Family Planning and Reproductive Health Commodity Needs Assessment

PAPUA NEW GUINEA

National Department of Health - UNFPA Pacific Sub-Regional Office

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Preface

The International Conference on Population and Development (ICPD) Programme of Action and the Millennium Development Goals (MDGs) both include universal access to reproductive health as a key target for achieving the goals. For reproductive health to be realised universal access to services and commodities is necessary. Reproductive Health Commodity Security (RHCS) is achieved when individuals are able to obtain and use the reproductive health commodities of their choice whenever they need them.

UNFPA's Programme of Assistance includes the provision of RH/FP/RHCS technical assistance and the provision of contraceptives & reproductive health commodities to fourteen island countries, including PNG. The Pacific Policy framework (PPF 2008 – 2013) was developed in 2008 and signed by a number of Ministers of Health in the Pacific. Key Strategies for improving RH services RHCS were outlined in the PPF.

UNFPA would like to express its sincere gratitude to the PNG DoH Family Health team Dr Lahui Geita and Dr William Lagani for their introductions. Also to Mr Jackson Pilyo, Ms Emily John and Mr Malcom Sabak who supported the review at provincial and district levels and arranging the itinerary during the Consultants mission in PNG.

The accessibility of reports commissioned or written by other developmental partners, especially UN agencies, WHO, and other NSAs whose ideas, experience and reports were invaluable to this consultancy.

Special thanks is extended to the consultant, Ms Tracey Lee, who undertook this review and wrote this report; the Health Systems/RHCS specialist, Mr. Peter Zinck who provided technical assistance, Quality Assurance and oversight in the compilation of this report; and the PSRO Communications Officer, Ms. Ariela Zibiah, for their input; and the PNG UNFPA Country Office Representative Mr. Walter Medonco-Filho, for facilitating this review. Without the support and contribution of the aforementioned persons, departments and organizations this report would not have been possible.

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Director, Pacific Sub-Regional Office (PSRO)
UNFPA Representative

Contents

Abbreviations

ANC Antenatal Care

AIDS Acquired Immunodeficiency Syndrome

AIP Annual Implementation Plan (formerly Annual Activity Plan)

AMS Area Medical Stores

CHS Christian Health Services

CHW Community Health Worker

CPR Contraceptive Prevalence Rate

CUG Closed User Group

CYP Couple Years of Protection

DDA District Development Authority

DFAT Department of Foreign Affairs and Trade

DHS Demographic Health Survey

eLMIS Electronic Logistics Management Information System

EOC Essential Obstetric Care

EmOC Emergency Obstetric Care

EPI Expanded Program for Immunisation

FPHC & SSHC Free Primary Health Care and Subsidized Specialized Health Care

GDP Gross Domestic Product

GoPNG Government of Papua New Guinea

HDI Human Development Index

HEO Health Extension Officer

HIV Human Immunodeficiency Virus

ICPD International Conference on Population and Development

IEC Information, Education and Communication

IUCD Intra Uterine Contraceptive Device

KAB Knowledge, attitudes and behaviours

LLG Local Level Government

MCH Maternal and Child Health

MDGs Millennium Development Goals

MMR Maternal Mortality Ratio

NDoH National Department of Health

NGO Non-government Organization

NHIS

PHA National Health Information System

Provincial Health Authority

PICTs Pacific Islands Countries and Territories

PNG Papua New Guinea

PPF Pacific Policy Framework

RH Reproductive Health

RHCS Reproductive Health Commodity Security

SEED Supply – Enabling Environment – Demand

SOP Standard Operating Procedures

STM Standard Treatment Manual

STI Sexually Transmitted Infection

TFR Total Fertility Rate

UNDP United Nations Development Program

UNFPA United Nations Population Fund

UNICEF United Nations Children's Fund

VHW Village Health Worker

WB World Bank

WHO World Health Organisation

Definitions

Buffer Stock
The amount of product held in reserve above calculated requirements in order to meet demand during supply disruption.

Client focused contraceptive services
Client focused services are those that enable couples make choices regarding spacing and / or limiting of children. They include confidential counselling and information, the supply of quality contraceptives and management of these contraceptives when circumstances change.

Contraceptive Prevalence Rate (CPR)
In this report it is the proportion of married women aged 15-49 years who are using any family planning method. If specified as CPR of modern methods it can be used as a proxy measure of contraceptive commodities used.

Couple Years of Protection (CYP)
Is a measure to describe the estimated protection in a one-year period, based on the unit number of all contraceptives distributed to clients. A conversion factor is used for each specific method.

It is the measure used in PNG for reporting contraceptive use because it offers a more accurate picture given the low levels of numeracy and manner in which data is collected and compiled at the point of service delivery (tally sheets relating to attendance).

Depo-Provera ®
The proprietary name for the long acting reversible method of contraception used in PNG – injectable

Jadelle ®
The proprietary name for the long acting reversible method of contraception used in PNG – subdermal implant

Kits
100% and 40% kits are those supplied to facilities under a donor assistance program and are provided to reduce a backlog

Logistics Management Information System (LMIS)
With reference to health and family planning, it refers to the information system for the management of pharmaceuticals and medical supplies. It may be manual or computerised system that collects data on consumption and stock status. It is used to forecast needs and to manage the supply chain to achieve efficiency and reliability. An eLMIS provides the same functions, electronically.

Logistics
In this report "logistics" is used to describe the forecasting, procurement, monitoring and movement of products from receipt into the country until the end user. It includes estimation of needs, ordering, storage and distribution but does not incorporate activities such as product registration.

Pull
The process used to by the health facility to order supplies based on their requirements (preferably calculated using stock on hand, minimum and maximum stock level requirements plus consumption). This is the system for routine bimonthly ordering.

Push
The process used by a central store to supply a calculated quantity to a facility without determining their actual requirement. This is the system used for supply of kits.

Quality Improvement (QI)
A process of measuring and improving performance more broadly.

Stock-Out
When one or more items that should be available, are unavailable regardless of the length of time. It indicates the unmet demand for a product that should be available. Stock out can occur at several levels either at the Manufacturer level, the central warehouse level or the service delivery point level.

Supply Chain Management
The management processes involved in the distribution of products from the source (manufacturer) through to the central warehouse all the way to the end user. It does not include product registration and customs clearance.

Executive Summary

This report documents an assessment commissioned by the United Nations Population Fund (UNFPA) to inform the Pacific Heads of Health Meeting of Papua New Guinea's progress since 2008, towards the Millennium Development Goal (MDG) 5B; universal access to reproductive health by 2015. Using focus group discussions and key informant interviews structured by the SEED[1] framework, Reproductive Health Commodity Security (RHCS) programs were examined.

Papua New Guinea (PNG) has a young population with 52%, 19 years or under (NSO, 2009). A high total fertility rate of 4.4, relatively high adolescent fertility (66.9/1000) and contraceptive prevalence of 24% (NSO, 2011) are key factors influencing the country's rapid population growth. Maternal and infant mortality indicators[2] are poor and reflect the state of services for reproductive health. Progress towards each of the MDGs has been slow and significant challenges persist, preventing the provision of equitable, high quality health services.

Key Findings

Some valuable elements are in place to support improved reproductive health outcomes for PNG, including advances in health policy, coordination and advocacy. It is too soon to see the benefits of these advances and since 2008, relevant health indicators have either remained static or have declined. Limited progress towards all MDGs including 5B has been achieved, indicating that PNG's initial commitment to ensuring universal access to reproductive health by 2015 will not be realized in this time frame. Themes identified in this review include:

- Increasing population with a large youth population and high rates of adolescent pregnancy;
- Inadequate terminal health services associated with weak outreach programs to serve rural and remote communities;
- Insufficient health workforce with insufficient training and skill to offer comprehensive reproductive health services that include family planning;
- Low levels of community engagement in rural and remote areas leading with a continued preference for larger families and low levels of demand for family planning services - there is a low level of knowledge of contraceptive benefits; and
- Limited services for vulnerable groups, especially young girls.

To make a difference to the health profile of PNG, a bold stance is urgently needed to ensure a coordinated and comprehensive approach is not only advocated at political level but also implemented across the entire sector. This means that political action that has already commenced needs to be followed through with change and appropriate resourcing at all levels of service delivery.

Summary of Recommendations

While this report is focused on reproductive health, at times it is impossible to isolate this specific aspect of health care, therefore some recommendations have a broader, more general reach. It could quite reasonably take more than a decade to build health infrastructure and workforce capacity to the level required. For this reason, to support improved services in the interim, creative strategies need to be employed, particularly to increase demand for reproductive health care and the knowledge of its benefits for individuals, communities and the nation.

1 Supply, Enabling Environment and Demand framework ™, Engender Health, 2011
2 Maternal mortality ratio of 733/100,000 live births is one of the highest in the region. Infant mortality too, is unacceptably high; 57/1000 (NSO, 2009).

	Area	Recommendations
Social determinants of Family Planning Demand & Use	Policy	1. Ensure effective implementation of all new policy directives through adequate dissemination and resourcing. 2. Advance commitments made within the Alotau Accord to review Papua New Guinea's Population Policy as a matter of urgency. Define realistic policy objectives and targets in conjunction with implementation strategies and then support these with the appropriate resources for action and change
	Advocacy	3. Expand political advocacy and family planning awareness to provincial level in order to mobilise communities. Engage with church and social leaders and the communities they represent to increase advocacy for and awareness of family planning, with focus on the importance of supporting young people to make healthy life choices
	Community Engagement	4. Meet the needs of vulnerable groups including youth and rural and remote populations through innovative service delivery such as community based distribution and partnership models. 5. Explore community-based distribution options with storeowners and young girls (peer-to-peer distributors). 6. Develop IEC messages that promote family planning, protection of the younger generation and effective family resource management.
Health System determinants of Family Planning Demand and use	Health Infrastructure	7. Sustainable health infrastructure enhancements (i.e. maintenance and replacement of facilities and staff housing) is a long-term priority
	Health Workforce	8. Address workforce shortages through training, registration and recruitment. Build capacity in training – consider in-line positions for tutors and clinical facilitators in order to deliver quality programs and build capacity of young educators that can lead into the next generation. 9. Ensure linkage between pre-service and in-service programs that are evidence based.
	Health Services	10. Reinvigorate integrated outreach services that include family planning, health promotion and clinical supervision. Pace programs through performance targets and consider incentivizing these targets with additional resources and funding directly linked to primary health care and family planning. 11. Provide school health programs that support teachers in delivering sexual health curriculum and have the capacity to address high rates of adolescent pregnancy through counselling and provision of confidential contraceptive services. Consider peer-to-peer services provided by young people. 12. Support effective referral through improved communication channels and mobile phone hotlines at provincial hospitals. Consider a closed user group for health which would offer free-calls throughout the network with a specified provider 13. Promote partnering as a service delivery model and capitalise on role modelling team approach to health care, resource sharing and combined expertise.
	RHCS and Medical Supply	14. Continue to procure quality reproductive health commodities through the *Access Reproductive Health Initiative* from UNFPA for the next 5-10 years: until broader procurement, management and distribution of medical supplies is assured. Allow for service expansion and commodity requirements. 15. Progress medical supply reforms that will also offer improvements for reproductive health commodity security.

