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Trip Report

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Country Visited: PAPUA NEW GUINEA

Date of Trip: February 4-15, 1986

Purpose: To conduct a training needs
assessment at the request of USAID/Suva.

LIST OF ABBREVIATIONS

ADB:	Asian Development Bank
AID:	Agency for International Development
APO:	Aid Post Orderly
CBD:	Community-Based Distribution
DOH:	Department of Health
FPA:	Family Planning Association
HEO:	Health Extension Officer
IMCH:	Institute for Maternal and Child Health
INTRAH:	International Training in Health
IPPF:	International Planned Parenthood Federation
IUD:	Intra-Uterine Device
MCH/FP:	Maternal and Child Health/Family Planning
NFP:	Natural Family Planning
NTSU:	National Training Support Unit
PHC:	Primary Health Care
PNG:	Papua New Guinea
RTSA/A:	Regional Training Service Agency/Asia
TOT:	Training of Trainers
UNDP:	United Nations Development Program
UNFPA:	United Nations Funds for Population Activities
USAID:	United States Agency for International Development

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EXECUTIVE SUMMARY

Lynn Knauff, Deputy Director of INTRAH, and Chita S. Quitevis and Asuncion G. Eduarte, INTRAH consultants from the Institute of Maternal and Child Health (IMCH) in the Philippines, conducted a training needs assessment in Papua New Guinea from February 4 to 14, 1986, at the request of USAID/Suva.

Meetings and interviews were held with Department of Health and other officials at central and provincial levels, and field visits were made to service sites and training institutions in Port Moresby and the Eastern Highlands Province.

Training needs observed and expressed included: family planning clinical skills, client counselling, contraceptive updates, client management, client follow-up, clinic management, development and use of client education materials, and sterile techniques. Often, the family planning clinical skills of trainers and supervisors were no more proficient than those who received training and supervision.

Both pre-service and in-service training designs and daily schedules which were reviewed reflected a need to incorporate updated content in family planning and adult learning techniques. There is also a need to link pre- and in-service training institutions and curricula.

Standards and protocols for family planning services and for each method were nonexistent, as were statements of duties (with respect to family planning) for each level of health personnel.

In view of the extent of training and technical assistance which will be required -- if the Department of Health (DOH) requests assistance -- the strategy recommended to INTRAH is to focus on building service and training capacity in one province (see Recommendations section, No. 1). As a first step, a core group of six nurses and health extension officers who have designated responsibilities in providing and supervising family planning services in the selected province should attend a six-week clinical training course at IMCH in the Philippines, including an out-placement practicum in an IMCH rural clinic. Upon return home, this core group of six and others should develop written standards for family planning services and statements of family planning duties of various categories of health workers, with assistance from INTRAH and IMCH.

Immediately thereafter, a service, training and supervisory plan should be prepared that emphasizes the integration of family planning into the maternal and child health service network and can, when implemented, guide improvements in the quality and availability of family planning services, training and supervision. Subsequently, pre-service and in-service curricula should be developed that incorporate sound, contemporary adult learning methods and content, and practice in topics and skills that are directly relevant to the provincial health workers' statements of family planning duties.

Should INTRAH be requested to provide assistance, a combined project development and technical assistance visit should be made immediately after the core group's clinical training in the Philippines. That visit will reveal the extent of technical resources required, which can then guide discussions and choices about inputs that INTRAH can afford, given the very high costs observed and experienced by the team.

SCHEDULE OF ACTIVITIES

- Tuesday**
February 4, 1986
- Arrived in Port Moresby from
Manila, Philippines at 2:00 p.m.
- Wednesday**
February 5, 1986
- Meetings at the Department of
Health with:
- Dr. Quentin Reilly
 - Dr. Levi Sialis, Dr.
Daniel Johns, Ms.
Tabora Lokoloko, and
Mrs. Mary Biddulph
 - Ms. Shirley Gideon
and Dr. Than Than
Wyn
 - Dr. Dragan Stern, WHO
(briefing)
- Thursday**
February 6, 1986
- Meeting at American Embassy with
Mr. Donald R. Cleveland (briefing).
- Meeting at UNDP with Mr. Raouf
Galal El Din and Mr. Maman
(briefing).
- Meeting at Family Planning
Association of Papua New Guinea
with Ms. Ruth Iangalio, Sr. Esther
Mirisa and Mrs. Mary Osborn.
- Meeting at Department of Health
with Dr. Warwick Davidson and Mr.
Robert Makai.
- Friday**
February 7, 1986
- Meeting at Department of Health
with:
- Dr. Isaac Ake
 - Ms. Esther Vagi,
Mrs. Dawa Masere and
Mrs. Mioko Manoa
 - Mr. Jonathan Vali
and Mr. P.P. Shrestha (WHO
consultant)
- Meeting at College of Allied Health
Sciences with:
- Mr. Simon Jugabi
 - Mrs. Apolonia Vanieb
 - Mr. Willie Vagi

SCHEDULE OF ACTIVITIES (Continued)

- Visit to Holohola Family Planning Clinic with Sr. Hilda Boga and Sr. Shirley Gideon (Quitevis only).
- Sunday**
February 9, 1986
- Flew to Goroka in Eastern Highlands Province. Arrived at 3:30 p.m.
- Monday**
February 10, 1986
- Meeting at Provincial Department of Health with:
- Mr. Leonard Loh
 - Ms. Julie T. Liviko.
- Met Dr. William Beiber, Secretary for Health, Eastern Highlands Province.
- Visited:
- Kintune Aid Post
 - Henganafi Health Center
 - Kompri Health Sub-Center
 - Kainantu Health and Training Center
- Tuesday**
February 11, 1986
- Visited:
- Goroka-Base Hospital
 - Eastern Highlands College of Nursing
- Returned to Port Moresby at 4:00 p.m.
- Wednesday**
February 12, 1986
- Meetings at the Department of Health with:
- In-service Training Steering Committee and MEDEX consultants
 - Dr. Levi Sialis and Dr. Daniel Johns (debriefing)
 - Ms. Jelilah Unia
 - Mr. Isaac
- Meeting at UNDP with Mr. Maman (Knauff and Eduarte only).
- Visited Lawes Road Health Center (Quitevis only).

