages did not have women represented in the trainings due to dropouts. The practical training covered pre and post-natal checks and care, identification of high-risk pregnancies and safe motherhood. This will enable them to be a source of maternal health (pregnancy, childbirth and postpartum) information within their communities.

Maternal health volunteers developed 152 action plans and completed 98 of these (completion rate of 64 per cent). Most of the action plans developed focused on increasing knowledge on maternal, sexual and reproductive issues such as the importance of antenatal checks, nutrition during pregnancy and reducing the workloads of pregnant women within their communities. Maternal health volunteers are already conducting referrals as part of their actions plans and were able to provide awareness, advice and referrals for antenatal checks for 384 women and 398 men including two men living with a disability.

**Community-wide action for healthy living environments is supported in target areas.**

The remaining 14 village health volunteers undertook Healthy Islands refresher training in May 2017 to serve their communities as village health promoters. Village health promoters encourage better water, sanitation and hygiene practices by assisting communities to build ventilated improved pit latrines and handwashing facilities, and spreading good hygiene messages and practices.

Village health promoters developed 135 action plans in consultation with their communities and 57 plans were completed (completion rate 42 per cent). These action plans involved holding awareness activities on safe, clean environments such as ventilated improved pit latrines and safe water. 2645 individuals (1415 men, 1230 women, including nine people living with a disability) have been reached through action plans developed by the village health promoters with messages on better hygiene and sanitation practices as well as safe drinking water.

A total of six community action plans were developed in one site (Umba) and three of these were completed. The other three could not be completed due to tribal violence. The community action plans that were implemented involved building dish racks and ventilated improved pit latrines for the school and the aid post. All dish racks and one of the ventilated improved pit latrine for the school was completed with one yet to be completed due to tribal fighting and deaths in the area.

A Healthy Islands Criteria Assessment was conducted in late 2017 in Umba and Yamaya using a 16 cell assessment tool[11] used previously for the pre-assessment. Communities rated their own community against 16 criteria[12] using a traffic light style system – green for yes (1 point), yellow for some (0.5 points) and red for no (0 points).

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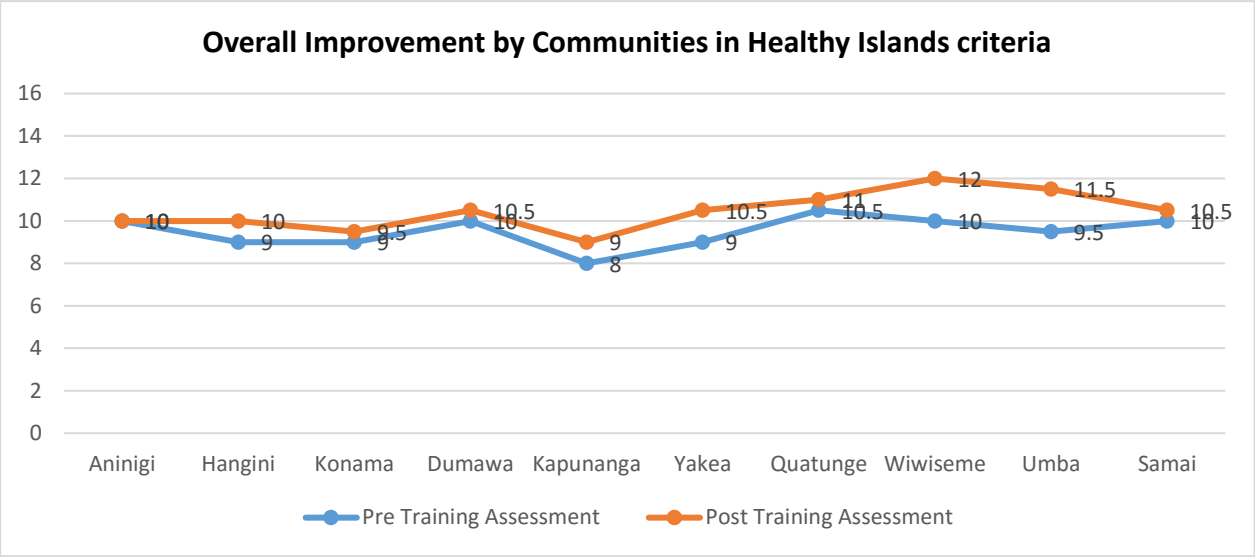
[10] Healthy Islands is a nationally endorsed approach that encourages communities to meet their self-care responsibilities by having a healthy living environment and leading health-promoting lives. Communities working towards becoming Healthy Islands are measured against Healthy Home and Healthy Family Criteria which include maternal child health clinic visits, family planning, building household VIP latrines, disposing of rubbish in covered pits, ensuring drinking water is clean, using mosquito nets.

