



# **Partnering for Strong Families (PSF) Evaluation**

**Human Development Monitoring and  
Evaluation Services (HDMES)**

**July 2022**

Copyright protects this publication. Except for purposes permitted by the *Copyright Act 1968* of the Commonwealth of Australia, reproduction, adaptation, electronic storage, and communication to the public is prohibited without prior written permission. Enquiries should be addressed to: Australian High Commission, Port Moresby.

All third party material, including images, contained in this publication remains the property of the specified copyright owner unless otherwise indicated, and is used subject to their licensing conditions.

## Document review and authorisation

Version	Date distributed	Issued to	Comments
1	3 June 2022	Anna Gilchrist and Daisy Rowaro	Initial draft report
2	15 July 2022	Anna Gilchrist	Incorporating feedback from Anna Gilchrist on initial draft
3	12 January 2023	Anna Gilchrist	Incorporating feedback from Anna Gilchrist on final draft

Key information	Details
Author(s)	Mary Larkin (Lead M&E Consultant)
Reviewer(s)	Liesel Seehofer (HDMES M&E Specialist Health), Erin Passmore (HDMES M&E Technical Specialist), Martin Aspin (HDMES Team Leader)
Submission date	15 July 2022
Reference no.	PSF_2022_1
Disclaimer	This document has been produced with information supplied to HDMES by the specified sources/data collection methods. While we make every effort to ensure the accuracy of the information contained in this report, any judgements as to the suitability of the information for the client's purposes are the client's responsibility. HDMES extends no warranties and assumes no responsibility as to the suitability of this information or for the consequences of its use

## Contact details

Details	Human Development Monitoring and Evaluation Services	Australian High Commission
Name	Liesel Seehofer	Daisy Rowaro
Job title	M&E Specialist Health	Senior Program Manager
Telephone	+61 484 558 072	+675 7200 7845
Email	Liesel.Seehofer@hdmes-png.com	Daisy.Rowaro@dfat.gov.au

# Contents

<b>Executive Summary</b>	<b>1</b>
<b>1. Project Overview</b>	<b>7</b>
<b>2. Approach to the Evaluation</b>	<b>7</b>
Evaluation Team	7
<b>3. Partnering for Strong Families Project Theory and Logic</b>	<b>8</b>
Problem Statement	8
Project Aim and Approach	8
<b>4. Methodology</b>	<b>9</b>
Analysis, Synthesis and Reporting	10
Limitations	10
Ethics	10
Key Evaluation Questions	10
<b>5. Findings</b>	<b>11</b>
Effectiveness (KEQ 1)	11
Efficiency (KEQ 2)	20
Relevance (KEQ 3)	24
M&E (KEQ 4)	27
GEDSI (KEQ 5)	28
Sustainability (KEQ 6)	30
Impact (KEQ 7)	32
<b>6. Recommendations</b>	<b>33</b>
<b>7. References</b>	<b>37</b>
<b>Annexes</b>	<b>39</b>
Annex 1 – PSF Phase 1 and Phase 2 Project Logic	40
Annex 2 – Partnering for Strong Families Phase 1 Theory of Change	41
Annex 3 – Partnering for Strong Families Phase 2 Project Logic	42
Annex 4 – List of FP/SRH and MCH Services Delivered by PSF partners	43
Annex 5 – Key Evaluation Questions	44
Annex 6 – List of People Interviewed	46
Annex 7 – List of Documents Reviewed	48
Annex 8 – Data Collection Tools	51
Annex 9 – PSF Phase 1 and Phase 2: Achievements against IO and Output Indicators and Targets	54
Annex 10 – PSF Phase 1 and Phase 2: Provinces, Locations, MSPNG and SSM Activities	63
Annex 11 – Key Success Factors for Working with Priority Stakeholder Groups	66
Annex 12 – Case Study: Adaptive Management during COVID-19 Pandemic	68

## Abbreviations and Acronyms

Term	Definition
<b>AHC</b>	Australian High Commission [Port Moresby]
<b>AIHSS</b>	Accelerated Immunisation Health System Strengthening
<b>ANC</b>	Antenatal Care
<b>ANCP</b>	Australian NGO Cooperation Program
<b>ARH</b>	Adolescent Reproductive Health
<b>CBM</b>	Community Based Mobiliser
<b>CEI</b>	Client Exit Interview
<b>CHW</b>	Community Health Worker
<b>CPR</b>	Contraceptive Prevalence Rate
<b>CSO</b>	Civil Society Organisation
<b>CYP</b>	Couple Years of Protection
<b>DFAT</b>	Department of Foreign Affairs and Trade [Australia]
<b>DPO</b>	Disabled Persons Organisation
<b>EOP0</b>	End of Project Outcome
<b>FGD</b>	Focus Group Discussion
<b>FP</b>	Family Planning
<b>GBV</b>	Gender-Based Violence
<b>GEDSI</b>	Gender Equality, Disability and Social Inclusion
<b>GoPNG</b>	Government of Papua New Guinea
<b>HCW</b>	Health Care Worker
<b>HDMES</b>	Human Development Monitoring and Evaluation Services
<b>HEFPN</b>	Hospital Embedded Family Planning Nurse
<b>HENO</b>	Hospital Embedded Nursing Officer
<b>HIV</b>	Human Immunodeficiency Virus
<b>IEC</b>	Information, Education and Communication
<b>IMR</b>	Infant Mortality Rate
<b>IO</b>	Intermediate Outcome
<b>IUD</b>	Intrauterine Device
<b>KEQ</b>	Key Evaluation Question
<b>KII</b>	Key Informant Interviews
<b>LARC</b>	Long Acting Reversible Contraception
<b>M&amp;E</b>	Monitoring and Evaluation
<b>MCH</b>	Maternal and Child Health
<b>MEL</b>	Monitoring, Evaluation and Learning
<b>MMR</b>	Maternal Mortality Ratio
<b>MOA</b>	Memorandum of Agreement
<b>MOU</b>	Memorandum of Understanding

Term	Definition
<b>MSI</b>	Marie Stopes International
<b>MSPNG</b>	Marie Stopes Papua New Guinea
<b>NCD</b>	National Capital District
<b>NCE</b>	No-Cost Extension
<b>NDOH</b>	National Department of Health
<b>NFPPN</b>	National Family Planning Provider Network
<b>NFPTWG</b>	National Family Planning Technical Working Group
<b>NFPTP</b>	National Family Planning Training Program
<b>NGO</b>	Non-Government Organisation
<b>NMR</b>	Neonatal Mortality Rate
<b>NOPS</b>	National Orthotic and Prosthetic Services
<b>NSO</b>	National Statistical Office
<b>OECD DAC</b>	Organisation for Economic Co-operation and Development – Development Assistance Committee
<b>PATH</b>	Papua New Guinea–Australia Transition to Health
<b>PHA</b>	Provincial Health Authority
<b>PLHIV</b>	People Living with HIV/AIDS
<b>PMGH</b>	Port Moresby General Hospital
<b>PMTCT</b>	Prevention of Mother to Child Transmission [of HIV]
<b>PNG</b>	Papua New Guinea
<b>PPE</b>	Personal Protective Equipment
<b>PPF</b>	PNG Partnership Fund
<b>PSEAH</b>	Prevention of Sexual Exploitation, Abuse and Harassment
<b>PSF</b>	Partnering for Strong Families
<b>RMNCAH</b>	Reproductive, Maternal, Newborn, Child and Adolescent Health
<b>SGBV</b>	Sexual and Gender-Based Violence
<b>SPAR</b>	Sector Performance Annual Review
<b>SRH</b>	Sexual and Reproductive Health
<b>SRMCH</b>	Sexual, Reproductive, Maternal and Child Health
<b>SRMNCH</b>	Sexual, Reproductive, Maternal, Newborn and Child Health
<b>SSM</b>	Susu Mamas PNG Incorporated
<b>STI</b>	Sexually Transmitted Infection
<b>TOR</b>	Terms of Reference
<b>UNFPA</b>	United Nations Population Fund
<b>VHV</b>	Village Health Volunteer
<b>WHO</b>	World Health Organization



## Executive Summary

The Partnering for Strong Families (PSF) Evaluation was commissioned by the Australian High Commission (AHC) in Papua New Guinea (PNG) to assess the effectiveness of the ***Wok Wantaim na Kamapim Strongpela Famili: Partnering for Strong Families*** project implementation, including its achievements since inception in July 2017, through to June 2022. It is an AUD34,646,035 investment delivered through a partnership between Marie Stopes PNG (MSPNG) and Susu Mamas PNG Incorporated (SSM) and implemented under the PNG–Australia Transition to Health (PATH) program, managed by Abt Associates.

### Background

The PSF project is designed to address Department of Foreign Affairs and Trade (DFAT) and Government of PNG (GoPNG) priorities to increase access to quality, integrated sexual and reproductive health (SRH), family planning (FP), and maternal and child health (MCH) services in PNG<sup>1</sup>. The PSF Phase 1 End of Project Outcome (EOPO) was to: ‘Contribute towards reducing Maternal Mortality Ratio (MMR), Infant Mortality Rate (IMR), Neonatal Mortality Rate (NMR) and Under-5 Mortality Rate through improved uptake of integrated SRH/FP and MCH services in 14 provinces of PNG’. The PSF Phase 2 intent remains the same, with the Phase 1 Activity 1 Outcome adopted as its EOPO: ‘Increased coverage and utilisation of sustainable high quality, inclusive, integrated SRH/FP and MCH services amongst women, men, adolescents, people with disabilities, infants and children in 6 provinces in PNG’.

Four main approaches were used to achieve project outcomes:

- Partnership and collaboration with national and subnational government to strengthen quality, reach and efficiency of integrated SRH/FP and MCH service delivery.
- Addressing both demand and supply through engaging with communities and scaling up delivery of integrated SRH/FP and MCH health services in project provinces.
- Strengthening public sector capacity to deliver high-quality FP services through training health care workers to deliver Long Acting Reversible Contraceptive (LARC) methods.
- Reaching disadvantaged groups and individuals by providing inclusive SRH/FP and MCH services.

**Phase 1** of the project was implemented between July 2017 and June 2020, as part of the PNG Partnership Fund (PPF) health program portfolio, which worked with high-performing organisations to expand the reach and coverage of interventions with the potential to deliver results at scale.

**Phase 2** commenced in July 2020 and aimed to consolidate Phase 1 results, but reduced the geographic focus for direct service delivery from 14 to 6 provinces. This phase aimed to bring an increased focus on strengthened partnerships with GoPNG for sustainable service delivery, and building Provincial Health Authority (PHA) capacity to manage and deliver inclusive, sustainable, quality FP/SRH and MCH services. Phase 2 is being implemented under the PNG–Australia Transition to Health (PATH) program, Frontline Health Outcomes workstream, and is scheduled to end in December 2022.

### Evaluation methods

This evaluation was conducted between 19 January and 3 June 2022, using a mixed methods approach that included a review of over 75 documents, interviews with 68 informants, and visits to GoPNG and SSM health facilities. Limitations of this evaluation included conducting interviews via remote means, rather than face-to-face, which influenced the quality of information and data

---

<sup>1</sup> See list of FP/SRH and MCH services provided by project partners in Annex 4.

gathered, requiring additional cross-checking of data and information. Additionally, a limited number of project provinces were visited, restricting opportunities to further collect and validate data.

## Key findings

### Key Evaluation Question (KEQ) 1: Effectiveness

Over Phase 1 and Phase 2 of the project, PSF provided a high volume of SRH, FP and MCH services in project provinces, including:

- 682,926 people reached with/accessing SRH/FP and MCH services<sup>2</sup>.
- 261,205 FP services provided in project provinces.
- 467,449 Couple Years of Protection (CYP) generated in project provinces.
- 19,180 pregnant women attending at least one antenatal care (ANC) visit (combined with Prevention of Mother to Child Transmission (PMTCT) of Human Immunodeficiency Virus (HIV)).
- 31,464 children under 5 immunised (3rd dose Pentavalent, Measles/Rubella 9–17 months).
- 34,575 children under 5 treated for malnutrition and pneumonia.
- 47,800 people treated for sexually transmitted infections (STIs) and HIV, including PMTCT.
- 686,267 women, men, youth and people with a disability reached by information, education and communication (IEC), awareness-raising, and demand-generation activities.

In 2019, the annual number of FP services delivered by the partnership (104,969) was double the 2016 baseline (50,178). Annual CYPs increased by 48% over the same period (from 120,000 in 2016 to 177,694 in 2019). Services were delivered via MSPNG and SSM static clinics; Port Moresby General Hospital (PMGH) and provincial hospital maternity wards; government community health facilities; outreach to rural, peri-urban and urban areas; joint patrols with GoPNG partners; and health care workers (HCWs) trained in LARC methods<sup>3</sup>.

As a result of training delivered through the National Family Planning Training Program (NFPTP), and according to the Marie Stopes International (MSI) Impact2 modelling tool<sup>4</sup>, FP services alone provided under this grant have averted an estimated 205,279 unintended pregnancies, 253 maternal deaths, and 22,443 unsafe abortions.

### Increased awareness and uptake of high-quality, integrated SRH/FP and MCH services in target provinces

In Phase 1, all service delivery targets were reached and the majority were exceeded. In Phase 2, the majority of service delivery targets were again reached or exceeded, despite the challenges of COVID-19. Greater use of social media contributed to the project exceeding targets for increased numbers of people reached with FP/SRH and MCH information<sup>5</sup>; however, the rural Community Based Mobiliser (CBM) network, an important source of community-based referrals to MSPNG,

<sup>2</sup> In Phase 1, Outcome Indicator 2.1 was 'Increased number of people reached with SRH/FP and MCH services'. In Phase 2, the equivalent indicator was 'Number of people accessing SRH/FP/MCH services'.

<sup>3</sup> The NDOH Sector Performance Annual Review (SPAR) reports that CYPs increased from 102 years per 1,000 women aged 15–44 years in 2016, to 135 years in 2020 (NDOH SPAR, 2020, p.11); however, the SPAR does not report the contribution of individual organisations to these outcomes and so it is not possible to identify the PSF contribution to any overall increase in CYP outcomes.

<sup>4</sup> For a summary of how estimates are calculated, and the data used for these estimations see the Marie Stopes (June 2018) 'Impact 2, version 5' at [https://www.msichoices.org/media/3319/impact\\_25\\_summary\\_of\\_changes\\_june\\_2018-1.pdf](https://www.msichoices.org/media/3319/impact_25_summary_of_changes_june_2018-1.pdf)

<sup>5</sup> In Phase 1, 178% of the target for Output 2.1.2: Number of women, men, youth and people with a disability reached by targeted awareness-raising and demand-generation activities MSPNG was achieved. In Phase 2, 229% of the target for IO3A: 1 Number of people reached with FP/SRH and MCH information through IEC materials and social media was achieved.

appears to have been underused. No substantial measurement of the impact of IEC and awareness-raising activities (e.g. on knowledge or behaviours) was conducted. In terms of quality and acceptability of partner services, internal clinical governance systems meet MSI global standards (for MSPNG) and GoPNG Health Service Standards (for SSM). However, annual MSPNG external audits and surveys of client satisfaction were delayed due to COVID-19 restrictions. The most recent measures of MSPNG and SSM service quality or PSF beneficiary satisfaction are from 2019.

### **Partnership and collaboration for sustainable and efficient FP/SRH and MCH service delivery**

National and subnational partners highly value the contribution of MSPNG and SSM to strengthening GoPNG health outcomes and were satisfied with their partnership with SSM. It was widely commented by Provincial Health Authorities that far stronger communication and collaboration from MSPNG is expected. A more substantial project logic and measurement of progress towards intended partnership outcomes is required.

### **Strengthened public sector capacity to deliver high quality FP/SRH services in target provinces in PNG**

Delivery of high quality training to enable a substantial number of health care workers to independently deliver long-term family planning methods is an important achievement. PHA interviewees stated that this had led to increased family planning coverage in their province; however, there has been inadequate communication by MSPNG concerning these activities. It is also critical to note that the NFPTP is a relatively high cost training model that does not adequately involve PHA clinicians and management in its delivery<sup>6</sup>. Progressing delayed plans to develop and deliver more cost-effective, acceptable, and sustainable models of training is important.

### **Improved equity, inclusiveness, and sensitive delivery of FP/SRH/MCH services in target provinces**

Achievement of targets in this area has been variable. In Phase 1, targets for reaching young people and gender-based violence (GBV) survivors were exceeded (335 of 260 referrals of GBV clients), but in 2021 COVID-19 restrictions and funding cuts affected performance in these areas and targets were not reached. Targets for men's attendance with partners at ANC visits and providing services to people with disabilities in Phase 2 were reached, but progress towards system strengthening for improved equity and inclusiveness could not be verified.

## **KEQ 2: Efficiency**

MSPNG and SSM bring complementary strengths to the PSF project. In 2019, MSPNG, with greater resources, a larger footprint, and a focus on providing permanent and long-term contraceptive methods, delivered 94% of CYPs; SSM with its local model of integrated family and youth primary health care was responsible for 75% of people reached with SRH/FP and MCH services. There was not adequate information to assess the relative efficiency of each organisation in delivering a specific service. The original intention that SSM and MSPNG would work together to develop a model of integrated SRH/FP and MCH services did not eventuate; however, alternative strategies were trialled, such as joint outreach with government and the Hospital Embedded Family Planning Nurse (HEFPN) model. A sudden reduction in funding by DFAT, and hence resources, impacted on the stability of programs and program delivery in 2020; and these were further affected by COVID-19 related restrictions. Partners sought to achieve efficiencies and reduce costs, but there is evidence that this negatively affected program quality. PSF partners valued the support provided by the PPF

---

<sup>6</sup> Compared to other proposed training models e.g. LARC training under the National Family Planning Provider Network and via pre-service training.



management team to improve project performance in Phase 1; however, this approach was not continued in Phase 2 under PATH.

### **KEQ 3: Relevance**

#### **PSF project approach**

Increasing access to quality, integrated, and people-centred SRH/FP and MCH interventions remains a critical priority for PNG. DFAT and GoPNG informants confirmed the important role of non-government organisations (NGOs) in the health sector in PNG, and the continued importance of donor support for direct service delivery. In the PNG context, partnerships with PHAs and building capacity to manage health service delivery are essential, as is the transition to PHA management of health services. However, the specific expectations and the pathway through which these are achieved are not adequately defined in the PSF project logic.

#### **Approaches to delivering SRH/FP and MCH services**

The PSF focus on increasing access to LARC methods remains appropriate and important. Outreach is critical for reaching more remote communities and those who face barriers accessing clinic-based care. While both partners are delivering essential services, SSM's model of integrated, community-based primary health care that is integrated with the GoPNG health system is more closely aligned to delivery of sustainable, integrated, and comprehensive SRH/FP and MCH care. The locally-developed HEFPN model is widely recognised as an effective, efficient, and appropriate model for increasing access to post-partum family planning in PNG.

### **KEQ 4: Monitoring and Evaluation**

Proposed operational research to generate learning and evidence for policy change and GoPNG decision-making in Phase 1 was not progressed due to lack of time and resources for MSPNG and SSM. PSF partners used internal reflection and learning to implement efficiencies and strengthen models of care, but learning was not disseminated in a formal manner. Rather than a top-down approach of 'sharing lessons learned', it would also be more appropriate to engage in shared learning with partners to both recognise local knowledge and develop collaborative, contextually-relevant approaches. To support stronger learning and accountability, project indicators and means of verification should be more clearly defined. More detailed progress reporting and stronger record keeping will contribute to greater transparency and better understanding of project activities.

### **KEQ 5: Gender Equality, Disability and Social Inclusion (GEDSI)**

The PSF investment has been directly focused on addressing barriers faced by women through increasing access to quality, client-centred family planning and SRH/MCH information and services. However, it does not directly address social norms around gender, nor implement a gender-transformative approach. SSM has a well-regarded model of disability-inclusive service delivery and provides services to women experiencing GBV. Both partners provided examples of practical strategies to reach men and young people. Nevertheless, relatively small numbers of clients from marginalised groups were reached. To better meet these needs, targeted design, strong resourcing, and clear delivery models for inclusive services are required.

### **KEQ 6: Sustainability**

The PSF project logic does not have a clear strategy for achieving expected sustainability outcomes beyond those associated with NFPTP LARC training. A concrete pathway for transferring services to PHAs has not yet been mapped. If DFAT is moving away from direct funding to NGOs, a workable, alternative financing mechanism is needed, together with a substantial program of PHA governance, management and administrative capacity building, and a strong system for partner coordination, as

per PATH's mandate. There is a clear and immediate need for future programming that is strongly aligned with government systems and recognises the role of PHAs as implementation managers with the authority to determine the nature of health interventions in their PHA, and to whom implementing partners are responsible.

## **KEQ 7: Impact**

Through this investment, DFAT has provided a large financial contribution to PNG's first donor-funded nationwide program that had a concerted focus on expanding access to LARC. As the evaluation was unable to measure the contribution by the PSF project to coverage or use of SRH/FP and MCH services in PNG, it relies on an assessment of results against intermediate outcomes. In filling critical gaps in-service delivery and capacity for service delivery, the PSF has resulted in a substantial increase in the number of people with access to quality SRH/FP and MCH care, which is known to result in improved maternal health, family wellbeing, and child survival. Subnational stakeholders considered that PSF and the work of MSPNG and SSM have made important and significant contributions to delivery of SRH/FP/MCH health services in their provinces. Further strengthening and consolidation of results is needed to secure inclusive, equitable, and sustainable access to these lifesaving interventions. Future projects need to incorporate measures for assessing progress towards EOPOs in the design of the Monitoring, Evaluation and Learning (MEL) Framework.

## **Summary Recommendations**

### **Recommendation Area 1 – Continue to support SRH/FP and MCH services in PNG**

**DFAT** should continue to invest in integrated SRH/FP and MCH service delivery to contribute to GoPNG national health priorities, gender equity, and reducing unmet demand for essential SRH/FP and MCH services in PNG.

### **Recommendation Area 2 – Design and resource program to achieve equity and inclusion objectives**

**DFAT** to determine the type of impact it intends to have in reaching under-served and disadvantaged groups and use best practice principles and specialist technical advice to design the program and ensure adequate resourcing to achieve that impact in future health programming.

### **Recommendation Area 3 – Recognise PHA leadership through program design and promote partnership at all levels**

**DFAT/Managing Contractor** to ensure that any new health interventions are co-designed with Provincial Health Authorities, in response to PHA priorities and the local health system context. Implementing partners must demonstrate alignment with PHA and subnational health systems, and actively engage and support the priorities of subnational stakeholders to deliver integrated, inclusive SRH/FP and MCH services.

