



# REPRODUCTIVE HEALTH TRAINING UNIT (RHTU)

## MONITORING & EVALUATION FINAL REPORT

JUNE 2017

## RHTU Monitoring and Evaluation (M&E) Final Report

Prepared by:

Jodi Thiessen, Michele Rumsey, and Caroline Homer

World Health Organization Collaborating Centre for Nursing, Midwifery and Health,  
University of Technology Sydney (WHO CC UTS)

Published: June 2017

### **About the M&E Team**

Jodi Thiessen is a Project Manager for the WHO CC UTS. Jodi has worked for more than a decade in the international development field for several United Nations agencies, in particular the World Food Programme. For the last eight years she has worked for WHO CC UTS as a senior project and M&E advisor, qualitative researcher; conducting data collection, writing reports and publications.

Michele Rumsey is Director of the WHO CC UTS. Michele is an experienced international health care consultant and policy expert, with expertise in nursing ethics, regulation, human resources for health, consumer participation and nursing regulation in the Western Pacific, South East Asian Region and Europe.

Caroline Homer is the Director of the Centre for Midwifery, Child and Family Health in the Faculty of Health and Deputy Head of the WHO CC at UTS. She is Distinguished Professor of Midwifery with an international reputation for midwifery education, research and development. She has led research into the development and implementation of innovative models of midwifery care and the development of midwifery practice and education.

## TABLE OF CONTENTS

List of Tables.....	2
List of Figures.....	2
Acronyms .....	3
EXECUTIVE SUMMARY.....	4
INTRODUCTION.....	6
OBJECTIVES AND PURPOSE OF THE RHTU.....	6
MONITORING AND EVALUATION OF THE RHTU.....	6
METHODS AND APPROACHES.....	7
KEY FINDINGS.....	9
RHTU Objective 1:.....	9
End of program outcomes.....	9
RHTU Objective 2:.....	13
RHTU Objective 3:.....	13
End of program outcomes.....	13
RHTU Objective 4:.....	16
End of program outcomes.....	16
RHTU Objective 5:.....	18
End of program outcomes.....	18
SUMMARY AND CONCLUSIONS .....	23
Appendix 1: Program Logic.....	25
Appendix 2: Recommendations from 2013 – 2014 .....	29
Appendix 3: Suspension of Strategic Objective 2.....	35
Appendix 4: Interview protocols .....	37
References.....	41

## LIST OF TABLES

Table 1: RHTU Objectives and Strategies.....	6
Table 2: A summary of Participants of M&E interviews and focus groups in total (2013-2016).....	8
Table 3: Number of website visitors since inception.....	10
Table 4: RHTU Training by Province 2012-2016.....	20

## LIST OF FIGURES

Figure 1: Cadre of health workers completing an RHTU course .....	11
Figure 2: Course attendee's employer .....	12
Figure 3: Health workers last year of qualification .....	12
Figure 4: Number of in-service trainings Health Workers reported for the last 10 years.....	12
Figure 5: Number of health workers reporting the most important things they will change in their workplace as a result of the course ( $n=1569$ ) .....	14
Figure 6: Suggestions to improve future course .....	15
Figure 7: Number of attendees per province and institutes .....	21
Figure 8: Courses attended by type and by sex .....	21
Figure 9: Percentage course attendees: Administrators, Clinicians, Educators, Supervisors .....	22

## ACRONYMS

CHW	Community Health Worker
CPD	Continuing professional development
DFAT	Department of Foreign Affairs and Trade
EmOC	Emergency obstetric care
EOC	Essential obstetric care
FP	Family planning
GoPNG	Government of Papua New Guinea
HEO	Health extension officers
HRH	Human resources for health
IST	In-service training
MCH	Maternal child health
M&E	Monitoring and Evaluation
NDoH	National Department of Health
NFPTP	National Family Planning Training Program
NGO	Non-governmental organisation
NHP	National Health Plan
NO	Nursing Officer
OHE	Office of Higher Education
O&G	Obstetrics and gynaecology
OSF	Oil Search Foundation
PEmOC	Pacific Emergency Obstetrics Care Course, RANZCOG/PSRH
PHA	Provincial Health Authority
PPA	Provincial Partnership Agreement
PNG	Papua New Guinea
PPP	Public-Private Partnership
RH	Reproductive health
RHTU	PNG Reproductive Health Training Unit
RPHSDP	Rural Primary Health Services Delivery Project
UPNG	University of Papua New Guinea
WHO	World Health Organization
WHO CC UTS	WHO Collaborating Centre, University of Technology Sydney
WHPHA	Western Highlands Provincial Health Authority

## EXECUTIVE SUMMARY

The Reproductive Health Training Unit (RHTU) in Papua New Guinea (PNG) is a Public-Private Partnership (PPP) between the National Department of Health (NDoH) which endorses continuing professional development and training, the Australian Government as funders and Oil Search Foundation (OSF) as grant manager and implementing partner. A Monitoring and Evaluation (M&E) Plan (see Appendix 1) was developed by the WHO Collaborating Centre for Nursing, Midwifery and Health Development, University of Technology Sydney (WHO CC UTS) and approved by the RHTU Steering Committee. M&E activities commenced in 2013 and finished in 2016.

This final report outlines the methods used to conduct the M&E, including stakeholders interviewed ( $n=230$ ) and a summary of the end-of-program outcomes.

### **The RHTU objectives were to:**

- Establish and implement formal communication and coordination systems for all RH training stakeholders in PNG
- Develop comprehensive and context-specific CPD/IST packages in essential obstetric care (EOC) and emergency obstetric care (EmOC)
- Demonstrate governance, planning and budgeting capacity at national and provincial levels and in training institutions for RH IST
- Increase health workforce capacity to provide quality EOC and EmOC IST/CPD to health workers in partnering provinces and relevant training institutions

**The RHTU met all these objectives. The Public Private Partnership was successful in implementing 128 courses, with 1,976 health workers attending from all provinces in PNG.** A Steering Committee set the agenda and oversaw decisions, and was maintained throughout; however, it did struggle to represent all reproductive health stakeholders. The RHTU brand was well recognised across Papua New Guinea and stakeholders recognised the courses as being endorsed by the NDoH. Communication tools were used effectively, such as a quarterly newsletter, website and detailed reports back to provinces.

Human resource data were collected from all course attendees providing information on previous continuing professional development they had undertaken, education qualification and year, gender, age, cadre, workplace, employer. Of the course attendees, 14% had never had any continuing professional development in the last 10 years and half had only received one episode of training (Figure 4). Post-course reports were consistently provided to provinces to help inform their planning.

Three packages, Essential Obstetric Care course, Emergency Obstetric Care course, and Essential Obstetric Care for Urban Health Centres course, were developed by RHTU and contextualised for PNG and are now available for ongoing use. Course attendees were overwhelmingly positive and reported learning vital lifesaving information during the RHTU course they attended. Making change in their workplaces sometimes proved more difficult, yet changes were observed by the health workers and their managers and a positive shift in attitude was seen among course attendees.

Educators were encouraged to attend RHTU courses with a total of 108 participating. The RHTU courses were incorporated into existing curriculum at the Divine Word University and the new national midwifery curriculum.

Capacity of the provinces to plan and implement RHTU courses was increased through strict adherence to agreed roles and responsibilities. While provinces continued to struggle to effectively plan for RHTU courses, there was a consistent decrease in cancellations due to strengthened provincial planning. Furthermore, 164 potential course facilitators were identified to the provinces, with 47 of these co-facilitating RHTU courses.

The transition of RHTU to an anticipated Phase II was not achieved prior to grant closure in early 2017. However, at that time, partners and stakeholders did agree there needs to be more public PNG “ownership” and a transition to a PNG institute would be ideal although a specific institute was not identified. An external review recommended that donor-support continue for the RHTU as it represents a suitable and cost-effective mechanism for investing in the community-based obstetric and midwifery workforce.

It is clear that **there is still a need to:**

- Advocate for continuing reproductive health in-service training and establish a mechanism for strengthening pre-service training for those involved in reproductive health;
- Support the accreditation process of in-service training through the Education Committee and Health Curriculum Committee in the NDoH;
- Maintain continuing professional development/in-service training throughout the provinces and increase the training capacity of health workers and educators; and
- Review the outdated curriculums for both the Community Health Worker Training institutions and the Schools of Nursing.

## INTRODUCTION

This is the final report for the monitoring and evaluation of the RHTU. This report is in-line with the M&E program logic and end of program outcomes which can be found in Appendix 1. Other reports available in regard to the M&E of the RHTU are:

1. RHTU Monitoring & Evaluation Annual Report 2013
2. RHTU Monitoring & Evaluation Annual Report 2014
3. RHTU Monitoring & Evaluation Annual Report 2015
4. Analysis of Lahara RHTU courses, 2015
5. Report on the Knowledge, Attitude and Practice of EOC and EmOC participants and observers, 2016 [8]

## OBJECTIVES AND PURPOSE OF THE RHTU

The RHTU was established at the request of the NDoH to meet the objectives in Table 1, which were linked with the Australian aid end-of-program outcomes.

Table 1: RHTU Objectives and Strategies

<b>SO1:</b> Formal communication and coordination systems established and implemented for all RH training stakeholders in PNG
<b>SO2:</b> Operational research for reproductive health (RH) in-service training (IST) in rural/remote facilities in pilot program (MBP) applied, evaluated and informing national approaches <sup>1</sup>
<b>SO3:</b> Development of comprehensive and context-specific CPD/IST packages in essential obstetric care (EOC) and emergency obstetric care (EmOC)
<b>SO4:</b> Demonstrated governance, planning and budgeting capacity at national and provincial levels and in training institutions for RH IST
<b>SO5:</b> Increased health workforce capacity to provide quality EOC and EmOC IST/CPD to health workers in partnering provinces and relevant training institutions

## MONITORING AND EVALUATION OF THE RHTU

The WHO CC UTS was contracted by OSF to provide M&E for the RHTU. The M&E Program Logic has remained the same since 2014 following a Deed of Variation which resulted in a revision of the detail for the Outputs and Targets. This M&E Program Logic was

---

<sup>1</sup> This objective was suspended and removed from the project design document; as explained in Appendix 3.



agreed to by the RHTU Technical Management Group, DFAT, OSF and HHISP. A summary of responses to recommendations from 2013, 2014 and 2015 is provided in Appendix 2.

## METHODS AND APPROACHES

A mixed methods approach was used to study progress of the four key RHTU objectives with data drawn from various sources including selected stakeholder interviews and focus groups, RHTU reports, Steering Committee minutes and various databases maintained by the RHTU. The focus for 2016 was to draw on data to produce publications for peer reviewed journals, to ensure dissemination of analysis of the RHTU and the Public Private Partnership.

A Technical Management Group, with representatives from the WHO CC UTS and OSF, oversaw the M&E activities to ensure that they were conducted in a timely fashion and in keeping with the agreed goals and objectives, and used culturally appropriate methods and tools. The Technical Management Group met up to four times annually.

### Qualitative data

Stakeholders from each of the partners in the PPP, Steering Committee members, donors, and RHTU staff were interviewed each year to monitor and track against the M&E Program Logic outcomes (Appendix 1).