Possible Interventions - Suggested starting point

Health System Determinants	
Supply Side – Now	**Supply Side – Soon**
• Promote population as a cross cutting issue in development • Advance commitments made within the Alotau Accord (PNG Population Policy) • Human resource development – build numbers and capacity • Expand partnership as a service delivery model for family planning • Address broader medical supply security (procurement, management and distribution) • Strengthen safe service delivery through improved communications using mobile phone networks	• Establish and implement community based contraceptive distribution strategies • Research – particularly in relation to servicing young people • Create strong linkage between pre-service and in-service, evidence based training • Pace programs through performance targets and consider incentivizing these targets with additional resources and funding directly linked to primary health care and family planning

Social Determinants	
Demand Side – Now	**Demand Side – Soon**
• Promote population as a cross cutting issue in development • Promote family planning within communities – focus on men and boys (traditional decision makers) as well as women and young girls (vulnerable groups) • Engage community leaders in population and resourcing discussions and decision making • Move away from typical service delivery models in favour of community based service	• Operational research particularly in the sphere of youth needs, knowledge, attitudes and behaviours • Strengthen education and health literacy relevant to sexual and reproductive health • Explore the opportunities of mHealth – using mobile telephony to engage communities

1. Purpose and Methodology

In 2008, Pacific Ministers of Health endorsed the "Pacific Policy Framework for Achieving Universal Access to Reproductive Health Services and Commodities "(2009-2015) with the view to ensuring achievement of MDG Target 5B[3], and for the continued improvement in regional reproductive health commodity security.

1.1 Purpose

This is one of a series of reports commissioned by the United Nations Population Fund (UNFPA). It documents a needs assessment of PNG's national programs for family planning and reproductive health commodity security (RHCS) and progress towards MDG 5B since 2008. It also offers recommended approaches to enhance family planning and reproductive health interventions for improved health outcomes. In doing so, it informs PNG's strategic direction in the context of the Pacific Policy Framework (2013-2017).

1.2 Objectives

Objectives of the review are to:

a) review areas to be covered according to SEED[4] assessment classification;

b) visit [Papua New Guinea], conduct in-country discussions and analyse the progress made in meeting the objectives of the Pacific Policy Framework; and

c) conduct a family planning and RHCS needs assessment for 2014 – 2017 using the SEED Assessment Guide and produce a report.

The specific scope of work:

- conduct a diagnosis of family planning and RHCS status;
- identify factors that limit or enhance family planning and RHCS prospects;
- process those findings to reach consensus on priorities for improving family planning and RHCS;
- make specific recommendations on how to move forward; and
- develop family planning and RHCS strategic action plan.

1.3 Methodology

The needs assessment comprised a desk review and in-country field assessment. Focus group discussions and key informant interviews were conducted using five modified SEED tools. These guided the consultations and subsequent analysis. The team was also invited to attend a High Level Family Planning Advocacy Meeting in Port Moresby (26-27 February) as observers. A desk review supported the assessment.

Findings from this assessment are presented and discussed here in the context of the SEED framework. Progress towards MDG 5B is highlighted and focal points to address opportunities and areas of weakness are identified.

The four provinces visited, one from each region, were selected by the National Department of Health: Central; East New Britain; Eastern Highlands and Morobe.

- A list of people interviewed is presented in Annex 4
- A list of documents reviewed is presented in Annex 2
- The High Level Advocacy Meeting program is presented in Annex 5

3 universal access to reproductive health by 2015
4 Supply, Enabling Environment and Demand Framework I Engender Health

1.4 Tools

The review used a simplified version of a framework. Five tools for examining supply, enabling environment and demand were drawn from Engender Health's SEED Assessment Guide (2011). These had previously been field tested in Vanuatu and the Solomon Islands.

The tools included

- SEED: Senior Health Managers and Health Promotion Staff
- SEED: Reproductive Health and Family Planning Service Providers
- SEED: Non-Government and Technical Organisations
- Reproductive Health Commodity Security - Central Level
- Reproductive Health Commodity Security - Facility Level

During the review, respective audiences (size, forum, membership) influenced how these tools were used and ultimately a flexible approach was adopted. The original intention was for the SEED tools to guide focus groups and the commodity security checklists to be used in interviews with key informants; in most cases this was achieved.

In Goroka, Eastern Highlands province, the size of the group indicated that a workshop approach would be more conducive. The group collectively identified key issues and then four themes were further explored to gain perspectives and to determine their root cause. This should not be seen as a deviation from the assessment guidelines but as an adjunct that elicited some strategies that might be adopted locally to address program weaknesses. Commodity assessments were conducted with key informants at all levels (central, provincial and district facility). Both church and government facilities were visited.

1.5 Limitations

It is well recognised that PNG is a diverse country and both the context and issues relating to health and sustainability are complex and layered. Logistics of travel, access and security always shape the scope of such reviews and therefore, perspectives gained. Observation of remote health settings was not possible though the team has extensive experience in remote areas of PNG and this knowledge and experience guided information gathering at provincial and district levels and the subsequent analysis.

The team acknowledges that while generalisations might be made about health system capacity, a generalised approach may not be appropriate in all areas or at all levels of service delivery. For this reason, we have not concluded this document with an activity plan but rather, we have provided a menu of strategies and activities that might be used in conjunction with local analysis of key priorities identified by local decision makers.

The SEED tools were used to guide discussions rather than as data collection tools in key informant interviews and focus group discussions. Triangulation was achieved in many instances as reproductive health services in PNG have been extensively reviewed, however data discrepancies are also apparent. The UNFPA High Level Advocacy Meeting addressed many issues and allowed the team to conveniently access perspectives of parliamentarians, provincial health advisers and partner agencies over a two-day period.

2. Introduction

Papua New Guinea is a signatory to the Pacific RHCS Plan of Action, developed in 2003 and the Pacific Policy Framework of 2008 that was adopted by Pacific Ministers of Health. Both guide the country's commitment to MDG 5B, that is, the commitment to provide citizens with "universal access" to the widest possible range of reproductive health information and services, including commodities, by 2015. Indicators for this goal are:

- contraceptive prevalence rate;
- adolescent birth rate;
- antenatal coverage; and
- unmet need for family planning.

Typical of the Pacific Island Countries and Territories (PICTs), PNG has a young population with high fertility rates and low contraceptive prevalence. Consequently, teen pregnancy is common, placing young women and girls at elevated risk of maternal mortality.

An initial review of progress achieved towards this goal was conducted in 2005 (UNFPA, 2008). It focused on the national policy and regulatory environment for RHCS, improved forecasting, logistics management, storage and coordination mechanisms. This forms a backdrop for the current assessment, which has been undertaken to document progress made since 2008 and informs reproductive health strategies beyond 2014. Analysis of findings is the basis of a menu of options to support family planning programs (Annex 3l Opportunities for Action) to strengthen PNG's immediate and mid-term response to MDG 5B.

2.1 Context

PNG is home to almost three-quarters of the population in the Pacific Islands. There are 22 provinces, 89 Districts and 326 Local Level Governments (LLGs), the latter being the third tier of government. Provinces are clustered into four distinct regions (Highlands, Islands, Southern and Momase) and the country has a rich diversity of geographical, environmental, social and cultural perspectives. Over 800 living languages have been identified (*Tok Ples*) alongside the more widely spoken languages of Tok Pisin, Hiri Motu and English. With a limited national road network, 80% of the population lives in rural and remote locations leading subsistence lifestyles. The remaining 20% are located in burgeoning urban centres.

Figure 1 l Map – Papua New Guinea

Highlands Region: Simbu, Enga, Jiwaka, Hela, Eastern Highlands, Southern Highlands and Western Highlands

Islands Region: East New Britain, Manus, New Ireland, Bougainville, (North Solomon's) and West New Britain

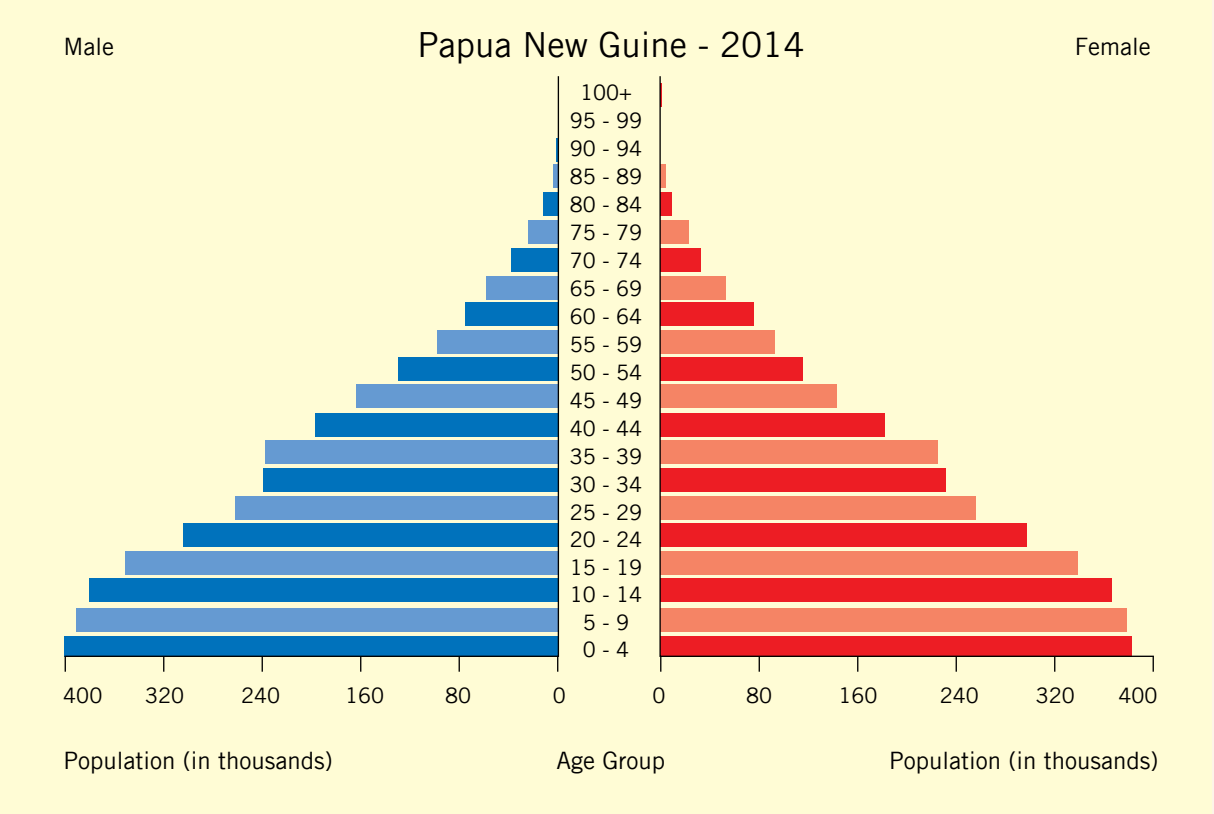
Momase Region: Madang, Morobe, East Sepik, West Sepik (Sandaun).

Southern Region: Gulf, Milne Bay, Northern (Oro) Western (Fly), Central and the National Capital District.

2.2 Population and Demographic Trends

Papua New Guinea's most recent census was conducted in 2011. The population was enumerated as 7,275,324[5] (NSO, 2014) with a current growth rate of 3.1%[6]; growth in the Highlands and Islands regions being greatest. The population structure is young (refer figure 2), sex ratio is 100:108 (female: male) with an average household size of 5.3; total fertility rate is 4.4 (NSO, 2009).

Figure 2 Population structure 2014 (CIA, 2014)



2.3 Key development indicators

PNG is rated as a low-middle income country (WB, 2014[7]) within the Pacific and the gross domestic product (GDP) in 2012 was $15.65 billion USD. GDP has grown between 8-10% in recent years and although this fell to 4% in 2013, in comparison to other Pacific countries, including Australia, the growth is still high.

Despite growth, significant development issues prevail. Most recent data available (WB, 2009) estimates 39.9% of the population is living below the national poverty line and the proportion of the population having access to improved drinking water and sanitation is 40% and 19% respectively (WHO, 2013). PNG is "Off Track" for all MDGs - key development indicators are shown in Table 1.

