

Family Planning Service Expansion & Technical Support

PN ABT-149

JSI LIBRARY

91171



SEATS

THE SEATS EXPERIENCE IN PAPUA NEW GUINEA (1991-94)

A

TABLE OF CONTENTS

Acknowledgements

Abbreviations

SCOPE AND PURPOSE OF REPORT 1

EXECUTIVE SUMMARY 2

I. OVERVIEW OF PAPUA NEW GUINEA 6

- History
- Government
- Economy
- Education
- Religion

II. HEALTH STATISTICS AND SYSTEMS 9

- Demographic Information
- Health Systems
- Family Planning Service Delivery
- Other Agencies Related to Family Planning Services

III. SEATS/PNG 12

- Introduction
- SEATS Activities
- Initial Strategies
- Training
- Management Information
- Logistics
- Information, Education and Communication (IEC)
- Clinic Improvement
- Facilitation Checklist
- Non-Governmental Organizations
- Quality of Services
- Professional Development
- Service Performance

LESSONS LEARNED 30

RECOMMENDATIONS 32

BIBLIOGRAPHY

ANNEXES

Annex 1 Daily Tally Sheet for Family Planning Services

Annex 2 Provincial Summary Sheet for Family Planning Services

Annex 3 Couple-Years of Protection

Annex 4 New Acceptor Method Mix

Annex 5 Chronology of Events

ACKNOWLEDGEMENTS

The following organizations and individuals assisted greatly in the preparation of this document through giving their time generously for interviews. SEATS would like to express gratitude to the professionals who gladly provided their time and insights:

Enoch Posanai, Assistant Secretary for Family Health (Department of Health, Port Moresby)
Dr. Timothy Pyakalyia, First Assistant Secretary (Primary Health Services)
Dawa Masere, DOH representative with AIDAB
Isu Aluvula, SEATS representative
Mioko Manoa, AIDAB
Jelilah Unia, AIDAB
Terry Murphy, AIDAB
Alan Bass, Child Survival Support Project
Keith Edwards, Child Survival Support Project
H. Paul Greenough, USAID

PROVINCES

MANUS

Sister Rubbie N'Draii
Mr. Boe Avue

MOROBE

Mr. Wani Bopi
Dr. Likei Theo
Alan Peterson, Area Medical Stores

NCD

Sister Florence Mokolava
Sister Ine Raepom

CENTRAL

Sister Singut Bieb
Orime Tipo
Api Leka

EASTERN HIGHLANDS

Sister Ruth Paliau
Mr. Kairu Opa
Ms. Julie Liviko
Sister Helen Kassam

ABBREVIATIONS

ADB	Asian Development Bank
AIDAB	Australian International Development Assistance Bureau
AMS	Area medical store
ASH	Assistant Secretary for Health
AP	Aid Post
CBD	Community based distribution
CYP	Couple Years of Protection
DFP	Department of Finance and Planning
DOH	Department of Health
DRHAY	Department of Religion, Home Affairs and Youth
DPM	Department of Personnel Management
FAS	First Assistant Secretary
FP	Family Planning
JHPTEGO	Johns Hopkins Program for Information and Education in Gynecology and Obstetrics
HC	Health Center
HSC	Health sub-center
IEC	Information, Education, Communication
IMR	Infant Mortality Rate
IPPF	International Planned Parenthood Federation
MCH	Maternal and Child Health

MMR	Maternal Mortality Rate
MIS	Management Information Systems
MOU	Memorandum of Understanding
NACPP	National Advisory Committee on Population Policy
NCD	National Capital District
NEC	National Executive Council
NGO	Non-government organization
NPC	National Population Council
NSO	National Statistical Office
PDOH	Provincial Department of Health
PEC	Post enumeration check
PIU	Project Implementation Unit
PNG	Papua New Guinea
PNGFPA	Papua New Guinea Family Planning Ass.
PP	Population Planning Unit
SEATS	Service Expansion and Technical Support Project
STD	Sexually Transmitted Disease
TFR	Total Fertility Rate
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
WHO	World Health Organization

SCOPE AND PURPOSE OF REPORT

This report reviews the Service Expansion and Technical Support (SEATS) project family planning experience in Papua New Guinea (1991-94). The report, written at the conclusion of the project, was requested by the Papua New Guinea Department of Health (DOH) as a means of documenting the SEATS experience in national family planning within the country. The report includes "unexpected issues encountered", "lessons learned" and "recommendations". It is considered useful background information for the next stage in the creation of sustainable, quality family planning services in Papua New Guinea.

SEATS is a United States Agency for International Development (USAID or AID) centrally funded project which was contracted to John Snow Inc. (JSI) in September, 1989. SEATS mandate was to work in countries where the contraceptive prevalence was low and family planning activities were the least developed. SEATS provides technical and financial assistance to reach their primary goal - increased access to quality family planning on a national scale.

In September 1990, SEATS responded to the Papua New Guinea Department of Health (DOH) request for assistance by conducting a country assessment and proposing a strategic plan for the revitalization of family planning activities in five of the nineteen provinces in the country, and the National Capital District. The DOH approved the plan in March, 1991 and the Ministry of Finance and Planning signed a memorandum of understanding with SEATS in July.

Since that time, many activities have been undertaken by SEATS in collaboration with the DOH, Johns Hopkins Program for Information and Education in Gynecology and Obstetrics (JHPIEGO), and local non-governmental organizations. While several of the activities carried out were exactly as programmed in the original strategy and MOU, some were revised along the way to suit the circumstances and particular developments in the PNG program. This flexible yet directed approach supports the evolution of national family planning programming and is a credit both to the SEATS project and to the Papua New Guinea DOH which steadfastly supported and encouraged the development of family planning throughout the country.

EXECUTIVE SUMMARY

Papua New Guinea (PNG), with a population of 3.8 million, is the second largest country in the South Pacific region. A nationwide family planning program had existed in the country; however, with independence both funds and expatriate-supplied technical expertise diminished leaving the family planning program at a virtual stand-still. In 1990, the Papua New Guinea Ministry of Health requested the assistance of SEATS in designing and establishing the foundation for a national integrated family planning program.

Papua New Guinea's (PNG) contraceptive prevalence rate, estimated at less than five percent, is largely attributed to a low level of awareness about family planning and inadequate access to services. In a country which encompasses rugged, mountainous terrain, dense tropical forests, and remote islands, *access* becomes a major obstacle to all aspects of designing a national program. In addition, with over 740 languages, programmatic challenges exist not only in logistics but in information, education and communication (IEC). Therefore, *the question initially posed in the development of the SEATS strategy was: How can a national family planning program be developed which can sustain and offer quality family planning services to this diverse population?*

The country assessment was the first in a series of steps creating the groundwork for the development of the national family planning strategy which SEATS and the DOH employed over the following three years. The ambitious goal of the project was to provide a sustainable foundation for family planning within targeted provinces in the country. In order to achieve this goal, SEATS was simultaneously involved with a multitude of activities which included:

- creating family planning messages which would be clear and concise;
- simplify family planning methods checklists, assessment protocols in order to make record keeping "user friendly";
- train family planning trainers from each province;
- offer training in logistics management and record keeping;
- provide institutional capacity building through assisting in the creation or reinforcement of a skilled, motivated, and informed management within the health care service structure.

In March of 1991, the DOH approved of the program strategy which would be implemented in the National Capital District (NCD), Morobe, Eastern Highlands, East Sepik, and Manus. The Central Province was added to the program at a later date. The major elements of the program were to:

- provide long term technical assistance through a full time Resident Advisor and short term technical assistance in the areas of management, MIS, training, logistics management, and the medical aspects of family planning;
- integrate family planning into the health facilities through training of service providers;
- renovate and equip five clinics to broaden contraceptive options, including VSC and IUD insertion;
- support selected mission hospitals in integrating family planning and assisting the Family Planning Association (FPA) to expand its community based distribution (CBD) program;
- develop management capability by providing management training and designing a management information system (MIS);
- improve contraceptive supply by creating an improved contraceptive logistics management system;
- collaborate with SOMARC in launching contraceptive social marketing and JHPIEGO in implementing training activities.

SEATS and the DOH have built the foundation for a national family planning program in Papua New Guinea through the development and implementation of the above set of interventions. As a result, family planning services are now reaching 40% of the population. The six project provinces had a large increase in new acceptors between 1990 and 1993, while the non-project provinces had either a drop or relatively small increase. In 1993, the six project provinces served an average 11% of the WRA in their provinces as new clients, while the non-project provinces served only 5.6%, a figure which had not changes in years.

In essence, there are six major components which contributed to the rapid advances made in establishing the SEATS/PNG program.

Training

Training is central to integrating family planning into existing health facilities, therefore, SEATS and JHPIEGO provided training of trainers to 1,400 service providers covering 600 health facilities in six provinces and developed a curriculum for training service providers. The trainers were trained in family planning technology, counseling, and clinic management. By institutionalizing family planning training in the Department of Health through a core group of trainers, training sessions and supervision will expand exponentially in each province.

Approximately thirty provincial staff people were trained as trainers (TOT) during the period November 1991 to February 1992.

Seven provincial trainers participated in a course organized by JHPIEGO to learn IUD technology in January 1993. These trainers are to train service providers in their provinces use of the IUD (Cu T 380A).

Clinic Improvement

Renovating and equipping five model clinics to provide a full range of family planning services and referral for Voluntary Surgical Contraception (VSC) offers not only adequate facilities for family planning but, in addition, serves as training centers for service providers as well as national centers for excellence in family planning. Four of the five clinics were renovated and in operation by March 31, 1994. The fifth opened in April.

