

Project Concern International

Mid-term evaluation

Child Survival IX:

Improving Maternal and Child Health Services
In
Morobe Province, Papua New Guinea

May 9-26, 1995

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LIST OF TERMS

APO	Aid Post Orderly
APW	Aid Post Worker (includes APOs and CHWs)
AusAID	Australian Agency for International Development (formerly AIDAB)
CHNS	Community Health Nursing Service
CHW	Community Health Worker
DIP	Detailed Implementation Plan
IEC	Information, Education and Communication
KPC	Knowledge, Practice and Coverage
MCH	Maternal and Child Health
MDOH	Morobe Department of Health (provincial)
NDOH	National Department of Health
SIC	Sister In Charge (nursing)
TOHP	Training Of Health Promoters
TOT	Training Of Trainers
TRC	Training Resource Center
VBA	Village Birth Attendant

INTRODUCTION

PCI's Child Survival IX project began September 1, 1993 as a continuation of activities of a Child Survival VI project, also in Morobe Province. The midterm evaluation was conducted after 20 months of project operation, from May 9 to 26, 1995. The purpose of the evaluation was to assess the progress of the project to date, to identify relative strengths and weaknesses of the strategies adopted, and to make recommendations to help guide the project to a successful completion.

The evaluation focused on the principal components of the project, including village birth attendant training and support, health education for village men, the training of community health promoters, the functioning of the training resource center and the tetanus toxoid and ergometrine pilot project. In addition, prospects for the sustainability of project activities were discussed.

The methodology of the evaluation consisted of interviews with national, provincial and district officials, PC1 staff and local health center **staff**; group discussions with **CHWs, VBAs**, mothers and health promoters; a review of project documents, IEC materials and routine monitoring data; and observation of selected training activities. The evaluation team met frequently to discuss their observations, record findings and draft the evaluation report. They discussed their findings and recommendations at length with **PCI/PNG** staff, and subsequently presented the results at a meeting of provincial and district health **staff**.

The evaluation team included Micah **Yawing**, HEO, DCH, Coordinator of District Health Services, Morobe Department of Health; **Jeff Billings, MPH, MIA**, Technical Support Officer, **PCI/HQ**; Joan **Brabec**, BSMT, consultant and former PC1 trainer; and **Keith Edwards, BSc, MBBS, F'RCP**, DCH, Program Manager for UNICEF. Each team member participated in all evaluation activities, with the exception of Dr. Edwards, who was available for a more limited period of time. David Prettyman and Harumi Karel, the present and former **PCI/PNG** Country Directors respectively, were available to the evaluation team as resource persons.

While the midterm evaluation was intended to assess the work of PCI, it also focuses by necessity on the provincial and district departments of health, especially the systems, staff and facilities integral to health service delivery in Morobe Province. This CS-IX project has been implemented, to a certain extent, as a partnership between PC1 and the department of health.

It is also very important to emphasize the constraints faced by any organization attempting to manage development activities, including health service delivery, in Papua New Guinea. PNG is a very expensive country in which to work; the physical infrastructure--particularly transportation--is quite rudimentary, especially in the rural areas; and adequate staffing of health facilities has been problematic, partly due to a shortage of funding in the health sector. For these reasons, it is unrealistic to expect the kind of rapid progress achieved by child survival projects working in more favorable environments. The evaluators have kept these factors in mind.

PART I: ASSESSMENT BY PROJECT COMPONENT

1. Village Birth Attendant Program

Since its inception, the core of PCI's Child Survival project has been the training of local women to serve as village birth attendants (**VBAs**). Through PCI's Child Survival activities to date, 245 **VBAs** have been trained in Kaiapit and Huon Districts, primarily by PC1 staff with assistance from local

health center staff. With the CS-IX project phase--which will bring PCI's involvement in Morobe Province to an end--PC1 is attempting to shift its role to that of trainer of trainers and provider of technical assistance and limited financial support, and to encourage the staff of the local health centers to assume primary responsibility for training and supervising **VBAs**.

PC1 has conducted three TOT courses thus far in which 36 trainers have been trained, 30 from within Morobe Province and six from outside Morobe Province. Those participants from Morobe Province were drawn from 11 health centers and two urban clinics. The others came **from** Western and Central Provinces, and the Chevron Niugini corporation based in Southern Highlands Province.

Since the CS-IX project began in September 1993, a total of 66 **VBAs** have been trained in four courses held in Kaiapit and Huon Districts, with PC1 either assuming a lead role or assisting local health center staff in conducting the course.

Because of the important role **VBAs** can play in extending health care services to the village level in PNG, as well as the central place of VBA training in the PC1 project, the midterm evaluation team focused much of its attention on this component. We were able to observe a VBA training course and interview two groups of trained **VBAs** and VBA trainers.

STRENGTHS:

- The National Health Policy identifies VBA training as an important strategy for reducing maternal mortality in PNG, and top DOH officials and consultants support PCI's VBA training efforts. VBA training will likely be included as a component of the AusAID-funded, national MCH project, which will begin in **1996**.
- UNICEF has also stated its willingness to fund VBA training in Morobe province, if districts can formulate detailed training plans and provide a reasonable matching contribution.
- Two **CHWs** trained as VBA trainers were observed in action nine months after their TOT course. **While** they deferred greatly to PC1 trainers, they demonstrated that they were able to play an active role in both the VBA training and the men's health education course.
- In spite of gaps in VBA support staff at several health centers, it appears that most of the trained **VBAs** continue to assist mothers in their villages.
- Community leaders stated their satisfaction with the services provided by the **VBAs**, and some **VBAs** reported that they receive gifts for their work, which was previously almost unknown
- The provincial CHNS Summary reporting form has been revised to include space for recording VBA activity data.
- A VBA liability form has been developed. The Project Director stated that it will be used, starting with VBA training in Bosadi village (May **1995**), and also taken to be signed by village heads in all villages where **VBAs** have already been trained. This is an important tool to help protect **VBAs** from liability for maternal or infant deaths. Currently, some husbands of **VBAs** do not allow their wives to practice for fear of possible liability.

WEAKNESSES:

- Selection of candidates for TOT training has not been appropriate in some areas. In Salamaua no male was selected, who could then conduct the men's health education, and no senior health center staff was involved. As a result, there was no support for the trained **CHWs** to prepare for VBA training.
- HC staff in some areas have not made village contacts or other preparations for VBA training to date, in some cases six months after their TOT training. Reasons for their inactivity include the following:

Health center staffing: There are too few qualified and motivated staff in some areas willing to assume responsibility for VBA training and support; and there is frequent movement of staff from one district to another, resulting in breakdown in continuity and planning.

Low priority: Delivery of curative services at the health centers is given a higher **priority than** village visits for preventive and promotive purposes.

Transport constraints persist due to insufficient funds for fuel, vehicles being assigned to activities other than mobile patrols, and a lack of funds for staff travel advances.

- PC1 staff have taken too large a role in VBA training since the TOT courses. Health center staff played only a marginal role in the Morobe and Yalu VBA trainings. An exception was the VBA training in Leron, where the Mutzing health center staff--who are very experienced with VBAs--took a leading role.
- Aidpost workers are not routinely included in the VBA training courses.
- Poor coordination and communication between PC1 and health center staff, in both Salamaua and Mutzing, has led to confusion over roles, resentment and inactivity, and has contributed to a lack of supervision and support of **VBAs**.
- VBA re-supply is problematic in the Bukawa area because there is no health center assigned to support this area.
- Chloroquine and Fefol tablets are not being routinely supplied to mothers by the **VBAs**.
- The VBA reporting system is not working due to breakdowns at various levels:

VBAs: developed a new VBA reporting form but has not distributed it to the **VBAs**. Instead, some **VBAs** use exercise books to record their activities. They submit their reports only when they visit their respective health center, or when the health center's mobile MCH patrol visits the **VBA's** village; for **VBAs** residing in remote villages, this is very infrequently. However, the situation seems to be better in some areas (such as Morobe subdistrict) than in others.

Health centers: VBA reports received at health centers are often times not compiled and forwarded to the MDOH or PCI. Health centers have not received and are not using the

new **CHNS** Monthly Summary form which includes space for recording VBA activity data. Again, some areas (such as Morobe sub-district) are performing better than others, but the quality and quantity of data received by PC1 is not good.

PCI: VBA activity information received by PC1 has not been well organized; staff do not seem to see the value in maintaining a good information system. The MDOH has not been receiving VBA activity reports **from** PCI.

- Community preparation visits have not been effective in many areas. As a result, there is misunderstanding about the need for community support for the **VBAs**. Many villagers feel that **VBAs** belong to PC1 or the government--not the communities--and that PC1 or the government should pay them. Community preparation visits have not been conducted in more isolated villages, and even in more central villages misunderstanding persists.
- Staff at health centers and hospitals sometimes do not welcome **VBAs** when they accompany mothers. VBAs report that they and the mothers are often mistreated.