-CONTINUED-

I. PURPOSE OF THE TRIP

The overall objectives of the assignment were:

1. To assess the training needs of nurses and other potential family planning providers (nurses aides, aid post orderlies, health educators, outreach workers, social workers).
2. To assess the prospects for building in-service training capacity.
3. To assess the potential for linkage between the Institute of Maternal and Child Health and institutions in Papua New Guinea.

II. ACCOMPLISHMENTS

1. The team met with and/or interviewed DOH and other officials in Port Moresby and the Eastern Highlands Province to clarify the objectives of the visit and to learn about current and proposed training activities.
2. Field visits were made to service sites in Port Moresby and the Eastern Highlands Province.
3. Training and service needs were observed and expressed in the following content areas: clinical family planning, contraceptive update, client counseling, client management, client follow-up, clinic management, client educational materials, and sterile techniques.
4. Briefings and debriefings were held at the DOH, and a briefing was held with Mr. Don Cleveland, who represents AID along with many other duties as the political and economic affairs officer of the American

Embassy in Port Moresby (see Appendices B and C for debriefing summaries from DOH meetings.)

III. BACKGROUND

This visit was made as a result of a request from Dr. Patrick Lowry, Health/Population/Nutrition Officer in Suva, Fiji by telephone when he was at AID/Washington in December 1985.

Neither RTSA/A nor INTRAH had conducted any previous visits to Papua New Guinea. During the summer of 1985, INTRAH, at the request of USAID/Suva, funded participant training for Ms. Ruth Iangalio, Executive Director of the Family Planning Association of Papua New Guinea, who attended the Population, Communication and Research workshop at the University of Chicago.

IV. DESCRIPTION OF ACTIVITIES

During interviews, meetings and site visits, the team attempted to obtain both an overview of and specific information about:

- policy guidance for family planning.
- intended and actual emphasis of family planning within maternal and child health.
- administrative and operational structures for health services planning, delivery, supervision, research and evaluation.
- service delivery systems for family planning.
- pre-service and in-service training programs, curricula, trainers, training support, and linkages between the pre-service and in-service systems.
- perceived needs for improvement and expansion of family planning services.
- perceived training needs.

- current level of service and training skills.
- current demand for family planning services.
- record-keeping and reporting systems for MCH/FP.
- traditional methods of family planning and cultural traditions associated with the maternity cycle and care of the newborn.

Appendix E contains a summary of information obtained from reports obtained from the Department of Health and other sources. The remainder of this section will provide information derived from interviews, meetings and site visits, and is organized by the organizational source from which the information or observation was obtained.

A. Headquarters Office of the Department of Health in Holahola, Port Moresby Metropolitan Area

The Secretary of Health, Dr. Quentin Reilly, called a briefing meeting for the team with senior managers, except for the training coordinator who was preparing to attend a seminar in Australia. The meeting provided the team with information related to the organizational structure of the DOH and current activities of various sections and divisions.

Relevant information and impressions gathered during the meeting were:

1. Health services have been decentralized in order to streamline administration and service provision, and to act on the health principles (see Appendix E) adopted in 1985. Each of the 20 provinces has its own department of health and assistant secretary and staff who supervise the service system.
2. Coordination within the headquarters office was said to be poor, and there is frequent change in the organizational structure in an attempt to decrease the number of headquarters staff.

3. Communications and coordination are difficult because of the terrain and inadequate transportation system, but also because of cultural and linguistic features which tend to further isolate clans and kinship groups from administrative centers. There are more than 700 language groups, and social organization is based on the clan or kinship group.
4. The 1980 census report showed that 95% of the population was estimated to be within two hours' travel time of a health facility and 75% were within one hour's time. There was, however, doubt expressed about the validity of those data.
5. Family planning services are managed by the provinces; therefore, the quality and quantity of services are variable. Services are reportedly provided by aid post orderlies, health extension officers, nurses and nurse's aides as a part of their MCH responsibilities.
6. The Family Planning Association was perceived as an urban service delivery source (although it was learned later that community-based distribution in rural areas is their major emphasis).
7. Aid post orderlies and nurse's aides will soon become health orderlies, male and female. They are the lowest-level of health service provider, and the orderly is the staff for aid posts.
8. The term and the unit, Family Health, embrace family planning and nutrition. There appeared to be one person responsible for family planning, who was also a trainer in IUD insertion.
9. The National Training Support Unit (NTSU) has replaced the Health Education Institute and has been established for the purpose of implementing a training project funded by the Asian Development Bank (ADB). The Unit is staffed by a consultant, Mrs. Biddulph. The source of technical assistance is MEDEX of the University of Hawaii. The project will provide for training of provincial-level PHC in-service training teams (a health extension

officer, a health educator/PHC project officer, a community-based nurse, a hospital or nursing school tutor, and a disease control officer). These teams, after receiving a four-week TOT and follow-up, will be expected to train district teams in various PHC topics.

The ADB project will also provide for assistance in review and modification of pre-service and in-service curricula including task analyses for each category of worker (who may be variously deployed, depending on provincial managers' decisions), development of posters and pamphlets, and will provide reference books and audio-visual and other equipment for the provinces.