Information, Education & Communication

Through launching a series of activities, including posters, pamphlets, folk dramas and radio spots, information about family planning is reaching thousands of people each day in remote areas of the country.

Community involvement through local women's organizations and folk theater has contributed significantly to program sustainability. Through local, grassroots activities such as the Wantok Popular Theater's mobile dramas regarding family planning, awareness concerning family planning options spread rapidly in villages, resulting in families being given the opportunity to make important choices which can benefit their health and economic well-being.

Senior DOH officials and other important leaders in family planning have made study tours to several countries in Asia. In particular, tours have been made to Indonesia for an assess their national program; the Philippines to review IUD and comprehensive family

planning training; and Thailand to study CBD activities. The motivation and knowledge gained on these site visits were vital components to tour members ability to actively facilitate family planning activities.

Community-Based Distribution

The development of community-based family planning education and service delivery programs facilitates sustainable family planning. Parastatal organizations such as the Eastern Highlands Provincial Women's Council, with over 200 community chapters, offer information and trained family planning volunteers to countless villages. The female volunteers, SEATS, and members of the DOH, have been pleasantly surprised by the active involvement of men in this volunteer program to educate communities about family planning.

Professional Development

SEATS has offered health care professionals insights into alternative program designs and applications through workshops and study tours. For example, a group of senior DOH officials visited the Family Planning Program in Indonesia and attended a workshop for provincial and district managers. Annual planning and review sessions have been held to follow-up on activities which have been inspired from this tour. Follow-up both in professional development activities and in training was highlighted in interviews as being a key element of program success.

Through the creation of an interagency team within the DOH, wider information dissemination and management training has become institutionalized.

In four provinces, SEATS has conducted workshops for health inspectors and supervisors on record keeping and reporting. The supervisors are offering in-service training to service providers.

Designing Systems to Improve Service Performance

Management Information Systems (MIS) have been designed to collect and analyze family planning service statistics needed for management decision-making. The improved MIS enabled managers to monitor the steady increase in new acceptors.

An improved contraceptive logistics system, the "push" system, has been devised to ensure regular supply of contraceptives to service facilities. Since the establishment of this system, contraceptive supplies are found in all health facilities in the six provinces and stock-outs have been rare. SEATS is working to further improve the system and to integrate logistics into the management information system. A workshop to facilitate these improvements was held in February 1994.

Other factors which proved instrumental to SEATS' positive reception was that the project planned for the continuation of work in the provinces by holding meetings in 1992 and 1993 with the donor community to insure a smooth transition from SEATS activities to those being developed by UNFPA or the World Bank/AIDAB. The World Bank/AIDAB project began in August 1993 and the UNFPA project is expected to start soon. In addition, SEATS initiated a financial reporting system which was less cumbersome for the DOH staff. Funds were sent through a private accounting firm (Kolta and Associates) which sped the delivery. All officials praised this system for meeting the needs of the provinces during the project. The budget for this large project was about \$2 million (US) over three years. This is a small budget relative to all the accomplishments made during the project period.

In summary, SEATS was not limited to specific technical areas and had the budgetary capacity to fund, and become involved with, a range of activities in the country. *SEATS devised an evolutionary, problem-solving approach to strategic planning which allows enough flexibility to be responsive to new situations as they develop, and open to new methods of addressing issues within the context of both the country and the particular situation.* This allowed SEATS to be **responsive** and conscious of providing **sustainable** activities throughout the country.

I. OVERVIEW OF PAPUA NEW GUINEA

HISTORY

Papua New Guinea (PNG) lies south of the equator on an island north of Australia. PNG forms the eastern half of the island of New Guinea, the world's second largest island. The Western half, formerly Dutch New Guinea, comprises the Indonesian province of Irian Jaya. The country has a land mass of 462,840 square kilometers which includes more than 600 offshore islands. As a land of great geographic diversity, PNG's topography ranges from mountains and volcanoes, to low-lying swamps, with over 75% of the island covered by tropical rain forests. The highlands in the center of the country running east-west separate the north and south coasts. There are many rivers, two of which (Sepik and Fly) are considered among the mightiest rivers in the world in terms of annual water flow and are navigable most of the year. The coast is ringed by coral reefs with a few deep landlocked harbors.

The people of PNG are composed of Papuans from Southeast Asia (thought to have been the first arrivals), Melanesians who inhabit the interiors of the mainland and larger islands, with some Micronesian and Polynesian influence on some of the smaller islands. The greatest concentration of the population is in the highland provinces. *The difficult terrain has fostered the separate cultural development of communities resulting in an estimated 740 languages, many spoken by only a few hundred people in highland valleys. Languages of common communication are English, Pidgin and Motu.* Over 80 % of the people live in rural communities where life is closely circumscribed by family and clan. The population count according to the 1990 census was 3,607,955 (excluding the North Solomons where a rebellion precluded the possibility of the census in 1990). It has been adjusted upward and is estimated by the National Statistical Office as 3,809,239.

The puzzle of PNG's pre-history is just beginning to be pieced together. It is now believed that people came from Asia approximately 50,000 years ago. The ice age caused the sea level to fall and made the journey easier. People reached the highlands about 30,000 years ago, and the valleys were settled over the next 20,000 years. Trade between the highlands and the coast has been going on for 10,000 years. *One of the most interesting discoveries is that gardens were cultivated in the highlands 9000 years ago, making PNG the site of the oldest known farming in the world -- possibly even older than the fertile crescent of the Middle East.* Pigs, which are very important to economic and ritual life, arrived about 10,000 years ago, with migrants from Asia.

Explorers from Spain and Portugal arrived on the shores of PNG in the sixteenth century. However, the Germans and British chose to colonize the north and south coasts. The Dutch were interested in the western half of the island to ensure a buffer between the German and British zones and their profitable islands of Indonesia. Britain recognized

Holland's sovereignty in 1824. In 1884, an arbitrary line was drawn east-to-west along the middle of the eastern half of the PNG island. The lower half of the island was claimed by the British and the top half by the Germans.

In 1906, British New Guinea became Papua and was handed over to the newly-independent Australians to govern. When WW I broke out, Australians overran the German settlements at Rabaul and for the next seven years Australians ran German New Guinea. In 1920, the League of Nations gave PNG to Australia as a mandated territory. Australians thereby governed the whole island -- the southern half (Papua) which was not prosperous or profitable, and the northern half where gold was discovered at Wau and Bulolo.

During WW II, all of the northern islands and the northern coast fell quickly to the Japanese. From there the Japanese went on to occupy all of the island except Port Moresby. By September 1942 the Japanese, with Port Moresby in sight, were forced to retreat. In 1945 the island was reclaimed by the Australians, however, the outer islands of New Ireland, New Britain and Bougainville were not recovered until the final surrender. Australia transferred a wide range of political powers to PNG in 1970. PNG became self-governing in 1973 and an independent state on September 16, 1975.

GOVERNMENT

PNG is a parliamentary democracy within the British Commonwealth with a President as head of state. There are 109 members in the unicameral National Parliament. PNG has embarked on a system of administrative and financial decentralization. The country has 19 provinces (plus the National Capital District) each with its own provincial government. Provincial governments are given grants by the national government to operate services in health, education, business development, and primary industry. There are also 150 local councils. Several political parties are in existence, usually forming alliances in order to gain a majority.

ECONOMY

PNG is essentially an agricultural nation with 80% of the population engaged in subsistence farming and the raising of live stock. Agriculture accounts for one-third of gross domestic product (GDP). The other important industry is mining, accounting for 40% of GDP. There have been discoveries of gold in Milne Bay and the western provinces. PNG has largely untapped forestry and fishing resources. Reserves of gold, copper, silver, nickel, oil and gas are frequently discovered. There is virtually no manufacturing industry. However, some food, soft drinks, cigarettes, plywood and coconut oil are being produced in-country. About 25 % of government revenues come from an Australian grant-in-aid.

EDUCATION

About 70 % of children begin school. The literacy rate is about 39 %. There are university colleges in Port Moresby and Lae where 3000 students are enrolled.

RELIGION

Most people in PNG are Christian, with Catholics as the largest single group. There are also remnants of the pre-Christian religious beliefs based on magic, observance of taboos, ancestor devotion and atonement to spirits.

II. HEALTH STATISTICS AND SYSTEMS

DEMOGRAPHIC INFORMATION

In 1993, the population of Papua New Guinea was approximately 3.8 million according to the 1990 census and government projections; approximately 22% were reported to be women of reproductive age. The average number of children born to a woman is about 5 and the maternal mortality is estimated at 800 per 100,000. The crude birth rate is estimated at 35 per 1000.

There has never been a contraceptive prevalence, demographic and health survey but estimates are that the prevalence rate for modern contraceptives plus the ovulation method was about three to five per cent in 1990. Because of the way service statistics are recorded and reported, there is not enough information from this source to estimate prevalence. The annual growth rate has been calculated at 2.5 % by the World Bank based on the post enumeration checks done after the 1990 census. The tables published by the Health Statistics Section (HSS) of the DOH give the 1993 growth rate at 2.03%, lower than the World Bank's estimated rate of 2.5 %. It is clear that there is still an abundance of basic demographic information to collect.

HEALTH SYSTEMS

The DOH's organization includes a national office with a Minister, Secretary, and First Assistant Secretaries for several areas, with family planning coming under Primary Health Care and the Assistant Secretary for Family Health. In the Family Health office, there are four senior nurses who deal with most of the family planning activities although they also work on other family health programs.

