

Evaluation Report of Save the Children Health and HIV/AIDS Programme, Papua New Guinea

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Sr Appelonia with her new delivery suite at Kaugia

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About this report

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Abstract

The New Zealand Government has supported Save the Children's East Sepik Women and Children's Health Programme (ESWCHP) since 1997. From the outset, this programme focused on developing a community-supported network of Village Health Volunteers (VHV) to provide primary health care in remote village settings in Papua New Guinea (PNG). A second phase of work began in 2003 with the purpose of making the programme sustainable. This phase is ending in September 2012.

The programme has achieved many of its Phase II objectives: over 1370 VHVs have been trained, a large infrastructure development programme has been completed, medical supplies have improved and include supplies for VHVs, health information systems are in place and are in keeping with National and Provincial health systems, and partners are now successfully managing the VHVs. The programme has worked successfully to integrate with and strengthen the PNG health system.

The health impact on women and children is not known because baseline data are not available to measure against, and the clinical quality and health promotion work of the VHVs is not assessed. However anecdotal reports and early stage research is suggestive that this work is making a contribution towards saving lives.

New Zealand Government funding of the Youth Outreach Programme (YOP) commenced in 2006. It supports the YOP in the Eastern Highlands, where 60 volunteers have been trained each year to deliver information about safe sex, importance of clinical tests, and provision of free condoms, to their peers. Data indicate the volunteers have contact with about 11,000 young men and women annually. Efficient and effective processes are in place, but the volunteers need further incentives, and additional encouragement and backing from community leaders to sustain their work.

Future programme activities must keep the community at the core of both ESWCHP and YOP, with gender training playing a central role in all ongoing activities.

Executive Summary

Background and Context of the Activity

An independent evaluation of Save the Children's (SC) Health and HIV/AIDS Programme in the East Sepik was commissioned because New Zealand Government funding for this programme is due to end in September 2012 after 15 years of support. The evaluation is required for accountability purposes. It also, through critique and the identification of lessons learned, provides recommendations for future work in health and HIV/AIDS in the PNG Health Sector, for MFAT, Save the Children and other interested parties.

Purpose and Objectives of the Evaluation

This evaluation assessed the overall performance of SC in delivering the key objectives of the Health and HIV/AIDS Programme, including ESWCHP and YOP, for the period of the current Grant Funding Arrangement (2009-2012) with a geographic focus on East Sepik and the Eastern Highlands. In addition, the evaluation was informed by a literature review that covered the whole period of the programme 1997-2012.

The evaluation addressed the five objectives according to the MFAT Terms of Reference: was the programme effective? Did it have an impact? Was it relevant and efficient? Will it be sustainable?

Methodology

The methodology used in this evaluation was participatory and transparent. It was guided by the understanding that MFAT and SC wanted to understand the overall achievements of the programme (especially the longer running ESWCHP) from the perspective of its effectiveness, impact, relevance, efficiency and sustainability. Importantly both parties wanted recommendations for the future of the programme, and to be able to identify lessons learned.

The evaluation was informed by an extensive literature review of the MFAT documents pertaining to this programme over the past 15 years. This was followed by 10 days in country, visiting the SC programme offices in Goroka and Wewak, and visits to programme sites around the East Sepik province.

Meetings were held with staff, partners, stakeholders and beneficiaries including youth volunteers and village health volunteers. Many health clinics were visited and health workers were interviewed. Feedback meetings were held with staff and stakeholders in the Goroka and Wewak offices, and in Wellington with MFAT and SCNZ representatives. Feedback from all these meetings has been included in the report.

Key Findings and Conclusions

ESWCHP

The overwhelming attitude expressed about the ESWCHP throughout this evaluation, at every meeting, was that it is a successful and effective programme. This view was offered by those interviewed at the PNG National Department of Health (NDOH), the Provincial Department Of Health (PDOH), Local Level Government (LLG), partner organisations, health facilities, VHVs, and people living in villages. Comments such as “this programme has saved lives” were made frequently, across the range of people interviewed. The response to questions about what would have happened had this programme not occurred was consistently that people would have died.

Effectiveness: The programme has achieved many of its objectives: over 1370 VHVs have been trained, a large infrastructure development programme has been completed, medical supplies have improved and include medicines for VHVs, health information systems are in place and are in keeping with National and Provincial health systems, and partners are now successfully managing the VHVs. The programme has worked hard to integrate with and strengthen the PNG health system.

Impact: It is not possible to fully assess the impact of the programme on women and children’s health because baseline data were not available at the start of the programme to measure against, and the clinical quality and health promotion work of the VHVs is not assessed. But the ESWCHP has set up a pilot programme to measure the cost effectiveness and coverage of VHVs within a community health post based system of maternal and child health outreach patrols. Data from this 12 month pilot programme (due by end of 2012) will be useful to assess the role of the ESWCHP as a model for use in other provinces.

Relevance: The ESWCHP is relevant to the health of people in the East Sepik, is in keeping with the National Health Plan 2011-2020, and the Child Health Plan 2008-2015. It is addressing the direct factors that contribute to preventable death and morbidity in women and children by making health services more available and accessible. It is also addressing underlying causes of poor health by looking at the village environments and promoting public health initiatives in villages.

Efficiency: A network of VHVs was developed so that there are now about 1000 VHVs providing some degree of primary health care, and health promotion advice, to a population of 313,000 people. A medical supply system, albeit patchy, provides medicines and some contraceptives/condoms, most of the time to health facilities or VHVs. The cost to MFAT of this programme has been about \$1,250,000 annually, or about \$4 per person in the districts included. Given the large number of patient consultations, supervised deliveries, medicines dispensed, referrals to health clinics, and infrastructure development, this would seem to be an efficient and cost effective use of donor funds.

Sustainability: There were two main areas of concern regarding sustainability; firstly, that VHVs were no longer receiving incentives or logistics support from their communities; secondly that if external donor support is not available, the benefits of the programme will diminish over the next few years. Although the partners in the programme have successfully taken over management of the VHVs, they remain unable to cover the costs of management and meeting the ongoing VHV training needs, particularly as PNG national and provincial health budgets have not increased.

Recent experience indicates that those communities which have had Health Island training, or similar, subsequently provide greater support to their VHVs. Despite two previous evaluations that recommended gender is re-introduced to the programme and made a central and cross cutting issue in all its components, this has not occurred. Nor has there been a consistent rights-based approach to the programme which would be expected of an NGO which states it focuses on child rights and women's 'issues'. This evaluation believes these omissions have played a not insignificant role in the lack of support coming from the community.

YOP

Effectiveness: This evaluation has found the YOP to be an innovative and thoughtful programme which is using youth to educate their peers on HIV/AIDS prevention. Many thousands of young men and women have received health and safe sex messages, and condoms, as a result of this programme.

Impact It is not possible to know whether the YOP is achieving its overall goal of reducing HIV/AIDS risk in young people because baseline data is not available to measure against.

Relevance: The young men and women volunteers have benefitted personally from their involvement in this work, and have reached out to many thousands of other young people in their communities.

Efficiency: The systems in place to monitor their work, their distribution of condoms, and the referral rates of clients to youth-friendly health clinics are effective, efficient and well managed.

Sustainability The sustainability of the programme and its impact depends on greater support in terms of encouragement, backup and small incentives from the community to enable the youth to keep functioning, and funding to keep activities and information systems in operation. The Peer Outreach Volunteers (POVs) could be further encouraged to embark on sustainable livelihood projects while involved in the YOP, and to plan to continue their education, so that involvement with YOP is seen to have a more direct link into career options and improved futures for those youth who participate with it.

Summary of Lessons Learned and Recommendations

Baseline data is essential if impact is to be measured.

Community support is essential for any health programme, and especially so when the programme is based on the use of volunteers.

Recommendations for the ESWCHP

Promotion of New Zealand as a development partner in rural health

New Zealand's long involvement and large financial commitment (over \$20m) with the ESWCHP provides MFAT with an opportunity to present itself as a thoughtful and committed development partner in PNG, with a special understanding of health and health care delivery in rural areas. It is recommended New Zealand consider building on its good reputation by supporting a new phase of this model of rural health care especially if it extends to other provinces.

Whole-of-programme strategic support

Current funding and reporting mechanisms have a tendency to support discrete aspects of overall development programmes. As a result, donors frequently are not informed about the entire programme, and its overall successes. A whole-of-programme funding arrangement could enable NGOs to be consistent in the framing of their work, rather than having to shape programme work according to the paradigm of the donor agency. This more strategic approach to programme support has been suggested in the past by MFAT and is worthy of re-investigation.

Medical supplies systems

ESWCHP should meet as soon as possible with AusAID to gain a better understanding of the new system of medical supplies distribution, and to advocate for an integrated supply system for VHVs medicines.

Research

The extensive data gathered in this programme should be analysed and published.

Advocacy to include all VHV data into PDOH/NDOH MIS

Further advocacy to the PDOH/NDOH to include VHV data is strongly recommended. The inclusion of the health information collected by VHVs is important to gain a full picture of health in PNG.

Ward Development Committee training

Training needs to include contract renewal between the committees and their managing health agency (CHS or PDOH). Contracts need to include commitments and provisions for VHVs from the committees. Importantly, WDCs need to have equal numbers of women and men.

Gender review / publish training materials

It is important that the many training manuals developed in this programme are reviewed by a PNG gender and health specialist. Following this exercise, update and publish this body of work.

Appointment of a health / clinical quality advisor

SC should consider the appointment of a health/clinical quality advisor to monitor the quality of VHV and MCH services.

Rights-based approaches to programme work

Adopting one consistent rights-based approach to its work would have eliminated the many and various iterations of programme objectives, the omission of children and women's rights, and the right to health, in the recent framing of the ESWCHP. It is recommended that SC has rights-based training for all staff and adopts a rights-based approach to its programme design so that it develops consistency between its mission statement and its work.

Community self-reliance and gender training as the foundation of all work

Community support for the VHVs is essential for the sustainability of this programme. Villages that have active health development committees, and which have had gender training, and rights awareness workshops, are reported to then have a decrease in violence against women, and provide more support to VHVs.

Formalise training and upskill VHVs to become CHWs

SC continue its deliberations about working with training institutes, the Medical Council and NDOH, to consider offering a formal and academically accredited, modular-based training programme for VHVs to become CHWs.

Recommendations for the YOP

Develop a database of youth volunteers so they can be tracked in the future with a view to determining if participation in YOP results in future employment.

More actively pursue livelihood options within the YOP for the POV in particular through the composting toilet opportunities, or growing yams.

Consider linking training into formal academic programmes so that POVs can gain credits for the work and training they do while in the programme.

Explore provision of scholarships into the Diploma in Youth Work which is commencing at Divine Word University in 2013.

Discourage POVs from remaining as volunteers for more than two years because with longer term services develop an expectation that they should be paid for their services.

Complete the proposed research on KAP and publish **POV training must address gender issues in a more deliberate and focused manner**, with opportunity to explore gender and violence and risk from women's perspectives. Greater safety and security measures should be in place to protect the female POVs from any violence related to the work they are undertaking.

Further investigation in to the drop out of young women volunteers could be considered.

Report

Background and Context of the Activity

An independent evaluation of Save the Children's Health and HIV/AIDS Programme in the East Sepik was commissioned because New Zealand Government funding for this programme is due to end in September 2012 after 15 years of support. The evaluation is required for accountability purposes. It also, through critique and the identification of lessons learned, provides recommendations for future work in health and HIV/AIDS in the PNG Health Sector, for MFAT, SC, and other interested parties.

Purpose, Scope and Objectives of the Evaluation

Purpose and scope

Although the focus of the evaluation was on an assessment of the latest phase of the programme (2009-2012), including the East Sepik Women and Children's Health Programme (ESWCHP) and the Youth Outreach Programme (YOP), this did require a thorough understanding of the programme since its inception in 1997.

This evaluation assessed the overall performance of SC in delivering the key objectives of the Health and HIV/AIDS Programme, including ESWCHP and YOP, for the period of the current Grant Funding Arrangement (2009-2012) with a geographic focus on East Sepik and the Eastern Highlands. In addition, the evaluation was informed by a literature review that covered the whole period of the programme 1997-2012. The evaluation identified lessons learned and has made recommendations for MFAT, Save the Children and other interested parties to advise any further engagement in the Papua New Guinea (PNG) Health Sector.

Objectives and evaluation questions

The evaluation addressed the five objectives according to the MFAT Terms of Reference: was the programme effective? Did it have an impact? Was it relevant and efficient? Will it be sustainable?

Questions were probed to answer each of these objectives, as seen in full in the Appended Evaluation Plan.

Effectiveness: has the programme achieved its own objectives according to its design documents informing the Grant Funding Arrangement 2009-2012?

Impact: Has the health of women, children and youth improved as a result of this programme?

Relevance: Is this programme, especially with a large focus on the work of VHVs, considered relevant to the health needs of women, men, youth and children in the regions where it is operating?

Efficiency: Has this programme used the funding for the programme in the way specified in the programme design and contract?

Sustainability: Has this programme progressed towards achieving its sustainability plans?

Methodology

The methodology used in this evaluation was participatory and transparent. It was guided by the understanding that MFAT and SC wanted to understand the overall achievements of the programme (especially the longer running ESWCHP) from the perspective of its effectiveness, impact, relevance, efficiency and sustainability. Importantly both parties wanted recommendations for the future of the programme, and to be able to identify lessons learned.

The evaluator discussed her thoughts, observations and findings, and outcomes of all the meetings, with staff of SCiPNG throughout the field visit. They were extremely helpful, well organised, open and genuinely keen to learn from the evaluation so that the programmes could continue to respond to an ever changing environment, and strengthen its work and outcomes.

The evaluation was also guided by Save the Children's global policy, adopted in 2003, of a rights-based approach to its work. SC designed Phase II of the ESWCHP after 2003, and its documents refer to its rights-based approaches. Accordingly, it identified that working to integrate its activities within the health system was essential for long term sustainability. To that end, the programme was explicit in its goal of strengthening the health system.

This evaluation, in order to be of maximum value for both MFAT and SC, has therefore assessed the work against MFAT's five objectives (as above), while using a rights-based evaluation framework to examine the integration of the programme into the PNG health system. The evaluation also considered the processes employed throughout the programme to see if rights-based approaches are always employed in the programme work, especially participation, equality and non-discrimination, and inclusion of the disempowered (particularly women and children, and people with disabilities).

Following is considerable detail of the methods of this evaluation of the YOP and ESWCHP, and it includes details of information provided at different locations. It is included in the methodology section so it is clear from what basis the key findings, conclusions and recommendations were made.

ESWCHP Evaluation Methods

The ESWCHP evaluation commenced with a review of the past 15 years of MFAT documentation on this project. This historical overview of the ESWCHP (appended to this evaluation report), was very helpful in providing the evaluator with a comprehensive understanding of the project before commencing the evaluation in country. A limiting factor in this literature review is that it drew exclusively on MFAT's extensive files not SCNZ's. These were not provided to the evaluator. MFAT requested this review so that they would have a summary of their support for the programme for future reference, and

their documentation enabled this summary document to be written. SCiPNG has undertaken activities throughout the programme that were not funded by MFAT, but which contribute to the overall effectiveness and reach of the programme. Such work is absent from the review. These activities have not always been reported to MFAT because donors are usually only informed about the specific activities they fund.

This method of reporting means that MFAT has not always received a full picture of the programme and its achievements. This has to lead to a recommendation about the adoption of more strategic monitoring, evaluation and reporting. Interestingly, in the period leading to the 2006-2009 tripartite Strategic Partnership Agreement, MFAT (NZAID) was encouraging SCNZ to enter into a more 'strategic' relationship with NZAID. It wanted a strategic partnership that provided funding to the organisation to direct to the overall strategic plan of ESWCHP, rather than a more activity based funding mechanism. However, this never eventuated. Adopting more 'whole-of-programme' funding support could enable and promote more comprehensive and useful reporting, so that all donors could benefit from seeing the outcomes of their combined financial support, which would be greater than the sum of the individual funding streams.

The in-country evaluation of the ESWCHP began in Port Moresby meeting with the General Manager of Family Health, NDOH, Dr Bill Legani, and a previous health advisor to the PDOH in the East Sepik Province, Annette Coppola. The purpose of these meetings was to gain a broader perspective of where the ESWCHP fits within the PNG health system, and to learn their views on its effectiveness, impact and sustainability. Both were very positive about the achievements of the programme, believed it was in keeping with the National Health Plan 2011-2020, but were concerned for its sustainability after MFAT funding ends. Dr Legani had accompanied SC to Laos last year to witness a VHV programme working effectively, and that convinced him of the major contribution VHVs can make towards improving rural health. A meeting at the New Zealand High Commission (NZHC) with Robert Turare, Development Programme Coordinator, was also instructive. Mr Turare was well acquainted with the programme and the similar use of VHVs in the Leprosy Mission's work in Bougainville. He too shared concerns about sustainability after NZ Government funding ends. Mr Turare told the evaluator that it was through the efforts of the NZHC that VHVs were included in the National Health Plan. Interestingly, this advocacy by the NZHC was not known to others in SC or their partners, who tended to think the NZHC had not always taken opportunities to promote NZ's 'investment' in the East Sepik health programme.

The eight days' field work in Wewak and the East Sepik province began with two days based in the SCiPNG office meeting staff, and close partners including the Catholic Church Health Services (CCHS), PDOH, and the Area Medical Store (AMS). These meetings provided the opportunity to receive latest data on programme activities and achievements, partnership developments and progress towards sustainability especially through partners managing VHVs. Visiting staff at the AMS (a division of the NDOH) was particularly eye opening in terms of seeing the physical capacity of the storage facility for medical supplies and in contrast the appalling conditions under which the management team had to function. This office in Wewak is the hub for medicines supply for the province and yet the management had no internet connection, no printer, one computer

pieced together from a partly functioning laptop, and a partially functioning desktop, and two broken chairs!

Further, the medical supply system, according to the AMS Manager Mr Eddie Bau, is now being side-lined by a new parallel distribution system funded by AusAID. This new system is apparently delivering set kits of medical supplies to health facilities irrespective of the needs of a facility, the level and qualifications of the staff at the centres, and at times even irrespective of whether the facility is currently functioning. This 'push' system of medicines supply does not include medicines for VHVs and is negating the effort and achievements of ESWCHP over the previous two years to include VHV medicines and incentives into the health facility packages, as well as leaving the AMS uncertain as to its own role in the future of medical supplies. This essential component in the functionality of VHVs is compromised by this development and leads to one of the recommendations of this evaluation: ESWCHP urgently meet with AusAID to gain a better understanding of the new system of medical supplies distribution, and to advocate for an integrated supply system which also acknowledges the need for and includes medicines for VHVs. ESWCHP might also call on NZHC and MFAT support in this advocacy effort.

Field visits to project sites then took place over three days commencing with villages along the Sepik River, followed by road travel into the Burui health centre, Kunjigini, and Brugam. The choice of health centres and villages seemed appropriate for evaluation purposes as they included facilities managed by the PDOH, CCHS and South Seas Evangelical Church (SSEC). These are the largest partners in the programme in terms of the amount of funding received and/or numbers of VHVs they manage and coordinate.

The evaluation began at the Chambri villages (Wombun, Indigai and Krimbit), which are at the very early stages of becoming "Healthy Island" (HI) villages. These villages are in somewhat 'disputed' territory regarding under whose management they reside for health services, but this seemed to be in the process of being resolved. One consequence of this lack of 'ownership' of these villages, was that the local VHV (Jimmy Manguan, a marasin man) had not received any supervisory visits for two years, he had no medicines, had not been enrolled in the VHV Competency Checklist programme, and said he had no community support, although he did have a recently constructed but incomplete haus marasin (VHV clinic). The LLG representative who participated in the day's visits, was encouraging the three villages which had started their HI and community self-reliance training (the workshops delivered by SCiPNG staff), to take responsibility for their own development. SCiPNG had stepped in to assist the villages with their HI progress because LLG was not providing any support.



Figure 1 Marasin Man Jimmy Mangin addressing the meeting in Chambri Lakes villages

Community leaders were proud of their improved villages and were keen to point out the beautification plantings and a new pathway being built on higher land (because of flooding from the high levels of the river which local people attribute to global warming). They discussed the removal of pigs from the villages, and spoke about the impact of the community self-reliance workshops. These workshops included gender training, “who does what” and ward development committee training. Women and men spoke about the positive changes in their communities following training, including less violence and women having a greater say in decision making. The local policeman supported these observations, especially less violence against women. The workshops had been delivered in the previous few months.

The first health facility visited in the evaluation was at Korogu, a Sepik riverside village, with the health services managed by the PDOH. Korogu will be a pilot (see below) Community Health Post (CHP), about to be constructed by SC. The community had built a temporary clinic out of bush materials, and 54 VHV's from the surrounding areas were in training and due to return to their villages in another week. These new VHV's will be linked into the CHP at Korogu, and the Burui health centre.

The community had also built three houses to accommodate the nursing officers who will be permanently located at the CHP. Medicines were in stock, and the VHV said that contraceptives were also ‘always’ available.

Korugu and the CHP pilot programme



Figure 2 A formal welcome for the SCiPNG team

The Korugu CHP was an important facility (site) to visit because it is the only CHP that SC is constructing as part of the ESWCHP. It plays an important role in SC's CHP pilot programme which is currently underway. This SC pilot is being done in response to the Government of PNG's (GoPNG) plan to replace all the dysfunctional aid posts and sub health centres (SHCs) with CHPs throughout the country, resulting in about four or five CHPs in each catchment. The GoPNG's plan is being trialled by the Asian Development Bank (ADB) and AusAID in two districts in each of eight provinces, including in the East Sepik at a cost of \$US 80m.

The SC CHP pilot has two purposes: firstly, it plans to calculate the costs of the infrastructure development, hoping to demonstrate CHPs can be built at a considerably lower cost than anticipated by the GoPNG. And secondly, it wishes to demonstrate that fewer CHPs are needed per catchment, if a system of using Maternal and Child Health (MCH) patrols operating from the HSCs or Health Centres (HCs) are used, and linked into VHV services. The SC pilot has selected three different centres from which to operate the MCH patrols, and each of these is managed by a different partner. SC, as part of the MFAT funding, is covering the costs of salaries in this pilot programme. The sites and partners are:

- Korugu, a new CHP which is under the Burui health centre which is managed by the PDOH
- Kubriwat, under the Yangrumbok HSC, managed by SSEC
- Boiken under Dagua health centre, managed by CCHS.

In both pilot programmes the MCH patrols to villages offer VHV supervision, HI village visits, MCH clinics, immunisation, health promotion and outpatient treatment.

The findings of this pilot are expected to be used to advocate a more efficient and cost effective means of delivering primary health care. SC has taken care to gather adequate baseline data and to involve the Burnet Institute (Melbourne) in the design of this research so that it has rigour and its results will have validity. If the results concur with SC's expectations, this will position the ESWCHP to be a model that can be rolled out in other provinces.



Figure 3 Bill Humphrey addressing a meeting at the Korogu CHP site

Burui Health Centre

The Burui Health Centre (HC), managed by the PDOH, is managed by a health extension officer (HEO), who is supported by two nursing officers. The evaluation met the staff and the MCH patrol team. The facility was quite run down with little space for additional administration or storage of drugs, and the medical supplies were in a rat-infested room, and consequently, a reasonable supply of medicines is lost to rats. There is no water in the clinic, no maternity ward, and the HEO delivers babies in a small, unpleasant and dark room.