A *Knowledge, Attitude and Practice protocol* [8] was also undertaken to collect data from health care workers who attended either an EOC or EmOC RHTU course as well as managers/supervisors. As part of this, 126 interviews were conducted in 2014 and 2015 in the following six provinces: 14 sites across Morobe, Autonomous Region of Bougainville (ARoB), Madang (in 2014), and 13 sites across National Capital District (Port Moresby) (NCD), Southern Highlands and West New Britain (in 2015).

Three main questions were asked of the interviewees, with prompting questions if required:

1. What are one or two important things you learned in the course?
2. Respectful Maternity Care was discussed in the course – can you fill in this attitude ranking for yourself before the course and for yourself after the course?
3. What are one or two important things you have changed in your practice?

Table 2 gives a breakdown of all interviewees from 2013-2016. Semi structured interviews were used for all stakeholders, the interview protocols are available in Appendix 4.

In addition to interviews, a structured survey was answered annually by RHTU staff to monitor outcomes and previous M&E recommendations. This, along with a review of the following documents were also analysed to gain an understanding of strengths and weaknesses of the RHTU:

- Steering Committee minutes
- Reports provided to provinces following course implementation
- Cancellation reports provided to provinces
- Newsletters and newsletter contact list
- Website

Table 2: A summary of participants of M&E interviews and focus groups in total (2013-2016)

Description	Participants
Southern Highlands RHTU course participants	16
West New Britain RHTU course participants	15
Morobe RHTU course participants	15
ARoB RHTU course participants	10
Madang RHTU course participants	12
Community Health Worker Training School MNH educators	10
School of Nursing MNH educators	16
Supervisors or administrators	14
Stakeholder focus group	23
O&G specialists	10
Provincial FHS Coordinators	6
Provincial Health Authority or Administration staff	13
Provincial Director of Policy and Planning	1
Donors	8
NGOs (Marie Stopes PNG, Susu Mamas, World Vision)	5
Clinical Midwifery Facilitators (MCHI)	2
World Health Organization, PNG	2
Reproductive Health Training Unit	21
Oil Search Foundation	6
National Department of Health	14
Department of Foreign Affairs and Trade	11
<b>Total overall participants</b>	<b>230</b>

*Note: MNH - maternal and newborn health; FHS – family health services; ARoB - Autonomous Region Bougainville; NGO – nongovernmental organisation*

## Quantitative data

Quantitative data was collected by RHTU staff and analysed as part of the M&E each year. This included:

- Database containing information on: identified apprentice facilitators, provinces implementing courses, selection criteria adherence (i.e. how many observers and participants attended), course participant assessments and skill station marks;
- Course participant demographics (age, qualification, year of qualification, gender, contact, profession, employment role, employment clinical area, employer, employment province, highest qualification, CPD attendance in last 10 years), and;
- Course evaluations were conducted following each course with a total of 1596 course attendees filling in a survey.

**Data analysis:** General patterns and emerging issues from participants' explanations and descriptions were identified through thematic analysis [4]. Due to the number of interviews, NVIVO qualitative analysis software was used to categorise into themes. Insights obtained through the interviews (including field notes, personal observations, historical knowledge, individual interpretations and collective reflexivity) were incorporated into the analysis [5].

## KEY FINDINGS

### RHTU Objective 1:

SO1: Formal communication and coordination system established and implemented for all RH training stakeholders in PNG

### End of program outcomes

- **Effective communication and coordination of RH activities**

Communication was difficult during the initial stages, however 2014 and 2015 saw an increase in external communications to the provinces and other stakeholders which had an impact on the acceptance of the RHTU and its courses. This was so well established that by 2016, momentum only needed to be maintained. Focused communication was vital in creating ongoing relationships in a complex health and governance system where health reform was underway and many provinces were transitioning to the new structure of Provincial Health Authorities.

*"It's taken such a long time to get people in this country to see the value of this unit. Some of them started quite quickly...but some provinces they look a bit skeptically at these outsiders, these public-private people, "who are they to come and tell us how to do anything." PNG is a bit like that, it's very conservative, very skeptical."*

*Stakeholder, 2015*

A standardised message of the RHTU brand as a stand-alone entity was maintained throughout regardless of the various 'ownership' agendas of the Public Private Partnership. This evaluation found that the provinces were particularly able to embrace the RHTU as it

was perceived as coming from the NDoH and therefore was endorsed by them. The NDoH also explicitly stated they wanted more ownership but acknowledged the lack of capacity for this to happen without support.

The website and newsletters and various focused presentations created good public relations and built the capacity of the RHTU staff. Such communication avenues helped build the knowledge throughout PNG of the RHTU. The quarterly newsletter reached important stakeholders such as: provincial offices/authorities; senior medical officers including obstetricians and gynaecologists, schools of nursing and community health worker training Institutes and previous course participants. Furthermore, the website grew rapidly as a source of information and storytelling, although a decline in website visits was noticeable in 2016 which coincided with a decline in RHTU staff numbers.

Table 3: Number of website visitors since inception

2013	2014	2015	2016
945	1869	2778	2112

It was recognised by stakeholders within the Public Private Partnership (PPP) that the Steering Committee was a vital decision-making body. Due to variable attendance by some members, and nursing and midwifery educators not being properly represented the Committee remained non-representative of all reproductive health stakeholders during Phase I. While an effective Steering Committee can oversee decisions and direction, maintain accountability and ensure representation of stakeholders, a dedication to building engaged members would need prioritisation for any ongoing RHTU activities. Given the complex environment in PNG, the rapid turnover of people within each institution and the health sector generally is an ongoing issue that would need constant focus and nurturing.

*“I think it's really important that we continue to converse about it and share challenges and successes because we are the same business and we learn from each other. So, the RHTU Technical Committee is really important...”*

*Stakeholder, 2015*

- **HR data informing provincial HRH planning**

Data were collected from all course attendees with the potential to be used to inform human resources for health planning. Details have been fed back to the provinces but whether the Provincial Health Authorities/Departments have used this data has not been tracked. The data do provide a retrospective baseline of training history, previous qualification, where

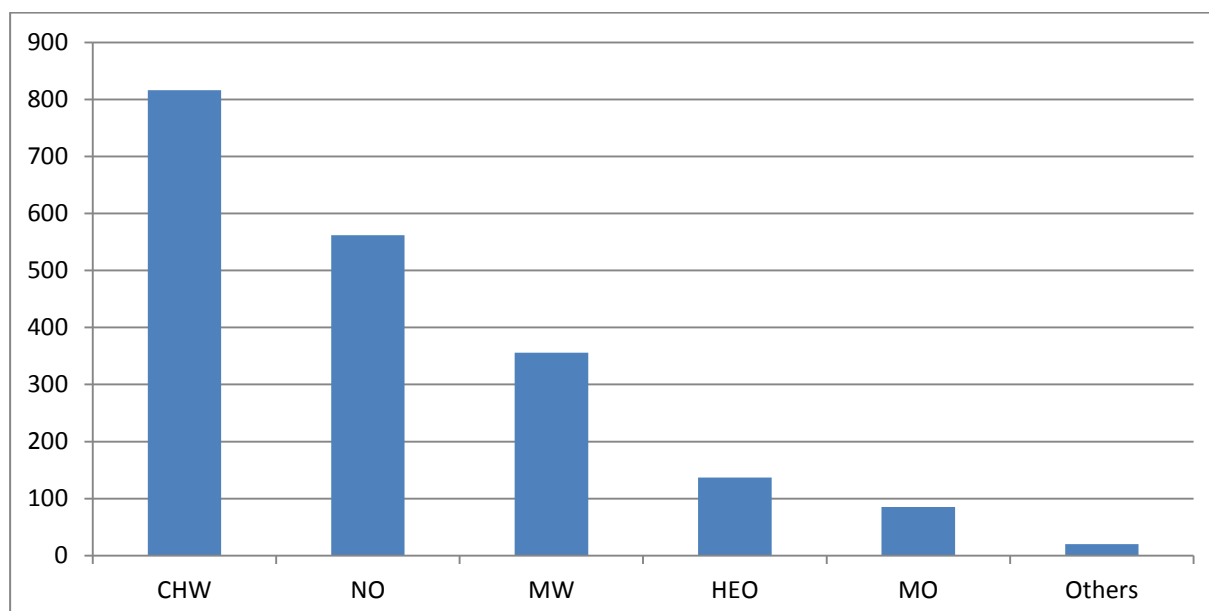
attendees work (church, government, and province), gender and age. This database should be shared with the NDoH as a de-identified source of public information.

Figure 1 shows that 41% of RHTU course attendees were CHWs, which reflects that CHWs are the largest proportion of the health worker cadre in PNG. Similarly, as expected, the NDoH and Christian Health Services were the largest employers providing in-service training for their health workers as shown in Figure 2. However, about half of all course attendees who provided information on their education were educated more than 10 years ago (i.e. prior to 2004), as shown in Figure 3. Yet the number reported to have received any continuing professional development or in-service training in the last 10 years remains low. For example, of the 1,873 course participants providing data on how many trainings they have received in the last 10 years, 14% have received none at all, and half have only received one training, see Figure 4.

*“I have not gone anywhere to train as a tutor so this has really helped me, I have really enjoyed how to be a good tutor, to plan the lessons for the students, using time and what resources I have available.”*

*Educator, 2015*

Figure 1: Cadre of health workers completing an RHTU course



*Note: CHW – community health worker, NO – nursing officer, MW – midwife, HEO – health extension officer, MO – medical officer*