The DOH is not in direct control of the various provincial departments (PDOH). In keeping with decentralization, the PDOHs are encouraged, but not obliged, to follow the direction of the DOH in its programs and strategies. In the SEATS project provinces, a family planning coordinator was named from among the senior nurses (or other senior level staff). The other provincial staff, especially in-service and training coordinators (ISTs), and health extension officers (HEOs) were also very involved in the training and facilitation visits for the SEATS project in the project provinces.

The structure of the health care delivery system at the provincial level consists of one hospital per province, health centers (HCs), health sub-centers (HSCs) and aid posts (APs). In general, there are no doctors below the hospital level. Nurses, nurses aides, nursing officers, health extension officers, aid post orderlies and community health workers staff

the health centers and sub-centers. The aid post orderlies staff the aid posts, which are five times more numerous than the other facilities combined.

There are 19 hospitals, 36 urban clinics, 195 health centers, 278 sub-centers and 2304 aid posts. Ninety percent of the aid post orderlies are male. Generally, they are the only staff person in the aid post. For the past few years, females have been trained as community health workers (CHWs) to staff the aid posts. Most observers and health workers acknowledge the cultural constraints of a male dealing with female clients especially for family planning needs. There are, however, a few workers who maintain that the sex of the provider is insignificant as long as the person is empathetic and professional. *In general, non-clinical methods (pill, condom, injectables) are provided widely even at the aid post level, but IUDs which have to be inserted by nurses are not available in most facilities. The ovulation method of family planning is strong in some health facilities/provinces and virtually non-existent in others.*

FAMILY PLANNING SERVICE DELIVERY

The first clinic was established in 1963 by the Papua New Guinea Family Planning Association in Port Moresby. In 1967, limited services were offered through the Department of Health (DOH). After independence in 1975, the country formulated a population policy. However, in 1978 the National Executive Committee (NEC) did not approve the proposed population policy, which covered several other aspects of population (migration, immigration) in addition to family planning. The DOH continued to provide services through the 1970s and 1980s but the number of new acceptors did not rise above 15,000 to 22,000 per year. Furthermore, the decentralization of responsibility to the provinces in 1983 weakened family planning efforts.

The current DOH recording system counts new acceptors only, no revisits or continuing acceptors. The logistics system has been less than adequate. Accurate records of incoming shipments and outgoing supplies are not recorded even at the principal port of entry (Lae area medical stores), therefore good records are also not to be found in area medical stores in Hagen, Rabaul and Wewak or lower down on the logistics chain.

There are frequent stock-outs. Contraceptive supplies have mainly been oral contraceptive pills (in various combined and progesterone-only formulations, according to donor or vendor); injectables (only one formulation to date- Depo-Provera); condoms; IUDs (in the past the Lippes Loop; now Copper T 380A are available). The contraceptive method mix (again for new acceptors) is weighted toward pills (about half) and injectables (about 30 %). The ovulation method does not have significant acceptance (about 5 %) and tubal ligation is a surprising 7 % -- the same as condoms. The IUD and vasectomy are the lowest with only about 1 % of acceptors for each method.

Despite start-up difficulties, data is beginning to be received and family planning service providers are recording information.

The table below shows the method mix from 1987 to 1991.

*Percentage of Methods Adopted by New Acceptors by Year
1987-1991*

Year	IUD	Pill	Inject	Condom	Ovulat	T.Liga	Vasect
1987	2.2	55.5	26.6	2.6	5.3	7.4	0.4
1988	1.4	44.3	25.4	16.7	4.0	7.5	0.7
1989	1.5	54.6	26.0	3.7	6.2	7.9	0.1
1990	1.0	54.6	30.9	2.8	4.0	6.4	0.3
1991	1.0	43.6	33.1	4.3	7.2	10.1	0.7

OTHER AGENCIES RELATED TO FAMILY PLANNING SERVICES

The Population Planning Unit (PPU) of the Department of Finance and Planning organizes support for the country program, monitors the progress toward meeting objectives, and analyzes data collected. The PPU also prepared the Population Policy statement which was submitted to and approved by the NEC in 1991. The FPA operates one clinic in Port Moresby and projects in two provinces (Morobe and East Sepik). The social marketing program, originally operated by SOMARC and currently by a locally operated firm, also sells pills and condoms at retail locations all over the country. In 1993 the National Women's Policy developed by the Department of Religion, Home Affairs and Youth (DRHAY) was endorsed by the NEC, and a potential for networking among village women exists in the programs of the Women's Division of the DRHAY.

III. SEATS/Papua New Guinea

INTRODUCTION

SEATS (1991-94) assisted developing countries with the lowest contraceptive prevalence and least developed health infrastructure to improve the quality and availability of their family planning services. SEATS has been active in over 20 countries throughout Asia, the Near East, Africa, and the South Pacific. Activities carried out with SEATS assistance include: comprehensive countrywide assessments; innovative pilot or service expansion projects; procurement of essential equipment and contraceptives; establishment of contraceptive logistics and management information systems; development of cost recovery programs. By providing a broad range of programs and technical assistance to its partner countries, SEATS affirms its goal of making quality family planning services more widely available and accessible.

The design of the SEATS project was particularly well-suited to the situation in Papua New Guinea. SEATS comprehensive mandate enabled the project to program activities for large nationwide impact. *While offering a flexible approach to project development, SEATS provided depth in a variety of technical areas including clinical family planning, logistics management, procurement and IEC.* This was coupled with strong working relationships with other cooperating agencies, and the Papua New Guinea Department of Health at both the national and provincial levels, who could offer complementary skills to the many projects SEATS was involved with during its life.

SEATS ACTIVITIES

SEATS placed a Resident Advisor (RA) in-country in 1990. The advisor spent half of his time working on the identification of agencies, activities and methods of implementation for the SEATS project and half working to set up a social marketing project for SOMARC/The Futures Group. The Resident Advisor, along with the SEATS Regional Director for Asia, conducted a country assessment in September 1990 and proposed that the DOH initiate a major project to expand and improve family planning service delivery systems, logistic systems and management information systems. SEATS signed a memorandum of understanding with the Department of Finance and Planning in July 1991 which called for SEATS to work with the DOH to expand and improve the family planning services in six provinces, as well as to work with the non-governmental sector on family planning. The project was planned to run from mid-1991 to mid-1994. The official title of the project is the Comprehensive Family Planning Program for Papua New Guinea.

Specifically, the goals for the PNG project were:

- integrating of FP into all health facilities through training of service providers
- renovating and equipping five clinics in provincial capitals to provide options such as the IUD and sterilization for clients
- supporting non-governmental organizations (NGOs) to expand or initiate community-based distribution systems (CBD)
- developing management capacity by training, study tours and provision of technical consultants
- improving contraceptive supply by creating an improved contraceptive logistics management system
- collaborating with SOMARC in social marketing plans and with JHPIEGO for training activities

INITIAL STRATEGIES

During the project's inception, the design of strategies for revitalizing the family planning program in PNG were developed. Initially provinces had to be chosen, therefore, selection criteria were created. The selection criteria for the provinces was as follows:

- one province from each of the four regions, where the province had less than the national average for contraceptive prevalence (estimated at three to five percent)
- the largest population in the region

Thus, provinces chosen were Morobe from the New Guinea Coast region, Eastern Highlands from the Highlands region, East New Britain from the New Guinea region, and National Capital District from Papua region. East New Britain was unable to participate therefore East Sepik was added even though another province from the New Guinea Coast (Morobe) was already included. Manus was added from the New Guinea region (although it has the smallest population of any province in the country). Finally, the Central province was added from the Papua region because it was easy to access and monitor and contained a very large population. ***The total population of the six provinces is 1,302,718, which includes about 36 % of the PNG population.***

In the next stage, the national and provincial DOH staff concerned with the implementation of the project travelled to Indonesia to review the Indonesian national family planning program. The group was accompanied by the SEATS Regional Director and the SEATS Country Representative. The Assistant Secretaries of East Sepik, Eastern Highlands, and Manus; the Principal Health Education Officer from Morobe; the Matron from the NCD; a senior nursing officer from the national DOH headquarters; and the current Secretary of Health constituted this study tour. These visits were preceded by a workshop in Port Moresby where SEATS staff lead discussions about what to expect and what to look for on these study tours. In addition, the DOH staff held a five day workshop for mid-level managers when they came back from overseas. *The tours were extremely helpful in allowing the key DOH staff to experience the framework and scale, as well as component elements, of a national family planning program and thereby instrumental in securing the cooperation of the DOH officials.* Moreover, these visits generated an enormous amount of enthusiasm in the staff, and a conviction that PNG could and should have such a program. *National and provincial DOH officials were unfailingly positive about the effects of the study tours and continued to retain a high level of enthusiasm for the program three years later. One important lesson learned is that it is important that the sites for these study tours be carefully selected and that they be guided by an experienced population professional who can assist the study tour group to sift through information and experiences in order to apply the most relevant points in their national programs.*

TRAINING

Training a number of people in a short period thoroughly required that providers be aware and motivated about family planning and trained in non clinical methods. In order to manage the training of service providers in six of the provinces, it was determined that eligible staff from all hospitals, health centers, sub-centers and aid posts be trained to provide pills, condoms and injectables. This was an ambitious undertaking involving 1400 persons from over 600 facilities in six provinces.

The number of sites and persons trained are cited in the table below.