SC is covering the salaries of three community health workers who make up the MCH patrol team as part of the pilot programme. It does not contribute to the costs (time) of the HEO who has to collate their data, nor those of the additional VHVs who will shortly commence work in the district. This is an added responsibility for the HEO, which had not been negotiated with her, and there is therefore a risk this data collation may not be completely in a timely manner. The PDOH is unlikely to appoint a VHV manager who would take over these responsibilities. When the pilot ends, the PDOH is equally unlikely to have the funding available to take over the salaries of the patrol team and so this aspect of the work will likely end. The process of creating additional positions into the PDOH is long, complex and not often successful. This is an example of the need for external donor funding to support a new phase of the programme.

The MCH patrol team said that when the pilot ends (after 12 months of activity) they will have visited every village in the catchment six times, and will have provided supervisory functions for the VHVs in each village. The quality and acceptability (to people in villages) of these visits is not monitored currently.

In order to demonstrate the effectiveness of this pilot programme, including cost effectiveness, it is important to have measures of clinical quality and acceptability. This evaluation recommends that as part of the research programme, clinical and acceptability indicators are developed and monitored. Presently nurses and patrol teams monitor the VHVs and reportedly identify training needs within the VHVs. This appears to be an informal process, although VHVs do keep a log book of their activities.

Prior to this pilot being established it was explained that although MCH patrols were meant to take place, only about one in three eventuated. This is because there were fewer staff at the health facility and so it is difficult to allow staff to travel if it results in the facility being left unattended.

The district manager of PDOH, Reuben Maiwax, said he would like to be able to control the district's own budgets and funds, so appropriate responses could be made to health needs. He is also keen to have the HSC operate as a local level medicines distribution centre. CCHS is also frustrated at the bureaucracy involved in centralised funding, and will not try to get funding directly from HSIP for future activities as they said it was simply too inefficient. They were both keen to advocate for direct district facility funding. Currently no one in the province can access funds in the HSIP as the PDOH has not fully acquitted previous funding, and this places an embargo on all partners in the province receiving additional funds.

Kaugia Health Sub Centre

The Kaugia Health Sub Centre (HDC) is managed by the CCHS. SC has built a maternity ward and delivery room here, as well as three staff houses. The Nursing Officer (NO) in charge, Sr Appelonia is very proud of her new maternity facility, and has worked with the local community to fully equip it.

Meetings were held with the Board of the HSC, Sr Appelonia, and VHVs (nine women and one marasin man). Some of these VHVs were first trained in 1996, so they had been working as volunteers for over 15 years. They expressed frustration that they were still unpaid, claiming they were originally told that after some time they would receive a salary. This was an issue raised at every meeting with VHVs, and is said to be a significant factor in the overall dropout rate of an estimated 30 per cent. Although 57 VHVs have been trained since 1996, presently there are only 22 active (13 MMs and 9 VBAs). CCHS has trained 800 VHVs in the province, of whom it would be expected fewer than 600 would be active.

The VHVs were receiving incentives (salt, soap) while SC was managing them, but this was discontinued under the transfer of management to the CCHS. Their village communities do not offer any support. One VHV said people in the community say,

“Whoever got you in, can get you out” – meaning, they remain the responsibility of the people who trained and appointed them. This was a sentiment expressed several times. Similarly, it was also stated on various occasions, irrespective of which church was managing health services and VHVs: “These people live here, why should we support them”.

Two of the nine VHVs had no haus marasin in their villages, which is a precondition for receiving medicines. The haus marasins must be provided by the community, one of the conditions they agree to when originally selecting a VHV for entry into the programme. Lack of a haus marasin tends to set up a downward spiral in which there are no medicines, so the VHV is limited in the service they can provide, which in turn leads to less support from the community. It would be timely for SC or the project partner to renew contracts with villages that have VHVs, to ensure they remain committed and aware of the terms of the programme. This could be part of the Ward Development Committee training which is offered by SC, and is included in the recommendations.

Several of the VHVs were on the second of three phases in the ‘VHV competency checklist’ programme (explained more fully below in Findings and Conclusions). They also received between two and four supervisory visits a year including those from MCH teams. They run out of medicines occasionally, and when this happens, they refer their patients to the HSC.

The VBAs deliver most of the babies in the villages, only sometimes accompanying mothers to a HC to deliver, even though the government policy is to encourage all women to deliver at a HC. They said mothers prefer to deliver babies at home or in their own village.

The VHVs and the NO believe they are doing a good job in their communities, and they want the programme and work to continue, but are anxious for recognition and some payment “before they die”.

At the meeting with the board (five men), they explained the role of the Board, which is to oversee and monitor the facilities and staff, and deal with any complaints the community may have. They decide on whether charge user fees, and if so, what level and to whom, for what purpose. They recognise the value of MM in the community, but want to see them getting more financial support (but not from the board). It was not made clear how user fees are used in the community.



Figure 4 Sr Appelonia outside the new Kaugia Maternity Ward and Delivery Suite



Figure 5 Staff housing in Kaugia

Kunjigini Health Centre / Training Centre

At this site, SC had built the training centre and dormitories, and the maternity ward. They had also upgraded the dispensary and put in shelving for good organisation of the medicines.

The centre is managed by CCHS, and the reports from the centre, including the VHVs' daily tally data are submitted monthly by CCHS to PDOH.

The visit to this HC also provided another meeting with VHVs, Ward Committee members (men) and community leaders (men). Of the six VHVs, three referred to themselves as MM/VBAs, two were VBAs, and one was an MM.

These VHVs again raised the issue of wanting to be paid, and wanting more community support. The community leaders echoed these sentiments, but did not suggest ways of engendering community support.

Although the NO said the “VHVs do their best, but they do misdiagnose”, she also added that no one has died because of VHVs, and in contrast, they have saved lives. All the VHVs believe they have saved lives, an opinion repeated at many meetings.

There was a two-week SC-funded community leaders ‘training of trainers’ workshop taking place in the training centre at Kunjigini during the evaluation visit.



Figure 6 Kunjigini training centre



Figure 7 Dispensary shelving supplied by the programme

Brugam Health Centre

Brugam is the administrative centre of Maprik health facilities, which has 10 aid posts, five health sub centres and one health centre. All the staff are employed by SSEC under the Officer in Charge, Nixon Sunblap. As with CCHS, SSEC receives a grant from the government through the Church Medical Council to fund operations and salaries. The administration of the grant has recently become more complex, with monthly payments that are always late, whereas until last year they were paid annually.

SSEC commenced the VHV programme in 2002 as a partner with SC and it now has 206 VHVs working in the province.

VHV performance is monitored by the coordinator and links into the health facility local management. The reports with MM/VBA data go to SC and PDOH. There is also an MCH programme for each village. Mr Sunblap is pleased with the whole system, but acknowledged the most challenging component regarding the VHVs is the community support. The AMS provides quarterly supplies, and SC assists with delivery of any extra medicines needed.

SC has built eight staff houses, general wards, and administration building, maternity ward and training centre. The houses are used for the purpose intended, nursing staff, and have helped attract staff to the programme. However, he said the maintenance cost of buildings is a financial burden to SSEC.

SSEC is one of the partners in the CHP pilot programme, and has received salary support for five community health workers and a VHV coordinator.

Mr Sunblap has been a national leader in implementing HI villages. In addition to the benefits of potable water, improved sanitation and cleaner environments, these villages

also have health development committees which are said to provide more active support for their VHVs.

The evaluator met with one of these health development committees, as well as many people in the Healthy Island villages of Ilahita and Ilahup. They were keen to talk about the improved health that had resulted from the HI process, with animals fenced, water being piped in, and houses being raised to increase ventilation. Men at the meeting said women were part of the committee, although this wasn't apparent, but men and women agreed that violence and alcohol use had reduced since HI implementation. Piped clean water had improved women's lives particularly, with far less distance to walk each day to gather water. The women said their children were cleaner and healthier. They were keen to show us the taps, and to drink the water for photographic record of its cleanliness. A primary school has also been built between two of the HI villages, just a few hundred meters from either.

The health centre (which had not been open for several weeks due to a sorcery claim over the death of a nurse, and resulting compensation which the centre had to pay leaving no money for staff salaries), had improved shelving in the dispensary (as part of the SC programme), and was well stocked, including with condoms and malaria treatments. The nurse in charge said they had seen a reduction in diarrhoea from the HI villages, but less so in malaria. She claimed there was a reduction in STIs, but she had no test kits to confirm this. She said violence against women occurred, but was not a 'big problem'. All meetings elicited comments that violence against women occurs in the community, although consistently the HI and community self-reliance courses were said to reduce its prevalence.



Figure 8 A mother and children from Ilahup Healthy Island village demonstrating clean potable water

Wewak meetings

On return to Wewak further meetings took place with the East Sepik Council of Women (ESCOW) and the Seventh Day Adventist (SDA) programme manager and VHV coordinating officer.

ESCOW, as has been documented in previous reports and reviews of this programme, initiated aspects of VHV work in the East Sepik in the 1970s. They have remained involved with some aspects of the programme, but since SC took over management in 1995, they have not been an implementing partner. The issues raised by ESCOW were largely around the lack of support for VHVs, which they believe is leading VHVs to give up their health work. There were active VHVs at the ESCOW meeting who spoke of the need for incentives. They also mentioned the difficulty around supply of medicines, and explained the VHVs are expected to travel to pick up their medical supplies, but their travel costs are not reimbursed. These can be high for those VHVs who must take boats on the river. They suggested good incentives from the community would include roofing iron and water. They spoke highly of the training and refresher courses delivered by SC. It is ESCOW's belief that at the beginning of the programme VHVs were treated as important women and their position had status, which encouraged the community to respect and support them. This was done by working closely with the women's groups, and it is the failure to continue this approach that has resulted in the VHVs no longer having community support. ESCOW claims women's village committees are still active, and SC could connect with women leaders through ESCOW. They would like to recommence this role, and also believe this would enhance the HI work, and support of VHVs. The earlier extent of community involvement is captured in a paper by the founder of the ESWCHP, Elizabeth Cox (Cox and Hendrikson 2003).

However, this evaluation acknowledges SCiPNG's comments that to engage with women's groups in each of the 800 or more villages in which VHVs are now active would be resource intensive and ESCOW does not have the capacity to provide this provincial reach.

SDA is one of the smaller partners in the ESWCHP. It has 127 VHVs and manages health care in four districts. They joined the programme slightly later than CCHS and SSEC and have not received infrastructure support from the programme, which causes a little tension, as it has done with the PDOH.

The VHV coordinator with SDA had her salary paid by SC until the end of 2011, and now SDA has the funding to retain her.

They described the programme as very good but difficult to sustain, as they discovered in their last supervisory visits. VHVs stop their service because they are not receiving the supervision they want, and as others have said throughout this evaluation, the VHVs don't believe they can carry on without pay indefinitely. They also cite lack of community support as a major disincentive for the VHVs. Of SDA's 127 VHVs, 71 per cent are active, have a haus marasin, and send in monthly reports.

Stakeholders meeting, final day, Wewak

On the final afternoon of the field trip there was a stakeholders' meeting which was attended by representatives of CCHS, SSEC, SDA, AMS and management and staff of SCiPNG. This meeting provided the opportunity to report on the overall findings from the field trip and to put forward recommendations for the future work of ESWCHP. This meeting lasted nearly three hours and generated good discussion on the whole programme and its future. Four main recommendations were presented to this meeting: returning community training and gender training to the core of the programme and the starting place for future work; a need for formal, robust research; compilation of training manuals; and development of a modular approach to CHW training so that VHVs could see a career path developing for them. Some refinements of these recommendations were offered but they were largely endorsed. These and further recommendations are presented below.

The YOP Methods

The YOP operates in two provinces, Madang and the East Highlands (EHP). It is jointly funded by AusAID and MFAT, with nearly all MFAT's funding (2.4m kina, over three years, 2009-2012), going to the EHP. The overall goal of the programme is to improve youth sexual and reproductive health behaviour, through a process of using peer education delivered by volunteers.

Following an initial review of the YOP programme design, reports, budgets, and monitoring and evaluation framework, meetings were held with the programme manager and field officers in Goroka. The YOP programme developed from the SC Poro Sapot project in PNG (peer education for HIV prevention amongst female sex workers and men who have sex with men). YOP adopts the same principles and uses youth volunteers to educate peers about prevention of HIV/AIDS. YOP benefits from some of the structural developments of Poro Sapot, especially the STI clinics which have made a deliberate effort to become youth friendly. The programme trains 60 POV each year in the EHP (aiming for 30 men, 30 women) to deliver peer education in HIV/AIDS, STIs, and other life skills.

Group meetings were held in Kainantu and in Goroka, with young men and young women volunteers, and male community leaders. (On enquiry as to whether women are ever community leaders, men said this happens occasionally, but none attended any of the YOP evaluation meetings.) The POVs and the community leaders spoke highly of the programme, and believed it was not just achieving greater awareness of HIV/AIDS and the need for safe sex in youth, but it this was extending out to others in the community. The POVs had a good understanding of STIs other than HIV/AIDS, and demonstrated that they knew when to refer people to their referral centres.

The community leaders and some of the POVs argued they should receive payments for their work. Some had been with the programme for quite a few years and said they could not be expected to bring up their children with no money. However, the contracts with the POV when they first enter the programme are quite explicit they are volunteers, and only expected to be on the programme for a one year period.

Two male youth volunteers accompanied the SC staff and evaluator on a tour of the settlements in the Goroka area where we met with a group of young men, and viewed the context in which the POVs worked. These youth in the settlement, who were peers of one of the POV accompanying the team, said they had understood the messages promoted about safe sex, and had received condoms from their peer.

There was also an opportunity to meet a smaller group of POVs (two men, two women) in advance of one of the larger group meetings in Goroka. These young people spoke of how the programme had changed their own lives, and they enjoyed the respect that they received from some people in the community. However, they also discussed the antagonism they have directed at them on occasion, and how they deal with this. The young women preferred to have private smaller meetings with young women, and never gave away condoms in a public place.

The evaluator visited the "White House" clinic in Kainantu, and the Lopi clinic in Goroka, both of which are the referral clinics for youth who wish to undergo testing, and counselling, for STIs and HIV. At these clinics the staff and managers explained the processes of referrals, counselling and testing. These staff and the clinic refurbishments are paid for from the Poro Sapot programme (from AusAID).

The manager of the YOP, Mactil Bais, Senior Project Officer, YOP, who is based in Madang, and the Goroka senior project officer for YOP, Wesley Lopele accompanied the evaluator throughout the two days. This provided plenty of opportunity for discussion about the programme, challenges and future opportunities.

At the end of the two days a meeting was held with the SC YOP team and senior management to report on initial findings, and to seek their feedback regarding these findings. In this meeting support was expressed by the YOP team for the proposed recommendation. These included the development of a database of youth volunteers so they can be tracked in the future with a view to determining if participation in YOP results in future employment or positions of community leadership. If positive outcomes from inclusion in the programme could be demonstrated, this would help encourage others to sign up.

They also responded well to the recommendation to more actively pursue livelihood options within the YOP for the POV - in particular through the composting toilet opportunities, or growing yams as had been tentatively considered.

The final recommendation at this time was to assist interested POVs to obtain sponsorship to progress into the Diploma in Youth Work which is commencing at Divine Word University in 2013. Gaining a formal qualification through the work as a POV would be a valuable outcome for volunteers.



Figure 9 Meeting with YOP volunteers in Kainanga

Limitations of the Evaluation (and the effect of these on the evaluation)

ESWCHP: Given the longevity and scale of this programme, this was a very short in country visit. The programme only permitted two days in the office in Wewak, which were taken up largely with partner meetings. It would have been beneficial to have had time to spend with more staff to understand how the various MCH and other roles all contributed to the ESWCHP. There was also only three days in the field, so it was not possible to travel to the more remote villages, to meet all the partners, and to fully understand all the complex arrangements that are in place to provide primary health care throughout the province.

In particular the evaluator would have welcomed the opportunity to explore the training provided by the SC team to VHVs, managers and the community. This is a crucial component of the programme but there was no opportunity to discuss it with trainers in the field. On examination of material provided on the final day in country, training materials appear to be lacking gender elements and are strongly faith-based. This is raised again in the findings and recommendations, and it would have been useful to have had the chance to discuss this in the field.

YOP: Similarly, the time allocated to undertake this aspect of the evaluation was very short – two days in the Goroka area visiting the programme offices in Goroka and Kainantu, but not the offices in the third Goroka area (Megabo), nor the Madang office. This meant there was no opportunity to visit a Youth Friendly Centre (Madang only), or to meet with youth or community leaders in their communities, aside from a brief encounter in a settlement in Goroka. The impact on the evaluation is that the evaluator was unable to adequately assess the sustainability of the programme by looking more deeply at issues around community ownership.

The evaluator was only able to meet four women volunteers, all of whom were enthusiastic about their community work. More time would have provided the opportunity to explore further the potential risks that undertaking this work poses for women volunteers, and for the young women with whom they work. Young women are under-represented in the programme, and it is likely that inherent dangers of promoting safe sex messages could be one of the reasons. It would have been useful to have discussed the inclusion of more practical risk-mitigating strategies in the recommendations.

Findings and Conclusions

The ESWCHP Findings and Conclusions

The overwhelming attitude expressed about the ESWCHP throughout this evaluation, at every meeting, was that it was a successful and effective programme: this view was offered by those interviewed at the NDOH, PDOH, LLG, partner organisations, health facilities, VHVs, and people in villages. Comments such as “this programme has saved lives” were made frequently, across the range of people interviewed. The response to questions about what would have happened had this programme not occurred was consistently that people would have died.

There was a high level of awareness that the funding for ESWCHP was from “NZAID”, and the partner agencies in particular were most appreciative of the New Zealand Government support for the programme. They referred to NZAID as having been a supportive, flexible and ‘understanding’ donor agency. The feedback workshop was unanimous that the NZ Government should be thanked, and should be given recognition for the role it has played in developing a successful model of health care delivery in the East Sepik. Stakeholders expressed their desire for MFAT to remain a part of the programme as it enters its next phase of piloting the VHV programme, comparing MCH patrol teams, VHVs and CHP with the proposed national model of CHPs.

“VHVs” is a term that covers four different categories of volunteer health workers – Village Birth Attendants, Marasin Meri or Marasin Men (medicine women or men), Community Based Distributors (CBD) and general Village Health Volunteers. Although programme managers, the PDOH and NDOH refer to this cadre as VHVs, the VHVs use the terms above. Previous reviews of this programme have recommended the terms MM and VBA are adopted again because they are better recognition of their work, but this has been difficult with the NDOH referring to VHVs in the National Health Plan 2011-2020.

Even though VHVs have only a short initial training period (two weeks), with follow on refresher training (about every two years but with the goal of being annual), they carry a large responsibility as the most available and accessible health worker to people living in remote, rural East Sepik. They are effectively ‘on call’ every day and night, and they receive no pay.

For the purposes of this review, there have been two phases of this programme: 1998-2003; 2004-2012. In the first phase, there was an apparent greater emphasis on women's empowerment and working with Women's Groups to select and support MMs, CBDs, and VBAs and make them an important person in the village. However, between 1999 and 2003 there were several changes of management in SCiPNG and with that this central platform faded away.

The second phase coincided with the appointment of the current programme manager in Wewak, and he viewed the ESWCHP more as an emergency response because there was, as he describes it, a total lack of health care in the province. His focus went into building health care services and facilities, and away from social and cultural factors that ultimately play a very large part in determining the use of clinics and health services.

Although SC had already adopted a global rights-based strategy before Phase II commenced, this approach is not consistently evident in the work of the programme. From a right-to-health perspective, it could be said that the phase one focused on the accessibility and acceptability of health care and the determinants of health (making sure that women and children could access appropriate health care by overcoming community imposed barriers), whereas the second phase focused more on the availability of health care by providing health workers, facilities and medicines. A rights-based approach addresses all these elements together, and ensures that women, children, any disempowered or marginalised groups, including people with disabilities, are included in the planning, delivery and accountability of services.

Effectiveness of the ESWCHP

In this section the six components of the health system as defined by the WHO (World Health Organization 2007), are examined to assess how effective the programme has been in terms of contributing to the health system, and supporting it to deliver sustained quality health care. The health system is recognised as the core institution through which the right to health can be fulfilled, and working in alignment and support of it is key to all rights-based health programmes (Backman, Hunt et al. 2008; Freedman 2009). In the second "sustainability" phase of the ESWCHP, the intent has been explicit to work to strengthen the health system so that VHVs' effectiveness is promoted and sustained.

1 Health workers

Since the ESWCHP commenced in 1995, (with first funding from MFAT being received in 1997) 1376 VHVs have been trained, for 802 villages, across six districts. The first 324 were trained before 1998, and the remaining 1052 since then. The number of VHVs still active is estimated at 1000 – each agency knows its overall numbers of active VHVs, but SC doesn't collate this into any database.

An active (functioning) VHV is one who is supported by his or her community, evidenced by the presence of a haus marasin or haus karim (maternity clinic), with medical supplies in stock, and delivery of regular (monthly) report to the nearest health facility with which he or she is affiliated.

The VHVs have been providing over 200,000 consultations annually for the past five years; they supervised over 2000 births in 2010, and provided family planning services for over 12,000 people in 2010. The VHV network now delivers a significant portion of MCH and malaria control services in the province. It is currently under negotiation that from 2013 the VHVs will also play an important part in using Rapid Diagnostic Tests (RDT) for malaria detection and if positive, follow on treatment with MALA-1. This will be funded through PSI and the Global Fund.

These achievements speak to the effectiveness of the network of VHVs, and the volume of work that this cadre of health workers undertakes. It is not possible to assess the health outcomes of this work as there is no reporting on the quality of the VHVs' work, nor the accuracy of their diagnoses, and appropriateness of treatments or referrals.

However, considerable effort is being made to continually improve VHV skills. The ESWCHP has delivered VHV refresher training to 16 facilities in this latest three year period, with five more refresher training courses due to be completed by the end of the contract.

As an example of staying aligned with the health system, SC quickly adapted the new "VHV Competency Checklist" approach to refresher training, so that the ESWCHP VHVs are now meeting the standards required by the NDOH. The ESWCHP also developed a VHV skills competency checklist training manual.

VHV referral records are entered into a logbook at health facilities for further follow up, and if the health facility notices deficiencies in a VHV's skills it is said to provide extra training for this person.

2 Health facilities and services

The large infrastructure component of the 2009-2012 Grant Funding Arrangement will be completed by September 2012, with the possible exception of one CHP. Construction materials have been purchased and delivered for this CHP and it will be completed by the end of the year.

Otherwise there have been five general wards, three maternity wards, one training centre and 18 staff houses completed, according to SC records. Over 52 buildings have been completed since 2004. The health facilities and staff houses are very much appreciated by the partners (and a cause of disappointment for those partners who did not receive any). The construction of staff houses according to partners has achieved its objective of attracting and retaining staff in the more remote areas. SCiPNG is also certain the infrastructure development has achieved its objectives.

The programme will also have upgraded medicines dispensary shelving at 15 health facilities to allow better storage of medicines for both ease of access and rodent-proofing.

It is to the credit of the programme that infrastructure development has only taken place in sites where partners are already working, and so it supports the current systems in place. The health facilities and houses built all have running water piped into them and

so the standard of hygiene provided in the new facilities is an improvement on previous buildings.

An indicator could have been (but wasn't) included in the M&E framework to measure whether new buildings increase the number of patients who attend clinics, and deliver babies at health centres.