### **Recommendation Area 4 – Design for sustainable transition to PHA management**

**DFAT** to investigate a program design with a clear pathway towards ownership by government and strong program logic developed together with PHAs and the National Department of Health (NDOH). This includes suitably resourced strategies for PHA governance and management capacity strengthening, and a mechanism for financing.

### **Recommendation Area 5 – Take advantage of PATH's proposed cross-program capacities to support partner program implementation and learning**

**PATH to work with DFAT** to reorient PATH's approach towards strong engagement with

implementing partners, improving monitoring, providing support for areas including GEDSI and PHA strengthening, and sharing lessons and expertise between partners.

#### **Recommendation Area 6 – Strengthen PSF project and contract management**

**DFAT/PATH** to work with MSPNG to implement remedial steps to address delayed outcomes, particularly relating to the revised NFPTP in-service and pre-service courses and the National Family Planning Provider Network (NFPPN). **DFAT/PATH and MSPNG** to strengthen contract and project management practices, so that programs are delivered as designed.

#### **Recommendation Area 7 – Strengthen collaboration and complete NFPTP training**

**MSPNG** to develop, resource and implement a plan for improving collaboration, planning and communication with NDOH, PHAs, and local health sector partners. **MSPNG** to ensure that all health care workers trained in Phase 1 are certified in a timely manner and provide regular reports and trainee action plans to subnational stakeholders at PHA level and below.

#### **Recommendation Area 8 – National SRH/FP and MCH coordination**

**United Nations Population Fund (UNFPA) and World Health Organization (WHO)** to support NDOH to define how the responsibilities of the National Family Planning Technical Working Group (NFPTWG) will be addressed under the new Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCAH) Technical Advisory Committee and support the operations of this committee, so that it can become an effective forum for national-level SRH/FP and MCH advocacy, collaboration, and coordination. **DFAT** to consider opportunities to support the capacity of the government to lead this group.

#### **Recommendation Area 9 – Ensure that M&E is fit-for-purpose and promotes learning**

**DFAT** to work with PATH and Human Development Monitoring and Evaluation Services (HDMES), or another entity, to design the M&E framework for any future SRH/FP and MCH investment and identify and progress priority operational research.

# 1. Project Overview

The *Wok Wantaim na Kamapim Strongpela Famili: Partnering for Strong Families (PSF)* project was designed to address DFAT and GoPNG priorities, and specifically address Outcome 3 of DFAT's Health Portfolio Plan:

'Integrated family planning, HIV and sexual and reproductive health: By 2023, in selected provinces and districts, selected government, church and NGO clinics delivering improved quality client-centred, integrated HIV, reproductive health, voluntary family planning services.'

Phase 1 of the PSF project received an investment of AUD23.2 million to scale up services in 14 provinces between July 2017 and April 2020, with a 3-month no-cost extension to June 2020. Phase 2 received an investment of AUD11,436,035 to consolidate the results of Phase 1, with a scaled-down geographic footprint for direct service delivery from 14 to 6 provinces.

## 2. Approach to the Evaluation

The PSF Phase 2 is coming to an end in December 2022<sup>7</sup>. DFAT commissioned an evaluation to assess the impact of both phases of the project at the subnational and national levels. The evaluation examines the effectiveness of the PSF project implementation and achievements since inception, with a focus on the extent to which EOPOs have been achieved. The report provides an overview of evaluation findings and a series of recommendations for consideration by DFAT and key stakeholders when planning the next steps of the project and future support for the health sector in PNG.

### Evaluation Team

The evaluation team was composed of Mary Larkin, an externally-engaged international SRH/Public Health specialist based in Australia; Laura Naidi, the HDMES Senior Policy Research Officer based in Port Moresby; and Liesel Seehofer, HDMES M&E Specialist; with the support of Dr Erin Passmore, HDMES M&E Technical Specialist. The evaluation team was further assisted by the HDMES unit based in Port Moresby, who provided logistical and technical support throughout the evaluation.

---

<sup>7</sup> During finalisation of this evaluation report, DFAT approved a costed extension of PSF for 12 months to 31 December 2023.

### 3. Partnering for Strong Families Project Theory and Logic

#### Problem Statement

Despite continued GoPNG and partner investments in maternal, neonatal, child and adolescent health in PNG, outcomes have remained weak. Key health indicators in PNG, such as maternal and neonatal mortality are poor in comparison to other countries in the region<sup>8</sup>. PNG's health system weaknesses<sup>9</sup>, high levels of poverty<sup>10</sup>, and gender inequality<sup>11</sup>, undermine women and children's health outcomes, and these are further entrenched in remote rural areas<sup>12</sup>. People with a disability<sup>13</sup>, young people<sup>14</sup>, and women and children experiencing gender-based violence, are particularly under-served by the health system<sup>15</sup>. PNG has a Maternal Mortality Ratio (MMR) of 171 deaths per 100,000<sup>16</sup>, and research indicates that it may be up to 900 per 100,000 in rural areas<sup>17</sup>. The Contraceptive Prevalence Rate (CPR) is 39<sup>18</sup> and the Total Fertility Rate is 4.2<sup>19</sup>, compared to the Low and Middle Income Country average of 2.8<sup>20</sup>. Infant mortality in PNG has been declining, but immunisation rates in PNG are extremely low, with measles vaccination coverage at 34%<sup>21</sup>.

#### Project Aim and Approach

The aim of the PSF grant is to contribute to improved maternal, child, and sexual and reproductive health outcomes in PNG. The PSF Phase 1 EOPO: was to 'Contribute towards reducing Maternal Mortality Ratio (MMR), Infant Mortality Rate (IMR), Neonatal Mortality Rate (NMR) and Under-5 Mortality Rate through improved uptake of integrated SRH/FP and MCH services in 14 provinces of PNG'<sup>22</sup>.

The Phase 2 EOPO was slightly altered, but with the same intent: 'Increased coverage and utilisation of sustainable high quality, inclusive, integrated SRH/FP and MCH services amongst women, men, adolescents, people with disabilities, infants and children in 6 provinces in PNG'.

Phase 1 of the project was implemented between July 2017 and June 2020 and delivered as part of the PNG Partnership Fund health program portfolio, which worked with high-performing organisations to expand the reach and coverage of interventions with the potential to deliver results

<sup>8</sup> Papua New Guinea Demographic and Health Survey 2016–18.

<sup>9</sup> Grundy et al., 2022.

<sup>10</sup> 39.9% of the population live under the basic needs poverty line (World Bank Group, 2020).

<sup>11</sup> PNG is ranked 160 out of 161 countries on the United Nations Development Programme's 2021 Gender Inequality Index (UN Women, n.d.).

<sup>12</sup> UNFPA Papua New Guinea, 2022. The PNG *National Health Plan 2011–2030* (p.11) states that '30–60 % of Level 3 and 4 facilities need significant remediation. Services to the most remote rural populations have decreased (48% aid post closures)'.

<sup>13</sup> National Disability Resource and Advocacy Centre, 2015.

<sup>14</sup> UNFPA, 2021a.

<sup>15</sup> Human Rights Watch, 2022.

<sup>16</sup> Papua New Guinea Demographic and Health Survey 2016–18.

<sup>17</sup> Mola & Kirby, 2013.

<sup>18</sup> Papua New Guinea Demographic and Health Survey 2016–18.

<sup>19</sup> Papua New Guinea Demographic and Health Survey 2016–18.

<sup>20</sup> Specialist Health Service, 2019.

<sup>21</sup> 2019 Sector Performance Annual Review, NDOH, p.16.

<sup>22</sup> The PSF Phase 1 Component/Activity 1 Outcome is: Increased coverage and utilisation of sustainable high quality, inclusive, integrated SRH/FP and MCH services amongst women, men, adolescents, people with disabilities, infants and children in 14 provinces in PNG (PSF Six Month Progress Report (July–December 2017)).



at scale. Phase 2 commenced in July 2020, and aimed to consolidate Phase 1 results but reduced the geographic focus from 14 to 6 provinces for direct service delivery. Phase 2 is being implemented under the PNG–Australia Transition to Health (PATH) program, Frontline Health Outcomes workstream, and will come to an end in December 2022.

The project is delivered through a partnership between Marie Stopes PNG (MSPNG) and Susu Mamas PNG Incorporated (SSM), whose long-standing experience, demonstrated capacity and on-the-ground relationships were considered to provide solid foundations for the investment. Four main approaches were used to achieve **Phase 1** project outcomes:

- Capacity building of national and subnational government to deliver quality, integrated SRH/FP and MCH services.
- Addressing both demand and supply through engaging with communities and scaling up delivery of integrated SRH/FP and MCH health services in project provinces.
- Training health care workers to deliver LARC methods through the National Family Planning Training Program.
- Reaching disadvantaged groups and individuals by providing inclusive SRH/FP and MCH services.

In **Phase 2**, PSF continued to implement the approaches from Phase 1, but aimed to bring an increased focus on developing sustainable partnerships, strengthening PHA management of FP/SRH and MCH services and capacity building via diversified LARC training courses and a National Family Planning Provider Network (NFPPN). Direct delivery of services was continued and partners aimed to increase equity through mainstreaming inclusive service delivery and working with organisations representing under-served groups.

A summary of activities and outcomes for the 2 phases of the PSF project is outlined in **Annex 1**. The proposed Theory of Change diagram included in the Phase 1 design document is provided in **Annex 2**, and the more detailed Phase 2 Project Logic diagram is in **Annex 3**. A list of SRH/FP and MCH services provided by partners MSPNG and SSM under the PSF project is included in **Annex 4**.

## 4. Methodology

The evaluation used a mixed methods approach to examine the Key Evaluation Questions (**Annex 5**). An initial rapid review of GoPNG policy documents, PNG health sector reviews, PSF project documents and progress reports was conducted to understand the national and subnational context, project design, and implementation.

Quantitative data related to activities, outputs, and outcomes was sourced from progress reports from July 2017 to December 2021. Qualitative data was collected through a review of project documentation, and field visits and interviews with national and subnational level key informants. Selection of interview participants was purposive. Interviews were conducted remotely via Zoom, Microsoft Teams and WhatsApp, and face-to-face. Field visits to Western Highlands and Morobe Provinces were undertaken to conduct interviews with project partners and site visits to hospitals and health clinics where MSPNG and SSM services were being delivered. A visit was also conducted to Port Moresby General Hospital in National Capital District (NCD).

Over **75 documents** were reviewed and **68 individuals** interviewed during the evaluation. **Annex 6** provides a list of stakeholders interviewed and **Annex 7** the documents reviewed. Semi-structured interview schedules, focus group discussion guides, and observation checklists are provided in **Annex 8**.

## Analysis, Synthesis and Reporting

Performance at Phase 1 and Phase 2 outcome and output levels was mapped against the logic framework. Evidence and key themes identified from stakeholder interviews were mapped against KEQs and project outcome areas. Follow-up discussions and email communication with key informants were conducted to verify information and gather additional details where necessary.

Initial findings and recommendations were presented to the Australian High Commission in an Aide Memoire presentation on 29 April 2022 and feedback was adopted in the evaluation. The draft report was peer reviewed, and evaluation findings and recommendations were presented to key stakeholders in a review workshop on 15 June 2022. Issues raised at the workshop were considered in the final report.

## Limitations

Due to the challenges of international and local travel within PNG, the evaluation was conducted through a combination of remote and PNG-based inputs. The majority of interviews were conducted remotely and this may have influenced the quality of the information gathered during interviews. PHA stakeholder availability was limited and interviews were conducted in only 5 of the 14 implementation PHAs. Visits were made to 3 of the 6 project provinces. Activities included visits to hospitals where HEFPNs were located. Outreach activities were not viewed and services in SSM clinics had been suspended when the evaluation was conducted. Due to logistical challenges, telephone interviews rather than the planned focus group discussions were conducted with MSPNG community-based volunteers and NFPTP graduates.

## Ethics

Data collection was conducted in accordance with DFAT ethical guidelines. Informed consent was sought from all participants prior to commencing the interview, with the interviewer explaining the purpose of the evaluation and the interview, and confirming that data would be securely managed and de-identified in the final report. Specific permission was sought prior to recording any interviews.

## Key Evaluation Questions

The Key Evaluation Questions and sub-questions for the evaluation are included in **Annex 5**. These questions are based on DFAT design quality and Organisation for Economic Co-operation and Development (OECD) Development Assistance Committee (DAC) evaluation criteria, and were developed in consultation with the AHC to address issues of interest.

## 5. Findings

### Effectiveness (KEQ 1)

#### To what extent has the program achieved the expected outputs and outcomes over Phase 1 and Phase 2 of the program?

##### Summary:

- All Phase 1 EOPO service delivery targets were achieved or exceeded. In 2019, the annual number of FP services delivered by the partnership was 104,969, double the number delivered in 2016 (50,178) and annual CYPs had increased by 48%, from 120,000 in 2016 to 177,694 in 2019. Despite the impact of reduced funding and COVID-19 restrictions, the majority of Phase 2 service delivery targets were achieved. A total of 31,248 FP services were delivered (123% of target) and 85,919 CYPs (141% of target) were reported between July 2020 and December 2021.
- NFPTP training and supportive supervision have been effective in increasing delivery of LARCs at scale. Through this process, 80% of trainees have achieved Level 1 competency, and trained HCWs delivered 143,425 CYPs between 2018 and 2021. The number of FP services and CYPs delivered through the NFPTP reported in Phase 2 is two to three times proposed targets<sup>23</sup>.
- National and subnational stakeholders value the contribution of MSPNG and SSM to improving SRH/FP and MCH service delivery outcomes in PNG; however, it was widely commented on by PHAs that far stronger communication and collaboration from MSPNG is expected. A more substantial project logic and measurement of progress towards intended partnership outcomes is required.
- Progress towards developing and piloting diversified NFPTP courses and establishing the NFPPN – which is important for improving sustainability, reach and efficiency of LARC training – has been significantly delayed.
- Achievements related to inclusive service delivery were variable. In Phase 1, targets for reaching young people and GBV survivors were exceeded, but targets for training and inclusive service delivery were not achieved. In 2021, COVID-19 restrictions and funding cuts affected performance. Targets for men's attendance with partners at ANC visits and providing services to people with disabilities in Phase 2 were reached, but reported progress towards system strengthening for improved equity and inclusiveness could not be verified.

#### **KEQ1.1: Improved partnership and collaboration for sustainable and efficient FP/SRH and MCH service delivery at the national and subnational level in target provinces in PNG**

##### Phase 1 and Phase 2 objectives

Phase 1 of PSF sought to strengthen the PNG health system at the subnational level to deliver integrated, inclusive SRH/FP and MCH services. This was to be achieved through establishing partnership agreements, participating in PHA coordination meetings and sharing results of operational research and lessons learned on delivery of inclusive, quality SRH/FP and MCH services. MSPNG supported national SRH/FP stakeholder coordination through collaboration with various SRH, NGO, government, and professional stakeholders, particularly in its role as the Secretariat for the National Family Planning Technical Working Group (NFPTWG). Phase 2 aimed to build on the success

<sup>23</sup> It should be noted that some CYPs generated by NFPTP trainees in Phase 1 were reported under Phase 2.

and learning from Phase 1 and increase the foundations for sustainable systems and partnerships at the national and subnational level.

### **Phase 1 and Phase 2 performance against targets**

Although Phase 1 targets for coordination with stakeholders and conducting high-level briefings were consistently achieved or exceeded (12 for a target of 8 high-level briefings held with key decision makers – Output 4.1.3), annual targets for signing and implementation of partnership agreements were not met throughout Phase 1. A 2019 review of the PPF project<sup>24</sup> observed that delays were attributed to PHAs' preoccupation with developing governance and administrative structures, while PHAs reported that it had taken time to gain agreement from implementing partners to align priorities with those of government. Stakeholders confirmed that MSPNG is a valued partner of the Government of PNG, but called for communication and reporting at the subnational level to be strengthened, and for MSPNG activities to be better aligned to PHA health systems to support their work and objectives more effectively.

In the first 6 months of Phase 2, despite the challenges of the COVID-19 pandemic, PSF reported meeting or exceeding partnership targets:

- 4 of 4 Service Agreements or MOUs were approved and executed with PHAs in project provinces – IO1.1.
- 1 of 1 PHAs showed evidence of integrating MSPNG/SSM learning into activity plans, programs, or budget plans – IO1.2.
- 3 of 2 NDOH Training Unit meetings held – Output 1.2.1.
- 3 of 2 National Family Planning Technical Working Group meetings held – Output 1.2.2.
- 18 of 5 multi-sector strategic government events and professional stakeholder meetings held – Output 1.3.1.

Meetings with multi-sectoral stakeholders to advocate for integrated, rights-based women's health were held face-to-face, online, and via telephone. However, results against targets for this outcome declined in 2021, with progress reports showing that only 3 of the 5 related targets were achieved:

- 1 of 3 service agreements or MOUs approved or executed with PHAs in project provinces.
- 21 of 8 national and subnational stakeholder meetings to assess health needs, disseminate operational research/lessons learned, and advocate for rights-based women's health.
- 3 of 2 NDOH Training Unit meetings.
- 6 of 4 NFPTWG meetings.
- 4 of 20 multi-sector strategic government events and professional stakeholder meetings held.

Although planned meetings with the NDOH Training Unit were conducted, neither the NFPTWG nor the newly established RMNCAH Technical Advisory Committee met in 2021. This was attributed to disruption in NDOH staffing, a focus on the COVID-19 response, and lack of MSPNG staff capacity to progress these activities<sup>25</sup>. Progress reports indicated that the target for number of PHAs showing evidence of integrating MSPNG/SSM learning into activity plans, programs, or budget plans was achieved; however, no evidence to verify this achievement was available to the evaluation team.

---

<sup>24</sup> Siegmann et al., 2021, p.15.

<sup>25</sup> As explained in the PSF 2021 Progress Report.

## Stakeholder feedback on partnership and collaboration

Subnational partners found that SSM's work was effective and closely aligned with PHA systems. Although there is room to improve SSM–PHA communication, key informants reported that the partnership with SSM was strong and they valued SSM's contribution to the delivery of health services in project provinces.

National and subnational stakeholders almost uniformly appreciated the work of MSPNG in delivering family planning services and training to health care workers and affirmed the importance of this work for the province and the PHA. Overall, however, MSPNG's communication and coordination of activities was not adequately consistent or to the standard expected by subnational government and NGO stakeholders<sup>26</sup>. Key informants expressed concern about MSPNG's failure to follow up on previously agreed activities or provide information about their activities to senior staff responsible for SRH/FP and MCH services in that area. PHA stakeholders consistently requested improved coordination, information sharing and MSPNG involvement in PHA health service planning. A more deliberate, ongoing and structured approach to communication and partnerships that is aligned with and oriented towards PHA requirements is needed from MSPNG if partnerships are to continue and develop in a substantial way. This evidence also underlines the fact that the presence of partnership agreements and participation in quarterly meetings, while necessary and valued by PHAs, is not adequate for partnership development. A more substantial logic and way to measure progress towards the intended outcomes needs to be addressed in any further project design<sup>27</sup>.

Performance against targets for all Outcome and Output indicators related to partnership and collaboration for Phase 1 (IO4) and Phase 2 (IO1) is shown in Annex 9.

## KEQ 1.2: Increased awareness and uptake of high quality, integrated SRH/FP and MCH services in the target provinces

### Uptake of high-quality integrated SRH/FP and MCH services

In Phase 1, partners met or exceeded all service delivery targets, as shown in **Table 1**.

**Table 1: Phase 1 performance against SRH/FP and MCH service delivery targets**

Phase 1	# people reached with SRH/FP/MCH services	# FP services	# CYPs generated	# women attending first ANC	# U5 children immunised	# U5 children treated for malnutrition/pneumonia	# people treated for STIs and HIV
Target	570,675	180,000	362,637	12,650	22,325	14,050	28,280
Achieved	600,326	222,209	352,857	16,282	27,351	31,380	41,814
% of target achieved	105%	123%	97%	129%	123%	223%	148%

<sup>26</sup> For example, in one PHA, a CEO expressed his satisfaction with the extent of coordination by MSPNG, and the Family Planning Coordinator often accompanied MSPNG to outreach visits; however, the Family Health Services Coordinator voiced concern that she had not received workplans or activity reports from MSPNG and, as she did not attend executive management meetings, she was unaware of the information shared at this level.

<sup>27</sup> Frameworks such as the University of Southern Maine's Partnerships for Success Rubric (2014), for example, provide a streamlined but solid approach to measuring partnership development.



Services were delivered via MSPNG and SSM clinics; in Port Moresby General Hospital, provincial hospitals, and government community health facilities; via outreach to rural, peri-urban and urban areas; and in joint patrols with GoPNG across 14 provinces and 48 districts.

In Phase 2, the project aimed to consolidate Phase 1 results and narrowed the number of provinces for direct service delivery from 14 to 6, commensurate with reduced project funding. Service delivery was restructured in response to the reduced budget: 2 of the 4 MSPNG fixed clinics were closed and MSPNG clinics were no longer funded by PSF; outreach teams were reduced from 15 (2019) to 5 (2020); and HEFPNs were reduced from 5 to 2. A listing of all PSF-supported MSPNG and SSM activities by provinces for Phase 1 and Phase 2 of the project is shown in **Annex 10**<sup>28</sup>. PATH provinces are highlighted. This resulted in a significant decline in the volume of services delivered by the project, as shown in **Table 2** below<sup>29</sup>.

Phase 2 outcomes were further affected by the impact of COVID-19-related travel restrictions and GoPNG health service protocols and priorities, particularly in the first half of 2020. Despite the continued challenges related to the pandemic, along with tribal fighting in Hela Province, the project met and exceeded 7 of the 9 (reduced) service delivery targets in the last half of 2020:

- 22,908 people accessed SRH/FP/MCH services in urban and peri-urban areas, exceeding the targeted 19,678 (116%).
- 10,788 accessed SRH/FP/MCH services in rural areas, exceeding the target of 8,282 people (130%).
- 7,748 FP services were provided, falling shy of the target of 12,695 (61%).
- 28,673.3 CYPs were generated in project provinces (services and NFPTP), exceeding the target of 18,134 (158%).
- 978 pregnant women attended at least 1 ANC visit (combined with PMTCT), exceeding the target of 560 (175%).
- 1,607 children were immunised in each province, exceeding the target of 1,000 (161%).
- 92 children under 5 were treated for malnutrition, falling shy of the target of 100 (92%).
- 1,015 children under 5 were treated for pneumonia in project provinces, falling shy of the target of 1,500 (68%).
- 2,329 people were treated for STIs and HIV, including PMTCT, exceeding the target of 1,600 (146%).