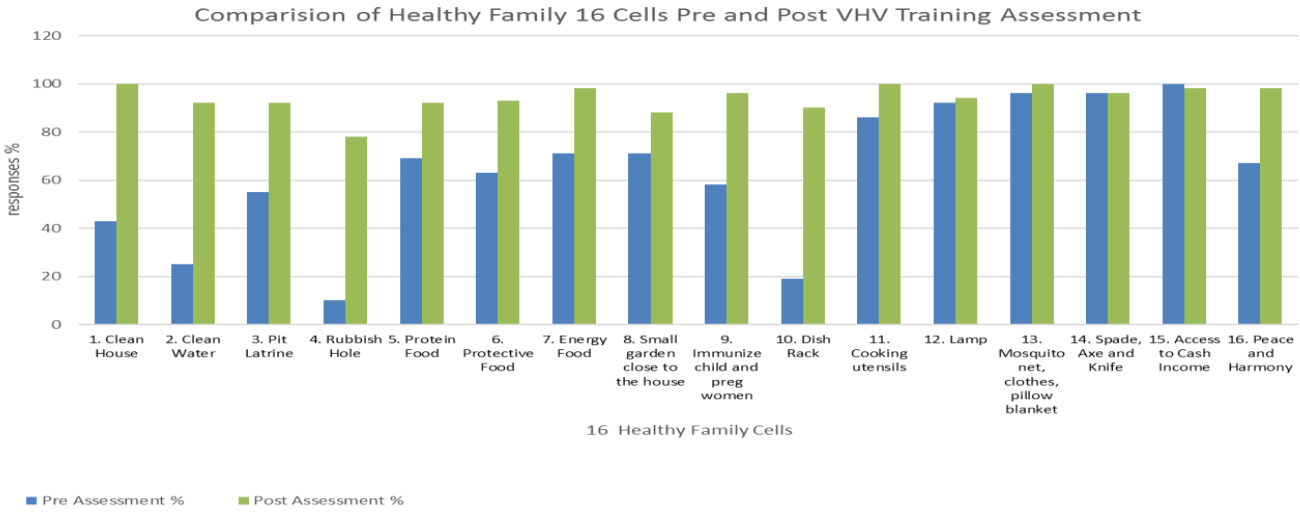
[11] The 16 cell assessment tool was developed by National Department of Health and considers 16 criteria (cells).

[12] Criteria included: Village committee, clean house with ventilation, clean water, clean environment, access to health services, access to place of worship, access to education, social groups, small harden close to the house,

The follow-up post assessment indicated that overall all communities in Umba and Yamaya scored between 9 and 12 out of the 16 cells. Most communities experienced some improvement since the pre-assessment in creating healthy living environments with an average increase of 0.95 points on the previous score or on average a 10 per cent increase. The strongest improvements were reported in relation to clean houses with ventilation, education about health, peace and harmony, and access to clean water. These correspond to key areas village health promoters focused on through their action plans.




A similar but slightly different 16 cell family assessment was also conducted alongside the community assessment.[13] It shows strong progress from pre to post assessment across the board of criteria, with strong gains recorded against use of clean water, pit latrines, rubbish holes, clean house and dish racks within families. These aspects were all emphasised by CARE's village health promoters through their action plans following healthy islands training.




good roads and transport, access to cash income, peace and harmony, community bank, maternal and child Health clinic visit, change to bad customs, education about health.

[13] The family assessment criteria included a yes, some or no response to the following : Clean house, clean water, pit latrine, rubbish hole, protein food, protective food, energy food, small garden close to house, immunise child and pregnant woman, dish rack, cooking utensils, lamp, mosquito net/clothes/pillow/blanket, spade/axe/knife, access to cash income, peace and harmony.

Together these two graphs show how village health promoters have supported improvements in healthy living environments which is essential for overall health and wellbeing of women, men and children.