3 Medical supplies, vaccines and products

A partnership with the AMS was effective in having medical supplies for VHVs added into the supplies delivered to health facilities. This was an important achievement in the programme. Further work is now needed to get delivery to the VHV villages. Some VHVs said they are expected to cover these costs themselves, and this can be high if they have to travel by boat.

As discussed earlier, the entire medical supplies system is currently undergoing reform, and AMS believes the VHV medicines supply is at risk. It is a recommendation that SC urgently investigates this new mechanism, and advocates for the inclusion of VHV supplies.

Other activities in this component included building health centre dispensaries, equipping clinics with shelving for storage of medicines, and paying the salaries of two staff to assist with the packaging of VHV supplies within the AMS. Given the current state of flux and uncertainty about medicine supply in PNG, it is not possible to evaluate longer term impact of this component.

4 Health information systems / health promotion

All data collected from the VHV tally sheets is collated and sent monthly to the nearest health facility. The data for the PDOH and NDOH is then extracted and sent to the PDOH, including births attended by VBAs, and all deaths. The partner then sends the tally sheets to SC for it to use any other data. Presently the PDOH is not using the other data collected by VHVs. I recommend that PDOH includes this data because it provides important information about the state of health in the province. Also, its exclusion could lead to incorrect interpretation of health trends. For example, as VHVs are treating more people with malaria, the numbers attending health clinics is decreasing. Malaria prevalence could easily be misinterpreted as falling if VHV treatment is not factored in.

The ESWCHP has included components to promote community self-reliance/Healthy Island programmes. This component was described repeatedly by people in villages as very effective at improving health in the village, empowering women and reducing violence.

On review of this particular manual developed by SCiPNG to guide trainers in delivery of the component, it was found that despite SC describing itself as 'secular', the community exercises are Christian-based, the manual is entitled a Devotional Guide, and it uses many Biblical references. This inconsistency should be addressed by SC. On reading through the manual it is also apparent that no exercises were conducted from a gender perspective. The trainers were never advised to separate the village participants into

groups of men and women, to see whether men and women identified similar or different 'community' issues and health problems. The manual does not include activities that would provide women with the space to voice any issues independently from men, to explore their opinions on how the village could be improved for better health outcomes for women and children, to investigate their barriers to health care, (will their husbands let them travel alone to a health clinic, etc), and to find out what women know about sexual and reproductive health, including contraception and STIs. In a culture where women are so disempowered, and where there is such a high and documented level of violence against them, it is not likely they would express views in a mixed gender setting, especially about sensitive subjects.

It is a recommendation that a PNG gender and health specialist reviews these tools and manuals to ensure that they achieve their objectives of improving women and children's health. On completion of this, it is further recommended that the tools could be compiled as a resource and offered as part of VHV models of care to other health providers and trainers in PNG, and used in conjunction with any development of training towards CHW training (see Recommendation 10).

The "Community Self Reliance: Healthy Islands, abuse prevention and democratic governance" component of the programme addresses objective two: *To improve public health awareness and practices by rural communities in selected project areas, particularly regarding the health of women and children in selected districts.* Activities have been undertaken in 50 wards to promote public health awareness, including gender awareness and rights training, albeit with the above limitations.

The villages visited during the evaluation which had participated in these activities had active ward development committees with five year plans, and annual activity plans written up. Although these villages consistently said there were women on the committees, it wasn't always obvious that this was the case. One village said the committee meetings were held in the 'spirit house' – ie, the men's house, but added that women could participate in the open meetings, along with children. There was little sense that the plans had been developed after gendered consultation on what activities would best benefit women and children, and improve their health.

5 Financing

The ESWCHP has been dependent on MFAT funding for nearly all its activities for the past 15 years. Even when it was accessing funding through the HSIP, that funding had been provided to the HSIP by NZAID specifically for ESWCHP activities.

The future costs of the ESWCHP will likely be considerably lower, provided more infrastructure development is not required, and that vehicles do not require replacing. However, even though the partners have taken over the management of the VHVs, they cannot afford to pay additional staff to continue with the responsibilities once SC ends its salary supports for the partner organisations.

Accessing HSIP is very difficult, and at the moment no funds can be paid to providers in the East Sepik province because previous funds to the PDOH have not been adequately acquitted.

SC is looking for donors to ensure its work can continue, but whether its partners are equally able to attract new funding streams is doubtful. Although the PDOH believes it will be able to appoint 600 new health workers, this has been promised since 2009. Even if this eventuates, the PDOH Health Administrator will only commit a couple of positions to VHV management.

Many of the people interviewed in this evaluation expressed the concern that without adequate external funding support, the benefits of this programme will reduce over time because PNG sources of funding, including the HSIP, would not be easily obtained.

6 Management

In the past three years there has been considerable attention paid to building the management capacity of the partner agencies. This included courses in VHV management, especially regarding the information system. Partners have also been trained in M&E and logframe revisions, and epidemiology.

Secondment arrangements have been made with partners, including the PDOH (2), SSEC (2), CCHS, (7), SDA (1) and PIM (1). These staff have become part of the ESWCHP team, working with the programme staff, gaining hands on knowledge and experience. The project also supports the salary of three VHV coordinators.

The ESWCHP management team reports that the strongest commitment for VHV management has been demonstrated by CCHS and SSEC - they are also the partners who have received the most support, capacity building and infrastructure development.

The handover of VHVs and the programme for catchments developed before 2004 was completed in 2011. A total of 395 VHVs in 10 of the early established health facilities were handed over to the partners. Catchments developed in Phase II did not require handover, as from the start they were managed by a partner.

All of these achievements under the six different components of a health system are effective contributions to the improvement of basic family health services to rural people (objective one). In terms of being effective in achieving women's and children's right to health, they have made facilities and health workers more available, they have funded services, established effective management systems that link in with the provincial and national MIS, and improved medicines supply.

What cannot be determined currently is whether the health workers are delivering an acceptable and quality service. A recommendation is therefore made to appoint a person who would monitor clinical and health outcomes, in conjunction with the VHV competency checklist process that is underway.

Impact

The total number of VHV reports submitted to SCiPNG between 1998-2011 is 27,820. The data contained in these reports has recently undergone cleaning and analysis by SCiPNG and the Burnet Institute, Melbourne. From this analysis, there has been an increase in the number of supervised deliveries. The VHVs also appear to be seeing more of the malaria cases, taking the load off the health centres.

The Burnet Institute report states: "The first and most important implication in East Sepik Province, VHVs are clearly an integral part of the rural health system, such that:

- District health planning must take their presence and potential contribution into consideration
- District health information systems must integrate VHV reporting if they are to gain a true picture of their local situation and
- The role of VHVs in relation to both new CHPs (or existing HCs) and increased outreach patrols needs to be discussed, planned and explicitly agreed in pilot and other areas.
- "...VHVs are fulfilling an important clinical role as well as provision of preventive/educative services. They are also clearly filling some gaps that the formal health system cannot presently address. So their role and function needs, not diminution, but careful examination to ensure that it is optimally effective" (O'Keefe 2011).

The Burnet Institute report, and the evaluator's own observations about the lack of clinical and health impact, leads to a recommendation that SC consider making a health quality advisor appointment. This person would develop measures of health impact and clinical effectiveness so that VHVs' and MCH patrols' diagnoses and treatments could be monitored and evaluated. This needs to be an important element in the current pilot programme as without it, there is little way of knowing whether the services being provided are of quality, and importantly, that no harm is being done.

SC has no focus on disability in children or adults. This appears to be quite an oversight, especially in a rights-based organisation. This should be addressed in future work, as the health needs of children and adults with disabilities are likely to be greater than other people in these settings.

Relevance

The ESWCHP is relevant to the health of people in the East Sepik, is in keeping with the National Health Plan 2011-2020, and the Child Health Plan 2008-2015. It is addressing the direct factors that contribute to preventable death and morbidity in women and children by making health services more available and accessible. It is also addressing underlying causes of poor health by looking at the village environments and promoting public health initiatives in villages.

Gender specific underlying health determinants, including women's disempowerment and lack of control in their lives in PNG, have not been identified in the programme or the M&E. Therefore it is difficult to state with any degree of certainty that the programme is relevant to these specific underlying needs of women and children.

The M&E Framework was developed in 2010, the year after the GFA was signed. SCNZ is critical of the GFA and the M&E framework, and in particular that the M&E was developed subsequent to the GFA. This evaluation has not focused especially on the design of the GFA, rather, the overall achievements of the programme. It has looked at the M&E to assess whether it enables reporting on the programme objectives, and is relevant to the programme. The M&E has 64 indicators divided into impact, outcome, output and process indicators. Many of which take a lot of analysis from multiple sources of raw data to determine a result. SCiPNG has two competent staff at SCiPNG dedicated to M&E, and they are concerned at the amount of work involved, and difficulty of completing the whole framework. Some of the indicators remain unobtainable, or certainly unverifiable (for example, using household survey data to determine child mortality rates). 'Strengthened capacity of partners to deliver improved health services' is measured through photos and construction reports, and attendance at training programmes, neither of which is actually an indicator of increased capacity. The M&E team will be collecting information from its own visits to villages where it will conduct focus groups to assess people's knowledge about many aspects of health.

However, SCiPNG believes that it has achieved "80%" of the impact and outcome indicators, and that over the next three months it will conduct further qualitative surveys to verify its success. It is to SCiPNG's credit that it has made such an effort to gather data to attempt to determine a baseline. It should also be remembered that when the programme began in 1998, and even in 2003, the development sector was not oriented towards evidence-based evaluation and research, so the fact that baseline data is not available is not a reflection of failing in this programme in particular.

Three main difficulties have been identified with the M&E, apart from its sheer size, in this evaluation:

1. There is a lack of real (not imputed) baseline data so the indicators will not easily show trends
2. The method of collecting data requires considerable input from other sources, and this will not always be available for the M&E team; for example, information on medical supplies requires information from AMS, and AMS does not have the capacity to be gathering or interpreting data; gathering partners' annual action plans which are expected to include VHV plans – the M&E team says this is difficult to measure and collaboration from partners' on this is poor; several indicators require data from LLGs and this is unlikely to be easily obtained.
3. The M&E, which addresses the 2009-2012 objectives and outputs, does not reflect either of the two frameworks that SC claims to take to its projects. Firstly, it is not looking at women and children's rights, including the right to health; secondly, SC believes there are five pillars upon which a successful VHV programme must rest. These are: community support; medical supplies; recognition by the nearest health centre; retraining; incentives. Only some aspects of these two frameworks are captured in the M&E plan currently.

Throughout the history of the ESWCHP the goal, objectives, activities and outcomes have been re-worded on numerous occasions, sometimes changed by SC, sometimes at the behest of the MFAT. But consistently since 2003 SC has stated it is a child and women's

rights organisation, and I would expect therefore that the purpose of this programme remains the same: to assist the GoPNG to respect, protect and fulfil the rights of women and children, especially the right to health. Such a constant position could have kept the framing of the work simple and consistent, and would have also ensured that the reasons women and children were suffering poor health and early death were kept central to the programme. This leads to a recommendation that SC has rights-based training for all its staff and adopts a rights-based approach to its programme design so that its work reflects its mission statement and its work.

Efficiency

From 1998 – 2012, the NZ Government has provided about \$20,000,000 to this health programme. There are many ways in which the cost effectiveness of this might be considered, but because there are no real measures of 'lives saved' or morbidity reduced, it is suggest this spending is viewed as follows.

A network of VHVs was developed so that there are now about 1000 VHVs providing some degree of primary health care, and health promotion advice, to a population of 313,000 people. A medical supply system, albeit patchy, provides medicines and some contraceptives/condoms, most of the time to health facilities or VHVs. The cost to MFAT of this programme has been about \$1,250,000 annually, or about \$4 per person in the districts included. Given the large number of patient consultations, supervised deliveries, medicines dispensed, and referrals to health clinics, this would seem to be an efficient and cost effective use of donor funds. (Although the CHS also receive funding for health services provided in the province, their funding goes to the services provided at health facility level. MFAT funding alone supported the development of the VHV network and its management, as well as community self-reliance, and all the capital / infrastructure developments at the health facilities.)

Furthermore, the cost effectiveness of this model of health care delivery is currently being investigated in the CHP pilot programme. This should provide additional information to demonstrate the efficiency and value of the programme.

Importantly, the ESWCHP has gone to great lengths to strengthen the health system in PNG. It has worked with the PDOH and other partners to train their staff, develop their infrastructure, improve medical supply systems, integrate the data from the VHVs into the MIS requirements of the PDOH and NDOH and improve overall management. It has avoided duplication of any local systems and has opted for the integration and strengthening of these systems. This is all evidence of efficiency in country.

One area in which there may be inefficiency is in the reporting, management, and funding flows between donors and SCiPNG, with SCNZ and SCA both having management functions. For an organisation that has strong management, design and reporting capacity in country, it has to go through many links in the chain before reaching the desks of donor agencies. Staff in SCiPNG were not able to provide substantive explanations as to why this arrangement is in place, or what benefits it brings. This was not further investigated in this evaluation, but it may well be worth SC itself assessing the value added by each of the links in this information/reporting supply chain.

Sustainability

The Sustainability Plan was developed in 2010, although in many ways the activities in the Plan were put in place at the very beginning of the second phase (2004-2012), as the period was always framed as a sustainability phase.

The activities in the Sustainability Plan have been executed and were relevant. The partners have been trained in VHV management and coordination and are all submitting the data from the VHV reports on a monthly basis. CCHS, PDOH and SSEC are also participating well in the pilot programme. Because all the work is integrated into, and strengthening, the health system, the partners seem to have no conflict with the overall direction of their work within this programme.

But as identified in the Plan, funding the ongoing management of VHVs remains the challenge. The PNG health system is grossly under resourced, and partners are finding it difficult to access HSIP or other sources of income.

Advocacy was seen to be an important aspect of sustainability, and within the Plan this particularly addressed advocacy at LLG and community level. Many of these activities have been carried out. But there has been little advocacy undertaken at a higher, NDOH level, in large part because NDOH has not been open to such initiatives. However, the visit to Laos last year which included NDOH staff was very effective, and there is now an influential supporter of VHVs within senior management levels of the NDOH. This leads to a recommendation that further advocacy is required at this level, and to consider this at a NZHC level.

The opinion was expressed at several meetings that NZHC appeared to take little interest in the programme, which seemed to surprise people as this programme was NZ's largest health initiative in PNG and it lasted for many years. SCiPNG reported that two NZ High Commissioners had visited the programme as well as MFAT staff, but not since around 2009. The High Commissioner visits were successful in raising the profile of the programme.

The view has also been expressed that NZ has not claimed the credit it deserves for the scale and success of this programme, but there could still be opportunity to do so if the programme becomes a model for deployment in other provinces. NZHC support on this would be appreciated by SC and programme partners.

VHV incentives It would seem that the greatest risk to the sustainability of this programme currently is the lack of community support for VHVs. Although the people spoken to in villages said they are pleased to have VHVs, this does not translate to any practical support for them. such as was originally envisaged by the founders of the ESWCHP. Since SC handed direct management of VHVs to its partners, the VHVs have received no incentives or practical support at all. This exacerbates their concern that when they retire they will have absolutely nothing to show for a lifetime's work for their community. Therefore, it is recommended that in addition to the community self-reliance programmes becoming the first component of engagement with a new village,

communities must also make a commitment to providing VHV support and incentives as part of their contract with the managing health agency.

Formalise and upskill training: The PNG National Health Plan 2011-2020 makes a commitment to developing community health posts especially in rural areas. It is proposed that each CHP is staffed by three health workers “skilled in maternal and child health, midwifery, health promotion and community awareness programs” (Government of Papua New Guinea 2010). Further, the Plan states that CHPs will be encouraging communities to use informal health care from the community, e.g., through VHVs. There is therefore, over time, going to be a high demand for CHWs. It is recommended that SC continue its deliberations about working with training institutes and the Medical Council to consider offering a formal and academically accredited, modular-based training programme to interested VHVs to upskill them to become CHWs. This could give them a strong incentive to continue to provide services if they see a career path ahead, and the possibility of paid employment at some point in the future.

The YOP Findings and Conclusions

This evaluation has found the YOP to be an innovative and thoughtful programme which is using youth to educate their peers on HIV/AIDS prevention. The young men and women volunteers have benefitted personally from their involvement in this work, and have reached out to many thousands of other young people in their communities. The systems in place to monitor their work, their distribution of condoms, and the referral rates of clients to youth-friendly health clinics are effective, efficient and well managed.

It is not possible to know whether the YOP is achieving its overall goal of reducing HIV/AIDS risk in young people because baseline data are not available to measure against. The sustainability of the programme and its impact depends on greater support from the community to enable the youth to keep functioning, and funding to keep activities and information systems in operation.

The evaluation has considered the effectiveness, impact, relevance, efficiency and sustainability of the YOP. It discusses each in turn below.

Effectiveness

The stated “narrative summary” in the GFA for the YOP is that out of school and unemployed youth impacted by HIV epidemic are better able to protect, respect and realise their rights. It has an indicator that, “X% [sic] of out of school and unemployed youth are leading a healthy and productive life”. Fundamentally, the goal is not well stated, and the indicator is non-specific and not measurable. Additional more specific indicators, e.g., “10% of targeted youth (age 15-25) report experiencing reduced risk factors for HIV transmission”, cannot be measured without research conducted on a selected youth population, and similarly for the indicator ‘10% decrease in incidence of HIV infection in the target areas’.

Recognising the difficulties of these indicators, the YOP management team, and with support from an AusAID grant, held three workshops to review their M&E systems and

develop a Monitoring, Evaluation, Learning and Sharing (MELS) framework. This new MELS has introduced more measurable indicators of outputs (not always outcomes or impact), has aligned the programme to National Health Strategy indicators, and has also resulted in good processes which bring the teams together on a quarterly basis to review work and plan.

While this is very good for the management of the YOP, it does mean that the team's internal quarterly reports do not match up with the annual reports for MFAT, as YOP is still required to report against the logframe as developed in the GFA. The team's efforts in improving M&E while being diligent with the GFA reporting requirements deserve recognition.

In EHP each of the three years of the programme has had an intake of 60 youth volunteers divided evenly between Kainantu, Goroka and Megabo. All the volunteers from 2011 reportedly completed the 12-month programme, and several have stayed on as "Senior Volunteers", a new initiative, to support this year's (2012) intake. This year there has been a significant drop out rate, with only about 14 volunteers remaining in each of Kainantu, Goroka and Megabo, and only four women volunteers in each of Kainantu and Goroka. The high dropout has been attributed to the recent removal of school fees, meaning that some of the volunteers have now gone back to school, which in itself is positive. There has also been a bumper year for coffee harvesting and it is yielding a high price, and so more work has been available for young people.

In the final quarter of 2011, there were 64 volunteers working in the EHP area: Megabo: 13 men, seven women; Kainantu:12 men and six women; Goroka:13 men and 12 women. These numbers included POVs from previous intakes.

By programme completion, 180 volunteers will have entered the programme, and as many as 160 may complete it. Each of these volunteers has conducted many peer education meetings, ranging from one-on-one talks, to large group meetings. Data gathered by SC indicates the total reach of these peers each year is about 11,000 young men and women. Each of these peers spoken to as measured by 'total reach' has at least received information about safe sex, importance of clinical tests, and knows a person from whom they can receive free condoms.

Upwards of 14,000 condoms (male) have been distributed annually; fewer female condoms are distributed, but there are problems with continuous supplies of these which SC is trying to resolve.

Literature would suggest that hearing messages about safe sex from peers is more effective than from older adults. Youth spoken to in the focus groups and the settlements conveyed correct understandings of STIs and HIV.

This evaluation believes the programme to be effective, but acknowledges real outcomes and impact to verify effectiveness are not available without baseline and repeat KAPs.

Impact

YOP gathers the data on number of referrals that each volunteer makes to the health clinic associated with the programme. In Kainantu the referred clients attend the "White House" clinic on Mondays and Fridays, and in Goroka they attend the Lopi clinic. The numbers of referrals made is compared with the number of clients who actually attend the clinic. Volunteers then make an effort to track down the non-attendees and arrange to help them get to the clinic.

The number of YOP referrals which attended the clinics in the most recently reported quarter (Sept to Dec 2011) was 540. All data is disaggregated by gender.

When asked about risks to themselves if seen by the community as promoting sex, different responses came from men and women. The men tended to talk about repeating safe sex messages to these critics, whereas the women discussed their strategies around giving condoms discreetly from their own homes, and just talking to people one-on-one rather than having larger group meetings, or working in groups rather than alone. These young women said that although fathers might be angry to think their daughters were being told about safe sex, in fact, mothers approach the POVs and ask them to speak to their girls. Such meetings are undertaken privately.

It is very difficult to measure the impact of this programme in the community itself, without conducting qualitative research. The repeat of the first KAP survey conducted three years ago will contribute to this understanding. This is being conducted in the next quarter, as part of the MFAT grant, and will be reported in the end of programme report. POVs were confident the programme had had significant impact on their own lives.

Relevance

HIV/AIDS, STIs and early pregnancy are all significant health and development issues for youth in PNG. This programme is addressing these problems in an innovative and relevant way, and is in keeping with the National Health Plan, Child Health Plan and the National Strategic Plan 2010-2050. It is therefore highly relevant to PNG.

In the focus group meetings the community leaders spoke of the support they were providing to POVs, mainly through endorsing their activities and advising the community that the POVs were doing important work. Beyond this, there was little tangible evidence of support coming from the community. However, the YOP management team spoke of an indicator they have developed around the number of POV meetings that are called by community leaders and at which community leaders speak. This indicator is not in the current M&E, but it would be a useful one to include.

In a small group meeting POVs indicated they were convinced not only of the programme's relevance to their peers, but also to themselves. They said "We have gained respect from clients. We help them and later, after they have had tests, they hug us and thank us." These POVs also said that these young people who have tests at the clinics talk to their peers, telling them that they like the doctors at the clinics, and are treated with respect.

When describing the two-week training that takes place at the start of the YOP, these young men and women said, "It really changed us". They all agreed on this. They stressed the life skills they had gained, problem solving, personal character development, as well as information on STIs, gender based violence, drugs and alcohol and the risk all of these pose to the spread of HIV. So on this basis the programme certainly has relevance to the POVs' own lives.

There was no indication that training for the women POVs was different from that for the men. Given gender and violence issues in PNG, and the high rate of sexual violence and abuse, the women POV and their peers with whom they are engaging in the community, have quite different experiences of sexual and reproductive health and safety than their male colleagues and community peers. For this reason, the training should address gender issues in a more deliberate and focused manner. It is also recommended that greater safety and security measures are in place to protect the female POVs from any violence as they go about their work.

Efficiency

The fifth objective in the program is the efficient and effective management of the programme. Several activities have taken place to achieve this objective, including AusAID funded capacity building for the current manager when she was holding an acting management position. The programme and related programmes within SCiPNG have all had high staff turnover in the past three years of this programme, which has made completion of all the activities difficult.

However, the team is now full and stable, except for the appointment of a MELS officer.

In terms of efficiency, there are synergies operating within the YOP. For example, the POVs are able to refer their clients to clinics that have been developed under the PNG Sexual Health Implementation Program (PASHIP) and implemented by SCiPNG. The National AIDS Council provides free condoms. The MELS framework was developed under a capacity building AusAID fund, and this also benefitted the MFAT funded work in the YOP in Goroka.

The data collected from the clinics have been carefully matched to NDOH information systems so that no duplication occurs. The cross referencing systems to check on client uptake of referrals is simple and does not require any additional work by the staff at the clinics.

