Reaching the Unreached Case Studies

Papua New Guinea

Community Based Best Practices for
Child Survival and Development

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Child Survival and Development

Contents

Lessons Learned

Community Teams: Linking local health workers and local political leaders

Establishing community-based teams that include health workers and local political leaders helps to place health and other child rights issues at the centre of village development. Community health workers act as a resource for the community team, not as a leader of the health initiative. This places the responsibility for action on the political leaders and community and ensures continuity which is particularly important due to the frequent transfers of government officials.

Operationalizing Bottom-Up Planning :

The will to promote bottom-up planning exists in many countries but the methodology is lacking. UNICEF has a useful role to play in developing the simple tools, accessible to illiterates, remote rural communities and other excluded communities, that can make systematic participatory planning and implementation a reality. UNICEF can help broker the respective roles that can be played by various stakeholders, including local politicians, health workers and district, provincial and other authorities to demonstrate how the system of bottom-up planning based around the rights of children is a viable and important development strategy.

Using appropriate aids : visual materials to involve non-literates in Triple A processes and cue cards to guide participation

The use of visual images and coloured markers helped non-literates identify, remember and monitor indicators of child health and nutrition, and enabled them to become involved in village planning. The cue cards helped the trainers (some of whom have little experience) keep the process on track, and participatory.

Establishing a location (the pikinini skel haus) as a tangible sign of community commitment as well as a centre for village activities for children

The construction of the pikinini skel house was a mark of community commitment to change. It became a multi-purpose building, used as a base for adult education and play school as well as a centre for child weighing, for cookery demonstrations and a place for monitoring village progress through the display of all the coloured houses.

No exclusion : Insisting on participation of entire community, husband and wife together

A policy of non-exclusion helps to mobilise communities and build community solidarity around child rights. Non-exclusion emphasises that all children have rights to health, education and so on. The involvement of

all families and husband and wife together in the process meant that couples, families and communities began to discuss health issues, sometimes for the first time. The incentive to change the colour of the house was matched by the incentive to collectively transform the colour of the village.

Introduction

The Setting

Bernard Jorimbi
Ward Member, Atemble Ward, Middle Ramu District, Madang Province

Atemble is just the same as any other village. We are very isolated because there are no roads here, only the river. We are two hours walk from the district headquarters at Aiome where there is a school and a health centre, but these are too far away for our children and too far for us to carry our sick people, especially during the night or during heavy rain and floods .

A typical Atemble home

Only three or four people in Atemble can read and write, and I am one of these. I used to have a job with the government as a cashier but after I was retrenched I came to Atemble because this is my wife's village. I was elected as the Ward Member[1] of Atemble in 1997. At that time I didn't think that health was so important but then we faced a big crisis. In a very short space of time, three village women died in childbirth because we could not get them to the health centre at Aiome. Atemble only has 347 people and so these losses affected all of us. Then we had terrible floods and my own children became very ill with malaria, but we couldn't get them to Aiome.

I told the people here, "Look, we cannot just sit here waiting for the government to come. We have to do something to help ourselves." I convinced the people that we should build a health post and a house for a community health worker. I promised that if they built these, then I would go to the district headquarters and try to get a female health worker. We especially wanted a female so that she could help the women in our village. It took us two months to put up the buildings and then I went off to Aoime and spoke with Paul Mabong, the Health

[1] Ward leader who represents the community on the Local Level Government which covered several wards.

Manager for this area. He told me that they did not have plans to put a community health worker in Atemble because it is a small place, but he came and looked at our facilities and he was impressed. He decided to help us.

Paul Mabong told us, "We will let you have a female health worker but you have to look after her because if you don't take good care of her she will leave and you will have to have a man instead." We agreed.