Number of Health Facilities and Persons Trained Per Province During 1992

Province	Hospitals	Health Centers	Sub-centers	Aid posts	# Trained
Natl Capl	1	13	2	3	183
Central	1	9	8	85	218
E. Highln	1	8	10	42	273
Morobe	1	17	10	226	375
E. Sepik	1	12	7	68	263
Manus	1	10	0	65	83
Total	6	69	37	489	1395

A small group of master trainers were trained and a "domino effect" developed whereby the master trainers trained the provincial trainers. The provincial trainers would, in turn, train the provincial service providers. At this point, the Johns Hopkins Program for Information and Education in Gynecology and Obstetrics (JHPIEGO) worked jointly with SEATS. JHPIEGO hired two senior nurses to develop a curriculum and conduct the training of trainers (TOT) courses for the provincial staff who would, in turn, train the service providers.

One of the nurses went to Mary Johnson Fertility Care Center (FCC) in Manila, Philippines in July 1991 for six weeks to be up-dated on contraceptive technology. This nurse carried out the first TOT training starting in November 1991 for two or three provincial officials from each of the provinces plus one from an NGO. These staff members were primarily family planning coordinators, in-service and training coordinators, nurses and health extension officers. The course was designed in two parts: a five week course in technology of family planning (organized by JHPIEGO) and a three week course in TOT (organized by a SEATS consultant).

In January 1992, the other senior nurse from JHPIEGO escorted provincial staff to Manila for a two week study tour. In February 1992, the two JHPIEGO nurses conducted the second TOT for provincial trainers of service providers. This course was eight weeks in duration. The stage was now set to begin the training of service providers in the provinces. It was also decided that the two JHPIEGO master trainers would travel to the provinces in order to assist the provincial trainers when they conducted their first course.

From March to December of 1992, staff from all of the provinces conducted from eight to ten courses in each province for those staff designated as service providers (nurses, nursing aides, officers-in-charge, health post orderlies, community health workers). *The result was the training of over 1400 service providers from over 600 health facilities during this ten month period.* The training lasted five days and followed the curriculum developed by JHPIEGO/SEATS staff. As the service providers were trained, they were supplied with contraceptives and reporting forms. After training, they were to initiate family planning services.

The curriculum covered sexuality, counseling, values clarification, logistics, recording, and community diagnosis. A half day was scheduled to cover pills, condoms and injectables. The training took place entirely in the classroom, creating a hands-on approach which allowed lively discussion; there was no practicum as part of the training. The participants received hand-outs during the course which the trainers had prepared covering the topics discussed during the day. In one case, service providers made visual aids for their facilities during the training period.

Each province organized its own system for training courses. *The trainers were encouraged to be innovative and adaptive.* Often the provincial trainers subdivided the training courses according to districts in the province. In most provinces, the provincial trainers worked with a health providers who had a wide range of experience with various levels of expertise. In others, the provincial trainers ran courses separately for aid post orderlies, who are generally less experienced. The trainers thought that it would be more useful to have sessions in a local language or Pidgin in order that the information could be more accessible. One trainer in the Central District deliberately put aid post orderlies in the same classroom with more experienced staff in order for information to be shared by the group which could highlight key issues. *This type of proactive innovation allowed trainers and participants to be more involved with the subject matter and was, no doubt, one of the reasons 1400 trainers were trained in such a thorough and relatively quick manner.* There was a difference in the site of the training: in some districts all trainees were asked to come to the provincial capital and in others the trainers went out into the districts to conduct the courses.

The trainers did not have training guides to help them deliver the training courses nor were visual aids available. As mentioned, there was no practicum. Nevertheless, the trainers felt that the service providers were sufficiently self-confident after the course to return and immediately begin providing services.

MANAGEMENT INFORMATION

In October 1991, SEATS arranged for an Indonesian consultant to review the management information system and propose modifications, if necessary. The consultant found that DOH reporting forms collected data on new acceptors by method, with no information on

amount of contraceptives dispensed or on any revisits. The consultant recommended new forms and new client cards to collect data on revisits by method. He also recommended that the flow of reports be from the aid post and sub-center to the health center which would collate them every month. The health centers would report to the provincial health office, which in turn, would report to SEATS and the DOH headquarters. Revised forms were printed.

SEATS then sponsored a Provincial Planning Workshop for senior government officials in December 1992 to train them to use the data from the forms to analyze activities and make decisions. SEATS also sponsored five courses for health inspectors and FP supervisors to enable them to offer immediate assistance to service providers with problems concerning their recording reporting system during facilitation visits.

In general, as would be expected, the reporting from service sites is improving over time. By June 1993, more than 34 % of all facilities were reporting monthly to DOH and SEATS. However, when viewed by type of health facility, the health centers were reporting at 74 %, the sub-centers at 59 %, and aid posts at 26 %. As previously noted, there are more than five times as many aid posts as other facilities combined, therefore, the very low response rate from the aid posts markedly affects the overall average rate. Moreover, the aid posts in one very large province (Morobe) had such an abysmal reporting rate (9 %) that it skewed the results. ***Clearly, the work to improve reporting needs to be concentrated at the level of the aid post at the present time.*** All of the health offices in the provinces and all of the service sites had bar charts prominently displayed showing their achievements by month and by contraceptive method for new and revisit acceptors.

Analyzing and interpreting the data remains an outstanding issue. There is a misunderstanding in several provinces regarding the "Revisit Acceptors" as collected on the "Daily Tally Sheet for Family Planning Services" (*Annex 1*) used in the clinic as well as the "Provincial Summary Sheet for Family Planning Services" (*Annex 2*). These reports are used at the sub-center, health center and provincial tier of programs; each collects, collates and forwards reports to the next higher level.

There is widespread confusion about the meaning of "Revisit Acceptors" as well as about how to use the data. The recording system in place counts revisits: a woman may come in and be counted as a new acceptor only once but she can be counted on all her other visits as a revisit acceptor. It is the same woman making multiple revisits during the year. If the data on revisit acceptors is to be used for calculating couple years of protection (CYP) it probably is a reasonably close approximation, and would be appropriate. However, in several provinces, the staff are using the number of VISITS for all methods to give the contraceptive prevalence rate (CPR), i.e. they are counting each visit as a separate person contracepting. It can be very confusing if not explained clearly since the other data collected on "New Acceptors" are in fact different persons. (*Annexes 3 & 4*)

Another important issue is the need to collect data on the number of pieces of contraceptives supplies. This is useful to the clinic in planning their requirements and is important to DOH officials in order to calculate couple years of protection (CYP), a measure of achievement. It may be possible to get the numbers from the new logistics system being installed. One would have to subtract one month's balance from the previous month's balance, ignoring receipts and any dispersal for non-client needs, for example to lend some condoms to another clinic. The need to ask service providers to collect still more data needs to be balanced against the need to have accurate records of commodity consumption.

LOGISTICS

The DOH system was plagued by stock-outs and suffered from a lack of routine records either of incoming or outgoing supplies at the area medical stores or health facilities. In the SEATS-supported project provinces contraceptive commodities and medical equipment were supplied via the main area medical store in Lae. From there they went to other area medical stores at Hagen, Wewak and Rabaul. The next step was to send supplies to the provincial health offices which in turn sent supplies to health centers. The supplies were stored there until sub-centers and aid posts called for them or until the health center staff went on a visit to that particular facility.

In 1992, SEATS in collaboration with the Child Survival Project assisted the DOH in designing a logistics management system to ensure a continual flow of contraceptives. The system is based on the "push" system where a certain amount of supplies are sent out to all the sites every two months. These supplies are boxed in Lae and marked for the individual health facilities. They are actually sent to the provincial health offices where they are either called for or delivered to the facility in question. The supplies at the provincial level are found in different sites which vary from province to province according to storage availability and presence of an area medical store. Some provinces are storing them in the FP clinics, while others store them in unused buildings or area medical stores. All provincial officers offered that they were making every effort to get the supplies out to the health facilities. Once again, the aid posts pose a problem as the most distant, least visited and low staffed (i.e. if the orderly were to come into town, the post would be unattended).

Despite these issues, the national and provincial officials were unanimous in their praise for the difference they have found in the logistics system since the advent of SEATS. They are happy to be able to provide contraceptives to those who need them, rather than turning them away due to lack of supplies. This has contributed to the increased morale of the service providers and provincial officials.

In August 1993, the SEATS coordinator made a tour to Bangladesh to study the logistics recording system. In February 1994, SEATS conducted a logistics management workshop for staff from all six provinces. These people will, in turn, train others in their provinces in logistics management. Forms for recording receipt, usage, shipment and balance of contraceptive commodities were revised and finalized at this workshop and will be printed/distributed to health facilities in April 1994. To date reports from visits with provincial and clinic officials show that they seem to be pleased about the new system and eager to implement it.

INFORMATION, EDUCATION AND COMMUNICATION (IEC)

There are several approaches to IEC which were being administered simultaneously. *Radio spots were produced for all provinces in the country and began being aired in 1993.* Spots were in local languages and were both informational and promotional. The messages included: where to obtain FP services and the importance of FP for maternal and child health, and family welfare. The provincial officials claim that most people listen to the radio daily and that it is one of the few means of easy communication in this nation of geographic obstacles. The effectiveness of this method in bringing in clients has not been evaluated as yet.