The manager of the programme reports good financial management systems within SCiPNG, with the provision of monthly financial reports to her in Madang. However, if she wanted to make any financial (or other) changes to the programme the process would involve these steps: request from Madang to Goroka, from Goroka to Melbourne, from Melbourne to SCNZ, from SCNZ to MFAT. Especially when there are people on leave, or positions vacant in that chain (as has been the case frequently over the past six years), it is a very long and time-consuming process. Therefore, the SC internal funding and reporting mechanisms may be an area that is less than efficient, but this evaluation has not investigated it further.

Sustainability

The long-term sustainability of this programme depends on two factors: financial support from donors for activities, supplies, and management, and community support for the POVs. Although the male community leaders spoke well of the programme, it was difficult to gauge whether this translated into actual support in the community. Activities being developed in the sustainability plan recently developed may well strengthen community support.

If the POVs view involvement with the YOP as a way of advancing their own career progression, this could help attract youth to leadership roles within the YOP. Therefore, a recommendation is made to further develop livelihood options within the programme for the POVs, such as the composting toilet, growing yams, and other ventures.

It would also be advantageous to keep a database of all the POVs so that positive career developments subsequent to, (and possibly as a consequence of) involvement with YOP could be tracked. This would demonstrate further effectiveness of the programme and could also be used to attract more POVs and garner more community support.

Furthermore, many of the POVs were keen to further develop their careers and undertake study in community development or social work. SC might consider linking its training into formal programmes with universities so that POV can gain credits for the work and training they do while in the programme. It might also wish to consider sponsorship for outstanding POVs to take on formal study.

Lessons Learned

ESWCHP

1. Community support, particularly involving women's groups and gender training, is an essential base on which to build a VHV programme. After the ESWCHP stopped focusing on women's groups in the communities, the VHVs started to lose their support from the communities, and ESCOW and others connect these trends.
2. All partners need to be treated equally to limit the impression that there are 'major' and 'minor' partners in the programme. Those who believe they are not treated equitably, especially with funding support for infrastructure development, may have a disincentive to meet their contractual requirements.
3. Contracts with partners should be signed and monitored with at least annual reviews and written reports on the contract implementation. Without documents outlining the obligations of partners, some of the more challenging responsibilities can be left unfulfilled.
4. Without a renewal of the contracts with the community on a regular basis, the communities start to overlook their responsibilities towards VHVs. This is understandable as communities may well have a high turnover of people on ward development committees or other responsible groups. Their new members need to be introduced to the arrangements.
5. SSEC believe that communities benefit from feedback from the VHV and health facility about their health trends. This can demonstrate the health impacts of reduced

violence, HI progress, better use of the VHV, and a constant supply of medicines and promotes further support of VHVs and health initiatives.

6. The goals and objectives of the ESWCHP were hard to measure without baseline data.
7. Much data has been collected throughout the programme, but it is only recently that it is starting to be fully analysed and published. The value of this analysis is now being realised to demonstrate the achievements of the programme
8. Literacy and numeracy training for the VHVs could be incorporated into their training so that they can better understand their IEC materials, and also any reports on health trends in their own areas.

YOP

1. The goal and objectives of the YOP were not measurable largely because baseline data was not available. The lesson is to either collect baseline data before programmes commence, or use objectives that do not rely on baseline data.
2. Because this programme is built on youth volunteers it is designed to have a fresh intake each year. However, some of the POVs continue to stay on the programme because they do not find employment, and want to make a useful contribution. There is a risk, as was seen in the two POV meetings, that over time resentment builds up and these POV believe they are being used (despite it being made clear at the start of the programme they are volunteers and will not be paid). SC might consider introducing a policy of forced disengagement after two years to stop this attitude developing and colouring other POV.
3. Community support from older community leaders is a key ingredient in having POV accepted in the community. Having community leaders call the meetings for POV to speak at is a successful initiative to promote the messages without discrimination against the POV.

Recommendations

ESWCHP

1 Promotion of New Zealand as a development partner in rural health

The New Zealand Government is presently supporting two large health initiatives in PNG – the ESWCHP and the Leprosy Mission’s work in Bougainville – both of which are using VHV networks to play a key role in the delivery of primary health care. These programmes provide New Zealand with an opportunity to present itself as a thoughtful and committed development partner in PNG, with a special understanding of health and health care delivery in rural areas. The ESWCHP is now undertaking a pilot study and carefully monitoring the costs and impacts of its VHV-based model of care in the province. It is undertaking this work now because of the imminent structural changes in PNG around delivery of rural health through Community Health Posts. It is recommended that New Zealand consider support of a new phase of this model of rural health care as it extends out to other provinces.

2 Whole-of-programme strategic support

SC receives funding from various donors to cover the costs of all the activities within the ESWCHP, and YOP. Each donor then requires M&E and reporting on those activities they fund, often within a specific template. As a result, SC is limited in the way it can report on the entire project, and each donor, (MFAT included) does not receive a report that captures the entirety of the work. Further, as there are synergies between various activities, narrow reports can sometimes fail to give the donor a good sense of how effective or impactful the project really is. An example with ESWCHP is that SCiPNG is likely to enter into a contract with the PSI (Population Services International) to deliver rapid diagnostic testing (RDT) for malaria and treatment with MALA-1, by VHVs. This will be an important development in the programme because it will demonstrate the functionality of VHVs and firmly integrate them into the health system as health care providers. However, under current funding and reporting arrangements, MFAT would not necessarily be advised of this development which will be testament to its investment in ESWCHP over the past 15 years.

A whole-of-programme approach would also enable SC to be consistent in the framing of all its work, rather than having to shape programme work according to the paradigm of the donor agency. In SC's case, this would allow it to use a consistent rights-based approach, in keeping with its stated mission.

3 Medical supplies systems

ESWCHP should meet as soon as possible with AusAID to gain a better understanding of the new system of medical supplies distribution, and to advocate for an integrated supply system which also acknowledges the need for and includes medicines for VHVs.

ESWCHP, taking into account, and working with, the NDOH future plans for medical supplies distribution systems, might also consider extending its medical supplies activities to help address the failing distribution of medicines throughout the province, especially down to health facility and (eventually) CHP level.

4 Research

There has been an enormous amount of data gathered by SC from VHV reports, at least since 1998. This data is rich with information about health in the East Sepik, the role of VHVs, their impact on disease trends and health facility use. It would be of benefit to SC, the Provincial and National Departments of Health, and to the broader health communities for it to be analysed, disseminated and used for advocacy and learning within the health and development communities in PNG and in other low resource settings.

Additional research and monitoring initiatives that need to be considered urgently would include:

- measurement of the impact of the newly introduced (parallel) models of medical supplies distribution;
- clinical quality of the VHVs and outreach (patrol teams) – contributed through the appointment of a clinical/health advisory role, see below;

- qualitative indicators to measure the acceptability of the VHV service to women and men in the community; and
- barriers to the use of health services for women, men and children

5 Advocacy to include all VHV data into PDOH/NDOH MIS

Further advocacy to the PDOH/NDOH to include VHV data is strongly recommended. The inclusion of the health information collected by VHVs is important to gain a full picture of health in PNG. Excluding this data will likely lead to a misinterpretation of health trends in PNG, as VHVs undertake more work in areas of serious disease, such as malaria.

6 Ward Development Committee training: needs to include contract renewal between the committees and their managing health agency (CHS or PDOH). Contracts need to include commitments and provisions for VHVs from the committees – especially the provision of a haus marasin and other incentives. Roofing iron, water provision, VIP toilet would be effective incentives, along with arrangements for collection of medicines, and additional soap for the VHVs. Importantly, WDCs need to include equal numbers of women and men on the committee, and each year the committee members should have gender training so men and women understand each other's' perspectives and needs for future planning.

7 Gender review / publish training materials

SC has throughout the past eight years developed and written many training manuals and designed various construction templates for wards, training centres haus marasins and so on. It would be of value to their own communities and others working in health throughout PNG to be able to share (and acknowledge) these tools. However, before doing so, it is important that the materials are reviewed by a PNG gender and health specialist so that the exercises provide women with a space to speak about their lives and health needs, and the ways in which the village could be improved to promote women and children's health. Following this exercise, SC should collate, update and publish these – and to integrate this activity into an advocacy campaign to support VHV integration into the health system throughout the country. Further these would make an effective contribution to the development of a modular CHW training programme (See Recommendation 11).

8 Appointment of a health / clinical quality advisor

SC should consider the appointment of a health/clinical quality advisor to monitor the quality of the services being delivered by VHVs and MCH patrol teams. After a short training period, and limited refresher training, it is very likely clinical errors are made by VHVs. This appointment would go some way towards measuring the real impact of their work, assisting their ongoing training, and limiting harm that could be done.

9 Rights-based approaches to programme work

Although SC states it is a rights-based NGO working for child rights and women's issues, this did not translate consistently into rights-based action (programme design, or M&E). Adopting one consistent rights-based approach to its work would have eliminated the many and various iterations of programme objectives, and the omission of children and women's rights, and the right to health, in the recent framing of the ESWCHP. It is

recommended that SC has rights-based training for all staff and adopts a rights-based approach to its programme design so that it develops consistency between its mission statement and its work. This training could also help SC operationalize other cross cutting issues such as designing and monitoring programmes to ensure children and adults with disabilities are included, and that gender based programming design always features.

10 Community self-reliance and gender training as the foundation of all work

Community support for the VHVs is essential for the sustainability of this programme. Villages that have active health development committees, and which have had gender training, and rights awareness workshops, appear to then have a decrease in violence against women, and provide more support to VHVs. Improving women and children's health requires addressing the underlying causes of poor health which include not just poor sanitation and water, but more systemic violence against women, abuse of children, and disempowerment so they are unable to remedy these problems themselves. Therefore, it is recommended that any a programme extension begins with communities training in HI/self-reliance with the strong involvement of women's committees.

11 Formalise training and upskill VHVs to become CHWs

SC continue its deliberations about working with training institutes and the Medical Council to consider offering a formal and academically accredited, modular-based training programme to interested VHVs to upskill them to become CHWs. The training centres in the districts could be used as the local venues from which the training could be provided, and together with modular approach, this would overcome the problem and cost of attending CHW training courses currently available. Such training could give VHVs a strong incentive to continue to provide services if they see a career path ahead, and the possibility of paid employment at some point in the future.

YOP

1 Develop a database of youth volunteers so they can be tracked in the future with a view to determining if participation in YOP results in future employment or positions of community leadership

2 More actively pursue livelihood options within the YOP for the POV in particular through the composting toilet opportunities, or growing yams as has been tentatively considered. This will assist in helping youth earn an income and develop further skills to progress their careers.

3 SC might consider linking its training into formal academic programmes so that POVs can gain credits for the work and training they do while in the programme. Gaining a formal qualification while working as a POV would be a valuable incentive for volunteers, and would also give increased credibility to the YOP.

4 Explore provision of scholarships into the Diploma in Youth Work which is commencing at Divine Word University in 2013.

5 Discourage POVs from remaining as volunteers for more than two years because with longer term services develop an expectation that they should be paid for their services.

6 Complete the proposed research on KAP and publish this so the programme has an impact beyond Goroka and PNG.

7 POV training must address gender issues in a more deliberate and focused manner, with opportunity to explore gender and violence and risk from women's perspectives. Greater safety and security measures should be in place to protect the female POVs from any violence related to the work they are undertaking.

8 Dropout rate of young women volunteers should be further investigated.



Figure 10 *Ornamented dancer in the welcome SingSing to SCiPNG*

Appendix A: Terms of Reference for the Evaluation

Terms of Reference for the Evaluation of **Save the Children New Zealand – Health and HIV/AIDS Programme**

Prepared by: MFAT IDG PNG Programme (Alicia Kotsapas & Steve Hamilton) and Save the Children New Zealand Overseas Programme Manager (Murray Boardman)

Final Draft Tuesday 9 March 2012

Overview

This document specifies the terms of reference for the evaluation of **Save the Children New Zealand – Health and HIV/AIDS Programme** (incorporating the East Sepik Women and Children’s Health Project and Youth Outreach Project).

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Purpose of the evaluation

These Terms of Reference (TOR) set out the purpose and approach for conducting the evaluation of the Health and HIV/AIDS Programme that Save the Children New Zealand (SCNZ) supports with funding from the New Zealand Ministry of Foreign Affairs and Trade (MFAT) (formally NZAID). The Health and HIV/AIDS Programme incorporates the East Sepik Women and Children's Health Programme (ESWCHP) and the Youth Outreach Programme (YOP). These activities are implemented by Save the Children in Papua New Guinea (SCiPNG), through a partnership with Save the Children Australia (SCA) who has the lead agency role. SCNZ manages the funding provided by MFAT through the New Zealand Aid Programme and contributes to the overall operations of the PNG Country Programme.

Given that New Zealand is due to cease funding for this activity in 2012 after a long-term investment (funding commenced in 1997) in the programme, an independent evaluation at the completion of funding is valuable for both accountability and learning purposes. An evaluation is a mandatory requirement under the New Zealand Aid Programme's Activity Operational Evaluation Policy¹.

The evaluation will assess the overall performance of Save the Children in delivering the key objectives of the Health and HIV/AIDS Programme (including ESWCHP and YOP) for the period of the current Grant Funding Arrangement (2009-2012). In addition, the evaluation will identify lessons learned and recommendations for both MFAT and Save the Children to advise any further engagement in the PNG Health Sector.

The Results of the evaluation will be reported and disseminated to relevant stakeholders including, but not limited to:

- New Zealand Government, Ministry of Foreign Affairs and Trade
- Save the Children (New Zealand, Australia, Papua New Guinea)
- Government of Papua New Guinea, Ministry of Health
- Provincial Health Department, PNG
- Field implementing Partners, PNG

Scope of the evaluation

The time period covered by this evaluation is 2009 to 2012 but the evaluation will be informed by a literature review that covers the whole period of the programme 1997-2012.

The geographic focus is East Sepik and the Eastern Highlands.

The target groups are those who the programme has been intended to benefit.

¹ New Zealand Aid Programme Activity Evaluation Operational Policy, effective 1 October 2011. Activity evaluations are a mandatory requirement for activities over NZD10,000,000.

The evaluation will consist of two parts:

1.Desk-based literature review for the period 1997-2012. The desk-based literature review will set the historical context, identify issues for the evaluation of current Grant Funding Period (2009-2012), and will inform the evaluation plan and structure of the evaluation, in particular the field visit. The literature review will include reviewing all available programme documentation (including but not limited to monitoring and evaluation reports). The review will be appended to the main report.

2. PNG-based field visit for the period 2009-2012. The field visit is expected to focus primarily on evaluating the current Grant Funding Arrangement period (2009-2012), and acquiring primary data where this is needed to fill in any gaps in the secondary data available.

Evaluation criteria and objectives

Criteria being assessed

The DAC criteria that will be assessed in this evaluation are:

- Effectiveness
- Impact
- Relevance
- Efficiency
- Sustainability

Objectives and evaluation questions

The objectives of the evaluation are to:

Objective 1: Assess overall effectiveness. Specific questions could include, but not limited to:

Was the intervention logic clear at the outset?

Was the intervention logic utilised for monitoring and reporting purposes?

Did Save the Children achieve the agreed goals, objectives and outputs?

Objective 2: Assess impact on health in East Sepik, Eastern Highlands and Madang. Specific questions could include, but not limited to:

What evidence is there that MFAT funded programmes have contributed to overall health impact in East Sepik and the Eastern Highlands at the individual and community level?

What has been the impact of the programme on the availability, access to, and utilisation of community health services?

Objective 3: Assess relevance. Specific questions could include, but not limited to:

What relevance does the VHV approach have as a priority both regionally and nationally.

Objective 4: Assess efficiency. Specific questions could include, but not limited to:

Has programme implementation been shown to be an efficient use of personnel, resources and funding?

To what extent has the programme provided value for money?

Objective 5: Assess sustainability. Specific questions could include, but not limited to:

How has the programme addressed sustainability (i.e. are the benefits of the programme likely to continue after funding from the New Zealand Aid Programme ceases? Why/why not?

Are local partners able to show functional capacity to implement activities?

What factors constrain or enhance project sustainability?

Methodology for the evaluation

Principles/approach

The principles underpinning this evaluation are strongly based on the various stakeholders working in partnership, and participation with community members, ensuring transparency and independence.

It is essential that the evaluation is independent in order to ensure objectivity in the assessment of achievements and impact, to provide accountability and lessons relevant to all stakeholders. The emphasis of the evaluation is to provide areas of learning, and critique, whereby effectiveness can be advanced in future programmes.

To ensure alignment with Save the Children child-right focussed development, it is essential the evaluation actively involves child participation. Where primary data is required, participation should be included as part of the data collection, survey design and analysis stages.

The consultant is responsible for presenting the findings, analysis and recommendations throughout the evaluation. In support of consultative participation, the consultant is expected to engage MFAT and Save the Children and other stakeholders as appropriate in the evaluation. The consultant will need to determine whether such involvement may influence the independence of the evaluation. Should issues arise, the consultant will need to raise these with MFAT and Save the Children who will agree resolution.

Evaluation Plan

The evaluation team will complete a desk (literature) review of the Save the Children Health and HIV/AIDS project (including ESWCHP and YOP) using documentation provided by MFAT IDG and Save the Children prior to developing an evaluation plan (using or being guided by the *Evaluation Plan Template*) outlining the detailed methodology for conducting the evaluation.

The Evaluation Steering Group is responsible for approving the evaluation plan.

The plan may need to be redrafted if it does not meet the required standard or is unclear. The evaluation plan **must** be approved prior to the commencement of any field work or other substantive work. The evaluation plan is to be appended to the main written report.

The intended results of the Activity/programme (i.e. the goal, outcomes and outputs) will be clarified and described in a Results Diagram (program logic, logic model) in the evaluation plan.

The evaluation plan will describe how cross-cutting issues (specifically gender) will be considered throughout the evaluation.

The evaluation will be constrained by limited time and budgetary constraints and this should be considered in the design described in the evaluation plan.

Team composition

The evaluation will be undertaken by a single evaluator with assistance from a local facilitator for the in-country fieldwork aspect of the evaluation.

The attributes (knowledge, skills, experience) required of the evaluator are:

- Evaluation for international development experience, including as the sole team member.
- Research, report writing and presentation.
- Experience working with civil society.
- Health sector expertise, in particular community health practices and issues in the Pacific context.
- Strategic planning, design and programme management skills.
- Some knowledge of Tok Pisin desirable.

Governance and management

The evaluation is commissioned by the Ministry of Foreign Affairs and Trade (MFAT), supported by Save the Children. The evaluator will be accountable to MFAT, through the appointed Evaluation Steering Group.

Oversight of the evaluation process will be the responsibility of the Evaluation Steering Group. Save the Children New Zealand, as a key partner, will be represented on the

Evaluation Steering Group and will contribute funding for the project as given in the Programme budget².

The MFAT PNG Development Officer is responsible for the day-to-day management and administration of the evaluation, including: contracting; briefing the evaluation team; managing feedback from reviews of the draft report; and liaising with the evaluation team throughout to ensure the evaluation is being undertaken as agreed.

The evaluator will be expected to complete a Save the Children Child Protection form and, where necessary, a police check.

² This budget will be used to support costs for field visit.

Outputs and milestones

No.	Output/milestone	Description	Inputs	Due date	Indicative payment proportion of fees or fixed price contract
1	Desk-based Literature Review and draft Evaluation Plan	Desk review/literature review for period covering 1997-2012, and draft Evaluation Plan	8 days	<i>(10 April - 18 April)</i> Wednesday 18 April 2012	
2	Evaluation Plan	Briefing and finalised Evaluation Plan	2 days	Friday 20 April 2012	10%
3	Field Work Complete	Field work complete and results provided to stakeholders during a stakeholder workshop	10 days in-country field work; 1 day for stakeholder workshop	<i>(23 April - 4 May)</i> Friday 4 May 2012	
4	Draft Report	Preparation of the draft report and submission to MFAT	5 days	<i>(7 - 11 May)</i> Friday 11 May 2012	45%
5	Final Report	Acceptance/approval by MFAT after any revisions of the draft are completed, and debriefing	3 days	Friday 18 May 2012	45%

Reporting requirements

The Draft Evaluation Plan is to be submitted by the evaluator to the Evaluation Steering Group for approval after completing the des-based review.

Copies of the Draft and Final Evaluation Report are to be delivered by email to the MFAT PNG Development Officer (Alicia.kotsapas@mfat.govt.nz). The final Evaluation Report (4 bound copies) should be couriered to MFAT, attention: MFAT (International Development

Group) PNG Development Officer. The Final Evaluation Report can include CD or DVD containing relevant data and associated analysis, photos, video and/or voice recordings.

The written evaluation report is expected to be around 50 pages long and be guided by the New Zealand Aid Programme *Evaluation Report template*.

The report must contain an abstract suitable for publishing on the New Zealand Aid Programme website. Instructions for the abstract can be found in the *Evaluation Report template*.

The evaluation report must meet quality standards as described in New Zealand Aid Programme Activity Evaluation Operational Policy. These quality standards are based on 2010 DAC Quality Standards for Development Evaluation and New Zealand Aid Programme Activity evaluation operational policy, guideline and templates. These standards are aligned to the evaluation standards expected by Save the Children.

The Draft Evaluation Report will be reviewed by MFAT staff, stakeholders and/or external experts. Further work or revisions of the report may be required if it is considered that the report does not meet the requirements of this TOR, if there are factual errors, if the report is incomplete, or if it is not of an acceptable standard. The Evaluation Steering Group will be responsible for approving the Final Evaluation Report.

It is MFAT and Save the Children policy to make evaluation reports publicly available (e.g. on the New Zealand Aid Programme website) unless there is prior agreement not to do so. Any information that could prevent the release of an evaluation report under the Official Information or Privacy Acts, or would breach evaluation ethical standards should not be included in the report³. The Final Evaluation Report will be approved for public release by the Deputy Director or Development Counsellor in the team responsible for the commissioning of the evaluation.

Relevant reports and documents

Relevant documents will be provided to the evaluation team prior to the evaluation. These key documents include:

MFAT

- MFAT/Save the Children Grant Funding Arrangement (2009-2012)
- MFAT/Save the Children Strategic Partnership Arrangement (2006-2009)
- All annual reports, and any additional monitoring and evaluation reports, associated with the above two arrangements, including the 2008 evaluation of the Strategic Partnership Arrangement.
- New Zealand Aid Programme Activity Evaluation Operational Policy and Guideline (October 2011)

³ E.g. consent must be given by participants if their names are to be included in the evaluation report.

- New Zealand Aid Programme Participatory Evaluation Guideline
- International Development Group Policy Guidelines
- New Zealand Aid Programme Screening Guide for Cross-Cutting issues

Save the Children

- Save the Children PNG Country Strategy Documents
- Save the Children Health Strategy Documents
- Save the Children Evaluation Plans
- Save the Children Sustainability Plans
- Save the Children Project Proposals

PNG

- PNG National Health Plan 2011-2020
 - PNG Child Health Plan 2008-2015
 - PNG National Strategic Plan for HIV/AIDS and STIs 2006-2010
 - PNG National Health Plan 2001-2010
 - PNG National Sexual and Reproductive Health Policy 2009
 - PNG National Report: Demographic and Health Survey 2006 (National Statistics Office)
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Appendix B: Evaluation Plan

Introduction

Background and Context to the Activity

An independent evaluation of Save the Children's Health and HIV/AIDS Programme in the East Sepik is taking place because New Zealand is due to cease funding of this programme after 15 years of support. The evaluation therefore has value for accountability and learning. It will also, through critique and the identification of lessons learned, advise on further engagement options in the PNG Health Sector, for MFAT, Save the Children and other interested parties.