RECOMMENDATIONS:

1. Before conducting any further TOT courses, PC1 should carefully assess the level of VBA training activity and support likely to be undertaken by the health centers in the project area. If it is clear that sufficient and committed manpower and operational funding (for village contact visits, initial and in-service training and VBA supervision visits) will be made available, then training of trainers should continue. If these resources will not be made available, then TOT courses would only be a waste of time and should not be conducted. Possible funding for operational support from UNICEF and **AusAID** should be confirmed.
2. PCI's Provincial Training Coordinator should supervise the initial VBA training and men's education courses conducted by each health center, to ensure that the health center staff perform satisfactorily and assume the leading role in the training.
3. PC1 and the MDOH should work closely to plan and monitor district health activities related to VBA training and support; and within the next 12 months, the MDOH should assume full responsibility for this role.
4. Integration with both the national Child Survival Program and Population and Family Planning Project should be maximized in terms of materials used and funding for supervision and support
5. The Church Medical Council should be requested to consider their role in the support for VBA programs.
6. PC1 should request the Morobe Department of Health to send a letter to all District Officers and health center staff, giving them an overview of the VBA program and stating that the program is both national and provincial policy, and requesting cooperation from all in the implementation, monitoring and evaluation of the program as a priority activity.

7. PC1 should prepare a proposal for the establishment of a national VBA Support Unit, based in Lae, which will grow out of PCI's current VBA training and support capability, and which will include:
 - A National **VBA** Coordinator supported by the NDOH
 - Other key PC1 staff supported by the MDOH, allowing PCI's TOT and VBA training assistance capacity to be maintained
 - Operational funds provided by the NDOH, **AusAID** or other donors involved in MCH programs in PNG
 - An initial focus in Morobe Province, with subsequent operations throughout the **country**
8. PC1 should review all candidates nominated for TOT-VBA training, to ensure that they are appropriate, and that the VBA training team at each health center includes at least one senior officer. If inappropriate candidates have been nominated, they should not be trained.
9. PC1 should work closely with district authorities to clearly define the roles, responsibilities and lines of authority for PCI's District Training Coordinators in Mutzing and Salamaua; and PC1 should begin discussions with district authorities to plan the roles and responsibilities of the new district VBA coordinators, which are planned to be created.
10. PC1 senior management should take immediate steps to resolve the conflicts between **PCI's** District Training Coordinator in Mutzing and the health center staff. If the conflicts cannot be resolved and a cooperative working relationship established, then the District Training Coordinator should be reassigned.
11. PC1 and relevant health center and aid post staff should visit those villages where misunderstandings about program ownership are a serious problem, and provide an education session to village men about the importance of reproductive health and the role of the **VBA**.
12. In the future, proper community preparation should be carried out in all project villages *before* VBA selection, to ensure community support for **VBAs**.
13. PC1 should not advocate for government programs, such as the **Village Service Scheme**, to pay **VBAs**, as this could create a dependency which may not be sustained in the long term
14. The TOT training manual is too detailed and should be simplified to eliminate irrelevant material. PC1 should consult with appropriate national and provincial officials to ensure that the course content and materials are consistent with that being used by the Diploma of Community Health Nursing Course at the College of Allied Health Science, Port Moresby.
15. **VBAs** should be taught to supply chloroquine and fefol to mothers and be resupplied by **APOs** and **CHWs**.
16. A VBA supervision checklist should be developed and used.
17. PC1 should produce picture identity cards for **VBAs**, to help improve their recognition at health centers and hospitals.

2. Men's Health Education

PCI's men's health education program consists of a two-to-three day course, conducted concurrently with VBA training, designed to better inform village men about health issues and the importance of the **VBAs**. Topics covered include: reproductive health, family planning, HIV/AIDS and child survival (nutrition, immunizations, diarrhea and acute respiratory infections). Husbands of **VBAs** are encouraged to attend, but the training is open to any men who are interested. PCI expects that educating village men will create more local support for the work of the **VBAs**.

STRENGTHS:

- There is much enthusiasm for these courses, which was seen at several villages in the project area.
- Men's health education is an excellent complement to VBA training, and represents an integral part of the project. It is widely seen as important for cultivating support for **VBAs** among the men in the villages. As the principal decision-makers, men have substantial control over their wives access to health services, such as referral to a health center.
 - a The course has the potential to significantly improve the antenatal attendance, immunization coverage and early referral of problem deliveries.
- All health centers in the project area, except Salamaua, sent a male CHW to attend the TOT-VBA course. These CHWs should then be able to conduct the men's health education sessions in conjunction with the VBA training in their areas.

WEAKNESSES:

- Due to communication problems, men attending the health education session in Bosadi village came only from nearby villages, and not **from** more distant ones. Thus many of the **VBAs'** villages were not represented.
- Younger men are often not included in the course, and they are an important group for HIV/AIDS and family planning knowledge.
- The training materials are not adequate. The pictures in the workbook are too small, and should be reproduced on posters. The female anatomy board was very useful; but there is only one set, and it must be shared with the VBA training. And because it belongs to PCI, it will not be readily available when needed by health center staff. (For recommendation, see section on Training Resource Center.)
- No-one is given specific responsibility at the health center level to plan and carry out these courses.

RECOMMENDATIONS:

1. When a VBA training is being planned, PC1 and health center staff should provide men's health education sessions in as many villages as possible and at every opportunity, such as during initial village contact visits and during mobile MCH patrols.
 2. During the two-week VBA training period, PC1 should conduct at least two men's health education courses in each area where VBA training is being conducted.
 3. Whenever possible, men of all ages should be allowed to attend the courses; and men from the same villages as the VBAs should be strongly encouraged to attend.
 4. A male staff member at each health center should be specifically trained to plan and implement the men's health education courses.
 5. The Officer-in-Charge of each health center should be requested by official letter from the MDOH to appoint one of his staff as Male Health Educator (as recommended in section 1 above).
3. Training of Health **Promoters**

The training of health promoters (TOHP) is a twoday course provided to selected leaders of community-based groups such as women's or youth clubs, churches, schools and health committees. The course is designed to prepare these leaders to become active health educators and promoters in their villages. Participants at TOHP courses conducted to date have also included trained VBAs living nearby. In this way, they too have been able to benefit from the information presented, and can potentially pass this information onto the mothers they help.

The evaluation team was able to observe one day of a TOHP course held in Buhalu village, which included a performance by a local drama group designed to reinforce the messages covered in the formal course. In addition, the team interviewed several health promoters who had been trained in another TOHP course held in November 1994.

PC1 staff administered pre- and post-tests to the participants at this course, to assess the level of learning achieved. The data has been entered into a computer, but not yet analyzed. Thus, to assess the TOI-IP course itself, the evaluation team had to rely on observation of a part of one course-- which cannot be considered a definitive assessment.

During the TOHP course in Buhalu village, the evaluation team noted that the participants were actively engaged, and both men and women felt free to ask questions and discuss issues openly together. The trainers (PC1 staff) presented the material in a clear manner, and the large AIDS flipchart was quite helpful.

The AIDS drama was a popular event, and a good break from the lecture methodology, although it was not clear how effective it was at imparting health information. Many audience members objected to the idea of condom use, because they felt it may cause promiscuity.

Only limited monitoring information has been collected on the activity of health promoters after the TOHP course, so it is difficult to quantify the achievements of this component of the project. PC1 staff **stated** that some health promoters verbally report on their activities when they visit the Training Resource Center to get posters and videos. An activity reporting form has recently been developed and given to health promoters trained since February, but PC1 staff report that only a few of the health promoters are using the form.

PC1 staff have visited a few trained health promoters in and around Lae, to observe their health education talks and to offer support and advice, as well as to take AIDS posters to them.

Anecdotally, trained health promoters reported that they are active in health education. Some said they give informal “health talks” every Friday in their villages, focusing on family planning, AIDS and sanitation; other health promoters are apparently somewhat less active. Health promoters interviewed stated that they have no *educational* materials to use during their presentations, although PC1 staff said at least one set of materials was provided to promoters in each village. If promoters do not have materials to use, this will undoubtedly limit their effectiveness as educators.

Further, health promoters admitted that they sometimes have difficulty answering questions posed to them by audience members. This finding was corroborated by the Mutzing SIC, who has observed health promotion sessions. She also reported that some of the information presented by the health promoter was misleading, and that it was necessary for her to step in and clarify certain issues, as well as to defuse controversies that arose regarding condom use, alleged promiscuity, and moral concerns.

Both the health promoters interviewed and the Mutzing SIC felt that the TOHP course was inadequate, and should be more extensive. The SIC suggested that health promoters be trained to refer **difficult** questions to **APOs** or other health staff, rather than giving misleading information.

STRENGTHS:

- The large AIDS flip chart is visually clear, helpful and well-utilized by the trainers.
- The health promoters selected for training are community leaders, whose status should make them more effective promoters.

WEAKNESSES:

- PCI staff have been unable to thoroughly follow-up the TOHP by attending the promoters’ first health education talks, and have not assessed the quality of the health promotion or the need for additional training or revision of the training curriculum. Only a few of the promoters’ health education talks have been observed.
- Information about the activity level of health promoters after training is incomplete. Only a few health promoters have used the activity reporting form.

