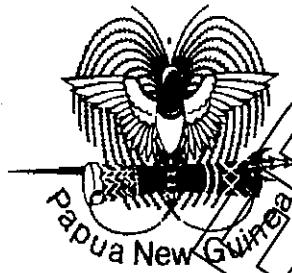


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Review of Reproductive Health Project between the GoPNG, UNFPA and GoNZ

Papua New Guinea – Strengthening RH in
the Context of the Health Sector
Improvement Program

June 2009

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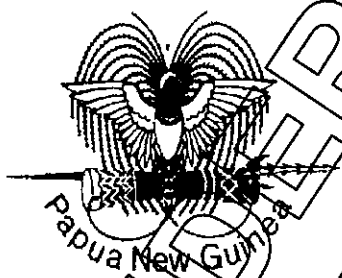
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Improvement Program

June 2009

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The Review Team

Port Moresby, June 2009

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List of abbreviations and acronyms

AAP	Annual Activity Plan
ADB	Asian Development Bank
ANC	Antenatal Care
ASR	Annual Sector Review
ASRH	Adolescent Sexual and Reproductive Health
BCC	Behavior Change Communication
CBD	Community Based Distributors
CBSC	Capacity Building Service Centre
CHW	Community Health Worker
CMC	Churches' Medical Council
CO	Country Office
CPR	Contraceptive Prevalence Rate
CST	Country Support Team
CTA	Chief Technical Advisor
CYP	Couple Year Protection
DHS	Demographic and Health Survey
DP	Development Partner
EOC	Essential Obstetric Care
EmOC	Emergency Obstetric Care
GBV	Gender-Based Violence
FBO	Faith-Based Organizations
FHS	Family Health Services
FP	Family Planning
HC	Health Centre
HCO	Health Extension Officers
HIV	Human Immunodeficiency Virus
HLM	Health Learning Materials
HMIS	Health Management Information
HR	Human Resources
HSIP	Health Sector Improvement Program
IEC	Information, Education and Communication

Strengthening Reproductive Health Services in the Context of Health Services Improvement Program
(HSIP)

IMRG	Independent Monitoring and Review Group
LMIS	Logistics Management Information System
MDG	Millennium Development Goals
MES	Multilateral Engagement Strategy
MMR	Maternal Mortality Rate/Ratio
MR	Mortality rate (e.g. Under 5 MR)
MTEF	Medium Term Expenditure Framework
NATO	"No Action, Talking Only"
NCD	National Capital District
NDOH	National Department of Health
NGO	Non-Governmental Organization
NSV	Non-Scalpel Vasectomy
NZ Aid	New Zealand Agency for International Development
PHA	Provincial Health Advisor
PHC	Primary Health Care
PNC	Post Natal Care
PNG	Papua New Guinea
RH	Reproductive Health
RHCS	Reproductive Health Commodity Security
SM	Safe Motherhood
SMO	Safe Motherhood Officer
SRH	Sexual and Reproductive Health
STI	Sexually Transmitted Infection
SWAp	Sector Wide Approach
TA	Technical Assistance
TFR	Total Fertility Rate
TT	Tetanus Toxoid
UNFPA	United Nations Population Fund
VBA	Village Birth Attendants
VHV	Village Health Volunteers
WHO	World Health Organization

Summary

Background of the Review

This review was originally scheduled for November 2008, close to the end of a three year USD \$2 million support through UNFPA to strengthen Reproductive Health in Papua New Guinea in a sector wide approach (SWAp) through the Health Sector Improvement Program (HSIP). Delays in project implementation (the budget is 60% expended) led to a no-cost one year extension through January 2010. At the time of the review objective external evidence through the Demographic and Health Survey (DHS) 2006 and the Annual Sector Reviews (ASR) show a doubling of maternal mortality and a several year plateau in supervised deliveries at over one third of women in Papua New Guinea. Equally worrying is the rising HIV prevalence (estimated at over 1.6% of the sexually active population). Resource flows for maternal health have been extremely low. The review therefore occurs at a critical time in PNG with difficult challenges facing the sub-sector of reproductive health.

Methodology and Stakeholder Participation

The review was conducted with two weeks of field visits in three of the ten provinces which received support (a fourth was visited during a related mission of the Independent Monitoring and Review Group by the team leader of the NZ review), and interviews held with key informants at all levels of government, with NGOs and service providers, and with communities themselves (men, women, adolescents). A semi-structured questionnaire (appended to the report) was used to trigger discussions. Health facilities (provincial, district hospitals, health centres and sub-health centres) and communities were visited. Extensive project documentation was reviewed. Efforts were made to continually keep NZ Aid, UNFPA, and NDOH aware of key findings. Data regarding contentious issues were triangulated, e.g. multiple perspectives were obtained on key findings in view of the highly politicized nature of PNG and the health sector. The review team was comprised of members of the implementing agencies (National Department of Health or NDOH, and UNFPA) as well as an external member representing NZ Aid.

Key Findings

Intended and Unintended Changes and Impacts

The project scores extremely highly in terms of relevance. The project exceeded its design intentions at the policy and standard setting (TA, RH, family planning) level; met its vehicle, most of its RHCS procurement and training commitments; but was challenged with any infrastructure and some capacity development largely because of the difficulties of working at the decentralized level with non-implementing agencies. Bottlenecks in the availability of funds from the Health Sector Improvement Program (HSIP) were one issue faced by the project, as well as dysfunctional relationships between levels and considerable challenges at the implementation level working in a decentralized under-resourced context. These problems were not unique to the project but faced by other partners. Similarly, project-specific monitoring of impact, effectiveness and efficiency were not possible, in part because of weak project monitoring generally, as well as a much underfunded sector with limited capacity for donor-specific monitoring and every indication that most relevant health service delivery indicators are not progressing well. In general the sector has not shown any impact of any supports to maternal health, from NZ Aid or any other donor, according to the Annual Sector Reviews, the Demographic and Health Survey, and the twice yearly Independent Monitoring and Review Group missions – except for some momentum in family planning which should be built upon. Sustainability is questionable when such little government commitment is noted to maternal health.

The project evolved flexibly to react to key sectoral challenges, for example additional resources were channeled by the project, as well as acted as an investment multiplier, for Reproductive Health Commodity Security (RHCS), and support was provided to the Ministerial Taskforce on Maternal Health 2008/2009. The selection of provinces for support and districts within these provinces also shifted over time, partly in response to political requests for equitable distribution of project resources.

The project was constrained in the implementation of other outcomes such as maternity upgrades to support essential obstetric care (EOC) and some of the training initiatives e.g. in non-scalpel

vasectomy (NSV), related to well acknowledged and severe bottlenecks in the system of funds disbursement by HSIP. Similarly, other funding streams that were not co-ordinated well and ultimately may have been lost to the health sector such as the supplementary budget, constrained project achievements if they were funding different aspects of upgrading one facility. The project training inputs appropriately shifted away from medical providers and towards nurses, midwives and Community Health Workers (CHWs). The project also tried with great success in limited geographic areas such as Enga Province to mobilize outstanding community participation which could help to model best practices e.g. for community constructed maternity waiting homes of bush materials. Serious issues in the sector which the project was not able to address such as user fees for maternity care, transport, and access to emergency obstetric care limited the impact of the project. These need wider attention in the sector as they represent serious barriers to care for poor women and are likely a factor in the low numbers of supervised births. Similarly the erosion of the primary health care (PHC) level with aid post closures, lack of supervision of staff etc. and failure to address outstanding issues such as low pay for rural nurses leading to a strike during the time of the project (contributing to further drops in facility births) were not well addressed by the health sector but were beyond the control of the project. Better links between stakeholders (NZ Aid, UNFPA, NDOH, the central agencies, lower levels of government and communities, with a communication strategy) will be needed to continue to mobilize political and financial support for maternal and reproductive health.

Stakeholders' Perceptions

During the community consultations, a sense of outrage was well articulated by the hundreds of people coming to each of the several health facilities we visited, angered that they had done their part (e.g. built maternity waiting homes from their own resources) only to see unmet commitments by government to upgrade maternity care in health facilities. The doubling of maternal deaths and the lack of resources directed to this sub-sector is severe and was noted during the Review to be one contributing factor leading to considerable social unrest. Community members in fact did not know that donors were involved, the involvement of NZ Aid was surprising to many as the larger share of resources that they have been expecting are government's own money. Money is clearly visible in PNG – mining revenues etc. but have not been made available appropriately to the social sectors. The Review itself was conducted in a narrow two week window before that geographic area was closed due to insecurity; a police guard stayed with the Team in a guest house in Enga because of the state of emergency, Riots followed in subsequent weeks because of racial tensions aggravated by the fact that jobs are more available to non-nationals than Papua New Guineans and the border at Mount Hagen was closed and expatriates evacuated. One Papua New Guinean member of the Review Team could not travel on her scheduled return date as she was from an area which was likely to be victimized by retaliatory killings following a murder. These are important issues of context that were experienced as components of the Review and have added to the Review Team's sense of urgency that government and donor commitments to the social sectors specifically prioritizing maternal health must be met and fast tracked.

The delays in implementation not just in this project, but in health sector initiatives generally, is contributing to widening social and gender inequities. Maternal health was noted to be under-resourced (IMRG May 2009) and more serious efforts (by donors such as NZ Aid, UN agencies such as UNFPA, and NDOH at all levels) are needed. The National Health Plan specifically exempts pregnant women from paying fees but these are widely charged and were repeatedly raised in the community consultations as a cause of concern by poor women who are unable to mobilize the money needed to save their own lives. Repeated heart wrenching stories were told of preventable maternal deaths. The positive moves made by the project towards gender equality have been threatened by a national system in which it has been extremely difficult to mobilize resources for women's health. There were widespread criticisms by stakeholders on the bottlenecks of funding by HSIP, while evidence was also found of non-transparent uses of funds (not specific to this project but found more generally, observed by other partners in NDOH and other donors, but often shrugged off as not possible or too personally dangerous to fight), leading to worsening morale and a deepening sense of cynicism by health staff. However, these problems seem worse in other non-HSIP sources of government funding.

Value for Money

Approximately 60% of the \$2 million USD project have been expended. It has been extremely difficult in view of weak project monitoring to track which results have been achieved for this investment, beyond minimal references to vehicle purchase, salaries, allowances, travel, workshops, fellowships,

and limited procurement of supplies. Efforts were made to save money (not upgrade totally dysfunctional buildings, only provide resources if the in charges of facilities were in post), as well as to obtain quotes from different service providers. The original plan was to only provide equipment once the facility was upgraded, and achieve economies of scale with bulk purchases; however with the delays in facility renovation, the Review Team recommends procuring equipment now and sending it out to the selected facilities. Training courses tried to get value for money with use of in-country training where possible. UNFPA endeavoured to screen requests for resources for their appropriateness and cost benefit. Efforts were made for multi-purpose events such as the RH strategic plan development in Madang in February 2008, and more work was done to progress the EOC upgrades in that province at the same time. Strong efforts were also made by UNFPA to try to lobby for more resources for maternal health from provincial and district budgets, with varying degrees of success. However, more money was spent than planned on travel and allowances, and the allocations for computer and related equipment for highly placed technical advisors in both the project and their counterparts had not been envisioned in the original project design and will displace resources from basic equipment such as delivery sets in facility maternities. Shifting of resources towards administration is problematic in the rest of HSIP and other health sector funded activities.

Recommendations and Follow Up Action

Tighter project management by UNFPA is necessary to track financial expenditures and re-budget the project for the remaining year. Transition planning will be needed for the additional staff hired under the project e.g. in RHCS and with geographic shifts. A higher profile for both NZ Aid and UNFPA in sector dialogue to mobilize attention and resources for maternal health would link this project to wider sectoral issues (the need to access what can be salvaged from the supplementary budget also intending emergency obstetric care upgrades, issues of human resources and health system strengthening). Continued work to strengthen the roles of CHWs in RH and SM/FP, as well as to promote more nurses for midwifery could help position this project with plans coming onstream to reduce maternal mortality. NZ Aid is advised to continue targeted support for training for maternal health, with a community focus, in a context where this remains severely underfunded.

Once the Ministerial Task Force on Maternal Health delivers its report and action plan, every effort should be made to operationalize its recommendations in the remainder of the project period (upgraded roles for CHWs etc.) and in any follow on project. This will include a strengthened focus on family planning which could include social marketing of contraceptives.

1. Introduction and Timing of the Review

NZ Aid initiated support to UNFPA in January 2006, for a three year project to strengthen Reproductive Health (RH) Services in Papua New Guinea (PNG) in the context of the Health Sector Improvement Programme (HSIP). This built on previous work UNFPA had been doing in four provinces supporting essential obstetric care, family planning, and Information Education and Communication (IEC) in Reproductive Health (RH)¹. Key informants such as Dr. Glen Mola (University of PNG) had worked with UNFPA to discuss the project design based on needs identified at the time in RH in PNG.

Of all the UN agencies, UNFPA could be seen as the most logical partner to support reproductive health in view of their commitment to gender, HIV prevention, poverty alleviation, population and development and family planning, work with adolescents, and maternal health. The Family Health Services (FHS) section of NDOH has the strongest responsibility for maternal and reproductive health, although disease control also addresses HIV prevention. So from the NZ Aid perspective, UNFPA and FHS (NDOH) would then be the most logical implementing partners to address the outstanding concerns in reproductive health (poor supervised delivery, high adolescent pregnancy, weak access to essential obstetric care, and rising HIV rates) in PNG.

The project did not develop a logical framework and did not identify specific monitoring indicators which challenged the subsequent monitoring and evaluation of the project. Both UNFPA and NDOH (National Department of Health) had implementing responsibilities to the funding agency, NZ Aid. For example, it is the responsibility of the NDOH head of Family Health Services to get an itemized report on the expenditures related to Essential Obstetric Care (EOC) and include that in the quarterly report to UNFPA to report back to NZAID. The Chief Technical Advisor Reproductive Health (CTA-RH) and the RH Admin officer are responsible to assist in getting the itemized expenditure on a year marked basis with this specific project. It is also the responsibility of the head of Family Health Services (NDOH) to ensure copies of requests and expenditures are kept in their file.

Little was determined with respect to project governance and monitoring in the original project document beyond an annual report of both technical and financial expenditure tracking. For example, it was not explicitly stated how modifications in the original project design such as adding new staff would be addressed, nor were any limitations outlined in terms of shifting of expenditure between line items in the project. An annual audit was planned (but did not take place), and annual backstopping envisioned from the Country Support Team in UNFPA Fiji (one visit has been conducted). A final project evaluation was planned and implemented.

Due to delays in the project, a no cost extension was granted by NZ Aid till January 2010. The Terms of Reference of the Review are attached as Annex 1. The review methodology includes document review (Annex 2). Key informant interviews and field visits to Gerehu, Wewak/Maprik in E. Sepik, Madang, and Enga (provincial and district health offices and administration, provincial and district hospitals, health centres, sub centres and aid posts, NGOs, communities) are outlined in Annex 3. It was also possible to obtain additional information during the Independent Monitoring and Review Group (IMRG) visit to Central Province.

¹ Madang, Manus, East Sepik, and Central Provinces.

The review was initially planned for November 2008 but was then rescheduled for April 2009, with a mixed team representing NZ Aid, UNFPA and the National Department of Health.² The review team wishes to thank all those at government, non-government, and community levels who generously gave their perspectives on the project and facilitated the work at every point. The semi-structured questionnaire which was used as a starting point for discussions with key informants at all levels is appended as Annex 4.

2. Main findings

2.1 Relevance of Project Design, Achievement of Outputs and Outcomes

2.1.1 National RH situation and appropriateness of project design

The project was built on the intentions of the National Health Plan for both safe motherhood and reproductive health and was consistent with the NZAID Multilateral Engagement Strategy (MES) which prioritized sexual and reproductive health and rights and more support for the Millennium Development Goals (MDGs). Reproductive health is extremely challenged in Papua New Guinea. According to the 2006 Demographic and Health Survey, maternal mortality (733 per 100,000 live births) has doubled since the 1996 review (based on data several years previously). Gender-based violence is common. This is the worst country for HIV in the South Pacific, now at the stage of a well-established generalized epidemic with an estimated prevalence of 1.6% in the reproductive age group and rising, and various sub populations with prevalence above the 5% threshold. There are many drivers such as gender inequality, violence, rural economic enclaves with male workers living away from their families, and deepening socio-economic inequities.

The key NZAID policy documents that were referenced at the design stage were both the NZAID Health Policy and the MES. The original project design intended to build on UNFPA's support to RH in four provinces, keeping two of these original sites (Central and East Sepik), and adding Western, Simbu, Bougainville, West Sepik and the National Capital District or NCD to total seven. The NDOH decided to keep Madang and Manus from the first project phase as some momentum had already been established. NDOH selected West New Britain, Morobe, and Milne Bay because their 2005 health indicators showed them to have poor maternal health.

As the project evolved, other provinces requested support (such as Enga). Total real per capita spending on health goods and services (including Provincial Government budget, development partners, and NDOH) had not increased by 2005 from a low inadequate base in 2001, and it was not seen by the NDOH as equitable that only some provinces would receive additional supports from this project and not others. However, the Review Team

² The project was to have been evaluated in November 2008, but the planned team leader Dr. Michael Douglas withdrew due to family illness, so the evaluation was rescheduled to precede the May 2009 Independent Monitoring and Review Group (IMRG) visit, with a new team leader for the review (who is responsible for RH/service delivery and human resources for health on the IMRG). As the IMRG tracks these issues in the sector, opportunities were recognized for synergy with HSIP monitoring and the UNFPA/NZ Aid RH review. The review team was comprised of Dr. Aham Isika, Chief Technical Advisor UNFPA, Dr. Betty Koka Reproductive Health Programme Officer UNFPA, Dr. Hilda Polume Principal Advisor Family Health Services National Department of Health part-time, and Dr. Gretchen Roedde of HERA (Health Research for Action) Team leader and report-responsible. Dr. Michael Douglas laid a strong foundation for initial planning of the provincial visits for the review, was able to meet with the new team leader early in the mission, and was available for consultation on key points.

could not find documentation specifically addressing the rationale for the geographic shifts in support, this was verbally communicated to the team by the FHS during the review.

Within the selected provinces the provincial health administration was asked to prioritize facilities for support which required urgent renovations. Some outcomes in the original project document were national in scope such as a comprehensive RH policy, a review of the Health Management Information System (HMIS) especially the Logistics MIS (LMIS), support to health promotion messages around safe motherhood and reproductive health and HIV prevention; and capacity building to the Family Health Services (FHS) section at the National Department of Health (NDOH). Others were provided at selected provincial and district levels, such as efficient quality RH services for women, men, and adolescents (Safe Motherhood, Emergency Obstetric Care or EmOC, Post Natal Care, Family Planning, prevention, screening and treatment of Sexually Transmitted Infections or STIs linked with HIV prevention; and procured RHCS and equipment) as well as RH training and upgraded Essential Obstetric Care facilities and skills.

It has been a challenge for the review team to track the shifts in the project design as these were not well documented. For example, no written reference could be found for the decision to add three additional staff mid project (in Reproductive Health Commodities, an admin assistant, and a driver), nor how this might affect other budget lines. Verbally it was explained to the Review Team this was based on the serious challenges noted in RHCS and the need for greater coherence in national RHCS programming, so this appears to have been a relevant mid course shift, but again, this is not clearly reflected in project files.

The first year of the project had several different technical advisors on short-term contracts (through WHO). Late 2007 the current CTA was recruited. Similarly, approximately 40% of the time of the UNFPA National Programme Officer who helps support RH amongst other tasks has been assigned to the project, which was not in the original design. Role clarification between this National Programme Officer RH and the CTA-RH are complementary but again, not well described. Until the current CTA was recruited, Betty Koka reported on the project, now it is Dr. Aham Isika. So it is possible that the varying reporting formats relate to these shifts in personnel and project design.

The roles between FHS and the UNFPA supports are also somewhat ad hoc. Where there are shared responsibilities (tracking financial expenditures) it has been difficult to clarify who is expected to do what. Similarly, HSIP in fact was found by the Review Team to have a broader overview of expenditures in the sector for EOC, by donor, than the FHS. Closer links therefore within NDOH (FHS and HSIP) might help improve the situation but the overload of work in both sections has resulted in information that is not updated.

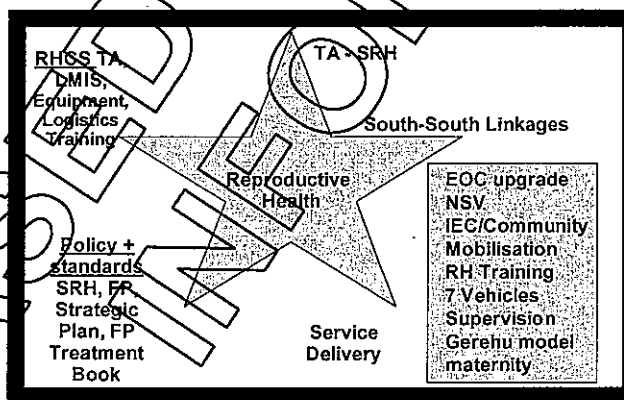
The original project design was highly relevant and comprehensive to address multiple levels of the system, and achieved additional synergies such as south-south linkages with facilitating other UNFPA Country Offices (CO, e.g. in the Solomons) to access the Non Scalpel Vasectomy Training (NSV) with their offices' own budget. The strategies to implement the project were integration with HSIP/FHS, support to monitoring and evaluation, linkages with the Medium Term Expenditure Framework (MTEF) and National Health Plan, an effort to respond to the challenges of decentralization, and to increase stakeholder involvement in implementation. Details of the extent to which these and other outcomes were achieved are addressed in chapter 2.4 with further details in Annex 6.

However, the project design did not have a log frame, did not link inputs, activities and outputs or outcomes. From various project reports and budget breakdowns the following table endeavours to link these.

Table 1 - Links Between Intended Inputs and Original Outputs/Outcomes³

Inputs	Outcomes/outputs
Chief Technical Advisor ⁴ and related travel etc. expenses	Reproductive Health/FP Policy (and others); capacity-building to FHS
Vehicles, operations research, fellowships, capital investments in upgraded maternities and equipment	RH service delivery supports, capacity building, non scalpel vasectomy and other RH training, model maternity at Gerehu health centre, improved supervision, community mobilization, Information Education and Communication or IEC; integration of HIV in RH services (including prevention, screening and treatment of STIs including HIV/AIDS).
Reproductive Health commodities and equipment (and staff added in mid-project); support from the regional country support team in Fiji	Equipment, supplies, logistics training
UNFPA overhead, audit.	Project management

Figure 1 - Comprehensive Project Design



The project design was well integrated with HSIP and the MTEF. Safe motherhood/family planning was one of the four priority program/public health strategic directions for the health sector (the others are immunization, HIV/AIDS and STI, and malaria prevention. TB has since been added). IMRG May 2009 noted maternal health has received a relatively low share of resources in absolute terms.