Scope of the Evaluation

Although the focus of the evaluation is on an assessment of the latest phase of the programme (2009-2012), including the East Sepik Women and Children's Health Programme and the Youth Outreach Programme, such an evaluation requires a thorough understanding of the programme since its inception in 1997.

Purpose of the evaluation

This evaluation will assess the overall performance of Save the Children in delivering the key objectives of the Health and HIV/AIDS Programme, including East Sepik Women and Children's Health Project (ESWCHP) and Youth Outreach Project (YOP), for the period of the current Grant Funding Arrangement (2009-2012) with a geographic focus on East Sepik and the Eastern Highlands. In addition, the evaluation will be informed by a literature review that covers the whole period of the programme 1997-2012. The evaluation will identify lessons learned and recommendations for both MFAT, Save the Children and other interested parties to advise any further engagement in the Papua New Guinea (PNG) Health Sector.

New Zealand Aid Programme evaluation principles underpinning this evaluation

This evaluation will be conducted in partnership with Save the Children New Zealand (SCNZ), Save the Children in PNG (SCiPNG) and Save the Children Australia (SCA), as well as with MFAT, and the various partners in PNG. The latter include the Church Health Services, Provincial Department of Health, and other stakeholders as nominated by SCNZ. A partnership approach to the design of the plan will mean it will include questions that will be useful to all the parties, and will provide them with an opportunity to have their successes and challenges addressed. The evaluation will be transparent, and representatives of stakeholders and beneficiaries will have the opportunity to comment on any observations, findings and reports produced by the evaluator. Transparency will mean the evaluator will be honest about her decisions to speak to various stakeholders, one on one or in group situations, and will respect the participants' wishes regarding anonymity or otherwise. All participants will be named in the report, but specific comments will not be attributed if that is the request of any participant.

The evaluator is independent from all Save the Children agencies, but has worked extensively in PNG, so is able to provide contextual understanding and awareness of the complexities of working in PNG.

Objectives and Evaluation Questions

The evaluation objectives and questions are:

Effectiveness: has the programme achieved its own objectives according to its design documents informing the Grant Funding Arrangement 2009-2012?

Were the objectives and outputs well selected at the outset and could they be reported against?

Was the M&E framework adequate to gather this information as specified at the outset?
Are health services for women, men, girls and boys in the rural communities of East Sepik becoming more available, accessible, acceptable and of good quality?

Do stakeholders in PNG (partners, VHVs, women, children and youth) believe the programme has improved basic family health services to rural people?

Have women been empowered through the activities of this programme to be able to access health care for themselves and their children?

Is data collected in the M&E plan relevant to measure effectiveness?

Have achievements resulted that were not anticipated at the outset?

If any objectives have not been achieved what are the explanations for this, and what lessons can be learned?

Did all partners contribute to the effectiveness of the programme?

Have there been changes (positive and negative) in health and HIV/AIDS in these regions (East Sepik and Eastern Highlands) that are not directly attributable to this programme?

Which modalities or activities have been most effective throughout the long term programme?

Impact: Have more women, children and youth been accessing community health services in the areas where the programme has been operating?

Do the surveys and routine data collection (or other research activities) show a change in health service use and outcome as a result of this programme?

Can we measure the impact has this programme had on the overall health system (especially health workers, health facilities, health information, medical supplies, pharmaceuticals and vaccines, financing and governance) in these regions?

Were the activities in this GFA well selected to have an impact on health, and have they been well executed?

How do the Provincial and National Department of Health staff regard the impact of this programme and do they wish to see the activities continue – and if so, with what/any changes?

How do other providers of health programmes, especially maternal, sexual and reproductive health programmes view the work of this programme and do they wish to see it continue - and if so, with what/any changes?

Is the timeframe of this evaluation sufficient to determine impact, but there are suggestions impact will be observed before the end of the programme?

Were the recommendations of previous reviews and reports taken into account in the design of this programme so as to maximise its impact?

Relevance: Is this programme, especially with a large focus on the work of VHVs, considered relevant to the health needs of women, men, youth and children in the regions where it is operating?

Are the objectives of the ESWCHP well aligned with those of the PDOH and NDOH?

Is the programme in keeping with the National Health Plan 2010-2020 and other key national development strategies?

Is this programme considered too broad or too narrow to address the high health demands of women and children in remote communities in PNG?

Has enough attention been paid to gender issues and women's rights which are crucial in understanding women's health?

Are the VHVs being trained so that they meet the national guidelines on VHV competencies, and thereby integrated into the health system?

Do the Youth relate well to the objectives and activities of the YOP?

Are youth changing their health behaviours as a result of the YOP?

Efficiency: Has this programme used the funding for the programme in the way specified in the programme design and contract?

Were the activities selected for this programme the most best use of funding to achieve the overall objectives?

Has this programme demonstrated 'value for money' in its various components: eg, infrastructure development; have the people trained remained with the programme?

Have good financial processes been used in the field with contractors?

Have appropriate people been selected for training within the various components of the programme?

Once trained, are appropriate levels of support put in place to enable staff to efficiently undertake the work they have been trained to do?

Have the mentoring visits and ongoing support been sufficient to enable VHVs to work effectively and efficiently?

Are the staff and any other health workers trained as part of this programme provided with the means and support and encouragement to provide the quality of reports required by the programme?

Does the programme work effectively with other health care providers and educators in the regions where it is working to minimise duplication, promote the same messages, and align with the health system?

Is the YOP programme reaching adequate numbers of youth, and identifying youth leaders who can bring about change in their peers?

Have there been efficient flows of information from the project sites through to SCNZ and MFAT?

Has the flow of funds, and acquittal reports, been efficient for all partners?

Sustainability: Has this programme progressed towards achieving its sustainability plans?

Has the capacity of Church Health Services or the Provincial Department of Health been built sufficiently to take over the management and employment of the VHVs trained by SciPNG?

Are the VHVs trained to the levels of competence so that they are a good fit in the health system?

Are MOUs in place that oversee a gradual transition of programme, health workers, any other staff to the Provincial Department of Health or the Church Health Services?

Does the community, especially people in rural villages, regard the programme highly and want the activities and roles of VHVs to continue?

Have SciPNG staff been well trained in management, financial management, donor relations and grant writing so that they could continue to operate without the same level of financial support from MFAT?

What partnerships are seen as critical for sustainability of this project?

Do the Provincial Department of Health and NDOH want this programme to continue?

Have any of the VHVs' (or other health workers) training programmes been formalized with any academic or training institutions in PNG?

Are youth leaders showing the interest and capacity to take on management and leadership roles in the YOP?

Have the ongoing costs of ESWCHP been calculated so that partners understand the financial and other resource implication of the sustainability plan?

Has long term commitment from the East Sepik Provincial Government (ESPG) to provide resources for partners to support of VHV activities been agreed in contracts?

The objectives and/or evaluation questions have been expanded on from those specified in the terms of reference.

- Additional questions have been added into each of the above categories, but additional categories have not been added beyond those of the TOR

Stakeholder Analysis

Stakeholders can be categorised into these groups:

- Primary stakeholders: MFAT, Save the Children NZ, Australia and in PNG
- Secondary stakeholders: Church Health Services, including: Catholic, South Seas Evangelical, Seventh Day Adventist and Nazarene
- Provincial Department of Health, Wewak General Hospital, and the Local Level Government structure, the East Sepik Provincial AIDS Committee, village and ward leadership structures
- National Department of Health (area medical stores and senior management)
- VHVs – those trained and wanting to be trained by SC
- Women, men, youth and children in rural communities, those who have been beneficiaries of SciPNG programmes and those who have not

Each of these groups in further analysed in the table below:

This table shows the stakeholders and outlines their interest in the evaluation, any issues or constraints and their expected involvement.

Stakeholder	Interest/stake	Issues/constraints	Involvement/participation
SC agencies MFAT	Primary stakeholders Funder	SC and MFAT are the gatekeepers to participants and much primary data for this evaluation – their efficient support is essential for the success of the evaluation SC has invested heavily in this programme for over 20 years and may have a strong interest in wanting to have its successes demonstrated; The evaluator will need to ensure that selection of activities to view and people to meet are not misrepresentative of SC’s overall activities	Participate in the design of evaluation Participate in meetings in PNG Assist with facilitation of workshops / meetings in PNG Contribute to draft findings
Church health services	Secondary stakeholders	CHS have received support from SC as part of this programme, in particular through new infrastructure and trained VHVs; an issue may arise that they wish to receive further support and will present their most successful developments for evaluation	Included in meetings in PNG Opportunity to show new health facilities/wards/accommodation Inclusion at concluding workshop
PDOH, LLG, Wewak Hospital	Secondary stakeholders	High staff turnover in some levels of government could mean lack of people to meet who have knowledge of the programme Vested interest in maintaining programme to keep infrastructure development happening	Meetings with evaluator Viewing facilities/infrastructure provided by this programme Inclusion at concluding workshop

Stakeholder	Interest/stake	Issues/constraints	Involvement/participation
NDOH	Secondary stakeholders	<p>Staff turnover in NDOH could find it difficult to locate anyone with direct experience of this program</p> <p>The evaluator has limited time in Port Moresby, and this may restrict access to appropriate NDOH staff</p>	Meetings with evaluator
VHVs	Secondary stakeholders	<p>Many of these health workers are very remote from Wewak</p> <p>These VHVs may not feel at ease to speak openly with SC staff present</p> <p>Those who have stopped working as VHVs may not be available, and may have a lot to contribute (lessons learned)</p>	<p>One-on-one meetings</p> <p>Workshop if possible</p>
Women, children, youth, men	Secondary stakeholders	<p>Difficult to locate, especially those who have not been beneficiaries</p> <p>Language / translation issues</p>	Focus group (if time permits) – especially women’s focus group to discuss gender issues, women’s rights and access to acceptable healthcare
Young men, young women in YOP in Goroka and Eastern Highlands	Secondary stakeholders	May feel constrained speaking to an older foreign woman	Group discussion re their understanding and opinion re YOP, plus their advice for its future

Evaluation Design

Intended Results of the Activity

PROGRAMME LOGFRAME – RESULTS DIAGRAM (ESWCHP)

NARRATIVE SUMMARY	INDICATORS	HOW THIS IS USED IN EVALUATION
<p>Goal: Improved basic family health status in the rural communities in six districts of East Sepik with particular focus on women and children</p>	<ol style="list-style-type: none"> 1 Decreased child (<5) mortality rate 2 Decreased maternal mortality rate 3 Decreased morbidity 4 Number of villagers expressing a perception of improved health status. 	<ol style="list-style-type: none"> 1 The ongoing data collected by SCiPNG under the structure of the M&E plan will be analysed to determine whether these indicators show a positive trend in all the parameters monitored. 2 The reliability and validity of this data will be examined 3 Local stakeholders will be asked whether they believe the ESWCHP has been a significant contributor to any positive (or negative) trends in child and maternal mortality and general health (especially malaria) 4 Have any social determinants of health changed throughout this program, especially improved water and sanitation and people’s understanding of health seeking behaviour? 5 Is the M&E plan aligning with data and other findings of this evaluation?

NARRATIVE SUMMARY	INDICATORS	HOW THIS IS USED IN EVALUATION
<i>Objective 1: Improved basic family health services available to rural people.</i>	5 Increased utilization of VHV and HSC services in project areas 6 Number of villagers expressing increased satisfaction with health care services	1 Data collected through M&E plan and VHV reports will be collated and analysed for trends 2 Reasons for increased or decreased utilization will be sought from women, men, youth and children in rural areas 3 What specifically has improved or worsened? 4 Are services now available, accessible, acceptable and of good quality?
Output 1.1: Strengthened capacity of Health sub-centres	7 Increased number of staff houses 8 Increased number of new/improved maternity wards and outpatient wards 9 Increased number of training centres at rural health facilities 10 Increased/improved administration buildings for rural health agencies 11 Number of rural health staff certified by NDOH as VHV trainers 12 Number of HSC staff trained who have improved VHV mgt knowledge and competency . 13 % of total VHVs managed by the partners in accordance with agreed management performance standards. 14 Evidence of improved record keeping by RHS related to VHV referrals to health facilities. 15 Number of HSC dispensaries that meet 80% of medical supply SOPs. 16 HSCs are unable to supply agreed levels	1 In addition to M&E reports on these facilities, the evaluation will seek to find out if the staff houses are occupied and by staff working in child and women's health 2 Are the new or renovated maternity wards and outpatient clinics being used for the ESWCHP project? 3 Are the training centres being used for ESWCHP purposes? 4 Are administration building renovations or constructions contributing to improved health management and administration? 5 Does the data on VHV training, certification, management and record keeping align with VHV and community perceptions of their work and value? 6 Medical supply chain improvements (or not) will be used in this evaluation as a proxy for whether health system strengthening (or not) is one of the outcomes of the ESWCHP 7 Data analysis of the supervised deliveries, antenatal visits and TT vaccination will extend to the outcomes of those deliveries

NARRATIVE SUMMARY	INDICATORS	HOW THIS IS USED IN EVALUATION
	<p>of approved medical supplies to a VHV less than 5% of the time.</p> <p>17 Number of supervised deliveries by a trained health worker (CHW, NO, MD)</p> <p>18 Increased number of women making at least one antenatal visit to HSC during their pregnancy.</p> <p>19 Increased number of women having at least two TTs during their pregnancy.</p>	
<p>Output 1.1: Activities</p> <ul style="list-style-type: none"> • Development of health facility infrastructure for CHS partners • Partner training on standard dispensary management practices • Train partners to develop and implement an M&E program through baseline surveys and impact assessment of the HI work. ⁴ • Conduct joint workshops with PDOH to assist rural health agencies to apply for HSIP funds, especially for VHV related activities. 		<p>1 Is the infrastructure development being used by CHS for the purposes intended, and to desired effect?</p> <p>2 Are partners conducting M&E as per the plan, and using the data to analyse and refine programme activities?</p> <p>3 Have partners been successful in attracting funding to support VHVs and programme activities?</p>
<p>Output 1.2: Strengthened VHV program</p>	<p>20 Increased % of VHVs who meet the revised (2010) competency criteria</p> <p>21 Number of VHV referrals to health facilities</p> <p>22 Quality and quantity of community support to VHVs increased.</p> <p>23 % of VHVs for which nil stock of important medical supply items never exceeds one month.</p>	<p>1 Do VHVs feel confident that their training provides them with the skills to deliver quality health services?</p> <p>2 Does community support extend to acceptance that VHVs should offer family planning advice?</p> <p>3 What are the outcomes of the maternity referrals from VBAs or VHVs? (An indication of life-saving services being accessible)</p> <p>4 Are VHVs/VBAs satisfied with contents of birthing kits</p>

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NARRATIVE SUMMARY	INDICATORS	HOW THIS IS USED IN EVALUATION
	24 Family planning supply chain established and functional. 25 Number of new acceptors relating to family planning supplies and practices. 26 Every VBA has a birthing kit. 27 Number of VBA assisted deliveries at community level.	
Output 1.2 Activities <ul style="list-style-type: none"> • VHV TOT and Refresher sessions • Training for new VHVs • VHV enrichment sessions on HIV-AIDs, Child Rights & Gender • Workshop with partners on roles and responsibilities of VHV trainer and health staff • Partner staff training on VHV MIS • Set up VHV Information Management system among partner organizations • Monitor partner use of VHV MIS in all health facilities • Improved M&E plan re VHV related activities developed with key partners 		1 Are partners now delivering appropriate, acceptable, quality training for VHVs and how is this measured 2 Who is managing MIS, what is the quality of the data being collected and to whom does this data get sent 3 Does this data feed back into program reporting and program refinement? 4 Is there a good link between data collected from health workers and M&E data requirements?
Output 1.3: Improved coordination and linkage among rural health agencies	28 The PVHVTMC is well attended by partner staff Partners develop and submit their AAPs in a collaborative and timely manner and include VHV related activities. Number of VHV related partner activities funded by government sources. Save the Children handover and sustainability plans implemented. Partner commitments as per MOUs implemented.	1 Are all partners working from the same programme documents and therefore share common goal/objectives and reporting requirements?

NARRATIVE SUMMARY	INDICATORS	HOW THIS IS USED IN EVALUATION
<p>Output 1.3 Activities</p> <ol style="list-style-type: none"> 1. Develop sustainability plans in collaboration with each partner 2. Develop MOUs with project partners 3. Conduct pre and post handover/takeover assessment of partner management of VHVs and other programs 4. Conduct handover/takeover ceremonies of VHVs in each catchment 5. Strengthen PVHVMC and handover PCG functions to the PVHVMC in a stepwise manner 6. Advocate with Provincial and local level governments for VHV support. 7. Assist PDOH to be more collaborative in use of the Annual Activity Planning process. 		<ol style="list-style-type: none"> 1 Are partners familiar with and committed to the Sustainability Plan 2 What indications are there that funding for the work of VHVs will be channelled through from HSIP / GoPNG or other revenue streams? 3 Is the PDOH committed to this programme to the extent it has budget lines covering costs of activities? 4 Have the future costs of this programme been calculated – can they be explained? 5 Are regular meetings taking place with all partners to guide the process of handover of activities and other matters outlined in the sustainability plan?
<p>OBJECTIVE 2: Improved public health awareness and practices by rural communities in project areas, particularly regarding the health of women and children in selected districts.</p>	<p>29 Healthier village environment in project areas 30 Decreased incidence of woman and/or child abuse</p>	<ol style="list-style-type: none"> 1 What commitment is the PDOH making to “Healthy Islands” approaches to rural health? 2 Is Healthy Islands a concept that promotes the availability, acceptability and quality of the underlying determinants of health (water, sanitation, etc) 3 Have people in villages participated in the design, implementation and managements of Healthy Islands projects? 4 What role have project partners played in the design, implementation and management of the Healthy Islands

NARRATIVE SUMMARY	INDICATORS	HOW THIS IS USED IN EVALUATION
		projects?
Output 2.1 Healthy Islands program (HIP) implemented.	31 Active engagement by LLGs and other partners in the Healthy Islands Program. 32 VDCs are engaged in public health activities. 33 Increased knowledge in communities about the causes of common illnesses (malaria, diarrhoea etc). 34 Community public health action plans implemented. 35 LLGs enact by-laws in relation to public health issues. 36 Decreased incidence of malaria. 37 Decreased incidence of diarrhoea diseases. 38 Decreased incidence of skin diseases.	Are men and women in villages supporting and understanding the need for public health activities Is there a correlation between healthy villages and data collected by VHVs, including decreased infant and maternal mortality?
Output 2.1: Activities <ul style="list-style-type: none"> • Conduct CAP/HI TOT training of partner staff. • Assist church health partners to establish a Healthy Islands program. • 		
Output 2.2: Increased community awareness of rights related to vulnerable rural groups (women and children).	39 LLGs endorse the inclusion of child rights and women's issues in development of ward plans. 40 LLGs enact by-laws in relation to rights issues for vulnerable groups. 41 Increased number of women in VDCs. 42 Increased number of proposals from VDCs submitted to LLGs. 43 Increased allocation of LLG resources	Are women taking leadership roles in the ESWCHP project? Do women participate in village decisions regarding health care? Are women able to access reproductive health advice and treatment?

NARRATIVE SUMMARY	INDICATORS	HOW THIS IS USED IN EVALUATION
	<p>towards community programs.</p> <p>44 AWAs in selected locations are active in advocacy and rights issues.</p> <p>45 Rural people have increased knowledge about duty bearers, including themselves, in the health sector.</p> <p>46 Rural people have increased knowledge about how to seek help in the case of rape and violence.</p> <p>47 Rural people have a better understanding of child rights and women's rights.</p>	<p>Has the M&E plan collected data which would demonstrate a 'better understanding of child rights and women's rights'?</p> <p>What activities have been undertaken that would have provided 'better understanding of child rights and women's rights'?</p>
<p>Output 2.2 Activities</p> <ul style="list-style-type: none"> • Conduct provincial and district-level TOTs on Child Rights (CRC), Gender (CEDAW) and LPA. • Assist partners (ward members and AWAs) to conduct child rights and LPA awareness at community level • Support partners to conduct village based Who Does What workshops to ensure the VHDCs understand their role in public health activities. • Conduct Who Does What workshops re the Health Sector. • Conduct Who Does What workshops re abuse cases. 		<p>1 what has been the impact of these activities and workshop – have gender roles and analyses been used before during and after these workshops?</p> <p>How many of each have been conducted and how has their impact been assessed by SCiPNGa and partners?</p>

PROGRAMME LOGFRAME – RESULTS DIAGRAM (YOP)

NARRATIVE SUMMARY	INDICATORS	HOW THIS IS USED IN THE EVALUATION
Out of school and unemployed youth impacted by HIV epidemic are better able to protect, respect and realize their rights	1. X % of out of school and unemployed youth are leading a healthy and productive life	2.
PURPOSE:		
By 2014, reduce risk factors ⁵ for HIV transmission among out of school and unemployed youth ⁶	3. 10% of targeted youth (age 15 – 18 and 19 – 25) report experiencing reduced risk factors for HIV transmission 4. 10% decrease in incidence of HIV infection among 15 – 18 and 19 – 25 year old in the target areas ⁷	5. Has a baseline been established? Is there an M&E plan for YOP and is it being used? Youth, young women and men, will be asked throughout this evaluation to tell stories about changes they have seen as a result of this programme. They will be prompted to view this through a 'most significant change' lens. This qualitative approach to the YOP will add to reports on the programme which capture the

- _____
- ⁵ Risk Factors include: alcohol and drugs, STIs, stigma and discrimination, gender, no access to condoms, lack of information, no access to services, low literacy, lack of marketable skills, lack of employment opportunities, unsupportive environment, parents and communities don't support youth, violence (domestic and otherwise) etc.
- ⁶ Ages 15 – 18 and 19 - 25
- ⁷ Target areas are selected communities in Madang and EHP

NARRATIVE SUMMARY	INDICATORS	HOW THIS IS USED IN THE EVALUATION
		indicators.
1. By 2010, out-of-school and unemployed youth in Eastern Highlands and Madang Province have improved capacity and ability to protect themselves from and prevent the spread of HIV	1 10% increase of youth reporting correct knowledge and behaviour in prevention of HIV and STIs 2 10% increase of youth accessing HIV and STI services 3 10% increase of youth accessing condoms and relevant IEC materials	Are young women and young men actively participating in the program, providing information, services and IEC materials?
2. By 2010, out-of-school and unemployed youth in Eastern Highlands and Madang Provinces have improved access to and use of sexual health services.	4 10% increase in youth accessing sexual health services 5 50% staff at appointed sites report improved knowledge and attitude of youth needs 6 50% young people attending appointed sites report improved 'youth friendliness' and quality of sexual health services.	
3. By 2012 out-of-school and unemployed youth and future parents in Madang Province have improved capacity and ability to make informed choices and take positive action in their own development.	1 10% increase of youth accessing Youth Friendly Centre services (by age and sex) 2 75% planned YFC sessions conducted successfully 3 # youth reporting positive life changes	4 Do positive life changes indicate less violence against young women?
4. By 2012, out-of-school and unemployed youth and future parents have improved family, community and stakeholders' support in Eastern Highlands and Madang Provinces, with regards to sexual and reproductive health and personal development.	7 50% increase of youth reporting parent and community support for volunteer activities 8 50% increase of parents and community of volunteers reporting support for youth activities 9 Increased number of youth participating in planning and evaluation of stakeholder activities	10 At face value – ensuring gender disaggregation – are parents allowing young women to be involved Are women equally participating in planning and evaluation?
5. By 2012, YOP has effective and efficient	11 All YOP staff implementing performance	15 At face value

NARRATIVE SUMMARY	INDICATORS	HOW THIS IS USED IN THE EVALUATION
program management and delivery systems.	management techniques according to agreed timeframes 12 All volunteer managers implementing adapted performance management techniques with their volunteers according to agreed timeframes 13 M&E data plan implemented 14 40% staff participating in project exchange and external learning opportunities	
6. By 2012, YOP incorporates SCiPNG cross-cutting issues into programming and delivery.	16 Indicators to be developed during operationalisation planning for Country Strategic Plan	17 Will this be a participatory exercise with young men and young women

Information Collection

This table shows what information will be collected and how.