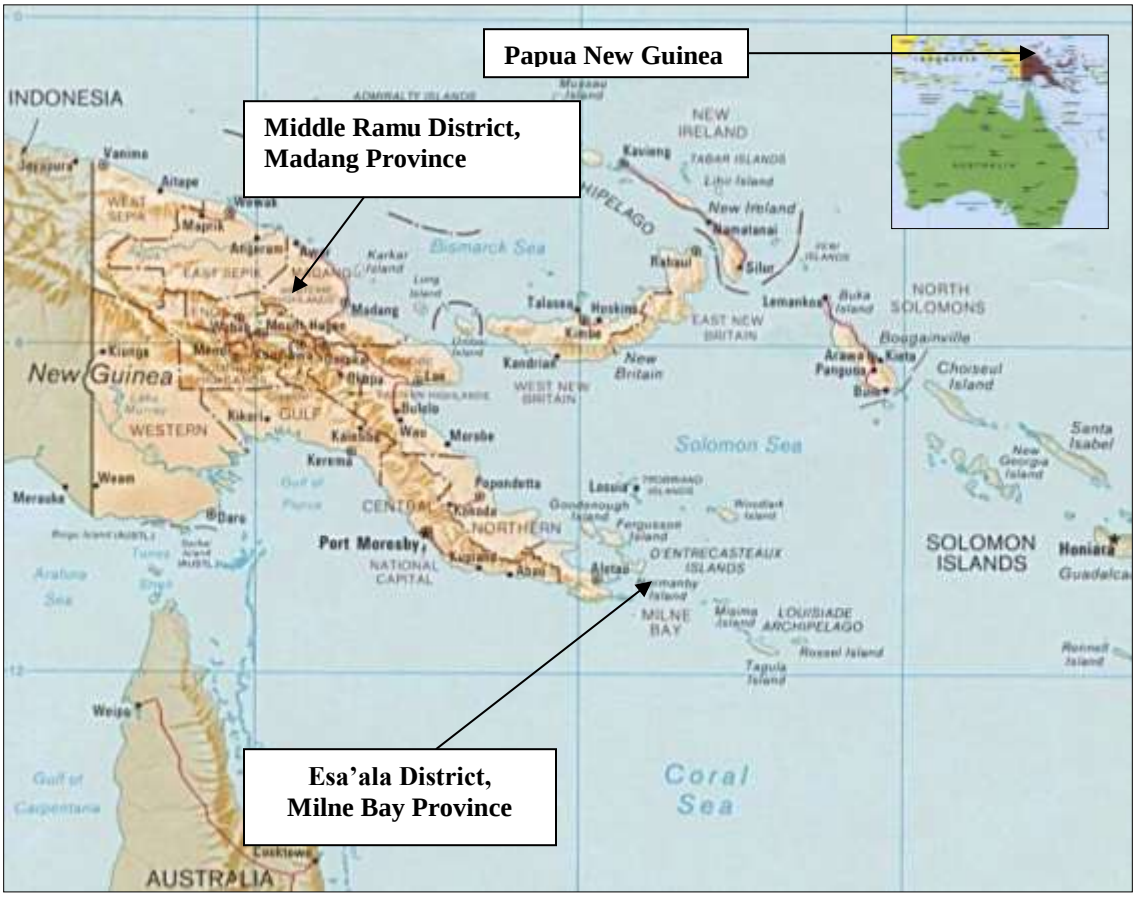
This was the beginning of the development in the village of Atemble. We had the same success with our school. We built a classroom and a house for a teacher and then we were able to get a teacher for the first two grades. Then we started with "Colour My House" and the family assessments and we began to see more changes happening. We built the *pikinini skel haus,* where we weigh the children and learn about health and nutrition. We sent a letter to the district, provincial and national health authorities demanding for all the children and all the women to get immunized, because there was an insufficient vaccine supply at the health centre. We began using iodized salt. Many of us prepared kitchen gardens. We also used the "Colour My House" activity to make a plan for the village that we are taking to the Local Level Government and the District. Many people came to see what we were doing. They said they could use what we were doing in Atemble to help villages all over Papua New Guinea.

Mother bringing her child for weighing in the Pikinini Skelim Haus, Atemble

The Situation of Children

Hundreds of thousands of children in Papua New Guinea live in conditions similar to those in Atemble. Their villages lie alongside rivers, or in the highlands of the interior or on the hundreds of islands that surround the "mainland." Their exclusion from health, education and other basic services is reflected in considerable disparities in virtually all indicators of child survival and development. There has been no apparent change in these indicators over the last twenty or thirty years.[2]