RECOMMENDATIONS:

1. Before conducting any further TOHP courses, PC1 should carefully assess the effectiveness of the TOHP program, on a *pilot* basis. Staff should attend the health education talks of a sample of promoters and evaluate their abilities and the quality of the information presented, before making a decision to proceed with further training. If the results are good, the program should be continued. If the results are poor, then refresher training should be considered.
2. PC1 should involve all local **CHWs** and **APOs** in the TOHP courses, and encourage them to attend and support the promoters' health education talks in their areas. The health promoters can then refer difficult questions to the **CHWs** and **APOs**.
3. PC1 should coordinate its TOHP program with the Child Survival Project's TOT program. The same materials should be used, including simple flipcharts and standard messages.
4. **Training Resource Center**

The Training Resource Center (TRC) was opened in July 1994 to serve as a training venue for PCI's TOT and other courses, a studio for the design and adaptation of IEC materials related to maternal and child health and HIV/AIDS, and a convenient repository for such materials, as well as journals and practical manuals. It is also equipped with two **Tvs** and **VCRs**, two overhead projectors, a slide projector, a generator and two pelvic models.

PC1 staff have publicized the TRC during speaking engagements at conferences and trainings. A descriptive pamphlet was also developed and copies sent to health centers, clinics, attendees at the **TRC's** opening, and other individuals.

The TRC has mainly been utilized by church groups, health center staff, and other **NGOs** active in health. A few PCI-trained health promoters have also borrowed videos to show to their respective groups. Generally, utilization of the TRC has been quite light, and the educational videos are the resources most frequently borrowed. Some district health staff have also borrowed books.

STRENGTHS:

- The TRC is well organized, open during business hours and conveniently located in downtown Lae, next to the public bus station.
- The MDOH is supportive of the TRC, and would like to see its activities continue if they are able to secure funding.

WEAKNESSES:

- The TRC is not sustainable in its current location, as the MDOH has little money to pay for rent of the existing facility, unless additional funds are found.

- Development and pretesting of materials has been ad hoc rather than planned, although PC1 staff feel that those used in the TOHP were clearly understood by participants.
- Formal printing and production of materials has been slow and availability is inadequate. No artist was available for materials development until recently.
- a The TRC is not a good training venue, due to its small size, and noise and other distractions related to its downtown location.
- There are not enough materials to lend out to health centers, including pelvic models, slide projectors and slide sets, anatomy boards and video cassettes.

RECOMMENDATIONS:

1. PC1 should collaborate with the national Child Survival Program to produce improved training and health promotion materials, especially related to maternal health. The appropriate PC1 staff should visit the CSP office in Port Moresby to observe their strategy and methods.
2. The production of materials should be planned and coordinated with the routine inclusion of screening for consistency and pretesting.
3. Care should be taken to make IEC messages consistent with standard guidelines, where available (eg. the six standard child nutrition messages developed by the PNG Pediatric Society, and Facts for Life), and easier to use for health promoters to pass messages on to others.
4. PC1 should produce or obtain more training **materials**, so that they can be lent out to health center staff for training courses.
5. PC1 should begin planning with the provincial health promotion office for the eventual transfer and utilization of the **TRC's** materials. This should include identification of an appropriate government facility. Suggested locations are the Momase Regional Support Unit or the Angau Memorial Hospital or School of Nursing.
6. TOT and other courses should be held at low-cost, out-of-town facilities which also provide low-cost accommodation on site. A good example of a suitable location would be St. Joseph's Pastoral Centre at **8-mile**. Alternatively, the courses could be based at the Momase Regional Support Unit where there is a good in-service classroom and accommodation is possible at the School of Nursing at certain times of the year.

5. Tetanus Toxoid and Ergometrine Pilot Project

Aidpost workers (**APOs** and **CHWs**) in the Bukawa sub-district were given a special training course to enable them to support the VBA program by the giving of prophylactic Synto-metrine injection to mothers delivering in the village. In addition, they were also taught to give tetanus toxoid to all women of child bearing age at the aidpost and to issue and enter immunizations given in the Mother's

Health Record Book The midterm evaluation team held a discussion with a group of aidpost workers gathered at the Situm aidpost to learn of their experiences with this pilot project. The team was not able to review activity data for the aidpost workers, as most of it was not available.

STRENGTHS:

- There were no adverse reactions (side effects following tetanus toxoid immunization) reported by the focus group participants.
- The community are enthusiastic for the giving of tetanus toxoid to mothers at the aidpost despite initial misunderstanding in one area where the men assumed the injection was a contraceptive.
- A full set of records from one aidpost (Gobadik) showed that over the course of nine months, the aidpost worker has fully immunized 94% of the estimated women of child-bearing age (53 women) and that 76% of these women were not pregnant at the time of full immunization.
- There was no anecdotal evidence of adverse effect on ante-natal clinic attendances.
- Rules on tetanus toxoid storage and usage appear to have been understood and followed correctly.
- This is a low-cost program which has the potential to markedly increase immunization coverage for women of childbearing age and the safety of village childbirth both from post-partum hemorrhage (mother) and also neonatal tetanus (baby).
- Women are immunized *before* they become pregnant so if they do miss out on antenatal care, their baby will still be protected from neonatal tetanus.
- Although only eight women are known to have received prophylactic Synto-metrine at the time of birth, four out of seven of the focus group members had given one or more injections of prophylactic Synto-metrine.
- Inspection of two **village** birth supervision report forms revealed that the forms had been completed correctly and that all required actions had been performed.

WEAKNESSES:

- The course was of short duration (one and one-half days).
- Not all community education material was supplied to participants (posters were not issued).
- No active monitoring or supervision was done in the first six months of the project.
- Communication and transport problems remain a significant barrier to the attendance of the aidpost workers at the time of village delivery, and also to the supervision of the **APWs** at the aidposts.

RECOMMENDATIONS:

1. The tetanus toxoid at aidposts intervention should be taught to all aidpost workers as part of their involvement in the VBA program. This could be done during their attendance at the VBA training.
2. The responsibility of the aidpost workers in village delivery should also be taught to the **APWs** who attend the VBA training. It is recommended that the Child Survival Program training and community education materials be used for this purpose and that the giving of prophylactic Synto-metrine and the supervision of the **VBA**s be stressed as the most important activities for the aidpost workers.
3. The Child Survival Support Project should **modify** their existing aidpost worker village birth training materials to include the giving of tetanus toxoid, and this package should be included in the third Nationwide Child Survival In-service Program.

PART II: Assessment by Child Survival Guidelines

1. Accomplishments

The CS-IX project began September 1, 1993 and has been operating for 20 months. The project is an extension of the original CS-VI project, which operated from September 1990 through August 1993. The principal inputs and outputs of the project are outlined in Appendix 1, and are compiled from staff activity reports. Data on outcomes such as immunization coverage and proportion of births assisted is not presently available, but will be measured by the project's final survey, to be conducted in mid-1996.

2. Effectiveness

The project has shown mixed results to date in achieving the output targets anticipated in the detailed implementation plan (DIP). As Appendix 1 shows, the DIP targets have already been exceeded for the training of community health promoters (129% of target) and the training of VBA trainers (123% of target). And the number of participants attending HIV/AIDS workshops has already reached 92% of the target.

Other targets, however, are behind schedule, such as the training of **VBA**s, in-service training for health staff, men's health education sessions, and the development of IEC materials.

In addition, several project activities were carried out which had not been planned in the DIP, including a malaria prevention and bednet treatment workshop, World AIDS Day educational events, village health committee workshops, and many other health education sessions for various audiences.

Project objectives stated in the DIP relate to knowledge, practice and coverage indicators, and cannot be measured at this time. Assessment of the level of their achievement will have to wait for the final project KPC survey, to be conducted in mid-1996.

3. Relevance to Development

The project has thus far trained 245 VBAs throughout the catchment area, thereby helping to increase the availability of health services at the village level. The VBAs are well-known in the villages, and seem to be eager to assist women if they are asked. Village mothers interviewed stated that they felt comfortable asking the VBAs for assistance. Some, however, viewed the VBAs as having a low level of training, and preferred to deliver at a health center or hospital if they could afford it.

The men's health education sessions which accompany VBA training courses are designed to make the principal village decision-makers more knowledgeable about reproductive health and more supportive of the work of the VBAs. This effort should help improve the accessibility and utilization of VBA services.

Health promoters trained by the project are also increasing the awareness and understanding among village communities of the importance of preventive health care and the availability of services at the health centers and aid posts. This increased understanding should translate into health-seeking behavior, provided that health services are accessible to the villagers.

4. Design and Implementation

4.1 Design

The only change in project area and impact population since the DIP has been an extension of the scope of VBA training of trainers. Beginning with the November 1994 TOT course, candidates have been invited from health centers, clinics and other institutions outside the original project area of Kaiapit and Huon Districts of Morobe Province. This expansion will allow the capability for VBA training to spread to other areas of the country. PCI's follow-up support for VBA training itself has remained restricted to Kaiapit and Huon Districts.