Question	Information required	Information source	Method
Objective 1: Effectiveness: has the programme achieved its own objectives according to its design documents in this phase?			
1. Were the objectives and outputs well selected at the outset and could they be reported against	Monitoring report Annual reports VHV reports	SCNZ / SCiPNG	Data analysis
2. Do stakeholders in PNG (partners, VHVs, women, children and youth) believe the programme has improved basic family health services to rural people?	Opinions from stakeholders	CHS and other partners in PNG PDOH VHVs Rural women Youth	Meetings Focus groups Workshops
Objective 2: Impact: Have more women, children and youth been accessing community health services in the areas where the programme has been operating?			
1. Do the surveys and routine data collection show a change in health service use and outcome?	Indicators include attendance at health clinics VHV data on diagnosis and treatment	Monitoring reports SCiPNG	Data analysis
2. What impact has the programme had on the overall health system in the East Sepik?	Monitoring reports Perspectives from health workers / managers	SCiPNG PDOH / CHS VHVs	Data analysis Meetings Focus group with VHVs
Objective 3: Relevance: Is this programme considered relevant to the health needs of women, men, youth and children?			
Are the objectives of the ESWCHP well aligned with those of the PDOH and NDOH?	National and provincial health plans 2010-2020	Published documents (National Health Plan) Or meetings with PDOH managers	Document analysis and comparison Discussion
Has enough attention been paid to gender issues and women's rights which are crucial in understanding women's health?	Perspectives from health workers Perspectives from women in rural areas	Health workers Women	Meetings Meetings and/or focus groups

Question	Information required	Information source	Method
Objective 4: Efficiency – has this programme used the funding in the way specified in the programme design and Grant Funding Arrangement ?			
Were the activities selected for this programme best use of funding to achieve overall objectives?	GFA Annual reports Previous evaluations Perspective of primary and secondary stakeholders	MFAT SCNZ SCiPNG Partners	Document analysis Meetings with all stakeholders
Have appropriate people been selected for training within the various components of the programme	Evidence of good selection processes using consultation with community and partners Perspectives of health workers/VHVs who have been trained Perspectives of partners	Annual reports from SCNZ SCiPNG Health workers /VHVs Partners	Document analysis Meetings with health workers Meetings with partners
Objective 5: Sustainability – has this programme successfully implemented its sustainability plan?			
Has the capacity of Church Health Services and PDOH been built to take over the management and employment of VHVs trained by ESCWHP?	Data on training courses / capacity building exercises Evidence of capacity – eg, monitoring reports or grant applications written by these partners Perspectives of CHS and PDOH Perspectives of SCNZ / SCiPNG	Monitoring reports Annual reports – From SCNZ, SCiPNG	Document analysis Meetings

Detailed Description of Evaluation Methods

1 Data or document analysis

This evaluation will be informed by an M&E plan which governs the collection of data for monitoring purposes. Much of this data is a quantitative measure of the use of inputs and activities that have been made by the ESCWHP – e.g., community use of health centres, VHV activities and so forth. The various documents that will be used (annual reports, monitoring reports, budget acquittals, PNG National Health Plan 2010-2020) provide a sense of trends from which we develop a picture as to whether more health services are being provided, to whom, where, and at what financial cost.

The YOP will also be assessed using data and document analysis to determine whether in the first instance it is meeting its own quantitatively determined outcomes (e.g., 10% reduction in incidence of HIV infection in youth in target areas).

SCiPNG data on focus groups and other participatory work with children will also be analysed to determine who children view the impacts, or experience this programme.

2 Meetings with SCiPNG staff and partners

Building on the data analysis, we then require qualitative methods to better explore the meaning of the data. Meetings with SCiPNG staff and partners will provide the opportunity to learn whether they believe the programme design continues to respond well to local needs, children's rights and women's rights. Development is a process of change, and programme designs can quickly be out of alignment with the situation on the ground. These meetings will enable the primary and secondary stakeholders to comment on whether the data as it is presented in reports conveys a full understanding of programme achievements. For example, if vaccination rates of children have remained stagnant, is that because the information and education programme isn't taking place, or did the medical supply and cold chain fail.

In particular, these meetings will explore whether these stakeholders value the programme, believe it is effective, efficient, relevant, impactful, and what it will take to become sustainable.

One on one meetings provides an atmosphere of security in which comments can be made that a person could not make in a more public setting – especially if their anonymity is assured.

YOP evaluation will also include one on one meetings with SCiPNG staff, and youth working on the programme. These will explore the effectiveness, efficiency, impact and relevance of the programme, and whether the monitoring reports and meetings produce similar findings about this programme.

3 Meetings with VHVs and health workers

Similarly, one on one meetings will be conducted with VHVs and other health workers who have been trained by the ESCWHP. Women in PNG are not empowered and often find it difficult to speak in a public meeting, so having one-on-one discussions is important. These meetings might also enable them to speak about some of the problems they encounter in this programme, such as resistance within the community to 'western' medicine, and contraception or advice on sexual health.

They will be asked to comment on trends revealed in the monitoring reports: eg, more women attending a health centre could mean rural women have received information and education about the value of receiving health care and trust the health workers in the health centre. But it might also mean there has been an outbreak of disease in the area. It is only through discussion with health workers that sense can be made of raw data.

Gender issues will also be raised in these discussions, especially to explore whether the ESCWHP has focused adequately on understanding the specific gender issues that prevent women and children accessing health care, or requiring more care – especially violence against women.

Further, they will be asked whether they believe the programme has the balance of activities right to address women and children's health. For example, if women cannot travel to a health clinic without their husbands' permission, has enough attention been paid in the programme to educating men about women and children's health.

VHVs and women and young people in villages will be encouraged to tell stories so that a narrative analysis can be undertaken, looking for evidence that ESWCHP and YOP has had an impact on their lives and health, and health seeking behaviour.

4 Focus groups

This evaluation will conduct three different sets of focus group meetings:

- With young men and women who have worked/are working in the YOP (possibly in one mixed gender group, or two single gender groups depending on advice from the young men and women) in the Eastern Highlands.

The purpose of this focus group is to engage with youth to elicit their attitudes to the effectiveness, impact and relevance of the YOP programme. A group meeting will also provide the opportunity to see whether leadership qualities, confidence, respect for women and communication skills are emerging in YOP workers. Their views on the future of the programme will also be sought. Further, this age group is likely to be more forthcoming when surrounded by their peers than in a one-on-one with an older foreign person.

- VHVs

This focus group is being held so that more views of key people in the ESWCHP program can be sought than would be possible otherwise. The information being sought in this focus group will pertain especially to understanding the value of VHV refresher training, their difficulties in delivering health care to women and children, systems failings that make their work harder, gender issues that make their work harder...and how ESWCHP has addressed all these factors in either the program design, or subsequently.

Issues such as their management being transferred to other partners will also be raised.

Their views on the future direction of the programme to best meet women and children's rights will be sought.

- Women, men and youth/children in rural villages

These focus groups (in single gender groups) will explore people's attitudes to VHVs, health centres, and women and children's rights, including right to health. Specifically, the focus groups will encourage people to discuss (when appropriate) the value of "healthy islands" initiatives in their villages, as well as generally if they consider that health of women and children has improved as a result of any of the activities the ESWCHP. They will be asked about impacts of the programme – both intended and unintended. Issues of access, acceptability and quality will all be raised.

Again, a focus group is one way of hearing the opinion of many people in a short time frame, as well as giving women and children an opportunity to speak in a public meeting.

5 Stakeholders workshop

At the end of the field visit a workshop with primary and secondary stakeholders in which the initial draft findings of the evaluation will be presented to participants. They will be asked for their opinions on these findings, as well as to consider elements of the program which the evaluation may have missed.

Again, the theme of this workshop will be to assess the five objectives of the evaluation: the effectiveness, efficiency, impact, relevance and sustainability of the ESWCHP. Findings relating to each of these objectives will be presented, and the participants strongly encouraged to add to the evaluator's understanding of the programme's overall contribution to women and children's health in the East Sepik.

Data/Information Analysis

Quantitative data where important for the evaluation will be entered directly into the evaluation report (e.g. VHV's saw xx,000 women in xx health centres in 2011, an increase of x% on the previous year...)

Notes will be taken throughout all meetings and at the end of each meeting, the key messages from that participant will be clarified with them. As soon as practical after each meeting the notes and summary of key messages will be added to the evaluator's file. Analysis of these meetings will be done by categorisation of the participant into the relevant stakeholder group (e.g. SCNZ staff, or VHV, or SCiPNG partner, etc), and repeated themes will be noted as they emerge. For example, if two of every three VHV's say women are not allowed to visit a VHV without their husband's permission, then this would be flagged as an issue that might need additional support in any future programme, and a lesson learned could be that more attention needed to be paid to gender relations, power and women's rights in programme design.

Where some issues are raised by a few people, but not at all a majority, these will be raised in focus groups and the final workshop for further discussion.

The focus group meetings will have key points noted during the meeting, and then a summary of the issues and range of opinion fed back at the conclusion of the meeting. A similar process of writing up afterwards and identification of emerging themes undertaken.

The workshop will be a more formal presentation, and feedback to the findings will be minuted.

The evaluator will at times be needing a translator, but will still follow the same process.

The evaluator will be transparent about the numbers of people interviewed and participating in all events, and how many times or people gave voice to opinions that led to final recommendations.

Cross-Cutting Issues

Gender: Gender is a key determinant of health in PNG. Women and girls are subject to power imbalances, violence, rape, and poor health outcomes as a result. Statistics from PNG show alarming rates of violence against women and girls, which inhibits their ability to participate fully in their communities, to freely access health care and health information. As a cross cutting issue in this evaluation there are several ways in which gender will be considered: all data from health services is collected by gender and will be reported by gender; the gender of all participants in the evaluation will be stated in the report; women and girls will be encouraged to participate, and will be given private places to speak to the evaluator because their voice is less likely to be heard in public meetings. Single gender focus group meetings will also be held to hear women's and men's opinion on sensitive subjects such as health and reproductive health. The evaluation will specifically consider whether the programme design was sufficiently gendered, and whether a project targeting the improvement of women and children's health had sufficient participation of women in its design. Did the design take into account the full context of women's lives, lack of power, and violence against them, and consider how these elements would affect women's access to quality health care? Has the programme had any success in changing men's views on women and children's health and access to health care.

Similarly, in the YOP, are these gender issues shaping the programme so that young women are able to live healthier, productive lives?

Human rights: the framing of this evaluation is rights-based. It is looking at the ESWCHP and the YOP as programmes that are supporting the PNG Government's duty to respect, protect and fulfil people's right to health, as well as women's right to security and freedom from harm, and children's rights. Rights-based approaches to development programmes employ key human rights concepts such as participation, non-discrimination and equality, information, and progressive realisation. In the context of Save the Children's work in PNG, this should mean that women and children were active participants in all stages of the programme design and implementation, and monitoring. That the services being provided are accessible, available, acceptable to all people, including the poorest and most marginalised. Accordingly, monitoring on the programmes should demonstrate these rights-based duties are being fulfilled.

Disability: This is another cross-cutting theme which is particularly important in the PNG context of a health programme. Women and children with disabilities are the most impoverished and marginalised in most communities. This evaluation will be looking for evidence that the rights of access to services and information for people with disabilities were considered in the design, implementation and monitoring of this programme.

Environment and climate change: Throughout the evaluation, the impact of the programme on the environment will be considered, especially in terms of the infrastructure components. That is, have the buildings been constructed in ways that were environmentally appropriate, and was adequate attention paid to water and sanitation issues in all aspects of the programme. This is also a feature of the Healthy Islands initiatives and so the evaluation will look to ensure that the broader environmental aspects of health are mainstreamed through every aspect of the programme, including the disposal of medical supplies and other waste. Climate change is likely to impact on the East Sepik in ways such as flooding. Not only should the programme be endeavouring to minimise its carbon footprint, but it should also be mitigating the impact of such events. This would include have emergency and evacuation policies at all its facilities.

Ethical Considerations

All participants will be advised by the evaluator or her translator that the purpose of the meeting is to evaluate the ESWCHP and YOP programme, and that they are free to participate or not. Further, that their name, position and any information they provide will not be used without their consent. If they consent to their name being added to the list of people consulted, then the evaluator will write their name on the log sheet which they will sign. Direct quotes will not be attributed to a specific person in the report, unless that person expresses a wish to be directly quoted. As this evaluation will not be published beyond the MFAT website, ethics approval through an academic institution will not be sought.

Participants will be assured that their participation per se will in not affect their employment status with SCiPNG or any of its partners. They will be advised that this

evaluation is of the final phase of the ESWCHP, and that the emphasis is on lessons learned.

As mentioned above in the gender section, great care will be taken to provide private meeting spaces for women in the evaluation. However, women in PNG who have participated in research on sexual and reproductive health have later been subject to violence from partners who believed their participation was inappropriate. Therefore, this evaluation will be careful not to put pressure on any women to participate if they are at all apprehensive about doing so. Furthermore, if a woman's husband insists on attending the meeting, that will be permissible.

The evaluation will ideally include conversations with children – boys and girls. These will be conducted in the presence of parents or guardians if the children are less than 16 years old. The children will not be named in the report to protect their privacy and security.

The evaluator has spent a considerable amount of time in PNG previously, but not in the East Sepik, and so will look to SCiPNG staff to guide her in appropriate cultural behaviour.

Limitations, Risks and Constraints

This table outlines potential or actual risks, limitations and constraints.

Risk/limitation/constraint	Likely effect on evaluation	How this will be managed/mitigated
Time constraints	It will be unlikely to manage to meet all people as planned, and hold as many focus groups as ideally required	Some phone interviews or email communications could be used with key stakeholders if meetings are not possible
Language barriers	Because of the rich diversity of languages in PNG there may be some village people and VHVs with whom it is difficult to communicate	A tok pisin translator from SCiPNG is being arranged, but she may also have difficulty in some languages. Further translators may be used locally, but if a reasonable understanding cannot be reached it is better to find people who do speak tok pisin or English

Risk/limitation/constraint	Likely effect on evaluation	How this will be managed/mitigated
Security issues	PNG has insecurity and violence which can erupt at political and personal levels. Areas can become inaccessible in a flash. Such events could stop access to a site that was planned to visit, in which case alternatives would have to be arranged as best as possible.	Personal security precautions will be followed to mitigate exposure to any danger.

Feedback of Findings

As discussed in the Section on data analysis, at the end of each meeting, the key points from the meeting will be confirmed with the participant and an indication given as to how that information will inform the overall evaluation.

There will be ongoing communication with SCiPNG staff at a senior level, with almost daily opportunity to discuss the findings as they start emerging. It is hoped this process will also guide further investigations and help with interpretation.

At a formal level, there will be a final workshop where the draft findings will be reported, and feedback on these will go into the draft report.

All primary stakeholders, including MFAT and SCNZ, will be expected to provide verbal and written feedback on the draft report.

Documents to be Used in the Evaluation

MFAT

- MFAT/Save the Children Grant Funding Arrangement (2009-2012)
- MFAT/Save the Children Strategic Partnership Arrangement (2006-2009)
- All annual reports, and any additional monitoring and evaluation reports, associated with the above two arrangements, including the 2008 evaluation of the Strategic Partnership Arrangement.
- New Zealand Aid Programme Activity Evaluation Operational Policy and Guideline (October 2011)
- New Zealand Aid Programme Participatory Evaluation Guideline
- International Development Group Policy Guidelines
- New Zealand Aid Programme Screening Guide for Cross-Cutting issues

Save the Children

- Save the Children PNG Country Strategy Documents
- Save the Children Health Strategy Documents
- Save the Children Evaluation Plans
- Save the Children Sustainability Plans
- Save the Children Project Proposals
- Save the Children Annual Reports

PNG

- PNG National Health Plan 2011-2020
- PNG Child Health Plan 2008-2015
- PNG National Strategic Plan for HIV/AIDS and STIs 2006-2010
- PNG National Health Plan 2001-2010
- PNG National Sexual and Reproductive Health Policy 2009
- PNG National Report: Demographic and Health Survey 2006 (National Statistics Office)

Timeline

This table shows the timing of key activities and deliverables.

Key activity	Deliverable (output)	Timing
Document review / planning with MFAT and SCNZ	Draft Evaluation Plan	18 April 2012
Document review, incorporating feedback	Final Evaluation Plan	20 April 2012
Field visit, meetings, evaluation	Draft Evaluation Report	24 May 2012
Incorporating feedback	Final Evaluation Report	31 May 2012

Appendices

Appendix A: Questions for Interviews or Focus Groups

This appendix contains lists of questions that will be asked in interviews or focus groups for the different stakeholder groups.

Interviews with SCiPNG

Is the ESWCHP improving the health of women and children in the East Sepik?

Are there some elements of the programme that are more successful than others, and if so, why?

Is the M&E plan collecting data that is useful to the programme here in PNG, and how could it be made more so?

Is the sustainability plan helping guide the transition of activities to other programmes?

Is the end of the programme support from MFAT (New Zealand) having unexpected consequences (staff insecurity, difficulty with partners?)

Were the findings of previous evaluations used to help shape the next stage of programmes? Eg, gender issues, or infrastructure planning?

Are there programme activities taking place that are not included in the GFA with MFAT? Have they developed after the GFA was signed or did they not fit with the objectives of the GFA?

Are there some partners who are weak in this programme? What is the impact of this?

Do you think the activities are strengthening the health system in East Sepik?

What are the weakest parts of the programme and how might they be strengthened?

Have women had sufficient involvement in all phases of the programme?

Interviews with CHS and other partners with SCiPNG

Has the ESWCHP contributed to improved women and children's health in the East Sepik?

What have been the greatest benefits of the ESWCHP to your own programmes in this region?

Do you have an agreed workplan and programme design document that guides your work with SCiPNG?

Are the buildings that ESWCHP provided to your programme being used for the activities as originally agreed?

Do you think the activities of the ESWCHP have been the best ones to improve women and children's health?

Are there written MOUs or contracts between your programme/organisation and ESWCHP governing buildings, staff, VHVs, and reporting requirements?

What parts of the health system (if any) is the ESWCHP helping to strengthen?

Are any ESWCHP trained VHVs now being managed by your own programme and if so, is this working effectively?

Have you calculated the ongoing costs of managing VHVs?

Is your programme continuing with training, refresher training and mentoring visits of VHVs?

Do you intend extending the VHV programme into other districts or provinces?

Have you applied for any funding / grants to help cover these costs, and if so, from whom, and with success?

Has your programme had support from ESWCHP to improve reporting and information systems?

Does the work of ESWCHP fit well with your own programme of health activities?

Are you actively involved in "Healthy Islands" villages and what does this mean in terms of your activities

Do you want the ESWCHP programme to continue to provide any support for your programme/organisation after 2012?

Interviews with VHVs and other health workers

How were you selected to become a VHV?

Did your community support your selection?

How long was your first training and when this was completed did you feel confident to work as a VHV?

Do you feel more confident now than when you completed your training?

Do you feel confident about making diagnoses and referrals?

Do you enjoy being a VHV?

Where do you provide your service from? Does it have water, sanitation, soap?

When women and children need to be referred to a doctor, how does this happen?

Did you leave the course with the equipment and medical supplies you needed to provide a quality service for women and children? What is in your birthing kit?

Are you now supported in your community? In what ways?

Are you able to provide women with any family planning advice or treatment (condoms, etc)?

Can you do this openly or does it have to be kept secret from men? Do you get any problems because of this service?

How often do you have visits from supervisors? Do you want more?

Do you ever run out of essential medical supplies?

What are the biggest challenges in your job?

How do you keep your vaccines cold?

Are you able to complete your reports on time?

Do you get feedback on your reports?

Is your village a "Healthy Islands" village? If so, or if not, what does this mean for VHVs?

Appendix B: Questionnaires for Distribution

n/a

Appendix C: Checklists for Participant Observation

n/a

Appendix D: Workshop Details

This appendix provides details of workshops that will be held, and the focus of the workshops.

i. Eastern Highlands YOP workshop

Description	Workshop to gain a rapid understanding of the successes and challenges of the YOP programme in Goroka
Participants	Boys and girls aged 16-25, Eastern Highlands
Focus	Youth understanding of sexual health and HIV/AIDS and how they perceive this programme

ii. ESWCHP feedback workshop

Description	Stakeholders in the East Sepik will have the opportunity to respond to the initial findings of the evaluator
Participants	SC, CHS staff, PDOH and Wewak Hospital staff
Focus	Presentation of initial findings of the evaluation inviting their comments and additional inputs

Appendix C: Literature review of SCNZ programme 1998-2012

Review of documents for the Evaluation of Save the Children Women and Child Health, and HIV/AIDS programme, Papua New Guinea

May 2012

The East Sepik Women and Children's Health Programme (ESWCHP) is a well-known and longstanding health initiative in Papua New Guinea (PNG). It began in the 1970s as a project of the East Sepik Council of Women (ESCOW) – an NGO that still exists as a village-based women's organisation in the East Sepik Province (ESP).

Save the Children UK provided financial support for the project activities in the 1970s and 80s as ESCOW responded to women's calls for basic health services [Cox and ESCOW] quoted in (Spratt 2003). They established a system of Marasin Meri (MM) (medicine women) who were volunteers nominated by villages to be trained in basic health care. The MM system was for a short time integrated with the National Department of Health's primary health care project that had attempted to create village health development committees (ibid). However, according to Cox and ESCOW the MM project eventually dissolved in the late 1980s because of institutional failings, lack of support, and the training of men as MMs. A parallel programme started in 1984 by the United Nations Fund for Population Activities (UNFPA) disseminated contraceptives and family planning advice. The project used Community Based Distributors (CBDs) to conduct the activities, similarly on a volunteer and community supported basis. However, this project also folded in the late 1980s, reportedly because of poor management and support (Spratt 2003).

In 1992 Save the Children New Zealand (SCNZ) was approached by both ESCOW and UNFPA to help revive and support these discontinued initiatives, but there was reluctance by UNFPA to allow SCNZ to include the activities of MMs and CBDs into one project. Finally in 1995 SCNZ began its project work, focusing on MM support with Elizabeth Cox appointed as the programme manager.

A key feature of this programme from its initial conception in the 1995 revival, and continuing through to its current phase, has been its intent on working with the National and Provincial Departments of Health, other partners and the community to ensure that the MMs were integrated into the health system while being supported by their communities.

There have really been four phases of the ESWCHP, although the documentation consistently refers to two phases, and this report will stick with convention and do the same. But to clarify:

- There was an initial phase prior to 1995 when the project existed but did not attract any (government) overseas development assistance. This period was summarised above.
- Phase One (1995-1998) is the period in which NZ Official Development Assistance (NZODA) began. Although Phase One is referred to as ending in 1998 in SCNZ records, NZODA made no such reference in its documentation and it continued to provide financial assistance in between Phases One and Two. It states in a document to the Minister

of Foreign Affairs and Trade in 2004: From 1999-2004, \$1,200,747 was provided to Save the Children NZ in annual grants of between \$200,000-350,000, "to address the problems of inadequate health services in rural areas of East Sepik Province by training and supporting volunteers that then provide primary health care, antenatal care, family planning services and referrals".