In one province (Eastern Highlands), SEATS supported the use of a folk theater group to travel around presenting shows on FP. The provincial officials initially held workshops for the troupe to explain the FP program and to discuss the themes of dramas to be created by the troupe. The troupe presented the dramas to the Eastern Highlands officials and revisions were made so that the material would be technically correct and clear. The troupe performed about 25-30 times in 1993 in the province. Initially, the troupe was alone at the performances but it was soon recognized that many questions coming from the audience needed to be answered by informed FP staff. Consequently, the provincial staff concerned with FP appeared at all further performances. The media proved to be a very popular one and hundreds of spectators were present at every performance. This is not surprising considering that for many villagers without electricity and television, this theatrical spectacle would be a welcome diversion.

When family planning service providers were trained and returned home to set up their own services, they immediately realized that they needed to have a visual means of reviewing all the methods when counseling clients. It was determined that a poster with a picture of all methods would be useful. The poster would also depict a couple from PNG who had two children. Eventually, this poster was produced and distributed to all service sites. It contains all methods, including the ovulation method, and male and female sterilization. In some clinics, real pills, condoms, and IUDs are attached to the poster next to their drawings. All service providers and provincial staff were very pleased with the poster. While the poster is currently in English, it will be produced for other languages soon.

An additional requirement in the service sites was for pamphlets on each method to explain the basic information necessary for the clients before they were fully informed to chose a method. *In 1993, SEATS supported the production of pamphlets on pills, condoms, IUDs, male and female sterilization, the ovulation method and injectables.* The information contained in them was to have been taken from the training modules so that information would be consistent. *These pamphlets are in English, which presents more of a barrier to the clients than the poster with drawings and few words.* The format of the pamphlets is question and answer. The pamphlets were in evidence in all facilities visited albeit these were facilities accessible to the road. However, in one province, two sets of pamphlets were found and it was unclear where the second set had been produced. On examining these pamphlets, it was determined that they had some different information or instructions from those pamphlets originally produced. The clinic nurse criticized the format of the new pamphlets saying that they should be more similar to each other, with the same questions in the same order and important questions at the beginning. She found that the last question on the condom pamphlet concerned effectiveness. She rightfully pointed out that the other pamphlets had this important question on effectiveness among the first four. This is annoying but is less serious than having different information circulating among providers and given to clients.

NOTE: In the next printing of the pamphlets, the appropriate DOH staff should carefully review the information contained to be sure that it is the same as that of "Family Planning Guidelines" from the DOH and the small red handbook written by Dr. Glen Mola. All service providers should receive a copy of Dr. Mola's handbook for reference.

CLINIC IMPROVEMENT

One of the objectives of the DOH-SEATS strategy to offer a choice of methods was to renovate clinical areas in five provinces (except Central) for comprehensive FP services including the insertion of IUDs, and male and female sterilization. The FP services in provincial capitals were integrated with maternal and child health (MCH) care, offering no private area for examinations and IUD insertion. The sterilization area renovation was put on hold because of difficulties in obtaining surgical space. Meanwhile, the clinic renovation was initiated. The idea was to take part of an area of a hospital or urban clinic which was not in use and make minor renovations to offer a space which met minimal requirements for IUD insertions. This area was usually next to the MCH services so that women attending that clinic could be referred for FP. The clinics in National Capital District, Goroka (Eastern Highlands) and Wewak (East Sepik) were completed in 1993. The clinic at Manus was inaugurated on March 31, 1994. The clinic at Lae (Morobe) was to be opened in April 1994. In all cases, the inauguration of these clinics was considered a very important affair, attended by the American Ambassador, an official from USAID, the First Assistant Secretary of DOH, the Prime Minister and/or the elected chief executive of the province.

The FP clinics have various features depending on the amount and configuration of space appropriated for their use. Three of them (Morobe, National Capital District and Eastern Highlands) have three exam rooms (Manus has one). All but one are in out-patient areas of hospitals: one (Manus) is in an urban clinic specifically designed to take over the out-patient care from the provincial hospital. All have planned for waiting areas outdoors for clients. Local provincial firms bid on these projects and were contracted by SEATS for the work.

Few nurses have been trained in IUD insertion at this point, so there are very few IUDs reported even in the provincial capitals, although some doctors and nurses previously trained in Lippes Loops do some insertions. Once the training occurs, it is expected that all the provincial service providers will refer IUD cases to the renovated provincial clinics for service. In provinces that will continue with the World Bank/AIDAB Population and Family Planning project, it is planned that other clinics will be renovated for IUD insertion.

Few vasectomies are reported. Tubal ligations reported are mainly post-partum and performed in the hospital. The future of voluntary sterilization in PNG requires further attention. Voluntary surgical contraception (VSC) services are, of course, more difficult to organize than temporary methods because VSC demands more of medical services and facilities: doctors, operating theaters, surgical teams, anesthesia, etc. Nevertheless, it would be worthwhile to review again in a year or two the situation with regard to VSC: the door to offering these methods should be left open.

FACILITATION CHECKLIST

Early in the project it was recognized that newly-trained staff in health facilities required visits to assist them in retaining and applying technical information and methods; recording and reporting of services provided and of commodities ordered/received/used; and to keep morale high. The staff wanted the visits to be of substance for those visited and not a "supervision type" visit. Accordingly, the term "facilitation visits" was developed and the elements of the visits were elaborated. A checklist was designed to be used by provincial level staff when visiting each facility to review the FP situation.

The facilitation checklist covered:

- technical skills (greeting, counseling, follow-ups, etc.)
- logistics and stocks and reporting
- IEC
- infection prevention
- action plan for future developments

- The checklist is used by most of those making facilitation visits. Some felt that it was an "inspection" and was resented by staff visited. In any case, most of the provincial level staff claim to use the facilitation checklist. Most of the provinces had completed one to two rounds of facilitation visits since 1992 after their training courses. *The checklist should be continued and reevaluated/ revised in one to two years.*

NON-GOVERNMENTAL ORGANIZATIONS (NGOs)

The agreement for SEATS called for the establishment of projects with several NGOs, namely the Braun Hospital in Morobe Province and the Seventh Day Adventist Church (SDA). In addition, the Family Planning Association (FPA) was approached to expand CBD activities in the National Capital District. SEATS declined to pursue the SDA because the church did not want to distribute commodities. Braun Hospital declined to participate on the grounds of avoiding controversy in the church. Two staff from the FPA were sent to the Center for African Family Studies to study family planning CBD programs and management skills. Following this, unfortunately, the FPA declined to participate because the staff was overextended with ongoing activities. At this point, the SEATS staff approached the Eastern Highlands Provincial Women's Council (EHPWC). After some negotiation about the size of the project in the province, SEATS and the Women's Council agreed to the activities, which began in July 1993. The EHPWC was already active in the province with 200 chapters and approximately 30 members per chapter. Other NGOs dealing with women's issues also are affiliated with the Council. These broad-based grassroots groups are thought to be the most effective in reaching their neighbors. The director of the Council had no experience with FP or with CBD and SEATS arranged for her observation visits to Thailand and Indonesia. Upon her return, she worked very closely with the provincial DOH staff, particularly the in-service and training coordinator who was interested in the CBD approach from his own visit to Indonesia with the initial DOH group in 1991.

The project called for the members of the women's chapters to be trained in CBD and to be supplied with pills and condoms. They were to provide FP education and resupplies of pills and supplies of condoms. For initial pill supply, clients were referred to the health center. The volunteers were to be in close contact with the DOH represented by the nearest health center. An innovation was made in that males were trained as well as women: this was to improve the legitimacy of the work and improve access to male clients. Male volunteers were often husbands of the women. Approximately 37 males and 60 females were trained in CBD using a prototype manual from SEATS. The provincial DOH staff training coordinator conducted most of the training in Pidgin and recommended that courses for aid post orderlies be conducted in Pidgin. Another important feature of this program is inclusion of the social marketing of commodities (pills and condoms) through the Social Marketing for Change (SOMARC) project.

While recording and reporting skills can be improved, more significantly, this project began very quickly in a large area with little or no controversy (in fact, with more demands for participation coming from men than could be handled!). The collaboration between the DOH and EHPWC is close, and there is no reason to believe that this project will not continue to improve or that it could not be duplicated in other provinces with similar women's groups (which are in most of the provinces). *The Assistant Secretaries of two provinces offered that CBD was the only way to reach all the people in such a difficult to access place as PNG.*

QUALITY OF SERVICES

There was no specific objective regarding "quality" in the memo of understanding or in SEATS mandate. Nevertheless, in reviewing the activities *one is struck by the extent to which a concern for quality is imbedded in all of the project's plans.*

Elements of quality which are the most commonly cited are: information and counseling; choice of methods; technical competence of providers; access to services; continuity of services; adequate/private space; considerate treatment of clients; and confidentiality.

The renovation of clinics provided space and allowed for another choice of methods (IUDs). Training improved competence of providers and introduced them to counseling, confidentiality and ideas of considerate treatment. Standardization workshops for techniques for IUD insertion were conducted by JHPIEGO staff or consultants as the five clinics were opened. By training all staff of aid posts and making FP available there, FP became available in five times as many sites thereby improving access. In addition, the DOH and SEATS staff through diligent work, frequent visits and responsiveness to the needs of the provinces, helped to keep morale high, which in itself fosters quality.

In April 1993, SEATS with assistance from the Child Survival Project conducted a "rapid assessment" of services in all the provinces. There were three questionnaires used: for the client, for the health worker and for the supply/storage system. A review of some of the completed questionnaires for the health workers showed that more professionally educated health workers scored better than the aid post orderlies. *A refresher course for aid post orderlies would be a worthwhile activity and giving the course in Pidgin would be particularly useful.*

Since quality is a concept which falls on a continuum (in fact every element of quality could fall on its own continuum), it can always be improved. The beginnings of an emphasis on quality of services have already begun and the need for continuous improvement of FP services is a concept readily accepted by service providers.