5 throughout the remainder of the report, rounded to 7.3 million in line with contemporary reporting in Papua New Guinea
6 Other estimations moderate population growth rate to 2.2% (NSO, 2009) or 2.1% (UNFPA, 2014) based on fertility, mortality and migration estimates (migration is negligible).
7 http://data.worldbank.org/country/papua-new-guinea

Table 1 Key Development Indicators in Papua New Guinea

Indicator	Measure	Source
Human development index	0.466	UNDP, 2013
Gross National Income ($US per person)	1,790	NHP, 2012
Total health expenditure (%of GPD) - $100 /person	4.1	WHO, 2013
Life expectancy at birth (years)	54	NSO, 2009
Adult literacy rate (%)	57.8	NSO, 2009
Crude Birth Rate (per 100,000 population)	34	NHP, 2012
Population growth rate (%)	2.2	NSO, 2009
Total fertility rate	4.4	NSO, 2009
Adolescent fertility rate (women 15-19 yrs, births / 1,000 women)	66.9	NSO 2009
Infant mortality ratio (per 1,000 live births)	57	NHP, 2012
Maternal mortality ratio (per 100,000 live births)	773	NHP, 2012
Contraceptive Prevalence Rate, modern methods %	24	NSO, 2009
Couple Years Protected	74	NHIS, 2012

2.4 Status of Reproductive Indicators

Maternal and infant mortality

A wide range of maternal mortality estimates is reported for PNG. On an annual basis, data is collected through the National Health Information System (NHIS) and Maternal Mortality Reviews. The Demographic Health Surveys (DHS) uses the sisterhood method of identification of maternal deaths as verification and reports maternal mortality ratio (MMR) as 733/100,000 live births. This is currently considered the most accurate estimate. Infant mortality is 57/1000 (NSO, 2009).

Fertility

The total fertility rate (TFR) has remained high in PNG though a decline was recorded between the 1996 and 2006 Demographic Health Surveys. Women in urban areas have a lower TFR than women in rural areas (3.6 and 4.5 respectively), and there are marked differences by region – ranging from 3.9 in the Highlands to 4.6 in the Islands. Adolescent birth rate is also high with women aged 15–19 having an estimated birth rate of 70 births per 1000; 22% of 19 year olds have at least one child and 6% have two or more children (NSO, 2009). The proportion of adolescent women who have commenced childbearing is 12.9% (NSO, 2009).

Universal access to reproductive health

An "Off Track" scorecard was recently awarded to PNG for progress towards all MDGs. A multitude of reports indicate an urgent need for family planning and increased access for comprehensive reproductive health services. The 2006 DHS clearly identifies the extent to which families want to space and limit children with 38% of women wanting to conclude their family. Wanted fertility rate is 3 children, but the actual rate is 4.4 indicating a high unmet need for family planning services (44% in 2012, MSPNG). Contraceptive prevalence is 24% (modern methods) (NSO, 2006).

Women are aware of the hazards of giving birth at home in the village and without the supervision of a skilled birth attendant (Ktumasi and Lee, 2009), yet the proportion of women who achieve a supervised birth remains low. Women birthing alone (no assistance at all) is a staggering 7.3% (NSO, 2009). On average, only 40% of infants are born within a health setting (Range; 24-63%). While there is local variation from year to year, the average rate of supervised births has remained static in recent years.

Figure 3 MDG progress

Some of the reasons cited for not seeking a supervised birth include poor water and sanitation infrastructure, attitudes of health workers, costs and inconvenience associated with being away from home i.e. distance from home, the need to travel, limited family support and food availability (Ktumasi and Lee, 2009; Kirby, 2013).

2.5 Cultural considerations - contraception vs. family planning services

Client focused contraceptive services offer information, counselling and supply of modern contraceptive methods for spacing and limiting pregnancy. Modern contraceptive methods include:

- oral contraceptive pills including emergency contraception;
- injectable preparations (Depo-Provera ®);
- long-term contraceptives such as intrauterine contraceptive devices (IUCDs) and subdermal implants (Jadelle ®); and
- permanent methods (tubal ligation for women, vasectomy for men).

Family planning services are more generalised, offering advice with or without provision of contraceptives; they may include advice regarding natural or ovulation method for spacing and limiting pregnancy. It should be noted that to be effective, this method depends on a couple's ability and willingness to negotiate sexual intercourse. As Papua New Guinean men are the primary decision makers within a family, this method has questionable efficacy in this cultural setting, but is frequently advocated, as approximately 25% of health services are Catholic run.

2.6 Social determinants of health

Education is an important social determinant of health and low levels of education are associated with poorer health outcomes. Many of the root causes influencing inequality in education mirror those influencing health inequality. Lower levels of school education are associated with low use of family planning and contraception.

> *'Women with no education are least likely to use family planning in the future with 35% reporting no intention to use family planning at any time in the future.'*
>
> *Source / NSO, 2009 p69*

The World Bank (WB) and the National Research Institute reviewed education services throughout the country. In 2002, they identified under-spending, possible mismanagement and misdirected funding within the education sector. In light of this, it is not surprising that the 2006 DHS found primary students places in both rural and urban schools inadequate, with only 44% of the school age population (6-24 years) attending school.

In comparison to boys, girls in PNG have lower school enrolment and retention rates. Only 23% of women in rural areas completed grade 7 or higher (NSO, 2009). The overall adult literacy rate in PNG is 57.8% and disparity between men and women is obvious, however comparison of data for youths shows higher literacy in the age group 15-24 years and women faring slightly better than men (ADB, 2011).

Graduates have limited formal employment opportunities with 6% of people of working age employed in this sector despite positive economic growth in recent years. Unless this growth addresses the deficits of today with regard to education and job creation, the projected needs of tomorrow's young people will remain unmet. A cycle of poverty, poor education and unemployment are contributors to serious law and order problems; rates of crime and violence are already high in PNG. They also negatively impact health.

2.7 Political context

The intricacies of the Organic Law[8] shape functional and administrative communication channels relating to governance. This process of decentralisation introduced in 1995 sees the District Health Office having direct lines of accountability to the District Administration rather than to the Provincial Health Office. Likewise, Provincial Hospital Boards and Provincial Health Offices are accountable to their respective Provincial Administrations.

The Provincial Health Authorities (PHA) Act was introduced in 2007 (Government of PNG (GoPNG)) to address weaknesses in public health and service delivery. Its aims are to strengthen linkages and accountabilities between LLGs, Districts and Provinces for united and integrated approaches to health service delivery. Governance of the Authorities is through a Provincial Board, which provides for community representation, is headed by a Chief Executive Officer and unites preventative (primary health care) and curative (hospital based) health services.

The PHA model is a voluntary one and currently three provinces operate under this model: Eastern Highlands, Western Highlands and Milne Bay. A further seven have commenced transition and expect to form in 2015. The strengths of the PHA model are that there is direct accountability between levels of service delivery and a coordinated mechanism through which health needs can be addressed: *One System Tasol*.

In 2013, a District Development Authority (DDA) Bill was tabled. It aims to further devolve responsibility to the Districts in order to 'get the money to the people', but also has the potential to undermine the linkages and accountabilities achieved under the PHA model. Under the DDA, Health Function Grants will be directed to the district and the PHA will not be able to function. It is crucial that parties work with the Law Reform Commission to manage significant concerns such as the mechanisms for funding, referral, human resource management and coordination of health services under the DDA. Facility based budgeting could provide a mechanism for effective funding within this framework.

2.8 Health system structure

PNG's National Health Plan 2011-2020 aspires to a hierarchical structure for health services commencing with Village Aid Posts or Community Health Posts that provide health promotion, health improvement, health protection, primary health and maternity care locally, to rural and remote communities (NDoH[9], 2012). Through a referral arrangement, this progresses through health centres, district hospitals, provincial public hospitals, regional referral hospitals and ultimately to the National Referral Hospital offering complex, tertiary level, clinical services. National Health Service Standards provide direction and guidance for the provision of safe and quality health care delivery and health facility design. They also inform clients, communities and stakeholders of the expected health service availability at each level, regardless of provider: government, church, Non-government Organizations (NGOs) or private sector (NDoH, 2011 National Health Policy, vol. 1).

Christian Health Services (CHS), government and private providers such as those commonly affiliated with industry, contribute to health service delivery in PNG. CHS are accountable for approximately 47% of overall health service delivery and 60% of rural health service delivery. All registered facilities attract government funding in the form of operational grants. Despite claims that CHS are under-funded, they offer some of the best health care in the country (CHS TAM, 2013). In 2013, CHS received 23% of the total health sector grants, the remaining 77% of funds were provided to government facilities that provide fewer than 53% of services.

Future service delivery models that have greater integration and accountability are proposed and transition has commenced in some provinces with the commitment to the PHA model and in some communities through funding and construction of Community Health Posts.

The future model allows for a village based health workforce such as community distributors and although church or NGO supported village health workers (VHWs) have previously proven to be effective in supporting reproductive health programs in PNG, numbers of active volunteers have waned in recent years due to diminished support. Recommendations have been made in support of a reinvigorated VHW program with expanded roles in HIV/AIDS awareness. They might also provide significant opportunities for improved reproductive health service delivery to rural and remote communities.

8 Organic Law on Provincial Governments and Local-level Governments, 1995

9 PNG Community Health Post Policy, 2012

3. Discussion of findings

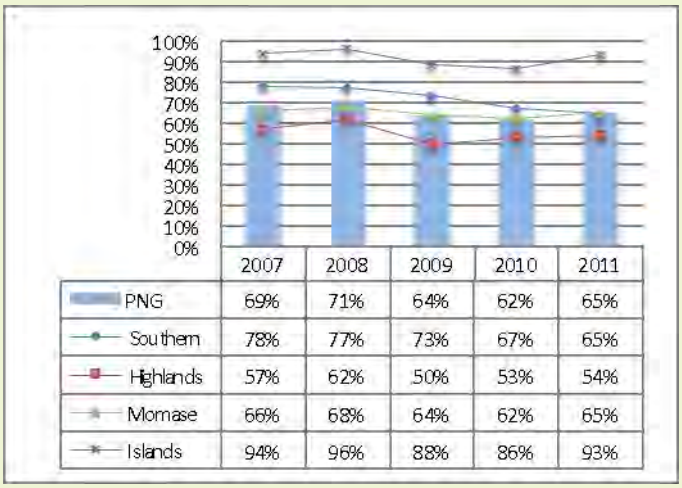
SUPPLY

3.1 Services

Reproductive health services are offered at all levels of service delivery. The National Health Information System (NHIS) collates data collected from the facility level and reports annually on outputs. The data quality was reported to be variable but the general view is that it provides a reasonable perspective on health sector performance. Presented below (Figures 6-8) are key data for reproductive health (2007-2011) as reported in the Annual Sector Review (NHIS, 2012).

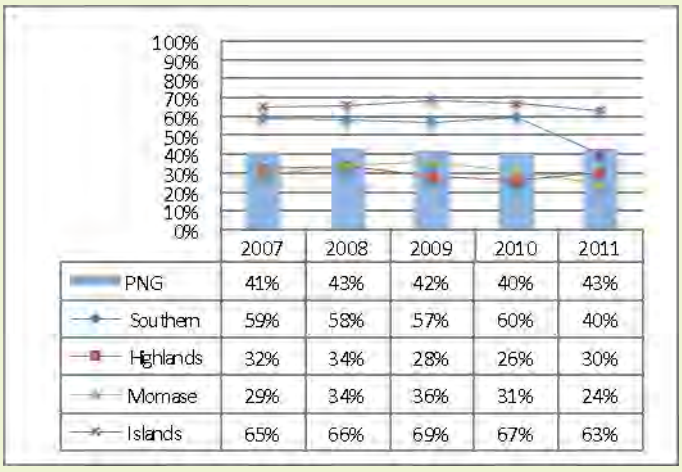
- While some level of Antenatal Care (ANC) is sought by 65% of pregnant women, supervised delivery rate in health facilities is static with 44% of pregnant women having a supervised birth by a skilled attendant in a health facility
- Contraceptive uptake in PNG is measured by Couple Years of Protection (CYP). CYP has declined in recent years to 70/1000 women 15-44yrs
- Antenatal coverage has fallen to 65%, supervised delivery is static at 43% and CYP has fallen to 74/1000 with lowest levels reported in the Highlands region, the fastest growing region in PNG (CYP 55/1000, 2011).