## Outcome 3: Health systems are supported to ensure high-quality services – particularly sexual, reproductive and maternal health services – are available, accessible and acceptable to local communities (Key Result Area 1, 2, 3, 4, 5, 7)

**Key achievements:**

- **Four local health workers** continually mentored over two years to provide health care to over 20,000 people.
- **50 health workers** trained across severe acute malnutrition, effective vaccine management and emergency obstetrics.
- **Water, sanitation and hygiene facilities upgraded** at four health facilities
- **Two government supervision visits** supported to remote aid posts
- **Outreach patrols** provided 55 women and 38 men with contraception and 200 others with family planning advice
- **6744** children and adults vaccinated
- **2733** children screen for malnutrition

**Partnerships that are essential to the achievement of the objectives are active**

The project strengthened partnerships and coordination with district and provincial government administrators in Morobe Province as well as both Lutheran and Evangelical Brotherhood Church health service, who manage health facilities that the project worked with. Memoranda of Understanding between CARE International in Papua New Guinea and the Morobe Provincial Department of Health were signed in early 2017. This followed extensive consultation and delays due to the El Niño drought response. These memoranda acted as an overall agreement that covered the District Health Services as well as included some cost sharing in terms of Water, sanitation and hygiene infrastructure rehabilitation in the aid post and Health centres within the districts and training of health staff on services relating to sexual, reproductive and maternal health and child health such as vaccinations.

**Staff at target health facilities have increased skills to provide improved sexual, reproductive and maternal health services.**

CARE's health project has increased the skill level of health workers to ensure improved quality service delivery.

Staff capacity assessments conducted at the commencement of the program found that all three target health workers at aid posts in Umba, Yamaya and Siaka had very little capacity to deliver sexual, reproductive and maternal health services and drugs, and medical equipment was seldom available. During project implementation, a fourth health worker at a health centre in Hengiapa was also included for mentoring activities at the behest of the District Health Manger and also because this aid post shared a catchment area with Umba.

After establishing their capacity development plans, all four health workers received regular mentoring and training from CARE and government staff on various topics such as:

- Aid post management including reporting and reordering of drugs;

- Village health volunteer management (roles and responsibilities) and competency requirements;
- Diagnosing and treating sexually transmitted infections; and
- Performing sexual, reproductive and maternal health functions such as immunisations, and pre and post-natal care.

These skills will help these health workers provide better care to over 20,000 people.

A number of health workers from target and neighbouring districts were also supported to complete the following trainings including obstetric training.

| Training | Participants | | | District |
|---|---|---|---|---|
| | Male | Female | Total | |
| Effective vaccine management/ expended program on immunisation training facilitated by Dr David from the World Health Organisations & UNICEF and National Department of Health representative Philip Posou. | 8 | 10 | 18 | Markham and Nawaeb |
| Severe acute malnutrition diagnosis and treatment training that was facilitated by Health Extension Officer Helen Palik – National Department of Health trainer and Dr Theresa Rongab, paediatrician at ANGAU memorial Hospital | 4 | 12 | 16 | Menyamya and Bulolo |
| Severe acute malnutrition and moderate acute malnutrition feeding protocols training conducted by Dr. Feilin – paediatrician. | 7 | 8 | 15 | Markham |
| Emergency obstetrics training was facilitated by the National Reproductive Health Unit in Mt Hagen and then in Port Moresby. | 0 | 1 | 1 | Markham |
| Total | **19** | **31** | **50** | Four districts |

**Increasing number of target health facilities improving against the National Department of Health minimum standards**

Through infrastructure upgrades CARE's health project has given target health centres access to running water which in turn has increased the number of facilities providing more hygienic supervised births.

Water, hygiene and sanitation infrastructure upgrades and maintenance were carried out in four target health facilities: Hengiapa Aid Post, Aseki Health Centre in Menyamya District, Siaka Aid Post, and Yasuru

Aid Post in Markham District. These upgrades will enable safer deliveries at these facilities benefiting an estimated population of more than 20,000.

- Hengiapa Aid Post received two 3000 litre water tanks, sink and plumbing maintenance in April 2017
- Aseki Health Centre had water infrastructure in the maternity ward upgraded in late 2016, providing running water to the centre for the first time in 13 years.
- In Siaka, water infrastructure and plumbing maintenance was completed in May 2017
- Water, hygiene and sanitation infrastructure materials were handed to Marham District Health Department staff in late 2017 for improvements to the Yasuru health facility.