4.2 Management and Use of Data

PCI is collecting routine activity data on project inputs and outputs, as well as qualitative reports of activities and accomplishments from staff and health workers at all levels. Written pre- and post-tests have been conducted during TOT courses and training courses for health promoters, and the results have been used to revise training curricula and improve subsequent courses.

A MACHIK survey (Maternal and Child Health Information and Knowledge survey) is conducted before each VBA training course to provide information on local beliefs and practices related to reproductive health. This information is then used to tailor instructional examples to local conditions, and to foster a sense of inclusion among the participants. For example, traditional cord care practices used in the area will be discussed in the course and assessed for their potential impact on the baby.

Standard KPC surveys are employed by the project for quantitative evaluation purposes, to measure objective indicators. Baseline surveys were conducted in the two project districts, and a final project survey will be carried out in mid-1996.

The project's health information system is not functioning satisfactorily. As described in the sections on the VBA Program and the Training of Health Promoters, routine activity data is not being consistently generated by village-level health workers and forwarded to the health centers, the MDOH and PCI. The appropriate reporting forms are not being used, although they have been available for many months. As a result of this situation, it is not possible to monitor project indicators such as the proportion of village births assisted by **VBA**s. Further, it is not clear that project staff have learned the lesson of the importance of reliable data collection and analysis to project management.

A similar situation exists at the MDOH, where the information unit has no properly trained staff, little available space, and an inefficient system for compiling data from the district to the provincial level. When data is available, little feedback takes place from the provincial to the district levels.

43 Community Education and Social Promotion

PCI's project includes both service provision and health promotion. **VBA**s are trained to provide delivery services to village mothers, and to identify and refer those mothers with high-risk signs. On the other hand, several project components focus on health education and promotion, including the training of health promoters, the men's health education sessions, HIV/AIDS workshops and the development of IEC materials. In addition, the World AIDS Day activities and other informal health education **talks** have contributed to health promotion. The health messages used have been borrowed from existing sources and adapted to some extent based on data from the project's baseline and MACHIK surveys, although they have generally not been field tested. In the case of the health promoters' educational talks, there is concern that the messages may even be misleading in some **cases**.

Another concern relates to the availability of health services--besides those delivered by **VBA**s--at the village level. District health centers are supposed to mount regular maternal and child health patrols to all villages in their catchment areas, which for many villages is the only source of immunizations, vitamin A supplementation and other preventive and curative services. However, it is clear that serious resource constraints have prevented the health centers from carrying out a regular schedule of MCH patrols. In this environment, PCI's health education and promotion activities could have the effect of creating demand for services that do not exist.

Printed materials used by the project have included illustrated training guides, flipcharts and posters. Most materials used by the project have been borrowed from other sources, including the Child Survival Support Project, WHO, UNICEF, the MDOH Health Promotion Unit, standard midwifery manuals, and Teaching Aids at Low Cost. Other materials, such as a family planning flip chart, were developed by project staff. Materials have not been pre-tested, but some have been revised over the course of several trainings, based on feedback received. An AIDS flipchart used during the training of health promoters seemed to have been an effective educational tool, based on observation and discussion with trainees.

The project has also made limited use of local drama groups to present messages related to HIV and AIDS. The evaluation team observed one such drama performance in a village, which was well-attended and lively. No assessment has been made, however, of the effectiveness of these performances as educational methods.

4.4 Human Resources for Child Survival

The staff of **PCI/PNG** includes the following positions, based in Lae:

Administrative: Country Director, Project Director, and secretary

Technical: Provincial Training Coordinator, District Training Coordinator for Huon District, District Training Coordinator for Kaiapit District, Men's Health Educator, Training Resource Center Coordinator, and Training Resource Center Intern

PC1 implements the CS-IX project in partnership with the Morobe Department of Health and the District Health Offices of both Huon and Kaiapit Districts. Several staff members of these agencies devote time to the project, as follows. In addition, PC1 has trained numerous staff and volunteer health workers who are expected to continue providing services, and are thus considered to be "involved" in the project.

Morobe Department of Health: Assistant Secretary, and Matron of Community Health Nursing Services

District Health Offices (Huon and Kaiapit): District Secretaries, and District Health Administrators from both districts

Health Center staff (throughout Morobe Province): Health Center Officers-in-Charge (3), Nursing Officers (15), Community Health Workers and Aid Post Orderlies (14), and one health inspector

Others: Village Birth Attendants (66), Health Promoters (194), and many other community members who have received health education

The staffing structure of **PCI/PNG** has gone through several changes, including the recent appointment of a new Country Director and his posting in Lae. PCI's former Country Director was based in the capital, Port Moresby, and relied heavily on the Project Director for daily management of project activities in Lae. With the Country Director now based in Lae, and taking responsibility for project management and supervision, as well as financial management, the role of the Project Director is somewhat unclear. There have also been difficulties with the role and functioning of the two District Training Coordinators (for details, see section 4.10 Assessment of Counterpart Relationships). Otherwise, the staff seem well suited for their positions, and there does not appear to be a problem with duplication of effort or an unreasonable burden of work

Community volunteers involved in the project include village birth attendants and health promoters. Descriptions of their activities and relevant findings of the midterm evaluation team are presented in Part I above. The evaluation team was only able to assess the VBA and health promoter components through group discussions with non-representative samples of these health workers, and through reports of PC1 and health center staff who are familiar with their work. No reliable quantitative data were available on VBA or health promoter activity levels or drop-outs. However, verbal reports from **VBAs** in one village suggest that they delivered an average of one to two babies per month during the last year.

After examining curriculum materials and observing one day of a training course, the evaluation team felt that the focus and materials were appropriate for VBA training, with the exception that the VBAs should also be taught to supply chloroquine and fefol to mothers, and that local **CHWs** and **APOs** should be encouraged to attend the VBA training courses.

During the course which the team observed, PCI's District Training Coordinator led almost all of the training, while the local health center staff assumed a more passive role or were absent entirely. This problem was due to **staffing** constraints at the health center, as well as a lower priority given to VBA activities.

No pre- and post-test evaluations are carried out for the VBA courses. Instead, trainers assess the participants' knowledge and skills verbally and through role plays at the end of the first and second weeks. Those participants found to be lagging behind are given additional attention. PCI training staff report that this method has been very successful for preparing **VBAs**. The midterm evaluation did not involve testing of **VBAs'** knowledge or skills.

For the training of **health promoters**, pre- and post-tests were conducted during the courses, but **PCI/PNG** staff have not yet analyzed the data. Reports from previously trained health promoters, as well as some health center staff who observed health promotion **talks**, indicated that at least some health promoters were insecure in their knowledge, and had difficulty responding to questions about health issues. Both the health center staff and the promoters interviewed felt that the health promoters' training was too short. In addition, health education materials have apparently not been provided to all health promoters.

The **men's health** education course observed by the evaluation team was enthusiastically received by the participants, who said they greatly appreciated the opportunity to learn about reproductive health for the first time. The evaluation team noticed, however, that the men attending the course were not always **from** the same villages as the **VBAs**, and that younger men are often not included, even though they are an important group for HIV/AIDS and family planning knowledge.

There seems to be confusion among PCI staff as to whether the men's courses are training or health education. The original objective was to increase the knowledge of village men--especially the husbands of VBAs--regarding reproductive health, so that they would be more supportive of the **VBAs'** work and more sensitive to the needs of pregnant women, including transport for emergency care. But according to PCI's Men's Health Educator, the purpose of the course is to prepare the men to become active health educators and promoters once they return to their villages. The present format is insufficient to train health educators and promoters, but is probably unnecessarily long for a health education session.

Further, as with the training of health promoters course, no educational materials--other than their own workbooks--were provided to the participants. And no pre- and post-tests are conducted as part of these sessions, so it is not possible to formally assess what the participants learned, or their ability to educate other men.

The evaluation team did not have the opportunity to observe a **VBA training of trainers course**. However, Dr. Ake, the Director of the national Department of Health's Child Survival Program, observed a VBA-TOT course in late 1994. He felt the course was very successful, but commented that the VBA-TOT manual was too detailed and recommended that it be simplified. The evaluation

team agreed that the training materials need to be simplified; in particular, the operational responsibilities of the VBA trainers need to be precisely defined.

Previous feedback from TOT participants had indicated that the course was too intensive, and had attempted to present too much information in too short a period of time. As a result of this feedback, the course was lengthened from two to three weeks.

Pre- and post-tests were conducted **as** part of the TOT courses, but the data from these tests is of limited usefulness, due to the confusing nature of the questions and the way the responses were recorded. PC1 trainers reported that the participants' knowledge and skills improved substantially during the courses, with the exception of certain issues, including the harmful effects of drinking and smoking during pregnancy, signs of high-risk pregnancy and post-partum infection, strategies for village selection and adult learning techniques.

No information was collected during the evaluation about the methodology or effectiveness of health **center** in-service training activities. The project has discontinued formal, week-long training workshops, but will continue to provide brief, informal training sessions during visits to health centers, especially focusing on data collection and reporting.