Figure 2: Course attendee's employer

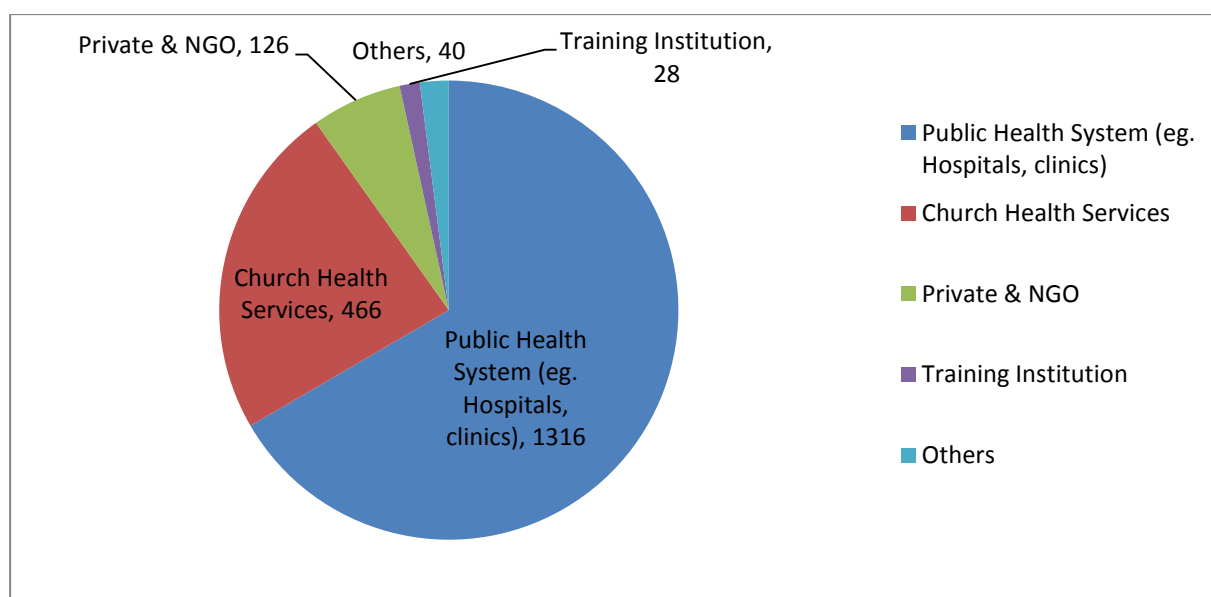
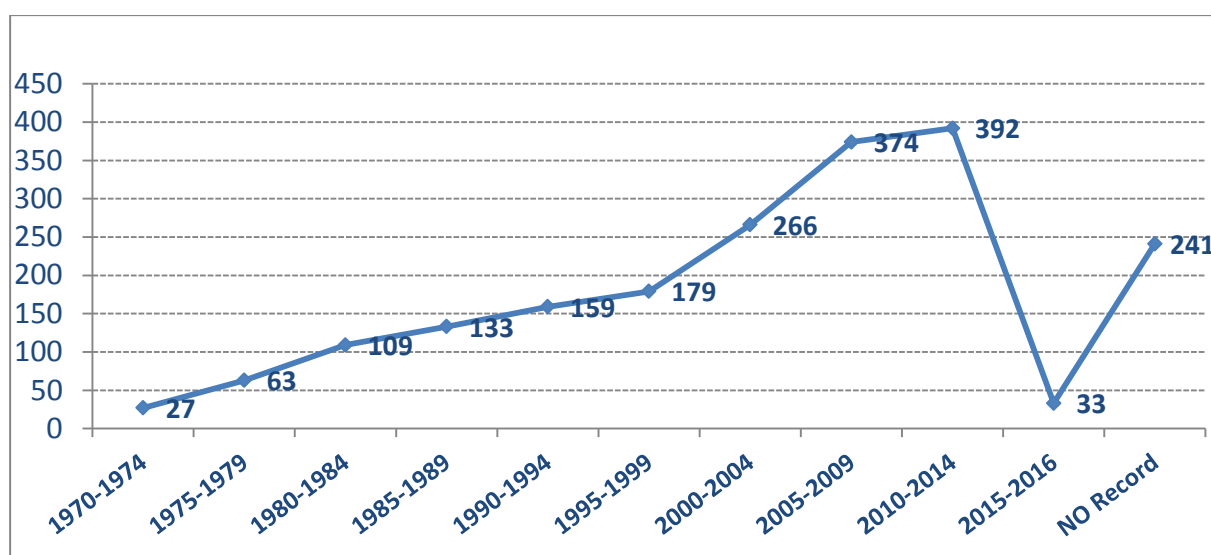
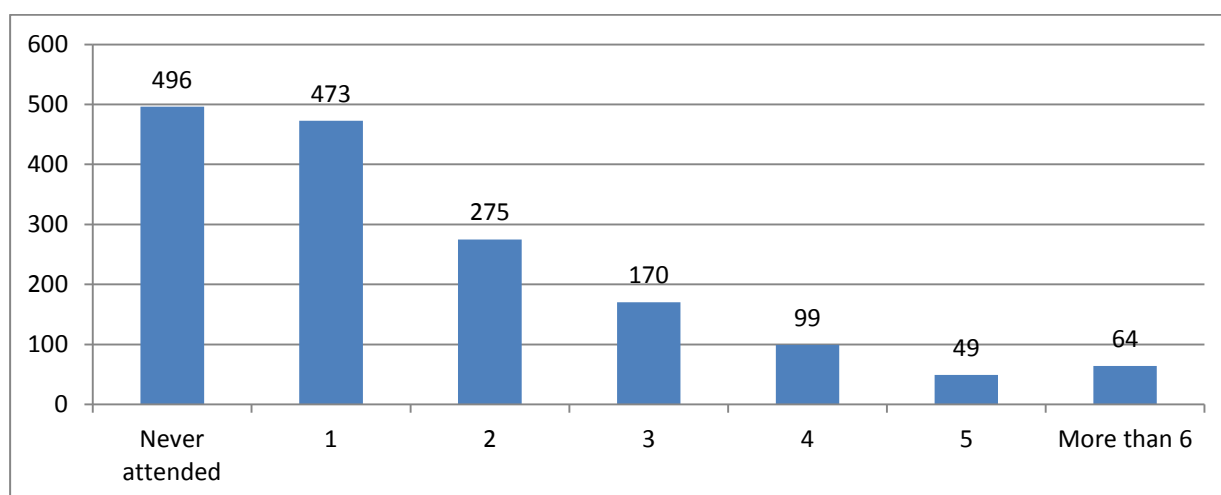


Figure 3: Health workers last year of qualification



Note: Health workers reported between 2013-2016 what their last year of qualification was

Figure 4: Number of in-service trainings Health Workers reported for the last 10 years



## RHTU Objective 2:

SO2: Operational research for RH IST in rural/remote facilities in pilot program (MBP) applied, evaluated and informing national approaches

Please see Appendix 3 for a justification of the suspension of this objective.

## RHTU Objective 3:

SO3: Development of comprehensive and context-specific continuing professional development/in-service training packages in EOC and EmOC

### End of program outcomes

- **At least two nationally accredited RH IST/CPD packages (EOC and EmOC), based on lessons learned during piloting and local expert input.**

Three RHTU packages were completed: Essential Obstetric Care (EOC), Emergency Obstetric Care (EmOC) and EOC for Urban Health Centres (UHC). The course structure, workbooks and presentations were revised to reflect lessons learned and course attendee feedback. All packages have been endorsed by the academic and clinical members of the Steering Committee and NDoH, however formal accreditation will need to be addressed for any future use. This will involve working with the Education Committee at the NDoH to build policy around such course. As yet there is no framework outlining how to accredit short courses administered through a Public Private Partnership.

Feedback from **stakeholders was overwhelmingly positive about the courses.**

**Stakeholders stated that courses were contextualised for PNG, contained relevant information and provided a standardized evidence-based way of practicing** which they reported was variable across educational institutes. Evaluations collected from 1,596 course attendees showed 99% would recommend this course to others. Some of the most important knowledge and skills participants gained were:

- neonatal resuscitation (46%),
- diagnosis and management of postpartum hemorrhage (23%),
- and getting the dates right (22%).

*“That’s been a major change, clinically I think there are more people who are proactively preventing and treating earlier postpartum hemorrhages. If there is a slim possibility that this is what’s happening - they are having a PPH - then people swing into action a bit quicker”* Management/observer, 2014

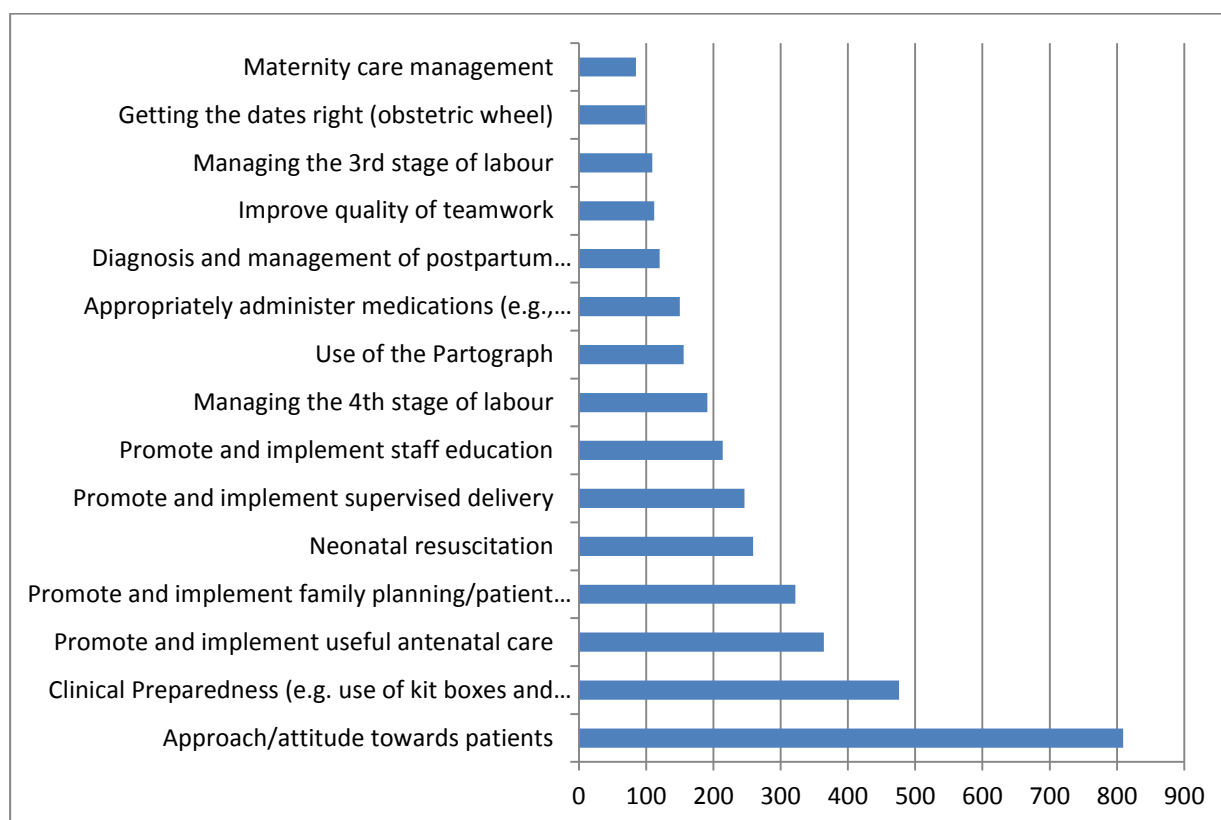
All of these link to the largest causes of preventable mother and child death in PNG. Course attendees also reported on what they plan to change in their workplace as a result of the course. These were:

- attitude towards patients (47%) see Figure 5
- clinical preparedness (30%).

This was confirmed through interview data which showed emergency kits had been implemented in all sites visited by evaluators and a reported shift in positive attitude was noted by course attendees and those in a position to observe.

However, with a destabilisation of the core RHTU staff, through the loss of the Director in early 2016 and lack of Midwifery Fellows, the team was weakened and they did not have the capacity to extend RHTU courses beyond bookings made in the previous year.