The project also provided two vaccine carriers each to health centres in Menyamya, Aseki and Mutzin, and one solar power inverter to Lutheran Health Services to improve cold chain supply management and storage.

**The governance and management of target health facilities supports the provision of sexual, reproductive and maternal health services**

In some instances remote health facilities are difficult (too far, treacherous terrain or too expensive) to reach and so government health services are not made available. CARE's comprehensive and integrated outreach model addresses these interrelated challenges to Papua New Guinea's health system. CARE's outreach model includes a mixture of health facility supervision, improving partnerships and coordination, health staff training and mentoring, infrastructure support, health promotion, community engagement as well as delivering key sexual, reproductive and maternal health services including immunisations and family planning.

Facilitating regular supervision by provincial health office and/or district management staff is a key part of this model, given that supervision is generally not prioritised by provinces with all 21 falling below the National Department of Health supervisory target of 80 per cent health facilities visited. This can adversely affect staff motivation and quality of service delivery. Assisting government health staff to visit these health facilities provides the opportunity to identify and support health centre staff in meeting the needs of their respective communities.

CARE facilitated supervision visits to all aid posts in the catchment areas in accordance with National Department of Health strategies for clinical supervision. Matilda Maborai, the Sister in charge of Aseki Health Centre, conducted a supportive supervision visit to Yamaya Aid post in March of 2017. Pascal Neldin, the Aid Post Supervisor in Markham district, was logistically supported to visit the Yasuru Health Centre in February 2017. These visits are an integral part of government health facility supervision and support but unfortunately rarely occur due to funding and logistical challenges. These supervision visits ensure that aid posts are managed well, and include meetings with the community and the health committee members. The supervisors also conduct assessments and mentoring of health workers regarding their clinical skills.

CARE also improved service delivery by strengthening partnerships and coordination between stakeholders including other non-government organisations. The below table illustrates recent outreach visits CARE has coordinated with partners to address family planning and immunisation needs.

| Location | Timing | Partner | Outreach Activities | Beneficiaries |
|---|---|---|---|---|
| **Umba/Hengiapa** | October 2016 | Marie Stopes | Family planning counselling, long-term contraceptives provision, | 25 women received contraception<br><br>38 men provided vasectomy<br><br>200 men and women received family planning counselling |
| **Siaka** | February 2017 | Marie Stopes | Family planning counselling, long-term contraceptives provision, Community Workshop Series follow-up, health worker and village health volunteer mentoring and follow-up | 30 women received contraception |
| **Siaka/Tombuna** | April 2016 , February & April 2017 | Mutzin Health Centre | Immunisation patrol | 192 (99 boys, 93 girls) children vaccinated with standard vaccines against tuberculosis, diphtheria, tetanus, whooping cough, hepatitis B, influenza, polio<br><br>20 women of childbearing age vaccinated against tetanus |
| **Menyamya** | March 2017 | Lutheran Health Services | Special Integrated Routine Expanded Program on immunisation | 1048 children (497 boys, 551 girls) vaccinated against tuberculosis, diphtheria, tetanus, whooping cough, hepatitis B, influenza, polio |

| | | | | |
|---|---|---|---|---|
| | | | | 35 women of child bearing age vaccinated |

In addition to these patrols, the team conducted multiple outreach visits during the El Niño response in the first year or this project. As part of these patrols the team vaccinated 5747 children and adults, and screened 2733 children for malnutrition and managed 109 malnutrition cases.

# Beneficiary numbers

| Project beneficiaries | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | Total | Women | Men | Girls | Boys | Women with disability | Men with disability | Girls with disability | Boys with disability |
| **Outcome 1** | | | | | | | | | |
| Community Work shop Series participants | 427 | 155 | 272 | 0 | 0 | 0 | 0 | 0 | 0 |
| Participants of community health promotion events[14] | 4131 | 818 | 699 | 1354 | 1255 | - | 16 | 1 | 4 |
| Community health and sexual, reproductive and maternal health resilience activity beneficiaries during El Nino response[15] | 8819 | 3620 | 3425 | 886 | 888 | - | - | - | - |
| **Outcome 2** | | | | | | | | | |
| Certified village health bolunteers[16] | 44 | 21 | 23 | 0 | 0 | 0 | 0 | 0 | 0 |
| Recipients of maternal health referral/advice | 780 | 382 | 396 | 0 | 0 | 0 | 2 | 0 | 0 |
| Individuals benefitting from village health promoter action plans | 2645 | 1230 | 1415 | - | - | - | - | - | - |
| **Outcome 3** | | | | | | | | | |
| Health workers mentored | 4 | 0 | 4 | 0 | 0 | 0 | 0 | 0 | 0 |
| Health workers clinically trained[17] | 50 | 31 | 19 | 0 | 0 | 0 | 0 | 0 | 0 |