Child Survival Training Program Summary

TYPE/#/DATES	TRAINING TOPICS	TOPIC HOURS	TRAINING METHODS FOR TOPIC
Training of Trainers for VBAS: 8/29 - 9/9/94 (10) 11/21 - 12/9/94 (14) 2/6 - 2/24/95 (13)	Adult education and training techniques, reproductive health, safe delivery, antenatal and postnatal care, high-risk signs, child health.	72 108 108	Lectures, group work and presentations, and group discussions. Role plays, coaching skills, demonstrations and practical sessions on teaching.
VSA Training: 3/14 - 3/25/94 (14) 11/7 - 11/18/94 (15) 4/17 - 4/28/95 (17) 5/15 - 5/26/95 (13)	Reproductive health, safe delivery, antenatal and postnatal care, high-risk signs, child health.	70	Lectures, group discussions, sharing of experience, role plays, demonstration, coaching C video shows.
Village Men (76 total to date): Concurrent with VSA Training above, plus: 3/13 - 3/15/95	Health education on reproductive health and the role of the VSA.	21	Lecture, group work & group presentations, group discussion C video shows.
Training of Health Promoters: One course per month on average (194 total trainees to day)	HIV/AIDS Family Planning Nutrition Immunization	14 7 7 7	Lecture, group work 6 group presentations, group discussions, demonstrations & Video Shows.
In-service Training for Health Center Staff: 12/6 - 12/9/93 (15) 6/21 - 6/23/94 (16) 3/16 - 3/17/95 (15) 1/18 & 1/25/95 (33) 2/3/95 (11)	Antenatal care, CDD, ARI, malaria, TB/leprosy, role of APO/CEWs, chain of command (VBAs-APCs/CEWs) TT immunization TT immunization, basic communication skills Anatomy & physiology, menstrual cycle, conception 6 fetal growth, ovulation method of PP TT immunization	28 18 14 4 2	Lectures, demonstrations, group discussions 6 video shows.

PCI's training manual for the VBA-TOT course, the reproductive health education module for village men, and the family planning module for health promoters are included with this report, but bound separately.

4.5 Supplies and Materials for Local Staff

The midterm evaluation did not include a survey of VBAs, to check their supply of materials. The team was told by PCI/PNG and health center staff that most of the supplies contained in the VBA birthing kit were available in local shops at low prices or from the health centers. One VBA in Zare village, whose birthing kit was examined, did not have any supplies. Most VBAs interviewed also did not possess the standard reporting forms produced by the project.

According to health promoters interviewed in Kaiapit District, they had not been provided with IEC materials to use during their community health talks, and this was a hindrance to them in

communicating with their audiences. PC1 staff, however, said that those health promoters who came into the PC1 office were given copies of printed materials and videos to use in their educational talks. As most health promoters live in rural areas, this does not represent an optimum distribution strategy.

Staff of **PCI's** Training Resource Center have developed some IEC materials and borrowed others, and they plan to collaborate with the national Child Survival Project to develop still more. A shortage of training equipment was identified by PC1 staff as a constraint. PC1 has only two pelvic models and one television/VCR set available for use during VBA training and men's education sessions. A problem would arise if training were held in more than one site simultaneously, which may be the case as VBA training skills are spread more widely.

In the pilot project area, the APO supervisor was able to keep all the APOs supplied with tetanus toxoid vaccine and disposable syringes. However, these APOs did not receive educational posters or pamphlets regarding ergometrine. APO supplies should be improved by the recent addition of a village birth assistance kit to the national Medical Stores Catalogue. The kit, which contains all the items required for the ergometrine project, can be ordered by the APOs as needed.

The evaluation also did not include a survey of the equipment and supplies available at the health centers or aid posts, which serve as referral sites for community-based health workers. At the Salamaua health center, however, the team saw a large shipment of equipment and supplies--recently received from AusAID--for use in carrying out village maternal and child health patrols.

4.6 Quality

For the most part **PCI/PNG** has relied on guidance from the national Department of Health, WHO, UNICEF and the international health literature to determine what knowledge and skills are essential for implementing successful child survival interventions. The specific points of knowledge and skills for each intervention have been detailed in the training curricula for **VBAs**, trainers of VBAs and health promoters.

The only evaluation of health workers' knowledge and skills carried out to date by the project involves pre- and post-tests during training courses for VBA trainers and health promoters, which have not produced useful information.

The project measured mothers' knowledge during the baseline KPC surveys (summarized in the DIP), and plans to repeat the assessment during the final survey. In addition, the MACHIK survey, conducted with VBA trainees at the start of their course, provides some information on common knowledge and practices of village mothers regarding pregnancy and childbirth. No written results of these MACHIK surveys are available.

The midterm evaluation was a qualitative exercise, and did not include a survey of mothers or health workers to test their knowledge and skills. Only anecdotal information was collected on VBA experiences assisting mothers with delivery.

4.7 Supervision and Monitoring

The health workers intended to be supervised under the CS-IX project include VBAs and community health promoters. Supervision of **VBAs** was planned to be carried out by district health center staff

and **PCI's** District Training Coordinators during the health centers' routine village health patrols. In actuality, however, very few village health patrols have been conducted, and as a result little supervision or monitoring of **VBA's** has been done. VBAs interviewed in Kaiapit District--where the bulk of VBAs have been trained--complained that they had been abandoned by the project. And those interviewed in Zare, coastal Lae, claimed that there had been only one patrol visit in the previous year.

There are indeed serious constraints to conducting village patrols. Transportation is in short supply; vehicles and boats are often not available for patrol, or there is no money to purchase fuel. In addition, relations between PCI's District Training Coordinator in Kaiapit and health center staff have been severely strained; and without coordination with health center staff, the District Training Coordinator is unable to travel to the villages, even when a patrol is able to be mounted. The alternative, walking for hours or even days to remote villages, is not a realistic option. Further, without PCI's presence, health center staff have not made VBA supervision a priority. No supervisory checklist has been developed by the project.

Routine supervision of community health promoters was not part of the project plan. The health promoters have been selected and trained (194 to date), and occasional monitoring visits have been made by PCI's men's health educator to only a few health promoters in Lae and other areas. But no systematic monitoring or supervision has been done. As discussed in the section on health promoters, according to some accounts this arrangement has not been satisfactory. The quality of health talks given and the confidence of the health promoters have been poor in at least some areas.

4.8 Regional and Headquarters Support

Administrative support is available to the CS-IX project at all times from PCI's headquarters in San Diego. Communication is by telephone, fax and courier. In addition, periodic technical assistance visits are made to PNG by either the headquarters-based Technical Support Officer or **PCI's** Asia Regional Technical Advisor, based in Maluku, Indonesia. These visits have generally been made to coincide with important project activities, such as proposal and DIP preparation and evaluations. Future visits will probably be limited to assisting with the final project survey and evaluation. This schedule of assistance seems appropriate for the project's needs.

Prior to April, 1995, the **PCI/PNG** Country Director was based in the capital, Port Moresby, and made brief trips to Lae approximately monthly. Although every attempt was made to keep communication open and frequent between Port Moresby and Lae--including daily phone calls and faxes--all parties agreed that this was not an optimal arrangement, and that project management would have been more effective had the Country Director been based in Lae. With the posting of the new Country Director in Lae, this issue has been resolved.

4.9 PVO's Use of Technical Support

External technical assistance received by the project to date has included the following:

- **PCI's** Asia Regional Technical Advisor assisted with preparation of the project proposal and DIP

- Dr. Keith Edwards of the national Child Survival Project provided training to Aid Post Orderlies as part of the tetanus toxoid/ergometrine pilot project
- The Deputy Matron of the Morobe Department of Health assisted with the **VBA** TOT course
- Two nursing officers from the Morobe DOH assisted with VBA training
- A nursing sister from the Lae School of Nursing assisted with the VBA TOT course

Regarding technical assistance needed but not received, PC1 staff stated that they had requested some training materials from the National DOH (eg. ergometrine posters), but had not received them. During the next six months, PC1 staff will seek assistance **from** the national Child Survival Project in the development of training materials. No constraints to this assistance are anticipated.

4.10 Assessment of Counterpart Relationships

PCI's principal counterpart in the CS-IX project is the Morobe Department of Health (MDOH), including the District Health Offices of both Kaiapit and Huon Districts. MDOH staff have taken part in almost all training courses carried out by the project, and have now been made responsible for future VBA training and supervision. Resources contributed to the project by MDOH and the District Health Offices of Kaiapit and Huon Districts include the following:

- funding for the salary of PCI's District Training Coordinator in Kaiapit District, for three years (1993-1995);
- funding for a new Nursing Officer position in the Huon District Health Office, which will be filled by PCI's Huon District Training Coordinator, and which will work directly with the health centers and PC1 to train and support VBAs and Health Promoters;
- a portion of health center staff time devoted to VBA training and other project activities;
- office and storage space, and utilities for **PCI** staff stationed at health centers;
- funding for training materials and supplies;
- occasional use of official vehicles and boat for transportation of personnel and materials; and accommodation during VBA TOT courses;
- staff assistance from the Communicable Disease Department for World AIDS Day educational activities.