Figure 4 Regional and National ANC coverage (first visit) 2007-2011 (NHIS, 2012)



	2007	2008	2009	2010	2011
PNG	69%	71%	64%	62%	65%
Southern	78%	77%	73%	67%	65%
Highlands	57%	62%	50%	53%	54%
Momase	66%	68%	64%	62%	65%
Islands	94%	96%	88%	86%	93%

Figure 5 Regional and National data, supervised health facility births, 2007-2011 (NHIS, 2012)



	2007	2008	2009	2010	2011
PNG	41%	43%	42%	40%	43%
Southern	59%	58%	57%	60%	40%
Highlands	32%	34%	28%	26%	30%
Momase	29%	34%	36%	31%	24%
Islands	65%	66%	69%	67%	63%

In 2009, The Ministerial Taskforce on Maternal Health in PNG reported that all reproductive health indicators have been low for more than 10 years and are associated with low levels of outreach services. Given the majority of the population is rural, outreach is integral to primary health care and an essential element to support if current deficiencies in services are to be addressed. Until a more integrated approach to regular (3-4 times per year) outreach is achieved or accessibility is improved through other means such as improved road infrastructure, it is unlikely that health care indicators will improve.

Health workforce

To provide integrated and comprehensive services that adequately provide reproductive health, a trained, competent and willing workforce is essential. Health worker density is an important determinant of maternal health and there is a critical shortage of health care professionals across all cadres in PNG. Chen *et.al.* (cited in WHO, 2006) suggests failure to achieve an 80% coverage rate for deliveries by skilled birth attendants or measles immunization is associated with a health worker to population ratio of less than 2.5 per 1000. The World Bank (2011) reports the 2009 health worker to population ratio in PNG as 1:786 (Doctors, nurses, Health Extension Officers (HEOs) and Community Health Workers (CHWs)), which is significantly less than Chen's suggested ratio. The Alliance for Human Resources for Health reported PNG's ratios as much lower; 0.58 per 1000 (1:1724) (cited in GoPNG, 2010, p14). Regardless, current training inputs are insufficient to bridge the existing supply - demand gap for all cadres and urgent action is required to meet the demands of a rapidly growing population and to avert deteriorating health status.

- PNG's health workforce is aging, with 54% due to retire within the decade (World Bank, 2011).
- Workforce replacement has not been adequately planned or resourced and training institutions do not have the capacity to mange the projected need for graduates in all cadres.

Recommendations:

- Reinvigorate integrated outreach services that include family planning, health promotion and clinical supervision. Pace programs through performance targets and consider incentivizing these targets with additional resources and funding directly linked to primary health care and family planning.
- Address workforce shortages through training, registration and recruitment. Build capacity in training – consider in-line positions for tutors and clinical facilitators in order to deliver quality programs and build capacity of young educators that can lead into the next generation.

3.2 Health worker training

Pre-service

There are 12 CHW schools and eight Schools of Nursing. Five of the nursing schools are church operated and four also conduct midwifery training (CHS, 2014). Across the country, the graduate output is inadequate for both the current and projected workforce needs. Several new training institutions have been recently established, but to date none have accredited programs, therefore graduates are ineligible for registration. Concern was also expressed during the assessment regarding:

- adequacy of clinical experience of teachers;
- extent to which practice and curricula are informed by evidence
- sufficiency of clinical practice for students - this is partly impacted by high competition for labour ward experience by doctors, nurses and midwives;
- high training costs and inadequate resource allocation for health worker training; and
- lack of coordination between training institutions and the health system or in-service training.

Australian Aid provides scholarships for specialist training such as midwifery, however, in the preceding nine years midwifery graduates have been unable to obtain national registration with the Nursing Council. There has been concern regarding the quality of training and consequently schools have not been recognised as accredited training institutions. With an imminent health workforce crisis it is essential that all training institutions be appropriately accredited so that graduates can become registered professionals. Capacity building support is currently being provided to the Nursing Council.

Australian Aid is also funding clinical midwifery facilitators in order to build the capacity of nursing training schools throughout the country. While this is an expensive model, the nursing schools have requested that the program continue as building capacity is key to expanding current pre-service nursing training school capacity and the quality of training that can be provided.

In-service training

A comprehensive reproductive health in-service program was established 10 years ago. While much of the information presented still has relevance and the program was endorsed by the National Department of Health (NDoH), there was no incentive for this resource to be utilised by staff in health facilities. To fill a void, the Reproductive Health Training Unit was established in 2011 as a public-private partnership between the NDoH, Oil Search Health Foundation and Australian Aid. Two reproductive health in-service training courses are available on invitation from the provinces: Essential Obstetric Care (EOC) and Emergency Obstetric Care (EmOC), each being held over five days. As enhancements to health worker training progress it is essential that alignment between in-service and pre-service curricula is achieved and that both maintain a contemporary evidence base.

Recommendations:

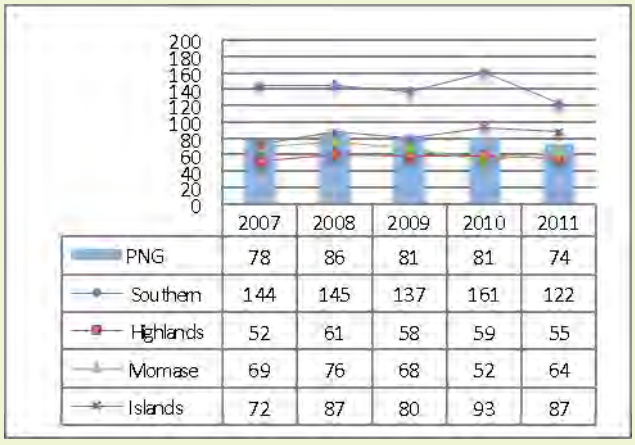
- Ensure linkage between pre-service and in-service programs and maintain contemporary evidence base for all health worker training.

3.3 Family Planning

There is a large unmet need for family planning and only 17.9% of women of reproductive age currently use a modern method of contraception (NSO, 2009). The National Health Plan 2011-2020 aspires to an ambitious contraceptive prevalence[10] of 65% by 2020. Strategies to progress this target include:

- Ensuring every health facility has the capacity to offer family planning services at all times;
- Advocating for the advantages of having fewer children and increased spacing of children; and
- Extending the reach of the village health workers (VHW) program and community-based distribution systems.

Fig. 6 Regional and National data, CYP / 1000 women 15-44years, 2007-2011 (NHIS, 2012)



	2007	2008	2009	2010	2011
PNG	78	86	81	81	74
Southern	144	145	137	161	122
Highlands	52	61	58	59	55
Momase	69	76	68	52	64
Islands	72	87	80	93	87

A recent account of health services indicates 2,608 health facilities; 31 hospitals and 2577 primary care service delivery points (personal communication Dr Geita, 2012). Aid Posts account for approximately 1800 of these facilities, 33% (NHIS, 2012) of which are closed. The service provider determines the scope of family planning services offered at a facility and Catholic services offer a limited service that may include natural methods, condoms for infection prevention and referral for permanent surgical options. A large proportion of the church-run health facilities are Catholic (45%; approximately 550 facilities) serving 20-25% of the population. While many

10 modern methods

men (30% do want their wives to use family planning (NSO, 2009, p66), the male cultural dominance within Papua New Guinea can also hinder a woman's reproductive choices and ability to plan or limit pregnancy.

Most services assessed reported a choice of at least three contraceptives (Depo-Provera, oral contraceptives and condoms) with referral to hospital for surgical procedures (tubal ligation and vasectomy). While it is not possible to draw conclusions regarding the availability of contraceptives at service delivery points from the limited data gathered during this assessment, a recent review of medical supplies (DFAT, 2013) indicated 64% availability[11]. Contraceptive availability combined with policy of the managing agency further decreases overall access to contraceptives in PNG. Compounding this situation, 20% of women have no knowledge of modern contraception (and the benefits it affords), 30% don't know where to get it and 44% have no intention to use it (NSO, 2009). This indicates that even if service delivery was excellent, there are demand side issues that need to be addressed to raise the profile of modern contraception as a healthy choice that can begin to alleviate poverty.

A new family planning policy paper is complete and awaiting final endorsement. More broadly this policy sits within the National Population Policy (further discussed below - Enabling Environment). Notable aspects of the revised family planning policy are:

- focus on choice and a client's freedom to make reproductive choices;
- promotion of partnership in service delivery;
- health workers' duty of care regardless of personal views; and
- removal of the requirement for consent for any person seeking services.

Recommendation:

- Ensure effective implementation of all new policy directives through adequate dissemination and resourcing.

On a day-to-day basis, clients are either seen in the clinic outpatient department or possibly in a mobile outreach service, and consultations include counselling and provision of the clients' choice of method. Flip charts developed and distributed 10 years ago are still in use in many clinics and are viewed as a useful tool to support client decision-making and health education. The most frequently reported change in service delivery is a move to offer family planning at every opportunity rather than as a limited service only offered on a specific day of the week. This is not to say that family planning is integrated at all points of service. A vertical service model still applies to all aspects of primary health care and clients must request family planning. Clients are not automatically offered contraceptives or counselling in conjunction with other consultations and the potential for missed opportunity is high. Staff interviewed indicated a strong preference for a vertical programming model and defined clinical roles. Consequently they expressed reservation about skills diversification to enable more integrated approaches to service delivery. This needs to be addressed in all levels of training but particularly pre-service training if there is to be a shift in workforce culture.

School health

The primary health care program includes the provision of regular school health services. Generally a program would include immunisation, health checks and health promotion. School outreach programs suffer the same fate as other outreach services with staff complaining that there are insufficient funds or resources (human and physical such as transport and fuel) to conduct regular (4 per year) outreach programs.

Teachers provide health education through the national curriculum that includes the subjects 'Personal Development' and 'Health Education to Prevent HIV and AIDS' however it was reported that they are often uncomfortable teaching some aspects of the curriculum relating to sexual and reproductive health. The opportunity to partner with teachers to enhance sexual and reproductive health services is obvious but not one that health workers that were interviewed have yet taken up. While they thought it was feasible, there are other barriers as noted above that are likely to hinder change. Partnership is more likely to be able to be supported in urban communities.

11 i.e 64% availability of select tracer medicines including Medoxyprogesterone depot injection 150mg/ml (see Medical Supply section for further detail)

Recommendation:

- Provide school health programs that support teachers in delivering sexual health curriculum and have the capacity to address high rates of adolescent pregnancy through counselling and provision of confidential contraceptive services.

3.4 Health Facilities

Composition

With 80% of the population distributed in rural and remote localities, primary health care services are the initial point of contact for the majority of people in PNG. Facilities serving primary health care include the aid posts, clinics and health centres.

In a new model of care, Community Health Posts are to be staffed by a midwife and two CHWs; one would focus on health promotion. These Level 2[12] facilities will gradually replace Aid Posts as the terminal points of service delivery (NDoH, 2012). A reason commonly cited for facility closure is the failure to meet minimum standards. The National Health Service Standards for PNG, 2011-2020 describe the minimum requirements for facilities across seven levels with Level 7 defining requirements for a tertiary, specialist referral hospital.