Figure 5: Number of health workers reporting the most important things they will change in their workplace as a result of the course (n=1569)

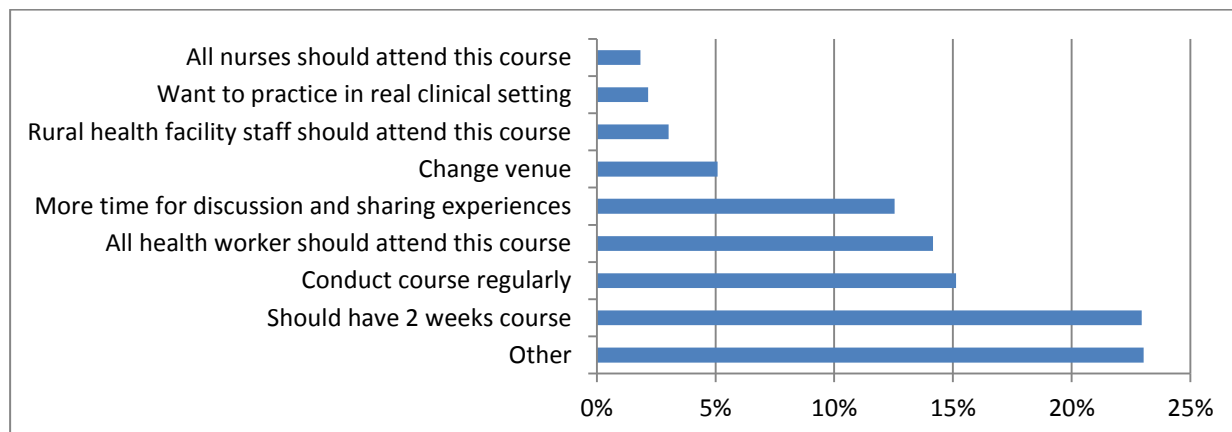


When course attendees were asked in an open-ended question to provide suggestions for the RHTU, the most common suggestions were that the existing one week course be extended to two weeks, that the courses be implemented more regularly and that all health workers should attend, see below. This was further corroborated during interviews with course attendees who suggested an urgent need for regular and ongoing continuing professional development opportunities. Furthermore, it was recognized the RHTU provided a standardized evidence-based training that was welcomed by participants who had received



different information depending on their educational institution. The midwifery curriculum was reviewed in 2014 and is currently being implemented, which includes both EmOC and EOC components. However, the CHW and nursing curriculums both need reviewing to not only update but to include best practice in a standardized way across PNG.

Figure 6: Suggestions to improve future course



## Case Study 1

### Improved attitude

Respectful maternity care was a major component of RHTU courses. Many course attendees interviewed as part of the *Knowledge, Attitude and Practice protocol* discussed how they were going to change their practice to be more kind, respectful and patient with mothers. This Nursing Officer described how when returning to his clinic after an EOC course, he spent time teaching and showing younger health workers how to treat mothers in both the antenatal clinics and during/after labour.

### Nursing Officer, West New Britain

"I noticed the nurses disrespecting the mothers. Sometimes the nurses get frustrated because they are hungry or there are a lot of patients to see. When they check women in the antenatal clinic, they might not notice the problems the mothers are having.



Maternity ward. PNG

There was a lot of mistreatment of patients, especially the mums. But, I think now, we changed. With the training that I did, we realised that these are human beings. I say to the others, tell me, put yourself in their situation, if you were there and I am here to assist you, and I mistreat you, just like you are doing right now, how would you feel about it? I did a lot of questioning of the other staff about their mistreatment of mothers. I then introduced the changes to make it better. There are a lot of changes here now. I'm happy with the other nurses here now as they are learning. I do my best to teach them every now and then, every case that comes in, I supervise, and at the same time, I can see how the nurses treat the mothers. But, I will retire soon, so we need to bring in new people to do the training."

- **Improved linkages between pre-service and in-service training in EOC and EmOC at relevant CHW, nursing and midwifery training institutions, Divine Word University's HEO training program; and the University of PNG's School of Medical and Health Sciences**

The RHTU has the potential to create sustainable change through the linkages it has created with pre-service educational institutes. The majority of CHW, nursing and midwifery training institutes had educators attend courses for both EOC and specific educator training.

Furthermore, Divine Word University has incorporated EmOC course as part of their Advanced Diploma in Emergency Medicine (for HEOs and nurses). The new midwifery program now also incorporates modules from EOC and EmOC training.

Since 2012, educators were encouraged to attend courses through the Provincial Health Authorities/Departments with **108 educators** attending since inception of the RHTU. Linking with educational institutions was due to persistence by the RHTU Director who devised extra courses specifically for educators. The potential impact of training educators in EOC and EmOC (where appropriate) cannot be understated.

Furthermore, the RHTU spent a lot of time building invaluable relationships with the provinces. Since inception the RHTU team communicated with interested training providers and **all provincial health offices** across PNG. This has resulted in course attendees from all provinces being represented either through provincial training, or through institutional partnerships conducting courses for their reproductive health workers (see RHTU Objective 5 for breakdown of numbers).

#### **RHTU Objective 4:**

SO4: Demonstrated governance, planning and budgeting capacity at national and provincial levels and in training institutions for RH IST

#### **End of program outcomes**

- **10 provinces with established MoUs with RHTU to provide RHT IST/CPD**

In 2015, the Steering Committee acknowledged that the long and formal process for developing and endorsing MOUs with provinces would create unnecessary barriers to RHTU course implementation. The Steering Committee therefore regarded the informal agreements made with each province as sufficient. As a requirement for RHTU to provide training, it was agreed that provinces would support their own health workers financially and through time out of their regular work place.

- **Improved national and provincial coordination for all EOC and EmOC IST/CPD**

According to the National Health Service Standards [6] it is up to health facilities to provide staff with in-service training. As the RHTU team worked across most provinces and also within institutions and with educational providers, the national and provincial coordination of EOC and EmOC in-service training increased immeasurably from what was almost non-existent prior to 2012. The capacity of provinces to plan and carry out RHTU inputs grew during in part due to:

- strict selection criteria encouraging the correct selection of course attendees;
- provinces required to support their own health workers financially to attend (i.e. provinces were responsible for funding venue hire, travel, accommodation, and per diems of the participants);
- strict cancellation policies carried out if a province did not uphold their end of the agreement (RHTU would not implement training if agreement was not fulfilled).

While creating daily work and extra communication, these policies resulted in more effective courses with strong provincial buy-in. Course cancellations were steadily reduced as understanding of RHTU requirements and provincial planning capacity increased. Five trainings were cancelled in 2016, with 6 cancellations in 2015, and 14 cancellations in 2014.

Sustainability and PNG ownership of the RHTU courses was always a concern. One area the RHTU developed sustainability was through identifying potential apprentice facilitators in each province. Since inception, a total of **164 potential facilitators** were identified<sup>2</sup> with an impressive 47 who acted as apprentice co-facilitators in either EOC or EmOC courses.

- **Established transition and funding arrangements for RHTU possibly within PNG institution**

The transition of RHTU to Phase II did not occur as originally intended due to several factors. In 2016 the Australian aid program went through a series of changes, including changes to its funding and program management mechanisms. The resultant position placed an emphasis on a prerequisite for the PNG Government to commit (conceptually) to a further phase of RHTU training. Early discussions were held with DFAT regarding future directions at the end of 2016. Unfortunately by early 2017 the key decision makers were no longer at the NDOH. Nonetheless, partners and stakeholders agreed the need for any future RHTU type program to have greater PNG ownership, primarily through a PNG academic or learning organisation.

---

<sup>2</sup> This number excludes the educators who work for RHTU and the midwifery fellows.

A review of the RHTU in 2016<sup>3</sup> found that “continued investment is needed in the community-based obstetric and midwifery workforce. The RHTU represents a suitable and reasonably cost-effective mechanism for achieving this, and continuation to a second phase of donor-funded support was recommended.”

#### RHTU Objective 5:

SO5: Increased health workforce capacity to provide quality EOC and EmOC IST to health workers in partnering provinces and relevant training institutions

#### End of program outcomes

- **Between 33-66 PNG clinicians/educators delivering EOC and/or EmOC CPD training packages to health workers, including, MO and midwives through the leadership program.**

There continues to be a severe lack of appropriately trained reproductive health educators in PNG. To increase the chance of sustaining RHTU courses, co-facilitators were introduced and encouraged to facilitate in all implementing provinces. Of the 164 potential co-facilitators identified, **47 have been involved in co-facilitation**. In this way, while this program outcome (33-66 PNG clinicians/educators delivering training) was never fully realised, it was progressed through not only specific training for reproductive health educators in both CHW and nursing training institutions but through identified co-facilitators.

Furthermore, Milne Bay Provincial Health Authority (MBPHA), with support from RHTU, has been very successful in planning and implementing EOC and EmOC for health workers, including clinical follow-up visits.

- **Between 750-1000 health workers and 30-40 health educators will have increased their knowledge, skills and confidence with the ability to provide EOC and EmOC training to students.**

In terms of the target for health workers trained (750 – 1000 by end of Phase I), the RHTU has exceeded its end of program outcome. **Since inception a total of 1,976 health workers have attended an RHTU course.** This is made up of 1,804 Participants and 172 Observers trained in 128 courses (EOC = 70, EmOC = 47, UHC = 11), representing 22 provinces. Table 4 gives a breakdown of training for provinces by institutions per year.

The biggest year for RHTU in terms of staffing, courses and participant numbers, standardised communication, and educational linkages was 2015 when the RHTU was

---

<sup>3</sup> Condon, R. (2016) Proposed Australian support for RHTU Phase 2: A concept note (internal document). Commissioned by the PPP and done in collaboration with the Steering Committee

staffed with a Director, three Senior Educators, a Project Coordinator and two Midwifery Fellows (interning). The team rapidly grew in capacity and strength and managed to provide training to 711 course attendees which was a 75% increase in course attendees from 2014 and fewer cancellations. With a change of staff and uncertainty about the future, in 2016 the number of course attendees dropped to 485. It was reported all of the courses held in 2016 were already booked during 2015.

Figure 8 and Figure 9 show that 77% of course attendees were female representing the fact that the majority of CHWs and nurses, the two largest cadre of health worker in PNG, are female. The majority of course attendees were clinicians (90%) indicating the strict selection criteria was a successful way of encouraging the right health workers to attend training.

## Case Study 2

### Improved assessment of Risk

Assessing high risk mothers can have a great impact on clinical preparation and also appropriate referral. Course attendees expressed that learning how to recognise risk was helpful for their practice. This Community Health Worker describes having the confidence to go beyond the authority of the Health Extension Officer (HEO) to refer a mother who was in distress, saving the mother and her baby's life.

### Community Health Worker, Autonomous Region of Bougainville

"After the [RHTU] training, we like to use the partogram. It shows us to detect whether the mother is progressing normally or not in labour. After the course, when we use the partogram, we found that three of the mothers needed referral. In one of the cases, I had stressed to the HEO (Health Extension Officer) that we needed to refer the mother, but the HEO said "no the mother will deliver here". I was not happy with him, I was sticking to the partogram, the descent of the head was still high, the cervix was fully dilated and she was not about to deliver. The next day I rang the midwife at the referral hospital, I told her the HEO said I should keep the mother, but when I look at the partogram and from my own observation the time for her to deliver is over and I need to refer. The midwife advised me to refer her straight away. I went to the Sister in Charge for money for the fuel to refer this mother; I said the mother has to go. We referred the mother and I saved the mother and the baby. At the hospital they had to use a vacuum to deliver the baby and we don't have vacuum.

I have saved three mothers since the course. That is why the partogram is very helpful. Before the course, we would never use a partogram and so we would not detect things like obstructed labour. We would just ignore it and think the mother would deliver."