Assistance was requested in writing the curricula.

It was learned later from a national short-term consultant to the project that the NTSU was supposed to be based at the College of Allied Health Sciences, not the Department of Health, in order to give it an institutional base appropriate to its objectives. However, Mrs. Riddulph was working in a DOH building and did not mention collaboration with the faculty of the College of Allied Health Sciences.

10. Family planning training is or will be carried out primarily through a UNFPA-assisted project (FY 1986 funds had not yet been received). A PNG national, Mrs. Gideon, was in charge of the project and is also the supervisor for family planning within the DOH. She is assisted by four United Nations volunteers, one of whom is in the headquarters office and works with Mrs. Gideon. The project area is or will be three provinces in which a series of four and one half day courses will be conducted for a variety of health personnel (see Appendix F for the project plan of action). The team was told that the same course and self-instructional course materials would be used for initial and refresher training. The training "curriculum" given to the team was a daily schedule, which was mainly knowledge-oriented rather than skills-oriented despite the acknowledged lack of skills of participants. Neither of the two persons who are responsible for the project had received training in training or had recently (within the past ten years) had a clinical family planning course.

The team was told that very often persons trained in family planning are transferred to positions where the training cannot be used, and though over the years many persons had been trained in family planning (through an earlier UNFPA-assisted project, terminated by the government) few were still in family planning supervisory or service delivery positions. During the earlier project, a senior nursing sister in each province had been clinically trained, but IUD insertion practice had been minimal.

The team had an opportunity to read the UNFPA Project Paper and addendum. Both documents indicate a broader scope for the project than was discussed with or observed by the team; for example, increasing the number and timing of antenatal visits and the number of supervised deliveries are also to be addressed, as is the training process which is to be more problem-based than didactic.

11. Natural family planning, specifically the Billings method, is provided by the National Catholic Family Planning Office which also provides training as and when requested by the DOH. No NFP training was included in training schedules shown to the team, although many copies of an NFP self-instructional booklet on the ovulation method were available.
12. The supervisor for family planning, Mrs. Gideon, requested a comprehensive family planning clinical course for herself both for updating her own clinical knowledge and skills and for providing her with ideas for in-country clinical training.
13. Data reporting functions were as complete as data input would permit; the provincial offices send in data which are based on data they receive from aid posts, sub-centers, health centers and hospitals. There is very incomplete reporting of births and deaths, which hampered precision of certain rates and ratios.

The amount of data collected is vast and field application appeared to be difficult, although summary and annual reports were available.

New monthly report forms have been designed, which are very detailed. They were being pilot-tested during the week following the team's visit.

Family planning data on new acceptors are available to the Research and Evaluation Unit, except for data from the Family Planning Association, which are submitted to the Family Health Unit.

14. The supervision and coordination of nursing education are provided by headquarters, within the Training Unit. Nursing services, however, are not coordinated with nursing education. Nursing education is oriented toward preparation of hospital-based nurses, although there is recognition of the need to re-orient the curriculum and faculty toward PHC. The team was told that nurses and midwives were given a family planning theoretical unit and practicum during basic training.

B. Provincial Health Office: Eastern Highlands Province (Goroka)

The provincial health office staff consisting of the secretary, provincial health extension officer, and the provincial nursing supervisor made arrangements for the team to visit various levels of health services outlets: hospital-based clinics, district health centers, mission clinics, aid posts, and a health extension officers' (HEO) training center. The nursing officer accompanied the team during the site visits.

1. The team was told by the provincial health staff that the planning, budgeting and management of health services are provincial responsibilities. Technical assistance is provided by the central office of the DOH, and the national government provides 90% of the annual operating budget, which is based on an annual plan submitted to the DOH.

2. The team observed health activities carried out at various levels by various categories of service providers: HEOs, nurses, nursing aides, and aid post orderlies. Service providers were interviewed regarding their current activities in child-spacing/family planning, as well as service delivery and training needs and problems.
3. The team visited a health extension officers' (HEO) training center in Haimantu. The training center was located in the same compound as a small hospital and clinic which serve as the field training site/practicum for the HEO students. Supervisors and providers of health services teach in the training center. Linkage between classroom teaching and the "reality" of the practicum sites is desired, but evidence of field experience being used in the curriculum was not apparent. Skills objectives did not appear to be linked to the teaching methods actually employed, and family planning was a negligible element in the curriculum.

There are two separate out-patient clinics for MCH and family planning. The family planning clinic was closed although according to the clinic schedule, it should have been open. The team was told that staffing has been a problem.

Both in this and another hospital which the team visited, there was no postpartum family planning education given to new mothers.

4. At the aid health post visited by the team, the aid post orderly had neither the space nor supplies to provide family planning. The post consisted of a small, unpartitioned room and a porch, which was packed with patients waiting for curative services. There was no water supply in the room and no facility for sterilizing instruments. The aid post orderly said he referred people to the health center if and when family planning services were requested.
5. The health center visited by the team had a well-baby clinic underway, which consisted of immunizations, and weighing/growth monitoring using rainbow charts. The clinic was packed, and the team observed that the work was done quickly and efficiently, but no counseling or conversation took place between the nurse/nurse's aides and the

clients. Whether this owed to the nurse-in-charge not being from the area and perhaps unable to speak the clients' language was not known. In any case, no family planning promotion was being conducted during the clinic visit, and no services other than those being given could possibly have been offered because of the space and overcrowded conditions.