As discussed in previous sections, the involvement of some health center staff in VBA training and support activities has been less than desirable, due to a number of factors. The evaluation team is also concerned about the level of future **VBA** and Health Promoter training, supervision and monitoring likely to be undertaken by health center staff once PCI's project involvement ends. These staff seem to possess the technical capability to continue project activities (although more staff need to be trained as VBA trainers), but they are severely constrained by a lack of funds and transport, frequent staff turnover, and a low priority placed on working with **VBAs**.

There also exist serious personnel conflicts between **PCI's** two District Training Coordinators and the respective health center staff, which have contributed to a very poor level of **VBA** supervision. Information has not been routinely shared, and there has been little joint planning and coordination--such as for village health patrols. **PCI's** Project Director has attempted to resolve the conflicts, but problems still exist. However, counterpart relations at the level of the District Health Officers and officials of the provincial Department of Health have been quite good.

4.11 Referral Relationships

The referral care sites used by the project consist of the district health centers and aid posts located in Kaiapit and Huon Districts. Referral is made primarily by VBAs who encounter women with signs of high-risk pregnancy or obstetrical emergencies. The health centers are the principal referral sites, as the aid posts are limited with the services they can provide to such women. Access to the health centers is good for women living in nearby villages, but can be difficult or even impossible for those in remote villages. Public transportation is limited, and some people have to walk for hours or even days to reach the clinic.

The quantity and quality of services offered at the health centers was not assessed by the evaluation. Only brief visits to three health centers and one aid post were made to meet and interview staff.

Staff of the Salamaua health center stated that **VBAs** occasionally accompany mothers with high-risk signs or obstetrical problems to the health center, although most women preferred to go directly to a hospital in Lae, a **90** minute boat ride away. Currently the health center has no water and the toilets are not functioning.

The Morobe health center reportedly receives very few patients. Staff complain that they have nothing to do, and sometimes simply go home. The situation at the **Mutzing** health center in Kaiapit appears to be better, with more patient activity and a motivated staff.

As mentioned previously, VBAs in some areas reported that health center staff sometimes mistreat them and the mothers they refer or accompany, causing them to feel unwelcome at these facilities.

As part of the project, **PCI** has conducted a series of in-service training sessions for health center staff, focusing on topics such as immunization, control of diarrheal disease, malaria, **TB/leprosy**, reproductive health, communication **skills**, health information and reporting, and the roles of community health workers. To date, nine such sessions have been held, for a total of 108 participants (some staff members attended more than one session). Five more sessions, for 75 participants, are planned for the remainder of the project.

4.12 PVO/NGO Networking

PCI staff, especially the Project Director, have been instrumental in establishing good communication with most organizations--governmental, NGOs and private sector--active in primary health care development in Morobe Province, and have arranged collaborative efforts with several of these, as follows:

- The World Vision Relief and Development project in Wantoat, Morobe Province sent staff members to assist PC1 with training courses, and likewise PC1 sent staff to assist World Vision's courses;
- Lutheran Medical Services conducted a joint training of health promoters for HIV/AIDS course with PC1 in Lae;
- ADRA International assisted PC1 with organizing World AIDS Day educational activities in 1994 and 1995;
- The Lae City Health and Social Services Department collaborated with PC1 in disseminating **HIV/AIDS** education information in Lae squatter settlements;
- The Child Survival Support Project, managed by John Snow Inc., provided a consultant to assist with PCI's **TT/ergometrine** pilot project;
- IDEAS, an **NGO** based in Western Province, sent two staff members to be trained in PCI's VBA TOT course.

Another promising development has been the establishment of the Morobe provincial IEC Committee, whose members will include **PVOs, NGOs**, church groups and government agencies active in health and population. Unfortunately, funding for the committee, which is planned to be provided by the new national Population and Family Planning Project, has been **delated**, and the committee is presently dormant.

PC1 has also taken a leading role in the provincial World AIDS Day Committee, which was formed to coordinate planning for the World AIDS Day activities in December. Other organizations represented on the committee include ADRA International, World Vision Relief and Development, the Morobe Department of Health and the Morobe Department of Education.

4.13 Budget Management

The original agreement budget for the CS-IX project totaled **\$1,133,889**, with \$852,227 provided by USAID and \$281,662 to be contributed by PCL. The budget for PCI's contribution to the project was written to cover largely cash expenditures, as well as a small contribution of local in-kind items.

The amount of cash that PC1 has been able to raise and expend to date on the project, however, has been much less than anticipated, and it appears that only limited additional cash will be contributed by PC1 for the remainder of the project. Instead, PCI will meet the bulk of its 25% match obligation with local in-kind contributions.

Because the amount of cash available to the project has been less than originally budgeted, it is likely that the project will have to cease operations earlier than originally planned, perhaps by two months or more. At this early stage, and given the likelihood that the project's activity plan will be modified based on recommendations of this evaluation, it is not possible to predict with any certainty when the end date will be. Following the evaluation, project staff plan to meet to formulate an activity plan for the remainder of the project. This exercise should allow for a more accurate projection of expenses over the next year.

The project's objectives relate largely to quantitative measures of knowledge, practice and coverage, and will have to be measured using the final project KPC survey. At this time, it is not possible to determine whether these objectives will be met, or whether the funding shortage will influence them negatively.

5. Sustainability

The following table lists the sustainability indicators presented in the project's Detailed Implementation Plan, as well as a summary of progress made to date toward reaching the indicators. For the most part, the steps needed have been discussed as recommendations in previous sections of the report.

Sustainability Indicators, Progress and Steps Needed

SUSTAINABILITY INDICATORS	PROGRESS TO DATE	STEPS NEEDED
1. Training Resource Center established with continued funding (collateral and government)	TRC has been established. So far no continued funding has been secured.	See recommendations in Part I, Section 4.
2. Health centers training VBAs without direct PCI assistance	Mutzing (Kaiapit) health center accomplished this, others (Morobe and Salamaua) have not.	See recommendations in Part I, Section 1.
3. Number of VBAs actively working in the community	No information is available on number of active VBAs. To date under CS-IX, 66 VBAs have been trained.	VBA supervision needs to be improved, as discussed in Part II, Section 4.7.
4. Government funding for health center staff to carry out VBA training and supervision	Government funding is not assured. Staff salaries are paid, but transportation resources are often not available.	See recommendations in Part I, Section 1.
5. Establishment of District Health Management Teams with institutionalization of HIS for monitoring	Concept initiated by PCI, but not followed up by either PCI or district health staff.	PCI staff to pursue and determine feasibility and usefulness.
6. Change of government policy on TT immunization to cover all women of child-bearing age	Current policy covers only pregnant women; but new National Health Plan (1996-2000) should include all women 15-44.	Implementation of new National Health Plan.
7. Policy for national use of TT (life-time) card for women	The NDOE plans to print large numbers of Women's Health Record Books for general distribution.	Printing and distribution of books.
8. VBAs distributing "Mothers Health Book"	Not yet done due to a lack of books; however, PCI has now discovered a stock of books.	Distribute books to VBAs and other district health workers.
9. Functioning Provincial AIDS committee	World AIDS Day planning sub-committee is active, led by PCI.	Encourage provincial health officials to take leadership of this activity.
10. Funds for TRC from donor groups for continued health education activities in HIV/AIDS	TRC Coordinator and Assistant Coordinator are funded by OED (Austrian donor).	See recommendations in Part I, Section 4.
11. Marketable BIV/AIDS health education 'package' for use in seminars by private companies, church groups, and community agencies	HIV/AIDS materials have been developed, but plans for a marketable package have not been pursued.	See recommendations in Part I, Section 4.

6. Recommendations

Recommendations specific to each project component are contained in the respective sections of Part I of this report.

7. summary

PCI's Child Survival IX project in Papua New Guinea was evaluated from May 9 to 26, 1995. The evaluation team included Micah **Yawing**, HEO, DCH, Coordinator of District Health Services, Morobe Department of Health; **Jeff Billings**, MPH, MIA, Technical Support Officer, **PCI/HQ**; **Joan Brabec**, BSMT, consultant and former PC1 trainer; and **Keith Edwards**, BSc, MBBS, FRCP, DCH, Program Manager for UNICEF. Each team member participated in all evaluation activities, with the exception of Dr. Edwards, who was available for a more limited period of time.

The methodology of the evaluation was qualitative, and consisted of interviews with national, provincial and district officials, PC1 staff and local health center staff; group discussions with **CHWs**, **VBA**s, mothers and health promoters; a review of project documents, IEC materials and routine monitoring data; and observation of selected training activities. These activities took place at offices in Lae city, and in villages and district centers in the Kaiapit and Coastal Lae (Huon District) areas of Morobe Province.