The majority of 2021 MCH service delivery targets were not achieved, likely due to the suspension of SSM services delivered under the PSF project from July 2021:

- 20,067 people accessed SRH/FP/MCH services in urban, peri-urban areas, falling shy of the targeted 39,356 (51%).
- 28,837 people accessed SRH/FP/MCH services in rural areas, exceeding the target of 20,406 (141%).
- 31,248 FP services were provided, exceeding the target of 25,390 (123%).
- 85,919 CYPs generated in project provinces (services and NFPTP), exceeding the target of 57,846 (149%).
- 1,920 pregnant women attended at least 1 ANC visit, exceeding the target of 1,600 (120%).

<sup>28</sup> Data for this table was based on service statistics provided by MSPNG and the summary table was cross-checked by MSPNG.

<sup>29</sup> When interpreting this table, it should be noted that Phase 1 covered 3 years and the Phase 2 results shown are for 1.5 years of this stage of the project.

- 2,506 children immunised in each province, falling shy of the target of 3,000 (84%).
- 111 children under 5 treated for malnutrition, falling shy of the target of 200 (56%).
- 1,977 children under 5 treated for pneumonia in project provinces, falling shy of the 1,000 target (66%).
- 3,657 people treated for STIs and HIV, including PMTCT, falling shy of the target of 4,000 (91%).

The number of people reached with quality, client-centred SRH/FP and MCH services and information across the 2 phases of the PSF project until December 2021 is shown in **Table 2**.

**Table 2: People reached with SRH/FP and MCH services and information through the PSF project**

Indicator	Phase 1 Jul 2017–Jun 2020	Phase 2 Jul 2020–Dec 2021	Total Jul 2017–Dec 2021
Project provinces – direct service delivery	14	6	–
People reached with/accessing* SRH/FP/MCH services	600,326	82,600***	682,926
FP services in project provinces	222,209	38,996	261,205
CYPs generated in project provinces	352,857	114,592	467,449
Pregnant women attending at least 1 ANC visit (combined with PMTCT)	16,282	2,898	19,180
Children under 5 immunised (3rd dose Pentavalent, Measles/ Rubella 9–17 months)	27,351	4,113***	31,464
Children under 5 treated for malnutrition and pneumonia	31,380	3,195***	34,575
Number of people treated for STIs and HIV including PMTCT in project provinces	41,814	5,986	47,800
Women, men, youth and people with a disability reached by IEC, awareness-raising and demand-generation activities**	46,034	640,233	686,267

Source: PSF 2017–2021 Annual Progress Reports and Annexes

Note: \* This target changed from ‘reached with services’ in Phase 1 to ‘accessing services’ in Phase 2.

\*\* In Phase 2, the indicator related to awareness-raising (3A 1) was ‘Number of people reached with FP/SRH and MCH information through IEC materials and social media’.

\*\*\* 100% of target for these indicators not achieved.

A further shift was that the majority of CYPs reported in Phase 2 were generated through services delivered by NFPTP trainees or graduates, rather than services directly delivered by consortium partners<sup>30</sup>. NFPTP CYPs increased from 20% of reported CYPs in Phase 1 to 70% of all CYPs reported in Phase 2. This is evidence that NFPTP training and supportive supervision for NFPTP graduates have been effective approaches for increasing LARC service delivery at scale.

<sup>30</sup> In line with Marie Stopes guidelines, ‘NFPTP CYPs’ are those generated during MSPNG-delivered family planning training and while trainees are under supervision (based on MSPNG guidelines); this is an 18-month period under the NFPTP model.

A breakdown of project CYPs by year and NFPTP CYPs reported in that year is shown in **Table 3**. It should be noted that some NFPTP CYPs reported in Phase 2 were delivered during Phase 1 of the project. NFPTP CYPs also came from services delivered across 11 provinces (not only the 6 target provinces for Phase 2).

**Table 3: Breakdown of NFPTP CYPs reported by year in PSF Phase 1 and Phase 2**

**Phase 1**

CYPs	2017* (Jul–Dec)	2018	2019	2020* (Jan–Jun)	Total
All CYPs	41,238	114,305	177,694	19,620	352,857
NFPTP CYPs	–	17,469	46,129	–	63,593

**Phase 2**

CYPs	2020 (Jul–Dec)	2021	Total
All CYPs	28,673	85,919	114,592
NFPTP CYPs	15,972	63,860	79,832

**Total NFPTP CYPs as % of all CYPs reported in each phase**

Phase 1	Phase 2
18%	70%

Source: PSF 2017–2021 Annual Progress Reports and Annexes

Note: \* No CYP outcomes for NFPTP graduates were reported in the 2017 report; and NFPTP supervision and training activities were suspended in the January–June 2020 period so NFPTP trainee service delivery data was not collected from health facilities.

### Health service quality and acceptability

MSPNG and SSM monitor and maintain the quality of their health services through internal clinical quality systems that meet MSI global quality standards (for MSPNG) and NDOH National Health Service Standards (for SSM). Although failing to meet clinical quality performance targets in Phase 1, MSPNG outlined efforts to address identified shortfalls. In Phase 1, client satisfaction was assessed through MSPNG’s annual Client Exit Interview survey. For Phase 2, MSPNG reported continued training and assessment of its staff and monitoring NFPTP graduate service quality, in line with MSI quality standards; however, neither of the proposed external quality assessments have been conducted in Phase 2. Although a small client feedback survey (n=78) and a ‘light’ Client Exit Interview in 2 non-PSF-supported MSPNG clinics were conducted in 2021, there was no substantial, recent information on health service quality and client satisfaction available to the evaluation team. In Phase 2, there are no quality indicators for SSM services and this should be addressed.

### Phase 1 and Phase 2 awareness-raising activities

In Phase 1, PSF partners exceeded performance targets for awareness-raising and demand-generation activities (46,034 of 25,934 individuals were reached – Output 2.1.2). Activities under this outcome included providing training and support for Community Based Mobilisers, who play a key role in: demand-generation and awareness-raising for MSPNG and SSM; health promotion and group counselling conducted by outreach teams; collaborating with NGOs, schools and universities to conduct awareness-raising, particularly for young people and men; and conducting SRH/FP information campaigns via radio and social media, centred on the MSPNG Facebook page.

More targeted use of social media resulted in a jump in the numbers of people reached with SRH/FP information in Phase 2 and overachievement of the key indicator for this activity (220% of the target reached). Although the MSPNG social media strategy has been successful in reaching young people and generating client bookings at the MSPNG Port Moresby clinic, it reportedly had low levels of reach into rural areas in PSF target provinces. More effective methods of generating referrals for FP services in project provinces, such as the CBM network, were underused and planned training for CBMs lagged in 2021 (23 of 60 CBMs/Village Health Volunteers (VHVs) were trained and supported – Output Indicator 3A1.1). MSPNG reported that a CBM mentor has been recruited to provide stronger support for this critical community network in 2022.

### **Impact of IEC, awareness-raising and community mobilisation activities**

Although increased uptake of SRH/FP and MCH services may be assumed to equate to greater acceptance of those services, evidence concerning the extent to which awareness-raising activities resulted in increased awareness of key audiences was mostly anecdotal. For example, a hospital nurse, who had worked at the same rural hospital for 4 years had seen an increase in women seeking long-term family planning methods:

‘Before more clients preferred Depo, now they prefer implants and a few IUDs [intrauterine devices]. This is because there’s been a lot of awareness around implants but also ruling out misconceptions, and from observations, we’ve started seeing more clients coming forward for implants.’

There was also no established baseline to measure changes over time in attitudes and behaviour that might result from IEC and awareness-raising activities. Given the wide range of activities conducted by partners in this area and the critical importance of identifying successful strategies to increase information access, awareness, and demand for SRH/FP and MCH services, as well as measuring and documenting the successes of this project, a structured assessment of effectiveness and impact of specific IEC and awareness-raising activities is likely to be informative and useful for future planning for SRH/FP and MCH programs.

Performance against all service delivery and awareness-raising targets for Phase 1 (IO2) and Phase 2 (IO3A and 3B) are available in **Annex 9**.

### **KEQ 1.3: Strengthened public sector capacity at the subnational level to deliver high quality FP/SRH services in target provinces in PNG**

The primary strategy to strengthen public sector capacity for FP/SRH service delivery in Phase 1 was the delivery of the National Family Planning Training Program, a 2-week in-service training course in LARC delivery for GoPNG and civil society organisation (CSO) nurses and Community Health Workers (CHWs). Targets for training in Phase 1 were achieved, with a total of **369 health care workers trained, across 17 provinces and 86 districts; 317 health facilities had the capacity to deliver LARC services** by the end of 2019<sup>31</sup>. The majority of trainees were government health workers, but also included were NGO staff (PNG Family Health Association, and Susu Mamas) and church health service providers (Lutheran and United Church Health Services). Through this process, 80%, or 296

<sup>31</sup> As reported in the PSF Six Month Progress Report, 1 January 2020–30 June 2020.

trainees, have now achieved Level 1 competency<sup>32</sup> and trained HCWs delivered a total of 143,425 CYPs between 2018 and 2021<sup>33</sup>. This is an important outcome.

NFPTP training is recognised as high quality and effective and has enabled a substantial number of GoPNG and NGO providers to independently deliver long-term family planning methods. According to several PHA interviewees, it has contributed to improved FP coverage in target provinces.

Phase 2 NFPTP-related service delivery targets have been greatly exceeded, as shown in **Table 4**.

**Table 4: NFPTP-related targets and achievements in Phase 2**

**2020**

Phase 2 Intermediate Outcome Indicator	Target	Achieved	%
IO 2.1 Number of health facilities at subnational level that have the capacity and are delivering high quality SRH/FP and MCH services in project provinces	24	0	0%
IO 2.2 Total number of services for SRH/FP through NFPTP	2,088	5,041	241%
IO 2.3 Total number of CYPs for FP through NFPTP	4,834	15,972.30	330%

**2021**

Phase 2 Intermediate Outcome Indicator	Target	Achieved	%
IO 2.1 Number of health facilities at subnational level that have the capacity and are delivering high quality SRH/FP and MCH services in project provinces	65	66	102%
IO 2.2 Total number of services for SRH/FP through NFPTP	8,000	21,255	266%
IO 2.3 Total number of CYPs for FP through NFPTP	20,000	63,860	319%

Source: PSF Annual Progress Reports 2020 and 2021

It was intended that the Phase 1 NFPTP outcomes would be consolidated in Phase 2 and delayed delivery of supportive supervision to NFPTP trainees and certification of graduates was to be completed. This did not proceed in 2020 due to budget constraints and COVID-19 restrictions. However, supportive supervision resumed in 2021, and the target for the number of supportive supervision visits was exceeded (66 visits compared to a target of 34 visits).

Nevertheless, PHA clinicians expressed concern that they do not have information on MSPNG plans to conduct supervision of trainees, the current levels of competency of their staff, or when trainees who attended training in Phase 1 will be certified as competent to independently deliver LARC services. As supervisors and managers of these HCWs, it is essential that this information is provided to PHAs. Trainees themselves report that they do not feel competent to deliver LARC services without certification. According to MSPNG guidelines, CYPs can be 'collected' from NFPTP trainees until they are certified and this contributes to meeting organisational CYP targets. This recognises the essential contribution of MSPNG to the production of CYPs. If certification is not progressed according to an agreed timetable, however, there is the potential that delays may be perceived as being due to a conflict of interests. It is therefore essential for MSPNG to increase transparency around the NFPTP training, supervision, and certification process.

<sup>32</sup> Level 1 competency means the trainee can independently deliver a service without supervision, providing a safe and effective procedure. After achieving Level 1 competency, a period of supportive supervision is provided by MSPNG, after which trainees are assessed and certified as competent.

<sup>33</sup> See Table 2 for further details of NFPTP-generated CYPs reported by year.



A fundamental weakness in the NFPTP training model rolled out in Phase 1 is that it substitutes rather than supports PHA clinicians and managers in their role, with MSPNG clinicians conducting training and supportive supervision largely independently of PHA clinicians who have responsibility for these activities. The relatively high cost of the NFPTP training model also decreases the likelihood that PHAs will agree to share training costs as initially intended. Substantial initiatives were planned under Phase 2 to diversify the NFPTP training course and establish a National Family Planning Provider Network to address these recognised weaknesses, but these have stalled. Content for the revised LARC in-service courses is still in development and the NFPTP TOR has been developed and presented to NDOH but no further progress on developing this model was reported. In the meantime, MSPNG clinicians are inviting PHA Family Planning Coordinators to accompany supervisory visits and have reportedly involved some PHA clinicians in training delivery, but this was not taking place across all PHAs.

Performance against targets for all public sector capacity building Intermediate Outcome and Output Indicators in Phase 1 (IO1) and Phase 2 (IO2) are shown in **Annex 9**.

#### **KEQ 1.4: Improved equity, inclusiveness, and sensitive delivery of FP/SRH and MCH services at subnational level in target provinces in PNG**

The delivery of high-quality, people-centred SRH/FP and MCH services and information to women, particularly those under-served by the existing health system, has been an important contribution of this project. It has expanded reproductive choices for women, with potential impacts on gender equity, access to education, employment and advancement, for under-served populations who would normally face major barriers to access quality essential health care. Affordability is another critical factor in increasing equitable health coverage, and MCH and SRH/FP services provided under the PSF are free of charge.

Despite these major achievements there has been mixed performance in delivering more inclusive services and reaching disadvantaged populations. In Phase 1, the project exceeded targets for the number of young people receiving SRH/FP and MCH services (23,401 of 18,000 clients under 20 years old reached – 130% of target), and SSM made progress in providing services to people experiencing GBV (335 of the target of 260 cases/referrals of GBV clients in project provinces – 129% of target achieved). Some of the measures credited with achieving these outcomes were: use of social media to reach young people; establishing a Men's Clinic and employing a young male HCW to see young men; and recruiting a GBV Counsellor to provide specialist support to clients. In Phase 1, MSPNG service data was not disaggregated by disability; thus performance in reaching people with a disability could not be assessed. None of the targets for training PSF staff in disability-inclusive, youth-friendly, and GBV service delivery in 2018 and 2019 were achieved, reportedly due to challenges in organising training. It also appears that training staff in delivery of inclusive services was considered to result in inclusive service delivery (Phase 1 Output Indicators 3.1.1 to 3.1.5), without measurement of whether and to what extent this was achieved.

In Phase 2, targets for the number of men supporting partners at ANC/PMTCT clinics, people living with disability served with information and FP/SRH/MCH services, and staff training in inclusion, PSEAH and child protection, were achieved or exceeded. However, there were some barriers to access; for example, SSM reported that numbers of young people accessing health care declined due to COVID-19 transport restrictions and the potential stigma associated with a positive result from the COVID-19 test, now a requirement for clients attending health centres. Transport restrictions also affected numbers of women experiencing GBV who were seeking health services, and GBV services were affected by PSF funding reductions (the specialist GBV Counsellor position could not be

maintained). Subsequently, neither of the IO targets (IO 4.1 and IO 4.2) were reached. It was also planned that project partners would work with PHAs to assist establishment of baseline service data for high need groups (Output 4.1.1). Although it was reported that targets were reached, MSPNG did not have evidence to verify these meetings or the outcomes from these meetings.

Performance against targets for inclusive service delivery Intermediate Outcome and Output Indicators in Phase 1 (IO3) and Phase 2 (IO4) are shown in **Annex 9**.

## Efficiency (KEQ 2)

### To what extent is the relationship between inputs and outputs timely, cost-effective and to expected standards?

#### Summary:

- The complementary models of MSPNG, a well-resourced specialist SRH/FP NGO, and SSM, a local NGO delivering integrated family and youth primary health care, have resulted in high numbers of people reached with SRH/FP and MCH services and increased access to long-term family planning methods. The intention that the two organisations would deliver ‘integrated FP/SRH and FP services’ was not achieved in Phase 1; however, alternative models of integration, such as joint outreach with government and the HEFPN model, have been implemented.
- PSF partners appreciated the support and guidance provided by the PPF management team during Phase 1, but this type of support has not continued under PATH in Phase 2.
- SSM valued MSPNG LARC training, but the proposed MSPNG organisational capacity building support to SSM was delayed.
- Abrupt reductions in PSF project resourcing and COVID-19 restrictions had a destabilising impact on both organisations. The reduced funding spurred MSPNG and SSM to look for efficiencies and, in some cases, this has affected project quality. Recent suspension of SSM funding has led to reduced MCH service outcomes.
- It is essential that delays are addressed in the planned diversification of NFPTP training and establishing the NFPPN, both necessary for achievement of IO2, which is 1 of the 4 Phase 2 IOs.

#### KEQ 2.1: The partnership’s organisational model (e.g. funding model, resource allocation, team structure and governance mechanisms)

This partnership was led by MSPNG, a specialist FP organisation with strong management, clinical quality systems and delivery capacity. MSPNG was responsible for overall management of the grant and reporting, and was the recipient of the majority of grant funding. Melbourne-based MSI Asia Pacific holds the contract and, together with the MSI Reproductive Choices team in London, provides organisational, clinical quality, data management and governance support to MSPNG to ensure compliance with organisational and donor standards. It was initially intended that MSPNG would use its experience and capacity to strengthen the organisational capability of its junior partner, SSM, with a view to SSM assuming a greater leadership role in the project over time<sup>34</sup>.

The complementary contributions of each partner to project outcomes, and their differing orientations to service delivery, are illustrated in the snapshot of services provided by MSPNG and

<sup>34</sup> As outlined in the PSF Phase 1 Concept Note, Phase 1 (p.10). SSM’s organisational capacity challenges were further noted in the PSF 2017 Progress Report, which stated that MSPNG plans to link more with SSM and provide increased and regular support (2018, p.14).

SSM in 2019 (Phase 1) shown in **Table 5** below. MSPNG, with strong resourcing, a larger footprint, and a focus on providing permanent and long-term contraceptive methods, delivered 94% of CYPs during that period; however, local NGO, SSM, with its model of family health service delivery supported by strong community engagement, was responsible for 75% of people reached with integrated SRH/FP and MCH services. There was not adequate information to assess the relative efficiency of each organisation in delivering a specific service. Furthermore, because of their different operating models and outputs, an assessment of efficiency is likely to depend on the desired results to be achieved.

**Table 5: PSF services delivered by organisation, 2019**

Services	MSPNG	SSM	Total	Total SSM %
Increased number of people reached with SRH/FP and MCH services	59,150	187,248	246,398	76%
FP services	56,873	48,096	104,969	46%
CYPs	167,467	10,227	177,694	6%

Source: Annual Progress Monitoring and Evaluation Plan, PSF 2019 Annual Progress Report – revised 9 May 2019.

### Integrated SRH/FP service delivery

It was originally intended that bringing together these two organisations would support the development of models of integrated SRH/FP and MCH services, to enable delivery of ‘integrated’ services, and reach at population scale, as defined in the Phase 1 EOPO<sup>35</sup>. Many of the Phase 1 partnership activities aimed at developing such models, such as co-located health services and joint service delivery, did not eventuate<sup>36</sup>. This was due to logistical and coordination challenges, the absorptive capacity of government clinics to host an integrated outreach service, as well as the focus on delivery of the national polio and supplementary immunisation campaigns in 2018–2019. Nevertheless, a range of alternative ‘integrated’ approaches were trialled, such as rotating MSPNG clinicians in SSM clinics, conducting joint outreach with government partners (MSPNG), managing and operating government facilities (SSM), and the Hospital Embedded Family Planning Nurse model (MSPNG)<sup>37</sup>.

### Partner communication and capacity building

MSPNG and SSM report having a good partnership and maintained communication during the pandemic via Zoom and email. LARC training and supportive supervision provided by MSPNG to SSM has given SSM in-house capacity to provide implant and IUD services, and SSM reports it has since adopted MSPNG clinical quality and capacity building approaches; for example, creating the role of a clinical mentor in the organisation. Although MSI Asia Pacific reported that capacity building and training was provided to SSM, and the evaluation heard reports of troubleshooting assistance being provided to SSM, there was no evidence of a proactive strategy to provide capacity building support to SSM’s management team.

<sup>35</sup> Phase 1 EOPO: Contribute towards reducing Maternal Mortality Ratio (MMR), Infant Mortality Rate (IMR), Neonatal Mortality Rate (NMR) and Under-5 Mortality Rate through improved uptake of integrated SRH/FP and MCH services in 14 provinces of Papua New Guinea.

<sup>36</sup> In 2018, 40 of 348 joint service delivery points were delivered and in 2019 less than 50% of joint MSPNG–SSM outreach patrols were conducted.

<sup>37</sup> Increases in conducting joint outreach with government were attributed to ‘better prioritisation, planning and resource management’ (PSF 2019 Progress Report).

## Impact of no-cost extension, Phase 2 budget reductions and COVID-19 pandemic

In Phase 1, the PSF project successfully delivered on its objectives of providing MCH and SRH/FP information and services at scale. This was demonstrated in the number of people accessing SRH/FP and MCH services, and CYPs generated through these services, steadily improving from 2017 through to 2019. These gains were attributed to strong remote management and internal efficiencies introduced during the year<sup>38</sup>. As Phase 1 of the PSF neared completion, a no-cost extension (NCE) was announced and the project extended for an additional 3 months<sup>39</sup>. Subsequently, the partners were required to drastically and rapidly scale down operations and staffing to reduce costs and stretch allocated funding to cover the no-cost extension period. This experience, described by key informants as ‘brutal’ and ‘traumatic’, resulted in the retrenchment of 70% of SSM staff and 51% of MSPNG staff (overall 63% of the partner workforce)<sup>40</sup>, and a loss of skills and experience from both organisations, including those who had received training in inclusive service delivery. Planned activities, such as supervisory visits to NFPTP trainees were cancelled, or suspended due to lack of funds, slowing certification of trainees; Service Agreements were ‘broken’, and SSM wound back its rural outreach services.

The combined effects of the COVID-19 pandemic, related restrictions, and closures of health facilities, saw PSF service figures plummet for the January to June 2020 period. The number of visits through mobile outreach dropped by 85% compared to the previous 6 months, and delivery of family planning services delivered fell from 57,085 in July–December 2019 to 9,377 in January–June 2020.

To offset this impact, both partners restructured their services, searched for more efficient ways of working, and diversified their funding sources, while implementing COVID-19 prevention measures and conducting COVID-19 community awareness and education. With greater stability in funding, despite the continued challenges of COVID-19 restrictions, service numbers began to recover. This was again disrupted due to the suspension of PSF funding to SSM in July 2021, resulting in SSM ceasing many services, and this led to reduced PSF annual performance outcomes for essential MCH and inclusive services.