6. At a Mission-sponsored health sub-center and hospital the team arrived after the morning clinic, which is devoted mainly to curative services and is staffed by PNG nationals with no Mission personnel in any health services position. There was no evidence of recent family planning services having been offered or family planning training having been received by the staff. The Mission facilities are not supervised by the provincial health office, which might account for the pneumonia patient who was housed in a locally -appropriate straw house; however it was filled with smoke emitted by an open fire set in a pit in the middle of the room and children were playing nearby the fire. The children had come with the patient's guardians who were responsible for cooking and caring for him.
7. The team visited the Goroka-Base Hospital family planning clinic which did have privacy and sufficient equipment and supplies for family planning. However, the staff had not received recent training in family planning although they were responsible for precepting nursing students during students' field practicum.

Here as was observed in two other clinic sites, 50 Lippes loops had been soaked in a Zablun solution for more than a week in anticipation of demand for IUD insertions which never occurred. The nursing student whom the team interviewed was knowledgeable about family planning and during a role play with the team demonstrated good skill in explaining the methods and responding to questions. The methods' chart she used was not equal to her presentation skills, but she easily transcended it.

The clinic did not have a follow-up system for missed appointments although the records were kept in chronological order, by method. The pill checklist was also used for IUDs and injectables, and was attached to the clinic record. The team

inquired about the appropriateness of the pill checklist for other methods, and was told the clinic had no other lists.

8. The Goroka College of Nursing was located in a wing of the hospital. It had just started up again after two years of shut-down as a result of faculty and funding shortages. The curriculum integrates child-spacing/family planning in the obstetrics theory portion, and the practicum includes well-defined criteria and standards, which are reflected in the clinic, the best family planning facility visited by the team.
9. The province has purchased a computer and also uses two-way radios for communication from and to vehicles and facilities, between facilities, and from and to the provincial office, hospitals and health centers.
10. The provincial team (nurse, HEO and assistant secretary) provides supervision to each health center once per quarter. Monthly HEO meetings in Goroka are also used for supervision.
11. The team debriefed with the Health Extension Officer, Mr. Loh, noting particularly:
 - the enthusiasm and skills of the nursing student;
 - the absence of counseling by the health center staff (he said counseling was not a subject in health personnel's basic course of study).
 - the attention given to the family planning practicum in the College of Nursing; and
 - the improbability of providing family planning services at aid posts.

C. Family Planning Association of Papua New Guinea, Holahola

The team made one visit to the office of the Family Planning Association of Papua New Guinea to meet Ms. Ruth Iangalio, Executive Officer; Sr. Esther Mirisa, Clinic Nurse; and Mrs. Mary Osborn, CBD coordinator.

Dr. Quitevis also observed the clinical services and facilities, which consisted of twice-weekly, nurse-provided services delivered in a poorly equipped and poorly maintained clinic room.

1. The Association's office and clinic are provided rent-free, by the Department of Health.
2. The Association's major activities are three CBD projects, one of which is funded by UNFPA, and a mail-order condom business.
3. Training conducted by the Association is confined to training for community volunteers who participate in the CBD project. The curriculum is a daily schedule which appears to rely heavily on didactic techniques and does not include skill-building in interpersonal and group communications.
4. The nurse who provides family planning services has not received recent training and has not been formally trained in IUD insertion techniques.
5. It was not clear that Ms. Iangalio's participant training in Chicago sponsored by INTRAH was directly relevant to her needs and the PNG family planning situation. She observed that the Chicago course was geared to the Caribbean and was therefore of limited value to her, although she was enthusiastic about content provided on the subject of influencing influentials about the consequences of rapid population growth and the need for a population policy.

D. School of Allied Health Sciences in Port Moresby

A conference with four of the full and part-time faculty members provided information that nursing and midwifery training is still basically hospital-oriented rather than community-oriented. Family planning coverage appeared to be minimal, but the team was told that students gain practical skills in the Port Moresby

Base hospital, which is situated adjacent to the school.

1. This school is one of two government-sponsored for Allied Health Sciences and trains nurses, midwives and community health nurses at undergraduate and post-graduate levels. The school in Madang trains health inspectors and health extension officers.
2. Like many service providers and faculty of other training institutions whom the team met, those who teach family planning have not had any refresher courses in recent years.
3. There has been no community health nursing course for the past four years, but the reason was not clear.
4. The newly-appointed dean of the school, Miss Unia, is a part-time consultant to the ADB-assisted training project. Her appointment to the deanship, reportedly, has divided the faculty, which is also disturbed about salaries, living quarters, allowances and working conditions. The school does not have a maintenance budget and the school facilities are housed in dormitories.
5. Teaching aids appeared to be insufficient and out-of-date. The library was stocked with sufficient coverage on primary health care, but almost no materials on family planning.

V. FINDINGS/OBSERVATIONS

The following findings/observations were made by the INTRAH team:

A. Status of Family Planning/Administrative Aspects

1. There is no population policy and no political support for one.
2. Family planning is perceived as an MCH service under the term, child-spacing.

3. The need for family planning is expressed through clients' requests; there does not appear to be use of an unmet need data base or strategies and tactics to systematically increase the number of contraceptive users.
4. Data are available from the DOH on the number of acceptors by types of methods chosen.
5. Guidelines for PNG health services include national health principles (see Appendix F, Country Health Information Profile). These health principles, however, did not appear to be observed in the delivery of family planning services.
6. Unmarried women are not eligible for DOH-provided services, and married women must have their husband's consent. Injectables are given only to para 2+, and tubal ligations are only provided to para 4+.
7. Family planning services are a provincial responsibility, not a national responsibility; however, family planning commodities are provided by the national office.
8. The provincial health office obtains 90% of its annual budget from the central office and 10% from the province (usually in the form of infrastructure).
9. The team confirmed the statement of Dr. L. Sialis, that there are poor coordination and communication within the Department of Health.