Status of health infrastructure

Of the facilities visited, facility refurbishments (planned and apparent) indicate recognition of the need to prioritise health infrastructure enhancement now, so as to accommodate future needs. At the same time, the team acknowledges that many facilities are in poor condition and in need of repair or expansion. Dispensaries are commonly too small to accommodate the safe storage of medical supplies and shelving is inadequate. As reflected in the wider evaluation coordinated by the Burnet Institute (DFAT, 2013), limited facility storage capacity negatively impacts on medical supplies and management practices.

The standard of labour ward equipment varies and even if in a poor state of repair, equipment will be used regardless of any infection control risk posed. Church-run services are often better maintained than Government facilities. The following issues are commonly raised when considering health infrastructure:

- Water and sanitation continue to be of an exceptionally poor standard and this is a common reason cited by women to show preference for birthing at home.
- Communication often depends on the health worker's personal mobile phone though some church-run facilities have provided phones to the clinic for use in emergencies.
- Lighting is unavailable and women deliver by torch or mobile phone light. Solar panels from radios and other lighting infrastructure projects are commonly stolen over time.

Recommendations:

- Sustainable health infrastructure enhancements (i.e. maintenance and replacement of facilities and staff housing) is a long-term priority

3.5 Referral

A referral process is supported by standard treatment guidelines and policy where consultation with and transport to the next in-line supervising facility is expected. In practice, referrals can be difficult to achieve due to limited road networks, insecurity and the unavailability of resources (vehicle and fuel). Because of challenging access issues, an extensive health radio network was installed under the AusAID (now Australian Aid) funded Health Sector Support Program (HSSP) that commenced in the late 90's. The aim was to improve communication for referral and consultative care. Health radios were non-functioning at all facilities visited and mobile phone is used in preference to telephone landlines, which are also commonly inoperable.

12 Refer to National Health Service Standards for Papua New Guinea 2011-2020, Volume 1, Annex One: 'Role Delineation for Health Services in Papua New Guinea'.

Since the 90's, mobile phone networks have rapidly expanded in PNG and offer a viable alternative for communications. A Closed User Group (CUG) might offer an affordable alternative for health communication and could be used to support an expanded phone referral system. Milne Bay and Western Highlands provinces have established a free call hotline based at the provincial hospital. Anecdotal evidence indicates that this service provides an effective link to the provincial hospital where advice can be given regarding referral and / or management to improve maternal and neonatal health outcomes. In addition to a CUG it could be feasible to partner with telecommunication providers to establish a call centre that provides health advice to new mothers, or young women, or men as partners in an effort to support effective community mobilisation strategies for health.

Recommendation:

- Support effective referral through improved communication channels and mobile phone hotlines at provincial hospitals. Consider a CUG for health that would offer free-calls on a subscription basis with a specified provider.

3.6 Medical Supply

Where medical supply systems fail, reproductive health commodity security is compromised. For many years, peripheral service delivery points have suffered from issues that relate to an under-resourced system, increasing health needs relative to population and disease burden and the persistent challenge of access. Inability to secure regular supplies and health workforce shortage are two factors that can constrain service delivery to communities. NHIS data reports 30% of Aid Posts closed in 2008 and 33% in 2011, reflecting no improvement in service availability at the periphery, disadvantaging rural and remote communities.

Strategies to address shortage of supplies at the Aid Post level have included a 'push' system of medical supply kits, either total or partial supply, based on population. The Burnet Institute undertook an evaluation for DFAT (2013) of medical supplies, reporting 64% availability of quality, essential medicines nationwide[13] and attributing the improvement of availability to these kits. The report recommends ongoing support to the country's medical supply and distribution through a 'push' system for the next three to five years while reforms are progressed. In this timeframe it is hoped that quantification and procurement will be enhanced through an Electronic Logistics Management Information System (eLMIS) (mSupply) and that greater capacity will in turn assist forecasting and budgeting as well as encourage greater transparency and accountability, generating value for money throughout the supply chain. Currently, national quantification for medicines is based on estimates made centrally.

There are two separate contracts affecting medical supply; one for procurement, the other for distribution. The current system for routine orders from Area Medical Stores (AMS) outsources delivery to a private company through a central contract administered by the NDoH. The carrier is required to collect packaged goods from the AMS and deliver these directly to the facility, however health workers throughout the country report that goods are sometimes delivered by public motor vehicle (PMV) or may not be delivered at all. There are multiple opportunities for misappropriation throughout the supply chain. In an endeavour to safeguard supplies in the most recent round of health centre kits funded by Australian Aid, payment was reserved until a Global Positioning System encoded photograph of the delivery of supplies to the facility, was supplied; an innovative approach that resulted in a high level of commodity security. While this process assured a delivery, staff do not inspect the goods on arrival before signing the proof of delivery slip. Frequent anecdotal reports regarding incomplete orders were provided during the assessment. The common commodities lost were antibiotics.

Standard operating procedures for management of medical supplies at facility level are poorly followed, limiting the ability of the Medical Supplies Branch to effectively forecast medical supply requirements. Data regarding commodity usage is not communicated from the point of service delivery to the AMS, primarily because there is no field for this data on the order form. In addition there is limited capacity for dispensary management in health centres with frequent ineffective use of registers or bin cards resulting in this data not being routinely available. It is the author's view that relying on commodity usage data collected at facility level would be fateful due to the high risk of errors. A more cost effective and accurate option would make use of data captured electronically from the eLMIS historical records. The accuracy and usefulness of the data builds over time with successive orders.

13 based on availability of select tracer medicines

Assuming invigorated family planning programs, there is a risk of under-estimation of reproductive health commodities, specifically contraception and this should be considered when placing orders over the next few years. As medical supply is undergoing significant reform, reproductive health commodities might best be assured with procurement via alternative channels during the period of transition.

Recommendations:

- Continue to procure quality reproductive health commodities through the *Access Reproductive Health Initiative* from UNFPA for the next 5-10 years: until broader procurement, management and distribution of medical supplies is assured. Allow for service expansion and commodity requirements.
- Progress medical supply reforms that will also offer improvements for reproductive health commodity security.

Equipment for reproductive health

Little information was gathered about the specific status of equipment for reproductive health care across the country, however, previous reproductive health surveys have noted the poor status of equipment inventory with maintenance often being a key factor for deteriorating equipment. Charles Kendall and Partners Ltd were responsible for procurement and distribution of reproductive health equipment kits to hospitals and health centres in 2013. Four types of kits were provided (delivery kit, vacuum extractor kit, manual uterine evacuation kit, caesarean section kit). All four kits were provided to hospitals with only the delivery and vacuum extraction kit provided to health centres. There are some reports of supplies not being received by health centres and this is being investigated further by the Technical Adviser, Reproductive Health Commodity Security (UNFPA / NDoH).

3.7 Management, Supervision and Quality

Management functions at District level vary with the capacity of the individual holding the leadership positions, but regardless of an individual's strengths and qualities, cultural issues always play a part in the level of effectiveness any leader might be able to achieve.

Supervision from province to district and district to facility level is infrequently practiced across all programs yet supervisory visits are essential for maintaining standards of quality care and health worker motivation. The *Clinicians Toolkit for Health Services in Papua New Guinea, 1st Ed.,* (NDoH, 2011b) is a valuable resource, providing a solid base for supervision. It covers a comprehensive suite of management issues including supervision, complaint and critical incident management, audit and quality improvement. Focus groups noted that supervisory visits, when they are conducted, remain cursory and issues identified are not resolved. AusAID (2009) noted that this is especially true where the root of a problem relates to performance.

Supervision checklists and quality improvement tools for primary health care have been made available in the past but they are not institutionalised and therefore not used. Poor application of formal processes for quality improvement renders supervision inconsistent in its quality and it is difficult to measure the effect of any supervision program undertaken.

ENABLING ENVIRONMENT

3.8 Political advocacy to address population and development issues

Final census figures for 2011 were recently released; the enumerated population at the time of census was 7.3 million with a growth rate of 3.1% (NSO, 2009) though other estimations moderate this to 2.1% based on fertility, mortality and migration estimates (migration is negligible) (UNFPA, 2014). The population has more than doubled since 1980 (31 years) and more than 52.1% of the population is 19 years or under (DHS, 2009, p12). The population is expected to double again within 25 years.

Direct action is urgently needed to slow population growth in order to prevent further pressure on already stretched capacity and resources. A high-level advocacy meeting was held in February 2014 to highlight this urgency and

showcase some local initiatives with potential to have immediate and long-term effect yet preserve the rights and dignity of couples to make choices and plan for their own futures. NGOs and individuals such as Marie Stopes PNG, Living Child and Rotary Australia are providing affordable family planning options to communities in both urban and rural communities.

Recommendations:

- Expand political advocacy and family planning awareness to provincial level in order to mobilise communities. Engage with church and social leaders and the communities they represent to increase advocacy for and awareness of family planning, with focus on the importance of supporting young people to make healthy life choices.

A strategic vision has been laid down in the Vision 2050 document (GoPNG, 2011). The vision is aspirational yet failure to successfully implement these aspirational strategies will severely constrain development and prosperity.

As one of the key initiatives of the Alotau Accord and its Platform for Action, the O'Neill Dion Government has committed to reviewing the National Population Policy. This is an important and potentially powerful initiative that should be progressed as a priority. Context, issues and priorities have shifted significantly since the publication of the National Population Policy for Progress and Development, in 199114 and targets outlined at that time such as an 'increase family planning prevalence from three percent now to about 22 percent by 1995 and 63 percent by year 2000' have not been met. It is essential to draw upon the vast body of works that critique population and reproductive health in PNG to define realistic policy objectives and targets in conjunction with implementation strategies and then support these with the appropriate resources for action and change.

The Parliamentary Committee for Population and Sustainable Development is also an effective vehicle for stronger leadership within government. It has an important role in advocating for funding to be directed to family planning initiatives.

Recommendations:

- Advance commitments made within the Alotau Accord to review PNG's Population Policy as a matter of urgency. Define realistic policy objectives and targets in conjunction with implementation strategies and then support these with the appropriate resources for action and change.

3.9 Resourcing

Health expenditure has risen significantly in recent years and expanding the health budget is a key priority for 2014 (GoPNG, 2013). In 2014, total funding for all agencies in the health sector will be K1.4 billion (PWC, 2013). In addition, a one off allocation of K20 million has been provided to support the Alotau Accord commitment and the policy for Free Primary Health Care and Subsidized Specialized Health Care (FPHC & SSHC) (2013) in PNG. While it is recognised that this sum will not necessarily meet the shortfall created from abolishing user fees for primary health care, it is intended to incorporate the allocation into recurrent funding in the future.

A longstanding comment presented by staff at provincial and district level concerns the delay in release of funding from the National Economic and Fiscal Commission. Funds are consistently delayed in the first quarter, stifling service delivery, and politicians control District Services Improvement Program funds. In Morobe, staff reported program budgeting of K10,000 per program, which provides K666 per health facility, per quarter. Sustaining outreach services with this level of funding is challenging. Smarter use of allocated resources is needed and might be achieved through integration and partnership.

Morobe health managers support the concept of facility based funding. A project was undertaken to trial the model in the Autonomous Region of Bougainville (NDoH, and WHO, 2013). Although the project was not without its challenges and requires building of capacity at each facility for effective financial management, there were notable improvements in outreach and outpatient services. The model warrants further consideration with view to a wider rollout. Rural district services are more expensive to manage than those in town and it has been estimated that the

14 http://www.hsph.harvard.edu/population/policies/PAPUA%20NEW%20GUINEA.htm

annual cost of running an Aid Post is K4,000-7,000 and for a health facility, K32,000 – 120,000, depending on the size and scope of services (personal communication, Glastonbury).