³ The project documents mix these terms, and they are listed differently in different documents, so the review has tried to synthesize the intentions of the project as possible.

⁴ In the first year of the project, different CTAs were recruited through WHO for 3 months at a time. Late 2007 a long-term CTA was recruited by UNFPA who has been asked by the NDOH through to UNFPA to extend his contract. In addition to the CTA, approximately 40% of the time of the UNFPA RH National Programme Officer is devoted to the project, and those related travelling expenses are charged to the project.

The project endeavoured to be comprehensive. As noted above, in response to the multi-faceted challenges of RH, support was provided to *service delivery*. This included EOC upgrades, training in non-scalpel vasectomy (NSV), IEC and community mobilization, RH training including HIV and STI prevention, provision of 7 vehicles to improve support supervision, outreaches and patient referral, and the development of a model maternity at Gerehu to relieve the pressure on the national referral hospital for routine deliveries.

South-South linkages were achieved by facilitating access to the Solomon Islands for NSV training in PNG.

Technical assistance in sexual and reproductive health was provided, initially by short-term and then longer term when a suitable candidate was recruited. This CTA has broad experience and appears to have been well utilized by the NDOH in a variety of roles including RHCS, the assessment of the needs in maternal health, support to NSV training etc.

RHCS was originally envisioned as equipment for the upgraded maternities, provision of female condoms (both as FP and HIV prevention), and test kits for syphilis testing in pregnancy which have been chronically stocked out. As the needs in the sector were recognized as being more challenged, linked with an ongoing crisis in drugs procurement, more supports were provided in terms of TA, logistics management training, and supports to the logistics management information system.

More support than anticipated was provided to *policy and standards*, such as the SRH and FP policies, the SRH and FP strategic plans, and an updated FP treatment book.

However, while the project design was highly relevant and its implementation somewhat flexible / responsive to upcoming needs, the strategies selected underestimated the challenges of implementation: the Human Resources (HR) constraints at all levels; the uncertainty in view of the NDOH restructure, and the variable management and leadership capacity at the decentralized levels. The strategies selected were relevant to the needs but not to the reality of the operating environment.

The impact of the NDOH restructuring and freezing of staff hiring could not have been foreseen at the design stage. The problem of working with two non-implementers (NDOH and UNFPA) should have been recognized at the outset as a design flaw. The challenges of working at the national level to implement at the decentralized level should also have been predicted, however, many development partners are facing the same challenge and the slow progress on revising the Organic Law with the Streamlining legislation has restricted many similar initiatives. The bottlenecks in HSIP could not have been predicted. At a sectoral level, this is now one of the triggers to a redesign of the SWAp to better respond to the decentralized context.

Other DPs have responded to this challenge differently. UNICEF does not put its money through the national HSIP system, but directly channels to provincial HSIP accounts for the specific initiatives it wishes to support.

The challenges have escalated during the implementation period. The lack of support and outright attacks by the central agencies on the health sector have been increasingly severe, of which the loss of the supplementary budget to Planning is a recent example. It is the Tender Board which has given period contracts to HSIP which have led to escalating prices from their suppliers so that direct procurement would in fact now be cheaper.

The environment is becoming increasingly difficult, with fragmentation of other donor inputs, multiple funding streams such as the supplementary budget which was also intended to

finance EmOC upgrades, and problems of governance and leadership. The pressure imposed on HSIP to manage large unanticipated grants from the Global Fund has escalated, even with additional staff that have been recruited and a large component of TA from WHO to help manage the grants. The integration of the project with HSIP looked good at the design level but contributed to bottlenecks in implementation as discussed below, and the fact that neither NDOH nor UNFPA sees their roles as implementers made it difficult to manage those elements of the project which did not occur at the policy level. These issues are further explored in 2.1.3, 2.1.4, and 2.1.5.

In addition, the fact that this project is integrated in an underfunded subsector has made it difficult to see impact and effectiveness. The National Economic and Fiscal Commission report "Closing the Gap" (January 2009) summarizes based on an analysis of 2007 spending: Health spending (including HIV) increased (because of HSIP and functional grants) by just over 10% between 2005 and 2007 – barely enough to cope with inflation and population growth, and distorted by high spends on HIV relative to maternal health. Health is relatively underfunded - it is intended this will improve with the increase in service delivery function grants to be spent on minimum priority activities (operation of rural facilities, integrated outreach patrols, and drug distribution). Health receives only 6% of internal revenues, which was a minimum pre-requisite to trigger access to HSIP funding. Education receives double this amount.

Health is the lowest priority of most provinces, and funding of primary health care continues to erode with closure of aid posts etc. Only Manus (it was a high-performing province in the 2009 Annual Sector Review and has also received project support) increased its support to health and achieved high performance relative to its fiscal capacity. Provinces only spent a third (including HSIP) of what was needed for a minimum level of service. HSIP expenditures are increasing. The nine highest funded provinces do not prioritize health. And within health spending including HSIP, too much is spent on administration and not on service delivery⁵. In medium funded provinces HSIP resources are making a difference. In the poorest provinces HSIP is a more important source of funding than their functional grant and internal revenue.

Summary – In a difficult context of declining health outcomes and a severely underfunded sub-sector of maternal health, this project has helped to keep government and DP focus on maternal and reproductive health. This project has endeavoured to integrate RH/maternal care (including STI/HIV prevention) in a sector wide approach, and in so doing has helped to counterbalance the major resources flowing into the highly projectized and heavily resourced disease control programs. The project design was highly relevant, and many of the challenges of implementation could not be foreseen.

Recommendation - The respective roles of the implementing agencies need to be considered by all parties. NZAID understands UNFPA's role to be one of coordination, advocacy, norm and standard setting but not one of implementing projects, unless they are pilots or meeting a significant gap that can't be addressed by other stakeholders. This is currently problematic. Until the Streamlining legislation comes on board, NDOH also lacks an implementing role. Given the serious challenges in maternal health, it needs to be acknowledged that UNFPA is meeting a role not addressed by other stakeholders. This needs to be carefully negotiated with NDOH, NZAID and UNFPA. Participation in the SWAp redesign may also shift the focus, as donors may channel money directly to the provincial HSIP accounts, so this will be an issue to consider at the design stage of any follow on project, and to be reassessed on an annual basis as the context can change dramatically over time.

⁵ Annex 5 outlines the priorities HSIP intends the health sector to allocate funds against. In reality, HSIP as well as other funding sources overspends on administration.

Recommendation - As per the NZ Aid PNG Country Programme Strategy, there is every indication of a high priority need for NZ Aid to continue its intention to keep supporting RH in PNG. The challenges of context are likely to continue, and may worsen. It may be difficult to see "results". An extremely long term view is needed, with good linkages between supports, such as NZ Aid is endeavouring with its support to midwifery training to help improve supervised deliveries.

2.1.2 Integration of project with HSIP and MTEF

NZAid and PNG are signatories to the Paris Declaration. This Review Team therefore assumes that NZ Aid is aware that project-specific achievements and attribution to a specific donor are limited in a sector wide context, especially when the original intention of the project was to strive for this very integration. The following comments therefore relate both to the issues around the integration with HSIP, as well as project-specific achievements. Section 2.1.4 gives further details of the monitoring of the sector wide approach as it relates to the activities supported by this project.

Project Management

UNFPA implements this project on behalf of NZ Aid, and receives an overhead for doing this. Their own financial tracking was observed by the Review Team to be weak. There is every evidence that the new Representative will be tightening management systems within the office, which should strengthen their role in the sector, and in management of a project such as this, considerably.

Annual backstopping was anticipated from the Country Support Team (UNFPA) in Fiji. One visit has occurred, and in another year the PNG RH staff went to Fiji to review their country programme as a project activity in lieu of a backstopping visit. The need for greater support to RHCS was identified as part of this backstopping and additional supports appropriately mobilized.

Shared responsibilities for management (NDOH, UNFPA, HSIP) have also added to difficulties, so that many tasks have fallen through the cracks or been assumed to be undertaken by other partners.

Though NZ Aid attends Health Sector Program and Finance Committee meetings, where issues such as problems with the supplementary budget and the NZ Aid EOC project have been discussed, UNFPA has not regularly attended these. This would be in the future an opportunity for a better interface to help resolve bottlenecks.

Monitoring and Reporting

Monitoring and reporting on this project have been inconsistent. It was difficult to determine how much of the budget was spent on fellowships, what equipment had been purchased, which facilities had been upgraded etc. either from NDOH or UNFPA. Isolated references (funds provided for travel, for workshops, vehicle purchase etc.) could be found going through extensive project files but there did not appear to be high level oversight to amalgamate this information. Financial tracking has been particularly difficult. In part this relates to the challenge of a project embedded in a sector wide approach, and whether the SWAp monitoring frame is sufficient or whether project-specific monitoring is expected. In part this also relates to the lack of a log frame at the design stage, and the decision not to track specific indicators of impact such as improved supervision, skilled attendance at

delivery or outreaches in those provinces which received additional support. It would still be impossible to attribute results, especially if provinces were selected based on the fact they were in high need and already underperforming. The evolution of the project over time has not been well documented and was a challenge to the Review Team to determine what changes (e.g. how the decision was made to hire new RHCS staff) had occurred, and why, and at what cost.

It is possible that some of the project challenges might have been addressed earlier, or at least better known, if the monitoring and reporting system was more robust.

HSIP is used for a variety of donors to channel funds to health activities. It receives earmarked (as in the NZ EOC Project) and pooled funds. Resources are tagged, so it should be possible to follow disbursements against the priority areas in the project at both input and output levels. It is the responsibility of the NDOH head of family health services to get an itemized report on the expenditures related to EOC and include that in the quarterly report to UNFPA to report back to NZAID. The CTA-RH and the RH Admin officer should be able to assist in getting the itemized expenditure and any expenditure not related to EOC should be reimbursed to EOC funds as it is year marked and a specific project. It is also the responsibility of the head of Family Health Services (NDOH) to ensure copies of request and expenditures are kept in their file.

This can be done for the remainder of the project but it is not possible at this stage of the review to obtain this information. Preliminary efforts by the review team found line items which were unclear as to their link with the EOC project (e.g. funding for integrated management of childhood illness, theoretically possible if the link is made with maternal and neonatal health), so further clarification will be sought by the UNFPA task managers but this will not be available in time for the finalization of this review. NZ Aid is aware this will be an evaluation limitation. UNFPA has committed to NZ Aid to tighten its own financial tracking of the project.

Funds Acquittal/management

An annual audit was anticipated at the design stage, but omitted as HSIP has its own audit process. Concerns have been raised elsewhere (IMRG May 2009) that there may have been some loss of integrity with a shift to a more nationalized auditing function within HSIP. This will be addressed at the sectoral level.

It was not possible to obtain an analysis of NZAID funds provided for this project, per year against expenditure, nor by project component per year including administration. A draft format for this was provided to both NDOH and UNFPA by the team leader of the review and copied to NZAid to complete for the remainder of the project period. The reasons for this lack of information are unclear, but will require tighter role definition between NDOH, UNFPA, and HSIP as well as more robust responses to the funders' requests for this information.

As one component of the review, information was obtained from HSIP-MB on all of the different capital investments and maternity renovation "EOC" projects⁶, funded from all sources including NZAid. These Excel files have been forwarded to UNFPA and NZAid as they illustrate in particular the overlap with the supplementary budget funded activities, and it is urgent to salvage as much as possible from these high priority activities.

Transaction costs of accessing HSIP are high. The District case study (2008-2009) which is looking at ways to get direct funding to health facilities, found facilities spent more trying to

⁶ These were the latest available information at HSIP-MB, but were not completely up to date.

get money through various red tape bottlenecks (1650 kina), than the cost reimbursed (1250 kina) for in this instance, repairs to an ambulance.

The same study found facilities are highly dependent on user fees a third of which are spent on drugs. Well documented global evidence has shown user fees are a barrier to care particularly for women. In PNG maternal care is supposed to be free in government facilities, but the Review Team for this project found women are charged for other items (use of a mattress for example, 10 kina) and are charged in church facilities for deliveries at an even higher level. Women were also noted during the Review to be paying for ambulance rides to access emergency obstetric care, often several hundred kina and also having to pay for hospital EmOC, all in violation of the National Health Plan.

While HSIP is under-expended, much of the reason for this is bottlenecks in distribution of funds (e.g. no funds were disbursed for three months in 2009 because of its audit) which constrains service delivery. More money is being pushed to provincial levels, but better management and priority setting is needed at lower levels (see Annex 5). The annual activity planning process is cumbersome. Plans are not yet formalized to get funding directly to health facilities. Money has been available from this project for clinical rotations of nurses and CHWs to update obstetric skills in provincial hospitals, very few provinces have tried to draw down this money according to the NDOH, although the provinces see the problem differently, as illustrated in the following stakeholders' perceptions from the community consultations:

"We cannot get anything done. The money never comes from HSIP. It slows down our activities! We should have the money in the provincial HSIP account." Provincial MSV

"I keep trying to get funding for clinical rotations for my rural nurses and CHWs, as well as preceptor training for their teachers. For three years I have put it in the AAP. It never gets funded." FHS co-ordinator at provincial level in a NZ EOC Province.

The Integration with AAPs and HSIP can be a bottleneck as flexibility is limited. This is not limited to the NZ project. For example, in September 2008 Kainantu was going to reopen its maternity. CBSC had funding available for a whole of site approach to EmOC training with the WHO advisor. The people wanted to be trained, to respond to a new service, the money was available, the trainers were available, but because the activity was not in the AAP it was not allowed to go ahead.

Within health sector spending including all sources, maternal health receives the least share. Disease control programs and immunization can access funding from the global health initiatives, but maternal health is last on the list for funding, so in most provinces and districts less than a fifth of maternal mortality reduction activities are funded. Annex 5 illustrates this with photos from one of the project provinces showing the deplorable state of most maternities at health centre level.

At least a third of this project was support to infrastructure to support essential obstetric care upgrades. Little of this has been spent. Capital investment will have recurrent cost implications which need to be resolved with better allocation of funding to goods and services. ESC was to receive additional resources (\$160 million) from the supplementary budget to complement NZ funded activities. For a combination of political reasons, these

funds were withdrawn from the Trust account managed by the NDOH/HSIP leaving unmet commitments for EOC. Similarly funds for nurses and midwives accommodation have been withdrawn. The challenges of a project trying to co-finance activities with other budget holders are reflected in these stakeholders' perceptions again solicited during the Review Team's consultations:

Father Jan's story

Head of a FBO teaching (rural doctors, midwives, CHWs) facility which is in a provincial capital. Upgraded maternity built but money cut off from frozen supplementary budget so contractors' bills unpaid.

Dr. William's story

Motivated medical officer at a provincial hospital who can do C-EOC. Hospital still resourced at the level of a health centre, staff shortages, terrible set up for maternity and C-EOC. Money promised since 2006 from supplementary budget and NZ EOC project, nothing yet.

Some improvement may be expected with the adoption in 2009 of the intergovernmental financing reform which will allocate more resources to poorer provinces.

The whole resource envelope available for health is not tracked. District politicians have received 1 million K for health and 1 million K for water and sanitation for their districts. There is little accountability for this money. Some vehicles and some delivery beds have been purchased, highly dependent upon the motivation of the local politician. UNFPA has lobbied for these funds to be used for maternal health. The Parliamentary Group on Population and Development is one such body that could push for this further.

Charlie's Story

Nursing officer in charge of a health sub-centre. Local politician provided a vehicle from government funds, for patient transfer and supervision. His supporters came and took the vehicle for their own use. Charlie has taken them to court but had to abscond from his job and was rehired at the district level.

Expenditure against budget

Financial tracking of the project has proved difficult. May 20 2008 (email correspondence on file in both agencies) NZ Aid requested UNFPA to update spreadsheets by requesting HSIP to reconcile expenditures quarterly to ensure UNFPA disbursements match HSIP releases. This has not been done in spite of repeated requests to HSIP MB. It has also proved difficult to release and track funds disbursed to the provincial HSIP trust accounts for program implementation. In the original project design, an annual audit was planned (\$5000), instead UNFPA relied on the HSIP audits. When irregularities were noted (UNFPA requesting three

quotes for computer purchase as per HSIP guidelines, HSIP then procuring a computer from a different source for three times the amount), there was no mechanism to follow this up. Strengthened UNFPA financial procedures should improve this. The Independent Monitoring and Review Group (IMRG) May 2009 has also followed up this issue as other Development Partners (DPs) such as ADB, and the NDOH have noted inflated prices as well.

A draft format was developed as an output of the review for UNFPA to use to assess planned expenditures in the project against actuals, for each year of the project. This will not be completed for incorporation with this report, but the partially completed draft with some indicative costings was circulated to UNFPA to use as a guide in their own work, and to NZ Aid for information purposes. Meetings have been held between UNFPA and NZ Aid to formally assess how to rebudget the remainder of the project, and to strengthen project technical and financial reporting.

In general terms, of the USD \$2 million, approximately \$800,000 is unspent. The CTA position will need to be rebudgeted, as only 2 years were originally envisioned. All 7 vehicles were purchased and distributed, but in the provinces visited, only Enga had a logbook to ensure the vehicle is used for priority purposes. It is not possible to track whether increased supervision or outreaches or patient transfer has occurred as a result of the vehicles. 4 boats were also acquired, though it is not clear if these were charged to the NZ project or another UNFPA fund. Travel and per diem were originally costed for just the CTA. In addition, 40% of the time of the UNFPA National RH Officer is charged to the project, as well as the occasional travel (e.g. to ceremoniously handover vehicles) by the UNFPA Rep and Assistant Rep. Of the 3 planned missions from the Country Support Team (CST) only 1 has taken place, to review RHCS. However, several UNFPA staff traveled to Fiji to discuss the Strategic Plan for RH in UNFPA, which could be considered one visit. Only one operations research activity has taken place, for much lower cost than intended, but the results of this (antenatal care in Enga Province) were never communicated to the Provincial Health Advisor so there has been no impact on service delivery. The \$300,000 intended to be spent to upgrade Gerehu maternity clinic has not yet been spent, the initial part of the upgrade has been done (not according to plan) by money from the supplementary budget. The money for fellowships will likely be spent, although some students will still be in training when the project ends in January 2010 so some mechanism will be needed to continue support to them through the end of their course. NSV training has occurred and should be within the budget, as have co-ordination meetings, support to RHCS. A bridge mechanism will be needed to assess how to transition the current staff who have been recruited with project funds (not originally planned) when the project ends unless that component rolls over into another phase. The evaluation took place as intended, though has now been linked with the IMRG May 2009 review.

Summary – This project has faced the same challenges of other health sector stakeholders of managing centrally (through HSIP, UNFPA and NDOH) in a highly decentralized environment. It has been difficult however to track project-specific inputs and outcomes, some of this is a contextual problem in a sector wide approach, some of this is a weakness on the part of the implementing agencies (UNFPA and NDOH).

Recommendation – The integration of projects such as this within HSIP has represented considerable challenges. Any follow on project needs to factor in role definition (NDOH/HSIP/Provinces/districts) more tightly; as well as to decide what additional monitoring information is needed that is project specific and what can be mobilized from the sector wide indicators. The opportunity to use a downstream project such as this to leverage upstream policy support e.g. to address the impact of user fees should be recognized as a responsibility of all implementing partners. NZ Aid needs to be clear that additional

monitoring tasks will require substantially more support⁷, and to also decide to recognize that one result of integration is the loss of project specific data. UNFPA needs to be more robust in its own responsibility to track project activities and expenditures, and work collaboratively with NDOH/HSIP to ensure this information is available. Tighter project management by UNFPA is necessary to track financial expenditures and rebudget the project for the remaining year.

2.1.3 RH capacity at national, provincial and district levels

The MTEF in PNG did not include salaries until this year, and is incomplete. Because of problems with HR, insufficient salary posts, "ghost workers" on salary but not in post, lack of clarity between levels of government on HR management, and a current freeze on health sector hiring etc., many health staff are paid out of goods and services funding as casuals. The MTEF (currently being revised) does not yet prioritize PHC, define allocations between levels, or track resource flows to maternal health etc. This has meant that there is insufficient RH staff in key positions to help address maternal health and HIV prevention.

The RH capacity building efforts of the project was limited by these HR constraints at all levels. For example, the FHS unit is overstretched so it is difficult to send people for training if there is no-one to back fill their positions. It is not possible at the present time given weak project documentation to quantify how many people have been trained, at which cost, in which types of skills, in order to strengthen the capacity of the FHS division of national and provincial, district health authorities to deliver quality RH services.

However, sifting through the extensive project files even in the absence of well documented high level oversight with quantitative gender-disaggregated information, it was evident that an important feature of the project has been its efforts to recruit candidates and fund RH training at different levels. It is not yet possible given the weak financial tracking to specify what proportion of the budget was allocated to this, but the project files show this was an important priority, gave preference to women, and appears well targeted. Of the original six planned fellowships for doctors in public health, this was appropriately shifted to four nurses for midwifery upgrading, only two physicians given long term fellowships, and several nurses and midwives given exposure to RH training in short regional courses and clinical attachments in country. At the community level Sexual and Reproductive Health (SRH) advocates were trained, especially in Enga, linked with general community Information Education and Communication (IEC) in RH. Men have been trained as partners in RH. HIV prevention has been prioritized in IEC, and adolescents have received some inputs though this could be further strengthened in view of the high proportion (at least one third) of maternal deaths occurring in adolescents as well as their role in driving the HIV epidemic. FHS at NDOH is requesting support from the CTA of the project to develop guidelines for Adolescent Sexual and Reproductive Health (ASRH) services in the country.

The decentralized context is one where the national level has a normative standard setting role while responsibility for service delivery lies at provincial and district levels and relationships between the levels are not very effective. This has contributed to difficulties in determining the appropriate types of capacity building required at each level.