B. Family Planning Services as an Aspect of MCH, at sites visited

1. Family planning services are integrated into MCH services.
2. Descriptions of who is doing what in family planning and who should do what were not available, despite the existence of a UNFPA-supported training project.

3. Organizations providing family planning services are:
 - Department of Health: clinic-based in rural areas
 - Family Planning Association of PNG (IPPF Affiliate): clinic-based in Port Moresby, three CBD projects, and a mail-order condom business
 - National Catholic Family Planning Office: ovulation method

4. Frequency of Services:
 - once or twice a week (afternoon only)

5. Distribution points of services:
 - rural and urban clinics
 - hospitals
 - the FPA clinic

6. Quality of Clinical Services:
 - No physical check-up/examination is done for FP acceptors. A pelvic examination is not done routinely.
 - There is much to be desired in most health centers visited in terms of: facilities, privacy, clinic equipment, and sterilization of instruments.
 - Aseptic techniques are basically inadequate both in DOH clinics and the FPA clinic.
 - The checklist used for oral contraceptives is also used for Depo and IUDs, even though contraindications are different.
 - There is no systematic client education for family planning in MCH clinics or postpartum wards.
 - There is a lack of materials for client-education.
 - There is no counselling in family planning service delivery; in general, the counselling aspect is absent in most other services, also.
 - There is no systematic follow-up of family planning acceptors.

- There are only two kinds of pills in use and one type of IUD (the Lippes loop), but supply of these is adequate.
- The quantity of the pill resupply is dependent on the distance of the client from the clinic.
- There was no postpartum patient education.
- NFP acceptors are referred to Catholic Mission clinics. No NFP is provided in the provincial health centers.
- Infertility cases are referred to hospitals for management, although there are few if any infertility specialists.
- It is not known how effective the traditional FP methods are or to what extent they are practiced.
- It is not known to what extent private practitioners are providing family planning.
- Nursing sisters provide family planning services, but are without supervision and recent updates in contraceptive technology and service delivery skills.

7. Recording/Reporting:

- Records are maintained on a standard DOH form except for those used by the FPA.
- The province reports on family planning are submitted to the central office which publishes a compiled and detailed report.
- There are no data on continuing use, but the newly-drafted form will ask for continuing user data.

8. There is no procedures manual on family planning. However, the following basic manuals are used by health service providers:

- Standard Treatment for Common Illnesses of Adults in Papua New Guinea.
- A Manual for Health Workers in Health Centers and Hospital Out-Patient Departments.
- Anaesthesia for Health Extension Officers in PNG.

- Standard Treatment for Common Illnesses of Children.

9. Presumptive treatment is given for pneumonia, malaria and STDs.
10. The two chemist shops in Goroka have no pharmacist. The shops sell pills by prescription, or upon presentation of an ID card. Contraceptives and costs are as follows:
- | | | | |
|-------|--------------------------|-----------------------|-----------|
| Cost: | Pills - K 3.90 per cycle | | |
| | Depo - K 6.60 | Delfen Foam - K 13.00 | |
| | Condom - K 4/doz. refill | | - K 11.00 |
| | | or 95 t. per piece | |

The salespersonnel claimed to have very few sales.

C. Training

1. Pre-Service (Basic Preparation of Nurses, Midwives and Nursing Aides)
- Nursing and midwifery training is still basically hospital-oriented rather than community-oriented; midwives generally are posted to hospitals, but many nurses are posted in provincial offices, health centers and hospital out-patient departments.
 - Family planning objectives in the health extension officer (HEO) curriculum are not reflected in the teaching methods, and there are no criteria or standards for the practicum.
 - The nursing syllabus of the College of Nursing in Goroka included the role/functions of nurses in family planning, the criteria/standards for the practicum, and communication/motivation for family planning. The amount of detail was a result of a tutor who had placed emphasis on communications and motivation.

- Family planning for nurses and midwives is included in the obstetrics unit with 15 to 20 hours in the curriculum devoted to it, at both basic and post-basic levels.
- Family planning in the community health nursing course is part of MCH, but there has not been a CHN course for the last four years.

2. In-Service Training

- There are three locii for training in the central office of the DOH: one, the Training Unit, which has responsibility for basic training and the training schools; two, the Family Health Unit, which has responsibility for in-service training in family planning and nutrition, and is responsible for implementing the UNFPA-assisted project; and, three, the National Training Support Unit (NTSU), which has responsibility for implementing the ADB-assisted PHC training project. The three units' work is not well-coordinated.
- No one has been recently trained to train others, although the ADB-assisted project offers the possibility and probability of TOTs for provincial and district teams.
- The UNFPA curriculum on TOT in family planning is for four and one half days, and the same curriculum and self-instructional materials are used for in-service and refresher courses for a variety of health personnel.
- The CBD training conducted by FPA does not include communication skills.
- Neither those who supervise nor those who train in family planning have had recent family planning clinical skills update or supervisory skills training, and did not have a supervised practicum during their initial family planning in-service training.

- Linkages between in-service and pre-service training and between services and training are weak.
- Training and teaching methods are primarily didactic and content-oriented.

3. Other

- Budget restrictions have hampered many aspects of health services' management and delivery, and basic preparation of health workers.
- There is a controversy about whether staffing shortage or staff distribution is at the heart of the problem of unfilled posts and/or inadequately-staffed services and poor supervision, and shortages of teaching faculty in health professions' schools.
- Owing to frequent staff turnover and transfers, persons trained may be deployed to a job where the training is irrelevant.
- Nursing strength is severely constrained by the lack of nurses in leadership (decision-making) positions, and internal conflicts.