3.10 Evidence-based decision making

The NHIS data has limited use in evidence-based decision-making because of its variable quality. It is useful for trend analysis but beyond that has limited application. There is an extensive lag between collection and collation for dissemination and limited distribution of the data. The current software and database is no longer adequate to support health information management requirements and data collection instruments are being revised under a donor-funded project.

At the point of service NHIS data is collected using tally sheets. These are then collated at district, provincial and national levels. Issues identified with data collection and management include:

- Tally sheets in their current form prevent disaggregation of data which might be useful for assessing trends and needs of young people; and
- Managers have limited skills to critique data on a monthly and quarterly basis at both district and provincial levels. Combined with limited numeracy skills, this limits the health system's ability to act responsively to the full suite of health needs presenting in local catchments.

Quarterly performance reviews are expected to be conducted with district and provincial staff. There is specific guidance provided in the *Clinicians Toolkit for Health Services in Papua New Guinea* (NDoH, 2011b), as already discussed (refer 3.6). To date, where these reviews occur, they more commonly assess progress against an Annual Implementation Plan (AIP) and associated spending without making effective use of NHIS data to critically review services and initiate responsive programming. Other innovative means of collecting data should also be explored. With a good level of mobile phone coverage in Papua New Guinea this technology could offer more immediate reporting capacity.

3.11 Partnerships and community engagement

The NDoH has partnered with the Reproductive Health Training Unit to provide in-service training to health workers in an effort to address skills shortage for basic obstetric services.

Marie Stopes PNG works in partnership with existing health services and will use programs such as the expanded program for immunisation (EPI) as a touch point for access to those that may also choose contraceptive services. This role modelling is invaluable to support invigorated outreach and relationships should be fostered. The NGO also operates mobile services where no facilities are available. Currently, procurement is through a parallel system but it is expected that government procurement processes will be used for all reproductive health commodities when their systems can assure commodity security.

Other opportunities for partnership exist, but the willingness of the Provincial Health Office to engage in a partnership is fundamental to national programs being able to tap into the energy, resourcing and expertise of these potential partners. Wendy Stein (Rotary Australia) is providing subdermal implant training and contraceptive services with the support of local political members. Her programs have been highly successful in various communities such as Kar Kar Island, Madang because of the support of the local member and local community. Due to the volume of implants her program supplies she is willing and able to train health workers to a level of competence so that local programs can expand the suite of methods they provide in their routine service. The uptake of the method indicates long term reversible methods are readily accepted by women and given cultural perspectives relating to gender and decision-making in PNG, also by men.

Recommendation:

- Promote partnering as a service delivery model and capitalise on role modelling team approach to health care, resource sharing and combined expertise.

DEMAND

3.12 Affordable services

It has been common for clients to pay for services even though primary health care services have always officially been free of charge. In practice, a user fee has been charged to help bridge the shortfall in service funding. There has been no regulation of the fees charged and a typical fee for supervised birth is 20 kina. Receipting is rare so the extent to which informal income supports health service delivery is not easily quantified. The income generated is often used to purchase supplies and employ casual staff.

Early in 2014, the FPHC & SSHC policy was announced with implementation of the initial phase - free primary health care services (Levels 1-3). The intent is to facilitate universal access to health care for the rural majority and the most vulnerable. Since the announcement, health services have reported an obvious increase in patronage. With the assured commitment to reproductive commodity security, family planning and supervised birthing should be able to continue to be provided without charge. The next challenge will be to address infrastructure demands in order to provide safe, hygienic and comfortable facilities for pregnant and birthing women. As discussed earlier, the current status of many facilities is a strong deterrent to women seeking the support of a skilled birth attendant in a health facility.

3.13 IEC, health promotion and social marketing

The Health Promotion Department has diminished capacity and now provides only a very basic service. There are no health promotion materials available for family planning and no certain plans to develop any in the near future, although a comic has been partially developed. Rural communities have lower levels of literacy and knowledge regarding the benefits of and options for family planning. To empower families to make reproductive health choices, information must be provided through a broad range of appropriate social media; theatre was the common mode advocated.

Recommendation:

- Develop IEC messages that promote family planning, protection of the younger generation and effective family resource management

3.14 Vulnerable groups with specific needs

Young people, those that are unmarried and those that are partnered but are yet without children, were the most underserved and vulnerable group observed during the review. Both staff and clients report that this group will not and do not access routine maternal and child health (MCH) services, as they feel uncomfortable doing so. Family planning services are most commonly associated with mainstream MCH services in health facilities and young people typically have no formal services tailored to their specific needs.

We met informally with several young women who were accompanying relatives attending family planning services at Marie Stopes PNG and government-run urban clinics. They stated that if they needed family planning, they would be more inclined to gain entry to the services accompanied by a sister or friend who was themselves attending the MCH services or to attend a private clinic such as Marie Stopes PNG where there is greater privacy.

Pre-pregnancy family planning information and contraception are the most cost effective means of reducing maternal mortality and slowing population growth, though this group do not have easy access to either. If high adolescent fertility is to be adequately addressed, this is the group that needs to be targeted through a series of interventions run in conjunction with school health programs or youth specific initiatives. The review team recognises that this strategy challenges traditional cultural values, however health workers interviewed readily acknowledge the increasing problem of pregnancy in young adolescents with reports of women as young as 14 years having been seen at the ANC and they are accepting of the concept of offering family planning services to this group. What is required is for communities to be engaged with the view of helping them become receptive to changing perspectives that do not fit with cultural stereotypes and traditional values.

Recommendation:

- Meet the needs of vulnerable groups including youth and rural and remote populations through innovative service delivery such as community based distribution and partnership models
- Explore community based distribution options with storeowners and young girls (peer-to-peer distributors).

Focus groups explored issues relating to service gaps by asking; who do family planning services fail to reach using the current service delivery model? In the order mentioned, they list:

- vulnerable populations - those that live far from health facilities, in remote communities and border regions;
- "destitute women" - those whose husband or father has died as they have no male figurehead to advocate or make decisions for them;
- widows - elaborating that these women are not expected by society to be sexually active - "*it's kastom*" | Health Worker, Morobe;
- single mothers;
- young females; and
- school age girls and young women.

Health workers commented that these groups of women may also have poor living standards, be involved in sex work or have no money to pay for family planning services.[15] Solutions offered generally centred around provision of services through alternative service delivery points such as working with partners and even those not directly involved in health care including the Department of Primary Industry or school inspectors. Other opportunities include:

- providing health promotion at cultural events;
- sponsoring family planning health messages on billboards at bus stops; and
- condom distribution at bus stops, especially popular with young boys.

The issue of induced medical abortion was also raised. Health workers report that it is mostly young unmarried women who request abortion. While abortion is illegal in PNG, it can be provided for medical reasons.

15 Referring to past practices of charging fees but acknowledging that this situation has now changed

4. Conclusion

Development issues of PNG have been widely assessed and documented. On the supply side, key issues impacting health relate to leadership, finance, skilled workforce, medical supply and infrastructure. Geographical isolation has a bearing on each of these and local access and security issues compound circumstances on the demand side of the equation. Population is now a crosscutting development issue for the nation. High rates of fertility, associated with poor service delivery assure poor reproductive health outcomes.

Maternal Mortality has significant cost to community. A woman's traditional role of caring for the family is already expansive but in today's society women are also important breadwinners for the family. Beyond the moral imperative, there are many reasons to strive to improve maternal health through spacing children and reducing the risk and physical costs of pregnancy, especially when things go wrong and there is no health worker or no medical supplies or no means of referral to save a woman's life.

Family planning and the provision of comprehensive contraceptive services through a broad range of delivery modes offers an affordable and cost effective approach to better resource management. This report recommends a range of strategies that might be employed to strengthen some very positive steps that have already been made. The development of national policy is creating a stronger enabling environment as PNG moves towards achieving universal access to reproductive health (MDG 5B). Some of these strategies are intended to strengthen routine activities for health service delivery. Others introduce innovations that tap into new and exciting possibilities for sharing health information between communities; strategies that rely on simple, durable and affordable technologies suitable for the demands of the Papua New Guinean environment.

Key to improving reproductive health status is the willingness and ability to address the unmet need of those that are most at risk, that is, the women and young girls made vulnerable by their gender and culture and those communities in rural and remote locations that are hard to reach. With continued pressure on finite resources, creative approaches that share resources and expertise through a partnership approach are likely to be most effective at enhancing service provision and to make a real difference.

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5.3 Annex 3 | Opportunities for Action

Opportunities for action are presented below with the intention of providing guidance for interventions that are needed to increase uptake of family planning in order to improve reproductive health outcomes.

Possible Interventions - Suggested starting point

Health System Determinants	
Supply Side – Now	Supply Side – Soon
• Promote population as a cross cutting issue in development • Advance commitments made within the Alotau Accord (PNG Population Policy) • Human resource development – build numbers and capacity • Expand partnership as a service delivery model for family planning • Address broader medical supply security (procurement, management and distribution) • Strengthen safe service delivery through improved communications using mobile phone networks	• Establish and implement community based contraceptive distribution strategies • Research – particularly in relation to servicing young people • Create strong linkage between pre-service and in-service, evidence based training • Pace programs through performance targets and consider incentivizing these targets with additional resources and funding directly linked to primary health care and family planning

Social Determinants of Family Planning Demand and Use	
Demand Side – Now	**Demand Side – Soon**
• Promote population as a cross cutting issue in development • Promote family planning within communities – focus on men and boys (traditional decision makers) as well as women and young girls (vulnerable groups) • Engage community leaders in population and resourcing discussions and decision making • Move away from typical service delivery models in favour of community based service	• Operational research particularly in the sphere of youth needs, knowledge, attitudes and behaviours (KAB) • Strengthen education and health literacy relevant to sexual and reproductive health • Explore the opportunities of mHealth – using mobile telephony to engage communities

GOAL: To contribute to increased access to sexual and reproductive health, promote reproductive rights and reduce maternal mortality and accelerate progress on the ICPD agenda and MDG 5b			
Goal Indicators: CPR, Unmet need, Adolescent fertility rate, antenatal coverage, HIV prevalence in youth (15 – 24 year olds)			
Outcome 1 | Enabling Environment: Policy, program, and community environments, plus social and gender norms support functioning health systems and facilitate healthy behaviours			
Issues	*Possible Interventions*	*Accountability*	*Implementer*
Total fertility and Adolescent fertility remain high	Advance commitments made within the Alotau Accord to review Papua New Guinea's Population Policy	Consultative policy development	Government
	Wide circulation of the Family Planning Policy	Availability within community (health services, partners, leaders	NDoH
	Expand political advocacy to provincial level in order to mobilise communities. Engage with leaders and communities to increase advocacy for and awareness of family planning, with focus on the importance of supporting young people to make healthy life choices	Monitor impact through population based surveys such as DHS In the interim, monitor social issues through the media	Provinces and Communities
	Increase female literacy through education and health literacy through school health programs and community education	Monitor through population based surveys such as DHS	Government Facilities

Outcome 2 | Supply of reproductive health services and commodities: Quality reproductive health services are accessible, acceptable and accountable to clients and communities served			
Issues	*Possible Interventions*	*Accountability*	*Implementer*
Insufficient health workforce to meet current and future needs Insufficient Skill level to support quality reproductive health (and family planning services	Build capacity of training institutions and registering bodies through strategies that could include - mentoring programs - capacity development projects - in-line appointments Ensure any expansion in programming also manages requirements for clinical facilitation	Number of graduates and registrations with Professional Councils	Government
	Build capacity of young educators that can lead into the next generation.	Level of funding and participation in capacity development programs	Government NDoH Training Institutions
	Offer family planning courses as electives within other health science programs	Course programming and registration	Training Institutions
	Ensure linkage between pre-service and in-service programs that are evidence based.	Curricula review / Mapping and accreditation	Training Institutions