Summary - The RH capacity building efforts of the project was limited by the HR constraints at all levels, even if it has made major efforts dates and fund RH training at all levels. This

⁷ E.g. the Global Fund has increased staff in HSIP, as well as in WHO, to help manage their grants.

project now needs to mobilize greater stakeholder involvement and focus more resources to the critical issues facing this sub-sector. This will include strengthening support for enhanced roles for nurses, midwives and community health workers in strategies to reduce maternal mortality: family planning, skilled attendance at delivery and essential and emergency obstetric care.

Recommendation - Important supports to improved RH capacity are: provision of fellowships for upgrading nurses as midwives; other supports to midwifery training to improve the quality of teaching and the numbers that can be trained; and the need for support to clinical rotations for service providers from rural units to the provincial hospitals. All health care providers have a mix of service delivery and management support roles, it is inappropriate to artificially separate these by output level. A follow on project should also consider linkages to strengthened CHW training as these are the service providers who do most of the deliveries, the links to the community for IEC on HW, and FP promotion. To the extent that UNFPA or NDOH becomes involved in these areas, better and gender-disaggregated documentation of numbers trained, the cost, location, types of training provided etc. will be needed for any subsequent evaluation. In addition, consideration should be given to raising this to the sectoral level monitoring, such as the numbers of clinical rotations which could help to show improved working relationships between the hospital and rural health services level.

2.1.4 Overview of achievement of project outcomes and outputs

Annex 6 details an assessment of this project by output/outcome level and their current implementation status to the extent it was possible to ascertain given weak project documentation.

In general, policy level achievements and the provision of RHCS supports exceeded the project design⁸; vehicle provision was achieved as per the project and was well documented; RH training, and the provision of TA achieved the intentions but were poorly documented, and EOC upgrades and the provision of equipment for maternities have been extremely challenged by the context of working in a decentralised service delivery environment. Clearly, efficient and quality RH services have not been provided in such a challenged context regardless of the project's intentions, and those of all sector stakeholders.

The current monitoring frame for the sector wide approach in PNG includes an Annual Sector Review (which tracks several key indicators), an Independent Monitoring and Review Group which reports to the government of PNG and its development partners including NZAid and which has visited PNG twice a year for the last three years, and there was a Demographic and Health Survey conducted in 2006 which addressed maternal and reproductive health amongst other topics including gender based violence. NZAid has committed itself to the principles of the Paris Declaration on Aid Effectiveness which limits parallel monitoring systems. At the present time, regardless of funding modalities, many of the areas of concern funded by NZAid's support to PNG through UNFPA have shown limited progress, a concern to the Government of Papua New Guinea and its development partners:

- The Annual Sector Reviews which track the sector wide approach or SWAp in PNG (under the HSIP) have shown no improvement in supervised births since 2002 which are estimated at just over one third of women, although the DHS 2006 shows this may be higher, closer to 50%.

⁸ Although as the RH policy is just being finalised, it is not time tested.

- The project's investments in infrastructure upgrades, RH training, and medical equipment are at such a preliminary stage and so geographically diffuse no impact would be expected.
- The sector does not track access to emergency obstetric care but barriers are well known with widespread unregulated user fees for maternal health in spite of the National Health Plan providing free maternal care as a policy, adding to the geographic and transportation barriers.
- In spite of the concerns about user fees as an issue, they have not really been high on the agenda of the sector partners but are increasing in visibility.
- The lack of a baseline for the availability of EOC and the fact that availability is not tracked, nor utilization (repeatedly raised as a concern at the sectoral level by IMRG) limits an assessment of this component of the project.
- Neither UNFPA nor NDOH have analysed the ASRs from the point of the view of the project inputs. With the limited or non-improvement in supervision and outreaches, it is not possible to attribute this as either a project success or failure as the inputs have been few (vehicles, seldom tracked with log books).
- The provision of essential drugs including reproductive health commodities has been extremely challenged which is problematic and appropriately has led the project to negotiate for additional funding (\$800,000) for RHCS.
- The positive momentum for family planning (see section 3.4 table 2) has assisted with procurement of female condoms (FP and HIV prevention) but stock-outs persist especially for injectables which will benefit from the proposed investment multiplier support.
- The positive momentum for family planning will benefit from the FP Standard Treatment Book when it becomes available, especially if it is geared down at a subsequent stage to CHWs.
- In spite of high rates of syphilis, screening for syphilis in pregnant women is hardly ever done (no testing was seen during the Review, and this issue continues to be raised as a concern by other partners such as WHO) because of lack of test kits. But the project has responded appropriately with limited procurement of simple test tests which should be increased.
- The limited progress in adolescent pregnancies makes this an important area of focus of NDOH and its CTA-RH.
- The project showed flexibility to adapt to changing circumstances and take advantage of new opportunities, e.g. with a mid course addition of staff to better support Reproductive Health Commodity Security, and redirecting resources to midwives rather than physicians as a primary target group for training.
 - The intended outcomes were delayed but positive unintended results also achieved (support to the Ministerial Taskforce on Maternal Health, support to upgrade midwifery training by planning to add midwifery at a nursing school in Rabaul, South-South linkages with NSV training in Solomons).
 - There were problems with the supplementary budget, which was withdrawn from the health sector⁹ and which co-financed many activities, constraining this project (EOC at Gerehu and elsewhere). More health strategic leadership is needed, with improved links to Planning which is now overseeing that budget, to ensure at least some of those activities will be financed.
 - Although 60% of the project funds have been expended, the lack of documentation of actual expenditures makes it difficult to determine effectiveness, efficiency, impact or sustainability. Three additional staff have been recruited (RHCS, an assistant and a

⁹ Both the Department of Planning and the Minister of Health had criticised the NDOH for not programming these funds quickly or effectively enough. In September 2008 over 200 million K for facility EOC upgrades and an additional allotment for nurses' accommodation was removed from the health sector by the National Department of 3.4 Table 2) Planning. The status of these funds and whether they are still available for these high priority health investments is currently unclear. This matter was forwarded to the IMRG to follow up further in the May 2009 mission.

driver) and it is not clear which line items in the budget will now have less resources as a result. The money allocated for the Gerehu clinic (\$300,000) is listed as expended, but in fact, only some equipment has been procured, and the allocation of NZ Aid money for the facility renovation has not yet taken place because the original project design has not been followed. This should be salvageable.

A project providing additional financial and technical resources in a context of worsening maternal mortality has to be highly *relevant*. However, reproductive health services are not showing improvements (*weak effectiveness and impact*), and there have been problems co-ordinating inputs from different partners which limits *efficiency*¹⁰. The severe government under-resourcing of the health sector raises serious questions of *sustainability*. The original project design was limited in terms of objectively verifiable indicators to assess the project. There was no log frame for example. While the sub-programme under review has some features of a "project", in fact it is well integrated with the entire health sector. Some of its engagement was national (policy level) and some provincial (facility upgrades) and some at district level such as training sexual and reproductive health advocates and the geographic boundaries changed over time, and many of these upgrades and equipment purchases have not yet taken place.

The links between a "project" and a "sector wide context" are complex. Should the project partners have pushed for stronger sector monitoring and strategic change on the basis of the ASRs and IMRG findings? For example, there was limited documented response by NDOH, UNFPA and NZ Aid to the findings in the ASRs that supervised deliveries have not improved over the last three years.

The fact that access to and availability of emergency obstetric care (EmOC) is not tracked and one missed opportunity was the omission of a question of Caesarean sections in the DHS which might have showed geographic and equity differentials in availability has been somewhat supported at a recent Summit, requesting an EMoC indicator be developed which hopefully can be part of the SWAp redesign.

Supervision of health facilities has shown little improvement and it is not possible to attribute this to the availability of the vehicles provided by the project. Outreaches have not improved. There is little improvement in adolescent pregnancies which account for at least one third of maternal deaths. The momentum in family planning is encouraging nationally and this project has been one support to family planning in terms of commodities and training in vasectomy. Many efforts by donors have not been well co-ordinated or are weak (testing of syphilis in pregnancy which the project did try to support well vs. stand alone underutilised Sexually Transmitted Infection Clinics from other donors.) Midwifery training which the project tried to assist indirectly was so troubled by quality that there has been the loss of two consecutive years of intakes and the graduates of several previous years could not be registered because of concerns over their skill levels. However, NZ Aid has responded very positively to this crisis in maternal health with enhanced support to midwifery training in a multi-bilateral engagement with WHO.

In such a challenged environment, it is therefore not possible to directly attribute achievements, or lack thereof, in the health sector to an individual donor's inputs. The Review Team has assumed that NZ Aid is well aware of this limitation as it has committed to sector wide engagement and the Paris Declaration.

¹⁰ For example, several different partners are independently procuring condoms. This project has tried to co-ordinate all players in this specific regard but this has been difficult as HIV is managed fairly separately from other aspects of the health sector.

The release of the 2006 DHS which showed a doubling of maternal deaths has raised serious attention to the problems of this maternal health sub-sector. Unfortunately, though the government of PNG responded in 2008 with the creation of a Ministerial Taskforce on Maternal Health, there has been no finalised report or action plan as of the time of this current review in June 2009. This would be an opportune time to mobilise political, financial, and technical attention to the serious situation of maternal health, and every effort should be made for the operationalisation of appropriate government led recommendations within the remainder of the project period, as well as to consider support in a follow-on project if this were to occur.

Summary - This project has faced the same challenges of other health sector stakeholders of managing centrally (through HSIP, UNFPA and NDOH) in a highly decentralized environment. It has had significant successes at the policy and standard setting level. It has helped to model best practices level in terms of its community level engagement helping to mobilize grass roots participation in reproductive health. It has made strong contributions to strengthening RHCS and this will be extended.

Recommendations - *Equipment procurement* should begin immediately, rather than waiting for facility renovation. *Transition planning* will be needed for the additional staff hired under the project e.g. in RHCS and with the planned geographic shifts in project support. A *higher profile* for both NZ Aid and UNFPA in sector dialogue to mobilize far more attention and resources for maternal health would link this project to wider sectoral issues (the need to access what can be salvaged from the supplementary budget also intending emergency obstetric care upgrades, issues of human resources and health system strengthening, direct funding to health facilities). Continued work to strengthen the roles of CHWs in RH and SM/FP, as well as to promote more nurses for midwifery could help position this project with plans coming onstream to reduce maternal mortality. More work is needed by the CTA to work with FHS/NDOH to help develop an ASRH strategy.

Work can be planned, and discussions can begin with NZ Aid about resourcing this in a follow-on project, to make a more *CHW-friendly version of the FP Handbook*. At the present time and format, it is geared to doctors, HEOs, and nurses.

Once the Ministerial Task Force on Maternal Health presents its report and action plan, the project should try to help operationalize these and look towards incorporating these strategies in a follow on project.

2.1.5 Constraints encountered and how they were addressed

Role of partners

It was challenging for the project to have two non-implementers (UNFPA and NDOH) trying to struggle with the practical difficulties of the project, which included problems accessing funds through HSIP. There were many complaints from the field that this contributed to a "NATO Alliance" (No Action, Talking Only). But policy level achievements exceeded the plan as detailed in Annex 6. And to some extent, UNFPA decided it had to engage as an implementer, becoming directly involved in training, or in brokering negotiations between dysfunctional levels of the system. They did not go as far as UNICEF, which often implements more directly in certain geographic areas.

Linkages between HSIP national and provincial accounts

Weak linkages were noted between levels, such as HSIP in NDOH and the provincial HSIP accounts, as well as between the national level Health Facilities Branch and provincial level works departments, hospital level architects and carpenters etc. which made construction and renovation of facilities very difficult. A typical example occurred in Bogia Health Centre in Madang Province. This is a government facility¹¹ which is very large and capable of handling a large teaching load for rural doctors, nurse and midwives, CHWs etc. The facility was surveyed in 2006, and was to be upgraded with multiple inputs (provincial budget, supplementary budget, and NZAid for the maternity). UNFPA co-ordinated a meeting of all stakeholders Feb. 26 2008 (NGOs, private practitioners, Divine Word University, the Provincial Works Department, the Governor, the Health centre in charge, and the Provincial Health Administration). Since then there has been no progress.

Lack of strategic leadership

Some of the challenges faced by this project have been brought up to higher level dialogue. For example, this project has tried to support clinical rotations of rural staff to upgrade in obstetrics at provincial hospitals. The need for a sector indicator that might see how well hospitals and rural services are working together includes the numbers of clinical rotations, which might help motivate provinces to organize these. A DP Summit resolution affirmed the need for a comprehensive RH policy, which will include links with HIV. As noted in Annex 6, this comprehensive RH policy has been achieved by the project. An earlier Summit identified the need for a capital asset management replacement program, the experience with this project shows this need clearly. The Summits have also prioritized rural hospitals for safe motherhood upgrades. The need for better feedback of the findings of the ASRs to health facility staff during supportive supervision has also been raised at the Summit, this was also observed by this project. So the project can provide a grounded perspective from its downstream work to help inform upstream policy dialogue.

Some problems have not been addressed at higher levels, and affected the implementation of the project. For example if a medical officer is not in post (e.g. on salary but has not worked for over a year), as in Angoram Health Centre in East Sepik, no renovations can take place nor medical equipment be provided. The Provincial Health Advisor has not been able to convince the provincial administrator he should be sacked and replaced, hence no project inputs can be provided to Angoram.

Gerehu is another example where an impasse has occurred between HSIP, St John's Ambulance, and NDOH. UNFPA has not been able to resolve it. The upgraded maternity is not according to plan but is intended for opening at the time of this Review, and further work is needed to ensure that the unspent \$300,000 from NZ Aid money (renovations and equipment) is appropriately spent.

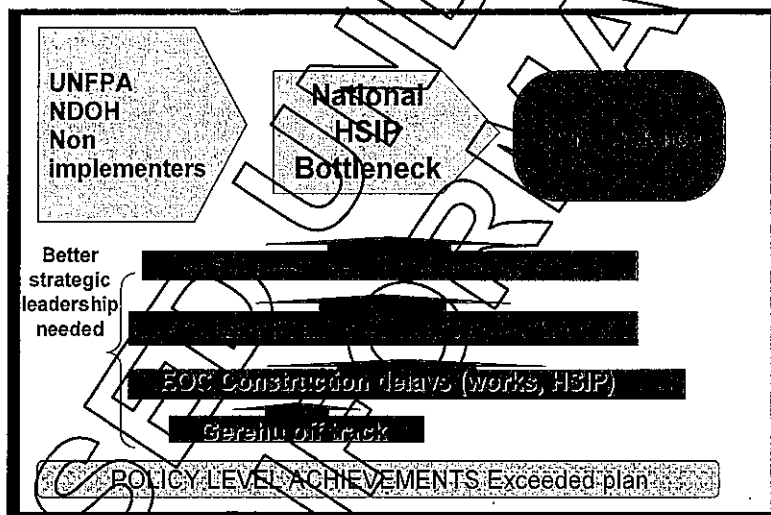
There is also some need for tighter financial management. This may seem paradoxical in view of the problems of the HSIP bottlenecks. But the fact that this project, other parts of NDOH, other DPs such as ADB, are noting that they are spending three times more for office equipment than what they could buy through competitive bidding on the open market, is problematic. One reason for the bottlenecks at HSIP was to ensure value for money. The fact the Tender Board has awarded a period contract for HSIP to a supplier that is now overcharging is an issue that needs to be brought up to higher level strategic dialogue.

¹¹ Though a government facility, Bogia has good connections with Divine Word University who want to help with its upgrade in order to host its students there.

Summary

So in this context, policy achievements can exceed the original design as noted at the base of the following figure, because this follows the appropriate normative roles of NDOH and UNFPA. But anything at the direct implementation level, such as the construction of the maternity at Gerehu, the other EOC constructions, equipment purchase etc. has been problematic and suggest the need for more direct funding to provincial levels, as well as tighter financial tracking. The figure below was developed in the course of the review by the various stakeholders in our consultations. The districts and provinces, endorsed by NDOH and UNFPA, complained bitterly about the non implementers NDOH and UNFPA “managing by remote control”, limited by the bottlenecks at HSIP to get anything done, and leading to a “NATO Alliance” – No Action Talking Only. It is difficult to determine how much of these problems are contextual, how much should have been anticipated at the design stage, and how much could be improved if UNFPA and NDOH tighten their project management. The fact that the whole SWAp is about to be reviewed and/or redesigned because of the lack of improvement in health indicators suggests these problems are not unique to this project.

Figure 2- Challenges of Implementation



Recommendation - NZ Aid, UNFPA, and NDOH should participate closely in the SWAp review process. This should change the context considerably for any follow on project. UNFPA can be considered a necessary gap filler, if so instructed by NDOH, to try to fast track implementation at this time for the remainder of the project period.

2.1.6 Integration of gender concerns

The project addressed gender by trying to focus attention on the critical and worsening problem of the doubling of maternal deaths between the 1996 and 2006 DHS rounds, and also conducted training in male involvement in family planning and sexual and reproductive health. Men were now observed for example in Enga, accompanying their wives to deliveries, and helping to build maternity waiting homes of bush materials. The project shifted the focus of RH training towards more female providers (nurses and midwives) and

away from male doctors. The project encouraged female sexual and reproductive health advocates and the wives of CHWs to support male CHWs in view of cultural sensitivities around birth. Gender based violence was addressed in community level IEC training, and the RH national program officer attached part-time to the project by UNFPA received additional training (May 2008, funded by other sources and linked with a visit to NZ Aid to maximize the use of resources) in the links between substance abuse and GBV, a serious problem in PNG, to help her with her own training inputs. The RH policy developed during the project, as well as the RH strategic plan, address GBV. The very positive shift of this project, towards a long-term male method (NSV), is an extremely important gender move as family planning globally has been female targeted, and again globally, women usually have a desired family size lower than men.¹² So any strategy that promotes men to take an active role in limited their families is very positive. Female condoms have been provided as both a female controlled FP method, and a female controlled HIV prevention method. But of concern in the sector as a whole, is the lack of representation by women on the HSIP Finance Committee at provincial levels. The Hospital CEO, and the PHA are usually signing authorities, and are usually male.

However, project gender-disaggregated data was absent (e.g. from training activities which were weakly documented in any case). The RH and FP policies addressed gender equality and women's empowerment, and for example, affirmed women's rights to family planning services without spousal consent. The project did not address the user fees issue so as to enable women's access, and in fact, this has been weakly analyzed at the sectoral level as a whole by all partners. The World Bank has offered to look at the impact of user fees, this has been declined by NDOH. The World Bank has offered to do an equity analysis of the DHS which would likely show that poor rural women are largely excluded from safe maternity care, this has so far been declined by the NDOH.

Summary - The project responded well to many concerns of gender in a very difficult environment.

Recommendations - More work on gender-disaggregated data and tracking this issue specifically would be of benefit in a follow on project. Support is needed at higher level dialogue on user fees, and a gender/equity analysis of the DHS data.

¹² It is recognised that non use of barrier methods e.g. condoms is an issue in a country with a generalised HIV epidemic. However, as FP is the most cost-effective maternal mortality reduction strategy, PNG is also a country which has seen a doubling of maternal deaths, so all FP is endorsed by the Review Team. Similarly, breastfeeding also transmits the HIV virus, but because the risks of diarrhoea/dehydration are higher than HIV deaths for the infant, all the UN agencies are endorsing universal breastfeeding in PNG even for HIV positive mothers. The community level IEC that has been done has discussed dual protection, e.g. condoms for HIV prevention as well as other FP methods.

3. Lessons learned

3.1 Value for money of project approach and risk management strategies

Unfortunately, due to the weakness of project financial and activity monitoring, it is not possible to outline how much each intervention has cost and the comparative results. It is therefore difficult to fully determine to what extent the project was successful in achieving value for money. This is not unique to this project – all sector stakeholders are currently grappling with the problem of large sectoral investments and extremely modest achievements, as well as difficulty tracking actual expenditures against activities (see IMRG May 2009).

The increased project attention to RHCS has led to an investment multiplier effect, with an additional \$800,000 being mobilized (an agreement should be signed in June 2009) from UNFPA Copenhagen for RHCS procurement. The original design targeted only doctors for masters in Public Health or RH training, more staff especially nurses have been trained in PNG and the region with the same amount of resources.

Efforts were made to save money (not upgrade totally dysfunctional buildings, only provide resources if the in charges of facilities were in post, provide equipment¹³ once the facility was upgraded, and achieve economies of scale with bulk purchases as well as to obtain quotes from different service providers.) Training courses tried to get value for money with use of in-country training where possible. UNFPA endeavoured to screen requests for resources for their appropriateness and cost benefit. Efforts were made for multi-purpose events such as the RH strategic plan development in Madang in February 2008, and more work was done to progress the EOC upgrades in that province at the same time. Strong efforts were also made by UNFPA to try to lobby for more resources for maternal health from provincial and district budgets, with varying degrees of success. A good example of this strong lobby is that some parliamentarians have decided to support RH programmes through the Parliamentarians in the PNG Population and Development group.

The community level engagement has generated momentum and even though it is relatively costly to use UNFPA to help mobilize community development,¹⁴ it has had a multiplier effect as well in terms of grass roots response which is creating a bottom up demand for improved services and increasing facility births. Similarly, though the per patient cost of NSV is high as travel and accommodation costs have been borne by the project to bring in patients as clients and to facilitate training of other providers, this will have long term impacts to increase male involvement in FP, and increase the roles of CHWs in NSV. Couple Year protection (CYP) goes up by 9 years if one partner is sterilized, nationally CYP increased 10% last year particularly in provinces with good records of sterilizations. UNFPA could help track the provinces in which they have pushed for NSV, to see how well it is reflected in this indicator in the ASR (indicator 13a). The training of men as partners in FP was also seen initially as costly by NDOH, but has had good spin off effects at the community level breaking down gender barriers around birth, sexuality, HIV, violence etc.

¹³ It is now recommended by the Review Team that procurement take place immediately because there have been so many delays in the construction and renovation components of the project.

¹⁴ It costs several thousand kina in travel and related expenses for the community development training that has taken place in the project.

However, more money was spent than planned on travel and allowances, and the allocations for computer and related equipment for highly placed technical advisors in both the project and their counterparts had not been envisioned in the original project design and will displace resources from basic equipment such as delivery sets in facility maternities. Shifting of resources towards administration is problematic in the rest of HSIP and other health sector funded activities.