## KEQ 2.2: Benefits from managing PSF under the PATH Frontline Health Outcomes workstream approach and due to other aspects of PATH (e.g. PATH’s GEDSI focus and adaptive programming approach)

From operating under the PNG Partnership Fund health sector consortium in Phase 1, PSF was moved across to the PATH Frontline Health Outcomes workstream in Phase 2. With its objective of increasing coverage and use of sustainable and integrated SRH/FP and MCH coverage, the PSF project is aligned with the PATH Equity and Essential Services outcomes. The intention to gradually transition PSF project activities to PHA management is also aligned with the PATH objective of building PHA capacity to lead health reform and manage essential health services in target provinces. Grantees had expected that PATH might therefore play a role in supporting PHA capacity building and engagement in line with the PATH program focus, but no such support was provided. The joint workshops, joint field visits, and reflection sessions that had been conducted by the PPF Managing Contractor in Phase 1 were seen as valuable opportunities to review performance and discuss strategies to strengthen project outcomes and better meet client requirements. However, these activities were not continued when PSF moved to the PATH program. It was not clear to the evaluation team why this was the case, other than, possibly, the lack of capacity due to PATH’s substantial additional workload associated with delivering COVID-19 response activities, reported

<sup>38</sup> MSPNG PSF 2019 Progress Report, p.31.

<sup>39</sup> PSF Phase 1 funding of AUD23.2 million over 3 years was reduced to AUD7.7 million for 2.5 years in Phase 2.

<sup>40</sup> PSF Progress Report 1 January 2020–30 June 2020, p.11.

high levels of staff turnover, and prioritisation of support for transition of Accelerated Immunisation Health System Strengthening (AIHSS) project management to PHAs in priority provinces. Instead, the relationship between PATH and PSF largely focused on contract management and program reporting.

### **KEQ 2.3: Program adaptations to increase efficiency and demonstrate cost-savings over time**

#### **NFPTP efficiencies and more cost-effective course formats**

Training delivered under the NFPTP is recognised as high quality and comprehensive. It is also reported to be one of the most-costly elements of the PSF project, with NFPTP training and supervision costs coming to an estimated average of over PGK17,000 per trainee to date<sup>41</sup>. Additional support, including family planning commodities provided to MSPNG by UNFPA and costs covered by the PHAs (e.g. per diems), should also be considered when assessing the cost of NFPTP training delivery. In Phase 2, measures were introduced to save costs for conducting supervision of NFPTP graduates. Sustainability and acceptability of this training model, however, are still significant concerns. The revised 1-week LARC in-service courses, delivered in partnership with the proposed National Family Planning Provider Network<sup>42</sup> and the planned pre-service LARC course, both promised a more efficient and potentially far more sustainable approach to skills development, thus increasing value for money delivered by this investment. The lack of progress in these significant activities raises questions about both the project and contract management in Phase 2.

#### **Balancing efficiency with delivering equitable and sustainable health services**

Implementing remote management strategies for outreach has reportedly reduced costs per CYP across the MSPNG country program. However, many of the costs of reaching rural and remote locations in PNG to provide services are 'baked in' to this model. This makes outreach one of the most expensive forms of service delivery, but it is still the most effective and sometimes the only vehicle to reach communities in these areas. This underlines that the drive to reduce costs or increase 'results' should not come at the expense of achieving project objectives or fidelity to project design. The evaluation heard of teams that no longer had time to deliver joint SRH/FP services with GoPNG partners, apparently due to pressures to achieve targets. The HEFPN model was reportedly not implemented as planned because of inadequate resources<sup>43</sup>, and the GBV Counsellor role that had been key to increasing SSM's GBV client numbers was no longer funded due to budget cuts in Phase 2. While it is not possible to avoid the reality of budget restrictions and performance requirements, it is essential that they are managed in a way that does not undermine the core objectives of the project.

<sup>41</sup> This is calculated using NFPTP expenditure between July 2017 and February 2022, divided by the total number of health workers trained (369); however, it does not yet include the cost of supervision and certification of the remaining 73 trainees. It also does not consider overhead costs and contributions by partners, including UNFPA (family planning commodities) and GoPNG (per diems).

<sup>42</sup> The original 2-week course in implant and IUD service delivery is to be broken down into a 1-week Implant and 1-week IUD course.

<sup>43</sup> It was initially intended that the HEFPN and CBM would work in 'feeder' facilities around the hospital, to conduct wider awareness-raising and expand the reach of this project.



## Relevance (KEQ 3)

**Is the approach undertaken across each of the project components (service delivery, community engagement, partnership with government, training, and capacity building through NFPTP and NFPPN) appropriate for the PNG context and situation?**

### Summary:

- Increasing access to SRH/FP and MCH interventions remains a critical priority for PNG and the PSF model is aligned to GoPNG health sector strategies and approaches.
- The project approach for subnational partnership needs to better recognise the role of PHAs as implementation managers, with the pathway for achieving sustainability clearly defined within the project logic. As implementing partners remain dependent on donor funding to continue delivery of SRH/FP and MCH services, transition to independent PHA management should be seen as a long-term objective.
- Increasing access to LARC is an important objective, particularly for women who lack regular access to health services. However, family planning must be delivered as part of an integrated primary health care approach that provides access to comprehensive SRH services. Models of health care delivery that are integrated with local health systems are likely to promote greater sustainability.
- The HEFPN model is widely recognised as an effective, efficient, and appropriate model for increasing access to post-partum family planning in PNG, but there are potential areas for improvement. A summary of ‘success factors’ of different ways of working with priority stakeholder groups across the project and ways to strengthen these in future is included in **Annex 11**.

### **KEQ3.1: Features of the service delivery, training and capacity building models most appropriate for the program context and objectives**

#### **Increasing access to SRH/FP and MCH interventions remains a critical priority for PNG**

Promoting health and human development are critical strategic elements of the GoPNG Vision 2050 and the Development Strategic Plan (DSP) 2010–2030<sup>44</sup>. Achievement of this vision is further defined in the new *National Health Plan 2021–2030*, with its goal of preventing ill health, addressing health risks, and providing accessible and affordable quality health care to all, through functional partnerships that provide equitable, high-quality, people-centred and integrated services that engage with and respond to community needs. These national strategies are underpinned by the GoPNG commitment to achieving the Sustainable Development Goal targets and health targets, key of which are the reduction of maternal, neonatal and infant mortality, and universal access to sexual and reproductive health services and essential health care. The NDOH *National Maternal and Newborn Health Strategy 2021–2025*<sup>45</sup> outlines targeted interventions needed to reach priority populations, including improving facility-based SRH care, increasing awareness and scaling up demand for SRH/FP and MCH services, and engaging communities and PHAs in improving delivery of integrated, people-centred reproductive and maternal health care.

<sup>44</sup> Department of National Planning and Monitoring, 2010.

<sup>45</sup> National Department of Health, 2022.

### **PSF is aligned to GoPNG strategies and approaches**

PSF uses a primary health care approach to provide essential SRH/FP and MCH interventions to the most under-served communities in PNG. MSPNG and SSM service delivery models employ well-trained teams applying comprehensive clinical standards with strong logistical support and good planning to deliver high-quality, client-centred family planning information and services. The assistance of Community Based Mobilisers and Village Health Volunteers is integral to generating community engagement and referrals. Training for HCWs and hospital-embedded specialist FP providers increased the reach of these services. Employment of these interventions, together with clinic-based services over the 4.5 years of the project, resulted in over 600,000 people having access to quality SRH/FP and MCH services in remote and under-served communities, where there are significant cultural barriers to the use of family planning.

### **NGO partners and direct service delivery remain relevant – when delivered in partnership with government**

Both DFAT and GoPNG interviewees confirmed the important role of NGOs in the health sector in PNG and the continued importance of donor support for direct service delivery. The objective of building PHA capacity to manage services and partnerships needs to be maintained and strengthened. The capacity of PHAs to manage provincial health services in PNG has significantly progressed, albeit at varying levels, since PSF commenced in 2017. Indeed, PHAs and subnational stakeholders are demanding that partners engage with them to design and implement health service delivery and it is no longer acceptable for health actors to conduct parallel delivery of services, regardless of their achievements. The PSF project objective of sustainable SRH/FP and MCH service delivery is aligned to this approach, as well as the less clearly stated expectation that the project will become independently supported by provincial governments. However, these expectations and the pathway through which they will be achieved have not been explicitly defined within the project logic. Implementing partners remain dependent on donor funding to continue delivery of services and all stakeholders consulted recognised that a transition to independent PHA management, particularly for SRH services, is a long-term objective. These issues are explored further under KEQ 6.

### **LARC remains important and relevant – but choice should be available**

Given the logistical challenges and costs that women and men face when trying to access a continuous supply of short-term contraception, particularly those living in poverty, with limited education and in remote areas, the focus on increasing access to LARC methods remains an appropriate, relevant and important means of increasing access to family planning. However, the evaluation team heard reports that in some cases women were not being offered method choices by non-PSF providers. This underlines the importance of continuing to prioritise the full range of reproductive health choices and rights as the basis for this work.

### **Integrated SRH services, not only FP**

Increasing family planning coverage has been a prominent focus within PSF and the majority of project resources support this focus. Family planning remains a critical need in the PNG context, but throughout the course of the evaluation several key stakeholders pointed out the need to expand this perspective when considering interventions to better address SRH needs in PNG. PSF service providers interviewed also informed the team that there was a demand from clients for a broader range of services, such as infertility counselling. The need to prioritise adolescent reproductive health (ARH) was emphasised by several stakeholders. This was captured in the comment of a PHA representative:

‘We would like to see programming in ARH – this is the biggest gap. We would like to see some activities or some support in NCD and CD [non-communicable diseases and communicable

diseases] related to SRH – cervical cancer, breast cancer, prostate cancers are also increasing. These are some things that we would like to see, apart from FP. We need to make sure that women are practising good sexual health. Also for STIs.’

### **Delivery of sustainable, integrated SRH/FP and MCH services**

While both partners deliver quality, client-centred and free-of-charge health care, Susus Mamas employs a model of integrated primary health care that is aligned with GoPNG health systems and involves close engagement with communities. There is a focus on use of clinical aids and building the clinical skills of health workers to provide a continuum of maternal and child health care, integrated management of child and adult illnesses, and sexual and reproductive health services for women and men. SSM also uses a client information system to track client progress and identify unmet health needs, and reports service statistics directly through the eNHIS. Further integration with the health system is delivered through SSM’s establishment of referral pathways and client transfers to specialist or higher-level services. MSPNG services address critical health needs and have also resulted in ground-breaking achievements through increasing access to long-acting methods of contraception in PNG. However, delivery of patient-centred integrated primary health care services and a localised approach is more likely respond to the objectives of delivering integrated care in sustainable manner.

### **Hospital Embedded Family Planning Nurse (HEFPN) model**

The HEFPN model is widely recognised as an effective, efficient, and appropriate model for increasing access to post-partum family planning in PNG. This model, initially developed at Port Moresby General Hospital, involved the placement of an MSPNG-trained nurse in the hospital’s postnatal ward to provide counselling and family planning services to new mothers. Hospital staff and PHA stakeholders interviewed for the evaluation expressed satisfaction with the way the HEFPNs worked with their teams and the positive impact of the program. It provided additional support to nurses and midwives, whose workload often meant that they were not able to offer family planning services, and to the hospital, which did not have the funds to employ additional staff. It also provides women with access to quality counselling and choice of contraceptive methods, at a critical point in their lives. As mentioned above, this program could be more effective if additional resources were available to support CBM and HEFPN outreach to lower-level facilities near the hospital. Hospitals are not always able to provide private spaces for counselling and this impacts on the quality of services that are provided.

The challenges and risks faced by NGO embedded staff should also be recognised: Although MSPNG provided a program of training and personal protective equipment (PPE) for all staff during the COVID-19 pandemic, the hospital ran out of PPE for staff and no other support for PPE was available. Staff are also sometimes faced with violent partners of clients, who oppose the use of family planning. Providing further support and stronger oversight could increase the quality and impact of the HEFPN program and better meet MSPNG’s duty of care. If this program is to continue, moving across to PHA resourcing may not be feasible given the under-resourcing of hospitals in PNG. Plans to move towards this outcome should nevertheless be strongly considered, due to the efficient and high-impact value this approach provides.

### **NFPTP training model**

The NFPTP model is a competency-based training model delivered directly by MSPNG-certified clinical trainers to maintain the quality of training and fidelity to the original content. The model addresses the quality control issues sometimes associated with train-the-trainer models and, as it did not require training of a cohort of PHA clinicians as master trainers, it allowed prompt roll out of the course to project provinces. Trainees were selected by the PHAs (or NGO/health service partner)

according to agreed criteria that encouraged the selection of those who were more likely to have the opportunity to apply the skills they had learned in their workplace. The drawbacks of this approach have been mentioned already: the failure to adequately involve local leaders and clinicians in training and on-the-job supervision of graduates affects sustainability and acceptability of this model. Effectiveness of trained HCWs will also depend on being able to access an ongoing supply of family planning and other commodities, and having the appropriate equipment to maintain infection prevention standards and conduct services. Continued efforts to strengthen health systems at both national and subnational levels are therefore essential for the benefits of this training to be realised.

The proposed diversification of the training courses represented important evolutions in the way that MSPNG delivers LARC training in PNG. If the NFPPN and revised LARC training is to go ahead, strong engagement with PHAs and sufficient flexibility so that the model can be adapted to the context and needs of the individual PHA will be critical to the success of these approach. Given that there are a range of options offered under MSI's Public Sector Strengthening approach to allow programs to be adapted to government needs, this should be a possible way forward<sup>46</sup>.

### **KEQ3.2: What were the key success factors of different ways of working with priority stakeholder groups – and how can partners strengthen these factors in the future?**

A summary of 'key success factors' is provided in **Annex 11** for models working with priority stakeholders through community-based service delivery, partnership with PHAs, inclusive service delivery, hospital embedded services, and the NFPTP training.

## **M&E (KEQ 4)**

### **How have the grantees used operational research and monitoring of progress and achievements for programming, learning and accountability?**

#### **Summary:**

- Proposed operational research was not progressed and, although PSF partners used internal reflection and learning to generate efficiencies and strengthen models of care, learning was not disseminated in a formal manner. In future, shared learning with partners to both recognise local knowledge and develop collaborative, contextually-relevant approaches may be a more appropriate approach and aligned to the partnership objectives of the PSF.
- To support stronger learning and accountability, project indicators and means of verification should be more clearly defined. More detailed progress reporting and stronger record keeping will contribute to greater transparency and better understanding of project activities.

### **KEQ 4.1: Developments and innovations that consortium partners have identified and applied**

Initial plans described in the Phase 1 design document proposed an important role for operational research, working with key actors such as the PNG Institute of Medical Research to 'identify the socio-cultural, gender, economic and health system factors and barriers affecting the uptake of SRH/FP and MCH services and practices'. Participatory research was to be undertaken to 'generate evidence and learning for policy change and GoPNG decision-making, contributing to the development of contextually-appropriate solutions'. Unfortunately, this work was not progressed.

---

<sup>46</sup> MSI Reproductive Choices, 2020.

The PSF was to undertake two pieces of operational research in Phase 1. An MPSNG consultancy in 2017 reviewed the implementation of the NFPTP, but its recommendations were focused on adjustments to an existing training model, rather than exploring suitable approaches for capacity building of health workers in the PNG context more broadly.

Throughout the two phases of PSF, partners used reflection and learning to develop project efficiencies and strengthen models of care. A key activity in both phases was to share lessons learned with government and other health sector partners; however, this was not conducted in a formal manner throughout the project. Furthermore, it is suggested that shared learning between stakeholders, rather than transfer of lessons, is more aligned with the partnership objectives of the project and development of contextually-appropriate approaches. This could be examined in future health programming.

Improvements in the M&E framework, including stronger definition of indicators and means of verification would also contribute to better project learning and accountability. For example, it was not immediately clear how achievements against 'IO1.2 Number of PHAs showing evidence of integrating MSPNG/SSM learning into activity plans, programs, or budget plans' could be demonstrated. Additionally, although it was reported that Phase 2 targets related to this indicator were achieved, no evidence to verify a meeting or how information had been used was available to the evaluation team. This is not a sufficiently robust approach to measurement of a key indicator for 1 of the 4 Intermediate Outcome areas. More detailed reporting of project service delivery – for example, disaggregated by organisation, province and type of family planning method – would enable analysis of results and better understanding of project activities.

#### **KEQ4.2: Applying Adaptive Management and Thinking and Working Politically**

Both PSF partners substantially adapted their work to address and respond to the COVID-19 pandemic, protect staff and clients, and minimise the impact on delivery of outreach and clinic-based services. A case study is included in **Annex 12**. The evaluation found limited evidence of PATH applying adaptive management and thinking and working politically in oversight of the PSF project<sup>47</sup>.

## **GEDSI (KEQ 5)**

### **To what extent has the grant considered and addressed the needs of, and challenges faced by, women, girls, young people and people with a disability?**

#### **Summary:**

- The PSF investment has been directly focused on addressing barriers faced by women through increasing access to quality, client-centred family planning and SRH/MCH information and services; however, it does not directly address social norms around gender, nor implement a gender-transformative approach.
- SSM has a well-regarded model of disability-inclusive service delivery and provides services to women experiencing GBV. Both partners provided examples of practical strategies to reach men and young people. Nevertheless, relatively small numbers of clients from marginalised groups

---

<sup>47</sup> MSPNG interviewees noted that previous PATH advisers had engaged them in informal strategic discussions (e.g. how they could work with church health services). However, more recently, interaction with PATH was restricted to contract-management-related activities.

were reached. To better meet these needs, targeted design, strong resourcing, and clear delivery models for inclusive services, are required.

## **KEQ 5.1: Addressing gender-specific barriers to accessing services and promote women's voice in leadership**

### **Gender-specific barriers**

Women in PNG face major cultural, social and economic barriers to access SRH/FP and MCH services, particularly in rural areas in PNG. While awareness-raising activities address misconceptions concerning family planning, and MSPNG's health promotion towards men in the Highlands has reportedly succeeded through an appeal to men's role as leaders of the family, they do not directly address social norms around gender or aim to implement a transformative approach to address the gender inequity that remains a fundamental barrier to sexual and reproductive health choice and underpins violence towards women<sup>48</sup>.

Conservative attitudes and stigma related to issues such as STIs (including HIV) and GBV prevents both men and women from seeking treatment. SSM has developed highly successful approaches to reach men through its Men's Clinic, prioritising women who attend ANC (combined with PMTCT) when accompanied by their partners, employing young male nurses as members of health care teams, and providing confidential STI services. This has boosted numbers of men seeking health care.

SSM has also developed referral pathways and partnerships to support provision of services to women and children experiencing gender-based and family violence.

### **Women's voice in leadership**

Women In Leadership, a program to support women health professionals to take subnational leadership roles in PSF target provinces, was to be a component of the National Family Planning Provider Network. However, the NFPPN had not yet been established at the time of reporting.

### **Disability-inclusive services**

MSPNG faced challenges establishing a partnership and workable model for providing disability-inclusive care in Phase 1 and its work in this area has not progressed substantially in Phase 2. SSM has developed a comprehensive model of disability-inclusive service delivery over the project period. This involved establishing an ongoing relationship with local DPO, Callan Services, to provide training to SSM staff and volunteers and conduct referrals between each organisation. SSM also has an established relationship with the National Orthotic and Prosthetic Services (NOPS) for the provision of health services to clients with a disability. In addition to having physically-accessible clinics, SSM prioritises people with disabilities who present to the clinic to prevent delays in seeing health care workers; and seeks support from Callan Services and local health services when necessary to communicate with clients. SSM conducts home visits to residential facilities, and local health volunteers assist SSM to identify people with disabilities in local communities to conduct home visits during outreach. As noted by Callan Services, the provision of this type of responsive, integrated and accessible care helps to minimise the stigma that many people with disability experience when accessing health services, which itself represents a major barrier to seeking health care.

---

<sup>48</sup> UNFPA, 2021b.



### Number of 'inclusive' services provided

Despite these efforts, as shown below, the number of women experiencing GBV, young people, and people with a disability, is still a very small proportion of all PSF clients and when compared to the proportion of people in need.

- Treatment or referral has been provided to 1,666 GBV survivors in Phase 1 and Phase 2, representing 0.24% of all clients accessing services.
- An estimated 4% of all clients over the life of the project were between 15 and 19 years old (28,441 out of 682,926 clients accessing SRH/FP/MCH services).
- Clients with a disability made up 1.3% of all people accessing SRH/FP and MCH services in project provinces in Phase 2.

To better reach these groups and individuals, a stronger and more deliberate focus is required in the design, resourcing, and delivery of the project. Organisations such as PNG Family Health Association and Plan International are implementing youth-focused projects to increase access to SRH/FP information and services for young people. CARE International has recently completed implementing a community-based SRH program that addresses social norms change to impact on community barriers to family planning and link women with SRH services. These approaches seem positive and current evaluations of the CARE International and Plan International programs may provide useful information.

The evaluation also learned of efforts led by clinicians at the subdistrict level in PNG to assess the needs of people with a disability in the catchment area as the basis for developing a program to provide services to meet these needs. MSPNG had been a 'big help' in Phase 1 of the PSF, providing a vehicle to assist the district team to travel to collect this data. However this support was no longer being provided and lack of transport and funding at a facility level remains a barrier to progressing these plans.

Expanding access to essential SRH/FP and MCH information and services, particularly for disadvantaged populations, requires national leadership to create an enabling environment. Australian Government interviewees considered that it is possible for DFAT, as one of the key partners of the GoPNG in the health sector, to play a role in supporting this alignment, which would benefit and likely increase the impact of Australian Aid investments across this critical area in PNG.

## Sustainability (KEQ 6)

### To what extent did the program build local ownership, leadership and capacity to continue service delivery beyond the end of the program?

#### Summary:

- The PSF does not have a clearly stated strategy for achieving expected sustainability outcomes beyond those associated with NFPTP LARC training, and a concrete pathway for transferring services to PHAs has not yet been mapped.
- If DFAT is moving away from direct funding to NGOs, a workable, alternative financing mechanism is needed, with a substantial program of PHA governance, management, and administrative capacity building, and a strong system for partner coordination, as per PATH's mandate.
- To better respond to the current stage of development of the decentralised health system in PNG, future programming needs to be strongly aligned with government systems and recognise

the role of PHAs as implementation managers with the authority to determine the nature of health interventions in their PHAs, and to whom implementing partners are responsible.