[14] Film nights, school and community health promotion.
[15] Water purification and community health training, village health volunteer refresher and water, sanitation and hygiene health education.
[16] Of these 21 women and 9 men are maternal health volunteers and the remaining 14 men are village health promoters
[17] Trainings included Effective Vaccine Management, severe acute malnutrition/moderate acute malnutrition treatment and prevention and emergency obstetrics

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Health Services provided via health systems supported by project[18] | 3,417 | 584 | 170 | 1,371 | 1,285 | 2 | 5 | 0 | 0 |
| Vaccinations administered during outreach patrols | 6744 | 2297 | 0 | 1951 | 2491 | 0 | 0 | 1 | 4 |
| Children assessed for malnutrition | 2733 | - | - | - | - | - | - | - | - |
| Cases of malnutrition managed | 109 | 0 | 0 | - | - | 0 | 0 | 0 | 0 |
| Family planning beneficiaries outreach patrols | 93 | 55 | 38 | 0 | 0 | 0 | 0 | 0 | 0 |
| **Total** | **29,996** | **9193** | **6445** | **5562** | **5919** | **2** | **23** | **2** | **8** |

# Challenges

- **Budgets and timeframes-** Initially CARE's health project was to run for four years at a total budget of approximately AUD$2.4 million. However before the commencement of the baseline survey the budget was cut by nearly a million dollars annually and was only to be funded for two years instead of four. To readjust activities and outcomes based on this new budget the team had to remove objective 3 - sexual, reproductive and maternal health governance and enabling environments: increased community-level and structural support for women's sexual, reproductive and maternal health - and were unable to implement the Sasa! gender-based violence prevention tool.[19] The project's implementation timeframe was further shortened by the secondment of staff to respond to the El Niño emergency response from October 2015 to July 2016 and the suspension of activities from May – July 2017 due to the national election and threat of violence. Activities and follow-ups were not able to be completed before the suspension of activities in May 2017 and so a no-cost extension was granted until December 2017. This shortened time frame represented a major challenge given the project's focus was around achieving behavioural and attitudinal changes which happen over a longer period of time. Despite this the project team has managed to complete most activities, albeit with shorter and less sustained follow-up, and to gather some data demonstrating impact, although the findings would be strengthened had there been time for a more rigorous evaluation.

- **Family and sexual violence** is a serious issue in Papua New Guinea. While this project had planned to train village health volunteers to respond to family and sexual violence through the Sasa! gender-based violence prevention tool, funding cuts and project delays inhibited this training. Family and sexual violence training for staff facilitating the Community Workshop Series was also not completed

[18] This includes Teltox injections, HIV counselling and wellness check among others.

[19] Sasa! is a methodology for addressing the link between violence against women and HIV/AIDS. Sasa! is meant to inspire, enable and structure effective community mobilization to prevent violence against women and HIV/AIDS

for similar reasons. The end of project review highlighted challenges associated with family and sexual violence in communities and the propensity of interventions to increase risks, especially when staff and volunteers are challenging gender norms yet unable to adequately prevent and respond to family and sexual violence, and without adequate referral pathways to support them. The end of project review made recommendations to improve the integration of family and sexual violence awareness and prevention into future project activities through specialised training for staff, health workers and village health volunteers, investigation of formal and informal referral pathways, improved family and sexual violence monitoring systems and alignment with the Papua New Guinea Gender-Based Violence strategy 2016-2025.

- **Alignment with government structures and priorities** – CARE's health project sites were selected in order to improve community support and engagement around the catchment areas of new Community Health Posts that were to be built by the Rural Primary Health Delivery Support Project and funded by Asian Development Bank in Umba and Yamaya. Unfortunately, during the implementation period the community health posts were not yet built. Despite community health posts not being built/completed in the time frame the project supported frontline health workers at aid posts to receive additional training to support antenatal and safe motherhood services which are the responsibility of community health posts.