Travel and accommodation costs are high in PNG. For example, even when three quotes were obtained, K2534.62 (over \$1500 NZD) was paid for a 3 day hire in Lae July 2007 (req. 299 PO #388). It was however unclear from reading the project files why senior UNFPA (not project) staff needed to travel and charge the project for this, rather than cover this with UNFPA overhead. Examples were also found where a province offered their own vehicle, and instead the project at NDOH request hired a very expensive vehicle including armed guards to travel to an area not deemed insecure by the UN. On a subsequent visit when this same request for an expensive vehicle hire from the same firm was made, UNFPA refused the armed guard component as a cost saving measure, informing NDOH this area did not meet the UN rules for that level of security. Other problematic areas have been the purchase of office equipment such as computers for project and NDOH staff. UNFPA has obtained three quotes, and could have done their own procurement more cheaply. HSIP has period contracts with a supplier, a contract awarded by the Tenders Board, and the supplier regularly charges prices up to three times higher than direct purchasing. This problem was noted by several donors as well as NDOH staff and is affecting the credibility of HSIP.

There have also been problems of poorly co-ordinated work.¹⁵ As NZ Aid was providing support to upgrade maternities, but the supplementary budget was paying for general facility renovations, teams have gone out just for the EOC component which was not linked to the general work which could have been assessed at the same time. Health Facilities Branch would do a survey in 2006, much of this work would need to be redone at a more detailed level by the Provincial Works department to allow tendering to occur. Poor communication between stakeholders has constrained some project components, such as the Gerehu maternity, where neither Health Facilities Branch, the NDOH, St. John's Ambulance, HSIP etc. are happy with the result and work may need to be redone. The delays in HSIP disbursement mean some jobs will now need to be recosted as prices have escalated.

These difficulties of implementation have required a lot of work by UNFPA to manage, but they also need to demonstrate more effectively that they are earning their overhead by responding to requests from the donor for better financial tracking. With the short time remaining, activities need to be fast tracked by delegating greater authority to the provincial Works department to move quickly on the renovation components. However, it is the responsibility of NDOH to screen and make a request to UNFPA for resource mobilization based on activities planned in the Annual Work Plan.

Working through HSIP, which is the most tightly controlled financial disbursement available under Papua New Guinean control, is already a risk management strategy. HSIP has been under conflicting pressures from different DPs who are more, or less, risk averse. Other risk management strategies have included caution as per UN rules for travel to areas deemed insecure. This review itself occurred in a narrow window when travel was permissible to the Highlands.

¹⁵ A letter Sept. 25 2007 commented re: the potential supports to Kupiano, by David Gole "The site visit, study and report were only for the EOC project. It ignored the work for the Supplementary Budget. This lack of co-ordination is a waste of limited resources and makes for difficult planning and causes confusion for all concerned."

3.2 Factors affecting project achievement, constraints, lessons learned

Project design

More realistic role definition is needed to address implementing a project in a decentralized context.

For example, requests were made by Enga Province for a vehicle and renovations to the labour wards at Laigam Health Centre and Wabag General Hospital. These had been visited by Health Facilities Branch in August 2006 who drew up a scope of works. Funds from both the supplementary budget and NZ Aid were allocated portions of the upgrade. The Provincial Works department did additional work to get these ready to be tendered. Other works were designed e.g. a midwife's house and waiting house at Laigam. These are ready for tender but no funds are secured, NDOH wants to prioritize the maternity block which is not yet ready for tender (e.g. needs further design details), so nothing has been done while the communities become increasingly impatient. The supplementary budget was recently removed from the control of the NDOH so no funds are available for those portions of the work to be funded from that source. Some facilities deemed priorities by NDOH, e.g. upgrades in Central province at Bereina HC visited by NDOH and UNFPA 6-9 August 2007 were then considered beyond the scope of the project.

Roles of partners

Complex and not very functional relationships between implementing partners have challenged project achievements. For example the Gerehu upgraded maternity involved Health Facilities Branch NDOH on a facility survey and specification for works and materials (Quotation No. HFB Q 067). Money was released from the supplementary budget to commence works (500,000 kina). \$300,000 of NZ funds were allocated against the maternity portion of the facility upgrade. NDOH requested UNFPA to release the \$300,000 of NZ Aid funds 27 September 2007 based on approval of this design. Between 2006 and 2009 renovations were done at Gerehu which included other construction (staff tea room). The labour and maternity renovations were not deemed to be according to the original plan and funds from HSIP were stopped. Funds from NZ Aid have not yet been fully expended. Some additional work can be done with the NZ money to get closer to the original design, but in spite of repeated visits by UNFPA CTA, NDOH FHS staff etc., all partners are unhappy with the current state of affairs (the St. John's Ambulance who are the health service and contracting partner, HSIP, and NDOH). At the moment, the lesson learned is what did not work, not what can be done to improve the situation.

Project Management, Monitoring and Reporting

The blurred roles between the project and the sector has allowed the implementing partners to avoid some of their contractual responsibilities in terms of management, monitoring and reporting. All stakeholders are aware of this problem and have committed to improve this for the remainder of the project period. Better linkages are needed between this downstream project and the upstream policy dialogue to fully utilize the valuable experience being gained. More advocacy is needed at political and community levels to mobilize resources for maternal health, to address the equity and gender issues which are not improving, etc.

HR Capacity Constraints

The lack of capacity of FHS at NDOH and provincial level as well as the lack of staff have limited implementation. This relates to HSIP as well as FHS, medical supplies etc. There have been delays in the distribution of RHCS. Funds from HSIP are not getting down to provincial level and below in a timely manner.

The Importance of Culture

There are several invisible issues needing further review. NDOH was critical of NSV training and client services being done away from patients' home communities. This was seen as culturally necessary for an innovative activity of involving males in FP. The training of men as partners in FP was initially opposed by NDOH (another workshop cost) and yet there have been results noted such as men now bringing their wives for delivery, and helping to build maternity waiting homes. This was discussed in the community consultations as a unique example of cultural change. One reason for the low levels of facility births may be not only the lack of drugs, staff, suitable maternities, and a referral system, but the cultural preferences of women to deliver in an environment more like their own. It is very positive in this context to see the maternity waiting homes built of bush materials, that the community feels "they own".

3.4 Emerging Issues in RH in PNG

According to the 2006 DHS, RH is extremely challenged in PNG, although there is a mixed picture in comparison with 1996 data. Neonatal mortality is essentially unchanged with the lack of improvement in skilled attendance at delivery. The improvements in post-neonatal mortality (improved immunization, yet decreases in the treatment of ARI and diarrhoea) improve the IMR, child mortality and under 5 MR. Yet maternal mortality has doubled from 370 to 733 per 100,000 livebirths between the DHS 1996 and 2006, although these figures reflect the situation 10-14 years before the survey). PNG's own national goal is to reduce the MMR to 300 per 100,000 livebirths by 2010. The Annual Sector Review monitors 21 key sectoral indicators on behalf of the Health SWAp, HSIP. The 2009 review, looking at 2008 data, has made some important conclusions. Outreaches (which include mother and child health services) have not improved nationally in spite of additional money available through HSIP. There has been a 10% decline in outpatient attendance (which would include assessment of RH problems) in the last 5 years. 30% of aid posts are closed. 37% of births are delivered in a health worker supervised environment, little changed. However, the DHS 2006 found that 50% of births were supervised, which may mean that not all hospital or private sector births are recorded by the Provincial Health Administration. There is also some discordance on the DHS and ASR findings for ANC. The DHS 2006 found only 16% of women had no antenatal care, the ASR found this to be 40%. In any case, health benefits are more pronounced for women who receive 4 visits in terms of the likelihood of a supervised birth.

Table 2- Implications of the DHS 2006 for future RH programming in PNG

2006 DHS Findings compared with 1996	Implications for RH programming
Marked improvement in <u>female literacy</u> with the percent of women who have completed grade 7 or more increasing from 17.1 to 27.8; and the percent of women with no education dropping from 39 to 30.1, accompanied by marked increases in <u>women's exposure to mass media</u> .	Behavior change communication can better use print, radio, and TV to teach women and their families warning signs in labour and delivery, the availability of subsidies for transportation for emergency obstetric care, the fact that maternal care is free, and the health benefits and availability of contraception.
Overall <u>socio-economic status</u> as indicated by parameters such as safe water and sanitation	This is accompanied by a shift in women engaging in farming/fishing for money, towards

<p>is worsening, with a decrease in the percent of households with piped water supply decreasing from 12.9 to 9.1 over the decade and the percent of households with their own flush toilet dropping from 9.1 to 5.3 over the same period.</p>	<p>subsistence suggesting a worsening of the monetary economy which would have implications on the ability to pay user fees for maternal health and transportation costs. Each district has been given 1 million K for water and sanitation. Stakeholders should insist these funds be tracked, especially for water supplies to maternity wards.</p>
<p>Some estimates have suggested that at least 30% of maternal deaths are experienced by <u>adolescents</u>. The median age at first marriage for girls has dropped from 19.9 to 19.5 and the median age at first birth has dropped from 21 to 20.5; although there is a slight decrease in the percent of girls 15-19 who have begun childbearing from 13.8 to 12.9.</p>	<p>A much stronger focus is needed on ASRH. Closer scrutiny of the detailed DHS (not yet available) will likely show that girls with education delay child-bearing. But that the situation for rural, poor, underserved and less educated girls is worsening so this is the priority target group. UNFPA/CTA should work closely with FHS/DOH on an ASRH strategy.</p>
<p><u>Family planning</u> is the most cost-effective intervention to reduce maternal mortality. There is some important momentum to build upon: the TFR has dropped from 4.8 to 4.4. There is increased knowledge of FP methods. The CPR modern methods has increased from 19.6 to 24.3 (PNG's goal is to reach 40% by the year 2017). CPR all methods has risen from 26% in 1996 to 32% in 2006. The method mix shows an increase in injectables from 6.8 to 9.1, the pill from 4.4 to 4.6, female sterilization from 7.6 to 8.6, but periodic abstinence rising from 2.9 to 3.8.</p>	<p>More work is needed to improve RHCS for the resupply methods (condoms, injectables and pills) and on male sterilization through the NSV campaign. More work is also needed on IEC/BCC – there has been little change in the over 27% of women who report lack of knowledge as the reason for non-use of FP. And only approximately 25% of women are aware they can access FP, and do not require their husband's consent to do so (as per the family planning policy). The momentum in FP is very positive, more work is needed to strengthen the role of CHWs in FP provision (including injectables, NSV), and link them to VHVs and CBDs, as well as use social marketing, to increase access to supplies. A CHW friendly version of the FP handbook would be a useful contribution. Social marketing of contraceptives should be explored.</p>
<p>Maternal health shows over 50% of women had at least 4 ANC visits, three-quarters had at least 1, and nearly 70% had TT. This has changed little in a decade except a 6% increase in women with 4 or more visits. <u>Skilled attendance</u>/facility births has essentially plateaued at just over 50% of births.</p>	<p>More work is needed to train and deploy the most accessible cadres of health worker capable of providing skilled attendance at delivery in rural facilities (the CHW). More work is also needed to strengthen the HMIS, as the Annual Sector Review shows skilled attendance at 37%, suggesting under-reporting, possibly from omitting some hospital or private sector statistics.</p>
<p>There has been an increase in the percent of live births associated with complications requiring <u>EmOC</u> from 34 to 43.3%; prolonged labour from 19% to 26.7%; excessive bleeding from 23.1 to 26.7%; and vaginal infections/ever from 11.4 to 14.2%. Convulsions (eclampsia/toxemia) have increased slightly from 7.4 to 7.8%.</p>	<p>A stronger focus on EmOC is needed, at both basic and comprehensive levels. This must include the availability of misoprostol for management of post partum bleeding and incomplete abortion, as well as a stronger focus on RHCS including iron and folate as anemic women are more likely to die from a bleed. Delivery sets, ergometrine, adequate supplies of strong analgesics, drugs for eclampsia, good light sources for delivery (e.g. a head lamp) vacuum assisted delivery</p>

	equipment, and appropriate delivery beds etc. are urgently needed.
<p>There has been increased awareness of <i>HIV</i>, with an increased percentage of women 45.5% to 58.2 % from 1995-2005 who have changed their behavior because of this. The decade shows an increase from 3.9% to 9.1% who now use condoms; and an increase from 32.5% to 41.9% who now have 1 partner. Still, of the 4.1% of women with non-cohabiting partners, less than one third of women used a condom. 17.4% of men admit to non-cohabiting partners in the previous 12 months and nearly 50% of them used a condom at last coitus with these higher risk partners. High number of neonatal deaths and stillbirths are attributed to syphilis (Port Moresby General Hospital statistics).</p>	<p>More work is needed on BCC for women to promote condom use. Social marketing strategies (condoms, as well as oral pills and potentially, could also include treatment for STIs as has been done in Uganda) need urgent acceleration. More work is needed to integrate HIV/STI and maternal health, so the projects support to syphilis testing in pregnancy are very important. To whatever extent it is possible to use the existing well-resourced STI clinics for routine ANC care and syphilis testing, or for BCC teaching, would help reduce the stigmatization caused by these free standing and underutilized facilities.</p>
<p>Village Health Volunteers (VHV) are only reaching 1% of the population.</p>	<p>More work needs to be supported for this grass-roots level engagement. With such poor health services, closing aid posts etc., it will be some time before CHWs and outreaches are available to the whole population. Government as well as churches and NGOs are training VHVs, in fact, this project collaborated well with the VHV section of MHS/NDOH to train SRH advocates. There was strong community requests for further grassroots training in safer deliveries. This is an area which often shows in AAPs but is seldom funded, and yet may be the most valuable investment in such a challenged country where the most robust and accountable leadership may be at the community level.</p>

3.5 Cross-cutting issues – human rights and equity

A sense of community outrage was noted when they had done their part (built maternity waiting homes) only to see unmet commitments by government to upgrade maternity care in health facilities. The doubling of maternal deaths and the lack of resources directed to this sub-sector is severe. The delays in implementation not just in this project, but in health sector initiatives generally, is contributing to widening social and gender inequities. Maternal health is the lowest priority on the agenda and more serious efforts (by donors such as NZ Aid, UN agencies such as UNFPA, and NDOH at all levels) are needed. The National Health Plan specifically exempts pregnant women from paying fees but these are widely charged and a cause of concern by poor women who are unable to mobilize the money needed to save their own lives. The positive moves made by the project towards gender equality have been threatened by a national system in which it has been extremely difficult to mobilize resources for women's health. There were widespread criticisms in the bottlenecks of funding by HSIP, while evidence was also found of non-transparent uses of funds, leading to worsening morale and a deepening sense of cynicism. However, these problems are worse in other sources of government funding. In the midst of these challenges, this project has helped support disempowered people at the grass-roots level.

Meck's Story

CHW who also acts as a trainer, teaches male involvement in FP, VHV training, healthy village training, Community Action Participation training. Has built a VHV training facility out of bush materials with his own resources. A spin off has been a community led initiative to build a maternity waiting house (bush materials).

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4. Conclusions and Recommendations

Why this project when maternal mortality reduction (MMR has doubled in the last 10 years) is supposed to be a national priority and therefore already receiving priority government funds?

Conclusions

In a difficult context of declining health outcomes and a severely underfunded sub-sector of maternal health, this project has helped to keep government and DP focus on maternal and reproductive health. It has faced the same challenges of other health sector stakeholders of managing centrally (through HSIP, UNFPA and NDOH) in a highly decentralized environment. It has had significant successes at the policy and standard setting level. It has helped to model best practices level in terms of its community level engagement helping to mobilize grass roots participation in reproductive health. It has made strong contributions to strengthening RHCS and this will be extended. It has endeavoured to integrate RH/maternal care (including STI/ HIV prevention) in a sector wide approach, and in so doing has helped to counterbalance the major resources flowing into the highly projectized and heavily resourced disease control programs. It has faced the same challenges as all others in the health sector, of poorly managed and insufficient human resources for health, as well as weak allocation of resources against the real public health priorities and maternal health in particular. It has helped to raise attention to the problems of the shift of the supplementary budget away from Health to Planning. It now needs to mobilize greater stakeholder involvement and focus more resources to the critical issues facing this sub-sector. This will include strengthening support for enhanced roles for nurses, midwives and community health workers in strategies to reduce maternal mortality: family planning, skilled attendance at delivery and essential and emergency obstetric care.

Recommendations

Project design

All Stakeholders; High Priority, Time Frame 2009-2010

NZ Aid, UNFPA, and NDOH should participate closely in the SWAp review process. This should change the design context considerably for any follow on project. In addition to the design of any follow-on project, UNFPA can be considered a necessary temporary gap filler, if so instructed by NDOH, to try to *fast track implementation* at this time for the remainder of the project period.

As per the NZ Aid PNG Country Programme Strategy, there is every indication of a high priority need for NZ Aid to continue its intention to keep *supporting RH in PNG*. The challenges of context are likely to continue, and may worsen. It may be difficult to see "results". An extremely long term view is needed, with good linkages between supports, such as NZ Aid is endeavouring with its support to midwifery training to help improve supervised deliveries.

The *Ministerial Task Force on Maternal Health* should shortly produce a report and action plan. It would be appropriate for NZ Aid and UNFPA to harmonize activities in the remainder of the project period and to design any follow-on project to be consistent with this action plan.

Continued support is needed for RHCS. In PNG the availability of medicines according to the Annual Sector Review 2009 is worsening. In addition to essential medicines for obstetrics, delivery sets, and simple light sources (head lamps with LED lights) would greatly facilitate the health workers who now are doing deliveries in the dark, holding candles, or torches in their mouths, or between their head and shoulder.

Project Management

UNFPA; High priority, Time Frame 2009 - 2010.

Tighter project management by UNFPA is necessary to track financial expenditures and rebudget the project for the remaining year. Equipment procurement should begin immediately, rather than waiting for facility renovation. Transition planning will be needed for the additional staff hired under the project e.g. in RHCS and with the planned geographic shifts in project support.

UNFPA/NDOH: High priority, Time Frame 2009 - 2011.

Work can be planned, and discussions can begin with NZAid about resourcing this in a follow-on project, to make a more *CHW-friendly version of the FP Handbook*. At the present time, and format, it is geared to doctors, HEOs, and nurses.

All Stakeholders, Time Frame 2009 - 2010.

A higher profile for both NZ Aid and UNFPA in sector dialogue to mobilize far more attention and resources for maternal health would link this project to wider sectoral issues (the impact of user fees, the need to access what can be salvaged from the supplementary budget also intending emergency obstetric care upgrades, issues of human resources and health system

strengthening, direct funding to health facilities). Continued work to strengthen the roles of CHWs in RH and SM/FP, as well as to promote more nurses for midwifery could help position this project with plans coming onstream to reduce maternal mortality. More work is needed by the CTA to work with FHS/NDOH to help develop an ASRH strategy

HSIP Integration; Monitoring and Reporting and Financial Management

All Stakeholders; High Priority, Time Frame 2009-2013 and beyond

The integration of projects such as this within HSIP has represented considerable challenges. Any follow on project needs to factor in *role definition* (NDOH/HSIP/Provinces/districts) more tightly; as well as to *decide what additional monitoring information* is needed that is project specific and what can be mobilized from the sector wide indicators. The opportunity to use a downstream project such as this to *leverage upstream policy support e.g. to address the impact of user fees* should be recognized as a responsibility of all implementing partners. NZ Aid needs to be clear that additional monitoring tasks will require substantially more support¹⁶, and to also decide to recognize that one result of integration is the loss of project specific data. *UNFPA needs to be more robust in its own responsibility to track project activities and expenditures*, and work collaboratively with NDOH/HSIP to ensure this information is available. *Tighter project management by UNFPA* is necessary to track financial expenditures and rebudget the project for the remaining year.

An *EOC baseline* has not been done. It is not clear which district hospitals provide comprehensive emergency obstetric care. It is not clear what the gaps are, in terms of physical infrastructure, or skills such as *sending nurses for a one year course as anaesthetists* to enable doctors to do Caesarean sections. UNFPA has done this well in other countries in collaboration with UNICEF and the government and FBO.

Roles of Implementing Agencies

All Stakeholders; High Priority, Time Frame 2009-2010

The respective roles of the implementing agencies need to be considered by all parties. NZAID understands UNFPA's role to be one of coordination, advocacy, norm and standard setting but not one of implementing projects, unless they are pilots or meeting a significant gap that can't be addressed by other stakeholders. This is currently problematic. Until the Streamlining legislation comes on board, NDOH also lacks an implementing role. Given the serious challenges in maternal health, it needs to be acknowledged that *UNFPA is meeting a role not addressed by other stakeholders*. This needs to be carefully negotiated with NDOH, NZ Aid and UNFPA. Participation in the *SWAp redesign* may also shift the focus, as donors may channel money directly to the provincial HSIP accounts, so this will be an issue to consider at the design stage of any follow on project, and to be reassessed on an annual basis as the context can change dramatically over time.

Capacity Development

All Stakeholders; High Priority, Time Frame 2009-2010

Important supports to improved RH capacity are: provision of *fellowships for upgrading nurses/as midwives*; other supports to *midwifery training to improve the quality of teaching and the numbers that can be trained*; and the need for support to *clinical rotations for service*

¹⁶ E.g. the Global Fund has increased staff in HSIP, as well as in WHO, to help manage their grants.

providers from rural units to the provincial hospitals. All health care providers have a mix of service delivery and management support roles, it is inappropriate to artificially separate these by output level. A follow on project should also consider linkages to strengthened CHW training as these are the service providers who do most of the deliveries, the links to the community for IEC on HIV, and FP promotion. To the extent that UNFPA or NDOH becomes involved in these areas, better and gender-disaggregated documentation of numbers trained, the cost, location, types of training provided etc. will be needed for any subsequent evaluation. In addition, consideration should be given to raising this to the sectoral level monitoring, such as the numbers of clinical rotations which could help to show improved working relationships between the hospital and rural health services level.

In view of the UN as One approach, all the RH technical advisors with the UN agencies are supposed to work as a team. In light of the specific recommendation from the Ministerial Task Force on Maternal Health to develop a six month assistant/midwife course, and the fact that WHO has been close to the plans of the Global Fund for health systems strengthening, it is recommended that these advisors work closely with the NDOH (FHS and HR, the CMC, and the regional hubs that might pilot such a course (possibly in Wewak, POM/Gerehu, Goroka, Rabaul/Kimbe). This could be done in co-ordination with the plans to add midwifery to the nursing school in Rabaul to serve the Islands region.

Together with NDOH, help guide the provinces to organise clinical rotations for their rural health service staff in midwifery, at the provincial hospital. UNFPA can help break down the barriers which currently exist between the NDOH and the PHA.