### **KEQ 6.1: PSF's engagement of local partners and the key successes, barriers and challenges in the approaches used**

The 2019 review of the PPF health sector programs noted the absence of a substantial strategy for achieving expected sustainability outcomes, beyond those associated with the impact of service delivery and training conducted within the life of the project<sup>49</sup>. This remains the case in Phase 2. A concrete pathway for handing over these services to PHAs has not yet been mapped or substantially considered in the project design.

The capacity in many PHAs to organise and manage their existing health services is limited. PSF partners depend on donor funding to continue delivery of services, and the conundrum of how these services might be continued has not yet been addressed. It is not feasible that responsibility for managing and funding these services can be handed over to PHAs without a clear plan that includes options for continued financing of these SRH/FP and MCH activities. Interviewees agreed that there needs to be a substantial program of PHA governance, financial management and administrative capacity building, together with a strong system for coordination between PHAs, implementing partners and other health sector stakeholders. Evidence from health system strengthening efforts internationally indicates the importance of adequately resourcing and empowering district-level health systems, not only those at the provincial level, as this is where responsibility for health service implementation lies<sup>50</sup>.

An immediate priority for any future investments is a much stronger alignment with government systems that recognises the role of PHAs as health system managers, with authority to decide the interventions in their areas, and to whom implementing partners are responsible. PHA personnel specified that this is an approach that they wish to see in the future. It was also strongly endorsed by stakeholders at the recent HDMES PSF/SRHIP workshop. As one PHA senior manager explained:

‘We’ve completed our corporate plan and are keen on selling our corporate plan to partners that would like to invest into supporting health care and service delivery in Morobe Province.

We’d have it introduced, outline our Activity Implementation Plan and say to partners, this is our plan, which part of this plan do you identify with, or can you support? At the end of the years, we’d like to see that we’ve achieved our corporate plan, design, or service implementation plan. This is the kind of approach we are taking.

We don’t want partners telling us what they can do and asking the PHA to go along with them, we must guide them, tell them our priorities and needs.’

---

<sup>49</sup> Siegmann et al., 2020.

<sup>50</sup> Alilio et al., 2022.

## Impact (KEQ 7)

### To what degree did the intervention generate positive or negative, intended and unintended effects?

#### Summary:

- Through this investment, DFAT has provided a large financial contribution to PNG's first donor-funded nationwide program that had a concerted focus on expanding access to LARC.
- The PSF addressed critical gaps in delivery of quality SRH/FP and MCH health services in target provinces, and almost 683,000 people were reached with SRH/FP and MCH services, and over 467,000 CYPs have been delivered over the 4.5 years of the PSF grant. Access to quality SRH/FP and MCH care is known to lead to improved maternal health, family wellbeing, and child survival outcomes. FP services alone delivered under the PSF have averted an estimated 205,279 unintended pregnancies, 253 maternal deaths, and 22,443 unsafe abortions.
- Further strengthening and consolidation of results, with attention to delivery of sustainable, integrated and comprehensive SRH/FP and MCH services in partnership with government, is needed to secure inclusive, equitable, and sustainable access to these lifesaving interventions.
- Future programs need to consider how EOPOs can be measured and incorporate this into the design of the MEL Framework.

#### KEQ 7.1: PSF's contribution to broader SRMNCH outcomes in PNG

Through this investment, DFAT has provided substantial support for the first nationwide SRH/FP and MCH program in PNG that focused on increasing access to LARC methods. The PSF and EOPO aim of reducing maternal, infant, and under-5 mortality in PNG through increased 'coverage and utilisation of sustainable, high quality, inclusive, integrated SRH/FP and MCH services amongst women, men, adolescents, people with disabilities, infants and children' remains a critical priority for the GoPNG.

The evaluation was unable to carry out the level of assessment required to measure the contribution of SRH/FP and MCH services delivered by the PSF project on population coverage or uptake of SRH/FP and MCH services in PNG<sup>51</sup>. It therefore relies on an assessment of results against intermediate outcomes. Future programs in this area will need to consider how EOPOs such as those for PSF are measured as part of project design and well before commencement of activities.

Despite these limitations, it is evident that the project has provided substantially increased access to SRH/FP and MCH services to communities in PNG that would not have otherwise been provided. Almost 683,000 people were reached with quality SRH/FP and MCH services and over 467,000 CYPs have been delivered over the 4.5 years that the PSF grant has been implemented, as outlined in Table 1 and Annex 9. These services are known to be effective, evidence-based, and essential to reducing maternal, infant, and under-5 mortality.

According to the MSs Impact2 modelling tool<sup>52</sup>, the family planning services alone, provided under PSF in Phase 1 and Phase 2, have averted the following negative health outcomes.

<sup>51</sup> A household survey, commonly used as a way of assessing health service coverage, was not possible within the scope of the evaluation. The proportion of all SRH/FP and MCH services in PNG delivered by PSF partners could not be estimated due to lack of data in a suitable format: eNHIS data is not disaggregated by organisation; and SPAR reports do not include the total number of SRH/FP and MCH services delivered.

<sup>52</sup> For a summary of how estimates are calculated, and the data used for these estimations, see the Marie Stopes (June 2018) 'Impact 2, version 5' at [https://www.mschoices.org/media/3319/impact\\_25\\_summary\\_of\\_changes\\_june\\_2018-1.pdf](https://www.mschoices.org/media/3319/impact_25_summary_of_changes_june_2018-1.pdf)

**Table 6: Outcomes averted**

Outcomes averted	Phase 1 <sup>53</sup> (Jul 2017–Jun 2020)	Phase 2 <sup>54</sup> (July 2020–Dec 2021)
Unintended pregnancies	133,600	71,679
Maternal deaths	167	86
Unsafe abortions	14,600	7,843

These outcomes, while critically important in themselves, also lead to further wide-ranging and intergenerational impacts on maternal health, family wellbeing, and child survival<sup>55</sup>. By increasing access to SRH/FP and MCH services in under-served rural, urban, and peri-urban communities, this investment has also made an important contribution to greater gender equity.

Subnational stakeholders uniformly considered that PSF and the work of the two partners, MSPNG and SSM, had made important and significant contributions to delivery of FP and MCH services in their provinces. The project has increased family planning service delivery capacity in the provinces where HCWs were trained and supported to become competent in delivering LARC services. The partners developed a number of successful approaches for reaching men, young people, people with disabilities, and women and children experiencing gender-based violence. These are important achievements. However, to ensure that these achievements are strengthened and the objectives of this project are realised, more remains to be done to increase access to inclusive, quality and people-centred SRH/FP and MCH services in PNG.

## 6. Recommendations

### Recommendation Area 1 – Continue to support SRH/FP and MCH services in PNG

The PSF project has resulted in important achievements; however, increasing access to SRH/FP and MCH information and services remains a critical need in PNG, as well as a priority for GoPNG and its national human development goals. The roadmap outlined in the new National Health Plan and Maternal and Neonatal Health Strategy presents a substantial opportunity for DFAT to engage with NDOH and PHAs to identify areas where support is most needed. As the leading donor in this sector, DFAT can have an important role in delivering these objectives in a way that embeds the achievements of PSF and supports GoPNG and partners to achieve sustainable change in an important area.

**DFAT** should continue to invest in integrated SRH/FP and MCH service delivery to contribute to GoPNG national health priorities, gender equity, and to meeting unmet demand for essential SRH/FP and MCH services in PNG, in areas identified in key NDOH policies. The PSF project has demonstrated that non-governmental providers can have an important role to play in supplementing GoPNG health services and providing quality health services through innovative and inclusive models of care. However, for greater effectiveness and sustainability, it is essential that interventions are provided within a framework of integrated primary health care delivered within a community setting and conducted in partnership with government; and should incorporate effective service delivery approaches, such as the HEFPN model, with adjustments to enhance impact and sustainability. If training in LARC methods is to be continued, any new design will need to examine the most

<sup>53</sup> PPF Health Phase 2 Design Document, 2020, p.3.

<sup>54</sup> P. Blundell, Regional Program Officer (Cambodia, Timor-Leste, Papua New Guinea), MSI Asia Pacific, personal communication, 18 May 2022.

<sup>55</sup> Bazile et al., 2015.

appropriate model for this training, so that it is effective, sustainable, and aligned to NDOH and PHA systems and needs.

### **Recommendation Area 2 – Design and resource program to achieve equity and inclusion objectives**

Equity and inclusion must be central to the delivery of health services, and particularly SRH/FP services. This need is reflected in international policy and evidence, the principles and values of the PNG health system, and the commitment of GoPNG to ‘leave no-one behind’. Some effective and practical approaches for inclusion, particularly for disability and reaching men, were developed through the PSF. However, the project in its current form does little to meet the broader needs of disadvantaged and marginalised populations in PNG.

**DFAT, PATH, and program partners** to clearly define the type and scale of impact that future programs intend to have in reaching under-served and disadvantaged groups and use best practice principles and specialist technical advice to design and resource the program to achieve that impact.

**DFAT** should, through design and scope documents, ensure that the program uses a gender-transformative and youth-friendly programming approach to address the barriers faced by adolescents, women, and men, in accessing comprehensive SRH and MCH health services and better reach under-served populations.

**DFAT** should ensure that service design is disability-inclusive and there is substantial involvement of people with disabilities and other marginalised groups in project design and implementation.

### **Recommendation Area 3 – Recognise PHA leadership through program design and promote partnership at all levels**

The leadership role and authority of PHAs in a decentralised health system must be recognised in all future design and delivery of DFAT-funded health programs.

**DFAT** to ensure that any new health interventions are co-designed with PHAs, and respond to PHA priorities and the local health system context. Partnership with subnational government and health system stakeholders at all levels should be central to the program design. Central to the selection of implementing partners should be their demonstrated ability to engage effectively with health system owners and stakeholders, alongside delivery of quality, inclusive, and integrated SRH/FP and MCH services.

**Implementing partners** must actively align interventions to PHA and subnational health systems and support the priorities of subnational stakeholders to deliver integrated, inclusive SRH/FP and MCH services. This must be combined with ongoing engagement, communication with, and reporting to PHA, district, and health facility managers.

### **Recommendation Area 4 – Design for sustainable transition to PHA management**

There is an expectation that the services delivered under the PSF project will transition to sustainable PHA management, but there is currently no clear definition or logic for how this will be achieved. The strength of health service NGOs is not in building government financial management systems and capacity. PATH is well-positioned to play a key role in developing this strategy and supporting implementation; e.g. with PATH advisers in PHAs supporting and acting as a focal point for those efforts at national and provincial levels.

**DFAT** to investigate a project design with a clear pathway towards ownership by government, and strong project logic developed together with PHAs and NDOH. This includes suitably-resourced

strategies to support PHA governance and management capacity strengthening, and a mechanism for financing that can reliably ensure continuity of funding to implementing partners and meet DFAT needs for accountability.

### **Recommendation Area 5 – Take advantage of PATH-proposed cross-program capacities and support partner program implementation and learning**

There has been limited engagement between implementing partners and PATH during PSF Phase 2. PATH can play an important role in promoting coordination, strategic direction, and integration across Frontline Health Outcomes projects and DFAT health investments more broadly, to both recognise its design direction and add value to DFAT's health investments.

**PATH** to reorient its approach towards strong engagement with implementing partners, improving monitoring, providing support for areas including GEDSI and PHA strengthening, and sharing lessons and expertise between partners.

### **Recommendation Area 6 – Strengthen PSF project and contract management**

Progress on delivering key project activities critical to the achievement of Phase 2 Intermediate Outcomes has been substantially delayed. There does not appear to be any plan to address these delays to meet contracted deliverables.

**DFAT/PATH to work with MSPNG** to identify and implement remedial steps to address delayed outcomes, particularly relating to the revised NFPTP in-service and pre-service courses and establishment of the NFPPN.

**DFAT/PATH and MSPNG** to strengthen contract and project management practices so that programs are delivered as designed. Where program deliverables are lagging, immediate steps must be taken to identify and address implementation barriers.

### **Recommendation Area 7 – Strengthen collaboration and complete NFPTP training**

MSPNG has provided an important contribution to family planning uptake in target provinces, however inadequate communication and collaboration with health system owners and other key government and NGO stakeholders undermines the acceptability and sustainability of its work.

**MSPNG** to develop, resource and implement a plan for strengthening collaboration, planning and communication with NDOH, PHA, local health sector, and other development partners, so that this engagement is treated as no less a priority than meeting service delivery targets.

**MSPNG** to develop a plan to ensure that, as far as possible, all health care workers trained in Phase 1 are certified in a timely manner. Regular reports listing the health workers trained by MSPNG and their last assessed competency levels, the schedule for conducting supportive supervision in the province, details of any assessments conducted (e.g. health facility audits), and trainee action plans, should be provided to subnational stakeholders at PHA level and below.

### **Recommendation Area 8 – National SRH/FP and MCH coordination**

The NFPTWG, formerly the main national coordination mechanism for SRH/FP and MCH in PNG, has been inactive for 18 months, and the proposed new coordination mechanism, the RMNCAH Technical Advisory Committee, is not meeting regularly. It is also unclear how the role and activities of the NFPTWG will be taken up by the committee.

**UNFPA and WHO** to support NDOH to define how the former responsibilities of the NFPTWG will be addressed under the new RMNCAH Technical Advisory Committee; and activate this committee, so



that it can become an effective forum for national-level SRH/FP and MCH collaboration and coordination.

**DFAT** to consider opportunities to support the capacity of the government to lead this group, which can play a key role in SRH/FP and MCH health policy development and strategic coordination to contribute to the creation of an enabling environment for quality, inclusive SRH/FP and MCH in PNG.

### **Recommendation Area 9 – Ensure that M&E is fit-for-purpose and promotes learning**

Data that would support measurement of progress for the project's EOPO was not available to the evaluation. Operational research and learning, critical to developing and documenting effective program approaches and models of care, was not adequately prioritised in the project and NGO partners do not necessarily have the expertise to organise, manage, or conduct such research. There is an important role to play for PATH, and other parties such as HDMES, in working with program partners and other key stakeholders to develop a fit-for-purpose M&E system, determine priorities for research, oversee this work, and manage dissemination of results.

**DFAT** to work with PATH and HDMES to design the M&E framework for any future SRH/FP and MCH program, and to identify and progress priority operational research.

**MSPNG/SSM** to work with DFAT, PATH, and HDMES, to address key M&E gaps identified by the evaluation, including lack of client satisfaction data and documentation of effective models of service delivery.

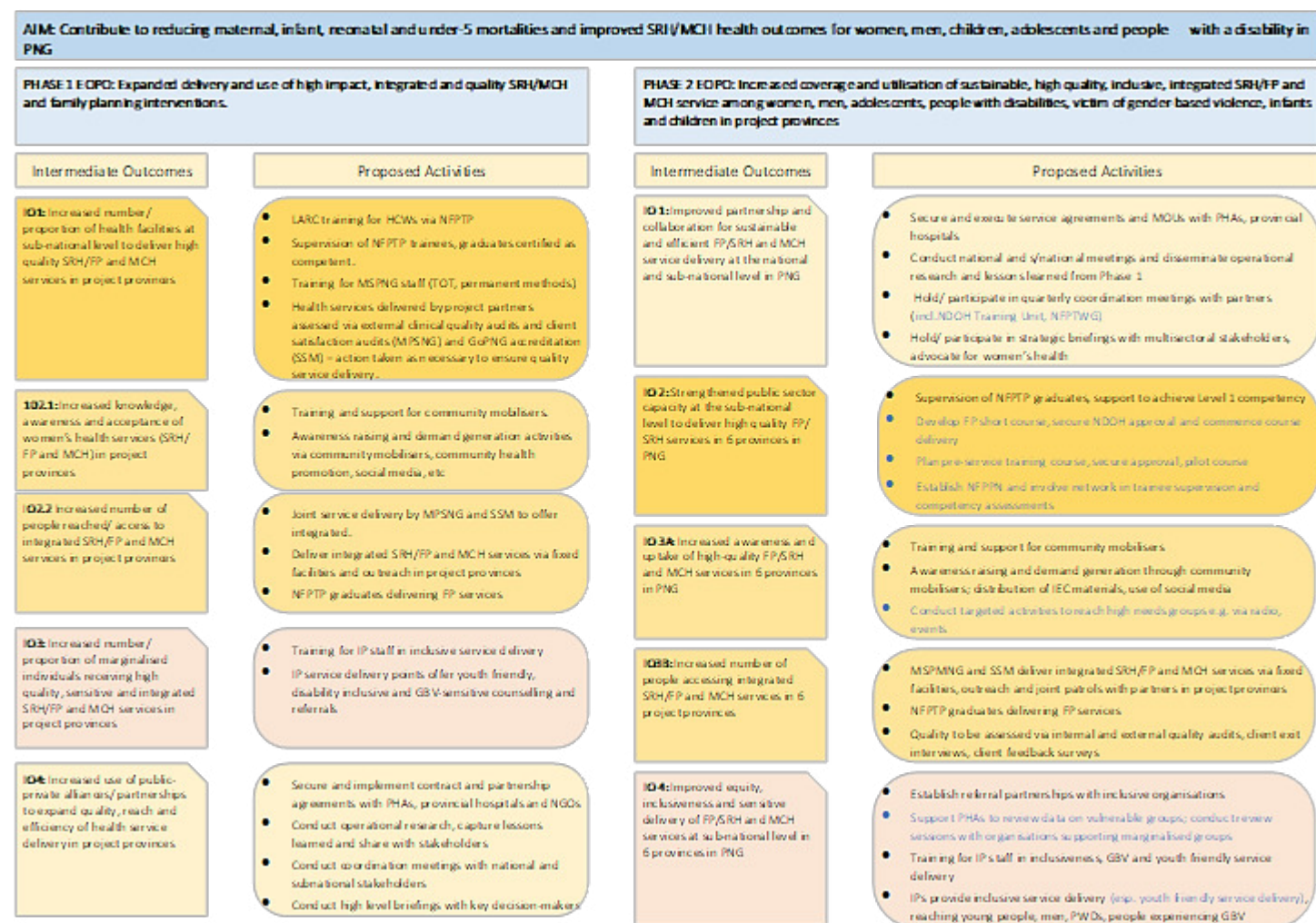
## 7. References

- Alilio, M., Hariharan, N., Lugten, E., Garrison, K., Bright, R., Owembabazi, W., Inyang, U., El-Din Hassan, S., & Saldana, K. (2022, April). Strategies to promote health system strengthening and global health security at the subnational level in a world changed by COVID-19. *Global Health: Science and Practice*, 10(2) e2100478. DOI: 10.9745/GHSP-D-21-00478
- Bazile, J., Rigodon, J., Berman, L., Boulanger, V.M., Maistrellis, E., Kausiwa, P., & Ely Yamin, A.. (2015). Intergenerational impacts of maternal mortality: Qualitative findings from rural Malawi. *Reproductive Health*, 12(Suppl 1), S1. <http://www.reproductive-health-journal.com/content/12/S1/S1>
- Department of National Planning and Monitoring. (2010). *Papua New Guinea Development Strategic Plan 2010–2030*. Government of Papua New Guinea. [https://www.treasury.gov.pg/html/publications/files/pub\\_files/2011/png-development-strategic-plan.2010-2030.pdf](https://www.treasury.gov.pg/html/publications/files/pub_files/2011/png-development-strategic-plan.2010-2030.pdf)
- Grundy, J., Dakulala, P., Wai, K., Maalsen, A., & Whittaker, M. (2019). *Papua New Guinea Health System Review. Vol. 9, No. 1*. World Health Organization, Regional Office for South-East Asia.
- Gupta, S., Bernays, S., Black, K.I., Ramsay, P., Bolnga, J., & Kelly-Hanku, A. (2020). Community attitudes and gendered influences on decision making around contraceptive implant use in rural Papua New Guinea. *Reproductive Health*, 17(136). <https://doi.org/10.1186/s12978-020-00985-w>
- Human Rights Watch. (2022). *World Report 2022, Papua New Guinea – Events of 2021*. <https://www.hrw.org/world-report/2022/country-chapters/papua-new-guinea>
- Kelly, A., Worth, H., Akuani, F., Kepa, B., Kupul, M., Walizopa, L., Emori, R., Cangah, B., Mek, A., Nosi, S., Pirpir, L., Keleba, K., & Siba, P. (2010). Gendered talk about sex, sexual relationships and HIV among young people in Papua New Guinea. *Cult Health Sex*, 12(3), 221–232. DOI: 10.1080/13691050903181107
- MSI Reproductive Choices. (2020). *Public sector strengthening*. <https://www.msichoice.org/what-we-do/our-approach/public-sector-strengthening/#>
- Mola, G., & Kirby, B. (2013). Discrepancies between national maternal mortality data and international estimates: the experience of Papua New Guinea. *Reproductive Health Matters*, 21:42, 191–202. DOI: 10.1016/S0968-8080(13)42725-8
- National Department of Health. (2020). *2019 Sector Performance Annual Review*. Government of Papua New Guinea.
- National Department of Health. (2021). *National Health Plan 2021–2030*. Government of Papua New Guinea.
- National Department of Health. (2022). *National Maternal and Newborn Health Strategy 2021–2025*. Government of Papua New Guinea.
- National Statistical Office (NSO) and ICF. (2019, May). *Papua New Guinea Demographic and Health Survey 2016–18: Key Indicators Report*. Government of Papua New Guinea. <https://dhsprogram.com/publications/publication-FR364-DHS-Final-Reports.cfm>

- PNG National Disability Resource and Advocacy Centre. (2015). Disability in PNG. In Mary MacKillop Today. (n.d.) *Where we work: PNG*. [https://www.marymackilloptoday.org.au/what-we-do/where-we-work/papua-new-guinea/#\\_ftn5](https://www.marymackilloptoday.org.au/what-we-do/where-we-work/papua-new-guinea/#_ftn5)
- Siegmann, L., Larkin, M., & Kulumbu, E. (2021). *PPF Health Grants Review – Final Report*.
- Specialist Health Service. (2019). *Analysis of key indicators: Papua New Guinea Demographic and Health Surveys 1996, 2006, 2016–18*. Abt Associates.
- United Nations Population Fund (UNFPA). (2021a). *My body is my body, my life is my life: Sexual and reproductive health and rights of young people in Asia and the Pacific*. <https://asiapacific.unfpa.org/en/publications/my-body-my-body-my-life-my-life-sexual-and-reproductive-health-and-rights-young-people>
- UNFPA. (2021b). *How changing social norms is crucial in achieving gender equality*. <https://www.unfpa.org/social-norms-change>
- UNFPA Papua New Guinea. (2022). *Sexual and reproductive health*. <https://png.unfpa.org/en/topics/sexual-reproductive-health-11>
- UN Women Asia and the Pacific. (n.d.) *About UN Women Papua New Guinea*. <https://asiapacific.unwomen.org/en/countries/png/about-un-women-png#:~:text=Papua%20New%20Guinea%20ranked%20160,developing%20policies%20on%20women's%20rights>
- University of Southern Maine – Rhode Island Partnerships for Success. (2014). *PFS Partnership Rubric*. <https://digitalcommons.usm.maine.edu/cgi/viewcontent.cgi?article=1038&context=mu>
- World Bank Group. (2020). *Poverty and Equity Brief East Asia and Pacific – Papua New Guinea*. [https://databank.worldbank.org/data/download/poverty/33EF03BB-9722-4AE2-ABC7-AA2972D68AFE/Global\\_POVEQ\\_PNG.pdf](https://databank.worldbank.org/data/download/poverty/33EF03BB-9722-4AE2-ABC7-AA2972D68AFE/Global_POVEQ_PNG.pdf)