The evaluation team met frequently to discuss their observations, record findings and draft the evaluation report. They discussed their findings and recommendations at length with **PCI/PNG** staff, and subsequently presented the results at a meeting of provincial and district health staff. The total cost of the evaluation was approximately \$15,500, which does not include fixed costs such as staff salaries, rent or utilities.

Since its inception, the core of PCI's Child Survival project has been the training of local women to serve as village birth attendants (**VBA**s). Through PCI's Child Survival activities under CS-VI and CS-IX, 245 **VBA**s have been trained in Kaiapit and Huon Districts, primarily by PC1 staff with assistance from local health center staff. With the CS-IX project phase--which will bring PCI's involvement in Morobe Province to an end--PC1 is attempting to shift its role to that of trainer of trainers and provider of technical assistance and limited financial support, and to encourage the staff of the local health centers to assume primary responsibility for training and supervising **VBA**s. This new model has the potential to be more sustainable than sole reliance on PC1 to carry out **VBA** training.

PC1 has conducted three TOT courses thus far in which 36 trainers have been trained. Since the CS-IX project began in September 1993, a total of 66 **VBA**s have been trained in four courses, with PC1 either assuming a lead role or assisting local health center staff in conducting the course. PC1 has also trained a total of 194 community leaders to serve as health promoters in the areas of HIV/AIDS, family planning, nutrition and immunization. In an effort to better inform village men about health issues and the importance of the **VBA**s, PC1 has conducted men's health education sessions (reaching 76 men to date) in conjunction with **VBA** training. Other activities have included in-service training for health center staff, HIV/AIDS workshops, World AIDS Day educational presentations and other health education sessions.

The evaluation team formulated over 30 recommendations for improvement of the project and its prospects for sustainability. These dealt with local health staff involvement in VBA training and supervision, men's health education and community health promoters' training; improvement of relations between PC1 and health center staff; cooperation with similar projects and agencies operating in PNG, community perceptions of the role and compensation of the **VBA**; planning for the establishment of a national VBA Support Unit; scheduling and target audience for men's health education sessions; quality of community health promotion talks; standardization and availability of educational materials; and expansion of tetanus toxoid and ergometrine pilot activities.

For other projects contemplating training village birth attendants, **VBA** trainers or community health promoters in PNG or other locations with similar, **difficult** conditions, the ideas contained in these recommendations and elsewhere in the report should prove quite useful.

APPENDIX 1

AC-NT OF PROJECT ACTIVITIES

PCI/PAPUA NEW GUINEA: CHILD SURVIVAL IX PROJECT
 Summary Progress Report on Achievement of Project Activities
 Years 1-3: September 1993 - August 1996

Activities Included in Detailed Implementation Plan

Activity	DIP Targets		Year 1		Year 2 To Date		Year 2 Remainder		Year 3		Achievements to Date			
	Activities Planned	Persons to be Trained	Activities Completed	Persons Trained	Activities Completed	Persons Trained	Activities Planned	Persons to be Trained	Activities Planned	Persons to be Trained	Activities Completed	% of Target	Persons Trained	% of Target
1. Training of VBAs	15	180	1	14	3	52	1	20	0	0	4	27%	66	37%
2. Training of Community Leaders to be Health Promoters (by Topics):	15	150	2	18	7	176	14	210	0	0	9	60%	194	129%
-HIV/AIDS			1	12	6	146	8	120	0	0	9		158	
-Nutrition			1	6	1	30	3	45	0	0	0		36	
-Family Planning			0	0	3	72	3	45	0	0	7		72	
-Immunization			0	0	1	30	3	45	0	0	2		30	
-CDD/ARJ			0	0	0	0	3	45	0	0	0		0	
3. One-Week In-Service Training for Health Staff	9	150	3	30	0	0	0	0	0	0	3	33%	30	20%
4. Two-hour In-Service for Health Staff (incl. HIS)	45	450	2	21	4	57	5	75	0	0	6	13%	78	17%
5. Men's Health Education Sessions	18	360	0	0	3	76	1	20	0	0	3	17%	76	21%
6. Training of VBA Trainers	5	30	1	10	2	27	0	0	0	0	3	60%	37	123%
7. Develop/Test Sets of IEC Materials for HIV/AIDS	18	n.a	1	n.a	0	n.a	6	n.a	0	n.a	1	6%	n.a	n.a
8. HIV/AIDS Workshops	6	90	1	60	1	23	0	0	0	0	2	33%	83	92%
9. Facilitate Provincial AIDS Committee Meetings	18	n.a	0	0	0	0	3	n.a	0	0	0	0%	n.	n.a
10. External Evaluations	2	n.a	0	n.a	0	n.a	1	n.a	0	n.a	0	0%	n.a	n.a

PCI/PAPUA NEW GUINEA: CHILD SURVIVAL IX PROJECT
 Progress Report on Achievement of Project Activities
 Year 1: October 1993 - September 1994

Activities Included in Detailed Implementation Plan

Activity	DIP Targets		Quarter 1		Quarter 2		Quarter 3		Quarter 4		Achievements to Date			
	Activities Planned	Persons to be Trained	Activities Completed	Persons Trained	Activities Completed	% of Target	Persons Trained	% of Target						
1. Training of VBAs	5	60	1	14							1	20%	14	23%
2. Training of Community Leaders to be Health Promoters (by Topic):	5	50	2	18	0	0	0	0	0	0	2	40%	18	36%
-HIV/AIDS			1	12		0		0		0	1		6	
-Family Planning			0	0	0	0	0	0	0	0	0		0	
-Immunization			0	0	0	0	0	0	0	0	0		0	
-Nutrition			1	6	0	0	0	0	0	0	0		10	
			0	0	0	0	0	0	0	0	0		0	
3. One-Week In-Service Training for Health Staff	3	50	3	30	0	0	0	0	0	0	3	100%	30	60%
4. Two-hour In-Service for Health Staff (Incl. HIS)	15	0	2	21	0	0	0	0	0	0	2	13%	21	n.a
5. Men's Health Education Sessions	6	120	0	0	0	0	0	0	0	0	0	0%	0	0%
6. Training of VBA Trainers	2	12	1	10	0	0	0	0	0	0	1	50%	10	83%
7. Develop/Test Sets of IEC Materials for HIV/AIDS	6	n.a	1	n.a	0	n.a	0	n.a	0	n.a	1	17%	n.a	n.a
8. HIV/AIDS Workshops	2	0	1	60	0	0	0	0	0	0	1	50%	60	n.a
9. Form Provincial AIDS Committee	1	n.a	1	0	0	0	0	0	0	0	1	100%	n.a	n.a
10. Conduct Baseline Survey	1	n.a	1	n.a	0	n.a	0	n.a	0	n.a	1	100%	n.a	n.a

PCI/PAPUA NEW GUINEA: CHILD SURVIVAL IX PROJECT
 Progress Report on Achievement of Project Activities
 Year 2: October 1994 - September 1995

Activities Included in Detailed Implementation Plan

Activity	DIP Targets		Quarter 1		Quarter 2		Quarter 3		Quarter 4		to Date			
	Activities Planned	Persons to be Trained	Activities Completed	Persons Trained	Activities Completed	Persons Trained	Activities Completed	Persons Trained	Activities Planned	Persons to be Trained	Activities Completed	Target	Person% of Trained	% of Target
1. Training of Community Leaders to be Health Promoters (by Topics):	5	50	2	34	2	67	4	100	0	0	8	160%	196	392%
-HIV/AIDS			2	34	1	32	4	100	0	0	7		166	
-Nutrition			0	0	1	30	1	26	0	0	2		56	
-Family Planning			2	34	1	32	1	26	0	0	4		92	
-CDD/ARI			0	0	1	30	0	0	0	0	1		30	
-Other			0	0	0	0	0	0	0	0	0		0	
3. One-Week In-Service Training for Health Staff	3	50	0	0	0	0	0	0	0	0	0	0%	0	0%
4. Two-hour In-Service for Health Staff (Incl. HIS)	15	150	0	0	4	57	0	0	0	0	4	27%	57	38%
6. Men's Health Education Sessions	6	120	0	0	1	30	2	62	0	0	3	50%	92	77%
d. Training of VBA Trainers	2	12	1	14	1	13	0	0	0	0	2	100%	27	225%
7. Develop/Test Sets of IEC Materials for HIV/AIDS	6	n.a.	0	n.a.	0	n.a.	0	n.a.	0	n.a.	0	0%	n.a.	n.a.
E. HIV/AIDS Workshops	2	30	0	0	1	23	0	0	0	0	1	50%	23	77%
9. Facilitate Provincial Committee Meetings	6	n.a.	0	0	0	0	0	0	0	0	0	0%	n.	n.a.
10. Mid-term Evaluation	1	n.a.	0	n.a.	0	n.a.	1	n.a.	0	n.a.	1	100%	n.a.	n.a.