ANNEXES

Annex 1. Terms of Reference

TERMS OF REFERENCE: TEAM LEADER

REVIEW OF UNFPA REPRODUCTIVE HEALTH SUB-PROGRAMME STRENGTHENING REPRODUCTIVE HEALTH SERVICES WITHIN THE FRAMEWORK OF HSIP

1. BACKGROUND

Sexual and reproductive health indicators for Papua New Guinea show that the country faces a particularly difficult situation combining a high total fertility rate of 4.6 and extremely high maternal mortality rates (found in a recent demographic and Health Survey to have doubled over the past decade from 370 to 733 per 100,000 live births). Almost one-third of maternal deaths are among teenage mothers. Related to this, approximately 40% of women in PNG receive no ante natal care, resulting in lack of pregnancy monitoring, treatment and prevention of malaria and nutritional deficiencies, neonatal tetanus and planning for birth. Less than 40% of births are supervised (in health clinics or supervised village deliveries) a decline from 50% a decade ago. Infant mortality remains high although the recent DHS indicates IMR has declined from 69.3 per 1000 live births in 1998 to 56.7 in 2006.

The UNFPA works closely with the Government and its external partners towards the government's stated goal to develop a health system that is responsive, effective, accessible and affordable to the people. A National Health Plan (2001-2010) has been adopted and is implemented through a Health Services Improvement Programme (HSIP). The main objectives include SRH objectives of decreasing maternal mortality from (in 2001) 370 to 300 per 100,000 live births, an increase in contraceptive prevalence from 20% to 40% and an increase of primary health care coverage from 45% to 90%. A Medium Term Expenditure Framework (MTEF) has been adopted in order to prioritise health sector activities and resource allocation. Priority programmes of the MTEF are immunisation, safe motherhood/family planning, HIV/AIDS and STIs and malaria prevention. The UNFPA programme addresses two of the priorities of the MTEF:

- 1) Safe motherhood/family planning and
- 2) STI and HIV/AIDS.

UNFPA Country Programme

UNFPA's engagement in PNG is guided by a country programme. The Goal of the 4th Country Programme covering the period 2008-2012¹⁷ is:

To contribute to nationhood and poverty eradication in PNG by improving the reproductive health of the population and enhancing the capacity of all levels of governance to implement a multi-sectoral population programme.

¹⁷ The goal of the previous five year UNFPA country programme similarly focused on "improved Reproductive Health: and a more balanced relationship between population and development".

The programme is comprised of three sub-programmes; namely: Reproductive Health (RH); Population and Development; and Gender equality.

Reproductive Health Sub-Programme

The outcome of the reproductive health sub-programme is comprehensive and high quality sexual and reproductive health information and services, including HIV/AIDS prevention available to and used by women, men and adolescents and youth.

- Output 1: increased availability of comprehensive RH services including FP, EOC, Antenatal care, STI/HIV/AIDS prevention and adolescent friendly health services
- Output 2: Increased awareness and understanding among adolescents and youth of reproductive health and population issues

Under the UNFPA Reproductive Health sub-programme, UNFPA had (prior to the commencement of NZAID project support in January 2006) been working with the National Department of Health (NDOH) to improve access to and quality of SRH services in four provinces (Madang, Manus, East Sepik and Central provinces) and to strengthen the capacity of NDOH staff in reproductive health service delivery and contraceptive logistics. Lessons learned from this stage included a) the need to strengthen project management capacity in order to reduce slippages and improve delivery, b) the need to improve supervision, monitoring and evaluation, c) the importance of ensuring reproductive health commodity security d) the need to improve the availability of reproductive health statistics to aid decision-making, planning and implementation of activities. These lessons informed the current project.

The Current Project: Strengthening Reproductive Health Services within the Framework of HSIP

This project is currently implemented in nine provinces (Central, East Sepik, West Sepik, Western, Simbu, Enga, Manus, Madang, and Bougainville).

NZAID is the sole funder of this project at a total cost of US\$2,000,000 over three years (Approx NZ\$2.8 million). Funding began in January 2006 and is scheduled to end in January 2009¹⁸. According to an agreement between NZAID, NDOH and UNFPA, funds for the implementation of interventions under this project have been channelled through the HSIP Trust Account.

Project Outcomes

Intended project outcomes are:

- A comprehensive, effective and time-tested comprehensive reproductive health policy

¹⁸ Note from GR – project is currently in a no cost extension phase, and will be rebudgetted.

- Efficient and quality reproductive health services such as safe-motherhood including essential obstetric care, emergency obstetric care, post-natal care and family planning services for women, men and adolescents in the 7 provinces.
- Prevention, screening and treatment of sexually transmitted diseases, including HIV/AIDS
- Strengthened Family Health Services Branch of the NDOH
- Procured relevant reproductive health commodities and equipment to strengthen the delivery of quality services

Project Outputs

Specific outputs for the project are as follows:

Output 1

Developed a comprehensive, effective and time-tested reproductive health policy for the country: *In order to standardise and streamline training and service provision a policy would be developed to set a framework for defining and prioritising the various components of reproductive health and clarifying the roles of agencies involved in the financing and provision of services and programmes and to address gaps and inconsistencies impeding the provision of RH services.*

A related output is the Production of an updated edition of the Family Planning Standard Treatment book

Output 2

Efficient and quality reproductive health services for women, men and adolescents in the seven provinces. *The strategies to achieve this output include i) improving on-the-job training and improving the supervision to the delivery of services, ii) strengthening health centres and aid posts to increase the range of reproductive health services and to improve the quality of care based on a systematic assessment of facilities in the seven provinces iii) undertaking operations research to improve access and quality of RH services and iv) strengthening the capacity of the health system to address gender-based violence*

The output includes specific activities aimed at strengthening i) essential obstetric care ii) emergency obstetric care iii) vasectomy training and programme

Output 3

Strengthened technical and institutional capacities of the Family Health Services for effective policy planning, management, supervision, monitoring and evaluation of reproductive health interventions. *In collaboration with all stakeholders the project will seek to strengthen the Family Health Services in order to enable it to improve the management of RH services.*

Related outputs include:

Fellowships provided for two health workers for each of the three years in reproductive public health at MPH level

Chief Technical Adviser to the FHS recruited

Technical supervision of rural reproductive health services facilitated.

Output 4

Model Midwifery based maternity and reproductive health centre at Gerehu hospital for the NCD. *The project would facilitate the establishment of a 24 hour reproductive health service delivery at Gerehu Hospital in order to reduce the pressure on the Port Moresby General Hospital created by the decreasing ability of women to access delivery and post partum care*

in rural areas and referral maternity facilities in urban areas being swamped by normal obstetrics so that they are no longer able to provide specialist care.

In addition to the specific outputs indicated above, the project design also indicates the intention to procure and distribute essential reproductive health equipment, assistance to strengthen the Health Management Information System (HMIS) and to strengthen the reproductive health and contraceptive logistical system.

2. SCOPE AND PURPOSE OF REVIEW

This review is being carried out in the fourth year of the project. Initially the project was intended to last for three years, but implementation has been slower than expected, and a one year extension was agreed. The purpose of the review is to ascertain the progress the project has made towards achieving its intended outcomes and outputs, to learn lessons and to provide recommendations for the future of the project and the funding relationship.

The review will cover the period from January 2006 until the present time.

3. OBJECTIVES OF REVIEW

Objective 1: To assess the relevance and appropriateness of the project design and the extent to which the project's intended outputs and outcomes have been achieved

Tasks

- Assess the national reproductive health situation and determine the appropriateness and relevance of the design including the outcomes, outputs and strategies of the project.
- Assess the extent to which the project was fully integrated into the Health Sector Improvement Programme (HSIP) and the Medium Term Expenditure Framework of the Department of Health including how the project was managed, monitored, reported on and funds acquitted.
- Assess the extent to which the project strengthened the capacity of the Family Health Services Division of the National Department of Health and relevant Provincial and district health authorities to deliver quality reproductive health services
- Assess the extent to which the project achieved its intended outcomes and outputs
- Identify the constraints encountered during the implementation of the project and how these were addressed
- Assess the integration of gender considerations during the implementation of the project.

Objective 2: To identify and analyse lessons learned from the implementation of the project.

Tasks:

- Assess the extent to which the project approach and strategies provided value for money
- Identify and analyse the factors affecting project achievements and constraints and identify lessons learned
- Identify and analyse emerging issues within the reproductive health domain of PNG and, based on this and the review findings and analysis, recommend interventions that should form the basis of the next project, and how these should be managed.

The Review Team will be expected to refine these key tasks. If additional questions and tasks are identified during the field work, the Team Leader has the discretion whether or not to address these.

4. METHODOLOGY

A methodology should be developed by the Review Team prior to undertaking the review, and approved by NZAID. If changes to the methodology are deemed necessary during the course of the field work, the Team Leader has the authority to make those changes.

The team should ensure that the review is carried out in a manner that fully engages relevant stakeholders at all level and intended beneficiaries. They should ensure gender issues are fully addressed and women are fully involved in the review at all levels. This may include convening separate meetings as necessary.

It is expected that the team will undertake consultations in Port Moresby with relevant stakeholders, will review documentation and hold discussions with UNFPA and NDOH in relation to work in all provinces and will visit up to four of the seven provinces involved in the project. One of these provinces (preferably East Sepik) should be from the two carried forward from the first phase of the project and up to from the second phase. A draft itinerary has been prepared and can be altered with agreement from NZAID, NDOH and UNFPA.

It is expected that the review will require 2 days preparation, 14 days in-country and 7 days report preparation.

It is expected the review will require the following tasks

- Finalise in-country arrangements with UNFPA, NDOH
- Desk review of relevant documentation
- Finalise Terms of Reference and methodology with team once in country
- Hold discussions with NZAID staff in Port Moresby (and Wellington by distance communication), UNFPA and NDOH, relevant provincial and district health officials
- Hold discussions with other key stakeholders (including as relevant HSIP Secretariat, other government agencies, development agencies, Provincial and District Health offices, NGOs and FBOs) and a cross-section of beneficiaries to ascertain project achievements and their opinions on the project
- Presentation of preliminary findings to NZAID, UNFPA, NDOH in Port Moresby
- Preparation of a draft report and circulation to all parties
- Preparation of a final report following feedback
- Teleconference discussion with NZAID

5. MANAGEMENT OF REVIEW AND REVIEW TEAM

The review is being commissioned by NZAID, with lead responsibility taken by the Development Programme Officer for the PNG programme.

The review team will be led by a consultant appointed by NZAID and will comprise representatives of UNFPA and NDOH as the key implementing partner. This is intended to enhance the learning opportunities of the review.

The primary roles of the members of the review team will be as follows:

Consultant appointed by NZAID

- Team leader
- Coordinate development of review methodology
- Coordinate logistical arrangements with UNFPA
- Ensure that ToR are successfully met; keep a wider perspective of evaluative criteria at a strategic level
- Main responsibility for writing the review report. Co-ordinate input from other team members, and feedback to finalize the Report

Representative from NDOH

- Assist in development of review methodology
- Coordinate with provincial and national health department officials
- Assist in drafting report

Representatives from UNFPA:

- Assist in development of review methodology
- Coordinate with Team Leader to arrange and manage logistical support required by the review team
- Coordinate with national and provincial health department officials
- Coordinate with DNPM – advise them of review four weeks prior to mission

6. OUTPUTS

A. REVIEW METHODOLOGY AND ITINERARY

B. DEBRIEF IN COUNTRY OF PRELIMINARY FINDINGS

Meeting with NZAID, UNFPA and NDOH in Port Moresby after field work is complete.

C. REVIEW REPORT

A draft report should be submitted to NZAID, UNFPA and NDOH by email. Feedback should be co-ordinated and once feedback is received, the report finalized and submitted by email to all parties. NZAID will print and distribute the report. A teleconference with NZAID will take place to discuss the final report.

The report should follow guidelines contained in the NZAID Guideline on the Structure of Review and Evaluation Reports, and meet the DAC Evaluation Quality Standards. NZAID will provide the Team Leader with these documents.

NZAID's policy is to publish summaries of review and evaluation reports on the website and release full reports if requested, unless there is a prior agreement not to do so. Any information that could prevent the release of the report under the Official Information or Privacy Acts, or would breach evaluation ethical standards must be placed in a Confidential Annex. Further detailed guidance is available in the NZAID Guideline on the Structure of Review and Evaluation Reports which NZAID will provide for the Team Leader.

7. REFERENCE MATERIAL

Relevant documents will be sent to the Review Team for thorough reading in advance of the review. These documents will include the following:

- UNFPA - NZAID Co-Financing Arrangement and project reports
- UNFPA documents
- GoPNG National Health Plan 2001-2010
- NDOH policy documents including MTEF 2006 - 2008
- NZAID Policies, Country Programme Strategy

8. CONTRACT MILESTONES

Milestone	Date	Event	Fees due
	6 April	Start date of contract	-
1	4 May	Fieldwork completed	50%
	27 May	Draft Report completed	-
2	8 June	Final Report completed	50%
		End date of contract	-

9. QUALITY INDICATORS

The Consultant shall ensure that the assignment is carried out with all due diligence, efficiency and economy in accordance with the time specified in this Contract, observing sound management and technical practices, and complying with professional consulting standards recognised by relevant professional bodies.

Annex 2. Selected List of Documents Reviewed

District Case Study. Progress Brief. 6 March 2009 and 14 May 2009 Power Point Presentations.

Government of Papua New Guinea, UNFPA, and the Government of New Zealand. Project Agreement Strengthening RH Services Within the Framework of HSIP/ January 2006.

Government of Papua New Guinea. National Department of Health. National Sexual and Reproductive Health Policy to Achieve Quality Sexual and Reproductive Health for All Papua New Guineans. January 2008.

Government of Papua New Guinea. National Department of Health. National Health Plan 2001 -2010.

Government of Papua New Guinea. National Department of Health. MTEF 2006-2008, and the one currently being prepared.

Health Sector Program Committee and Health Sector Finance Committee Meetings National Department of Health. Minutes of all meetings held in last 3 years.

Independent Monitoring and Review Group Papua New Guinea Reports No. 3 (Review of the Sector Wide Approach and Technical Assistance) and No. 5 (Prioritizing IMRG Recommendations) November 2007 and October 2008

National Department of Health (and DPLGA). Joint case Study of District and Facility Service Delivery Funding, Interim Summary of Eastern Highlands Field Visits 3-17 November 2008 and 25-28 January 2009.

National Department of Health. Health Facilities Branch. Selected Site Inspection Reports 2006-2008. Tingou HC, Maintenance to the Maternity Ward. Hantoa HC. Upgrade of the Labour Ward. St. Joseph's Rural Hospital Mingende. Lorengau General Hospital. Tender Laigam Duplex House. Hantoa HC Bougainville invitation to tender. Report on Upgrade and Refurbishment of Marrik District Hospital. Repair Labour Ward Angoram HC. Renovation of the Existing Ward Laigam HC. Manus Provincial Administration EOC Report. Bogia HC 2006. Magen HC.

National Department of Health. HSIP. Excel spreadsheets 2006-2009 EOC facilities upgrade all funding sources.

National Department of Health. Annual Sector Review 2007 and 2008.

National Department of Health. Maternal Mortality Task Force Summary, and back ground presentations. 2008-2009.

National Economic and Fiscal Commission, 2009. Closing the Gap, Review of all Expenditure in 2007 by Provincial Governments. Papua New Guinea. January 2009.

New Zealand Agency for International Development and Government of Papua New Guinea Country Programme Strategy 2008-2018. July 2008.

NZAID: United Nations Population Fund Agency Engagement Framework 2009.

Papua New Guinea Society of Obstetrics and Gynecology. Manual of Family Planning for Doctors, MZOs, and Nurses in Papua New Guinea. 2009 draft.

UNFPA - NZAID Co-financing arrangements and project reports.

UNFPA NZ Project files (4 large binders)

UNFPA. EOC Project Site Support Visit to Central Province 11-14 June 2007 (and other visit reports from the project files).

UNFPA EOC Program Meeting Facility Upgrade 5 May 2008.

World Bank. Draft Aide-Memoire Papua New Guinea, Health Program and Sector Work Options Mission Feb. 21-March 5, 2009.

RELEASED UNDER THE OFFICIAL INFORMATION ACT

Annex 3. Mission Itinerary and persons met

Itinerary for NZAID Funded UNFPA/ECC Project review. Field visits attended by Dr. Koka, Dr. Isika and Dr. Roedde. Meetings in Port Moresby attended by entire review team except the debrief when Dr. Koka had to remain in Enga for security reasons.

Team members:

- UNFPA – Dr. Betty Koka and Dr. Aham Isika
- NDoH – Dr. Hilja Pokume (part-time)
- Team leader/facilitator – Dr. Gretchen Roedde

Excellent facilitation provided by Dr. Betty Koka and Dr. Aham Isika and their provincial and district counterparts in setting up meetings.

- Provincial and district visits – UNFPA and PMA have advised, including the emphasis on community level facilities and community participation as much as possible.
- **Communication was provided as soon as possible**, with letters to health-centre OIC and community groups. Flexible scheduling was accommodated.
- Logistics support required – PHO and district vehicles were available to support district visits

Accommodation – Betty has organised as detailed.

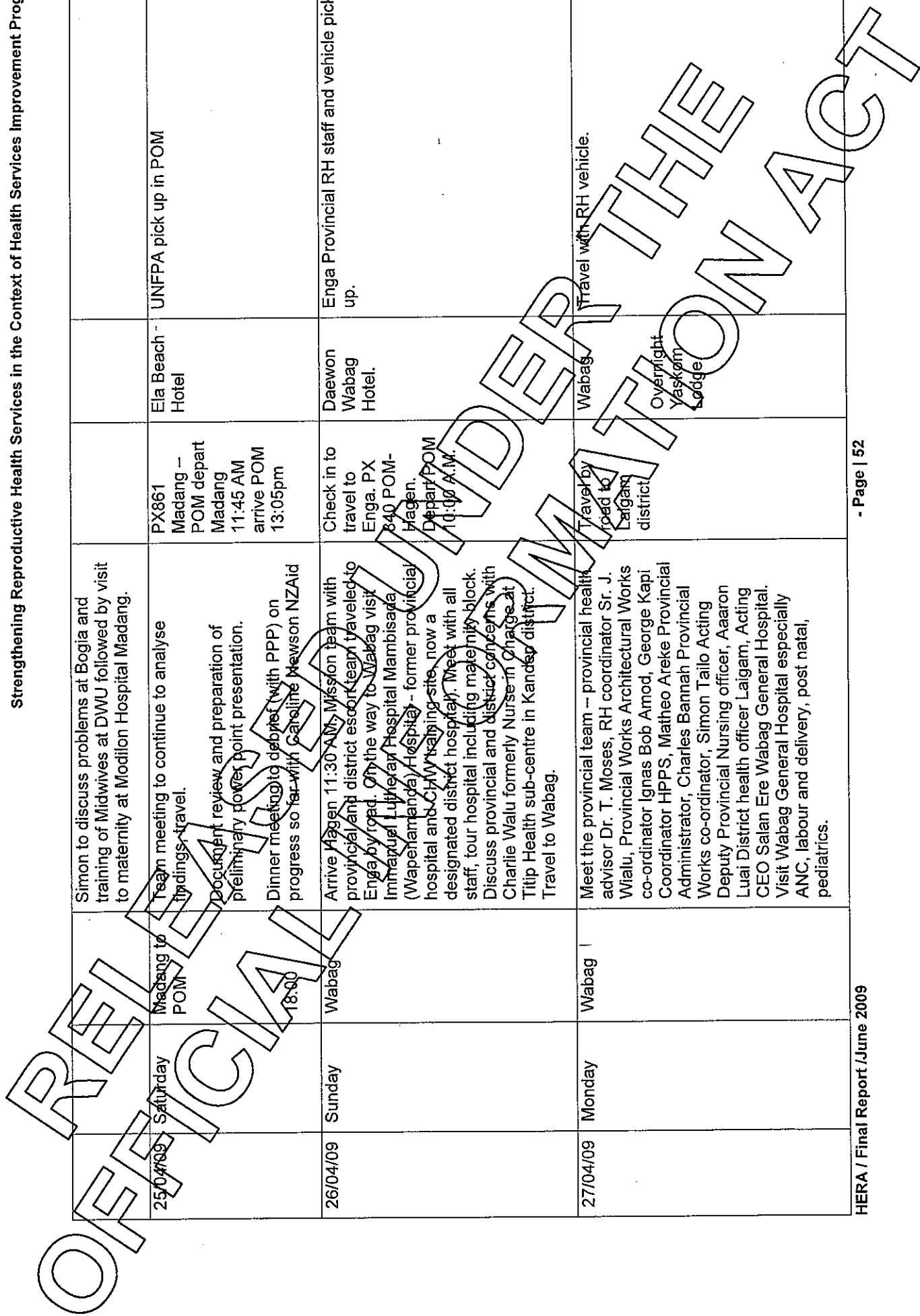
Date	Day	Location	Meetings and Consultations	Travel	Logistics	Other needs
19/04/09	Sunday	Travel	Document Review Dinner meeting with Pati Gagau and Caroline Newson NZAid.			POM – Ela Airport Pick up by Hotel Beach
20/04/09	Monday	POM	UNFPA. Briefing with Dr. Betty Koka, Dr. Aham Isika, and Mr. Golden Mulilo, OIC			Ela Beach UNFPA vehicle

		<p>UNFPA NDOH Enoch Posanai (Executive Manager Public Health) Eva Lionel (Director HSIP MB) Dr. Luc N. John (Senior Medical Officer STUHM) Dr. Hilda Polume (Principal Advisor Family Health Services) Mary Rignol (Principal Advisor HR Training) Caroline Newson (NZ Aid Programme Development Officer) Kali Kato (Medical Supplies Branch) Dr. Dakulala (Deputy Secretary Health WHO) / Dr. Norbert Rehls NDOH / Dr. Clement Malau (Secretary of Health)</p>	<p>8:30-10:10 10:30-11:30</p>
		<p>HSIP Daryl Martini (re: extracting NZ funded budget lines) NZ High Commission Caroline Newson NZ Aid Programme Development Officer, Pat Gagau NZ Aid. Dinner meeting Dr. Michael Douglas and Dr. Glen Mola</p>	<p>11:30-12:30 13:00 – 13:30 13:30 – 14:00 14:30 – 15:45 19:30 – 21:30</p>
<p>21/04/09</p>	<p>Tuesday</p>	<p>POM Gerehu Hospital. Dr. Ake Medical Director, Doug Kelson Chief Commissioner St. John's Ambulance NDOH Dr. Hilda Polume HSIP Daryl Martini</p>	<p>POM 9:00 – 11:00 11:30 – 12:30</p>
	<p>Travel to Wewak</p>	<p>Check in 13:25 PX 112 POM- Madang Depart 15:25 arrive</p>	