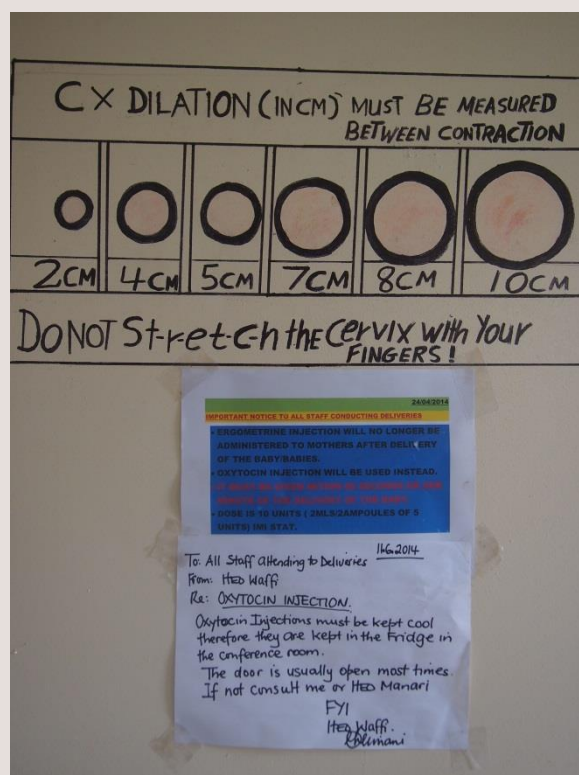


Table 4: RHTU Training by Province 2012-2016

	2013		2014		2015		2016		Total
	O	P	O	P	O	P	O	P	
ARoB	10	38	5	46	9	41		4	153
Central		44						5	49
Chimbu		22						1	23
EHP	4	35				54		36	129
ENB					11	36	1	32	80
Enga					5	37		35	77
ESP					4	36		16	56
Gulf								29	29
Hela								24	24
Jiwaka								3	3
Madang	3	22	1	15				5	46
Manus								2	2
Milne Bay		19							19
Morobe		51	15	110	7	72		29	284
NIP							6	80	86
NCD		15			2	16		2	35
Oro			7	32	7	31			77
SHP			12	52	3	51		31	149
WP			12	37	8	33		28	118
WHP	8	75			4	44	10	97	238
WNB		23	1	21	4	51		2	102
WSP								7	7
<b>Institution</b>									
CHS (central)						29			29
CHS ENB					2	33			35
CHS (WP)					3	11			14
SON						15			15
CWHTS						11			11
SMHS			4	13		17			34
DWU			1	14	3	21			39
PNG DF				13					13
<b>TOTAL</b>	<b>25</b>	<b>344</b>	<b>58</b>	<b>353</b>	<b>72</b>	<b>639</b>	<b>17</b>	<b>468</b>	<b>1976</b>

Note: O- Observer; P- Participant; ARoB – Autonomous Region of Bougainville; EHP – Eastern Highlands Province; ENB – East New Britain; ESP – East Sepik Province; NIP- New Ireland Province; NCD – National Capital District; SHP – Southern Highlands Province; WP – Western Province; WHP – Western Highlands Province; WNB – West New Britain Province; WSP – West Sepik Province; SONs – Schools of Nursing; CWHTS – Community Health Worker Training Schools; SMHS – School of Medical Health Sciences; PMGH – Port Moresby General Hospital; DWU– Divine Word University; CHS – Catholic Health Services.

Figure 7: Number of attendees per province and institutes

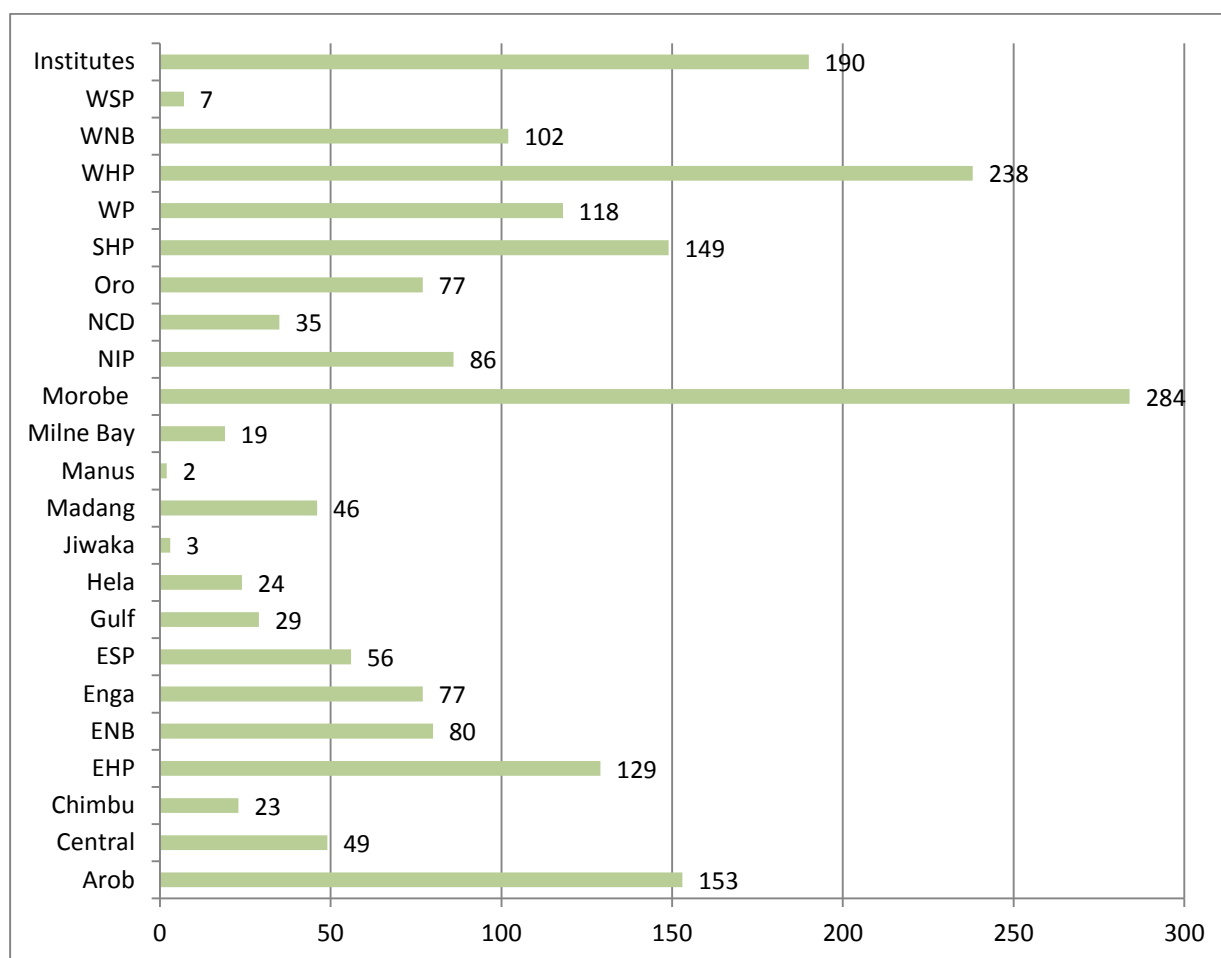


Figure 8: Courses attended type and by sex

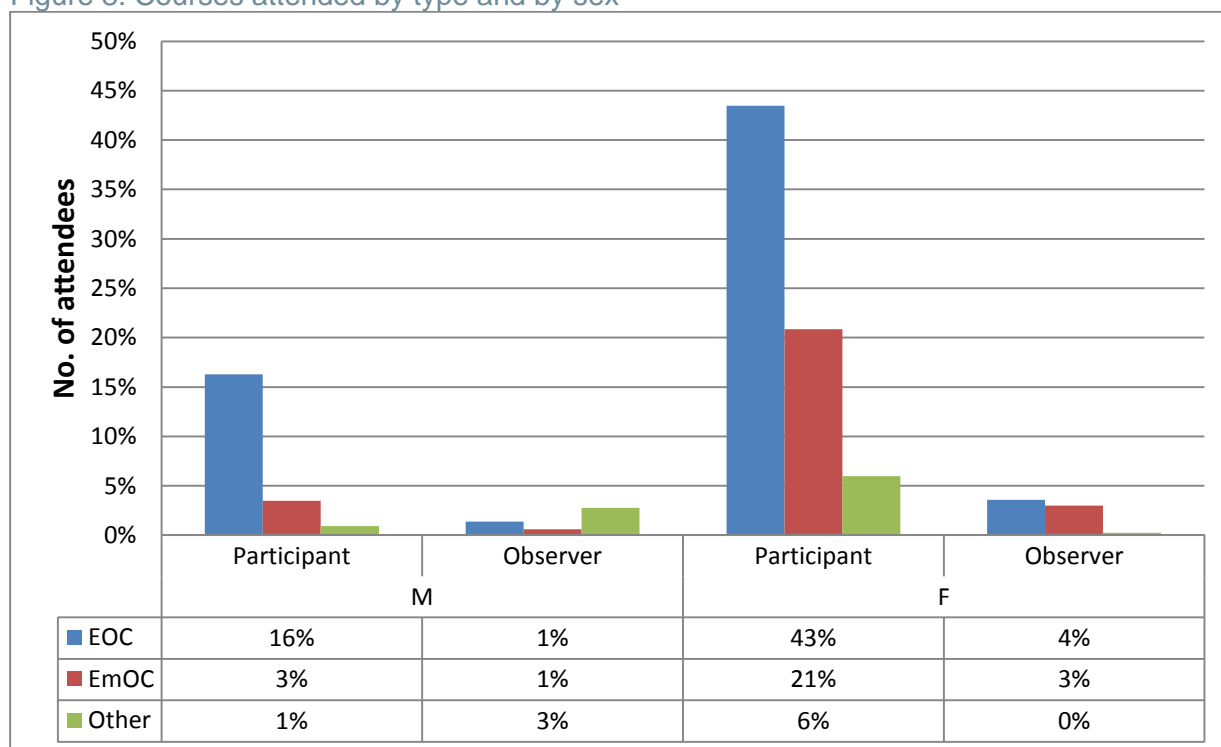
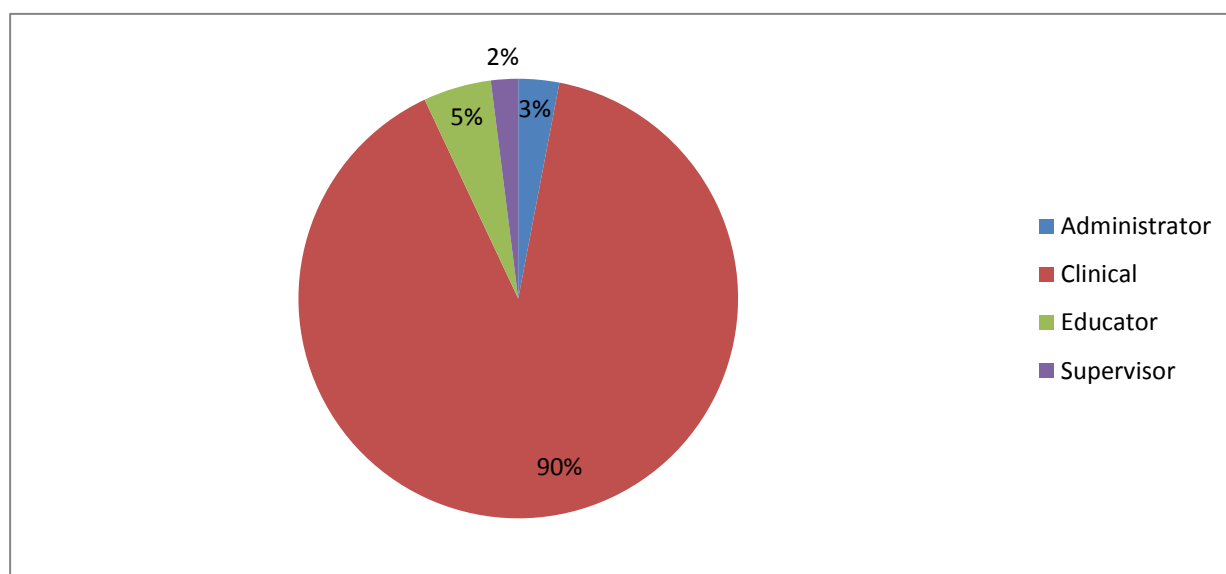




Figure 9: Percentage course attendees: Administrators, Clinicians, Educators, Supervisors



### Knowledge, Attitude and Practice

To determine any changes in the knowledge, skills and confidence a purposive sample of participants was interviewed in 2014-2015. This is discussed in detail in the report on the *Knowledge, Attitude and Practice of EOC and EmOC Participants and Observers* [8].