  Another issue was the, at times, conflicting priorities of the Government of Papua New Guinea and rural communities. The Government of Papua New Guinea has a policy that all women should birth in a health centre. However where CARE works the majority of women do not birth in health centres due to lack of access, trust, money and cultural factors. In these instances, village health volunteers invariably assist women through birth, so CARE trains village health volunteers in basic safe birthing practices. Navigating these tensions between government policy and the reality in remote areas is challenging. CARE continues to emphasise that village health volunteers need to encourage all mothers to attend clinics for antenatal checks and birthing, and advocates to government at the provincial and district level through health systems strengthening activities about the health needs of remote communities.

# Lessons learned and reflections

- **Importance of challenging harmful norms** - While training village health volunteers and health centre staff is important for improving outreach and uptake of health care, this alone will not guarantee that families will use health facilities. It is necessary to also address the underlying gender and cultural norms that are barriers to care. For example in Siaka, where there was a functioning aid post and maternity wing and trained village health volunteers since 2015, it was only in 2017 that the first birth was recorded in the health facility. Community members attributed this change to the Community Workshop Series, which guided community leaders through discussions to identify harmful norms to sexual, reproductive and maternal health, and devise community action plans to overcome this. In Siaka, there was a belief that men would get sick if they were near women giving birth, so women would not birth at the health centre. As a result of the Community Workshop Series, the community came together to discuss this cultural norm and its validity and decided that they would no longer abide by this practice. As of November 2017, 24 women have given birth in the Siaka Health Centre, demonstrating the power of cultural change.

  The effectiveness of empowering communities to take ownership of their own health and challenge harmful cultural norms is expressed in multiple Papua New Guinea Government health policies and strategies. Under Key Result Area 7, communities are encouraged to take ownership of their own health and that of their communities, while the Community Health Post Policy sees local health facilities as paramount for building community skills and knowledge so they actively engage with health services. The rights-based and gender-focused approach of the Community Workshop Series

fulfils key strategies contained within the National Department of Health 2014 gender policy namely increasing awareness of the links between human rights, health and gender, enhancing women's decision-making in relation to health practices, and encouraging women and men to support each other to seek care.

As these policies suggest, achieving long-term change in sexual, reproductive and maternal health outcomes requires a gender-informed and rights-based approach that enables communities to take charge of their own health and shift harmful norms that prevent women and men seeking care.

- **Engaging families –** While engaging community leaders to lead and role model change within their communities is important, it is also essential to engage couples, given that family is important within Papua New Guinean culture. Going forward, the Community Workshop Series could investigate ways to ensure more couples, especially young couples, partake in the workshops to make it family as well as community oriented. This would also serve as a good risk mitigation strategy given the issues the project had with female workshop participants experiencing pushback when trying to enact cultural change when their male partners had not been present at the workshop.

- **Leveraging the village health volunteer network** - Interventions aimed at exploring and challenging harmful cultural and gender norms are key to improving sexual, reproductive and maternal health outcomes for women, and the established village health volunteer system may be a platform for extending such approaches more widely and sustainably. CARE has already involved village health volunteers in the running of the Community Workshop Series this year, with village health volunteers encouraging community participation, assisting with the coordination of the workshops and attending themselves. From this experience, CARE believes that in the future village health volunteers could become a vehicle for running these trainings with the appropriate support from district/church partner health staff trained in the CARE Community Workshop Series methodology.

- **Capacity building the health workforce –** While it is important to drive community demand for health services from the bottom up and work with government from the top down, it is critical to support health workers who are at the nexus of these two processes and on whose work success ultimately depends. Health workers need to be supported to provide high quality services to the community through clinical training and mentoring, but also through contact with Provincial Health Administration staff through supervisory and outreach visits.

- **Increasing skills of health centre staff to collect better data.** Health centres in the target areas struggled to provide health centre data on key national health priorities including antenatal visit, family planning uptake and Sexually Transmitted Infection tests. This made it difficult to quantitatively verify some of the claims that village health volunteers, Community Workshop Series participants and health workers would make regarding improvements in health seeking behaviour. In the future, and with sufficient resources, it would be beneficial to align monitoring processes to government health priorities and indicators by completing baselines with all health centres on key maternal health result areas.