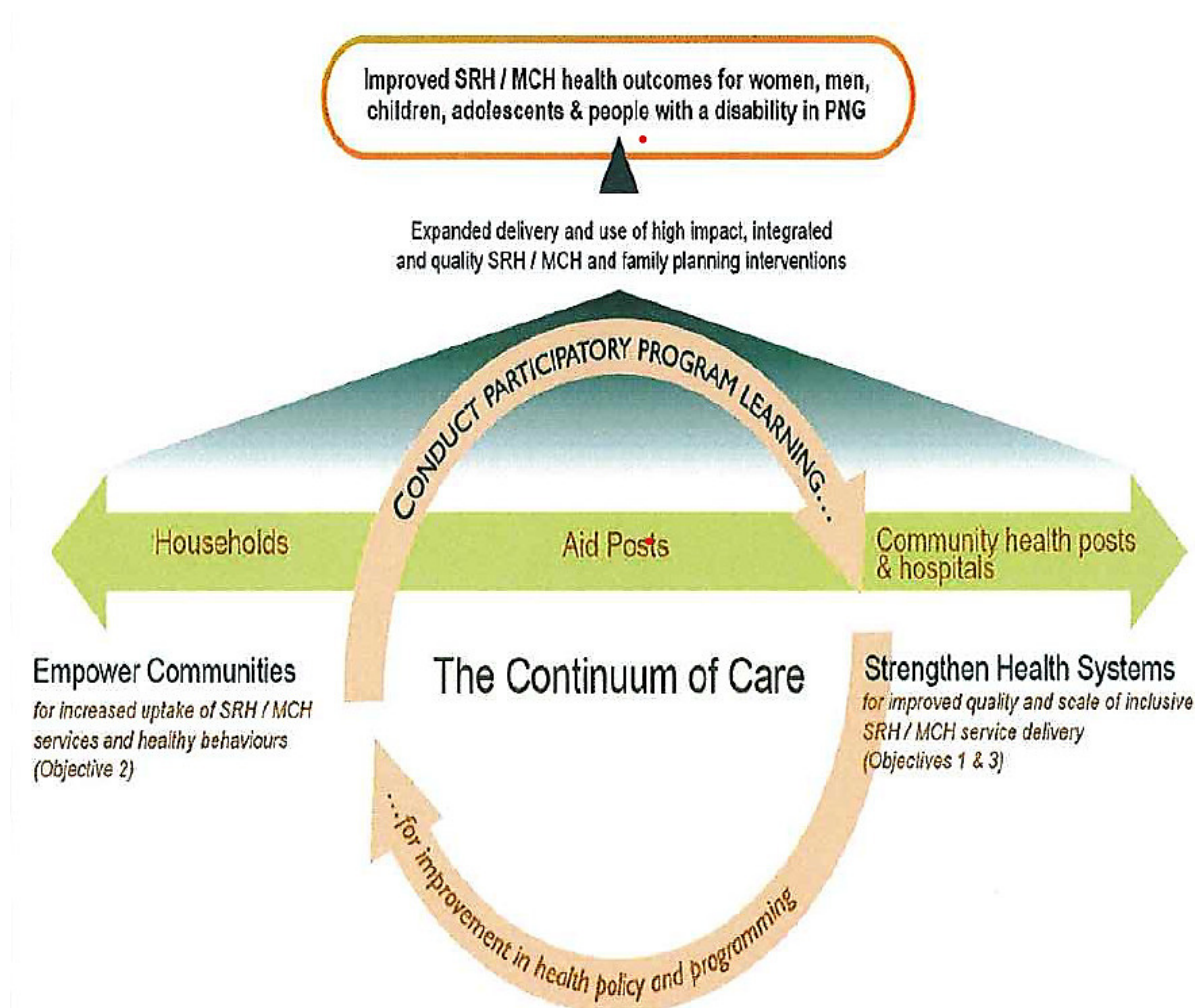
## **Annexes**

## Annex 1 – PSF Phase 1 and Phase 2 Project Logic



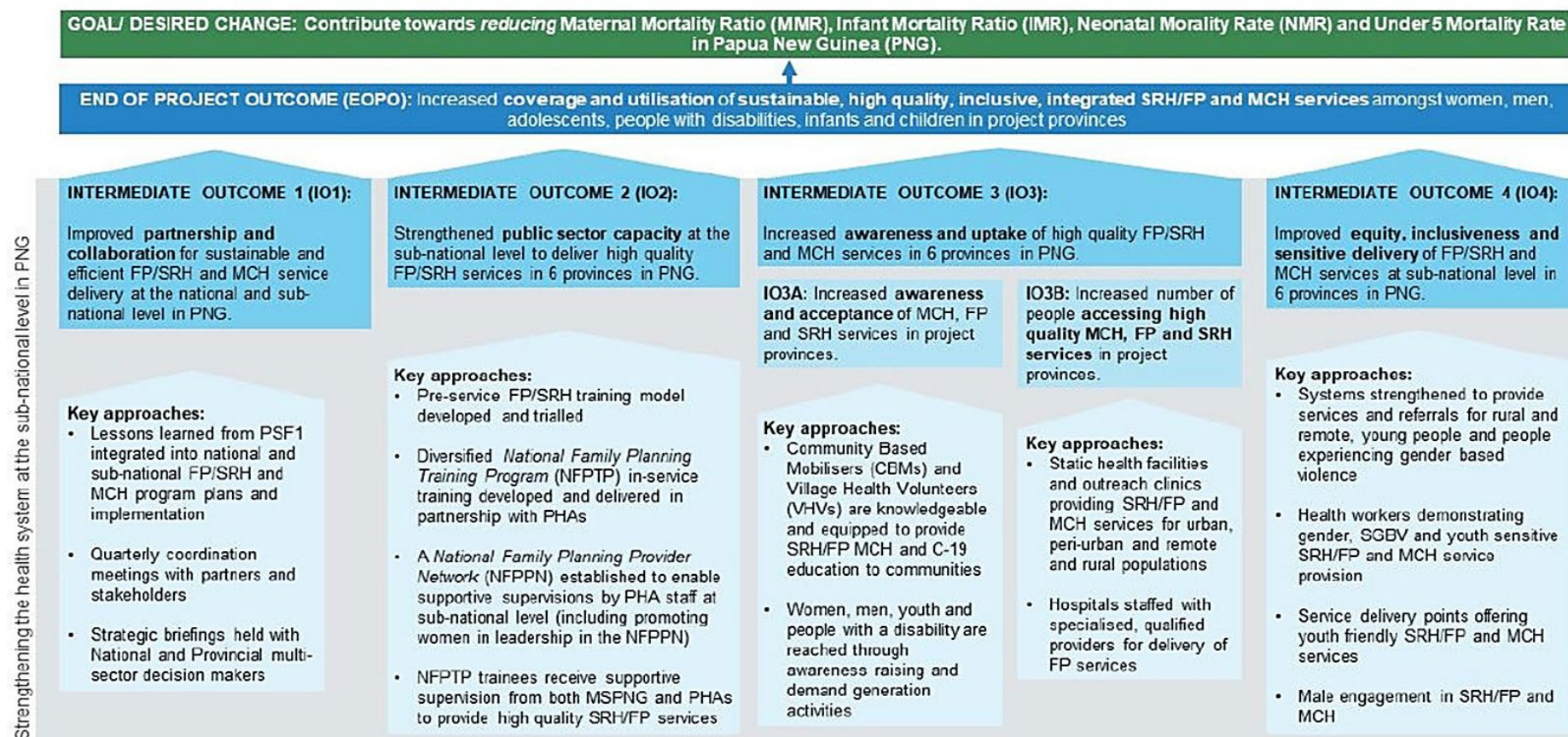
There are Intermediate Outcome (IO) numbering changes from Phase 1 to Phase 2, but IOs are consistent across the two phases. Shading shows corresponding IOs and related activities across the two phases. New activities in Phase 2 are shown in blue text.

## Annex 2 – Partnering for Strong Families Phase 1 Theory of Change





## Annex 3 – Partnering for Strong Families Phase 2 Project Logic



## Annex 4 – List of FP/SRH and MCH Services Delivered by PSF Partners

FP/SRH services were delivered by MSPNG in PSF target provinces through outreach, MSPNG clinics (Phase 1 only), and Hospital Embedded Family Planning Nurses. SSM delivered FP/SRH and MCH services through its fixed clinics and outreach services in PSF target provinces<sup>56</sup>.

FP/SRH and MCH Services	MSPNG	SSM
FP counselling	X	X
Emergency contraception and short-term methods (pills, injectables, male and female condoms)	X	X
Long Acting Reversible Contraception (LARC): Implants and intrauterine devices (insertion and removal)	X	X ****
Permanent methods: vasectomy and tubal ligation	X *	Referral only
Screening and treatment for sexually transmitted infections (STIs)	X**	X
Antenatal care and PMTCT (including provision of antiretroviral treatment)	–	X
Infant and young child nutrition (breastfeeding counselling, nutrition screening and treatment)	–	X
Treatment of pneumonia, malaria and other childhood illnesses	–	X
Immunisation	–	X
Emergency transfer for delivery	–	X
Postnatal care	–	X
GBV counselling and referral	–	X
Circumcision	X***	–
Infertility counselling	X***	–
Pregnancy crisis management/Post-abortion care	X***	–

### Notes:

\* Service not provided by MSPNG HEFPN (referral only).

\*\* Service not provided by MSPNG HEFPN and limited service provided by outreach teams.

\*\*\* Provided in Port Moresby and Lae clinics only.

\*\*\*\* MSPNG-trained SSM HCWs delivered services independently in Phase 2.

<sup>56</sup> For further details of the location of services delivered by MSPNG and SSM in Phase 1 and Phase 2 see **Annex 9**.

## Annex 5 – Key Evaluation Questions

DFAT Quality Criteria	Key Evaluation Question	Indicative Sub-questions
<b>Effectiveness</b>	To what extent has the program achieved the expected outputs and outcomes over Phase 1 and Phase 2 of the program, and contributed to Outcome 3 of the PNG Health Portfolio Plan?	<p>1.1 To what extent has the program resulted in improved partnership and collaboration for sustainable and efficient FP/SRH and MCH service delivery at the national and subnational level in target provinces in PNG?</p> <p>1.2 To what extent has the program resulted in increased awareness and uptake of SRH/FP and MCH services in the target provinces?</p> <p>1.3 To what extent has the program strengthened public sector capacity at the subnational level to deliver high quality FP/SRH services in target provinces in PNG?</p> <p>1.4 To what extent has the program delivered improved equity, inclusiveness, and sensitive delivery of FP/SRH and MCH services at subnational level in target provinces in PNG?</p>
<b>Efficiency</b>	To what extent is the relationship between inputs and outputs timely, cost-effective and to expected standards?	<p>2.1 To what extent is the partnership's organisational model (e.g. funding model, resource allocation, team structure, governance mechanisms) effective and efficient?</p> <p>2.2 Are there benefits from managing PSF under the PATH Frontline Health Outcomes workstream approach and due to other aspects of PATH (e.g. PATH's GEDSI focus and adaptive programming approach)?</p> <p>2.3 How has the program adapted to be more efficient and demonstrate cost-savings over time?</p>
<b>Relevance</b>	Is the approach undertaken across each of the project components (service delivery, community engagement, partnership with government, training, and capacity building through the NFPTP and NFPPN) appropriate for the PNG context and situation?	<p>3.1 What features of the service delivery, training and capacity building models were most appropriate for the program context and objectives?</p> <p>3.2 What were the key success factors of different ways of working with priority stakeholder groups – and how can partners strengthen these factors in the future?</p>
<b>M&amp;E</b>	How have the grantees used operational research and monitoring of progress and achievements for programming, learning and accountability?	<p>4.1 What are the developments and innovations (if any) that consortium partners have identified and applied throughout the project?</p> <p>4.2 What is the program's experience of applying the Adaptive Management and Thinking and Working Politically approach to its work?</p>

DFAT Quality Criteria	Key Evaluation Question	Indicative Sub-questions
<b>Gender Equality/GEDSI</b>	To what extent has the grant considered and addressed the needs of, and challenges faced by, women, girls, young people, and people with a disability?	5.1 To what extent has PSF sought to address gender-specific barriers to accessing services and promote women's voice in leadership and decision-making in the program and its activities. 5.2 What are the lessons learned regarding implementation of effective, locally-led GEDSI approaches at the community and subnational level?
<b>Sustainability</b>	To what extent did the program build local ownership and leadership and capacity to continue service delivery beyond the end of the program?	6.1 To what extent were local partners engaged by the program and what were the key successes, barriers and challenges in the approaches used?
<b>Impact</b>	To what degree did the intervention generate positive or negative, intended and unintended effects? <sup>57</sup>	7.1 To what extent did the program contribute to broader sexual, reproductive, maternal, newborn and child health (SRMNCH) outcomes in PNG?

<sup>57</sup> This KEQ uses the OECD DAC definition of impact as 'positive and negative, primary and secondary long-term effects produced by a development intervention, directly or indirectly, intended or unintended.' (OECD DAC, 2010).

## Annex 6 – List of People Interviewed

Organisation	Name and Position
<b>NDOH</b>	Dr Edward Waramin, Manager of Population and Family Health NDOH Training Unit Manager, Mary Kilolo Mr Wai, Head of Policy Division
<b>DNPM</b>	James Ruru, Principal Aid Coordinator – Australia Aid, Health/Education Alois Kaluweh, Aid Coordinator – Health/Education Chi-haru Sai, Acting Principal Aid Coordinator – Private Sector and Infrastructure Demot Bagasel, Aid Coordinator – Private Sector and Infrastructure
<b>PHAs</b>	<b>Enga Bay</b> (group interviewed together) Dr Betty Koka, Director Public Health Dr Kanadras Lahui, Director Curative Health Services Sr Julie Wialu, Program Officer, Family Health Services Dr Antonia Kumbia, Obstetrics and Gynaecology Specialist, <b>Milne Bay</b> (group interviewed together) Dr Perista Mamadi, Chief Executive Officer Dr Karui, Team Leader Dr Tai, Obstetrician, Alotau General Hospital Dr Daelfroid, Paediatrician, Alotau General Hospital <b>Morobe PHA</b> Mr Kelly Mesere, Public Health Director Sr Patricia Mitel, Family Health Service Coordinator Lucy Mendali, Family Planning Coordinator Miriam Key, Officer-in-Charge, Buomo Health Centre, Lae District <b>Western Highlands</b> Mr Dannex Kupamu Acting Director Public Health
<b>Hospitals</b>	<b>Morobe Province</b> – Angau Memorial Hospital Lizzy Honeakii, Nurse Manager, Post-Natal Ward Florence Nick, Sister-in-Charge of Labour ward Sr Gaudi Philip, MSPNG HEFPN <b>Western Highlands Province</b> , Mt Hagen General Hospital Sr Angela Pyandi, Second-in-Charge Obstetrics and Gynaecology Department Sr Angela Kilawe, HEFPN
<b>DFAT</b>	Junita Yehira, Assistant Program Manager, Health Security, AHC Dianne Dagam, Senior Program Manager, Health Security, AHC Anna Gilchrist, First Secretary, Health Security AHC Will Robinson, former Health Counsellor, AHC
<b>PATH</b>	Luke Elich, former Senior Manager of RMNCH Ray Krai, Manager for Sexual and Reproductive Health Programs Ayesha Lutschini, GEDSI and Safeguarding Elizabeth Boyd, HSIP Public Financial Management Adviser Danny Beiyo, AIHSS Manager Kelwyn Brown, former Social Safeguards and Inclusiveness Adviser, HSSDP
<b>MSPNG</b>	Hannelly Kiromat Geno, Acting Country Director and Projects Director Peta Blundell, Program Manager Marie Stopes Regional Office Marcellina Kinna, Clinical Governance Director Helen Pinia, PSS Channel Manager Dr David Ayers, former Country Director

Organisation	Name and Position
	<p>Monica Kolkia, former Service Senior Delivery Manager</p> <p>Phyllma Timea, former Marketing and Communications Coordinator</p> <p>Liesel Seehofer, former MSPNG Director of Partnerships and Programs</p> <p>Adolf Kot, Monitoring and Evaluation Manager</p> <p>Matthew Taleo, Monitoring and Evaluation Officer</p> <p>Tom Anjo, CBM, Morobe Province</p> <p>Martha George, CBM, Wampit, Morobe Province</p> <p>Margen Ivan, CBM, Situm, Western Highlands Province</p> <p>James Koipa, CBM, Kotna, Western Highlands Province</p>
<b>SSM PNG</b>	<p>Caroline Ninnies, Health Systems Program Manager</p> <p>Theresita Waki, General Manager</p> <p>Yvonne, Health Manager, Lae Clinic</p>
<b>Health sector partners (other)</b>	<p>Marianne Kehalie, AIHSS Manager (interviewed with Danny Beiyo)</p> <p>Professor Glen Mola, Head of Reproductive Health and Obstetrics and Gynaecology, University of PNG</p> <p>Martin Taylor, former PPF/AHC Health Adviser</p> <p>Marielle Sander, UNFPA Country Representative</p> <p>Dr Titilola Duro-Aina, Technical Adviser SRHR, UNFPA Pacific Sub-Regional Office</p> <p>Madeleine Salva, RMNCH Technical Officer, WHO</p> <p>Dr Edith Digwaleu-Kariko, Senior Health Specialist, World Bank PNG</p> <p>Graham Apian, Projects Director, Catholic Church Health Services</p> <p>Mr Katu Yapi, Secretary, Lutheran Health Services</p> <p>Michael Salini, General Manager, IPPF/PNG Family Health Association</p> <p>Olive Oa, Program Manager, Child Fund PNG, Central Province</p> <p>Daniel, Callan Services, Mt Hagen</p> <p>Jacqui Joseph, Equal Playing Field</p> <p>Tanushree Soni, Senior Program Manager Gender and Women's Empowerment, Plan International Australia</p>



## Annex 7 – List of Documents Reviewed

Document Category	Title
<b>PNG Health Portfolio Plan</b>	Health Portfolio Plan 2018–2023
<b>National Strategic Development Plan and other national policies</b>	PNG Medium Term Development Plan III 2018–2022, Volume One: Development Planning Framework and Strategic Priorities National Population Policy 2015–2024_21052015
<b>National Health Plan/Strategy</b>	National Health Plan 2011–2020: Volume 1 Policies and Strategies Working Draft_National Health Plan 2021–2030, Volume 1: Policies and Strategies_210429
<b>National Health Service Standards</b>	National Health Service Standards for Papua New Guinea 2011–2020, Volume 1
<b>National MCH Policies/Strategies</b>	Working Draft_Maternal and New Born Health Strategic Plan 2019–2024_Latest 190728 Papua New Guinea, Child Health Plan 2008–2015 National Department of Health, Integrated Management of Childhood Illnesses Policy 2014
<b>National SRH and Family Planning Policies/Strategies</b>	National Department of Health, National Sexual and Reproductive Health Policy, October 2013 National Department of Health, National Family Planning Policy, June 2014
<b>PNG Health Sector Reviews/Assessments</b>	Asante, A., & Hall, J. (2011). <i>A review of health leadership and management capacity in Papua New Guinea</i> , Human Resources for Health Knowledge Hub, University of New South Wales, Sydney. National Department of Health. (2019). <i>Sector Performance Annual Review: Assessment of Sector Performance 2015–2019 National Report August 2020</i> . Government of PNG. National Department of Health. (2018). <i>Consultation report: Review of PNG health related law. Moving towards integrated health governance and service delivery</i> , Draft v.2.1 26/11/18. Grundy, J., Dakulala, P., Wai, K., Maalsen, A., & Whittaker, M. (2019). <i>Papua New Guinea Health System Review. Vol. 9 No. 1</i> . World Health Organization, Regional Office for South-East Asia. Wiltshire, C., Watson, A.H.A., Lokinap, D., & Currie, T. (2020). <i>Papua New Guinea's primary health care system: Views from the front line</i> . ANU and UPNG.
<b>PNG Demographic Health Survey</b>	National Statistical Office (NSO) and ICF. (2019, May). <i>PNG Demographic and Health Survey 2016–18 – Key Indicators Report</i> . Government of Papua New Guinea. Specialist Health Service. (2019). Analysis of key indicators: Papua New Guinea Demographic and Health Surveys 1996, 2006, 2016–18, Abt Associates.
<b>PHA Policies and Strategies</b>	Department of Implementation and Rural Development, PSIP, DSIP, LLGSIP Administrative Guidelines Presentation. Provincial Health Authority: Management and Structures, Independent Review March 2015.
<b>PATH Design and Program Reports</b>	Papua New Guinea–Australia Transition to Health (PATH) Program Design Document (Draft). Linking PATH Program Strategies to Program Outcomes – PATH Program Logic. PNG–Australia Transition to Health (PATH) Quarterly Progress Report (1st January–31st March 2021).