In summary, in 2014-2015, 75 course participants and 42 staff in management or administrator<sup>4</sup> positions who could provide observations were interviewed in five provinces: Morobe, Autonomous Region of Bougainville, Madang (2014) and Southern Highlands Province, West New Britain (2015). The findings were overwhelmingly positive. Overall, there were three main thematic areas: (1) increased clinical knowledge and changes in practice; (2) improved attitudes to women; and (3) impact of confidence gained.

---

<sup>4</sup> This denotes stakeholders who have not attended a RHTU course however are in a position to observe, or hear about those who have attended.



### Case Study 3

#### Being better prepared

Many health facilities visited as part of the Knowledge, Attitude and Practice protocol, now have comprehensive emergency kits and health workers reported using them. This Community Health Worker has also implemented a “staff only” birth room to ensure privacy for the mothers, and so resources are kept neat and orderly.

#### Community Health Worker, Autonomous Region of Bougainville

“The course developed my skills a lot. Before, in the labour ward things were not in order. At the EOC course I learned to put things in order, we never thought of that before! I learned how to pack things properly and put them neatly away. Before it wasn’t like that - the delivery pack was everywhere and we never concentrated on getting things in order and setting-up things for a delivery.



After the training, I now boil all the instruments and get ready for the next mother. Every time when a mother comes in I use a separate PV [vaginal examination] tray and I don’t use the delivery tray. When a mother comes in for labour we should not open the delivery tray (to keep it sterile). We use the PV tray that I’ve already got ready then when the mother is fully dilated we use the delivery tray. Now I try to keep this place clean.

I’m still encouraging the other nurses to continue to be better prepared. Even this morning we sat and I talked about this again. I was talking to them about how important it was to keep the labour ward clean. Some years ago we had an increased number of neonatal infections because the labour ward was not clean. After the course, by having discussions in the morning it encourages the staff to keep the labour ward clean at all times.

### SUMMARY AND CONCLUSIONS

The RHTU achieved or exceeded its objectives throughout Phase I. This took creative energy and persistence in finding innovative ways of problem solving. For example, a provincial ranking was provided for cancellations, feedback letters to all the provinces were provided, a project management course was undertaken, special educator EOC trainings were implemented and midwifery fellows were engaged as interns.

The RHTU team grew in capacity to reach their full potential in 2015. This was unfortunately weakened in 2016 through staff changes, in part caused by uncertainty about future funding for the RHTU. An external review conducted in September 2016 [7] described a potential future design and recommended continuing the provision of continuing professional development/in-service training for reproductive health workers. However, at the time of this

report (May 2017), no further funding has been secured although an ongoing commitment to finding solutions to continuing with the program in a new form remains.

The strict selection criteria helped ensure appropriate course attendees were chosen.

Clinical attachments were always recommended for course participants, but this was not seen as a priority, or within the capacity, of the provinces despite constant recommendations for clinical supervision and/or attachments.

Course attendees were overwhelmingly positive and reported to have learned vital lifesaving information during their RHTU course. Making change in their work places sometimes proved more difficult yet changes were observed and a positive attitude shift was seen among course attendees.

Despite ongoing requests from provincial partners for RHTU courses, the future of RHTU type training funded through the Australian aid program is uncertain.

**It is clear that there is still a need to:**

- Advocate for continuing reproductive health in-service training and establish mechanisms for strengthening pre-service training for those involved in reproductive health;
- Support the accreditation process of in-service training through the Education Committee and Health Curriculum Committee in the NDoH;
- Maintain continuing professional development/in-service training throughout the provinces and increase the training capacity of health workers and educators;
- Review the outdated curriculums for both the Community Health Worker Training Institutes and the Schools of Nursing.

## APPENDIX 1: PROGRAM LOGIC

RHTU Objectives	End of program outcomes	Short-term outcomes (18 months)	Outputs	Targets	Status (end 2016)
SO1: Formal communication and coordination system established and implemented for all RH training stakeholders in PNG	<b>M&amp;E O1: Monitor communication and coordination between reproductive health training partnership and stakeholders</b>				
	Effective communication and coordination of RH activities.	1.1 Stakeholders collaborate/share in planning, implementing and reporting of training.	a) Agreed stakeholder list developed b) A standardised message provided to stakeholders [R1, R10] c) Membership maintained on NFP Working Group <sup>5</sup>	<ul style="list-style-type: none"> <li>RHTU attend all NFP Working Group<sup>1</sup> meetings</li> <li>At least four meetings held annually to provide information on RHTU and build relationships</li> </ul>	<b>Exceeded</b> – knowledge of RHTU well established resulting in increasing the number of courses implemented
		1.2 Strengthened Steering Committee with relevant members for collaborative decision making.	d) Steering Committee established and membership refined. [R3] e) PPP roles and responsibilities developed [R8]	<ul style="list-style-type: none"> <li>Annual SC meetings held in accordance with TOR</li> <li>PPP roles and responsibilities disseminated to all partners</li> </ul>	<b>Met</b> – SC established and roles refined, however full and consistent partner participation was variable.
		1.3 Improved information on RH training and RH trained health workers in PNG	f) Website designed, implemented and updated by admin assistant & educators g) Website calendar of RHTU courses updated h) RHTU Newsletter published and distributed to developed stakeholder list [R4] i) Risk mitigating strategy developed. [R13]	<ul style="list-style-type: none"> <li>Website updated quarterly with calendar of RHTU courses.</li> <li>Newsletter disseminated to stakeholder list bi-annually</li> <li>Risk Matrix updated annually.</li> </ul>	<b>Exceeded</b> – website and newsletters continued to provide updated information to stakeholders.

<sup>5</sup> The M&E program logic annexed in the OSF contract with DFAT describes in this outcome the NFPTP – National Family Planning Training Program which is under the auspice of Marie Stopes PNG. This has been changed to NFP Working Group – National Family Planning Working Group which has a broader agenda and incorporates the NFPTP.

RHTU Objectives	End of program outcomes	Short-term outcomes (18 months)	Outputs	Targets	Status (end 2016)
	HR data informing provincial HRH planning	1.4 Strengthened retrospective baseline of health workers trained in RH IST/CPD.	j) Previous RH training data reported in participant database and provided to provinces.	<ul style="list-style-type: none"> <li>Information on previous training in RH IST/CPD collected from all Participants.</li> </ul>	<b>Exceeded</b> – data collected and provided to provinces
SO2. Suspended	<b>M&amp;E O2: Monitor and evaluate pilot site for RH model for rural/remote health facilities on the D'entre Casteaux Islands, MBP</b>				
	This pilot project will not be undertaken. The reasons were described in the Deed of Variation contract with DFAT and the M&E annual report 2014				
SO3: Development of comprehensive and context-specific CPD/IST packages in EOC and EmOC	<b>M&amp;E O3: Monitor and evaluate the concept of RHTU</b>				
	At least two nationally accredited RH IST/CPD packages (EOC and EmOC), based on Lessons Learned during piloting and local expert input *	3.1 Training modules delivered within timeline (and/or timeline revised)	k) RHTU staff retained for RH training unit [R7] l) Training modules and training aids developed for context-specific training packages in EOC and EmOC in line with NDoH policies [R2] m) Participant course evaluations analysed and used to influence course content, attendance and structure	<ul style="list-style-type: none"> <li>Employed a technical advisor/director, project leader, at least 2 mobile midwifery educators, &amp; administrative assistant</li> <li>EOC and EmOC courses meet accreditation needs of NDoH</li> <li>100% Participants evaluate RHTU courses they attended.</li> </ul>	<b>Exceeded</b> – three courses for EOC, EmOC and EOC for Urban clinics developed. All course attendees evaluated and data analysed.
	Improved linkages between pre-service and in-service training in EOC, and EmOC at relevant CHW, nursing and midwifery training institutions, DWU's HEO training program; and UPNG's School of Medical and Health Sciences. *	3.2 Improved collaboration with health training providers, Provincial Health Authorities and health offices	n) Communications conducted with training providers and Provincial Health Offices. o) Educator Participants included in RHTU courses	<ul style="list-style-type: none"> <li>Communicate with each educational institute and 10 Provincial Health Offices/Administrations.</li> <li>Two educator Participants from each institution attending EmOC and EOC training.</li> </ul>	<b>Exceeded</b> – communication with provinces continued to improve. Educators encouraged to attend RHTU courses resulting in 108 educators attending.
SO4: Demonstrated governance, planning and budgeting	<b>M&amp;E O4: Monitor governance and planning capacity for RH training at provincial level</b>				
	10 provinces with established MoUs with RHTU to provide	4.1 Established relationship with provincial partners;	p) Criteria for MoU developed and agreed on with provincial partners	<ul style="list-style-type: none"> <li>MoUs signed with all provinces engaged in RHTU IST/CPD</li> </ul>	<b>Outcome changed</b> - No formal MOUs signed, but responsibilities of provinces