# Sustainability

Despite the shortened implementation timeframe, CARE has embedded sustainability mechanisms into all of CARE's health project interventions by building capacity and fostering relationships across multiple levels from the community to the district authorities. These sustainability measures include:

- Encouraging local leaders who participated in the Community Workshop Series to continue to drive cultural change within their communities through their developed action plans and role model agreements.

- Working through and cost sharing with government and church health systems and building their skills and knowledge via in-service training, outreach clinics and supervisory visits
- In-service training for rural health workers on vaccine management, malnutrition and obstetric care as well as on-site mentoring in aid post management, village health volunteer management, immunisations, and pre/postnatal care.
- Training village health volunteers to support pregnant women and their families and link them to the health centre
- Training government and church health staff to train, manage and supervise village health volunteers
- Ongoing management, supervision of village health volunteers by rural health centre staff – including Menyamya/Markham District Health and Evangelical Brotherhood Church

# Annex 1 – Alignment with *Pacific Women Shaping Pacific Development* indicators

| Intended Outcome: Enhancing Agency | Outcome 1 – Driving community demand for gender equality and sexual, reproductive and maternal health healthcare | Outcome 2 – Supporting village health volunteers and communities to create healthy environments | Outcome 3 – Strengthening health systems to provide quality sexual, reproductive and maternal health services |
|---|---|---|---|
| **Enhancing Agency in Policy or Legislative Reform**<br>Have you delivered activities which target policy or legislative reform in this reporting period?<br>Has there been any evidence of increased effectiveness of activities which target policy or legislative reform in this reporting period?<br>How would you rate the effectiveness of activities which target policy or legislative reform during this reporting period? | N/A | N/A | N/A |
| **Enhancing Agency by Building Coalitions**<br>Did you **support a coalition** in this reporting period?<br>How many **women** were involved in coalition activities in this reporting period?<br>What were the outcomes of your coalition activity in this reporting period?<br>Has there been any evidence of increased effectiveness of the coalition in their advocacy roles to increase govt resourcing, support and coordination of services and referral processes in this reporting period? (Choose from the list.)<br>How would you rate the effectiveness of the coalition during this reporting period? | - | - | - CARE partnered with the Morobe and Eastern Highlands Provincial health Departments and Marie Stopes to conduct outreach visits involving 18 women and 16 men.<br>- Four health outreach patrols conducted resulting in over 1200 children under four vaccinated, 55 women and 38 men provided contraception and 200 receiving family planning counselling.<br>- Four aid posts received minor infrastructural improvements |
| | - 272 male community leaders participated in at least one session of the | - 23 men trained as village health volunteers, 9 | - |

| | | | |
|---|---|---|---|
| **Enhancing Agency by Engaging Men**<br><br>Are you actively engaging **men** in your activities?<br><br>How many **men** were involved in activities to engage men in this reporting period?<br><br>Has there been any evidence of increased effectiveness of activities engaging men in this reporting period?<br><br>How would you rate the effectiveness of activities engaging men in this reporting period? | Community Workshop Series<br><br>-Men are challenging traditional norms around not assisting pregnant women and are walking their wives to health centres for antenatal check-ups since the Community Workshop Series. 95 per cent of respondents affirmed that pregnant women need to go to the health centre (51 per cent baseline).<br><br>- Over half Most Significant Change stories mentioned men sharing household workloads as a key change, with gardening, household chores, and childcare most frequently mentioned.<br><br>- Men are more willing to adopt or allow their wife to adopt contraception with an estimated 3-9 per cent increase in contraceptive use.<br><br>- A quarter of Most Significant Change stories mentioned engaging in consensual sex as a key change, with men and women reporting more respectful relations and nearly half of Community Workshop Series action plans aiming to reduce forced sex. | maternal health volunteers and 14 village health promoters | |
| **Evidence of effectiveness – enhancing agency**<br><br>Has there been any evidence that your activity has increased women's agency in this reporting period?<br><br>Are you undertaking any research on enhancing agency? (Choose from the list.) | - 155 women participated in the Community Workshop Series as community leaders<br>- 24 per cent more women feel more confident to speak to their husband about family planning than at baseline<br>- Contraceptive use increased across project sites between 3-9 per cent | - 21 women trained as maternal health volunteers and provided referrals to 780 people. | - 31 female health workers provided with clinical training |