Issues	*Possible Interventions*	*Accountability*	*Implementer*
Health services are insufficient to meet current and future needs	Improve availability of services at first-level facilities – Explore community based distribution options with storeowners and young girls (peer-to-peer distributors)	NHIS (CYP) Evaluate long-term progress with DHS	Provinces Facilities
Outreach services are poor	Promote partnering as a service delivery model and capitalise on role modelling team approach to health care, resource sharing and combined expertise.	NHIS (Outreach)	Provinces Facilities
Referral costs are high for obstetric emergencies	Procure quality reproductive health commodities through UNFPA for the next 5-10 years: until broader procurement, management and distribution of medical supplies is assured. Allow for service expansion and commodity requirements.	Commodity procurement reports / eLMIS	NDoH
Low rates of supervision demotivate health workforce	Progress medical supply reforms that will also offer improvements for reproductive health commodity security	Availability of supplies at service delivery points	NDoH
	Prioritise sustainable health infrastructure enhancements (i.e. maintenance and replacement of facilities and staff housing) is a long-term priority	Health infrastructure inventory, funding, projects	NDoH
	Pace programs through performance targets and consider incentivizing these targets with additional resources and funding directly linked to primary health care and family planning.	AAPs NHIS	NDoH Provinces
	Support effective referral through improved communication channels and mobile phone hotlines at provincial hospitals. Consider a closed user group	Research to monitor referral + obstetric emergency management, workloads, outcomes	Provinces

Outcome 3 | Individuals, families and communities (including vulnerable populations) have knowledge and capacity to ensure sexual and reproductive health and seek services/care

Issues	*Possible Interventions*	*Accountability*	*Implementer*
Rural communities have poor access to regular services through usual, heath services delivery points and high unmet need for family planning	Increase innovative service delivery such as community based distribution and partnership models.	Commodity usage assessed through eLMIS reporting for community based distribution	NDoH, Provinces, Facilities, Communities
PNG has poor maternal and child health indicators	Provide school health programs that support teachers in delivering sexual health curriculum Provide counselling and confidential contraceptive services. Consider peer-to-peer services provided by young people.	Commodity usage School health outreach program reporting Changed knowledge, attitudes and behaviours (KAB) for reproductive health in young people (egg adolescent pregnancy rates)	Provinces, Facilities, Communities

Issues	*Possible Interventions*	*Accountability*	*Implementer*
	Conduct research into adolescent pregnancy to establish more detailed baseline data	Publication Research informs policy and programs	NDoH
Low levels of knowledge of family planning and its health benefits	Develop IEC messages that promote family planning, protection of the younger generation and effective family resource management	Publication and distribution KAB changes (requires baseline data obtained through preliminary research)	NDoH
Poor understanding of family planning's role in poverty alleviation Poor maternal and child health indicators	Improve quality of facility-based care and encourage participation of VHWs in facility based care	ANC and Supervised delivery rates	Facilities

5.4 Annex 4 List of people met

Name		Role
Ms Cindy	Milford	UNFPA, International Program Coordinator
Dr Gilbert	Hiwalyer	UNFPA, Assistant Representative
Walter	Mendonca-Filho	UNFPA, Representative
Daphne	Ian-Ghabu	NDoH, Technical Adviser - RHCS
Dr Lahui	Geita	NDoH, Technical Adviser, Women's Health
Dr William	Lagani	NDoH, Manager Family Health Services
Dr Subatara	Jayaraj	IPPF Regional Manager, ESEAOR
Mr Vali	Karo	NDoH, Manager Medical Supplies Procurement and Distribution
Ms Cathy	Fokes	Safe Motherhood Alliance
Prof. Glen	Mola	UPNG, School of Medicine and Health Sciences
Mr Jimmy	Ravao	District Health Coordinator, Kwikila
Mr Moses	Kenava	Officer in Charge, Kwikila HC
Sr Rhoda	Selapui	District Family Health Officer, Kwikila
Mr Peter	Pahu	Assistant Dispensary Officer, Kwikila HC
Mr Dika	Kevau	Dispensary Officer, Kwikila HC
Mr John	Mark	Officer in Charge, Aide Post (Salvation Army)
Mr Michael	Kilip	Health Worker, Kwikila District
Mr Lindsay	Pilawas	NDoH, Manager, Health Promotion
Dr Alex	Stephens	DFAT, 2nd Secretary Health & HIV Program Australian Aid
Ms Etene	Boyama	District Health Coordinator, Kupiano HC
Ms Rigolo	Moicela	District Family Health Services Coordinator, Gazelle District
Ms Rebecca	Naime	Health Worker, Kairuk HC
Mr McKenzie	Kupo	Assistant District Health Coordinator, Kairuk HC
Mr Tim	Timothy	HSIP Clerk, Konedobu - PHO
Ms Marpa	Auka	EPI Coordinator, Konedobu - PHO
Ms Gladys	Allan	Medical Services Coordinator, Konedobu - PHO
Ms Marineth	Amos	Village Health Volunteer Coordinator, Konedobu - PHO
Sr Singut	Bieb	Family Health Services Coordinator, Konedobu - PHO
Mr Tom	Ellum	Country Director, Marie Stopes PNG
Mr Nicholas	Larme	Provincial Health Adviser, Kokopo PHO
Sr Lorna	Kuamin	Training Officer, Kokopo PHO
Sr Connie	Wuki	Officer in Charge, Butawin Health Centre
Ms Gillian	Meauri	Officer in Charge, Dispensary, Nonga General Hospital
Ms Rebecca	Peneia	Acting NUM, Consultant Clinic, Nonga General Hospital
Ms Cathleen	Telo	Health Worker, Paparatava HC
Ms Roselyn	Karup	Health Worker, Paparatava HC
Ms Roselyn	Dawag	Health Worker, Paparatava HC
Mr Alfred	Minong	Health Worker, Paparatava HC
Ms Rita	Tanangbel	Health Worker, Paparatava HC
Ms Bernadette	Ray	Health Worker, Paparatava HC
Mr Nerius	Gogor	National Health Information Officer, ENB PHO
Sr Estelle	Jojoga	Head of Division of Nursing, UPNG
Dr Paul	Sikosana	Technical Officer / Team Leader, WHO
Ms Lilian	Siwi	CEO, Eastern Highlands PHA
Ms Suaito	Reuben	Provincial Logistics Officer EHP PTS

Name		Role
Sr Jackie	Terra	Asaro Clinic - FHS Coordinator
Mr Kum	Topma	Asaro Clinic - OIC
Mr Jack	Kuntin	District Health Manager
Sr Nehlyn	Clancy	Family Planning Clinic – OIC, Goroka Hospital
Ms Joan	Haili	Family Planning Clinic, Goroka Hospital
Ms Anna	Pongua	MCH Officer, Kainantu
Mr Gabriel	Wau	District Family Health Officer, Lufa
Sr Benedicta	Arana	District Nursing Officer, Lufa
Karina	Waingi	District Nursing Officer, Heganofi
Korito	Homonas	District Nursing Officer, Okapa
Alwyn	Poli	Acting Dsitrict Nursing Officer, Kainantu
Mr Terance	Ofa	Family Planning Clinic, Goroka
Mr Pop	Siwi	District Family Health Officer, Heganofi
Asina	Urafime	Health Worker, Sigerehe HC
Mr K	Opa	Deputy Director Public Health, Goroka PHO
Boko	Mehio	Health worker, Ungai-Bena
Mr Geoff	Miller	Technical Adviser - EHP PHA, Goroka
Mr Michael	Muri	District Health Officer, Goroka
Mr Seva	Korape	Pharmacy, Goroka Hospital
Mr Larswan	Dengen	EBC Health, Obura Wanenara-Kassam
Ms Suaito	Reuben	Provincial Logistics Officer
Dr Max	Manupe	Acting Director, Curative Health, Eastern Highlands
Sr Jackie	Terra	Asaro Clinic - FHS Coordinator
Mr Kum	Topma	Asaro Clinic - OIC
Mr Michael	Makao	Director Corporate Services, Eastern Highlands
Ms Julie	Liviko	Assistant Director, Public Health, Eastern Highlands
Mr Jack	Aita	Associate Health Adviser, Morobe PHO
Mr Michah	Yawing	Health Adviser, Morobe PHO
Mr Kusunan	Popau	District Health Manager, Buolo District, Morobe
Mr Kelly	Mesere	Technical Officer, Morobe PHO
Mr Ricther	Posath	District Health Manager, Finschafen District, Morobe
Ms Lynna	Albert Japu	Deputy Coordinator, Family Health Services Morobe PHO
Mr Omin	Gunua	District Health Manager, Menyamya District, Morobe
Mr Boning	Gowiong	District Health Manager, Kabwumn District, Morobe
Ms Lucy	Mendali	Family Planning Coordinator, Morobe PHO
Ms Pendek	Sitong	District Health Manager, Markham District, Morobe
Ms Veronica	Waffi	District Health Manager, Lae District, Morobe
Mr Wani	Bopi	Provincial Health Promotion Officer, Lae
Ms Marie	Numiora	Provincial Nutrition Officer, Lae
Ms Arah	Ecke	Province Manager Marie Stopes PNG
Ms Rhoda	Dengo	PNG Family Health Association in collaboration with IPPF
Ms Daphne	Kahu	Malahang HC, Lae District, Morobe
Ms Wendy	Stein	Project Director, Rotary Australia
Ms Ingrid	Glastonbury	Health Consultant
Mr Steve	Groves	Manager – Projects, B-Mobile
Dr Miriam	O'Connor	Director, RHTU

5.5 Annex 5 lProgram High Level Advocacy Meeting 26-27 Feb 2014

DEPARTMENT OF HEALTH

'Family Planning Advocacy Meeting' Forum Program

Day 1 – Wednesday, 26th February2014	
08.30 – 9.00am	**Registration**
	Facilitators: Dr P Dakulala / Dr G Hiawalyer / Dr W Lagani
	Welcome & Objectives–Health Secretary, Mr Pascoe Kase
9.00 – 10.15am	
10 mins / Welcome 15 mins/ Opening	**Opening Address** – **The bigger picture of population and development and resource matching** – Minister for Planning & Monitoring, Hon Charles Abel
20 mins/ Keynote 30 mins/ Session	**Keynote Message**: UNFPA Asia Pacific Regional Office – Mr Peter Zinck
	Session One: Background & Synopsis 'An overview' – Prof. Glen Mola
10.15 -10.45 am 20min/ Session 10min/ Panel	**Session Two: Current status of Maternal Health &Family Planning in PNG** – Dr L. Geita Panel discussion: Dr William Lagani / Dr Augerea / Dr Mola / Dr E Kariko
10.45 – 11.00	**Morning Tea**
	Session Three: Provincial planning for Family Planning
	Presenters –Dr Glen Mola (SMHS), Dr Lagani (NDOH)& Dr Lin Citto (WHO)
11.00 – 1.00 pm	
40min/ Session 30min/ Data 30min/Discussion 20min / Hon. Tabar	**Distribution of Provincial/District data** Discussion
	PNG Parliamentary Group for Population and Sustainable Development: Championing reproductive health & family planning – Chair, Hon. Malakai Tabar
1.00 – 2.00pm	**Lunch** ***Melinda Gates video clip***
2.00 – 3.00 pm	**Session Four: Partnerships 'Who are they and how do you find them'**
10min/ LG	• Introduction – Dr Lahui Geita
15min/ JS	• Church Health Services & Family Planning – Mr Joseph Sika
	• Marie Stopes 'partnering in the Provinces' – Mr Tom Ellum
15min/ TE	• Reproductive Health Training Unit (RHTU) – Dr M Dokup
15min/ MO 15min/ Discussion	Panel discussion: Dr Lahui Geita / Regional Representatives
	[Provincial concerns & constraints] Afternoon Tea
3.00 – 3.20pm	**Afternoon Tea**
23.20 – 3.50pm	**What is next? The way forward**
15min/NDoH 15min/ MS	Facilitated discussion: SMALL PNG
	Session Five: Client Focused Services 'Consumers perspectives'
3.10 – 3.20 pm	NDoH - Dr L. Augerea Marie Stopes - Dr E Kariko
3.50 - 4.00pm	**Wrap Up** – Dr Paison Dakulala / **Close of Day One**