Strengthening Reproductive Health Services in the Context of Health Services Improvement Program (HSIP)

	<p>22/04/09</p> <p>Wednesday</p> <p>Wewak</p> <p>8:00 AM</p> <p>Maprik District PM</p>	<p>Provincial Health Office PHA Albert Bunat, Sr. Line Ale, CEO Wewak Hospital, Dr. Dr. Godfrey Naboom, O&G specialist,</p> <p>Maprik health centre. Meet with health centre in charge and other staff including midwife, CHWs, visit whole health centre, maternity wing, waiting house built by UNICEF (unused), meet with NSV clients and vasectomist CHW Gerald.</p> <p>Wewak Hospital and Provincial Health office Team Meeting- Dr. Sainak-CEO Wewak Hospital, Dr. Naboom, Hospital architect. Visit maternity wing and MCH clinic Wewak Hospital</p>	<p>Travel to Maprik Health Centre</p> <p>Travel back to Wewak</p>	<p>Wewak Airport Lodge</p> <p>Wewak</p> <p>Wewak Airport Lodge</p>	<p>Pick up by Family Health Services coordinator, Sr. Linna Ale in RH vehicle.</p>
<p>23/04/09</p> <p>Thursday</p> <p>Wewak</p> <p>AM</p> <p>PM</p>	<p>Final meeting with Provincial team and Wewak hospital staff.</p> <p>Team meeting to begin to discuss preliminary findings. Plane from Wewak to Madang delayed.</p>	<p>Wewak Airport Lodge</p>	<p>Wewak Airport Lodge</p>	<p>Wewak Airport Lodge</p>	<p>RH vehicles for meetings and to airport next morning.</p>
<p>24/04/09</p> <p>Friday</p> <p>Madang</p> <p>PM</p>	<p>Provincial Health Office - PHA M. Katchau and FHS co-ordinator Sr. Jennifer Simon and Manager- Provincial Works Dept.,</p> <p>Meeting at Divine Word, - Fr. Jan - President DWU, Principal Lutheran School of Nursing, Sr. Jill Unia and 3 other staff from Pathfinder, Provincial Works Dept., PHA M. Katchau and FHS co-ordinator Sr. Julie</p>	<p>PX927 WAWK -MAG (flight delayed)</p>	<p>Madang</p> <p>Madang Lodge Hotel</p>	<p>Madang</p> <p>Madang Lodge Hotel</p>	<p>Pick up by PHA and FHS with RH vehicle.</p>

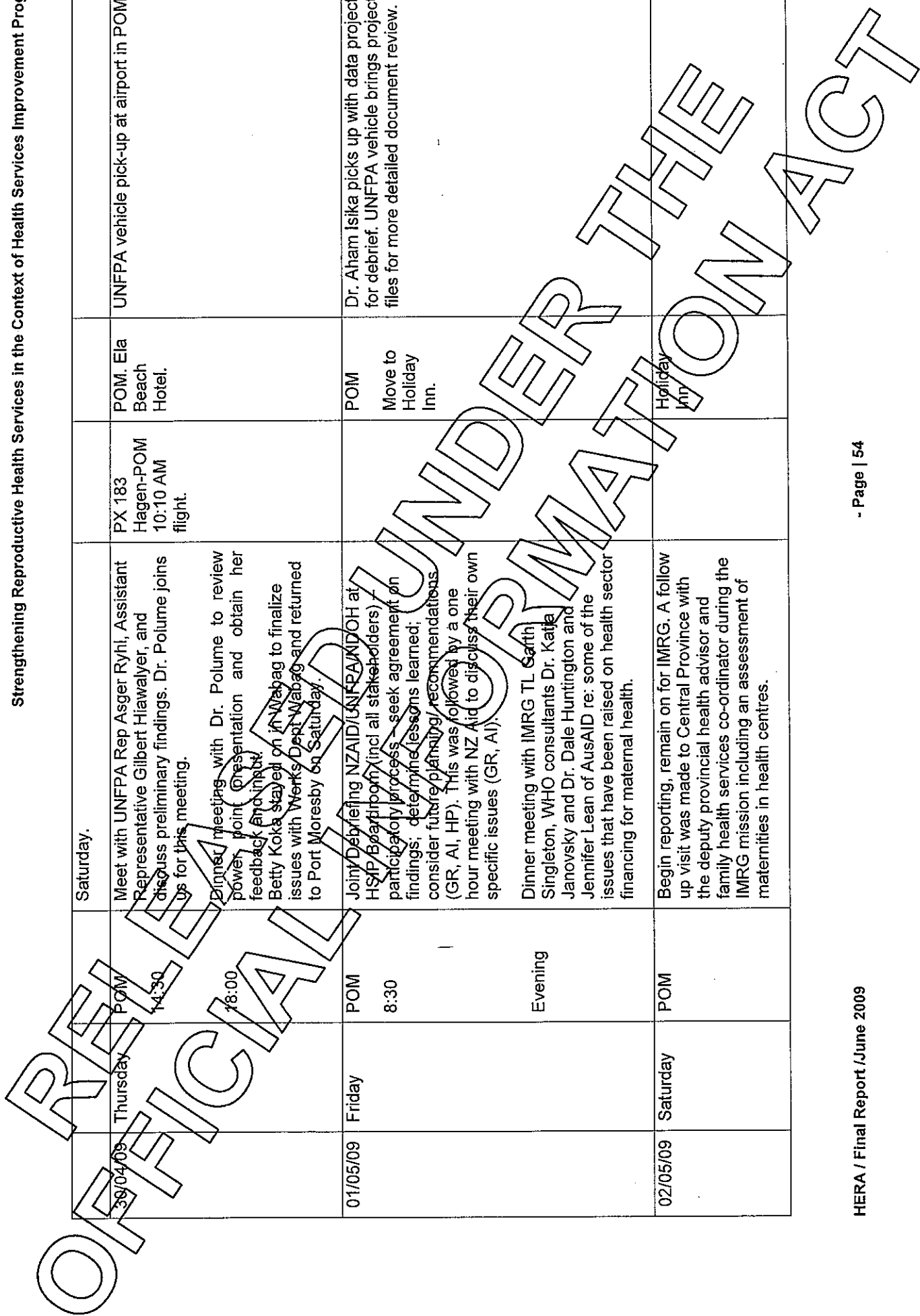
25/04/09	Saturday	Madang to POM 18:00	Simon to discuss problems at Bogia and training of Midwives at DWU followed by visit to maternity at Modilon Hospital Madang.	Team meeting to continue to analyse findings-travel. Document review and preparation of preliminary power point presentation. Dinner meeting to debrief (with PPP) on progress so far with Caroline Newson NZAid	PX861 Madang - POM depart Madang 11:45 AM arrive POM 13:05pm	Ela Beach Hotel	UNFPA pick up in POM
26/04/09	Sunday	Wabag	Arrive Hagen 11:30 AM. Mission team with provincial and district escort team traveled to Enga by road. On the way to Wabag visit Immanuel Lutheran Hospital Mambisada (Wapenamanda Hospital) - former provincial hospital and CHW training site, now a designated district hospital. Meet with all staff, tour hospital including maternity block. Discuss provincial and district concerns with Charlie Walu formerly Nurse in Charge at Titip Health sub-centre in Kandeda district. Travel to Wabag.	Check in to travel to Enga. PX 840 POM-Hagen. Depart POM 10:00 A.M.	Daewon Wabag Hotel.	Enga Provincial RH staff and vehicle pick-up.	
27/04/09	Monday	Wabag	Meet the provincial team -- provincial health advisor Dr. T. Moses, RH coordinator Sr. J. Wialu, Provincial Works Architectural Works co-ordinator Ignas Bob Amod, George Kapi Coordinator HPPS, Mattheo Areke Provincial Administrator, Charles Bannah Provincial Works co-ordinator, Simon Tailo Acting Deputy Provincial Nursing officer, Aaron Luai District health officer Laigam, Acting CEO Salan Ere Wabag General Hospital. Visit Wabag General Hospital especially ANC, labour and delivery, post natal, paediatrics.	Travel by road to Laigam district	Wabag Overnight Yaskam Lodge	Travel with RH vehicle.	



Strengthening Reproductive Health Services in the Context of Health Services Improvement Program (HSIP)

	<p>Tambitanis HC. Pore, Sirunki, Watapam villages</p>	<p>Travel to Laigam district. On the way visit Tambitanis HC, meet the staff and community (over 100 people, and discuss SRH issues with them in an open forum). Meet the community in Pore village and visit community constructed waiting house. Visit VHV training site in Sirunki. Visited Watapam villages + Healthy Village concept.</p>	<p>Travel back to Wabag by road.</p>	<p>Wabag. Overnight in My Kids' Lodge.</p>	<p>Travel with RH vehicle.</p>
<p>28/04/09</p>	<p>Tuesday</p>	<p>Laigam</p>	<p>Meeting with district team (administrator, district health officer, QIC, district RH coordinator, district L.S. President). Travel to Muritaka health sub centre. Meet with community volunteer SRH advocates, discuss SRH issues with over 100 community members in an open forum, and officiate at the opening of the maternity waiting house they have built at the centre. Visit maternity block. Visit Laigam District Health centre, town maternity. Community meeting of over 100 people in Laigam District including councillors, re: reasons for delays in proposed funding.</p>	<p>Travel with RH vehicle, drop off.</p>	<p>Portman Hotel Mount Hagen.</p>
<p>29/04/09</p>	<p>Wednesday</p>	<p>Wabag</p>	<p>Final debriefing with provincial and district teams and present preliminary power point presentation for their input, as well as all team members. Dr. Betty Koka requested by TL (GR) not to travel by road and therefore would have to miss debrief (insecurity re: possible revenge killings against Laigam people, NB no-one else from the Laigam team accompanied us for same reason). Betty later came to Hagen on Friday under escort to connect flight to Port Moresby on</p>	<p>Travel with RH vehicle, drop off.</p>	<p>Portman Hotel Mount Hagen.</p>

30/04/09	Thursday	POM 14:30	Meet with UNFPA Rep Asger Ryhi, Assistant Representative Gilbert Hiawalyer, and discuss preliminary findings. Dr. Polume joins us for this meeting. Dinner meeting with Dr. Polume to review power point presentation and obtain her feedback and input. Betty Koka stayed on in Wabag to finalize issues with Werks/Dept Wabag and returned to Port Moresby on Saturday.	PX 183 Hagen-POM 10:10 AM flight.	POM. Ela Beach Hotel.	UNFPA vehicle pick-up at airport in POM.
01/05/09	Friday	POM 8:30	Joint debriefing NZAID/UNFPA/DOH at HSP Board room (incl all stakeholders) - participatory process - seek agreement on findings; determine lessons learned; consider future planning/recommendations (GR, AI, HP). This was followed by a one hour meeting with NZ Aid to discuss their own specific issues (GR, AI).		POM Move to Holiday Inn.	Dr. Aham Isika picks up with data projector for debrief. UNFPA vehicle brings project files for more detailed document review.
		Evening	Dinner meeting with IMRG TL Garth Singleton, WHO consultants Dr. Katie Janovsky and Dr. Dale Huntington and Jennifer Lean of AusAID re: some of the issues that have been raised on health sector financing for maternal health.			
02/05/09	Saturday	POM	Begin reporting, remain on for IMRG. A follow up visit was made to Central Province with the deputy provincial health advisor and family health services co-ordinator during the IMRG mission including an assessment of maternities in health centres.		Holiday Inn	



Annex 4. Review Methodology

The project will be reviewed within the context of a Sector Wide Approach in which it may not be possible to draw out specific contractor inputs and outputs. NZAid is committed to the Paris Declaration on Aid Effectiveness, and to joint reviews of mutual progress. The involvement of both NDOH, UNFPA, and an external representative on the team reflects that commitment, as well as the effort to harmonise with the ongoing Independent Monitoring and Review Group mission.

The review was a participatory evaluation, which engaged stakeholders in the definition, and solution, of problems encountered. Consensus on the way forward was obtained to the extent possible.

To conserve the time of busy NDOH staff, they were met with collectively in the main, then followed up as needed. Dr. Polumé was unable to join for the field work, but was briefed by phone and had inputs to the final debrief before presentation. The final power point presentation was developed collectively with inputs from community, district, provincial, and national perspectives as well as the core Review Team.

Evaluation tool - Assessment of Reproductive Health Sub- Programme UNFPA/NAid STRENGTHENING REPRODUCTIVE HEALTH SERVICES WITHIN THE FRAMEWORK OF HSIP

Questions	Community							
	DPs	Sr. Gov. Officials/ Provincial/ District Health officials	UN Org.	CBSC	UNFPA CO	NGOs (FHI, Save, Pathfinder etc.), CSO, Susu Mamas	Research/ Academics ¹⁹ Health Service Providers	Community Members ²⁰

Output 1A – Develop a comprehensive, effective and time-tested reproductive health policy for the country

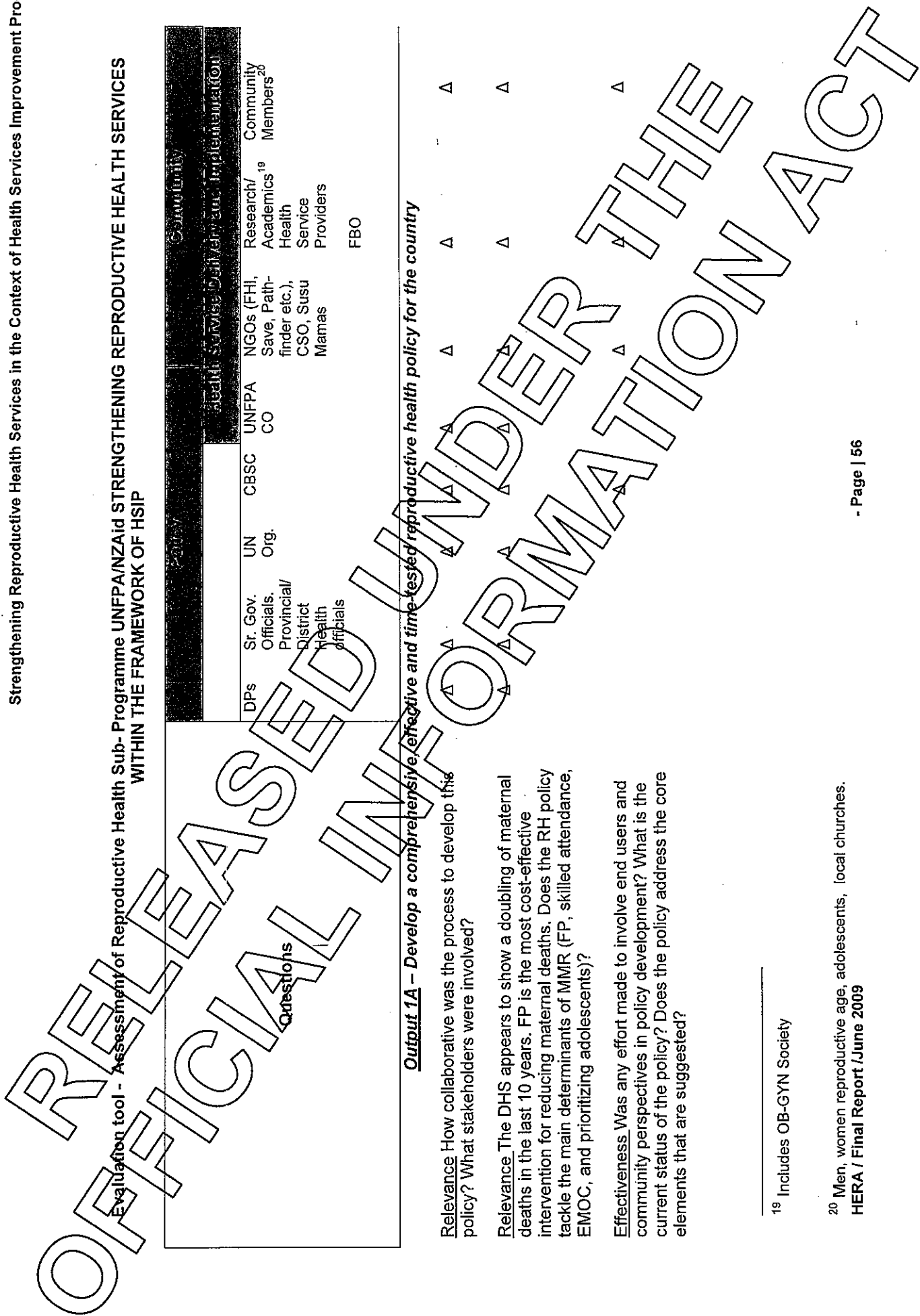
Relevance How collaborative was the process to develop this policy? What stakeholders were involved?

Relevance The DHS appears to show a doubling of maternal deaths in the last 10 years. FP is the most cost-effective intervention for reducing maternal deaths. Does the RH policy tackle the main determinants of MMR (FP, skilled attendance, EMOC, and prioritizing adolescents)?

Effectiveness Was any effort made to involve end users and community perspectives in policy development? What is the current status of the policy? Does the policy address the core elements that are suggested?

¹⁹ Includes OB-GYN Society

²⁰ Men, women reproductive age, adolescents, local churches. HERA / Final Report / June 2009

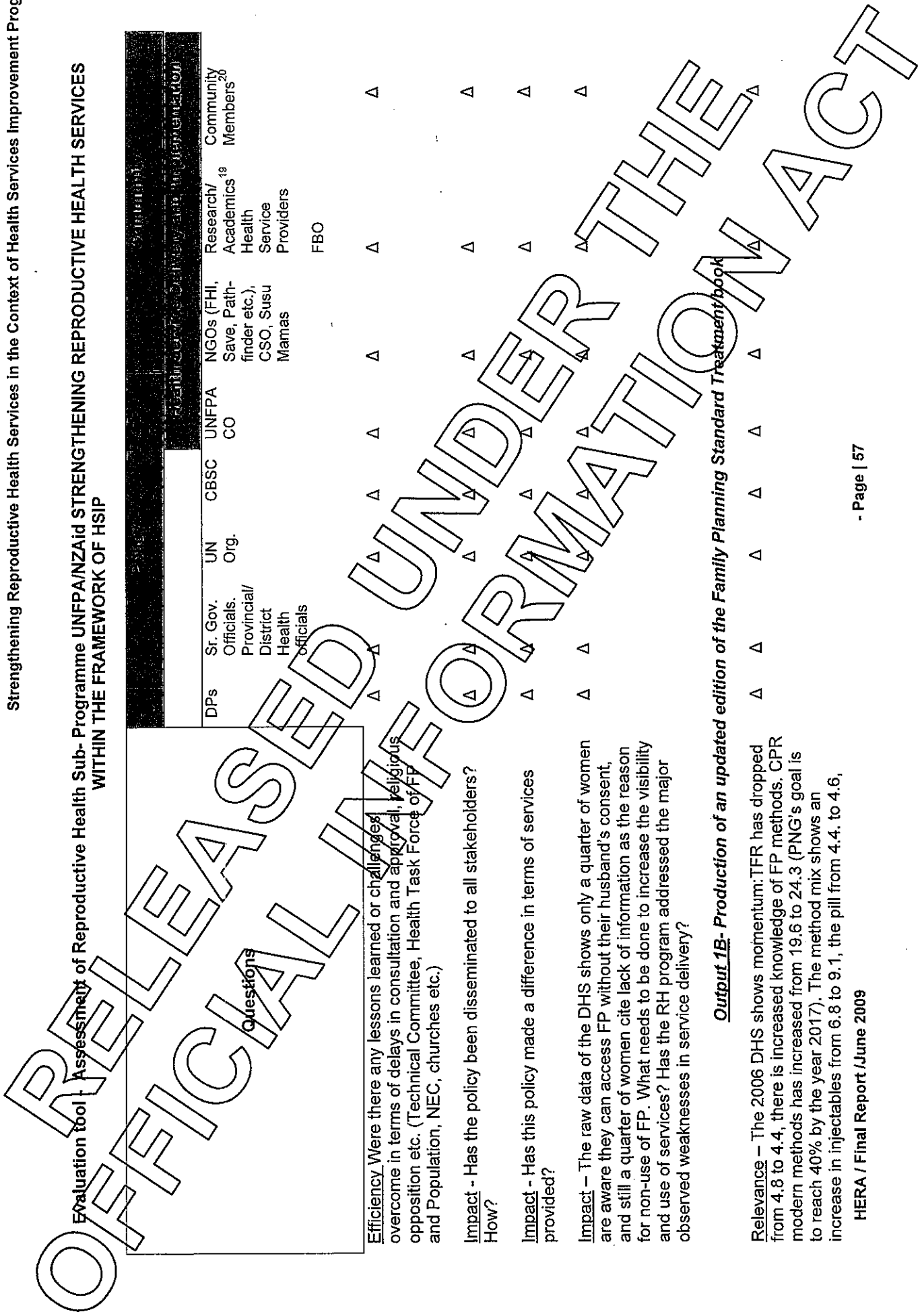


Evaluation tool - Assessment of Reproductive Health Sub-Programme UNFPA/INZaid STRENGTHENING REPRODUCTIVE HEALTH SERVICES WITHIN THE FRAMEWORK OF HSIP

Questions	DPs	Sr. Gov. Officials/ Provincial/ District Health officials	UN Org.	CBSC	UNFPA CO	NGOs (FHI, Save, Pathfinder etc.), CSO, Susu Mamas	Research/ Academics ¹⁹ Health Service Providers	Community Members ²⁰
<u>Efficiency</u> Were there any lessons learned or challenges overcome in terms of delays in consultation and approval, religious opposition etc. (Technical Committee, Health Task Force of FP and Population, NEC, churches etc.)	Δ	Δ	Δ	Δ	Δ	Δ	Δ	Δ
<u>Impact</u> - Has the policy been disseminated to all stakeholders? How?	Δ	Δ	Δ	Δ	Δ	Δ	Δ	Δ
<u>Impact</u> - Has this policy made a difference in terms of services provided?	Δ	Δ	Δ	Δ	Δ	Δ	Δ	Δ
<u>Impact</u> - The raw data of the DHS shows only a quarter of women are aware they can access FP without their husband's consent, and still a quarter of women cite lack of information as the reason for non-use of FP. What needs to be done to increase the visibility and use of services? Has the RH program addressed the major observed weaknesses in service delivery?	Δ	Δ	Δ	Δ	Δ	Δ	Δ	Δ

Output 1B- Production of an updated edition of the Family Planning Standard Treatment book

Relevance - The 2006 DHS shows momentum: TFR has dropped from 4.8 to 4.4, there is increased knowledge of FP methods. CPR modern methods has increased from 19.6 to 24.3 (PNG's goal is to reach 40% by the year 2017). The method mix shows an increase in injectables from 6.8 to 9.1, the pill from 4.4, to 4.6.