Further issues surrounding quality that need to be addressed include:

- the acceptability of providers of one sex serving clients of the other sex, specifically male providers serving women;
- continuation rates for a clinic and for the various methods in that clinic;
- suggestions from clients on improving the services;
- reasons for discontinuation of methods.

In fact, some of this data collection is already being collected informally in select service sites: one site was collecting data on reasons for discontinuation; one was charting each client's repeated visits over a year's period to facilitate follow-up.

PROFESSIONAL DEVELOPMENT

As mentioned throughout this report, there were many opportunities for professional development available by the DOH-SEATS project, ranging from the out-of-country trips for policy makers and health care workers (Indonesia); technical competence (IUD, training, MIS); and CBD (FPA, EHPWC). In-country there were many workshops on training, service provision, MIS, planning, logistics, etc. The provincial staff, as well as national staff, claimed that through the workshops supported by SEATS they learned how to manage their activities and were grateful to SEATS for these opportunities. As mentioned previously, there is no doubt that the study tours trips made all the difference both in the participants' understanding of a FP program or activity but also in their enthusiasm and interest in continuing the work.

SERVICE PERFORMANCE

It is not possible to determine the number of total acceptors from the way service statistics are collected. However, the number of new acceptors is recorded and is likely to be a good approximation of the actual number of new clients. We can compare new acceptors in the period pre-project with those in 1993 to determine whether there was any increase in new acceptors and if so, how much of one. The table below shows the number of new acceptors from 1990 to 1993 in each province. (The number of women of reproductive age (WRA) is given to provide a guide to the size of the provinces vis a vis each other.) The number of 1993 new acceptors divided by the number of the 1990 new acceptors gives the growth in the project provinces' FP program.

*Comparison of Number of New Acceptors in Project Provinces
1991-1993*

Provinc	WRA 1990- 1993	New Acc 1990	New Acc 1991	New Acc 1992	New Acc 1993	1993 New Acc as % of 1990 New Acc
Central	29959- 31638	863	1842	656	3680	426 %
Ntl.C D	45650- 48214	2328	3235	5257	8013	344 %
E. Highl	67091- 70879	2664	2739	3554	4264*	160 %
Morobe	84105- 88774	3423	3432	4971	4832*	141 %
E. Sepik	55813- 58911	664	442	4402	1490*	224 %
Manus	7382- 7794	262	295	394	363*	139 %

* December not reported

It can be seen that all project provinces had a significant increase in new acceptors. The smallest increases (39 % in Manus and 41 % in Morobe) are not insignificant but are dwarfed by the huge increases in N.C.D. or Central with 1993 running at 344 % and 426% of 1990 figures. ***Clearly, the FP activities in project provinces were significantly greater in 1993 than in 1990.*** Without comparative statistics from non-project provinces, it is not possible to discuss absolute gains due to project inputs. Similar or even higher increases in other provinces are possible.

For a comparison, the table below shows the 1993 number of new acceptors compared to the 1990 number for some non-project provinces.

*Comparison of Numbers of New Acceptors in Non-Project Provinces
1990-1993*

Provinc	WRA 1990- 1993	New Acc 1990	New Acc 1991	New Acc 1992	New Acc 1993	1993 New Acc as % of 1990 New Acc
Milne Bay	34151- 36058	973	1422	16951	1955	200 %
Norther	20038- 21255	519	579	852	612	118 %
Madang	54262- 57301	1058	1617	903	820	<78 %>
W. Sepik	30193- 31864	669	497	808	532*	<80 %>
New Ireland	17151- 18113	331	514	437	468	141 %
W. High lands	74325- 77928	1367	1115	1020	963*	<70 %>

* December not reported

The picture here is very different: in three provinces, 1993 performance was less than 1990. In the three provinces with increases, the increases were much less than the project provinces: only Milne Bay with 100 % increase and New Ireland with a 41 % increase compare to the project provinces' growth. ***Overall, the project provinces had a significantly higher increase in new acceptors than the non-project provinces.***

We can also compare the coverage of new acceptors in each of the provinces in 1993 to the national average coverage of new acceptors at 5.6%. We can determine whether project provinces fared better or worse than the national average. The following table shows the number of new clients served in 1993 by province. Then it gives the number of women of reproductive age (WRA) in each province. Dividing the number of women served by the number of WRA gives an idea of the coverage of new acceptors in the province. Finally, this percentage is compared to the national average coverage of 5.6 % coverage for new acceptors.

*Coverage of New Acceptors from Six Project Provinces
Compared With National Average Coverage. 1993*

Province	NCD	Central	E. Highl	Morobe	Manus	E. Sepik
No. New Clients 1993	7536	3140	7544	7409	954	5775
Popula WRA	48214	31638	70879	88774	7794	58911
New clnts as % of WRA	15.6 %	10 %	10.6 %	8.3 %	12.2 %	9.8 %
Nationl average 5.6 %	2.8 times nationl average	1.8 times nationl average	1.9 times nationl average	1.5 times nationl average	2.2 times nationl average	1.75 times nationl average

Looking at the second row from the bottom, we can see the coverage for new acceptors expressed as a percentage of the population of WRA in each province. Project provinces served 8.3 % to 15.6 % of all WRA in their particular provinces as new acceptors. These percentages are significantly higher than the national average of 5.6 %. The last row shows how many times greater the particular project province's coverage of new acceptors is compared to the national average of 5.6 %. All of the project provinces are covering significantly more of the women in their provinces, anywhere from one and a half (Morobe) to almost three (NCD) times as many. These are very significant findings and show a clear difference in coverage in the project provinces.

Viewed another way, the project provinces served a total of 32,358 new acceptors in 1993 of a population of 306,210 WRA. This is an average coverage rate of 11 %, twice as high as the national average of 5.6 % for coverage of new acceptors. When one considers that these six provinces cover 36 % of the population, one can appreciate how this DOH-SEATS project has benefitted a large number of couples with respect to their FP needs.

As noted, the non-project provinces do not count revisit acceptors, and the project provinces count visits, not individual acceptors so a comparison of revisit acceptors or revisits across the provinces cannot be made. One important issue to bring up is the confusion between revisits and (for want of a better term) "continuing acceptors", which has been described above. Some provincial officials were delighted to declare that their "prevalence" was 27 % or 36 %. However, when asked how they arrived at this prevalence rate, they explained that they had added the prevalence rate of new acceptors to that of revisit acceptors. This is not a correct way to proceed and some of them

immediately understood this (usually the provincial officials). More often the staff in service facilities did not understand the difference. *The problem goes back to the very language used: "revisit acceptors" seems to indicate persons not visits, in much the same way as "New Acceptors" measures number of persons. (This problem began in the forms from the MIS consultancy in 1991.) If another term could be used such as "number of revisits" or "number of visits for follow-up", it would be clearer that one is counting visits, not persons.* In order to actually count the number of different persons seen in a year no matter the number of visits, different sophisticated systems are required. For the time being, the system in place is adequate as long as all staff understand the distinction between revisits and actual number of continuing acceptors. Perhaps the forms could change the term "Revisit Acceptors" to a clearer one at the next printing.

In terms of measuring the achievements by couple years of protection (CYP) based on the standard number of supplies to be given to acceptors on different types of visits growth in numbers of new visits was observed between 1992 and 1993 with a marked increase use of the pill. This shift may be due in part to an improved supply of pill and condom use. Injectables, while readily popular, were not as readily available in addition counselling for more effective methods may have led far more to the observed reduction in NFP. SEATS has also been tracking Couple Years of Protection (CYP), an aggregate measure based on quantities of contraceptives distributed to users. The attached chart indicates a moderate growth in CYP achievement over the course of the project. CYP achievement was roughly 70,000 in March, 1994; however, it may be higher due to underreporting.

In addition to SEATS, other agencies are working in FP or related areas in PNG. JHPIEGO was the principal player with SEATS in this project: two of their staff worked with SEATS and DOH staff during the early months of the project to develop a cadre of provincial trainers capable of organizing and managing the large training requirements of the project. As mentioned, the SOMARC project is supporting social marketing activities. Project CONCERN is running a project in East Sepik training village birth attendants (VBAs), apart from delivering babies, this project educates and refers women for FP. Save the Children (New Zealand) will be operating the CBD program in East Sepik district under the UNFPA project expected to begin early in 1994. FPA runs a clinic in Port Moresby and some community activities in East Sepik (Marpik). The World Bank/Asian Development Bank/AIDAB have begun a FP project in six provinces, three of which are SEATS project provinces.

LESSONS LEARNED

1. ***Infinitely more can be accomplished when the government department is an enthusiastic and knowledgeable partner with the implementing agency.***

The many accomplishments of the SEATS work in PNG would have been impossible without the active support of the DOH which provided a vehicle for the SEATS representative; allowed national and provincial staff weeks off to be trained or to participate in study tours; gave SEATS office space in the DOH family health office; and made themselves available for SEATS staff and consultants all during the three years of the project. SEATS helped to induce this state of affairs by offering study tours to key officials which paid off handsomely by developing a cadre of supportive staff committed to a revitalized national family planning program for PNG.