Day 2 – Thursday, 27th February2014

9.00 – 9.10am	**Summary of Previous Day** – Dr P Dakulala
9.10 – 9.45am 20min/ LG 15 min/ Media	**Session One: Pre -Launching of the new Family Planning Policy –** Dr Lahui Geita Media Questions& Discussion
9.45 – 10.25 20min/TE 20min	**Family Planning in operation – 'Outreach, quality services & the National Family Planning training program** Marie Stopes – Tom Ellum Discussions
10.25 – 10.45	**Morning Tea**
10.45–12.00pm 15 min/ Hon Ken F 20 min/ WS 15 min/ SD 30 min	**Partnership Illustration** Hon Ken Fairweather – **Providing Family Planning to Electorate** Ms Wendy Stein – **Implementing & Training in Family Planning** Living Child Inc– **Implementation of Family Planning in East Sepik** Discussions
12.00-12.30pm 15 min 15 min	**Partnership Agreements 'Not for you but with you'** Rob Akers – **Rural Primary Health Services** Discussion
12.30 – 1.30pm	**Lunch** ***Melinda Gates video clip***
1.30 – 2.30 pm 10 mins 30 mins 20 mins	**Small Group Discussion – 'Getting on with Provincial Family Planning'** Facilitator/s – Dr Geita & Dr Augerea Facilitated discussions: HIGHLANDS/MOMASE/SOUTHERN/ISLANDS Reporting back (20 minutes)
2.30 – 2.50 pm	**Afternoon Tea**
2.50 – 3.10 pm 20 mins	**What is next? The way forward** Facilitated discussion: SMALL PNG
3.10 – 3.20 pm	**Wrap Up by Facilitators -** Dr Lagani & Dr Augerea **Close Day Two.**

5.6 Annex 6 | Eastern Highlands Focus Group Summary

On March 4 2014, a discussion was held at Lutheran Guest House, Goroka to determine strategies to improve family planning service delivery in the Eastern Highlands Province. While the initial program[16] recommended a focus group discussion using the SEED Tool[17], the number of attendants and the meeting was better suited to using problem solving approach to issues already identified in key informant interviews. Three group activities were conducted:

Task 1: Local issues impacting family planning service delivery were identified by the entire group – brainstorming activity

From this list, the facilitator identified four core problems from this list that addressed Supply, Enabling Environment and Demand

Task 2: using the problem tree tool, four groups of 4-6 participants identified root cause of the issues – feedback was provided to the group

Task 3: Strategies were identified to address the issues – feedback was provided to the group

Table 1: Key issues that impact FP services in Eastern Highlands Province

Supply	Enabling Environment	Demand
Medical supply is inadequate / unreliable	Family planning hasn't been prioritised by the NDoH	Myths re modern methods
Workforce capacity limitations	Competing priorities	Approval from husband
Staff have multiple responsibilities -	Cultural beliefs including need for husband's approval	Access issues
	High level advocacy is needed with the church	Cost / Incentives

Participants identified the following key areas as those needing to be addressed by various levels of government, health care providers and communities:

- National support is needed to strengthen the enabling environment in PNG, particularly in relation to the church as 50% of health care is provided by the Christian Health Services
- Medical supplies reform is one of the most pressing priorities – strengthening this aspect of health service delivery impacts the entire system and therefore has flow on effects for reproductive health commodities security. It is recognised that interactions at all levels from political levels through to individuals in the community have a bearing on medical supply in PNG
- Adolescents are a vulnerable group currently untargeted by the health system yet they comprise a large proportion of the population and have one of the highest needs with regard to reproductive health and family planning. To date, limited resources have been directed towards developing an understanding of this groups needs and priorities. Health service providers need to work with young people themselves in conjunction with schools, community groups, NGOs and other partners to develop effective strategies once their specific needs are identified
- Continued political support and advocacy is required to for family planning to be effectively prioritised.

The following tables present the information relating to 4 core problems explored. Strategies notes are options that the Province may wish to explore further in their endeavours to strengthen family planning services. Responsibility for strategies is indicated in parentheses e.g. (NDoH)

16 UNFPA review of PNGs progress against the Pacific Policy Framework – for 2008-2013
17 Supply, Enabling Environment Demand tool for family planning programming

SUPPLY			
Cause	**Core Problem**	**Effect**	**Strategies**
• Inadequate submission of orders • Poor Management and supervision by provincial and district officers • Facility staff not following SOPs (may be untrained) • Staff taking on multiple roles therefore not able to do their best job – staff ceiling not met	**Issues relating to medical supplies impact service delivery for Family Planning**	Stock outs and inadequate supplies Stock rationing Complaints Clinic closure Bad image of AMS	• SOP Training (NDOH / Province) • Promote the use of bin cards for stock management during supervision • Orders need to be placed on time (to provincial logistics officer / AMS) – Bimonthly orders are due in the first week of delivery month (Facility / Province) • Develop an order schedule (Facility) • Improve Dispensary Infrastructure – refurbishment to ensure adequate storage space and appropriate shelving (Facility / Province)
• Area Medical Store (AMS) (Lae) supports EHP but with the closure of Rabaul AMS, it now supports 11 provinces		Staff are not able to plan their supplies due to unavailability of consumption data which is needed for forecasting AMS is overloaded	• Prioritise the completion of the Provincial Transit Store (PTS) – needs roles and responsibilities to be defined by the NDOH and equipment (NDOH) • Build human resource capacity for PTS – recruitment (Province) • NDoH to continue to progress reforms for Medical Supplies
• LD logistics have not met their full contractual obligations • Staff have not understood their role in signing the proof of delivery (POD) notice		Delayed deliveries Stock is missing on arrival at delivery point (lost in transit) or does not arrive Alternative transport mechanisms are used by LD logistics (PMV)	• District Managers advised that the staff should not sign POD until they have checked supplies received against slip that details contents of order. Next step is to disseminate this information to offices at facility level (District). • Develop a checklist for all levels to use to review the performance of contractors (requires someone to collect / collate and report on data collected)

DEMAND			
Cause	**Core Problem**	**Effect**	**Strategies**
• Young people are not aware of their needs and are unaware of family planning options • Limited awareness activities target this audience either at school, home (taboo), in the community / health services • Teachers are not comfortable teaching sexual health subject matter • Health workers don't provide enough awareness programs in the clinics or on outreach	**Low numbers of young people and adolescents access family planning service – there are no youth friendly services**	Young people comprise a large proportion of the population in PNG There are no youth friendly services and limited opportunities for awareness	• Provide in-service training to health workers • Up skill using partners such as Marie Stopes PNG for counselling, family planning options and implant insertion • Support teachers to provide sexual and reproductive health curriculum through school health program or in-service to the teachers • School nurses could provide a confidential opportunity to provide education and services in schools • Young persons check up could also address family planning needs in this target group • Create an environment for youth promoting life choices • Supervision to be provided by managers
• Cultural barriers prevent discussions re sex / family planning • Restriction from parents • Traditional healers continue to play a role in communities including pregnancy prevention		Rising teenage pregnancy rates - this has a flow on effect, especially for your girls who may be unable to complete schooling – leads to lower female literacy rates and fewer opportunities for employment	• Involve traditional healers and elders in family planning discussions
• A fee for service is sometimes charged despite national policy		Increased number of abortions	• Free services must be provided for family planning • Conduct awareness programs in community
• Health staff are unfriendly towards young people or have poor attitudes towards young people / unmarried			• Young person's check up • Involve peers is developing and providing education • Consult young people to find out what they need and how they would like youth friendly services to be provided
• Levels of illiteracy are relatively high			• Involve artists to develop appropriate IEC materials

SUPPLY & DEMAND			
Cause	**Core Problem**	**Effect**	**Strategies**
• Insecurity can create barriers to service delivery • Law and order disturbance • Tribal fight	**Poor access to family planning services – it is difficult for rural communities to come to the clinic.** **There are also challenges for health workers conducting outreach**	High pregnancy rates High maternal deaths Large numbers of young people / limited resources Overcrowding Law and order problems Communities are dissatisfied with health services and health workers	• Difficult to address • ? Provide security awareness in communities
• Facility closure (lack of supplies and skilled staff, rundown infrastructure) • Family planning not included in pre-service training			• Province to plan regular facility maintenance • Where staff have no pre-service training in family planning,
• User fees are charged			• Services to be provided free of charge
• Religious beliefs • Myths about implants – "mark of the beast" - it was suggested that these myths are being propagated by church groups in some communities			• Engage churches in negotiations re messages and approaches that are able to be supported by churches – High level advocacy by NDOH / politicians
• Husbands don't approve of their wives using family planning – even though a mans permission is not required			• Include men in programs – family planning, antenatal and delivery
• Women don't know or understand about family planning choices • Low levels of education • Low literacy			• Awareness by health workers
• No IEC materials			• NDOH to provide IEC materials
• Village Health Workers (VHWs) are underutilised – need further training to be effective			• If VHWs are to be used they would need training in all areas of family planning relevant to their defined role • Community based distributers may need incentives – they would definitely need reliable supplies to be effective.

ENABLING ENVIRONMENT			
Cause	**Core Problem**	**Effect**	**Strategies**
• No new recruitment • Diminished capacity in Department of Personnel Management and PNG Nursing Council • Reduced numbers of Nursing graduates in recent years	**Political advocacy is required involving** **Politicians / NDoH / Churches / other leaders and decision makers** **Family Planning is a Cross-cutting Issue**	Aging health workforce Delayed nursing registration No Family Planning dedicated positions Limited IEC materials Church objects to modern family planning methods including implants VHWs are not equipped to provide family planning or safe motherhood advice	• Create a position for Youth and adolescent officer at provincial level – it may be possible to combine this with a School health coordination function • EH PHA restructure – Interim Arrest (HR)
• 26+ agencies and NGOs in EHP providing health care			• There are opportunities to reach rural communities by partnering with other agencies or integrating health programs e.g. EPI • MOUs between PHA and partnering agencies (NGOs / FBOs / Private companies e.g. mining) would be required – PHA to manage these
• A variety of methods for providing awareness to rural communities is well accepted in PNG – these are not available at this time – only Helt Tok's			• Mobile phone could be used for messaging (Pidgin / English). Messages need to be developed regarding ○ Family planning methods and choice ○ Rights based approach to choosing FP ○ Needs of and services for young people including adolescents ○ Availability / location of services ○ Every opportunity ○ Dates of foot patrols • Staff suggest the development of messages for: ○ Comic strips, pamphlets, posters, billboards, drama / TV, community Tok Piksa
• Christian Health Services manage 50% of health services in PNG and some refuse to provide family planning services other than ovulation method.			• Continued dialogue is needed at political / national level to advocate for the inclusion and acceptance of modern methods that are acceptable to the churches and their communities • Include church leaders in appropriate awareness activities to gain acceptance / increased understanding of these issues
• Family Planning is Cross-cutting			• Advocate across sectors including Education, Mining, industry etc and relevant ministries