VI. RECOMMENDATIONS TO INTRAH

- A. INTRAH's best strategy would be to focus efforts on one province if:
1. pre-service and in-service training systems can be linked;
 2. the province has or will develop a family planning policy and gives family planning a priority in the annual plan;
 3. there are or will be family planning statements of duties (job descriptions) for each category of health worker (APO, nursing aides, nurses, HEO);

4. standards for family planning services and each method are or will be clearly spelled out;
 5. the "core" clinical service providers are or will be assigned to do family planning jobs; and
 6. the promotion of family planning through recruitment and follow-up of continuing clients is or will be taken seriously.
- B. A core group of six nurses and HEOs or four nurses from one province who have designated responsibilities in the provision and supervision of family planning services should go to IMCH for the six-week clinical skills training course, including an out-placement practicum in IMCH clinics. It may, however, be difficult to obtain release for six weeks.
- C. For this core group to be prepared to train others they will also have to undergo a TOT course, and will have to have a training budget from the province.
- D. In-country training by these core trainers will be dependent on sufficient family planning client load. Therefore, in-country training by this core group will need to await a much expanded client population.
- E. IMCH and INTRAH should have responsibility for following up the core group including assistance with family planning protocols and standards, job descriptions, curricula, and a TOT.
- F. INTRAH should send samples of client education materials to Goroka c/o Julie Liviko and should put her and Mrs. Gideon on the mailing list.

- G. INTRAH should start small scale and see what happens with the initial investment because involvement in Papua New Guinea can be very expensive.

APPENDIX A

PERSONS CONTACTED/MET

American Embassy

Mr. Donald R. Cleveland, Political and Economic Affairs
Officer and AID Affairs Officer

Department of Health Headquarters

Dr. Quentin Reilly, Secretary

Dr. Levi Sialis, First Assistant Secretary

Dr. Daniel Johns, Coordinator for Family Health Services

Ms. Tabora Lokoloko, Coordinator for Nursing Education
Section

Ms. Shirley Gideon, Training Officer, Family Health Unit

Ms. Mary Biddulph, Consultant, National Training Support
Unit

Dr. Warwick Davidson, Coordinator for Policy, Planning and
Evaluation

Mr. Robert Makai, Evaluation Officer

Dr. Isaac Ake, Coordinator for Training

Mrs. Esther Vagi, Coordinator for Nursing Services Division

Mrs. Dawa Masere, Deputy Coordinator for Nursing Services

Mrs. Mioko Manoa, Project Officer for Nursing Services

Mr. Jonathan Vali, Primary Health Care Project Officer

Mr. Isaac, Aid Post Orderly Training Coordinator, Training
Unit

Dr. Than Than Wyn, United Nations Volunteer, Chief Medical
Officer, Family Health Unit

-CONTINUED-

Department of Health, Eastern Highlands Province, Goroka

Dr. William Beiber, Assistant Secretary

Mr. Leonard Loh, Provincial Health Extension Officer

Ms. Julie T. Liviko, Provincial Nursing Officer

Department of Health, Kainantu Health Center

Mr. Padugaga, Dean of Health Extension Officer Training School

Sr. Esme Unjisi, Community Health Supervisor

Sr. Philomena, Nursing Sister, Maternal and Child Health Services

Department of Health, Henganafi Health Center

Mr. Opa Kairu, Health Extension Officer-in-charge

Sr. Salome, Nursing Sister

Kompri Health Sub-Center (Swiss Mission)

Sr. Sohane, Nursing Sister

Department of Health, National Capital District

Sr. Hida Boga, Nursing Sister, Hohola Health Center

Sr. Florence Makolaua, Supervisor, Lawes Road Clinic

Sr. M. Igo, Nursing Sister, Lawes Road Clinic

Sr. Vagac Phileota, Nursing Sister, Lawes Road Clinic

-CONTINUED-

Department of Health, Goroka Base Hospital

Ms. Helen Kassam, Supervisor, Community Health Nurses
Sr. Theresa Onafi, Nursing Sister Student

Eastern Highlands Regional College of Nursing

Sr. Lilian Siwi, Principal
Ms. Allison Hunter, Tutor

College of Allied Health Sciences

Ms. Jelilah Unia, Dean
Mr. Simon Lugabai, Assistant Dean
Mrs. Apolonia Yaueib, Tutor, Community Health
Elthy Cockran, Tutor, Midwifery
Willie Vagi, Tutor, Medical Technology

Family Planning Association of Papua New Guinea

Ms. Ruth Iangalio, Executive Officer
Sr. Esther Mirisa, Information/Education/Communication
Officer, Family Planning Sister
Mrs. Mary Osborn, Community-Based Distribution Project
Director

World Health Organization, Papua New Guinea

Dr. Dragan Stern, Resident Representative
Mr. P.P. Shrestha, Health Education Consultant

-CONTINUED-

United Nations Development Program

Mr. Raouf Galal El Din, Deputy Resident Representative

Mr. Maman, Coordinator for United Nations Volunteers

MEDEX

Mr. Frank White, Consultant

Mr. Greg Miles, Consultant

International Health Assistance Program

Mr. Rob Hubbard (by phone)

APPENDIX B

Summary of

Debriefing with Dr. Quentin Reilly, Secretary of Health

8:30 a.m., February 1986

Observations:

1. As far as child-spacing, we have observed problems in clinical skills, client counselling, client management, client follow-up, clinic management, development and use of client education materials and use of sterile techniques which we believe have emerged from lack of written standards for provision of family planning services.
2. Those who train, supervise and provide family planning are no more skilled than those they are training and supervising which may be due to lack of attention to family planning skills training both at the pre-service and in-service levels.
3. Until standards for family planning services are established and statements of duties (job descriptions) in family planning are defined for each level of personnel, training in child-spacing will be wasteful.