2. ***A core of trainers in the provinces can be used to do all kinds of training courses required for a national program.***

Once trained as trainers (TOT), they can carry out the technical, MIS, logistics, etc. training for the province. The TOT courses tend to be long but are worth the time in order to develop a cadre of personnel with diverse training skills and with an investment in the program.

3. ***SEATS employed a flexible strategic planning which emphasized institutional capacity building and IEC from the beginning.***

This exercise produced a highly visible, successful and dynamic foundation for future family planning in the country. During the project, there was the feeling of action and excitement. There was not any sense of the project being bureaucratic or "bogged down" at any time. The opposite is true: at any one time many activities were going on at different levels. (*Annex 5* for a chronology of events during the SEATS years.) SEATS managed to involve officials at all levels and to keep them interested in what was happening. This was not just a pose: when a problem was identified, it was dealt with as soon as possible rather than ignored. During the SEATS project, problems were faced squarely. Relevant people pulled together and usually were able to work out a solution. SEATS followed up to review implementation regularly. People in all the provinces as well as at the national level expressed the wish for SEATS to continue. Everyone hopes that the follow-on projects (with the World Bank and UNFPA) will be as productive as SEATS, and that the staff will be as easy to work with.

4. ***The service providers uniformly stated that the most important thing about the project was the on-going supply line of contraceptives.*** Visits from donors/technical agencies was considered the next area of importance for project success.

RECOMMENDATIONS

1. The SEATS project should be studied by AIDAB and UNFPA. One of the fundamental strengths of this project was its adaptive and proactive nature as well as its breadth in scope.
2. The CBD aspects of the project are viewed as important by almost all DOH staff who are aware of them. CBD activities should be continued at least in some of the provinces supported by UNFPA and World Bank.
3. The service providers in the provinces should be visited often. After all, the service site is the end point of all of our work, where all the elements come together. Not to visit them is to miss a great source of information and of pleasure.
4. The system of training trainers and then using them for their own provinces for different types of training is working very well. They may need help during their first training course so a master trainer (or one of the experienced project trainers) should be on hand to assist, as was done in the SEATS project.
5. The plans for how IUD training will be carried out in the provinces needs to be addressed soon. Will there be a didactic portion as well as the practicum? Who will teach it? Where will training take place- at renovated clinics only or at other sites as well?. How many nurses will be trained at one time? Is there a minimum number of IUDs for a nurse to insert during training? How is proficiency judged? Should clients be recruited for IUDs? How can enough clients be recruited during the training? Will the provinces control all aspects of the training? If there are to be certificates, who will issue them?
6. A review of the MIS with the service providers and provincial staff is in order to clarify the concepts on the Daily Tally Sheet and Summary Provincial Sheet. Service providers are pleased with the SEATS forms for revisit acceptors and new acceptors. Rather than changing the form now, it would be wise to re-train the workers to understand the difference between a visit and a person in the revisit acceptors section of the recording form. The form does provide information which can be used to calculate CYP, a measure of achievement which is adequate for the time being.
7. A demographic and health survey should be conducted soon.

8. Conducting training courses in different ways for different levels of workers should be tried starting with aid post orderlies and CBD volunteers in Pidgin rather than English. To improve retention, materials should be prepared in Pidgin with the main points of the training. There should be enough drawings and pictures to make clear as much material as possible.
9. Produce IEC materials in Pidgin, Motu, etc. as well as English.
10. Try out some different demand generation activities in different provinces. Evaluate the response.
11. Conduct refresher training for aid post orderlies already trained.
12. Arrange for trips to different provinces for those who indicate an interest and would be able to make use of the information acquired.
13. Autoclaving equipment is not available in many clinics and they take their equipment to the hospital. This may prove to be a problem if IUDs become popular, and fast turnover of IUD kits is required. Also if larger amounts of equipment start appearing at the hospital for autoclaving there may be a backlash against the FP clinic. The problem needs to be studied and creative solutions proposed/implemented.

SELECTED BIBLIOGRAPHY

General Background and Information

Family Planning in Papua New Guinea, Carol Jenkins et al, 1991. A report of a KAP survey carried out for SOMARC.

Making Family Planning More Effective-Papua New Guinea Style, PNG Medical Journal, Glen Mola, 1991. An editorial supporting contraception and asking for community based distribution.

Some factors Affecting Acceptance of Family Planning in Manus, Boe Avue et al, undated. A report of a survey of women attending a clinic in Manus, as well as the health workers.

Fertility and Infertility in Papua New Guinea, Carol Jenkins, undated. A report of a study of secondary infertility due to sexually transmitted disease, contraceptives, birth and abortion.

Maternal Death in Papua New Guinea, 1984-1986. Glen Mola, 1989. A report of the risks of maternal mortality which are 500 times greater in the developing world than in the developed world.

Family Planning Attitudes and Action, Andrew I. Tulloch, PNG Medical Journal, 1986. A report of two surveys which show urban use of contraceptives to be 13 %.

An Experience of Over 200 Woman-Months of the Lippes Loop in the Highlands, E.J. Watson et al, PNG Medical Journal, 1973. A report of experience of pregnancy, removal and expulsions of Lippes Loop.

Termination of Pregnancy in Papua New Guinea: The Traditional and Contemporary Position. Ian A. McGoldrick, PNG Medical Journal, 1981. A review of the worldwide experience with legal and illegal abortions.

Papua New Guinea Contraceptive Attitude and Usage Study, Carol Jenkins, 1991. A report of a study carried out in three provinces.

An Alternative to Unattended Delivery- A training Program for Village Midwives in Papua New Guinea, William A. Alto, 1991. A report of a program in Eastern Highlands to train village women to deliver babies.

Indigenous Childbirth Practices: Information Gathering with the Machik Interview, Part II. Carol Jenkins, PNG Medical Journal, 1984. A report of a new questionnaire to use to learn about traditional practices.

STD in the Tari Basin, Jenny Hughes, 1991. A report of a study of STDs in Tari basin from 1983 to 1990. A report of knowledge of STDs among men and women and of perceived infertility due to them.

Population Trends in Papua New Guinea, National Statistical Office in Population, Family Health and Development: Papers from 19th Waigani Seminar, Vol. 1, 1993. Discusses the population growth since the 1920s in different parts of the country.

Proceedings of the National Strategy Meeting on the Health of Women in Papua New Guinea, Rumona Dickson in Population, Family Health and Development: Papers from the 19th Waigani Seminar, Vol. 2, 1993. Discusses the situation of women in PNG.

Social Marketing of Contraceptives in Papua New Guinea, Andrew Pillar in Population, Family Health and Development: Papers from the 19th Waigani Seminar, Vol. 2, 1993. Discusses the contraceptive social marketing program in PNG.

Documents

Staff Appraisal Report, Papua New Guinea, Population and Family Planning Project, 1993. A report of the strategies recommended by the World Bank for one of the projects succeeding SEATS.

Papua New Guinea: An Integrated National Population Policy for Progress and Development. Prepared by the Department of Finance and Planning, 5th June 1991.

Project Request from the Government of Papua New Guinea to the United Nations Fund for Population Activities, July 1990. A plan for UNFPA activities in PNG as part of the SEATS follow-on plan.

Report on the Baseline Survey for Coastal Lae Area, Morobe Province, Project Concern International, 1992. A report of women in Morobe concerning health related issues.

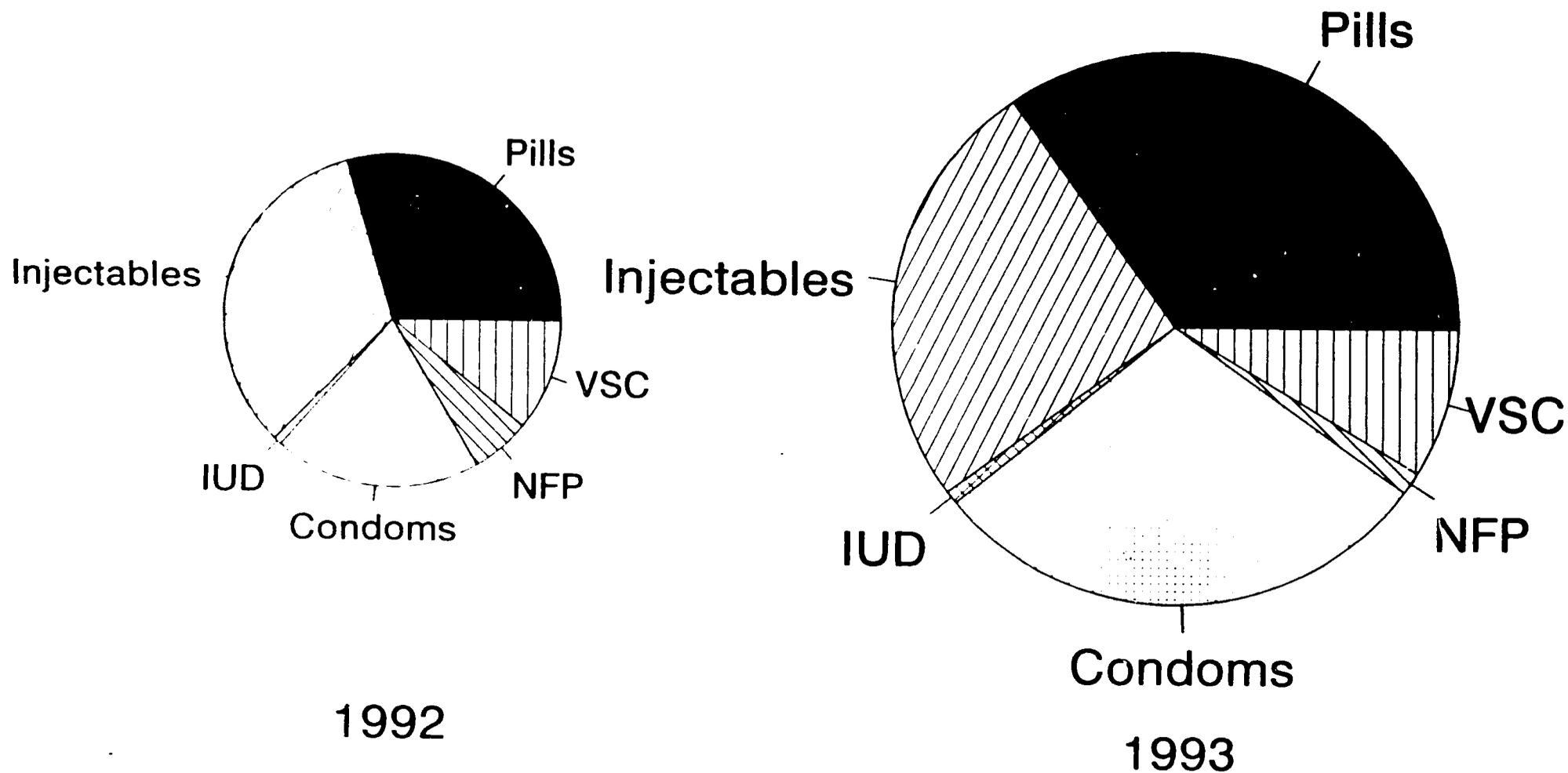
Report on the Final Survey for Kaiapit District, Morobe Province, Harumi Karel, Ph.D., October 1992. A report on a survey to compare levels of knowledge among women in Morobe after the Project Concern intervention compared to the country as a whole.