- Intermediate Phase (planning for Phase II) – 1998-2004
- Phase II: (2004-2012) Achieving Sustainability

There have been three contract periods in Phase II as follows:

- The first funding component of Phase II was from 2003-2006 (although funding was from 2004-2005) - \$NZ 4,236,442
- 2006-2009, during which time the programme was structured as a Strategic Partnership Arrangement with the Government of PNG, NZAID and SCNZ (K13,200,000)
- 2009-2012 – a Grant Funding Arrangement between NZAID and SCNZ (K14,382,539)

Therefore, in total, not allowing for currency fluctuations and some variations on contracts, the overall funding support for this programme since 1998 until 2012 has been about \$NZ 20 million.

Phase One: NZODA support

When SCNZ first sought official development assistance from the New Zealand Government in 1997 the project had the following partnership arrangements in place: the Provincial Department of Health (PDOH) provided specialist training, referral access from MMs to primary and secondary health care, as well as medical supplies and some contraceptives; The Church Health Services assisted with specialist training; and ESCOW, through its women's groups, encouraged leadership from women and generally mobilised the community to provide support for the project, although this was apparently less successful than hoped.

"Village women volunteered and were trained for two different roles. Marasin Meris were responsible for primary health care. Community Based Distributors counselled couples in family planning and distributed contraceptives. Later CBDs also received training as Village Birth Attendants (VBAs) which enabled them to attend births in the village and refer women (with) complications" (Spratt 2003). These women were chosen carefully, and it was important that they had some education, a supportive husband and were nominated by the entire village. The community also had to commit to building a haus marasin (medicine house). Villages most remote from health services were especially targeted to join the programme.

The districts selected for inclusion were:

- Angoram – population 31,031 in 113 communities, mainly only accessible by river;
- Ambunti: population 6,870 in 28 communities, mainly only accessible by river;

- Maprik: population 14,378 in 39 communities;
- Wosera-Gawi: population 13,954 in 40 communities.

By 1998 when a review of the programme took place, a total of 324 volunteers had been trained in 163 villages. It was found the MMs were generally working well, but the CBDs were having difficulty countering communities' anti-contraception attitudes. However, there were many health system, community, and underlying determinants of health that were presenting obstacles to achieving greater success.

These can be examined from the six building blocks of the health system as defined by WHO (World Health Organization 2007): health services and facilities; human resources; financing; medical supplies and pharmaceuticals; health information; and management.

- 1** Health services and facilities: Infrastructure (health centres, aid posts, staff housing) were lacking or severely run down in the districts;
- 2** Human resources: the MMs and CBDs were not receiving the supervision and mentoring and lacked confidence, exacerbated by lack of community support for them in the ways it had first been envisaged. For example, the community was meant to include provision of meals and gardening help for the MMs but this was not normally forthcoming. "Villages that were most supportive were those with a women's group with strong leadership and with acceptance from both men and women" (Spratt 2003).
- 3** Medical supply systems for provision of medicines, birthing kits, and contraceptives were very weak
- 4** Information systems: communication was an enormous problem and there was little information flowing to or from the NDPH
- 5** There was no funding support for this project from the national health system and so it was easily overlooked
- 6** Management at national level was weak, and there were also management problems at project level with rifts developing between ESCOW and ESWCHP, with "a misunderstanding over roles and expectations" (ibid).

Furthermore, underlying determinants of health, such as clean water and sanitation, were lacking in most villages.

Despite the difficulties both in the programme itself, and with a high staff turnover at management level and general discontent, the work continued. However, there appears to be an absence of a guiding design document from 1998-2002, as one which was drawn up was not supported by staff, and not all its activities took place. In some ways then, the achievements of this period are all the more remarkable.

The 2003 Programme Implementation Document for Phase II notes the following achievements.

In 2002 SCNZ had 380 Village Health Volunteers (VHVs) (MMs, VBAs and CBDs were now collectively referred to as VHVs) active in 220 villages, serving a total population of 66,233. (Therefore only 56 more VHVs were operational than seven years earlier, in 57 more villages.) In 2002 48 per cent of the population in the East Sepik was aged under 16 years, and average life expectancy at birth was 48.9 years for males and 49.5 years for

women. Income levels in the districts were very low ranging from less than 20 Kina to 100 Kina per year per person.

In 2002 VHVs conducted over 84,000 consultations. The VBAs assisted with 391 deliveries and the CBDs made around 5000 consultations every month. The CBDs provided information, contraceptive pills and condoms.

The VHV consultation data was collected monthly and collated into annual statistics, which also enabled analysis of main diseases experienced in the district (presuming VHV diagnosis was correct). Malaria was the most commonly recorded disease, with over 17,000 cases recorded in 2002.

That same year a four-week full time refresher training was provided to 390 VHVs (noting this is more than the total number of VHVs said to be in service). In-service training of VHVs was provided with groups of five spending one to two weeks at a rural health facility getting practical experience.

Key lessons learned from the period 1995-2002 are summarised in a Project Design Document for Phase II, written in 2002 (Dowton and Ashworth, 2002).

Program management: implementing VHV programs in remote rural locations is inherently difficult, invariably time-consuming and inevitably frustrating, requiring high degrees of professionalism in development management, design and implementation...

Inclusiveness: community awareness activities should encompass entire communities and be representative, embrace traditional social structures and be undertaken on a continuous basis. Excluding particular groups either intentionally (men from family planning) or inadvertently (traditional leaders) can undermine community support and jeopardize project objectives

Improving knowledge and changing attitudes and practices in rural PNG communities is essential to achieving improvements in health indicators. It is, moreover, a long-term, gradual process requiring persistence with continuous, appropriate health education programs

Continuous in-service training is critical to the success of VHV programs and rural health sub-centres operating in remoter rural areas with inadequate transport routes and poor communication

The importance, complexity and resourcing implications of operational issues, invariably compounded in PNG rural areas by broken physical infrastructure, enervating climates, rough terrain and the 'unexpected', should not be underestimated.

There is no way of verifying the accuracy of these records or of the diagnoses. Indeed, with so little training having been given to the MMs, combined with no access to pathology labs to confirm diagnoses, and frequent stock outages of essential drugs, the impact of their work was impossible to assess.

In 2002, NZAID also summarised key lessons from its support of the project to this time. These included: that the impact of the project was not known, although they suggest the monitoring data would indicate it had had a considerable impact on the access of rural

communities to primary health care, "which is very likely to have led to improved health status". It also stated the project is aligned with NZAID's focus on poverty elimination, and furthermore has a strong gender focus, and works with the communities." It said it could not comment on cost effectiveness, and expressed concern that evaluations were based on SCNZ reports. Further, "like many projects in the PNG programme, support for this project has been opportunistic rather than strategic..."

SCNZ and NZAID had agreed to enter into another phase of the programme, during which an overriding aim was to make the ESWCHP sustainable by transferring it to the East Sepik health system. A "Sustainability Concept Paper" was produced after consultation with stakeholders.

In 2003, SC described its work in PNG as designed to "achieve lasting benefits for children within the communities in which they live, by influencing policy and practice based on its experience and study in different parts of the world" (Toki 2011). Further it stated its commitment to making a reality of children's and women's rights. With this mission driving the organisation, it developed a rights-based approach to the design of the second phase of its work in PNG.

The consultations, which were quite extensive and included over 160 VHVs and 500 village women and community leaders, as well as ESWCHP, PDOH and CHS staff. Particular attention was paid to women, especially pregnant mothers and young children, who were identified as the most vulnerable groups in rural communities.

The consultations revealed the following problems:

- 1** Health facilities and services: lack of access to formal health services; maternal and infant mortality remained high; maternal and child health clinics were not functioning well and immunisation rates were low;
- 2** Human resources: VHVs felt inadequately trained
- 3** Health information: there was a lack of health education and awareness in the villages especially around safe motherhood, family planning, disease prevention
- 4** Medical supplies: stock outages were common

Underlying determinants of health: poor sanitation and polluted water remained a problem in most villages.

Communities did not support the work of the VHVs

Despite this, the VHVs remained committed to serving their communities and support to integrate the programme into the church health services was strongly supported.

Other strong rights-based components of the design process by SCNZ included a health system analysis and integration plan. Phase II was informed by a detailed understanding of the national health system, and importantly in the East Sepik province, it included the relative contributions of the church health providers. It recognised the weaknesses of the health system, especially those relating to supervision and communications, lack of good management, policy and planning, deteriorating facilities, and health worker shortages and lack of capacity. The program was designed to integrate with the health system and included a table showing how this engagement would take place (Save the Children NZ-Australia 2003, p24).

In March 2004, NZAID provided funding up to \$349,747 as an interim measure to June 2005 to ensure the programmes activities could continue until the Phase II programme was due to commence in 2005.

Phase II – Sustainability

Phase II was described as aiming to strengthen the rural health care system in East Sepik through a multi-pronged approach that focused primarily on developing capacity with the CHS in rural areas and PDOH. "The Phase II design is built on strategies to achieve sustainability and efficiency in all facets of rural health care."

Total Phase II funding request from SCNZ was for a total of \$10,174,723 to the end of 2011 (eight years). This was a ten-fold increase on the previous seven years' expenditure by NZAID of just \$1.2 million.

2004-2007 –\$4,236,442 (\$400,000 was to be a separate and additional contribution through the PNG Health Sector Improvement Programme Trust Account – a multi-donor Sector Wide Approach (SWAp) account mechanism)

2008-2011 – \$5,938,281

(It is interesting to observe that the funding levels increased after the initial request from SCNZ.)

SCNZ wrote the funding application, the Programme Design Documents and Programme Implementation Documents, which were then reviewed by the NZAID Programme Manager and an NZAID health specialist, both of whom visited the programme as part of the review process. They recommended an extended period of funding to allow for a handover period during years five to eight to the PDOH, and an overall reduction of the funding in years one-three by \$1.5 million to rationalise the infrastructure expenditure.

NZAID agreed to support this initiative, 2004-2011, based on the following:

- 1 A merging of this project into the SWAp over the next five years with increasing funding being channelled through the HSIP Trust Account over that time
- 2 That SCNZ/NDOH enter into a Partnership Agreement based on the guidelines laid down in the National Policy on Partnerships in the Health Sector for PNG
- 3 That the project continue for an interim three year period, but that infrastructure costs are dropped by approximately 20-30 per cent per annum
- 4 That initially \$100,000 of the ESWCHP project budget for the next FY (increasing in later years) be channeled through the HSIPTA and be used for operating and not infrastructure costs
- 5 That ongoing support for the project be subject to the following conditions:
 - a. A review of the project and its future funding requirements after two years
 - b. The development of a documented and agreed exit strategy (agreement that Phase II in its extended form over 8 years is the exit strategy)

- c. The inclusion, within the already approved budget, of an integrated and improved data collection mechanism that captures data from the project and from church and government services

Analysis of programme support Phase II, 2003-2006

The overarching goal of Phase II was to provide the VHV programme long-term sustainability by embedding it in a permanent East Sepik health institution – namely, the Church Health Services (CHS). VHVs were to be integrated in the health system, by connecting them to the health centre (HC) and health sub centre (HSC) level throughout the districts.

The CHS was selected because they were part of the permanent health system and report to the Provincial Division of Health, but had a history of being more efficient, effective, and service-oriented than the government service. It was recognised however that CHS would require institutional strengthening to be able to support this added service, and report on services delivered according to the monitoring and evaluation requirements.

PHASE TWO LOGFRAME (2003)

The Logframe for Phase II included the following long-term goals or outcomes, each with verifiable indicators:

- 1 Improved basic family health within East Sepik rural communities
 - a. Changes in key family health, especially maternal and child health indicators
 - b. Changes in family attitudes (and practices) towards family planning and health prevention
- 2 To put in place an integrated, effective and sustainable quality basic family health care delivery system in rural East Sepik
 - a. Evidence of the management, operational and monitoring systems being in place and fully functional
 - b. Evidence that the integration of the ESWCHP and CHS rural health system has been achieved
 - c. Evidence that the integration of the PDOH Aid Post system and the CHS rural health system into a unified rural health delivery system has been achieved
 - d. The flow of funds is adequate to meet the needs of the rural health delivery system
 - e. Evidence of core health programmes operating effectively
 - f. Evidence of positive perceptions of the beneficiary communities of the adequacy and quality of the rural health service
- 3 Outputs/results
 - a. Improved infrastructure and staff capacity among key rural health service providers especially CHS
 - b. Improved policy planning, financial administration and management capacity and integration within and among key health sector providers, programmes and activities

- c. Improved funding and delivery of quality basic family health services to East Sepik rural communities
- d. Improved community knowledge of factors contributing to poor family health and community support for and ownership of rural health programmes

Components of the Phase II program were originally conceived as:

- 1 Institutional capacity building – which was entirely infrastructure development (office facilities, health buildings and staff housing, transport and communications, 4WD vehicles and boats) taking 63% of proposed funding. In total 64 buildings were to be constructed.
- 2 Human resource development, which included training midwives as well as for project staff to plan, manage finances and report – 4% of the budget
- 3 Curative and preventative health care: including strengthening malaria control, improving child immunization, safe water, birthing kits and re-starting family planning activities – 14%
- 4 Community self-reliance in health care: to promote community based projects aimed at promoting health village life. – 2%
- 5 Staff salaries and management – 17%.

An MOU between Stakeholder Agencies was agreed in July 2004 and it stated that the ESWCHP was a 'joint program owned by Save the Children, the PDOH, the Church Health Services, the VHV's and their communities in rural areas. It is also agreed that these stakeholders are in a collaborative relationship aimed at improving the rural health services in East Sepik'. NZAID and the NDOH were included in the MOU as partners, with their inputs specified. SCNZ and Save the Children in PNG (SCiPNG) were the agencies managing and implementing the programme.

A transition sub-project period from July 2004-June 2005 was put in place to provide even more time to set up the inclusion of HSIP (Health Sector Improvement Program) into the Phase II programme, and to design the long-term programme. The stated objective of the sub-project was to ensure that the ESWCHP would be well poised to begin Phase II by equipping the project with an implementation plan, appropriately located and equipped office facilities, tested and client approved prototype building designs and adequate capacity to liaise with Church Health Service in rural health facilities.

A review was conducted in late October 2005, and this resulted in a re-working of the goals and objectives of the programme. By the time the 2006-2009 funding agreement was reached, the ESWCHP had been reframed so that it then focused on 'themes' – these being NGO capacity building, HIV/AIDS and health (see below).

Strategic Partnerships era

NZAID in its early years (2003-2005) had developed a strategy to work in partnership with NGOs, recognising NGO capacity to work effectively with grassroots organisations to alleviate poverty. This strategy informed the design of the contract between SCNZ and NZAID covering the period 2006-2009, and it also promoted the enthusiasm of NZAID to include SCNZ as the first NGO to participate in the HSIP.

However, this approach was difficult to put into practice. By June 2005, the programme was still waiting on the NDOH to sign an agreement for additional HSIP funds beyond the Transition Project to be committed to the ESWCHP. The difficulty was in part getting meetings with senior management in the NDOH, and the acquittal processes experienced by SCiPNG during the transition period were challenging. The funds required to meet acquittal processes were sometimes as great as the cost of the actual activities due to be acquitted (eg, paying for an HSIP officer to visit a construction site).

The project report Jan-June 2005 stated: Transition project funding was mainly through HSIP funds, a process that required us to comply with HSIP controls and procedures. Also, as the first NGO to access HSIP funds we had to collaborate with NDOH to test out new funding mechanisms...Accessing NZAID bilateral funds through HSIP has been more challenging and to date (June 30) we have not been able to draw down any of the K800,000 allocated for the current phase of ESWCHP.

The 2005 opening of a maternity ward in Kunjigini by the NZ High Commissioner gave him the opportunity to visit the area. He commented that the project was important and acknowledged its successes and hardworking staff. However, he raised three problems:

- 1 The centralised funding system was failing to get resources out to the provinces and hospitals
- 2 Many women volunteers lacked community support. He had raised the issue of providing an allowance for VHVs with stakeholders but it was decided instead to boost public recognition of their work. He suggested this might need to be revisited.
- 3 Church's attitude to contraceptives – but agreed this could be worked around.

He concluded: "all in all this was a timely visit that should allow NZAID to feel confident that the project is going well, that difficulties are being addressed in a positive way, that working relationships are good and that NZ ODA funds are being put to good use in bringing basic health services to Sepik people that would otherwise receive very little" (Laurie Markes, email to MFAT, 2005).

In early 2006 ESWCHP was also considering a response to the HIV/AIDS situation and had a workshop with other NGOs and it considered its best approach might be to extend its Poro Sapot Project (PSP) – the Youth Outreach Project was in a phase of development.

The first mention of any specific HIV/AIDS initiatives in SCNZ's work in PNG was raised in February 2006. SCNZ proposed to NZAID that they support an HIV/AIDS project, which AusAID had turned down. SCNZ stated that it was appropriate to fund because HIV/AIDS was a development priority for NZAID. In an email response, NZAID stated, "we agreed that we would like to work towards a strategic partnership (funding arrangement) with SC generally, (containing key themes, HIV most probably being one of them – this could include the East Sepik work, PSP and other PNG NGOs that you're working with.) How this works is that we would fund against 'your' 3-5 year strategic plan for the whole of PNG – and then we would agree on priorities to fund within the strategic plan".

However, there is no evidence that this approach ever developed any further. Instead, specific project activities within all of SCNZ and SCiPNG's overall programmes were funded, and reported against.

Throughout the first few months of 2006 there was much correspondence over the development of the second funding cycle in the eight-year programme covered by Phase II. The purpose of the programme was at this time stated as: To put in place an integrated, effective and sustainable quality basic family health care delivery system in rural East Sepik.

The initial funding request at the start of correspondence was for 5,899,126 PGK for three years, but by the time the negotiations were concluded some months later, this had increased to 10,800,000 Kina. The final amount agreed on signing was 13,200,000 Kina. Included in this amount was SCNZ management fee of 10%, and 2.4m Kina which was to be transferred to the programme via the HSIP mechanism.

In May 2006 a Program Implementation Document for the second funding cycle (2006-2009) was submitted. It had the following changes to scope, which it explained were the result of "the evolution of SCiPNG, the HIV/AIDS epidemic, the onset of the European Union – Rural Water Supply and Sanitation project and the strengthened focus on gender related issues". (As it transpired, SCiPNG never received EU funding for rural water and sanitation projects. However, one of its partners, SSEC did, and as a result there is now a small dam feeding water to some of the Healthy Island villages in the Brugam district.)

Finally in August 2006 a new agreement was signed by NZAID and SCNZ, covering 2006-2009, and this was framed as a tripartite Strategic Partnership Agreement with the Government of PNG (GoPNG) as the third partner. However it took until October 2007 before the GoPNG signed because they couldn't see what their role was.

The logframe had changed significantly from that in the 2004-2006 period, and even from how the programme was spoken about as recently as a few months earlier. Rights-based approaches were described as the overall framing of the work.

The first theme goal (NGO capacity building) was: To enhance the capacity of civil society in PNG to effectively design, deliver and manage large complex development projects with a child rights focus.

Second theme (HIV/AIDS): to mitigate the negative impacts of HIV and AIDs among young people and PNG's most vulnerable groups

Third theme (health): to improve the health of vulnerable groups in selected regions of PNG.

Within these themes, there were still 'components' that corresponded to the first contract, plus an additional one covering healthy villages. It was quite a complex way of framing and reporting on the programme. The budget took up 14 pages of the contract, and was further divided into a summary of recurrent and capital (developmental) expenditure, and to add another layer, the overall themes were summarised into two elements for the ESWCHP: "to put in place an integrated effective and sustainability quality basic family health care delivery system" and "to incorporate principles related to gender, HIV and AIDS and Child Rights in the design and delivery of our own and our implementing partners' projects". To add one final layer of complexity, the monitoring and evaluation, at SC's

request, was based on a child rights methodology of achieving change and measuring the impact of the change.

Despite the changes in framing, it appears the work still focused predominantly on training VHVs to provide basic health care in the remote villages of the East Sepik province. Reports provided to NZAID throughout the period demonstrate an ongoing and ever increasing volume of work being conducted by these VHVs. The ESWCHP received about 66 per cent of funding, the Youth Outreach Programme (in the budget for the first time) was about 18 per cent, and ESWCHP "women's empowerment" had its own budget line, of around 5 per cent of total budget. (Management fees made up the remaining 10 per cent.)

Gender and the ESWCHP

In 2006 a Gender Advisory Support project reviewed the ESWCHP. The rationale for this review was to honour NZAID's commitment to provide technical support and to spend time with grassroots communities involved in each project to ensure that both men and women and boys and girls benefit from increased access to health care and other health-related services.

It made the following comments and recommendations: "once an explicit goal of gender equality and women's empowerment disappears, the focus on ensuring women's issues is lost and with it the focus on the need to support the core people in this project – the women providing critical health and development services at the most distant ends of a network...The result has been a preoccupation with formal health or development issues and the demise of issues related to gender equality and women's empowerment." The review stated that in the Phase II intervention strategy, the absence of women in the project is obvious from the outset...The project goals are to improve basic family health but do not explicitly refer to women as being the core of the project both as women are the major health care providers as well as being critical for sustaining improved livelihoods. It is no surprise then that the purpose of the project has no reference to women's empowerment" (Underhill-Sem and Peutalo 2006).

The following recommendations were made:

1. Addressing gender inequality and promotion women's empowerment must be explicitly mentioned in the core aims of projects...they cannot just be an add-on.
2. Project staff, beginning with project managers, must have gender skills training from a human rights perspective
3. Place the empowerment of women back into the core aims of the project. Rework the project implementation plan to ensure the empowerment of women is made explicit.
4. Return to using the terms marasin meri and marasin man to describe the grassroots health care workers, instead of 'voluntia'
5. Ensure regular and complete replenishment of medical supplies even if this means another budget line as a fall back for shortages
6. Expand the basic medical kit to include materials for personal hygiene (bath soap, clothes soap, bleach) as well as for night work (lamps and fuel)
7. Pay more attention to advocacy activities such as negotiating and updating village contracts; liaising with grassroots health care providers regarding personal issues (illnesses, threats from community, family strains); translating operational

- challenges into policy frameworks at provincial and national levels; and liaising with related development activities in the province (eg, rural water supply, transport and communication infrastructure)
8. Address gender equality and women's empowerment issues within the organisation by closely examining work practices around hiring, capacity building, up-skilling and re-skilling
 9. Work more closely with other development NGOs in East Sepik in order to leverage better development services from donors
 10. Reward grassroots health care providers with service awards presented in their communities
 11. Work more closely with other development NGOs in East Sepik to ensure other cross-cutting human rights issues are addressed, especially HIV/AIDS and violence against women.

The ESWCHP report submitted to NZAID in April 2006 (on period July-Dec 2005) commented on advocacy for increased support for VHVs in their communities. No response to the gender recommendations appears to have been made by SCNZ at that time.

The PID for 2006-2009 however did focus on some of the gender review recommendations, namely: training management staff on gender issues; entrenching women's empowerment into the goals and aims of the project documents; incentives for VHVs and advocacy for community support for VHVs and networking with NGOs in order to advance women's rights and cross cutting issues.