RHTU Objectives	End of program outcomes	Short-term outcomes (18 months)	Outputs	Targets	Status (end 2016)
capacity at national and provincial levels and in training institutions for RH IST	RH IST/CPD *	MoUs signed and provinces engaged in strategic process.			and institutes agreed and criteria met .
	Improved national and provincial coordination for all EOC and EmOC IST/CPD*	4.2 Engaged provinces develop a structured program to refresh and reinforce the reproductive service provision	q) Province-specific planning tools developed (to plan, fund, implement, evaluate, acquit, and report): these will take place upon request by the provinces. r) Database of apprentice facilitators produced and identified to partnering provinces s) Selected key facility workers recommended for clinical attachments at their provincial hospital.	<ul style="list-style-type: none"> <li>10 Provinces request assistance from RHTU for developing achievable training plans</li> <li>All identified facilitators co-facilitate subsequent RHTU courses</li> <li>At least one identified participant recommended for clinical attachment per course.</li> </ul>	<b>Met</b> – this outcome is reliant on the provinces capacity to a certain extent. All engaged provinces were offered assistance in planning; a database of apprentice facilitators was built and reported to the provinces; all RHTU course participants recommended for clinical attachment.
	Established transition and funding arrangements for RHTU possibly within PNG institution.*	4.3 Established plan for sustainability of RH IST/CPD	t) Hand-over partner identified and agreed with SC; plan developed [R11].	<ul style="list-style-type: none"> <li>Hand over plan completed.</li> </ul>	<b>Unmet</b> – transition arrangements not agreed to prior to end of Phase I
SO5: Increased health workforce capacity to provide quality EOC and EmOC IST to health workers in partnering provinces and relevant training institutions	<b>M&amp;E O5: Monitor and evaluate RHTU's performance and effectiveness including partners and target satisfaction with activities associated with RHTU</b>				
	Between 33-66 PNG clinicians/educators delivering EOC and/or EmOC CPD training packages to health workers, including, MO and midwives through the leadership program*	5.1 Relevant health workers selected for Fellowship.	u) List of midwifery graduates identified for Fellowship program developed.	<ul style="list-style-type: none"> <li>Two Fellowships provided annually.</li> </ul>	<b>Exceeded</b> –there is a pool of 164 potential co-facilitators across PNG.  1,976 health workers have attended RHTU courses, representing all 22 provinces.  108 health educators have attended RHTU courses.
	Between 750-1000 health workers will have increased their knowledge, skills and confidence with the ability to provide	5.2 Increased knowledge for all Participants across all health cadres on EOC and EmOC 5.3 Improved teaching	v) Participant database developed to map and track Participants and Observers: Selection criteria encouraged [R12] w) Test scores analysed and	<ul style="list-style-type: none"> <li>80% of attendees being health workers who deliver reproductive care; up to 20% being Observers (ie managers/supervisor etc)</li> <li>100% participant test scores</li> </ul>	

RHTU Objectives	End of program outcomes	Short-term outcomes (18 months)	Outputs	Targets	Status (end 2016)
	<p>quality EOC and EmOC services to mothers, their newborn and communities*</p> <p>Between 30-40 health educators from pre-service and post-basic graduate training facilities will have increased their knowledge, skills and confidence with the ability to provide EOC and EmOC training to students.*</p>	<p>and learning ability for relevant RHTU Participants/clinicians</p> <p>5.4 Increased educational and other resources available.</p>	<p>x) Reports provided to provinces and certificates of attendance provided to Participants.</p> <p>y) Educator training courses developed and delivered with SC approval.</p> <p>z) Training materials and other resources supplied to provincial educators and clinicians [R5]</p>	<p>reported.</p> <ul style="list-style-type: none"> <li>• 100% provinces receive evaluation reports.</li> <li>• 100% Participants receive certificate of completion</li> <li>• 10 selected Participants receive educator training annually</li> <li>• Resources provided at every course.</li> </ul>	

\* Denotes outcomes specified in revised Program Design Document with Australian aid

## APPENDIX 2: RECOMMENDATIONS FROM 2013 – 2014

### 2013

- 1. Collaborate with relevant professional registration and regulation groups to provide a standardised message.**

A standardised message was consistently given throughout 2014 with several meetings taking place with PNG Nursing Council and other relevant units within NDoH.

- 2. Keep in line with any changing accreditation needs for Nursing Council and Medical Board.**

Meetings with PNG Nursing Council have been conducted. As yet the Medical Board has not been engaged.

- 3. Discuss with NDoH the possibilities for a nursing and midwifery representative, community health worker, and health extension officer representative on the Steering Committee.**

Representation on the Steering Committee still needs to be discussed. HR Training Unit which may be able to represent all these cadre has not as yet attended. An educator representative was chosen in 2015, however has yet to attend

- 4. Expand contact list of those to receive RHTU newsletter.**

Contact list was reduced in 2014, but was built back up in 2015 with the employment of a Project Coordinator, it is now reaching a much wider audience.

- 5. Continue to investigate opportunities for training/educational material that can be produced by OSF and sanctioned by NDoH.**

Producing training/educational materials was beyond the capacity of RHTU in 2014 and 2015. OSF did not appear to have the same branding needs in 2015 but the future of the partnership will impact this.

- 6. It is recommended the Steering Committee decide the way forward for this pilot project in line with the delayed timelines.** Has been permanently suspended.

- 7. It is recommended salary packages are continuously reviewed to balance retention of staff while remaining in-line with salary packages within the education sector.**

Staff retention has been good with the educators remaining on throughout 2015 with the addition of a senior educator position. A PNG project coordinator was employed mid-2015 which was a much needed position.

- 8. Roles and responsibilities of the PPP members need to be defined and clarified;**

**once this occurs the RHTU could work towards adequately informing relevant sections at NDoH of RHTU training and invite collaboration and attendance.**

This document was developed and agreed upon by the Steering Committee, relevant sections at NDoH are being communicated with. However, the future of the PPP is under discussion in 2016 and all the roles and responsibilities will change.

**9. Defined formal protocols of communication with the NDoH would assist RHTU in communicating more effectively with them.**

Formal protocols of communication have not been defined, however communications with NDoH have been more positive in tone in 2014 and 2015. The most significant outstanding requirement is for HR Training Unit representative to attend the Steering Committee and for RHTU to creatively seek ways for this to happen.

**10. Investigate opportunities to conduct formal presentations on the concept, roles and responsibilities of the RHTU when stakeholders are convening in Port Moresby (e.g. Deans' annual meeting).**

Deans' annual meeting was cancelled at the last minute, however RHTU was prepared to provide a presentation and has presented to several meetings throughout the year in 2014 and in 2015.

**11. Plan exit strategy based on any decisions made regarding hand-over of RHTU to local body.**

Nine strategies for sustainability of the RHTU have been put forward by RHTU to the Steering Committee. This is still under discussion and will be a priority in 2016.

**12. Strengthen communication with provinces so that relevant Participants are selected by the provinces for training.**

Selection criteria have been adhered to for the most part with only 17% Participants deemed not appropriate and 14% Observers in 2014 and 5% Participants and 11% Observers deemed not appropriate in 2015.

**13. Develop a quality assurance process (including a risk mitigating strategy linked to the Risk Matrix), with adequate guidelines to assist the ongoing improvements in RHTU operations and courses.**

Quality assurance processes for OSF were started in 2014, nothing specific for RHTU. Once the project coordinator started in 2015 the focus shifted to data management with changes to the structure of the database as well as inputting protocols. The result is a better functioning database. The risk mitigating strategy was also updated.



1. **The Steering Committee needs to further discuss membership for 2015 to ensure that the membership represents the key areas and invite and encourage relevant stakeholders.**

Key areas for reproductive health workers and educators as well as all partners are represented at the Steering Committee. There remain issues of attendance and engagement from decision makers.

2. **While beyond the current scope of the RHTU, it is suggested the original idea of tracking and mapping reproductive health continuing professional development programs/training is undertaken in Phase II.**

RHTU invite others to let them know what trainings are being conducted so they can be included in the online calendar. This has not occurred yet and would take a dedicated person to track down and engage with other continuing professional development trainings, this is currently beyond the capacity of the team.

3. **Production of a newsletter three times a year and development of a dissemination list should be prioritised. The newsletter should be posted on the website and Facebook could be explored as an option for further publicising the RHTU.**

It was discussed and agreed two newsletters a year would be adequate and the M&E program logic changed to reflect this. Two newsletters were developed this year once the project coordinator position was filled.

4. **The risk mitigating strategy should be reviewed at the start of each year.**

The risk mitigating strategy was updated in July, once the project coordinator position was filled.

5. **Attention to quality assurance on data input is required to mitigate incorrect data being used or archived.**

The database structure was changed to include pull down menus to mitigate incorrect data being added. This, along with input protocols and a sharing of the data management has ensured a cleansing of the database.

6. **Relationship building with NDoH HR Training Unit should be continued, to provide help and capacity building, allowing the accreditation process to move forward**

The relationship with NDoH HR Training Unit remains the same, attendance at Steering Committees remains poor, yet communications between the RHTU and HR Training Unit are respectful. NDoH HR Training Unit is supportive of RHTU courses and implementation schedules.

7. **A draft MoU template is finalised in 2015 to facilitate conversations and agreements with all engaged provinces.**

It has been recognised that MOUs are a long and protracted process that should not

hinder the implementation of RHTU courses. As agreements are in place within the PPP structure, which includes the NDoH, agreements are in place between the provinces as the NDoH. Formal MOUs are not being prioritised. Relationship building and partnership agreements on roles and responsibilities between RHTU and the provinces are developed instead so training can move ahead.

**8. Capacity building for developing planning tools is required to help mitigate the late cancellation of courses, including if feasible, a project management course for local course organisers**

A project management course was not undertaken in 2015. The cancellation ranking, has allowed the team to recognise which provinces struggle with planning and has helped mitigate some of the issues.

**9. Discussions within OSHF are undertaken to develop a strategy for fulfilling requirements of OSHF recognition while maintaining RHTU brand identity.**

Oil Search Foundation is receiving positive feedback and no longer has the branding requirements they did during the initial stages. The partnership agreement will change in 2016 so all the partners' roles and responsibilities will be reviewed.

**10. It is understood that some Observers are previous participants who have returned for refresher training. This should be delineated in future data collection so tracking of refresher training is possible.**

Refresher training is not being carried out yet, however some Participants do undertake repeat training. This can be found in the database.

**11. A structured approach to the Midwifery Fellowship should be established, with clarity on expectations, goals and performance reviews.**

The senior educator position took on the role to facilitate the midwifery fellowship. They were provided with a very clear set of goals, job description and mentoring program with the educators.

**12. Only a pass/fail be provided in the report back to provinces to ensure not too much importance is placed on the written test, while still flagging those workers who may be working beyond their scope**

Marks are no longer provided to the provinces, but rather a pass, fail or borderline indication and a description of some of the reasons why a participant failed and ways this may be overcome.

**13. Resources left in each province should be tracked in one database so an asset list can be developed and referenced in the future.**

An Asset Register has been developed to map and track resources left behind after RHTU courses.

1. **The continuation of a Steering Committee into Phase II of RHTU is vital to maintain accountability and representation of relevant stakeholders.**

Steering Committee continued to be strengthened throughout Phase I, however there was continuing non-attendance and therefore under-representation of many stakeholders.

2. **These roles need to be discussed and reviewed in 2016 depending on Phase II of the RHTU, it is recommended another focused planning meeting is held.**

The Steering Committee was unable to lead the RHTU through a transition period to a new design phase. The sustainability of its programs were not agreed upon, nor was funding confirmed.

3. **Finalisation of the RHTU courses (i.e. packaged) should be prioritised as soon as possible.**

RHTU courses were finalised and packaged.

4. **Further work needs to take place on what accreditation process is required, therefore extra meetings with NDoH HR Training Unit are recommended.**

The RHTU courses remain not accredited, but are endorsed by the NDOH. For accreditation a policy and process needs to be developed with the NDOH.

5. **It is recommended in Phase II structured mentoring is continued to capacity build the provincial health authorities, and to increase possibility of non-engaged provinces requesting courses and reduce cancelations.**

Poor planning and capacity at the provincial level continued throughout. However, cancellations due to poor planning reduced, capacity increased in some provinces and the creative measures used by the RHTU such as a provincial ranking, planning and time management courses, constant communication and feedback did help increase provincial buy-in.