# Annex 2 – Alignment with Papua New Guinea Government Key Result Areas

| Key result areas | Outcome 1 – Driving community demand for gender equality and sexual, reproductive and maternal health healthcare | Outcome 2 – Supporting village health volunteers and communities to create healthy environments | Outcome 3 – Strengthening health systems to provide quality sexual, reproductive and maternal health services |
|---|---|---|---|
| **KRA 1 – Improve service delivery**<br>- Increase access to quality health services<br>- Rehabilitate health infrastructure and equipment<br>- Improve skills of health workers | - | - | Five immunisation and family planning patrols undertaken<br>Four health workers continually mentored and 50 provided professional health training<br>Two government supervisory visits supported |
| **KRA 2 – Strengthen partnerships and coordination with stakeholders** | - | - | MoU signed with Eastern Highlands and Morobe Provincial Department of Health |
| **KRA 3 - Strengthen health systems and governance**<br>- Improved health facility leadership, management, governance<br>- Medical supply procurement and distribution | - | - | Health facility management capabilities enhanced through continual mentoring of four health workers<br>Two vaccine carriers and one solar inverter provided to improve cold chain supply management. |
| **KRA 4 – Improve child survival**<br>- Increased coverage of child immunisations | Siaka Aid post recorded 24 supervised deliveries as of November from a base of zero with communities attributing this success to norm | Maternal health volunteers provided 780 people with advice or referrals related to sexual, reproductive and maternal health | 6744 children and adults vaccinated<br>2733 children screened for malnutrition and 109 |

| | | | |
|---|---|---|---|
| - Decrease neonatal deaths<br>- Reduce malnutrition. | change through the Community Workshop Series. | | cases managed during El Nino patrols. |
| **KRA 5 – Improve maternal health**<br>-Increased family planning coverage<br>- Increased capacity for safe and supervised deliveries<br>- Improve emergency obstetric care<br>- Improve sexual and reproductive health for adolescents | Reported uptake of contraception following the Community Workshop Series increased across project sites by three - nine per cent<br><br>36 per cent more respondents can now name a modern contraceptive compared to baseline.<br><br>95 per cent of post-test responses indicate that women should go to a health centre | 44 village health volunteers (30 maternal health volunteers and 14 village health promoters) were certified to promote sexual, reproductive and maternal health and healthy lifestyles within their communities<br><br>Maternal health volunteers and village health promoters have created 287 action plans to improve sexual, reproductive and maternal health knowledge and promote healthy lifestyles through safe water and pit latrines. | 55 women and 38 men provided contraception through patrols and 200 families counselled<br><br>Two health workers trained in emergency obstetric care.<br><br>Health centre upgrades enabled four health facilities to perform safe deliveries |
| **KRA 7 – Promote healthy lifestyles**<br>-Reduce outbreaks of water and food borne diseases<br>- Increase individuals and communities involvement in their own health | 427 men and women were empowered through participating in the Community Workshop Series to take ownership of their own sexual, reproductive and maternal health<br><br>Partners are sharing household workloads more equitably, discussing family planning more openly, and more often engaging in consensual sex.<br><br>4131 people benefitted from community health promotion events including film nights and school presentations | 2645 people reached through village health promoter actions plans to improve community health and sanitation by building latrines and pot racks.<br><br>Average 10 per cent improvement on Healthy Island scores for target communities | Water, sanitation and hygiene upgrades and maintenance provided to four health centres to improve capacity for supervised deliveries. |

## CARE Australia

1800 020 046
info@care.org.au
care.org.au
ABN: 46 003 380 890

## Canberra Office

Ground floor
243 Northbourne Avenue
Lyneham ACT 2602
Phone: (02) 6279 0200
Fax: (02) 6257 1938

## Melbourne Office

Level 8, 406 Collins Street
Melbourne VIC 3000
Phone: (03) 9421 5572
Fax: (03) 9421 5593

## About CARE

CARE works with poor communities in developing countries to end extreme poverty and injustice.

Our long-term aid programs provide food, clean water,basic healthcare and education and create opportunities for people to build a better future for themselves.

We also deliver emergency aid to survivors of natural disasters and conflict, and help people rebuild their lives.

We have 70 years' experience in successfully fighting poverty, and last year we helped change the lives of 72 million people around the world.