National Family Planning Guidelines, Papua New Guinea, Department of Health, 1991. A reference manual for clinicians.

Strengthening Reproductive Health Clinical Training and Service Delivery in Papua New Guinea, JHPIEGO, 1992. A paper outlining JHPIEGO's plans in PNG.

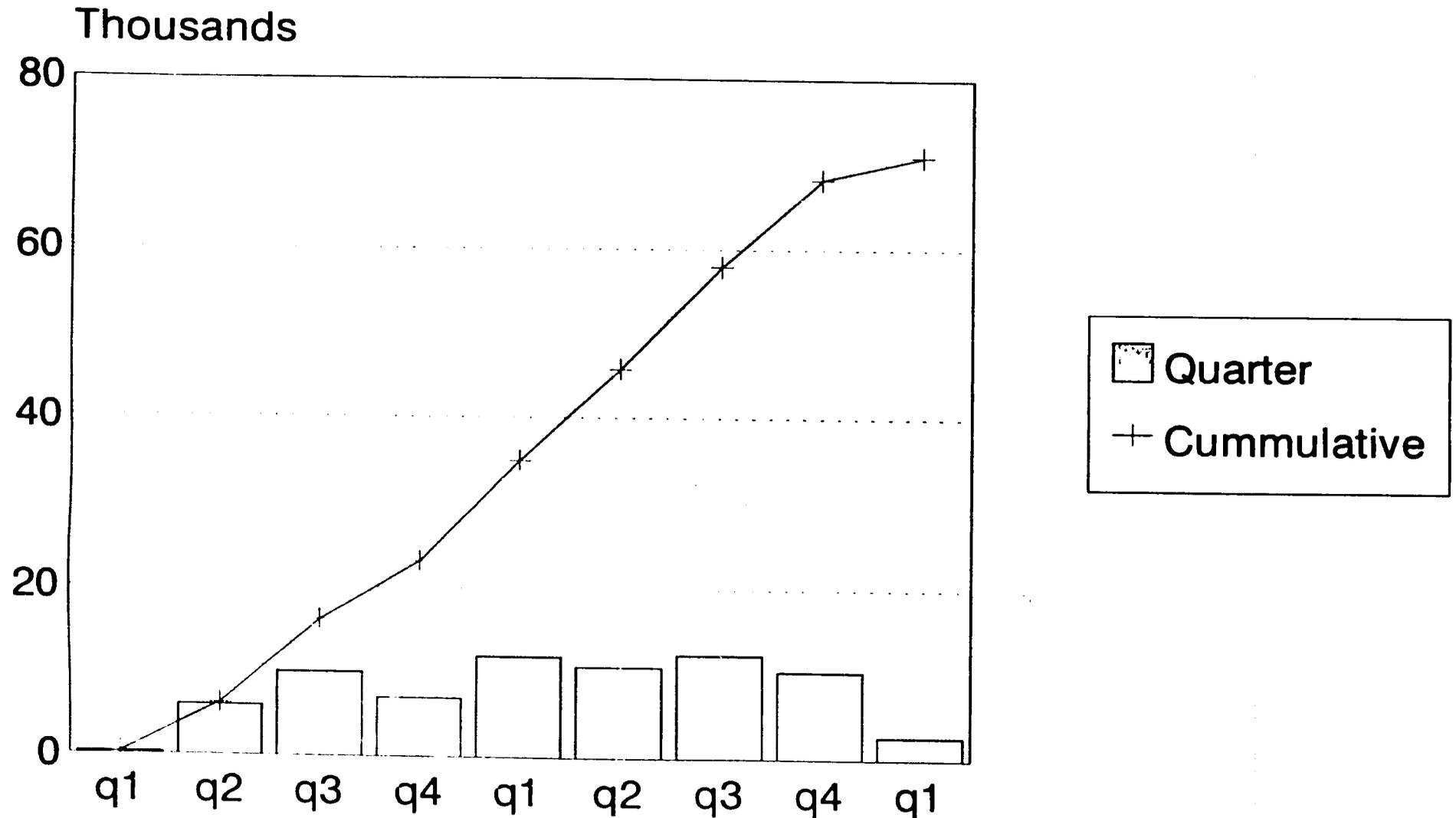
New Acceptor Method Mix

(SEATS provinces only)



Couple-Years of Protection

January 1992 - March 1994



CHRONOLOGY OF MAIN EVENTS DURING SEATS PROJECT IN PNG. 1991-1994

1991 May	Receive authorization for clinic space in five hospitals
	Visit of SEATS staff for training for National Youth Service (NYS)
July	JHPIEGO trainer to Manila for TOT training for six weeks
	official beginning of DOH-SEATS program
	National Executive Committee approves PNG population policy
	seven DOH personnel to Indonesia for two weeks
August	SEATS staff conducts management workshop with two staff from each of five provinces
October	consultant from Indonesia for management information system for six weeks
November	first TOT (of two) supported by SEATS carried out by one JHPIEGO trainer. Provincial staff who would train service providers were in attendance. (seven weeks)
1992 January	new SEATS Resident Advisor begins work
February	second TOT supported by SEATS carried out by two JHPIEGO trainers for provincial staff who were to train those in their provinces. (seven weeks)
March	SEATS consultant finalizes renovation plans and equipment list for hospital FP clinics

March to December	provincial staff who received TOT begin training of staff from health centers, sub-centers, aid posts in their provinces. Eligible staff included nurses, nurses aides, aid post orderlies, sisters in charge, officers in charge, community health workers. Course lasted one week. A total of 1400 persons from 700 odd facilities were trained.
	services begin in health facilities after staff return from training
September	Executive Director of Family Planning Association and coordinator of community based distribution (CBD) to Kenya in preparation for SEATS-supported CBD activity
	nurses from all provinces to Manila to learn IUD insertion
October	Provincial review and planning meeting held (first of two)
November	Second provincial review and planning meeting held for mid-level managers (for NCD)
December	Workshop on management information systems (MIS) held (for NCD)
1993 January	JHPIEGO consultant conducts IUD clinical course for seven staff from NCD, Central, Port Morseby General Hospital and Eastern Highlands
February	new SEATS coordinator begins work
March	discussions with Eastern Highlands to launch new social marketing product, Secure oral pill

	JHPIEGO consultant conducts workshop on standardization of technique for IUDs for three DOH or JHPIEGO staff who were trained in Manila and three others
	East Highlands Women's Provincial Council (EHPWC) agrees to a CBD program for the entire province
	SEATS Regional Director and Country Coordinator visit area medical stores, provincial offices, health centers and sub-centers, aid posts to review logistics systems and flow through the pipeline.
	DOH, SEATS and Child Survival staff conduct field survey of all provinces with three questionnaires: client exit, worker, logistics systems.
April	JHPIEGO consultant visit for second standardization workshop in Wewak for six DOH staff from five provinces
May	Luthern Church and Seventh Day Adventist Church decide not to participate in CBD programs with SEATS
July	two management training courses held for all provinces
	EHPWC signed CBD project with SEATS
August to September	DOH in-service coordinator of EHP trains volunteers from CBD project. Total of 114 men and women trained.
August	SEATS coordinator to Bangladesh for logistics training
September	consultant physician visits and evaluates medical standards of facilities

October	contract for Wontok Theater to perform in EHP ends
November	SEATS project assistant to D.C. for financial training
December	SEATS coordinator to D.C. for annual meeting
1994 January	EHPWC coordinator to Indonesia and Thailand to study CBD programs
February	SEATS conducts logistics management workshop for all provinces with the idea that these will return and conduct own workshops. Logistics forms reviewed and finalized.
March	SEATS Country Coordinator completes service
	consultant visit to document SEATS activities