Document Category	Title
	PATH Annual Report 2021 and Annexures.
<b>PSF Contracts</b>	MSPNG. 14 August 2020. Letter: Amendment No. 3 to Subgrant agreement for <i>Wok Wantaim Kamapim Strongpela Famili</i> ('The Project') in Papua New Guinea.
<b>PSF Design Documents and Progress Reports</b>	<p>MSPNG Design Document PPF Extension Phase 2 and Annexes.</p> <p>2018 MSPNG–SSM Review and Reflection Workshop, Final 30 Jan 2019.</p> <p>MSPNG Six Month Progress Report (July–December 2017) – Partnering for Strong Families.</p> <p>MSPNG–SSM PPF Annual Progress Report 2018 (final 30 Jan 2019).</p> <p>PSF Annual Work Plan (January–December 2019).</p> <p>MSPNG–SSM PPF Annual Progress Report 2019.</p> <p>MSPNG–SSM Six Monthly Progress Report January–June 2020.</p> <p>MSPNG Design document PPF Extension Phase 2.</p> <p>PSF–MSPNG Six Month Progress Report July–December 2020 Final.</p> <p>PSF Annual Work Plan (January 2021–December 2021).</p> <p>Partnering for Strong Families, Six Month Progress Report 2021, January–June 2021.</p> <p>Partnering for Strong Families, Annex 1, Six Month MEP January–June 2021.</p> <p>Partnering for Strong Families, Six Month Progress Report 2021, July–December 2021.</p> <p>Partnering for Strong Families, Annex 1, Six Month MEP Jan–June 2021.</p>
<b>MSPNG Quality Assessment and Technical Assistance Reports</b>	<p>Marie Stopes Papua New Guinea – Technical Assistance Support 2019 Report – Consultant: Dr Geoffrey Okot.</p> <p>MSPNG 2018 Client Exit Interview Summary Results.</p> <p>Marie Stopes PNG Mystery Client Survey Report 2019.</p> <p>MSPNG Clinical Quality Report, Q3 2021.</p> <p>MSPNG PSS Clinical Quality Internal Audit Checklist 2022.</p>
<b>NFPWTG Meeting Minutes</b>	<p>Draft_National Family Planning Working Group Meeting Minutes, March 29th, 2019, 19.04.19.</p> <p>Draft_National Family Planning Working Group Meeting Minutes, Friday, August 2nd, 2019, 06.08.18.</p> <p>Draft_National Family Planning Working Group Meeting Minutes, Wednesday, November 25th, 2020.</p>
<b>PHA Meeting Minutes</b>	MSPNG, Meeting Minutes: WNBPHA Meeting 22nd June 2018.
<b>National Family Planning Training Program plans, training materials and reports</b>	<p>PATH MSPNG FP Public Sector Support Framework.</p> <p>PNG Family Planning Provider Training: Trainer Guide, Version 1.6 February 2014.</p> <p>National Family Planning Training Program Review, May 2017.</p> <p>Heidi Brown and Maya Goldstein. MSPNG Public Sector Strengthening Technical Assistance, Trip Report, 13–17 August 2018.</p> <p>National Family Planning Training Programme, Training Report – West Sepik Province, Nuku/Telefomin 17th May–2nd June 2019.</p> <p>National Family Planning Training Programme, Training Report – West Sepik Province, Nuku/Telefomin 23rd September–12th October 2019.</p>
<b>National Family Planning Network planning documents</b>	<p>Draft 2_National Family Planning Training Program (NFPTP), Terms of Reference, 2021</p> <p>Draft 2_Marie Stopes Papua New Guinea, PSS Stream 2, Terms of Reference -Family Planning Assessor.</p> <p>Draft_Selection Criteria for National Family Planning Provider Network (NFPPN).</p>

Document Category	Title
	PSS, Stream 2, National Family Planning Provider Network, Women's Leadership TOR.
<b>MSPNG: Other meeting minutes</b>	MSPNG, Meeting Minutes: Meeting with Ben Theodore, President of National Board for Disabled Persons, Friday 08th December 2017.
<b>PSF Service Statistics</b>	MSPNG – SSM PSF Phase 1 Aggregated Service Statistics (by organisation, channel, location, service). MSPNG – SSM PSF Phase 2 Aggregated Service Statistics (by organisation, channel, location, service).
<b>MOUs and Service Level Agreements</b>	15 current MSPNG Memoranda of Understanding and 13 Service Level Agreements.
<b>MPSNG IEC Materials</b>	MSPNG, Your Future Your Choice – Low literacy (English and Tok Pisin versions). MPSNG Referral/Follow up card (English and Tok Pisin versions).
<b>MSPNG Organisational</b>	MSPNG Organisational Chart 18.2 202110.
<b>SSM PNG</b>	MSPNG. 14 August 2020. Letter: Amendment No. 3 to Subgrant agreement for Wok Wantaim Kamapim Strongpela Famili ('The Project') in Papua New Guinea.
<b>Partnership Frameworks</b>	Break Away and The Haiti Compact. (2017). <i>Rubric For Assessing Community Organization Partnerships June 2010 (revised January 2017)</i> . Rhode Island Partnerships For Success. (n.d.). <i>Partnership Rubric</i> .
<b>Inclusive service delivery</b>	Gender Equality Disability and Social Inclusion (GEDSI) Strategy, Marie Stopes Papua New Guinea, 2021–2023. Larson, A., Raney, L., & Ricca, J. (2014). <i>Lessons learned from a preliminary analysis of the scale-up experience of six high-impact reproductive, maternal, newborn, and child health (RMNCH) interventions</i> . Jhpiego. Pride in Health and Wellbeing. (n.d.). <i>Inclusive service delivery: Gap Analysis Self-Assessment Tool Version 2</i> . <a href="https://www.prideinhealth.com.au/wp-content/uploads/2021/09/Getting-Better-Audit-Tool-2022.pdf">https://www.prideinhealth.com.au/wp-content/uploads/2021/09/Getting-Better-Audit-Tool-2022.pdf</a> WHO SEARO (South-East Asia Regional Office). (2011). <i>Adolescent friendly health services, Supervisory/Self-Assessment Checklist: User's Guide</i> . Pathfinder International. (2002). <i>Clinic assessment of youth friendly services: A tool for assessing and improving reproductive health services for youth</i> . <a href="https://www.pathfinder.org/publications/clinic-assessment-youth-friendly-services-tool/">https://www.pathfinder.org/publications/clinic-assessment-youth-friendly-services-tool/</a> Peterson, A. et al. (2020). <i>Youth engagement in sexual health programs and services: Findings from the Youth Engagement Network's environmental scan</i> . Marie Stopes International. (n.d.). <i>Delivering sexual and reproductive health services to young people: Key lessons from Marie Stopes International's programmes</i> . World Health Organization. (2009). <i>Promoting sexual and reproductive health for persons with disabilities: WHO/UNFPA Guidance Note</i> . World Health Organization Regional Office for the Western Pacific. (2020). <i>Disability-inclusive health services toolkit: A resource for health facilities in the Western Pacific Region</i> .

## Annex 8 – Data Collection Tools

### 1. Key Informant Interview Guide – Implementing Partners

What do you see as the key success and challenges of the program – over both Phase 2 and Phase 2?

How effective do you think that MSPNG/SSM has been in adapting its approach? What have been some of the successes and challenges?

Can you tell us about the program activities related to:

- Collaboration with PHAs
- Strengthening public sector capacity to deliver high quality FP/SRH services
- Increased awareness and uptake of FP/SRH and MCH services
- Improved equity, inclusiveness, and sensitive delivery of FP/SRH and MCH services.

What changes have you seen as a result of your work – at the national level, provincial and service delivery level? To what extent has local capacity been built for delivery of high-quality, inclusive and integrated SRH/FP and MCH services?

What were the strengths/weaknesses of the approaches used and lessons learned in each area above?

How did you work with PATH to implement Phase 2 of the program – how did this collaboration and this approach contribute to the program?

How did the program and partners respond to the challenges that it faced – including COVID-19? How did the COVID-19 pandemic affect the delivery of services and other activities over the life of the program?

Were there any unintended (positive or negative) outcomes?

Where do you think the program needs to focus in the future – to achieve greater effectiveness, sustainability, impact? What aspects of the program would you like to retain/change?

### 2. Key Informant Interview Guide – GoPNG and Health Sector Partners

Can you explain how the program and implementing partners worked (at the national/subnational level/with your organisation)?

In your view, how well did the project deliver on its objectives (collaboration with government at national and subnational level, training and capacity building, delivery of services, inclusive service delivery)?

Was the program appropriately targeted – geographic area, target groups for service delivery and training, ways of working, addressing GESI?

How were PSF partners involved in technical working groups/meetings and collaboration?

What were some of the strengths/weaknesses of the program/ways of working?

*Explain the change in focus in Phase 2; i.e. a focus on collaborating with PHAs, building capacity etc., to build sustainability together with direct service delivery.*

Was the approach used in Phase 2 an effective one?

How well is the program addressing the needs of GoPNG and objectives to improve sexual, reproductive, maternal and child health (SRMCH) in PNG?

What would you like to see in the future – what could be done better or differently – to better align with and support GoPNG objectives, be more effective?

How well did the partners adapt to changes/work with partners in PNG to address the impact of COVID-19 on SRMCH service delivery?

Do you have any recommendations for the program or DFAT about how the program could be adapted to better respond to SRMCH and health system strengthening needs in PNG; how to strengthen systems to provide quality SRH/FP and SRH services?

**For DFAT/AHC interviewees only**

What would sustainability look like for DFAT?

**For NDOH partners only**

What do you think will be NDOH's focus and the needs going forward?

### **3. Semi-structured Interview Guide – NFPTP Trainees/Graduates**

Can you tell us what training you attended (when, where, how many days/sessions)?

How would you rate the training and support – from 1 to 5 with 5 being most positive (go around the group)? What is the reason for the rating?

Was MSPNG/the NFPPN able to help you after the training? If yes, what sort of support did they provide?

Have you been able to put the training into practice at work? If yes, how?

What enabled you to do this?

What things prevented/made it difficult for you to implement the new skills and knowledge in your work?

What would make the training and follow up activities better next time?

### **4. Semi-structured Interview Guide – Community Based Mobilisers**

Can you tell us about your work with MSPNG – main activities that you were involved in, where, when, for how long?

Why were you interested in working/volunteering with MSPNG as a VHV with SSM?

What worked well? What was difficult?

How did MSPNG help you to do this work? Can you tell us what sort of support MSPNG provided (e.g. any training provided)?

How did this work contribute to improving people's attitudes to FP/encouraging people to seek SRH/MCH services?

What do you think would make FP-MCH education and awareness-raising in the community be more effective – recommendations for the future?

Sometimes there are people who are left out of FP and MCH education programs in the community. What would help to include these people?

### **5. Clinic Observation Checklist**

The evaluation team should ensure that an explanation of the purpose of the evaluation is provided to clinic management and staff before the visit. On arrival provide a brief overview of the purpose of

and ensure that specific permission is sought before seeking access to any restricted staff/patient areas in the clinic.

		Y	N	Comments
<b>Accessibility</b>				
1.	Is the clinic in an easily accessible area of the town/village?			
2.	Is the clinic accessible to people with a disability or people who may have mobility issues?			
2.1	Are there any steps/rough ground that may make it difficult for people with limited mobility to access the clinic?			
2.2	Is there a ramp where necessary to ensure wheelchair access?			
2.3	If there are steps in the clinic, is there an alternative route for people with limited mobility to enter/ move around the facility?			
<b>Physical Layout</b>				
3.	Is the entrance visible – easy to see from the street – and is it welcoming?			
4.	Is the reception area easy to find?			
5.	Is there a space for patients/clients to sit out of the sun and the rain?			
6.	Does the clinic appear to be in good repair/well maintained?			
7.	Is the clinic an adequate size			
8.	Does there appear to be good patient/client flow through the clinic (i.e. number of people waiting is not too long?)			
<b>Quality</b>				
9.	Does the clinic appear to be clean – grounds, waiting areas, clinic interior?			
10.	Are health promotion materials displayed throughout the clinic?			
11.	Is there running water and a toilet for patients/ clients			
12.	Is the clinic applying COVID-safe protocols e.g. physical distancing, use of masks, displaying COVID-related guidance and information?			
13.	Does the clinic have private consultation rooms?			
<b>Other</b>				
14	Any other comments/observations?			
<b>Photographs – please list photos taken during visit</b>				



## Annex 9 – PSF Phase 1 and Phase 2: Achievements against IO and Output Indicators and Targets

### Partnering for Strong Families Phase 1 Achievements

Legend	Level of achievement
Δ	Over 90% achieved
Ω	Over 50% achieved
e	Under 50% achieved
Σ	Data unclear, incomplete or could not be verified

**Intermediate Outcome 1: Increased number/proportion of health facilities at subnational level that have the capacity to deliver high quality SRH/FP and MCH services in project provinces.**

Indicators	EOPO Target	EOPO Achieved	% Variation		Notes
<b>IO 1.1:</b> Number/proportion of health facilities at subnational level that have the capacity to deliver high quality SRH/FP and MCH services in project provinces.	300	307	102%	Δ	–
<b>Output 1.1.1:</b> Number of health providers who graduate NFPTP.	360	369	103%	Δ	–
<b>Output 1.1.2:</b> Number of NFPTP graduates certified as competent to provide high quality SRH/FP services.	360	169	47%	e	–
<b>Output 1.1.3:</b> Proportion of project service delivery points adhering to SRH/FP, MCH and primary health care guidelines throughout project: <ul style="list-style-type: none"> <li><b>MSPNG:</b> Proportion of service delivery sites achieving 90% rating against MSI Partnerships global quality standards for clinics and outreach.</li> </ul>	65%	75% (2017)	–	Σ	2017 result only reported
<b>Output 1.1.3:</b> Proportion of project service delivery points adhering to SRH/FP, MCH and primary health care guidelines throughout project: <ul style="list-style-type: none"> <li><b>SSM:</b> All health facilities/service delivery points meet National Health Service Standards accreditation standards.</li> </ul>	3	3	100%	Δ	–
<b>Output 1.1.4:</b> Percentage of clients recommending MSPNG services to a family/friend.	75%	75%	100%	Δ	–

**Intermediate Outcome 2: Increased knowledge, awareness and acceptance of women's health services (SRH/FP and MCH) by women of reproductive age, men, youth and people with disabilities in project provinces.**

Indicators	EOPO Target	EOPO Achieved	% Variation	Notes
<b>IO 2.1:</b> Increased number of people reached with/accessing SRH/FP and MCH services.	570,675	600,326	105% Δ	–
<b>IO 2.2:</b> Increased number of FP services in project provinces.	180,000	222,209	123% Δ	–
<b>IO 2.3:</b> Increased number of CYPs generated in project provinces.	362,637	352,857	97% Δ	–
<b>IO 2.4:</b> Increased number of pregnant women in each project province attending at least 1 ANC (combined with PMTCT) visit.	12,650	16,282	129% Δ	–
<b>IO 2.5:</b> Increased number of children under 5 immunised in project provinces.	22,325	27,351	123% Δ	–
<b>IO 2.6:</b> Increased number of children under 5 treated for malnutrition and pneumonia in project provinces.	14,050	31,380	223% Δ	–
<b>IO 2.7:</b> Increased number of people treated for STIs and HIV including PMTCT in project provinces.	28,280	41,814	148% Δ	–

**Intermediate Outcome 2.1: Increased knowledge and awareness and demand for SRH/FP and MCH services in project provinces.**

Indicators	EOPO Target	EOPO Achieved	% Variation	Notes
<b>Output 2.1.1:</b> Number of Community Based Mobilisers who are knowledgeable and equipped to provide SRH/FP education to communities – MSPNG (CBMs trained).	600	621	104% Δ	–
<b>Output 2.1.2:</b> Number of women, men, youth, and people with a disability reached by targeted awareness-raising and demand-generation activities – MSPNG.	25,934	46,034	178% Δ	–
<b>Output 2.1.3:</b> Number of referrals from CBMs/VHVs for SRH/FP and MCH services.	22,700	24,106	106% Δ	–

**Intermediate Outcome 2.2: Increased number of individuals taking up integrated SRH/FP and MCH services in project provinces.**

Indicators	EOPO Target	EOPO Achieved	% Variation	Notes
<b>Output 2.2.1:</b> Number of (fixed) health facilities/centres offering SRH/FP and MCH services for urban and peri-urban populations has increased – MSPNG, SSM.	9	9	100% Δ	–
<b>Output 2.2.2:</b> Number of mobile outreach sites offering SRH/FP and MCH services for rural and remote populations – MSPNG, SSM.	1,363	1,579	116% Σ	2018 and 2019 targets and data only
<b>Output 2.2.3:</b> Number of mobile outreach visits.	1,500	1,982	132% Δ	–
<b>Output 2.2.4:</b> Number of joint service delivery points.	750	163	22% e	–
<b>Output 2.2.5:</b> Number of hospitals.	5	5	100% Δ	–

**Intermediate Outcome 3: Increased number/proportion of marginalised individuals receiving high quality, inclusive and integrated SRH/FP and MCH services in project provinces.**

Indicators	EOP0 Target	EOP0 Achieved	% Variation	Notes
<b>IO 3.1:</b> Increased number/proportion of SRH/FP and MCH clients with a disability in project provinces.	9,182	Data not collected by MSPNG Σ	NA Σ	Disability disaggregated data not collected
<b>IO 3.2:</b> Increased number/proportion of SRH/FP and MCH clients under 20 years old in project provinces.	18,000	23,401	130% Δ	–
<b>IO 3.3:</b> Increased number of cases/referrals of GBV clients in project provinces.	260	335	129% Δ	–
<b>Output 3.1.1:</b> Number of service delivery points demonstrating disability inclusive access to (and data capture of) SRH/FP and MCH services.	17	5	29% e	–
<b>Output 3.1.2:</b> Number of health workers trained in and demonstrating disability-inclusive provision of SRH/FP and MCH services.	579	165	28% e	–
<b>Output 3.1.3:</b> Number of service delivery points offering youth-friendly SRH/FP and MCH service delivery has increased.	67	67	100% Σ	2019 target and data only
<b>Output 3.1.4:</b> Number of health workers trained in and demonstrating youth-friendly provision of SRH/FP and MCH services.	605	312	52% Σ	2018 and 2019 targets and data only
<b>Output 3.1.5:</b> Number of health service providers who complete integrated GBV and SRH/FP training and demonstrate competency in sensitive counselling and referrals.	575	190	33% Σ	2018 and 2019 targets and data only

**Intermediate Outcome 4: Increased use of public – private alliances/partnerships to expand quality, reach and efficiency in health service delivery in project provinces.**

Indicators	EOPO Target	EOPO Achieved	% Variation	Notes
<b>IO 4.1:</b> Increased/expanded number of contracts and partnership agreements (MOAs/MOUs) with government and non-government providers signed and implemented.	20	19	95% $\Sigma$	Progress reports for this period show 17 agreements signed and consistent underperformance on this indicator
<b>IO 4.2:</b> Evidence of operational research findings informing approaches to service delivery models.	2	2	100% $\Sigma$	2019 targets and data only available
<b>Output 4.1.1:</b> Lessons learnt captured and shared across all stakeholders (partners, donors, GoPNG, other NGOs) – (LARCs, health seeking behaviour, youth and PWD).	3	3	100% $\Sigma$	2018 and 2019 targets and data only available
<b>Output 4.1.2:</b> Number of regular (quarterly) coordination meetings held with partners and stakeholders throughout project – (national and subnational level).	8	21	263% $\Delta$	–
<b>Output 4.1.3:</b> Number of high-level briefings held with key decision-makers where key data, challenges and successes of integrated SRH/FP and MCH shared.	8	12	150% $\Delta$	–

**Notes:** The majority of results data and EOPO targets for Phase 1 outcome and output indicators was sourced from Annex 3: MSPNG Annual Progressive Data Jan–Dec 2020, PSF Progress Report July–December 2020. Where data against indicators was not available or where this data differed from information reported in annual progress reports, the data from progress reports was used to calculate the results against this indicator for Phase 1 of the project. Where data for only part of the PSF Phase 1 project period was available, this has been noted. Any discrepancies in data reported is also flagged above.