The programme planned to use a consultant in 2006 to assist them to design women's empowerment activities (which had attracted 5 per cent of the programme funding). A new output was introduced into the programme: Output 5: Empowerment of rural women strengthened through recognition of VHV contributions and increased networking among local women's groups and NGOs. But this gender focus was essentially still an add-on, rather than gender being a key element of all aspects of the programme –it was being allocated to just one output. Furthermore, by the time the Strategic Partnership Agreement was signed, it was no longer in the documents.

A review of the proposed Strategic Partnership program in 2006 flagged that it needed to make clear how much of the budget was 'development' and how much 'recurrent', because without this information, it was not possible to assess sustainability.

It also stated; "the ESWCHP project has only partly addressed the recommendations of the NZAID Gender Report...The recommendations they appear to have NOT taken up relate to the re-insertion of women's empowerment as an explicit goal of the project, the return of the names MM and MM and the expansion of the medical kits to include personal hygiene items."

SCNZ responded that they had no issue with the recommendations of the gender review, and had re-inserted an explicit goal for women's empowerment. In the revised PID, the goal was, at this time, changed to "to improve basic family health, safe motherhood and rights of women and children within the East Sepik rural communities". It also stated the term MM was not aligned with rest of health system, and government would not add the hygiene components to the VHW kits.

However, as seen above, the stated objective of the ESWCHP in the contract was: "to improve the health of vulnerable groups in selected regions of PNG", and more specifically, "put in place an integrated effective and sustainable quality basic family health care delivery system". Women's empowerment, women and children's rights, were absent in the objectives.

Reframing, re-formatting and reporting difficulties

At programme level in PNG there were many staff changes, as there were with SCNZ and NZAID. This resulted in on-going re-formatting and re-framing of reporting methods.

General reporting and financial reporting problems have featured throughout this programme and from the documentation on file, it is particularly difficult to match funding flows against activities. In part this arises from underspends which result in some allocations then being held back until needed, but this then means there is a mismatch between the tranches as specified in the original contracts, and the actual funds dispersed. There have also been several interim funding allocations (bridging contracts) to give the programme additional time to complete activities, or to design a new phase before new contracts, or next annual activities agreed. This is not unusual or unexpected in such a large programme that covers so many years, but it makes calculation of the total expenditure and its acquittal difficult.

Comments made by NZAID in March 2008 are an example of the reporting difficulties: "my main comment is that reporting was focussed perhaps too much at the activities/outputs level. Though it is of interest exactly what has been done during the year (and I'm not necessarily suggesting this is cut back) it would also be useful to have some more direct reporting against expected outcomes and indicators at the objective level."

Throughout 2008/09, communication between NZAID and SCNZ was addressing the formatting of the workplan and its links to budget rather than the content or progress of programme itself. The difficulties for SCiPNG in accessing its funding through HSIP continued, and it was also proving very difficult for NZAID to get responses from HSIP, and to include them on any evaluations of the reports or the programme itself.

NZAID made these comments on the budget report in 2009. "It is difficult to complete a thorough analysis of this budget because NZAID is not the only donor, and SCNZ only submit a budget to NZAID for the specific activities which they wish us to fund. For example, in comparison with the 2007/08 budget it seems that many core operational costs such as salaries, rent, etc have apparently been omitted in 2008/09. We realise that these omissions don't necessarily mean the expense no longer exists – it may be that SCNZ no longer seeks NZAID funding for it, or that costs have been dealt with differently... however, we can't completely rule out the possibility of SCNZ error. The potential enquiry involved in investigating every such instance would be inconsistent with the high level nature of the partnership, so an aggregated, high level approach has been adopted with specific questions for a limited number of items of significance." Further it was noted that the budget was inaccurate – up to 92,640 K omitted in error. Similar budgeting errors were found in this literature review of various different budgets throughout the history of the programme.

NZAID documents mention on various occasions that the strategic partnership approach was looking for deeper, longer and more effective ways to engage in development and in partnership with countries. There was a sense of frustration that despite being called a Strategic Partnership Agreement, in essence the ESWCHP remained a project-based series of activities that NZAID supported.

Comments of the draft report of the 2008 review from NZAID included that they had been trying to get SCNZ to move towards a "more integrated country programme, and the Strategic Partnership was a kick-start for that. They [NZAID] wanted a more overview type report of all SCNZ's work, higher level."

All the partners accepted that the tripartite partnership lacked clarity. NZAID commented "We need to look closely at the current and intended nature of our partnership in the future and whether it fits within the framework of a Strategic Partnership as it is now defined by NZAID."..."We aren't sure that it's realistic to expect various branches of NDOH (and other parts of GoPNG) to engage SC on the programme as suggested and certainly not on a frequent basis. ..."

In 2008 SAVE introduced a new way of measuring its impact, was a global SAVE framework. These paragraphs from NZAID's review are instructive:

"The SAVE alliance has introduced a global approach to measuring its impact. This framework is based on UNCROC [UN Convention of the Rights of the Child]...and encompasses five 'changes' which are laid out in the report. No other information is provided regarding when this framework was introduced, how Alliance members are expected to integrate it into current monitoring systems, or how SCNZ or SCiPNG has done or intends to do this. The report states that it will capture progress towards changes at impact and outcome levels within the three themes, but it is not clear what the indicators are at this level, and much of the narrative seems to address inputs. The 'changes' under which achievements are discussed for each theme use different language from the five dimensions of change and are not explicitly linked back to them, nor to the workplan objectives." It should be noted however, that as stated above, these impact measures were in fact written into the Strategic Partnership Agreement – so they had in fact been agreed to by NZAID in 2006.

A midterm review of the second funding round (the Strategic Partnership Arrangement) was undertaken in 2008. The recommendations encouraged a less rushed approach to the development of the final contract to cover the years 2009-2012, with greater clarity around the roles and benefits of the programme to all the partners. The review recommended improved monitoring of business practices, construction processes, and greater attention paid to VHV refresher training. It also suggested that

"SCiPNG considers how best to address the lack of village support for VHVs, for example, by piloting gender training for leaders in some villages where VHVs practice. SCiPNG considers surveying VHVs with a view to understanding why only 57 percent of those trained remain active." It also referenced the ongoing problem with provision of medical supplies.

Health system strengthening outcomes from 2006-2009

Throughout this three-year period, progress towards strengthening the health system, and realising children and women's rights, continued in the following areas of work:

Health services and facilities

Seventy-nine buildings were completed, including staff houses, maternity wards, general wards and training centres. These were handed over to the CHS partners to enable them to retain quality health workers as well as provide better health services in local areas.

Human resources

At the start of the 2006-2009 period there were 616 VHVs active out of a total of about 900 that had been trained since project inception. About 75% had been partially transferred to the CHS and government partners but those partners had not taken full management of the VHVs. In 2006 a six-week study was commissioned to collect and analyse data on the 'effect' of the program on the target beneficiaries and partner institutions. The report concluded that "There is no doubt, from talking with VHVs, CHS, rural people and others that the Project is having a significant and positive impact on the lives of rural people in the East Sepik. (Heather, R: ESWCHP Project Monitoring Report 2006.)

By the end of 2009, over 1200 VHVs had been trained, and they were working in 657 villages in six districts. Included in this number were 481 VBAs. At least 81 rural health workers had undergone training to train VHVs, and 14 of these had received NDOH certificates.

Medical supplies systems

Starting in 2006, SCiPNG partnered with the Area Medical Stores (AMS) and was able to get medicines repackaged for the VHVs. As written in the PID for the next stage of Phase II, "This was a significant breakthrough as the VHVs are now perceived as a bona fide tier of the health system and the precedent is established for them to be allocated supplies directly from AMS."

Partnering with the Catholic Health Services created problems with the distribution of contraceptives. To overcome this, the ESWCHP developed a network of Catchment Level Distribution through which the contraceptives were supplied to the VBAs and CBDs.

Over 1300 birthing kits were distributed to the VBAs trained through the programme.

Information and reporting (including community education in health)

Over 3000 people had received family planning information. Over 760 in 227 villages attended training in Community Action and Planning. This resulted in 681 community health education plans that reportedly reached over 70,000 people in various districts.

Management

The process of handing over the management of the VHVs to the PDOH and the CHS commenced in 2007.

Women's empowerment

This work focused mainly on training women as VHVs, as well as providing leadership training to 16 women in ESCOW. There were no specific gender based workshops for men or women, and the project at no time specifically addressed gender based violence or looked specifically for gender-based reasons as to why women did or did not access health care and family planning.

Planning for the final contract 2009-2012

A tripartite meeting was held in November 2008 to discuss the program and to develop a timeframe to work towards a new strategic partnership to replace the 2006-2009 agreement. Following the review recommendation that more time should be taken to develop the next contract, meetings commenced in February for a contract that was to be signed in June.

In a document entitled "Future of SCNZ/NZAID/GoPNG partnership", dated 30/1/09, the question of the role of the HSIP in any future agreement was raised. It was tentatively suggested that the contracting mechanism could be kept as simple as possible, eg, GFA with SCNZ (and GoPNG if necessary for HSIP). There were still concerns that the entire partnership agreement was not of the depth or quality that a strategic partnership should demonstrate.

"SCiPNG essentially constructed (the) programme for the Strategic Partnership – they called it the Strategic Partnership Programme. The next partnership must not be like that. It must support their Strategic Plan or (preferable) specific projects that comprise their overall Country Programme. Given the extensive investment from NZ thus far, ESWCHP must be the central (if not the sole) focus of the partnership. The review has also indicated that there needs to be an intensive concentration on East Sepik if that is to become sustainable. Furthermore ES is identified as a focus province in NZAID's country

programme strategy, and continued/greater engagement would be of benefit...However, we are not sure if the funding from NZAID has been of direct benefit to SCiPNG, given the increased reporting burden that they faced and the capacity difficulties in managing the programme."

This document raised the question as to whether GoPNG really brought anything to the agreements/contract and it asked whether a formalised three-way partnership was necessary. It also posited that despite the difficulties of HSIP funding, "keeping a proportion of the funding channelled through the HSIP would be ideal. SC needs to understand the importance of this long term – for sustainability, even if it is frustrating."

The initial focus of the 2009-2012 period was limited to health and HIV/AIDS. NGO capacity building was dropped – to get funded from elsewhere. A concept paper was written by SCiPNG/SCNZ in which they asked for \$NZ 18m over three years. NZAID described this as a 'massively increased budget' when it was expecting the programme to attract the same level of funding as it had received in the previous three years. NZAID also expressed concern at the length of time it had taken SCiPNG to produce the concept note.

Just before the 2009-2012 contract was signed, SCNZ in an email to NZAID stated: "The boards of both SCNZ and Save the Children Australia (SCA) have agreed to transfer the lead agency role for SCiPNG to SCA by July 09." This would mean that thereafter, funding from NZAID would go to SCNZ, then to SCA, before being sent to SCiPNG. Staff in SCiPNG were not part of the discussion, and even when the 2012 evaluation took place, they remained unable to explain why this change happened and in what ways it benefitted their work.

NZAID had concerns that gender was a side-lined issue and indicators relating to this were not integrated into the logframe and M&E framework, that while reference was made to 'interacting more' with the AMS, there was no explanation as to what that meant. NZAID also commented that there did not appear to be a plan for achieving better integration with, and ownership by, the formal sector. However, in a meeting in March 2009 in the East Sepik with all the partners, the PDOH made a clear commitment incorporating VHV's into the health system and the Provincial Health Advisor announced that 600 new positions would shortly be funded in the province, of which at least two would be allocated to manage and coordinate VHV's. (At the time of writing this review, May 2012, such positions were still not created or filled, but the current PHA was giving the same message.)

Although the NZAID DPM was sceptical, believing (rightly as it transpired) it was "all too good to be true"... the meeting lead NZAID to believe that the provincial administration was fully supportive and planning ways of integration and eventual takeover.

This was a time of crisis for the ESWCHP as there was no manager in PNG, operations management was changing from SCNZ to SCA, funding cuts from NZAID looked likely and they were also having problems accessing 1,000,000 K in the HSIP that had been due since the end of the previous year.

Finally in May 2009 a revised concept plan was accepted by NZAID, and a decision made not to put further funding through the HSIP. NZAID insisted that an M&E plan and a sustainability plan were to be written over the following year to guide SCNZ and NZAID's exit from the programme in 2012.

In a letter to the Minister of Foreign Affairs and Trade, seeking his approval, it is stated: The programme is in its final phase, running from 2002-2012, and is designed to prepare for total handover of the programme to the church health services and to the PDOH.

This final three-year contract was framed as a Grant Funding Agreement (GFA) between SCNZ and NZAID. The Government of PNG was no longer a partner to the contract, and the relationship between the NZAID and SCNZ reverted to being simply a funding agreement. The funding allocation for the entire three years covered in the GFA was 13,568,433 Kina, plus an additional 6 per cent (814,106K) as a management fee.

The contract had two components: a health one, and an HIV and AIDS one.

Health component

The goal of the health component was: Improved basic family health in the rural communities of East Sepik with particular focus on women and children.

There were three objectives

Objective one: To improve community access to quality health care through the training and integration of VHVs to health facilities

Objective two: To empower communities to seek and take ownership of health care services in East Sepik

Objective three: To strengthen capacities and linkages among provincial institutions towards a sustainable and integrated health system

HIV and AIDS component

Goal: Out of school and unemployed youth impacted by HIV epidemic are better able to protect, respect and realise their rights

Objective One: by 2010 out of school and unemployed youth in Eastern Highlands and Madang Provinces have improved capacity and ability to protect themselves from and prevent the spread of HIV

Objective Two: by 2010 out of school and unemployed youth in Eastern Highlands and Madang Provinces have improved access to and use of sexual health services

Objective Three: by 2012 out of school and unemployed youth and future parents in Eastern Highlands and Madang Province have improved capacity and ability to make informed choices and take positive action in their own development

Objective Four: by 2012 out of school and unemployed youth and future parents in Eastern Highlands and Madang Province have improved family, community and stakeholders' support with regards to sexual and reproductive health and personal development

Objective Five: the Youth Outreach Programme (YOP) has effective and efficient program management and delivery systems

Objective Six: YOP incorporates SCiPNG cross-cutting issues into programming and delivery

The two parts of the programme were framed quite differently, including their structure within the logframe, and varying use of objectives and outputs. A new logframe was developed in 2010, as were the M&E framework and the all important Sustainability Plan.

A bridge funding agreement covered the period July-September 2009. The report on this brief period referred to the impact of the period before the GFA was signed where there was uncertainty as to whether the programme funding from NZAID would continue. This had an impact on the construction programme and the community self-reliance components. However, it was reported that the partnership with the PDOH had further strengthened with a new secondment arrangement in place. This enabled a PDOH staff member to work within the SCiPNG programme to have their capacity built to manage and coordinate VHVs.

In 2010, MFAT had identified in an email to NZ High Commission staff in Port Moresby that there were several issues that SC needed to grapple with during this last MFAT funded period. These included VHV retention, quality of supervision provided to VHVs, drug supplies, quality of the buildings being constructed, less than optimal use of the new buildings partly through the on-going difficulty in attracting staff to work in remote locations. There was a separate very positive comment: "NZ can take significant credit for agreeing to fund, and maintaining support, over a long period for a project that has had a lasting impact on health service provision in one of the poorest parts of PNG. With careful management the next 2.5 years should see those impacts well realised."

In the YOP report to June 2010 major problems included retention of the peer outreach volunteers (POVs), especially the young women, availability of condoms and IEC materials, activities getting affected by natural and man-made disasters, and infrastructure and security issues. It also identified risks, including the increasing mobility of young people which contributes to increased vulnerability. This was due to the major economic development activities, eg, LNG. It also contributed to the challenges such as staff turnover of POVs, increasing vulnerability of the youth, and increasing risks of the spread of HIV.

The new logframe, M&E and sustainability plans were developed and incorporated into the programme in 2010, so that reporting against these commenced for the final two years of the programme.

An NZAID field visit in December 2010 emphasised that further support was needed in maternal and child health programme activity. "VHVs can't achieve maternal mortality reduction without this level of support." (Barbara Mulligan report, NZAID, Dec 2010). It was planned to employ an MCH advisor, but funding could not be found for this appointment and the position remained unfilled at the time of the evaluation.

Achievements by 2012

By 2012 it was still not possible to measure the impact of the programme on the health of women and children, because baseline data was missing, and quality and clinical indicators of the VHV work were not collected. However, much had been achieved as follows:

Total number of VHVs trained under the programme since it commenced: 1370

Trainers of VHVs trained: 80, awaiting certification from the NDOH

VHV management workshops conducted for partners, and a VHV performance standard manual was drafted

Medical supplies for VHVs have been added to health centre supplies for more efficient distribution, although further work is required to get these supplies out to VHVs in the villages

Infrastructure development completed with five general wards, three maternity wards, one training centre/dormitory, 18 staff houses and one community health post completed between 2009-2012, and over 52 buildings since 2004.

By 2012 all the VHVs were being managed by partner agencies – with the Catholic Church Health Services (CCHS), South Seas Evangelical Church (SSEC) and PDOH being the largest three. Smaller church groups make up the remainder.

The MFAT evaluation of the programme just before its completion found that the programme was held in high regard throughout the province, and more widely in PNG. It had achieved considerable success, although actual impact on health was difficult to measure without baseline data or clinical and quality monitoring indicators. Partners and stakeholders were all pleased with the programme and most grateful for the very long-term support provided by the New Zealand Government.

The evaluation found though that programme management had not taken up all the recommendations from previous reviews, especially those pertaining to gender issues and community development. It found that the lack of community support for volunteers (in both the YOP and ESWCHP) would be an obstacle to sustainability.

However, this historical overview of one of the New Zealand Government's longest running development programmes must end on a positive note: the indications are that this health programme has saved women's and children's lives. It has made a significant contribution to health and the development of a cadre of health workers in a country that is notoriously difficult to achieve health gains. At a time when health indicators were otherwise worsening, this programme achieved a positive change. For that, the New Zealand Government, the staff of MFAT, and importantly, the staff of SC, especially those in PNG, deserve to be acknowledged and congratulated.

ACRONYMS

CBD	Community Based Distributor
CCHS	Catholic Church Health Services
CHS	Church Health Services
ESCOW	East Sepik Council of Women
ESWCHP	East Sepik Women and Children's Health Program
GFA	Grant Funding Agreement
HC	Health Centres
HSIP	Health Sector Improvement Program
HSIPTA	Health Sector Improvement Program Trust Account
MFAT	Ministry of Foreign Affairs and Trade
MM	Marasin Meri / Marasin Men
NDOH	National Department of Health
NZODA	NZ Official Development Assistance
PDD	Programme Design Document
PDOH	Provincial Department of Health
PID	Programme Implementation Document
POV	Peer Outreach Volunteers
SHC	Sub Health Centres
SCIPNG	Save the Children in PNG
SCNZ	Save the Children New Zealand
SPA	Strategic Partnership Agreement
SSEC	South Seas Evangelical Church
SWAp	Sector Wide Approach
VBA	Village Birth Attendant
VHV	Village Health Volunteer
YOP	Youth Outreach Programme

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Appendix D: List of Data Sources

Documents used in the evaluation include:

MFAT

MFAT/Save the Children Grant Funding Arrangement (2009-2012)

MFAT/Save the Children Strategic Partnership Arrangement (2006-2009)

All annual reports, and any additional monitoring and evaluation reports, associated with the above two arrangements, including the 2008 evaluation of the Strategic Partnership Arrangement.

New Zealand Aid Programme Activity Evaluation Operational Policy and Guideline (October 2011)

New Zealand Aid Programme Participatory Evaluation Guideline

International Development Group Policy Guidelines

New Zealand Aid Programme Screening Guide for Cross-Cutting issues

Gender Advisory Support for Grass-roots Health Projects in PNG Report, 2006

Save the Children

Save the Children PNG Country Strategy Documents

Save the Children Health Strategy Documents

Save the Children Evaluation Plans

Save the Children Sustainability Plans

Save the Children Project Proposals

Save the Children Annual Reports

Burnet Institute Report to Save the Children: Analysis of the level of services and coverage of Village Health Volunteer in East Sepik, and comparison to health centre services, 1998-2010

PNG

PNG National Health Plan 2011-2020

PNG Child Health Plan 2008-2015

PNG National Strategic Plan for HIV/AIDS and STIs 2006-2010

PNG National Strategic Plan 2010-2050

PNG National Sexual and Reproductive Health Policy 2009

PNG National Report: Demographic and Health Survey 2006 (National Statistics Office)

People consulted in this evaluation

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 Annette Coppola, health advisor, NDOH, Port Moresby
 Robert Turare, Development Programme Coordinator, New Zealand High Commission, Port Moresby
 Bill Humphrey, Programme Coordinator, Save the Children PNG
 John Kolip, Programme Officer, SCiPNG
 Glenda Yakuna, M&E Officer, SCiPNG
 Somo, M&E officer, SCiPNG
 And all other staff at SCiPNG, Wewak

Sr Celine, Catholic Church Health Services
 Mr Nixon Sunblap, SSEC
 Mr Albert Bunat, Provincial Health Advisor, ESP
 Sr Ale, Maternal and Child Health, PDOH
 Mr Eddie Bau, Area Medical Stores
 Sophie Mangai, President, ESCOW
 (and nine other members of ESCOW)
 Roslyn, VHV coordinator, SDA
 Mr Malaitom, Health Secretary, SDA
 Jill Sakupati, ESCOW in Mabrik
 Michael Manguan, LLG

Nursing staff and VHVs at:

Korogu, Kaugia, Kunjigini, Brugam

Women and men in the villages of:

Chambri Lakes, Korogu, Ilahita, Ilahup

Youth Volunteers at Goroka and Kainantu

MFAT staff, SCNZ staff

Glossary of Acronyms

The following acronyms are used in this report.

ADB	Asian Development Bank
AMS	Area Medical Stores
ANC	Antenatal clinic
AP	Aid Post
CBD	Community Based Distributor
CHS	Church Health Services
CCHS	Catholic Church Health Service
CHW	Community Health Worker
CLD	Catchment Level Distributor
EHP	Eastern Highlands Province
ESCOW	East Sepik Council of Women
ESPG	East Sepik Provincial Government
ESWCHP	East Sepik Women and Children's Health Project
GoPNG	Government of PNG
HC	Health Centre
HF	Health Facility
HSC	Health Sub-Centre
HI	Healthy Islands
HSIP	Health Sector Improvement Program
IEC	Information, Education, Communication
KAP	Knowledge, Attitude, Practice
LLG	Local Level Government
LVHVM	local VHV manager
MIS	Management Information System
MOU	Memorandum of Understanding MCH - Maternal and Child Health
MM	Marasin Meri / Marasin Man

NHIS	National Health Information System
NDOH	National Department of Health
NGO	Non Governmental Organization
NO	Nursing Officer
PDOH	Provincial Division of Health
PHA	Provincial Health Advisor
POV	Peer Outreach Volunteer
PSI	Population Services International
PVHVMC	Provincial VHV Management Committee
RDT	Rapid Diagnostic Test (malaria)
SCA	Save the Children Australia
SCiPNG	Save the Children in PNG
SDA	Seventh Day Adventist
SOP	Standard Operating Procedures
SCNZ	Save the Children New Zealand
SMC	Safe Motherhood Coordinator
SPO	Senior Project Officer
SPP	Strategic Partnership Program
SSEC	South Seas Evangelical Church
TOT	Training of Trainers
VHV	Village Health Volunteer
VBA	Village Birth Attendant
YOP	Youth Outreach Programme

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