Recommendations:

1. The best strategy is to focus on a province which is interested in promoting child-spacing as an aspect of MCH and gives family planning a priority in the annual plan.
2. A core group of four nurses who have designated responsibilities in the provision and supervision of family planning services in the selected province should go for the six-week clinical skills training course at IMCH in the Philippines, including an out-placement practicum in IMCH clinics. Unless the "core" group return to their family planning services and supervision assignments, training will be wasteful.

Discussion:

1. The core group of four and others will be involved upon their return in developing the written standards for provision of family planning services and statements of duties of various categories of health personnel under the guidance of the provincial health extension officer. Dr. Reilly expressed the need for technical assistance to be provided to the group in developing written standards for family planning services and the statements of duties.
 - a. In developing the standards for provision of family planning services, there needs to be involvement of all categories of personnel.
 - b. The assistant secretary would need to give full support to this working group; otherwise, their output will be a waste.
2. Dr. Reilly and the INTRAH team agreed that by focusing efforts in one province, successes and failures of this approach could be determined. That province could also be used as a training site for other provinces if the approach were successful.
3. The province preliminarily identified was the Eastern Highlands Province which also offers a linkage between the basic preparation of nurses, nursing aides and HEOs, and in-service training.
4. The team told Dr. Reilly that INTRAH resources could not support a nationwide program and a small investment has potential for both improving a provincial family planning service system and indicating how services could be improved in other provinces.
5. INTRAH will follow up with a letter to Dr. Reilly (copies to Dr. Lowry, USAID; Mr. Leonard Loh, Provincial Health Extension Officer; and Dr. W. Beiber, Assistant Secretary) which re-states INTRAH's proposed plan which could not be acted upon before September, 1986.

APPENDIX C

Summary of

Debriefing with Dr. Sialis and Dr. Johns

1. We observed needs for training in:
 - clinical skills
 - client counselling
 - client management
 - client follow-up
 - clinic management
 - development and use of client-education materials
 - sterile techniques

2. We observed the need for improved screening of clients through:
 - development of a checklist for each method rather than a general checklist for all methods
 - expanded physical assessment of family planning clients
 - improved/expanded history taking

Screening would result in the administration of an appropriate method according to the client's profile.

We believe that oral contraceptives are the primary method used now because that is what the service providers know about.

3. We have read the health principles and it seems to us, in our limited observations, that as far as family planning is concerned the principles are not being observed. We believe this may be a result of the current pre-service and in-service training and also, a lack of clarity about who is supposed to do what in family planning.

Any pre-service and in-service training in family planning needs to reflect the health principles. It would then be easier to determine who should get training and what type of training should be given.

4. Family planning curricula we have seen cannot prepare service providers for high quality and comprehensive family planning services that include counselling, follow-up, clinic management, client management, coverage of all major methods, practice of aseptic techniques, and an attitude of caring for the family planning client.
5. Few family planning service providers and family planning supervisors have themselves received adequate family planning training. Few service sites could be considered adequate in either service provision or as family planning training sites.
 - A core group of four nurses who are designated family planning providers and are supervisors of family planning services should go to IMCH in the Philippines for a six-week clinical skills training including an out-placement practicum in IMCH clinics.
 - The core group will be followed up in-country by IMCH.
6. In-service clinical training in this country will be very difficult until there is a sufficient client load that will enable every trainee to confidently and competently perform at an acceptable level of skill.
7. Decentralization gives the provinces the major responsibility for family planning service delivery. Since improved service delivery can result from
 - a clear family planning policy;
 - standards for service delivery;
 - job descriptions for service providers; and
 - linking of pre- and in-service training

we recommend that INTRAH's contribution can be best made if INTRAH works in one province on pre-service and in-service training.

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APPENDIX D

Page 21 2266. Telex NE22248.

Slap in the face

'Concerned' of Hohola, (Nius January 30) congratulated the Wingti-Chan Government of re-appointing Dr Reilly for the post of Health secretary.

I also wish to convey my congratulations to the Wingti-Chan Government for at least making a permanent appointment for

the post.

I wish to bring to the attention of 'Concerned' that if he/she was in the department when Dr Reilly was first made secretary three years ago.

There was a then mass resignation of experienced staff at the headquarters.

This was because it was a slap in the face for many of these experienced staff who were overlooked by the appointment of Dr Reilly who was not a citizen of PNG at the time of appointment.

Dr Reilly became a naturalised citizen sometime after he was appointed the Health Secretary.

Being an Australian citizen Dr Reilly has dual citizenship.

The Health Department, since the appointment of Dr Reilly, had not seen any development of new works and capital works.

The current Asian Development Bank Loan for the improvement of the rural health services and the primary health care activities were initiated before Dr Reilly came into the office.

Following Dr Reilly's appointment, there has been many new faces in the Health headquarters.

To date, how much of these new faces know of the Health set up and activities is yet to

 SOUTHERN PACIFIC HOTEL

OPERATING: TRAVELODGE . PARKROYAL . BOULEVARD BEACH . PORT TULLAGH
IN AUSTRALIA . NEW ZEALAND . FIJI . PAPUA NEW GUINEA . TAHITI . COOK ISLANDS

UNION

'Eye Opener'
Baraka NCI

AYSIA

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APPENDIX E

Country Health Information Profile

1. Population

1980 census: 3.01 m. persons of whom 87% live in rural areas. 15.8% < 5 years. Current growth rate is 2.3%.