## Partnering for Strong Families Phase 2 Achievements

Legend	Level of achievement
Δ	Over 90% achieved
Ω	Over 50% achieved
e	Under 50% achieved
Σ	Data unclear, incomplete or could not be verified

**Intermediate Outcome 1: Improved partnership and collaboration for sustainable and efficient FP/SRH and MCH service delivery at the national and sub-national level in PNG in 6 provinces in PNG.**

Indicators	Jul-Dec 2020 Target	Jul-Dec 2020 Achieved	Jul-Dec 2020 % Variation	Jan-Dec 2021 Target	Jan-Dec 2021 Achieved	Jan-Dec 2021 % Variation
<b>IO 1.1:</b> Number of Service Agreements or MOUs approved and executed with PHAs in project provinces.	4	4	100% Δ	3	1	33% e
<b>IO 1.2:</b> Number PHAs showing evidence of integrating MSPNG/SSM learnings into activity plans, programs, or budget plans.	1	1	100% Σ	6	9	150% Σ
<b>Output 1.1.1:</b> Number of national and sub-national stakeholder meetings to assess MCH/FP/SRH needs, disseminating PPF1 operational research, lessons learnt and advocate for rights based integrated women's health.	11	13	118% Δ	21	8	38% e
<b>Output 1.2.1:</b> Number of NDOH Training Unit meetings.	2	3	150% Δ	4	6	150% Δ
<b>Output 1.2.2:</b> Number of National FP Working Group meetings.	2	3	150% Δ	4	0	0% e
<b>Output 1.3.1:</b> Number of multi-sector strategic government events and institutional and professional stakeholder meetings attended to advocate for integrated rights-based women's health.	5	18	360% Δ	20	4	20% e

**Intermediate Outcome 2: Strengthened public sector capacity at the sub-national level to deliver high quality FP/SRH services in 6 provinces in PNG.**

Indicators	Jul-Dec 2020 Target	Jul-Dec 2020 Achieved	Jul-Dec 2020 % Variation	Jan-Dec 2021 Target	Jan-Dec 2021 Achieved	Jan-Dec 2021 % Variation
<b>IO 2.1:</b> Number of health facilities at sub-national level that have the capacity and are delivering high quality SRH/FP and MCH services in project provinces.	24	0	0% e	65	66	102% Δ
<b>IO 2.2:</b> Total number of services for SRH/FP through NFPTP.	2,088	5,041	241% Δ	8,000	21,255	266% Δ
<b>IO 2.3:</b> Total number of CYPS for FP through NFPTP.	4,834	15,972.30	330% Δ	20,000	63,860	319% Δ
<b>Output 2.1.1:</b> Pre-service training assessment, planning and approval completed.	1	0	0% e	0	0	0% e
<b>Output 2.2.1:</b> FP/SRH short course developed and approved by NDOH.	2	0	0% e	0	0	0% e
<b>Output 2.3.1:</b> Number of health workers graduating from NFPTP short courses.	12	0	0% e	24	0	0% e
<b>Output 2.4.1:</b> Number of PHA staff trained to provide supportive supervision under NFPPN.	0	0	0% e	10	0	0% e
<b>Output 2.4.2:</b> Quota of female leadership in NFPPN.	70%	0	0% e	70%	0	0% e
<b>Output 2.5.1:</b> Number of MSPNG NFPTP and PHA NFPPN led supervisions and competency assessments – (note: only MSPNG supervision conducted).	6	8	133% Σ	NFPTP=12 NFPPN=6	NFPTP=27	– Ω
<b>Output 2.5.2:</b> Number of NFPTP graduate achieving competency assessment Level 1.	24	45	188% Δ	50	77	154% Δ



**Intermediate Outcome 3: Increased awareness and uptake of high-quality FP/SRH and MCH services in 6 provinces in PNG.****IO 3A: Increased awareness and acceptance of MCH, FP and SRH in project provinces.**

Indicators	Jul-Dec 2020 Target	Jul-Dec 2020 Achieved	Jul-Dec 2020 % Variation	Jan-Dec 2021 Target	Jan-Dec 2021 Achieved	Jan-Dec 2021 % Variation
<b>IO 3A 1:</b> Number of people reached with FP/SRH and MCH information through IEC materials and social media.	59,200	155,336	262% Δ	220,000	484,897	220% Δ
<b>IO 3A 2:</b> % of clients who feel supported by their community to access SRH information and services.	50%	52%	104% Δ	60%	73%	122% Δ
<b>Output 3A 1.1:</b> Number of CBMs/VHVs trained and supported with IEC materials in targeted provinces.	30	28	93% Δ	60	23	38% e
<b>Output 3A 1.2:</b> Number of clients referred through CBMs.	5,760	5,100	89% Ω	11,250	7,209	64% Ω
<b>Output 3A 2.1:</b> Number of referral partnerships with organisations supporting marginalised groups (youth, DPOs and sexual and gender-based violence (SGBV) organisations) engaged through CBM/VHV program.	3	2	67% Ω	6	6	100% Δ
<b>Output 3A 2.2:</b> Number of campaigns targeting high need groups (youth, rural and remote, GBV, and disability) through radio, events, and audiovisual content.	2	0	0% e	4	5	125% Δ

**Intermediate Outcome 3: Increased awareness and uptake of high-quality FP/SRH and MCH services in 6 provinces in PNG.****IO 3B: Increased number of people accessing high quality MCH, FP and SRHH services in project provinces.**

Indicators	Jul-Dec 2020 Target	Jul-Dec 2020 Achieved	Jul-Dec 2020 % Variation	Jan-Dec 2021 Target	Jan-Dec 2021 Achieved	Jan-Dec 2021 % Variation
<b>IO 3B 1:</b> Number of people accessing SRH/FP/MCH services at the urban, peri-urban areas.	19,678	22,908	116% Δ	39,356	20,067	51% Ω
<b>IO 3B 2:</b> Number of people accessing SRH/FP/MCH services at rural areas.	8,282	10,788	130% Δ	20,406	28,837	141% Δ
<b>IO 3B 3:</b> Number of family planning services provided.	12,695	7,748	61% Ω	25,390	31,248	123% Δ
<b>IO 3B 4:</b> Total number of CYPs generated in project provinces (services and National Family Planning Training Program).	18,134	28,673.30	158% Δ	57,846	85,919	149% Δ
<b>IO 3B 5:</b> Number of pregnant women attending at least 1 ANC visit (combined with PMTCT) visits.	560	978	175% Δ	1,600	1,920	120% A

Indicators	Jul–Dec 2020 Target	Jul–Dec 2020 Achieved	Jul–Dec 2020 % Variation	Jan–Dec 2021 Target	Jan–Dec 2021 Achieved	Jan–Dec 2021 % Variation
<b>IO 3B 6:</b> Number of children immunized in each province (3rd dose Pentavalent, Measles/Rubella 9–17 months).	1,000	1,607	161% Δ	3,000	2,506	84% Ω
<b>IO 3B 7:</b> Number of children under 5 treated for malnutrition.	100	92	92% Δ	200	111	56% Ω
<b>IO 3B 8:</b> Number of children under 5 treated for pneumonia in project provinces.	1,500	1,015	68% Ω	3,000	1,977	66% Ω
<b>IO 3B 9:</b> Number of people treated for STIs and HIV, including PMTCT.	1,600	2,329	146% Δ	4,000	3,657	91% Δ
<b>Output 3B 1.1:</b> Number of static health facilities offering SRH/FP and MCH services.	5	5	100% Δ	5	5	100% Δ
<b>Output 3B 1.2:</b> Number of outreach sites providing SRH/FP and MCH services.	146	269	184% Δ	363	468	129% Δ
<b>Output 3B 1.3:</b> Proportion of service delivery schedules in line with PHA annual activity and COVID-19 plans.	60%	60%	100% Δ	70%	90%	129% Δ
<b>Output 3B 1.4:</b> Number of joint SRH/FP/MCH patrols and services with partners for urban, peri-urban and rural remote populations.	250	79	32% e	360	92	26% e
<b>Output 3B 1.5:</b> Number of high need cases referred to service providers for high priority patients or suspected COVID-19 cases with influenza-like illness.	430	361	84% Ω	710	149	21% e
<b>Output 3B 2.1:</b> Number of hospital facilities staffed with embedded family planning nurses (HEFPNs).	1	2	200% Δ	2	2	100% Δ
<b>Output 3B 3.1:</b> External quality technical assurance undertaken to meeting international clinical governance requirements.	OR 90% PSS 90%	0	– Σ	OR 90% PSS 90%	QTA not done	– Σ
<b>Output 3B 3.2:</b> % of FP clients who say that they would recommend MSI to a family or a friend.	75%	75%	100% Δ	75%	99%	132% <sup>58</sup> Σ
<b>Output 3B 3.3:</b> Number of PHA data from MSPNG reported monthly and fed into each PHA NHIS through PHA NHIS Officer.	6	5	83% Ω	7	7	100% Δ

<sup>58</sup> This is the result of the Light Client Exit Interview (CEI). The target was intended to measure results of the larger CEI survey, which was postponed due to COVID-19 restrictions.

**Intermediate Outcome 4: Improved equity, inclusiveness, and sensitive delivery of FP/SRH and MCH services at subnational level in 6 provinces in PNG.**

Indicators	Jul-Dec 2020 Target	Jul-Dec 2020 Achieved	Jul-Dec 2020 % Variation	Jan-Dec 2021 Target	Jan-Dec 2021 Achieved	Jan-Dec 2021 % Variation
<b>IO 4.1:</b> Number of clients 15–19 years in project provinces presenting for SRH/FP/ANC and other illnesses.	1,329	2,214	167% Δ	4,000	2,826	71% Ω
<b>IO 4.2:</b> Increased number of cases/referrals of GBV clients.	110	85	77% Ω	230	122	53% Ω
<b>Output 4.1.1:</b> Number of PHAs/project provinces with established baseline service data for high need groups and unmet need.	1	1	100%* Σ	6	6	100%* Σ
<b>Output 4.1.2:</b> Number of PHAs/project provinces reviewing inclusiveness, by analysing data for rural/remote, SGBV, people living with HIV/AIDS (PLHIV) and youth, disaggregated by gender and age for quarterly review sessions with inclusive-organisations to inform, guide and refine service improvements.	1	0	0% e	6	3	50%* Ω
<b>Output 4.1.3:</b> Quarterly review sessions with inclusive organisations to inform, guide and refine service improvements.	2	2	100% Δ	4	4	100% Δ
<b>Output 4.1.4:</b> Number of people living with disability served with information and FP/SRH/MCH services.	–	–	– Σ	770	970	126% Δ
<b>Output 4.2.1:</b> Proportion of staff trained in GBV, youth and inclusiveness.	90%	80%	89% Ω	95%	95%	100% Δ
<b>Output 4.2.2:</b> Number of SGBV patients and child protection cases treated in SSM facilities.	110	85	77% Ω	220	122	55% Ω
<b>Output 4.2.3:</b> Number of SGBV and child protection patients in safe houses receiving in situ health care services and treatment.	18	21	117% Δ	36	49	136% Δ
<b>Output 4.2.4:</b> Number of men supporting partner at ANC/PMTCT clinics.	130	312	240% Δ	400	658	165% Δ
<b>Output 4.2.5:</b> Proportion of MSPNG and SSM staff trained in PSEAH and child safeguarding.	50%	50%	100% Δ	100%	100%	100% Δ
<b>Output 4.3.1:</b> Number of youths (<20yrs) accessing services though joint clinics and remote rural patrols.	1,232	1,402	114% Δ	2,400	2,826	118% Δ

**Notes:** Phase 2 progress reports did not consistently provide details of EOPO targets and, as the project has been extended beyond the originally-planned end date, EOPO targets will have changed during the Phase 2 project period. Results and performance against targets for the periods July–December 2020 and January–December 2021 are therefore reported in separate columns.

## Annex 10 – PSF Phase 1 and Phase 2: Provinces, Locations, MSPNG and SSM Activities

Legend	Responsibility for activities
X	PATH Demonstration Province
Y	MSNG activities
Z	Susu Mamas activities (note: details are for activities conducted prior to July 2021)

Province		Phase 1 Activities		Phase 2 Activities		Non-PSF Activities and Locations
Autonomous Region of Bougainville (AROB)	X	MSPNG Arawa OR Team: Central Bougainville, North Bougainville, South Bougainville	Y	–		–
Central		MSPNG OR Team: Rigo, Kairuku-Hiri MSPNG NFPTP (1 HCW)	Y	MSNG Central OR Team: Abau, Goilala, Kairiku-Hiri, Rigo MSPNG NFPTP (10 active HCW <sup>59</sup> )	Y	–
Central		SSM OR	Z	SSM OR	Z	AIHSS funded by PATH in a consortium with Clinton Health Access Initiative, World Vision and Save the Children in the same districts Z
National Capital District (NCD)	X	MSPNG Clinic: Port Moresby MSPNG HEFPN (PMGH) MSPNG NFPTP (20 HCW)	Y	MSPNG NFPTP (15 active HCW)	Y	MSPNG clinic Australian NGO Cooperation Program (ANCP)-funded since July 2020 MSPNG Hospital Embedded Nursing Officer (HENO) based at Port Moresby General Hospital funded by DAK Foundation Y
National Capital District (NCD)	X	SSM Clinic: PMGH	Z	SSM Clinic: PMGH SSM OR: Moresby South Supporting Five Mile Clinic	Z	–
East New Britain (ENB)	X	MSPNG HENO: Nonga Base Hospital, Rabaul MSPNG NFPTP (4)	Y	MSPNG NFPTP (27 active HCW)		MSPNG HENO (Nonga Base Hospital) funded by Mundango in Phase 2 Y
East Sepik		MSPNG NFPTP (5)	Y	MSPNG NFPTP (24 active HCW)	Y	–

<sup>59</sup> An active HCW is an NFPTP-trained health workers who had been certified and is actively providing services as reported by the MSPNG PSS Channel Manager. The district in which the HCW is located not provided in this map.

Province	Phase 1 Activities	Phase 2 Activities	Non-PSF Activities and Locations
Eastern Highlands	MSPNG Goroka OR Team: Dauilo, Goroka, Henganofi, Kainantu, Lufa, Obura-Wanenara, Okapa, Unggai-Bena MSPNG Clinic— Goroka MSPNG NFPTP (3) Y	MSPNG Goroka OR Team (transitioned from Hela to Goroka in January 2022)  MPSNG NFPTP (14 active HCW) Y	MSPNG HENO based at Goroka General Hospital funded by DAK Foundation Y
Eastern Highlands	SSM OR Z	—	—
Enga	MSPNG Mt Hagen OR Team 2: Kompam, Lagaip-Porgera, Wabag, Wapenamanda MSPNG NFPTP (6) Y	MSPNG NFPTP (14 active HCW) Y	MSPNG HENO based at Wabag General Hospital funded by Bucchorn Y
Gulf	MSPNG NFPTP (7) Y	MSPNG NFPTP (8 active HCW) Y	—
Hela	—	MSPNG NFPTP (24 Active HCW) Y	MSPNG OR team and NFPTP funded by Oil Search Foundation in P 1 Y
Jiwaka	MSPNG Goroka OR Team/Mt Hagen OR Team 1 and 2: Anglimp-South Waghi, Jimi, North Waghi MSPNG NFPTP (22) Y	MSPNG Mt Hagen OR Team: Anglimp-South Waghi, Jimi, North Waghi MSPNG NFPTP (6 active HCW) Y	—
Jiwaka	SSM OR Z	—	—
Madang	MSPNG Madang OR Team/Goroka OR Team <sup>60</sup> : Bogia, Madang, Middle Ramu, Rai Coast, Sumkar, Usino Bund MSPNG HENO – Modilon Hospital, Madang MSPNG NFPTP (8) Y	MSPNG HENO – Modilon Hospital MSNG NFPTP (13 active HCW) Y	—
Manus	MSPNG NFPTP (5)	MSPNG NFPTP (10 active HCW) Y	—
Milne Bay	MSPNG HEFPN: Alotau General Hospital <sup>61</sup> Y	—	—
Morobe X	MSPNG Lae OR Team 1 and 2/Madang OR Team: Bulolo, Finschafen, Huon, Kabwum, Lae, Markham, Menyama, Nawae, Sohe, Tewai-Siassi MSPNG Clinic: Lae MSPNG HEFPN: Lae Public Hospital MSPNG NFPTP (11) Y	MSPNG Lae OR Team: Bulolo, Finschafen, Huon, Lae, Markham, Menyama, Nawae, Sohe  MSPNG NFPTP (22 active HCW) Y	MSPNG HEFPN's at Angau Memorial Hospital currently funded by DAK Foundation MSPNG Clinic-Lae is funded by ANCP Y

<sup>60</sup> The OR team in Madang was made redundant in February 2020 due to reduced funding.

<sup>61</sup> HEFPN at Alotau General Hospital was made redundant in February 2020.

Province		Phase 1 Activities	Phase 2 Activities	Non-PSF Activities and Locations
Morobe	X	SSM Clinic: Lae SSM OR: Huon Gulf SSM work with safe houses to provide home based care for survivors of SGBV Z	SSM OR: Huon Gulf SSM Rural Health Facility SSM work with safe houses to provide home based care for survivors of SGBV Z	Accelerated Immunisation Health System Strengthening (AIHSS) funded by PATH and in consortia with Clinton Health Access Initiative, World Vision and Save the Children in the same districts Z
New Ireland		MSPNG NFPTP (12) Y	MSPNG NFPTP (19 active HCW) Y	MSPNG HENO based at Kavieng General Hospital funded by Bucchorn Y
Oro (Northern Province)		MSPNG NFPTP (13) Y	MSPNG NFPTP (26 active HCW) Y	–
Sandaun (West Sepik)		MSPNG NFPTP (19) Y	MSPNG NFPTP (51 active HCW) Y	MSPNG HENO based at Vanimo General Hospital funded by Bucchorn Y
Simbu		MSPNG Goroka OR Team/Mt Hagen OR Team 1 and 2: Chuave, Gumine, Karimui-Nomane, Kerowagi, Kundiawa-Gumboil MSPNG NFPTP (2) Y	MSPNG Mt Hagen OR team: Chauve, Kerowagi, Karimui-Nomane, Kundiawa-Gembogl MSPNG HEFPN: Kundiawa Hospital MSPNG NFPTP (11 active HCW) Y	–
Southern Highlands		MSPNG Mt Hagen OR Team 2: Ialibu-Pangia, Imbonggu, Kagua-Erave MSPNG NFPTP (15) Y	MSPNG Mt Hagen OR Team: Imbonggu MSPNG NFPTP (28 active HCW) Y	–
West New Britain	X	MSPNG NFPTP (18) Y	MSPNG NFPTP (14 active HCW) Y	MSPNG HENO based at Kimbe General Hospital funded by Bucchorn Y
Western Province	X	–	–	Daru OR, Kiunga OR, Daru HENO, Kiunga HENO, Balimo OR Y
Western Highlands	X	MSPNG Mt Hagen OR Team 1 and 2: Dei, Mount Hagen, Mul-Baiyer, Tambul-Nebilyer MSPNG Clinic: Mt Hagen MSPNG NFPTP (17) Y	MSPNG Mt Hagen OR Team: Dei, Mount Hagen, Mul-Baiyer, Tambul- Nebilyer MSPNG NFPTP (14 active HCW) Y	MPSNG HENO based at Hagen General Hospital funded by DAK Foundation Y
Western Highlands	X	SSM Clinic and Men's Clinic space: Mt Hagen SSM Rural Health Facilities: Terlga, Tambul-Nebilyer SSM OR: Kagamuga, Mt Hagen Z	SSM Clinic and Men's Clinic space: Mt Hagen SSM Rural Health Facilities: Terlga, Tambul-Nebilyer SSM OR: Kagamuga, Mt Hagen Z	–



## Annex 11 – Key Success Factors for Working with Priority Stakeholder Groups

This table details Key Success Factors of different ways of working with priority stakeholder groups – and how partners can strengthen these factors in the future.

Ways of Working	Success Factors	Less Effective/Ways to Improve
<b>Community-based health service delivery</b>	<ul style="list-style-type: none"> <li>• Free services – affordability critical for increasing access.</li> <li>• Well defined, culturally-appropriate strategy to engage with target community.</li> <li>• Community network with supported and trained community-based mobilisers/volunteers.</li> <li>• Staff with appropriate clinical skills guided by strong clinical governance/quality framework.</li> <li>• Access to family planning supplies/medical commodities and equipment.</li> <li>• Strong logistical support, especially transport.</li> <li>• Well-developed reporting and client information systems to support data informed decision-making.</li> </ul>	<p><b>Less effective</b></p> <ul style="list-style-type: none"> <li>• SMS ‘blasts’ for demand generation.</li> </ul> <p><b>Ways to improve:</b></p> <ul style="list-style-type: none"> <li>• Integrated model – to maximise efficiency and outcomes.</li> <li>• Inclusive services – to reach under-served groups.</li> </ul>
<b>Partnership with PHAs</b>	<ul style="list-style-type: none"> <li>• Prioritising communication, collaboration and engagement.</li> <li>• Activities aligned with PHA plans responsive to PHA needs.</li> <li>• Locally-based staff conducting regular, ongoing communication.</li> <li>• Ongoing coordination across all levels.</li> <li>• Plans and reports (service statistics and narrative) shared.</li> </ul>	<p><b>Less effective</b></p> <ul style="list-style-type: none"> <li>• Communication with PHAs as an add on to planned activities; e.g. ‘dropping in’ to PHAs for discussions.</li> <li>• ‘Siloed’ approach to planning and delivery of program.</li> </ul> <p><b>Ways to improve:</b></p> <ul style="list-style-type: none"> <li>• Co-design and joint planning and monitoring.</li> </ul>
<b>Inclusive services</b>	<ul style="list-style-type: none"> <li>• Evidence-based Theory of Change with clear objectives and strategies to address barriers, developed with the advice of affected individuals.</li> <li>• Organisational commitment to/management of change.</li> <li>• Adequate, dedicated and ‘ring-fenced’ resourcing.</li> <li>• Technical advice/support for design and delivery.</li> </ul>	<p><b>Less effective</b></p> <ul style="list-style-type: none"> <li>• Staff training only.</li> <li>• No adaptation made to existing model of care.</li> </ul> <p><b>Ways to improve:</b></p> <ul style="list-style-type: none"> <li>• Dedicated resourcing.</li> </ul>

Ways of Working	Success Factors	Less Effective/Ways to Improve
	<ul style="list-style-type: none"> <li>• Ongoing applied training for staff/volunteers trained in inclusive approaches.</li> <li>• Model of care with clear entry points and strong referral pathways.</li> <li>• Disaggregated data, to monitor, report, adjust approach as required.</li> </ul>	<ul style="list-style-type: none"> <li>• Partnership with disabled persons organisations and other organisations representing marginalised groups to guide design and delivery of services.</li> <li>• Referral networks with organisations providing specialist services.</li> <li>• Mechanism to identify vulnerable/disadvantaged individuals in community and refer for services.</li> </ul>
<b>HEFPN family planning services</b>	<ul style="list-style-type: none"> <li>• Clear logic model developed with hospital clinicians.</li> <li>• Sufficient trained staff.</li> <li>• FP and medical commodities.</li> <li>• CBM providing client counselling before seeing nurse.</li> <li>• Regular monitoring and logistical support.</li> </ul>	<p><b>Less effective</b></p> <ul style="list-style-type: none"> <li>• Inadequate staffing and resourcing and support.</li> </ul>
<b>NFPTP-trained providers</b>	<ul style="list-style-type: none"> <li>• Selection of appropriate trainees.</li> <li>• Clinicians trained, regular supervision and certification.</li> <li>• Ongoing access to commodities, equipment and suitable infrastructure.</li> </ul>	<p><b>Less effective</b></p> <ul style="list-style-type: none"> <li>• Unreliable stock of FP commodities/supplies.</li> <li>• Lack of access to equipment for sterilisation.</li> <li>• Weak demand generation.</li> </ul>

## **Annex 12 – Case Study: Adaptive Management during COVID-19 Pandemic**

The COVID-19 pandemic and related restrictions have been one of the key challenges faced by implementing partners in 2020–2021.

MSPNG initiated a strong focus on a risk management approach and duty of care to clients and partners. Staff were trained in COVID-19 preparedness and prevention, including use of PPE, infection prevention and client screening and triage, to ensure that offices and services were COVID-19 compliant. There was a focus on vaccination of all staff using a ‘carrot and stick’ approach, which saw unvaccinated staff placed on leave without pay. As a result, MSPNG staff were not as affected by staff absences due to COVID-19 illness compared to their colleagues who were unvaccinated.

Both organisations mobilised resources to provide COVID-19 information to key stakeholders, with MSPNG distributing IEC materials to facilities and developing and disseminating a widely-viewed information video on the impact of COVID-19 on SRH and family planning. SSM provided education on COVID-19 prevention and hygiene, established handwashing stations in partner communities, and was engaged with Provincial Emergency Response Units in the development of Provincial Preparedness Plans. SSM established a system for testing all clients who attended its clinics, referring clients with respiratory issues to a pop-up clinic established in the clinic grounds.

After a shut-down during initial weeks of the pandemic, MSPNG services resumed where allowed. To avoid the strong backlash from communities concerning COVID-19 vaccination and dilution of family planning messages, MSPNG teams focused on family planning information and did not talk about COVID-19 as part of community health promotion.

Implementing partner branding – ‘blue shirts’ of the PSF teams – also helped to differentiate the team from the ‘yellow shirts’ of immunisation teams. A major effort was invested into scheduling services to allow continuation of outreach. This did not prevent a large decline in client numbers in the first half of 2021 due to restrictions on travel, community concern about public gatherings, and stigma around COVID-19 testing; however, the actions taken by MPSNG and SSM teams helped each organisation to respond to these restrictions and to maintain consistent service delivery.