Evaluation tool - Assessment of Reproductive Health Sub-Programme UNFPA/ZAID STRENGTHENING REPRODUCTIVE HEALTH SERVICES WITHIN THE FRAMEWORK OF HSIP

Policy		Community	
Health Service Delivery and Implementation			
DPs	Sr. Gov. Officials/ Provincial/ District Health officials	UN Org.	CBSC
		UNFPA CO	NGOs (FHI, Save, Pathfinder etc.), CSO, Susu Mamas
			Research/ Academics ¹⁹ Health Service Providers
			FBO
			Community Members ²⁰

Questions

female sterilization from 7.6 to 8.6, but periodic abstinence rising from 2.9 to 3.8. Is the FP Standard Treatment (ST) book user friendly, and does it build on the most popular methods? How does it address periodic abstinence which is increasing?

Effectiveness - How well disseminated has the family planning standard treatment book been? How could it be better used to improve women's awareness of FP?

Efficiency - How have cost issues been addressed, e.g. to produce and distribute the FP ST Book?

Impact - Have efforts been made to involve end-users (CHWs etc.) in the field-testing of the FP ST Book?

Sustainability - How well addressed is sterilization (male and female) in the FP Standard Treatment Book, as currently the method mix relies heavily on resupply methods?

Output 2: Efficient and quality reproductive health services such as safe-motherhood including essential obstetric care, emergency obstetric care, post-natal care and family planning services for women, men and adolescents in the 10 provinces.

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Evaluation tool - Assessment of Reproductive Health Sub- Programme UNFPA/ZAid STRENGTHENING REPRODUCTIVE HEALTH SERVICES WITHIN THE FRAMEWORK OF HSIP

Policy		Community	
Health Services Delivery and Implementation		Community Members	
DPs	Sr. Gov. Officials/ Provincial/ District Health officials	UN Org.	Research/ Academics ¹⁹ Health Service Providers
		CBSC	NGOs (FHI, Save, Pathfinder etc.), CSO, Susu Mamas
		UNFPA CO	FBO

Questions

Relevance Which cadres have been targeted for in-service training? How much has been provided to CHWs, nurses, midwives, doctors? Should more training be provided to lower levels of the system (CHWs)? Who has received post-graduate training? What is the appropriateness of a trained midwife per HC? How can secondary and tertiary maternal health services be more accessible?

Effectiveness -What efforts have been undertaken to improve on-the-job training and improving the supervision to the delivery of services?

Effectiveness - What has been done to strengthen health centres and aid posts to increase the range of reproductive health services and to improve the quality of care based on a systematic assessment of facilities in the seven (10?) provinces? Has there been a community perspective in culturally appropriate quality of care (birthing position etc.)?

Effectiveness - HSIP is supposed to prioritise maternal mortality reduction through the annual activity plans. Has that worked? Does this UNFPA supported program work better? Why?

Effectiveness - What role has the CTA played in improving the effectiveness of this output?

Evaluation tool - Assessment of Reproductive Health Sub- Programme UNFPA/ZAid STRENGTHENING REPRODUCTIVE HEALTH SERVICES
WITHIN THE FRAMEWORK OF HSIP

Community

Health Services Delivery and Implementation

DPs	St. Gov. Officials/ Provincial/ District Health officials	UN Org.	CBSC	UNFPA CO	NGOs (FHI, Save, Pathfinder etc.), CSO, Susu Mamas	Research/ Academics ¹⁹ Health Service Providers	Community Members ²⁰
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Questions

Efficiency – Different UN agencies (especially in a context of UN as One), NGOs, service providers, DPs etc. have worked to improve RH services including EmOC. How have duplications and gaps been addressed?

Efficiency – Would a stronger community interface, and support for women themselves to access funds to better utilise RH services (transportation subsidies etc.) improve the efficiency of improved RH services?

Efficiency – What lessons learned have there been with respect to delays in implementation and how could those challenges have been better overcome? Has HSIP been one of the bottlenecks?

Efficiency – there are different models of EmOC funded by government, DPs. Are there differences in the efficiency of the different approaches? (getting money to provincial level and below, bulk ordering and purchasing of equipment/supplies etc.)

Efficiency – How well integrated are prevention, screening and treatment of sexually transmitted diseases, including HIV/AIDS with the RH program? How routine is RPR testing (syphilis) and HIV testing in ANC? When and if is treatment offered to positive cases? What links does UNFPA have with ADB, PSI, Save,

Δ	Δ	Δ	Δ	Δ	Δ	Δ	Δ
Δ	Δ	Δ	Δ	Δ	Δ	Δ	Δ
Δ	Δ	Δ	Δ	Δ	Δ	Δ	Δ
Δ	Δ	Δ	Δ	Δ	Δ	Δ	Δ

OFFICIAL INFORMATION UNDER THE ACT

Evaluation tool - Assessment of Reproductive Health Sub- Programme UNFPA/ZAid STRENGTHENING REPRODUCTIVE HEALTH SERVICES WITHIN THE FRAMEWORK OF HSIP

DPs	Sr. Gov. Officials/ Provincial/ District Health officials	UN Org.	CBSC	UNFPA CO	NGOs (FHI, Save, Pathfinder etc.), CSO, Susu Mamas	Research/ Academics Health Service Providers	Community Members ²⁰
<p>RELEASSED UNDER THE OFFICIAL INFORMATION ACT</p>							

AusAID's support to STD clinics etc. to improve efficiencies?

Impact - Give examples of operations research to improve access and quality of RH services undertaken and with what results.

Has the program been able to aggregate research and use these results to inform policy?

Sustainability - Give examples of how the capacity of the health system to address gender-based violence has been strengthened.

Sustainability - What links have been made with NGOs such as ESWCHP/SCI/PNG and BHCP in Bougainville?

Sustainability - What have been the lessons learned and challenges overcome of the NSV programme? How could it be improved, especially using satisfied clients?

Output 3 - Strengthened technical and institutional capacities of the Family Health Services (FHS) for effective policy planning, management, supervision, monitoring and evaluation of reproductive health interventions.

Evaluation tool - Assessment of Reproductive Health Sub- Programme UNFPA/ZAid STRENGTHENING REPRODUCTIVE HEALTH SERVICES
 WITHIN THE FRAMEWORK OF HSIP

	DPs	Sr. Gov. Officials/ Provincial/ District Health officials	UN Org.	CBSC	UNFPA CO	NGOs (FHI, Save. Pathfinder etc.), CSO, Susu Mamas	Research/ Academics ¹⁹ Health Service Providers	Community Members ²⁰

Questions

Impact - What in your view has been the impact of fellowships provided for two health workers for each of the first five years in reproductive public health at MPH level?

Effectiveness - Could there have been a more effective use of these funds?

Effectiveness - A Chief Technical Adviser to the FHS has been recruited. What lessons have been learned and challenges overcome to improve the effectiveness of this input?

Sustainability - Technical supervision of rural reproductive health services is supposed to be facilitated in this programme, yet the Annual Sector Review shows that supervision nationally is down. How can the sustainability of this intervention be improved?

Efficiency - To what extent is the UNFPA programme therefore "double funding" activities in NDOH which should be funded from the (underutilised) pooled HSIP funds?

Sustainability - Describe the advocacy work done with MPs to increase allocations of budgets to RH services at the province and below. Does FHS have a role here?

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Evaluation tool - Assessment of Reproductive Health Sub-Programme UNFPA/NZaid STRENGTHENING REPRODUCTIVE HEALTH SERVICES WITHIN THE FRAMEWORK OF HSIP

Country	UN	CBSC	UNFPA	NGOs (FHI, Save, Pathfinder etc.), CSO, Susu Mamas	Research/Academics/Health Service Providers	Community Members ²⁸
	UN Org.		CO			
DPs	Sr. Gov. Officials/ District Health officials					
						FBO

Questions

Sustainability – Vehicles have been provided to improve supervision. Who will pay the recurrent costs?

Output 4 - Model Midwifery based maternity and reproductive health centre at Gerehu hospital for the NCD

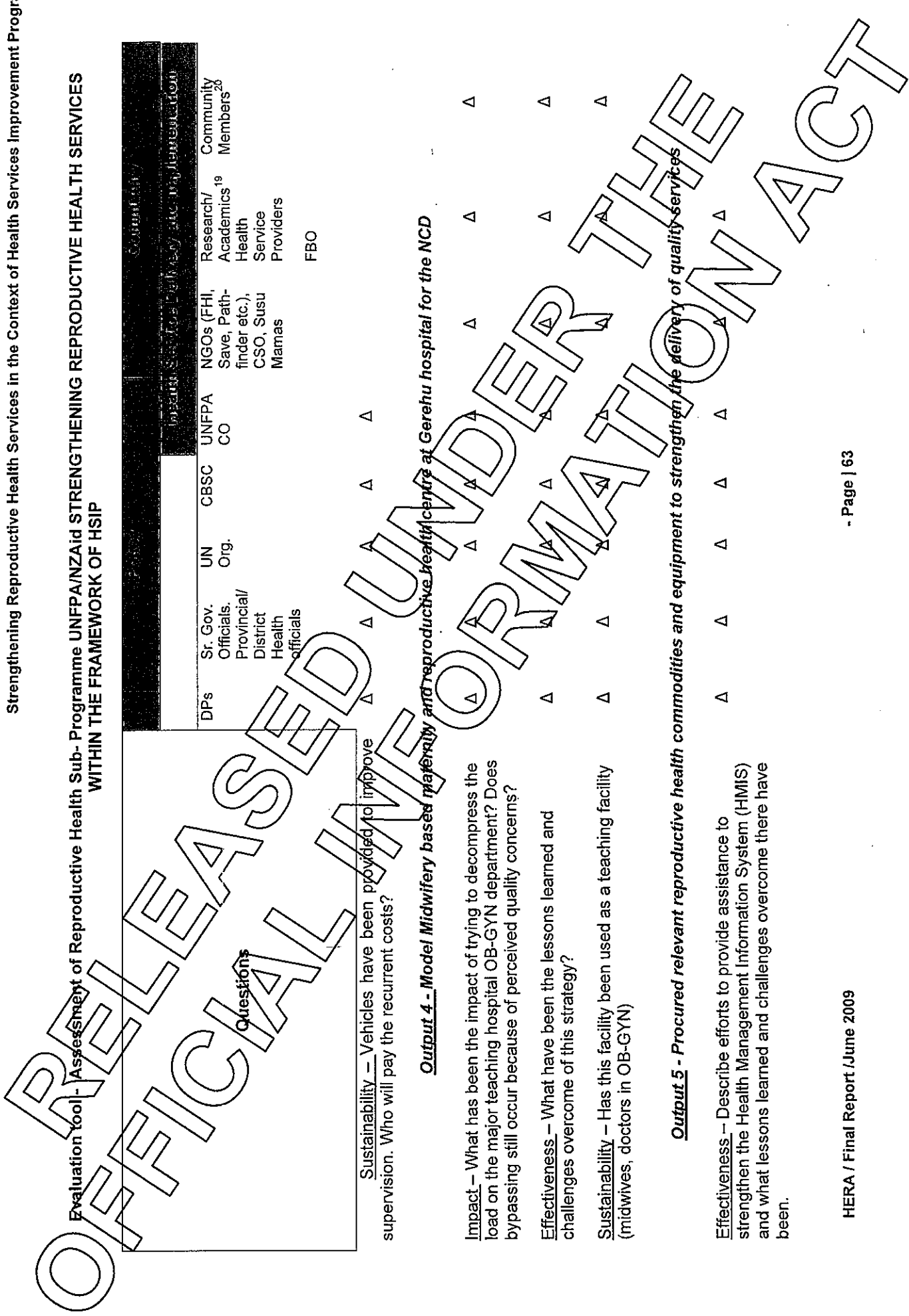
Impact – What has been the impact of trying to decompress the load on the major teaching hospital OB-GYN department? Does bypassing still occur because of perceived quality concerns?

Effectiveness – What have been the lessons learned and challenges overcome of this strategy?

Sustainability – Has this facility been used as a teaching facility (midwives, doctors in OB-GYN)

Output 5 - Procured relevant reproductive health commodities and equipment to strengthen the delivery of quality services

Effectiveness – Describe efforts to provide assistance to strengthen the Health Management Information System (HMIS) and what lessons learned and challenges overcome there have been.



Evaluation tool - Assessment of Reproductive Health Sub-Programme UNFPA/ZAID STRENGTHENING REPRODUCTIVE HEALTH SERVICES WITHIN THE FRAMEWORK OF HSIP

Community		Health Services Delivery and Implementation	
DPs	Sr. Gov. Officials/ Provincial/ District Health officials	UN Org.	CBSC
		UNFPA CO	
		NGOs (FHI, Save, Pathfinder etc.), CSO, Susu Mamas	
		Research/ Academics Health Service Providers	
		FBO	
			Community Members

Questions

Effectiveness – how can the human resources for health constraints on injectables (most popular FP method) be addressed?

Efficiency – Should there be a stronger social marketing component for resupply methods?

Impact – What has been the impact of efforts to strengthen the reproductive health and contraceptive logistical system? What can be done better or differently? From a health systems perspective, are there lessons that can address the pitfalls of the current area medical stores difficulties?

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Annex 5 – HSIP Priorities for the AAPs

Table 3 - HSIP Priorities for the AAPs

Rank	Activity/expenditure	Level
1	Patrol costs (including fuel, travel allowance)	High
2	Distribution of essential medicines, medical supplies, mosquito nets	High
3	Water supply to health centres (labour ward)	High
4	Minor repairs of equipment and facilities	High
5	Quarterly review Provincial Health Board/District Health officer travel and accommodation	High
6	Administrative and Clinical Supervisory Visits, fuel for vehicles, travel allowances	High
7	Basic maintenance of essential vehicles and buildings	High
8	In-service training workshops for priority programs	Medium
9	Minor renovation of health centre and aid posts other than water	Medium
10	Renovation of offices and purchase of furnishings	Low
11	Non essential workshops, conferences	Low
12	External training, post graduate university training	Low
13	Computer hardware, software	Low
14	Phone, office costs	Low

One challenge which faced the project was the fact that it has been difficult to target resources from any source of funds towards the priority public health strategic directions which include maternal mortality reduction and to follow the priorities as listed above. In one province which was an "EOC" province, i.e. under the potential support from NZ Aid, the floor in the toilet adjacent to the labour and delivery room was rotted through, the walls were

falling down, the only new piece of equipment had been a stand alone gift of a delivery bed (not NZ Aid), the nurse in charge slept on the floor in an adjacent room, the only refurbished part of the building was a VCT centre. The provincial health administration had diverted just under 30,000 kina for a new concrete path near their office and a few flower pots which would never have cost that much, which are illegible expenditures under HSIP which ostensibly only allows money for rehabilitation if it is for a maternity, but which were cleared by HSIP.

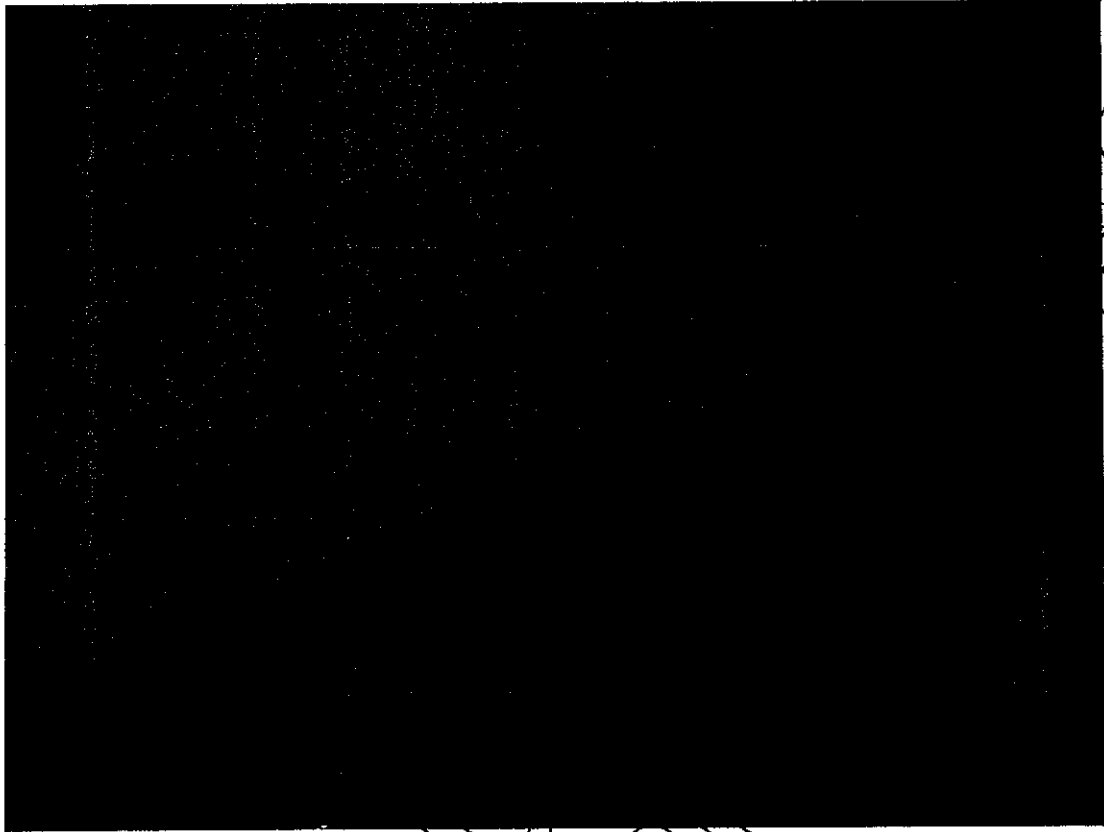


Toilet adjacent to maternity.

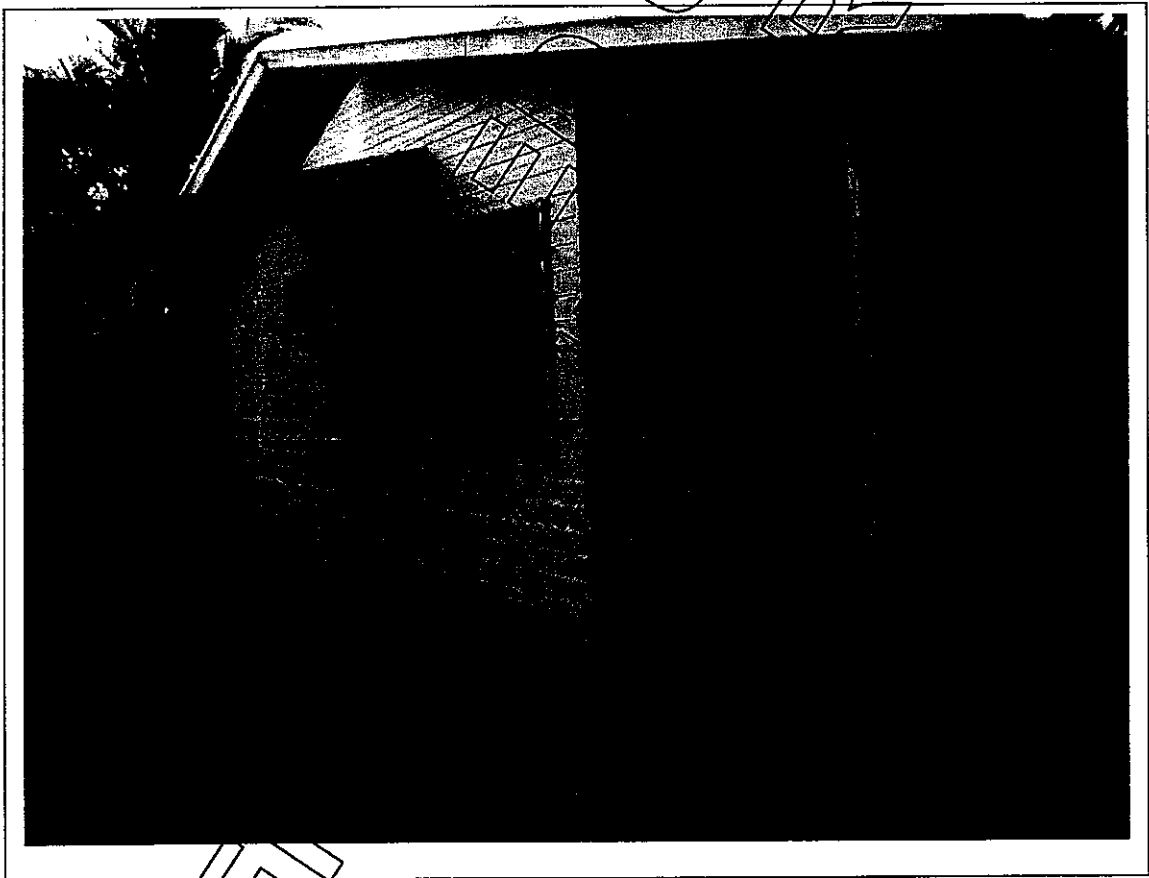


Nurse in charge pointing to rotted wall, with new delivery bed from another donor as a stand alone gift.

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TRACT



Above - Room where the nurse/midwife lives in the health centre. Left - the newly constructed VCT centre in the same facility.