2. Major health problems:

- unattended deliveries
- respiratory diseases: pneumonia, the leading cause of reported deaths, chronic lung disease, influenza
- malaria
- GI diseases
- malnutrition
- tuberculosis
- accidents and injuries
- STDs
- leprosy
- chronic disease

3. Sources of Health Care:

- government agencies
- church health services (25%)
- private health services
- industrial health services
- community initiatives

4. Health Budget:

- 47.5%: primary health services
- 41.1%: secondary health services

5. Maternal and Child Health and Family Planning:

- < 1/3 of deliveries are supervised in hospital or health centers. Maternal mortality rate is estimated to be as high as 18/1000. Traditional midwives often are not used; women deliver themselves in "birth houses."
- 42,000 women, 15-44 (7%) of married women of reproductive age, are using family planning, which requires husband's consent.
- In 1983, new acceptors chose the following methods:

Lippes Loop	933
Other IUDs	1,194
Pills	7,644
Injection	4,270
Condom	442
Ovulation	1,163
Tubal Ligation	978
Vasectomy	118
Others	570

6. Functions of the National Department of Health:

Monitors, inspects, assists and coordinates health services and national health policy generally.

1. Ultimate responsibility for all hospitals, medical, dental, nursing, preventive health and disease control services.
2. Monitoring of standards of health service activities across the country and ensuring that appropriate standards are maintained.
3. Pharmaceutical services.
4. Mental health, radiotherapy and specialist medical services.

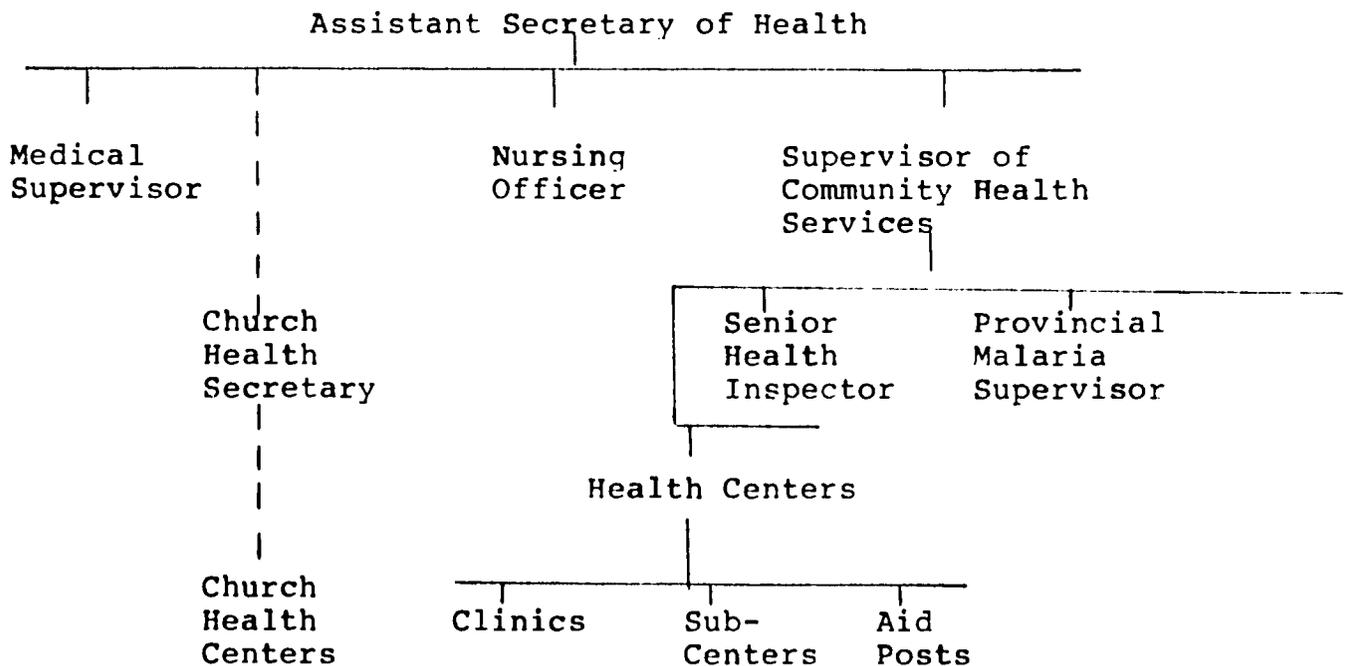
5. National health legislation, policy formulation and evaluation.
6. Medical and paramedical training institutions.
7. Provision of services to the Medical Board, Nursing Council and other committees and organizations relating to the functions of the Department of Health.
8. Quarantine at all ports.

"The essence of the relationship between the national department and provincial department of health is that of providing information, and monitoring activities."

7. Provincial Functions:

- a. Hospitals, malaria control, health inspection, nutrition and disease control.
- b. Rural health services including health centers, health sub-centers and aid posts.
- c. Day-to-day management and financial control.

PROVINCIAL HEALTH ORGANIZATION



8. Health Principles:

1. Appropriate health care should be provided to all the people as close to their homes as possible.
2. Standards of health services should be maintained at a level appropriate to community and national development.
 - Decisions should be made at level closest to implementation level.
 - Provincial officials should employ the least trained health workers who can adequately perform the task required (lowest level of manpower who can adequately deliver the required services).
3. Health resources should be concentrated where the maximum community benefit will be attained.
4. Health services must be delivered in such a way that they are integrated with all sections of health and other services.
5. Decisions about health services quality and delivery should involve people and communities (decentralization, self-treatment, community involvement). Local administration should promote community involvement.