PC/PAPUA NEW GUINEA: CHILD SURVIVAL IX PROJECT
 Progress Report on Achievement of Project Activities
 Year 3: October 1995 - August 1996

Activities Included in Detailed Implementation Plan

Activity	DIP Targets		Quarter 1		Quarter 2		Quarter 3		Quarter 4		Achievements to Date			
	Activities Planned	Persons to be Trained	Activities Completed	% of Target	Persons Trained	% of Target								
1. Training of VBAs	5	60	0	0	0	0	0	0	0	0	0	0%	0	0%
2. Training of community Leaders about:	5	50	0	0	0	0	0	0	0	0	0	0%	0	0%
-HIV/AIDS			0	0	0	0	0	0	0	0	0	0%	0	0%
-Nutrition			0	0	0	0	0	0	0	0	0	0%	0	0%
-Family Planning			0	0	0	0	0	0	0	0	0	0%	0	0%
-Immunization			0	0	0	0	0	0	0	0	0	0%	0	0%
-CDD/ARI			0	0	0	0	0	0	0	0	0	0%	0	0%
3. One-Week In-Service Training for Health Staff	3	50	0	0	0	0	0	0	0	0	0	0%	0	0%
4. Two-hour In-Service for Health Staff (Incl. HIS)	15	150	0	0	0	0	0	0	0	0	0	0%	0	0%
5. Men's Health Education Sessions	6	120	0	0	0	0	0	0	0	0	0	0%	0	0%
6. Training of VBA Trainers	2	12	0	0	0	0	0	0	0	0	0	0%	0	0%
7. Develop/Test Sets of IEC Materials for HIV/AIDS	6	n.a	0	0%	n.a	n.a								
8. HIV/AIDS Workshops	2	30	0	0	0	0	0	0	0	0	0	0%	0	0%
9. Facilitate Provincial Committee Meetings	6	n.a	0	0	0	0	0	0	0	0	0	0%	n.a	n.a
10. Final Evaluation	1	n.a	0	0%	n.a	n.a								

PCI/PAPUA NEW GUINEA: CHILD SURVIVAL IX PROJECT
 Summary Progress Report on Achievement of Project Activities
 Years 1-3: September 1993 - August 1996

Additional Activities Not Included in Detailed Implementation Plan

Activity	DIP Targets		Year 1		Year 2		Year 3	
	Activities, Planned	Persons to be Trained	Activities Completed	Persons Trained	Activities Completed	Persons Trained	Activities Planned	Persons to be Trained
1. Malaria Prevention & Net Treatment Workshop	n.a.	n.a.	1	26	n.a.	n.a.		
2. World AIDS Day	n.a.	n.a.	1	n.a.	1	1000		
3. Health Education for Villagers at Lae Town Clinic			1	17	n.a.	n.a.		
a. Two-Day Workshops for Village Health Committee	n.a.	n.a.	n.a.	n.a.	1	28		
5. Health Talks to Villagers	n.a.	n.a.	n.a.	n.a.	3	610		
6. Health Education Sessions by PCI-Trained Health Promoters	n.a.	n.a.	n.a.	n.a.	11	2821		

PCI/PAPUA NEW GUINEA: CHILD SURVIVAL IX PROJECT
Progress Report on Achievement of Project Activities
Year 1: September 1993 - September 1994

Additional Activities Not Included in Detailed Implementation plan

Activity	DIP Targets		Quarter 1		Quarter 2		Quarter 3		Quarter 4	
	Activities Planned	Persons to be Trained	Activities Completed	Persons Trained						
1. Malaria Prevention & Net Treatment Workshop	n.i	n.i		2						
2. World AIDS Day	n.i	n.i		n						
3. Health Education for Villagers at Lae Town Clinic	n.i	n.i		1						

PCI/PAPUA NEW GUINEA: CHILD SURVIVAL IX PROJECT
 Progress Report on Achievement of Project Activities
 Year 2: October 1994 - September 1995

Additional Activities Not Included in Detailed Implementation Plan

Activity	DIP Targets		Quarter 1		Quarter 2		Quarter 3		Quarter 4	
	Activities Planned	Persons to be Trained	Activities Completed	Persons Trained	Activities Completed	Persons Trained	Activities Planned	Persons to be Trained	Activities Planned	Persons to be Trained
1. Two-Day Workshops for Village Health Committee	n.a.	n.a.	1	28						
2. Health Talks to Villagers	n.a.	n.a.	3	610						
3. World AIDS Day	n.a.	n.a.	1	1000						
4. Health Education Sessions by PCI-Trained Health Promoters	n.a.	n.a.	11	2821						
5. Health Education for Female Inmates/Guards at Bulmo Prison, Lae	n.a.	n.a.	n.a.	n.a.	1	20				
6. Health Education (HIV/AIDS & FP) for Catholic Women's Association	n.a.	n.a.	n.a.	n.a.	1	50				

APPENDIX 2
COUNTRY PROJECT PIPELINE ANALYSIS

PIPELINE ANALYSIS
 GRANT - FAD-0500-A-00-3030-00 - (204) CSIX
 FOR PERIOD - 09/01/93-06/30/95
 FILE NAME - CSIX0695

	ACTUAL EXPENDITURES TO DATE (09/01/93/-06/30/95)			TOTAL AGREEMENT BUDGET (09/01/93/-08/31/96) ^{TU}			REMAINING DELICATED FUNDS (07/01/95/-08/31/96)		
	AID	PCI	TOTAL	AID	PCI	TOTAL	AID	PCI	TOTAL
PERSONNEL	276,533	03,337	379,870	374,33	94,348	478,679	97,798	1,01	98,809
TRAVEL/PER DIEM	69,584	2,088	71,672	108,980	3,188	112,168	39,396	1,130	50,526
CONSULTANTS	8,729	0	8,729	46,900	4,000	50,900	38,17	4,000	42,171
PROCUREMENT	22,564	38,124	60,688	26,320	5888	32,208	3,756	20,076	23,832
OTHER DIRECT COSTS	92,083	19,342	111,425	116,575	37,00	153,575	24,492	17,738	42,230
IN-DIRECT COSTS	109,800	41,241	151,041	179,121	64,816	243,937	69,321	23,575	92,896
TOTAL	579,293	204,132	783,425	852,227	28,662	133,889	272,934	77,530	350,464

APPENDIX 3
SCHEDULE FOR EVALUATION

SCHEDULE FOR CS IX MID-TERM EVALUATION
Project Coricem **International/PNG**
(May 7-27, 1995)

- Sunday, May 7** **Jeff Billings arrives (6:50 PX 393 Sin-POM)**
Pickup by driver from Lamana Hotel (tel: 23-2333)
Free day.
- Monday, May 8** **Meeting with evaluation team members: Joan Brabec and Harumi Karel (tel: 25-5955).**
- Tuesday, May 9** **Interviews with National DOH officials:**
- 10:00 Dr. Ake, former Secretary**
- Travel to Lae (dep.12120 PX 104 Lae-POM arr. 13:05).**
Check-in Melanesian Hotel (tel: 42-3744).
Visit PCI/Lae office for introduction to staff.
Meet with CD.
- Wed., May 10** **8:00 Evaluation Team Preparation Meeting**
9:00 Interview with Dr. Theo, Asst. Secretary, Provincial DOH
10:00 Interview with Sr. Wahazoka, Community Health Nursing Services Matron
11:00 Interview with Mrs. Elizabeth Maulingin, District Health Administrator, Huon District
13:00 Interview with District Secretary, Huon District
14:00 Travel to Buhalu by vehicle
19:00 Theatre Group Performance
- Thurs., May 11** **Training of Health Promoters (HIV/AIDS)**
Return to Lae after training.
- Friday, May 12** **9:00 Travel to Situm by vehicle (joined by Keith Edwards)**
10:00 Focus group discussions with CHWs for Tetanus Toxoid Pilot Program
13:00 Return to Lae for interviews with PCI staff.
- Saturday, May 13** **Evaluation team review session**
Report writing
Harumi Karel departs (13:30 PX 105)
- Sunday, May 14** **Free**
- Monday, May 15** **Travel to Morobe by boat**
- Tuesday., May 16** **Observe VBA training**
Interview Health Center staff

Wed., May 17 Men's health education session

Thursday, May 18 Focus group discussions with VBAs

Friday, May 19 Travel to Salamaua by boat
Interview with Salamaua Health Center staff
Return to Lae by boat

Saturday, May 20 Evaluation team review session
Report writing
Keith Edwards departs.

Sunday, May 21 Free

Monday, May 22 7:00 Travel to Mutzing by vehicle.
9:00 Interview with Mr. John Nicholas, District Secretary,
Kaiapit District
10:00 Interview with Mrs. Veronica Wapi, District Health
Administrator
11:00 Interview with Sr. L. Ambrias, Sister-in-Charge Mutzing
Health Centre
13:00 Interview with District Health Committee
15:00 Focus group discussions with VBAs
17:00 Return to Lae by vehicle.

**Tues-Thursday
May 23-25** Report writing

Friday, May 26 10:00 Presentation of findings to Provincial and District
Department of Health

Saturday, May 27 Jeff Billings and Joan Brabec depart (11:45 PX 113 arrives
POM 12:30)
Jeff Billings departs (16:30 PX 392 to Singapore)