OFF

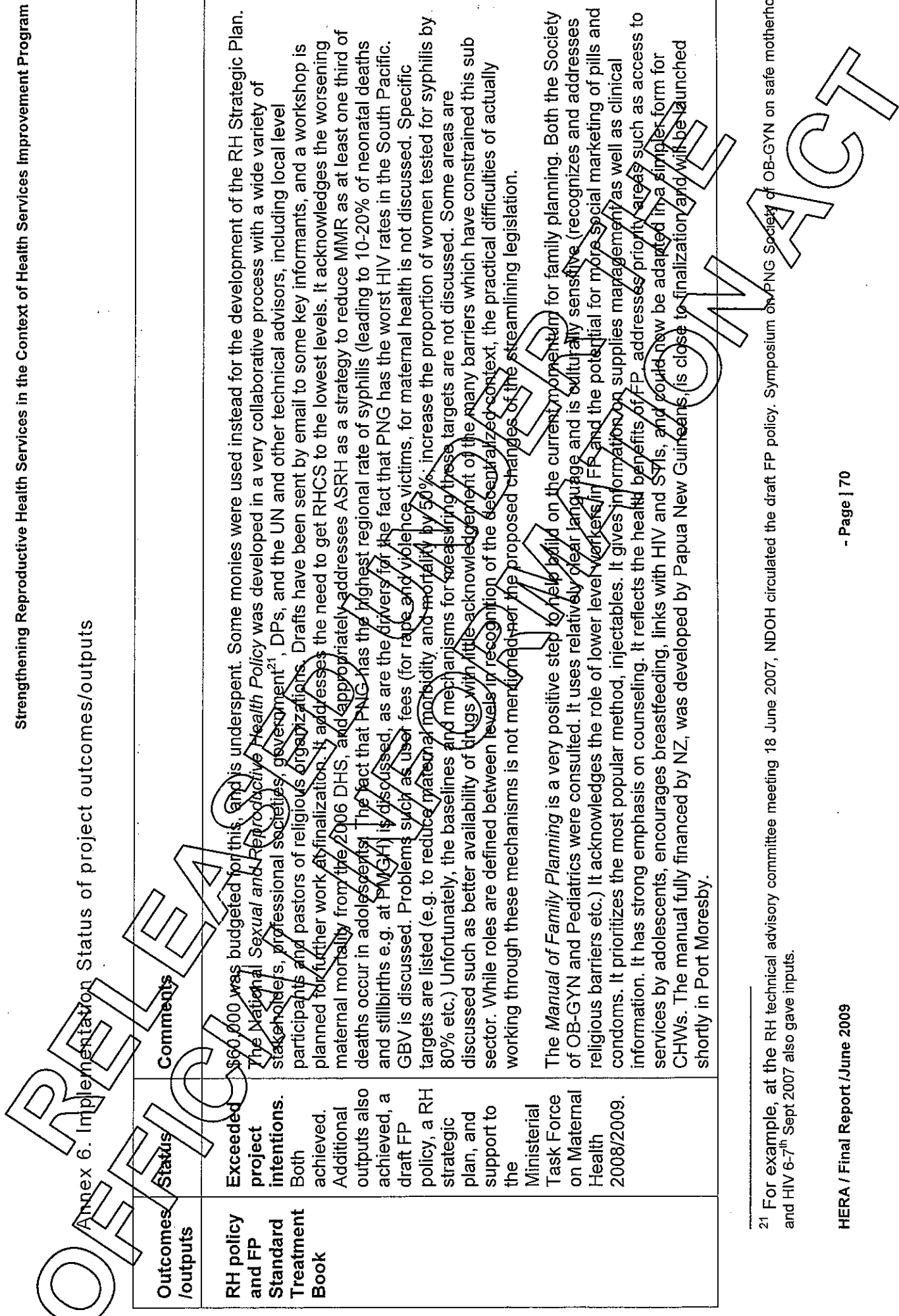


New cement path and flower pots at Provincial Health Administration, not eligible for HSIP funds but cleared with a justification letter while maternity renovations were not done

Annex 6. Implementation Status of project outcomes/outputs

Outcomes/outputs	Status	Comments
RH policy and FP Standard Treatment Book	Exceeded project intentions. Both achieved. Additional outputs also achieved, a draft FP policy, a RH strategic plan, and support to the Ministerial Task Force on Maternal Health 2008/2009.	<p>\$60,000 was budgeted for this, and is underspent. Some monies were used instead for the development of the RH Strategic Plan. The National Sexual and Reproductive Health Policy was developed in a very collaborative process with a wide variety of stakeholders, professional societies, government²¹, DPs, and the UN and other technical advisors, including local level participants and pastors of religious organizations. Drafts have been sent by email to some key informants, and a workshop is planned for further work finalization. It addresses the need to get RHCS to the lowest levels. It acknowledges the worsening maternal mortality from the 2006 DHS, and appropriately addresses ASRH as a strategy to reduce MMR as at least one third of deaths occur in adolescents. The fact that PNG has the highest regional rate of syphilis (leading to 10-20% of neonatal deaths and stillbirths e.g. at PMGH) is discussed, as are the drivers for the fact that PNG has the worst HIV rates in the South Pacific. GBV is discussed. Problems such as user fees (for rape and violence victims, for maternal health is not discussed. Specific targets are listed (e.g. to reduce maternal mortality and mortality by 50%, increase the proportion of women tested for syphilis by 80% etc.) Unfortunately, the baselines and mechanisms for measuring these targets are not discussed. Some areas are discussed such as better availability of drugs with little acknowledgment of the many barriers which have constrained this sub sector. While roles are defined between levels in a decentralized context, the practical difficulties of actually working through these mechanisms is not mentioned nor the proposed changes of the streamlining legislation.</p> <p>The <i>Manual of Family Planning</i> is a very positive step to help build on the current momentum for family planning. Both the Society of OB-GYN and Pediatrics were consulted. It uses relatively clear language and is culturally sensitive (recognizes and addresses religious barriers etc.) It acknowledges the role of lower level workers in FP and the potential for more social marketing of pills and condoms. It prioritizes the most popular method, injectables. It gives information on supplies management as well as clinical information. It has strong emphasis on counseling. It reflects the health benefits of FP, addresses priority areas such as access to services by adolescents, encourages breastfeeding, links with HIV and STIs, and could now be adapted in a simpler form for CHWs. The manual fully financed by NZ, was developed by Papua New Guineans, is close to finalization and will be launched shortly in Port Moresby.</p>

²¹ For example, at the RH technical advisory committee meeting 18 June 2007, NDOH circulated the draft FP policy. Symposium on PNG Society of OB-GYN on safe motherhood, FP and HIV 6-7th Sept 2007 also gave inputs.



		<p>The RH Strategic Implementation Plan was a participatory process involving national, provincial, district health staff as well as senior obstetricians in the country (process financed by NZ). It addressed safe motherhood, family planning, reproductive tract infections and HIV, adolescent sexual and reproductive health, men's involvement in RH, and GBV. Issues such as policy and legislation, standards, human resources, training, supplies and logistics, monitoring and evaluation, research, IEC/BCC, community involvement and security were addressed.</p> <p>The NDOH had a draft RP policy which was ready for NEC approval. A number of political factors intervened which delayed this process considerably. It is now ready for resubmission and has received project inputs to be finalized. It will be launched regionally, with some provincial and district inputs.</p> <p>The Ministerial Task Force on Maternal Health received technical inputs from this project. It is close to presenting its main findings, somewhat delayed. While it included many stakeholders, it was medically dominated, although the project tried to lobby for midwives and other community service providers to be involved. It will endorse the 6 month assistant midwife course for CHWs as a post graduate course and it is recommended that a follow on project support this work.</p> <p>The NDOH appears satisfied with the CTA, 23 June 2008 NDOH requested to extend CTA contract endorsed UNFPA July 2008.</p>
<p>Quality RH services all target groups</p>	<p>Partially</p>	<p>NSV Training About 65% of the money planned for this has been spent. This takes place with a training of trainers approach. For example, in Madang province 2 doctors have been trained (O and G registrar at Mochlon Hospital and a medical officer at Yagaum District Hospital which is Lutheran. The Yagaum doctor trained 2 CHWs (who then become certified) and the Modilon doctor trained an SMO. The trainees then perform the NSV or clients under supervision until they become proficient. Dr. Geita is the master trainer so this has now cascaded through three levels. In Madang province in 2006 there were 66 clients operated at the hospital, and 258 in the province at rural facilities. An additional 326 clients were operated in Madang for NSV in 2007. NSV has a long impact, and greatly increases the couple year protection. Training has both theory and practice, and comprises 10 modules. Training is being standardized. More provincial trainers need to be trained, funds need to be available, and provinces need to put NSV in their AAPs. NSV kits should be distributed to all hospitals with trained medical officers. Training manuals should be distributed to all involved in NSV training.</p> <p>In Wewak training took place 11-15th February. The total cost of training was K42,233.00</p> <p>RH Training All 10 provinces have had training (safe motherhood, ASRH, gender, men's involvement, FP, SRH advocator's training including HIV. NDOH has committed 165,000 K. The process begins with training needs assessments at facility, district and provincial levels. Then appropriate courses are found, with priority given to in-country training. Some regional courses have also been used. For example, 10-14 September 2007 5 health workers (nurses) attended an RH continuing education course in</p>

Samoa for a total cost of 39,591.40K. (Emerging SRH Challenges in the Pacific, organized by the Pacific Society for RH, which included the use of misoprostol for management of haemorrhage which has now been endorsed in PNG). 25-27 July 2007 in Lae, an RH Workshop was held with over 60 participants. Provinces²² sent 2-7 participants. Approximately one third were women. Priority is given to nurses for upgrading as midwives, and for clinical rotations of rural health workers in obstetrics at provincial hospitals (8 week course). Each of the 10 provinces have plans for these clinical rotations and money has been allocated but communication problems exist with NDOH FHS who states the provinces are not drawing down the funds. UNFPA should act to help break down those barriers and get those moving. Doctors (the CTA himself identified 2 doctors for further training) and nurses have been identified for longer term RH training. There are models for whole of site EmOC training (a South Pacific module) which could also be reviewed and supported in provincial AAPs with UNFPA resources. Much more can be done in a follow on project to sponsor nurses for clinical attachments, upgrade them as midwives through fellowship provision, and sponsor nurses to be trained as nurse anaesthetists to assist with EmOC. 3 PNG nurses received a Fiji public health midwifery certificate course in 2006.

Vehicles - November 2007 vehicles for EOC targeted health facilities were procured at a total costs of K674,145.22K. The facilities were Gerehu Clinic, NDOH HQ, Gumine HC in Kundiwa Simbu, Laiagam HC in Wabag Enga, Angoram HC in Wewak east Sepik, Bewani HC in Vanimo WSP, and Nuku HC in Vanimo WSP. This complemented 19 vehicles procured from other budgets. Additional costs included flights and accommodation (so far at least 10,000 K has been tracked) for NDOH and UNFPA staff to hand over the vehicles. 4 boats were also procured. On the other hand, Central province spent just over half of that to launch one vehicle handover from a politician - which was in an accident 2 months later and removed from the HC.

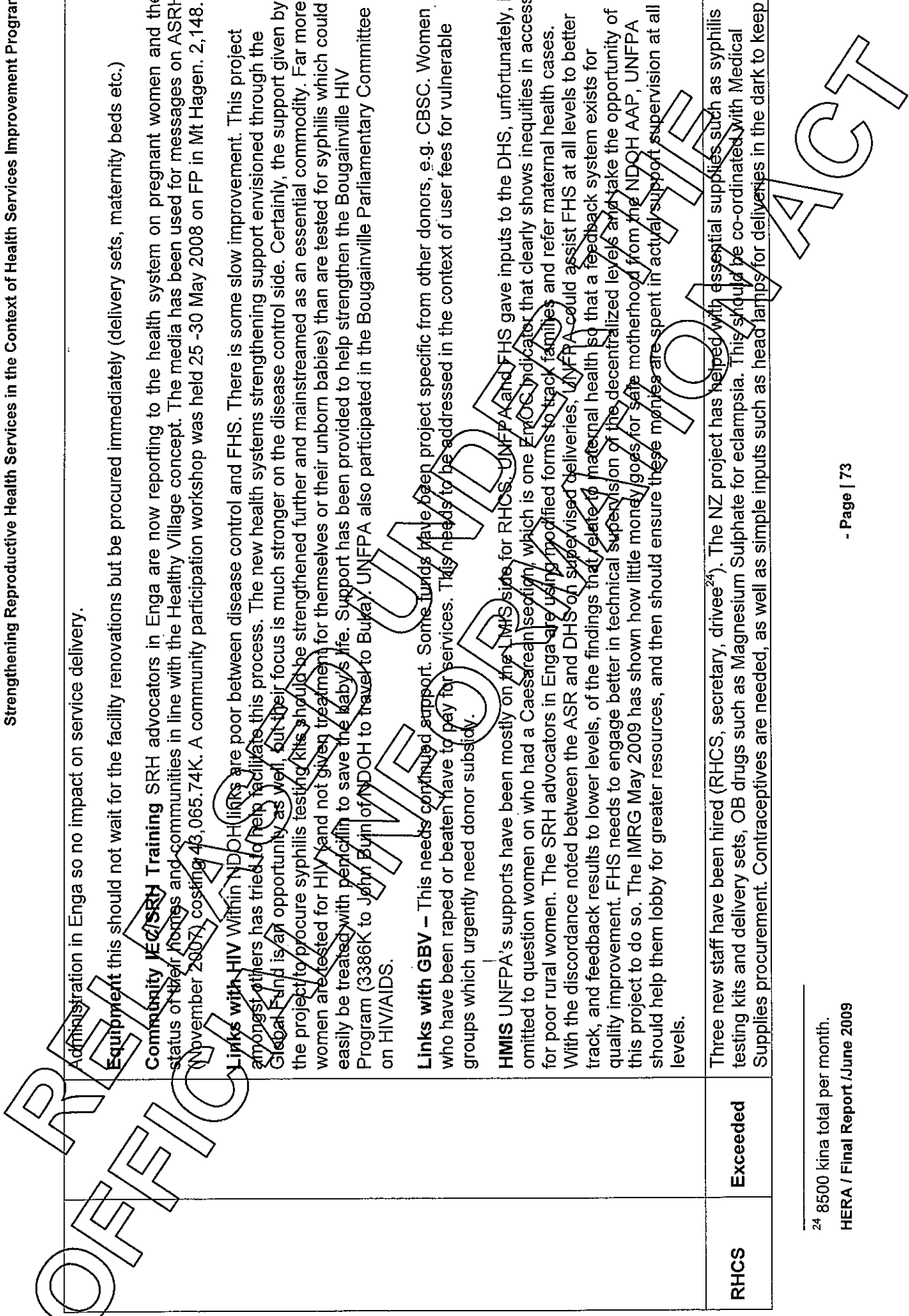
EOC Upgrades In Bougainville, Manus, and Chimbu 80-100% of the planned infrastructure has been completed. In Enga tendering has begun. In Central²³, East Sepik, Eastern Highlands, West New Britain, Madang, and Western province nothing has started. To fast track this proves more work is needed to empower provincial levels of government and enable them to access HSIP money directly and undertake the work through their own works departments and engaging hospital architects and carpenters when available. \$600,000 was originally planned for EOC upgrades and equipment, it is not clear the current status. But some costs are a concern: Visits to Madang including Bogra, where nothing has been done, cost 16,660.56 kina in travel and allowances just to assess the situation (2-7 Dec. 2007 although it was linked with NSV training to conserve costs, following previous visits with additional costs). The Port Moresby General Hospital in NCD which acts as the referral hospital for Central Province as well, received air conditioning for the antenatal ward, costing over 24,000 kina in March 2007, though in November 2006 the deputy rep UNFPA had reported this would be an ineligible expenditure.

Operations research 10,000 kina were spent on this research on ANC. The results were not fed back to the provincial Health

²² Bougainville, Simbu, Sandaun, Western, East Sepik, Central, Enga, Manus, Madang, Milne Bay, West New Britain, Eastern Highlands Province, Oro, Morobe. NDOH and UNFPA also attended. Participants included Provincial Health Advisors, Officers in charge of rural facilities, OB-GYN specialists, nursing and midwifery officers, and technical facilitators.
²³ Scope of works has been done for Kupiano HC - immediate costs would be 56,000K and long-term improvement 250,000K. With the problems accessing the Supplementary Budget and NZAid, other sources of funds are being mobilized.

	<p>Administration in Enga so no impact on service delivery.</p> <p>Equipment this should not wait for the facility renovations but be procured immediately (delivery sets, maternity beds etc.)</p> <p>Community IEC/SRH Training SRH advocates in Enga are now reporting to the health system on pregnant women and the status of their homes and communities in line with the Healthy Village concept. The media has been used for messages on ASRH (November 2007) costing 43,065.74K. A community participation workshop was held 25 -30 May 2008 on FP in Mt Hagen. 2,148.</p> <p>Links with HIV Within NDOH links are poor between disease control and FHS. There is some slow improvement. This project amongst others has tried to help facilitate this process. The new health systems strengthening support envisioned through the Global Fund is an opportunity as well, but their focus is much stronger on the disease control side. Certainly, the support given by the project to procure syphilis testing kits should be strengthened further and mainstreamed as an essential commodity. Far more women are tested for HIV and not given treatment for themselves or their unborn babies) than are tested for syphilis which could easily be treated with penicillin to save the baby's life. Support has been provided to help strengthen the Bougainville HIV Program (3386K to John Burn of NDOH to travel to Bukay UNFPA also participated in the Bougainville Parliamentary Committee on HIV/AIDS.</p> <p>Links with GBV – This needs continued support. Some funds have been project specific from other donors, e.g. CBSC. Women who have been raped or beaten have to pay for services. This needs to be addressed in the context of user fees for vulnerable groups which urgently need donor subsidy.</p> <p>HMS UNFPA's supports have been mostly on the LMS side for RHCS UNFPA and FHS gave inputs to the DHS, unfortunately, it omitted to question women on who had a Caesarean section, which is one EnOC indicator that clearly shows inequities in access for poor rural women. The SRH advocates in Enga are using modified forms to track families and refer maternal health cases. With the discordance noted between the ASR and DHS on supervised deliveries, UNFPA could assist FHS at all levels to better track, and feedback results to lower levels, of the findings that relate to maternal health so that a feedback system exists for quality improvement. FHS needs to engage better in technical supervision of the decentralized levels and take the opportunity of this project to do so. The IMRG May 2009 has shown how little money goes for safe motherhood from the NDOH AAP, UNFPA should help them lobby for greater resources, and then should ensure these monies are spent in actual support supervision at all levels.</p>
<p>RHCS</p>	<p>Exceeded</p> <p>Three new staff have been hired (RHCS, secretary, driver²⁴). The NZ project has helped with essential supplies such as syphilis testing kits and delivery sets, OB drugs such as Magnesium Sulphate for eclampsia. This should be co-ordinated with Medical Supplies procurement. Contraceptives are needed, as well as simple inputs such as headlamps for deliveries in the dark to keep</p>

²⁴ 8500 kina total per month.
HERA / Final Report / June 2009



	<p>design</p> <p>midwives hands free. An RHCS working group was established by NDOH with UNFPA inputs (July 2007). NDOH requested in that month additional TA from UNFPA for RH forecasting, management and logistics including programming for the female condom. A RHCS advisor from the CST Fiji visited 29 October – 9 November 2007 (changed to 3-11/15 Nov) one of the 3 proposed backstopping visits in the original project design). A third party agreement for RHCS procurement has triggered an investment multiplier of an additional \$800,000 worth of commodities to be procured through UNFPA Copenhagen. Training in MIS is planned and more is anticipated. There has been 1 mission from Fiji Country Support Team of UNFPA to assist with RHCS, 2 more are planned in the original budget (each estimated at \$5000).</p>
<p>FHS</p>	<p>Achieved, limited by HR.</p> <p>FHS has been supported to have coordination meetings. This links national and provincial levels. The key interventions needed for safe motherhood are outlined, and provinces districts and facilities are helped to make their AAPs. For example, 25-27th July 2007 this took place, with MDOH. The NDOH draft FHS AAP was presented, provinces brought forth their experiences (East Sepik, Madang and Manus) and the participants were helped to prioritise their own plans. They have also been supported to provide support supervision visits to the provinces. This is not sustainable. FHS needs to put this in their own AAPs and needs to be supported to have this important work funded – HSIP spends too much money on administration and not enough on technical support to the priority public health programs. FHS had requested support for their own restructuring, the government has now frozen recruitment and the restructure. Hopefully, an additional staff person in FHS will be allowed to be recruited as the process was well underway April 2009.</p>
<p>Office Equipment²⁵</p>	<p>Not originally planned.</p> <p>January 2008 an additional vehicle was obtained for the NDOH FHS (90,810.50K) and a laptop for 7042.63 K. The laptop was 3 times more expensive than the lowest quoted price as it was procured through HSIP's period contract supplier. The CTA and RHCS staff have also received computers (9,098.60 K). NSW trainers have received AV equipment and laptops to help with teaching. The CTA and NDOH staff have all received wireless internet at several thousand kina July 2008, which is well appreciated.</p>
<p>Gerehu</p>	<p>Underway</p> <p>Money transferred to HSIP for this \$300,000. (822,000.00K) November 2007. This has not all been spent. The money they were expecting from the supplementary budget was frozen after the first tranche of 800,000 kina. The NZ money could now help salvage this situation so it is more in accordance with its original intention of becoming a model maternity communication problems between all players (St. John's, HSIP, NDOH, UNFPA) have not resolved the impasse. This will have great potential as a teaching site for CHWs as assistant midwives. But the process of building has been costly, nearly 10,000 K just for a site</p>

²⁵ E.g. in Nov 2007 Office supplies for RH/CTA, 9,098.K (computer, printer, radio etc.).

	<p>inspection</p> <p>When it is functional, it will have 24 hr service, 2 delivery beds, a labour ward of 6 beds, and a post natal ward of 10 beds. There will be 12 midwives and 12 auxiliary staff. An ambulance was provided. This is an important intervention as this model can be extended to decongest provincial hospitals.</p>	
<p>Project management</p>	<p>Ongoing</p>	<p>UNFPA received \$138,750 to manage the project as overhead. It is unclear of various traveling expenses of senior UNFPA staff are part of that, in any case they were charged to the project. For example, the UNFPA rep attended the annual medical symposium in Rabaul 31 August - 1 September, and it was charged to the project. CTA, Rep and Deputy rep traveled to Fiji 7-13 September to discuss the PNG Country programme. These costs were also charged to the project, likely to replace one of the 3 CST backstopping visits. No money has been spent on audit (\$5000 x 3 expected) so this money could be reprogrammed.</p>

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