6. **It is recommended for Phase II that the role and capacity of apprentice facilitators is explored to develop an appropriate course.**

After each course, potential co-facilitators were identified when appropriate. This was proving successful with many identified facilitators being released from their work to co-facilitate RHTU courses.

7. **It is recommended in Phase II that a funding stream for clinical attachments be explored, including the issues of accommodation, with RHTU partners.**

Clinical attachments and supervision is an urgent priority for health workers throughout PNG.

8. **It is recommended while a cost breakdown from Oil Search has been supplied, further details are discussed with partners so they, or future stakeholders understand the full costs of this model for reproductive health CPD.**

Funding has ceased and the PPP has dissolved at this current time.

- 9. It is recommended the Fellowship continue into Phase II; however a discussion on how the Fellows can be supported in their provinces is needed by the Steering Committee to ensure training outcomes are achieved.**

The midwifery fellowship discontinued in 2016.

- 10. The two Lahara Courses for CHWTS and Schools of Nursing MNH educators was considered a worthwhile course and should be continued annually.**

The specialised educator EOC courses were discontinued in 2016.

## APPENDIX 3: SUSPENSION OF STRATEGIC OBJECTIVE 2

### **SO2: Operational research for reproductive health in-service training in rural/remote health facilities in pilot program (Milne Bay Province) applied, evaluated and informing national approaches**

This is a description provided to DFAT for the Deed of Variation of the original Project Design Document.

**Strategic Objective 2** for the PNG RHTU was designed to show that a single week of classroom based IST/CPD *alone* was unlikely to have as much impact at service delivery level without providing additional support to the health workers in an enhanced working environment.

In an effort to achieve a shared direction for activities in Milne Bay, OSF sought to establish a **Health Service Agreement** with the Milne Bay Provincial Health Authority (MBPHA), the overarching purpose of the Agreement being to improve health outcomes for the people of Milne Bay Province, with a specific focus on reproductive health.

#### ***Progress in relation to the Agreement to date***

MBPHA has failed to engage the PNG RHTU to deliver any in-service training for their health workers apart from 2 weeks in January 2013. Multiple, genuine attempts were made to establish contact with a variety of key stakeholders at the PHA in 2013 and 2014 without response until they eventually booked 2 weeks in November 2014. Unfortunately, a PHA representative (SMO O&G) sent a notice via SMS to cancel this engagement on October 5<sup>th</sup>.

In addition, OSF spent in excess of two years negotiating with MBPHA stakeholders to reach the Health Services Agreement. Multiple visits to Milne Bay took place and the Agreement was finally signed on 26 March 2014.

Following the Agreement signing, further stakeholder engagement took place with a specific request for MBPHA to detail health facility and health provider foci for the Agreement period. To date, despite multiple communication attempts, including further face-to-face visits, no detail has been forthcoming from any of the MBPHA partners. As a result, **no agreed activities have been established with MBPHA**, as no authority, apart from the Agreement, to work with named health facilities has been granted.

OSF has recently been undergoing an organizational restructure that is premised on OSF maintaining a priority focus on those geographic areas where it has a clear comparative advantage and keen engagement. As a result, a decision was taken by the OSF Board to disband all Milne Bay activities by the end of Q1 2015. This was communicated to MBPHA on 03/12/14.

### ***Implications for the RHTU***

During PNG RHTU Steering Committee meetings in 2013 and 2014, the issues related to poor engagement from the MBPHA were raised and various advice was given and taken in an attempt to progress agreement and action.

At the most recent Steering Committee meeting on November 12<sup>th</sup> 2014 the following points were discussed:

1. After nearly 2 years, MBPHA has not taken up RHTU's offer to assist with EOC and EmOC CPD/IST inputs for their province, and has failed to meaningfully engage in discussion on offers to assist;
2. Phase I of the PNG RHTU ends in June 2016;
3. There has been no action on the Health Services Agreement between OSF and MBPHA since signing in March 2014 and will be disbanded end of Q1 2015

Given these changes, and taking into consideration the above points, the RHTU Steering Committee feels that it is too late to implement a useful program of work to support the intent of the PNG RHTU's SO2, per original PDD and that the RHTU's Strategic Objective 2 should be suspended with immediate effect.

## **APPENDIX 4: INTERVIEW PROTOCOLS**

### **RHTU Director**

1. How has this year progressed in terms of the RHTU?
2. Any reflections on the PPPs development?
3. What happened with the PPP roles and responsibilities, has it changed? Does it need updating?
4. How effective is the SC? Are there changes that need to be made?
5. Are there any updates to the accreditation of the EOC and EmOC with NDoH?
6. How is the relationship going with NDoH HR Training?
7. What changes were made to the courses following evaluations – any examples?
8. Which provinces have been communicated with – might be worthwhile doing a synopsis of those that are now NOT engaging.
9. What is enabling the implementation of the RHTU's training at the provincial level?
10. How has the apprentice facilitator "program" working? Are any released to facilitate?
11. How is the Fellowship program going? Has that been successful do you think?
12. Are selected workers, that are recommended, undertaking any clinical attachments that you know of?
13. How important do you think the M&E process is – do you think it should be done differently?
14. What is the ideal scenario going into Phase II (post June 2016?)

### **RHTU staff**

1. How do you think RHTU is perceived? Is a standard message getting out do you think?
2. Do you know if the website is effectively being used as a place for existing training to be made public as well as NDoH policies?
3. Who updates the website? When?
4. Is RHTU adequately staffed to meet demand?
5. What is your impression of the Lahara? Is this something that should continue?
6. What changes were made to the courses following evaluations – any examples?
7. How has the midwifery fellowship been going this year?
8. What is your overall view of the relevancy of participants in the courses? Have the provinces been cooperating on who is selected to attend?
9. Have you seen any evidence of RHTU having an impact?
10. What have been some of the facilitating factors for implementing the RHTU?
11. What have been some of the barriers for implementing the RHTU?

12. Is there anything that you think the RHTU can do to improve its impact in PNG?
13. Can you foresee any challenges that may hinder the training of Reproductive Health workers across PNG?

### **Fellows**

1. What have you done as part of the Fellowship?
2. How has the Fellowship prepared you to conduct training in your province?
3. Will this be a possibility when you go back home?
4. Do you have any suggestions for future Fellowships?

### **Oil Search Foundation**

1. What do you see as the strengths of the PPP?
2. What sort of challenges have affected the PPP?
3. What do you see as the future of the RHTU within the organisation?
4. What major changes have occurred since its inception between OSF and RHTU?  
What lessons have been learned?
5. Do you have a perception of how RHTU is received? What people know about it?
6. How effective do you think the SC is? Could it be more effective? How?
7. What do you think of the M&E processes has it been important for the RHTU?
8. What would OSF like the next phase to be – post June 2016?

### **NDOH and DFAT**

1. What do you see as the strengths of the PPP?
2. What sort of challenges have affected the PPP?
3. How does RHTU work with you –if there are barriers, what are they? Are there any between RHTU and DFAT?
4. How is the communication between RHTU and you?
5. Is the Steering Committee effective? Does it have the correct membership?
6. Have you seen any evidence of RHTU having an impact?
7. Is there anything that you think the RHTU can do to improve its impact in PNG?
8. What would you like to see happen with the RHTU post June 2016?
9. What do you think of the M&E processes, has it made any difference do you think to the RHTU?
10. Can you foresee any challenges that may hinder the training of Reproductive Health workers across PNG?

### **Other Stakeholders**

1. What do you know of the PNG Reproductive Health Training Unit (RHTU)?



2. What is your involvement with them?
3. How are the Human Resources for Health (HRH) and continuing professional development (CPD) challenges affecting the delivery of the RHTU training in PNG?
4. In what way do you think a program like the RHTU can impact reproductive health services in PNG?
5. What barriers have you found for implementing the RHTU courses?
6. What do you think of the communication and coordination between RH stakeholders and the RHTU – are there issues?
7. What is working well with the implementation of the RHTU's training at the provincial level?
8. Is there anything that you think the RHTU can do to improve its impact in PNG?
9. Have you seen any benefits of the RHTU courses?
10. What agreements are in place between you and RHTU? What do you have to do to ensure courses run?
11. What do you think should happen with the RHTU's programs going in the long term?
12. Can you foresee any challenges that may hinder the training of Reproductive Health workers across PNG?

#### **KAP Decision makers/supervisors**

1. What do you see as the benefits of the RHTU course to your services?
2. During the course 'respectful maternity care' or 'woman friendly care' was taught as the recommended way of caring for women and families. Here is a list of a few behaviours or attitudes that are part of the way we care for pregnant women and new mothers every day.
3. Can you tell me what, if any, are one or two of the changes you have seen in the practice of the participant(s) following the RHTU course?
4. RHTU is offering assistance to help develop reproductive health training plans. Have you had an opportunity to take up this offer?

#### **KAP**

1. Since completing the RHTU course, what was the thing that you learned most about / or that was definitely new learning for you?
2. During the course you would have probably heard of the terms 'respectful maternity care' or 'woman friendly care'.
3. Here is a list of a few behaviours or attitudes that are part of the way we care for pregnant women and new mothers every day. For each of these statements, please

mark on the form if you think that they are never / maybe / sometimes / or always a part of how you practice.

4. With regard to your practice, since completing the RHTU course, can you tell me one or two things that you have changed or do differently now?
5. Have you seen a change in referrals?
6. Do you have any stories of change that have made a difference?

#### **Lahara**

5. What institute are you from and your role?
6. How many educators in your school can teach maternal health and EmOC?
7. How were you selected for this training?
8. What continuing education have you received in the past 3 years?
9. What are one or two new things you have learned from this course?
10. What are one or two specific things you have learned for your role as an educator?
11. What other areas would you like to learn?
12. What are the issues in education/what trouble Participants have with curriculum/training resources.
13. How many schools have NMH educators
14. How comfortable do you feel teaching reproductive health

## REFERENCES

1. Biermann, F., '*Earth system governance*' as a crosscutting theme of global change research. *Global environmental change*, 2007. **17**(3): p. 326-337.
2. Government of Papua New Guinea [GoPNG], *National Health Plan 2011-2020*. 2010: Port Moresby.
3. World Bank, *Capacity development in practice: dimensions*. *Capacity Development Resource Centre*. 2006, World Bank.
4. Rice, P. and D. Ezzy, *Qualitative Research Methods: A Health Focus*. 2000, South Melbourne, VIC: Oxford University Press.
5. Hansen, E., *Successful qualitative health research: a practical introduction*. 2006, New South Wales, Australia: Allen and Unwin.
6. Government of Papua New Guinea, *National Health Service Standards for Papua New Guinea 2011-2020*. 2011, Government of Papua New Guinea: Port Moresby.
7. Condon, R. (2016) Proposed Australian support for RHTU Phase 2: A concept note (internal document). Commissioned by the PPP and done in collaboration with the Steering Committee
8. Thiessen, J., et al. (2016). RHTU: Report on the Knowledge, Attitude, Practice of EOC and EmOC Participants and Observers. Sydney, Australia, WHO Collaborating Centre for Nursing Midwifery and Health Development, University of Technology, Sydney.