[2] DNPM/UNICEF 2000

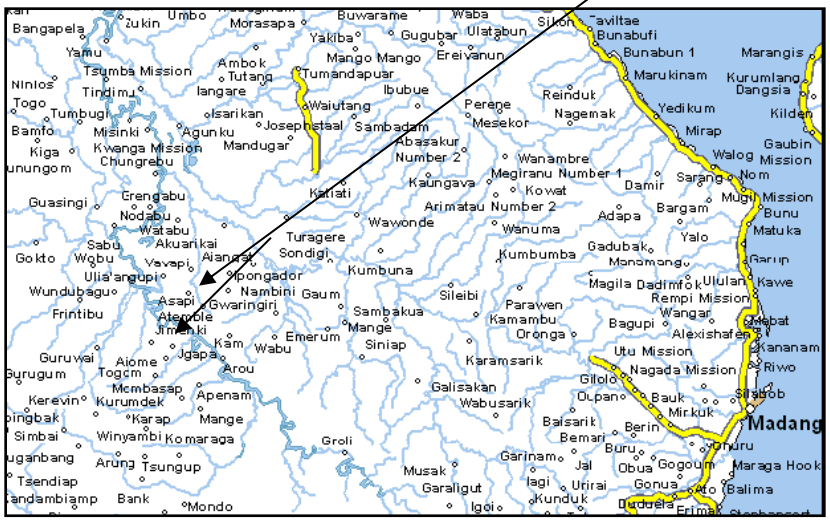


Papua New Guinea is the largest of the Pacific Islands Nations. It comprises of the eastern half of the island of New Guinea in the western Pacific Ocean, several large volcanic islands and some 600 small and scattered islands to the east and north in the Bismarck and Solomon Sea. Total land area is over 462,840 square kilometres. It has a land border with the Indonesian province of Irian Jaya, and sea boundaries with Solomon Islands and Australia.

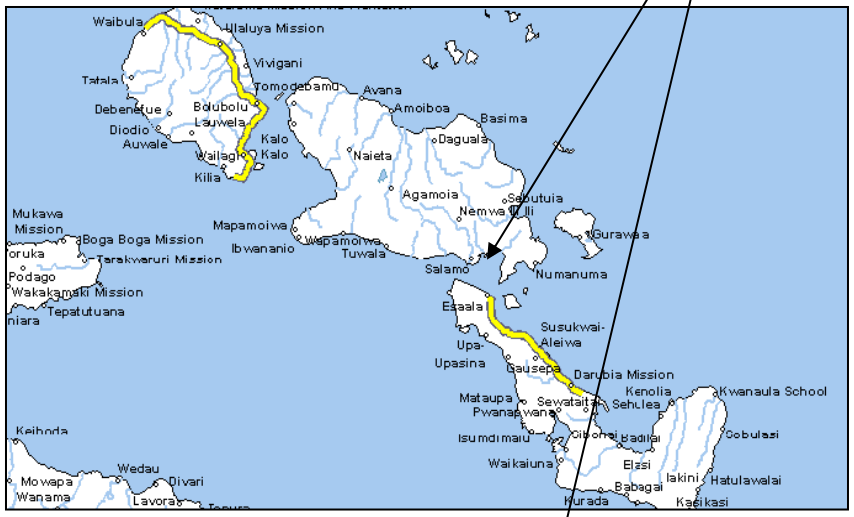
The topography of Papua New Guinea is among the most rugged in the world, with altitudes of over 4000 metres. Large geographical diversity exists with offshore islands, lowland forests and extensive marches, dry savannah and temperate highlands. Only 13 % of the country is inhabited. Infrastructure is under developed which places a heavy burden on service delivery, as overhead costs are high.
Papua New Guinea is noted for its cultural and linguistic diversity with over 700 languages spoken

(NSO, 1994)

Madang Province, Location of Atemble and Aiome



Milne Bay Province, Location of Esa'ala



Madang and Milne Bay

The hinterland of Madang Province is covered with thick forest, cut by rivers tumbling from the looming escarpment of the highlands in the west. The traditional economy is built on cultivation and trade in beetle nut. Everybody chews the nut (a risk among children since it depresses the appetite) and rural markets are more filled with nuts than with any food.

Milne Bay Province consists of a mass of islands, surrounded by a turbulent sea. The traditional economy is built on complex systems of reciprocity – the best foods were always given away. Yams form the staple diet. In most cases, sea transportation is the only possibility yet for at least six months of the year the waves surge to more than thirty feet high. In some places, for a sick child or a woman suffering through difficult labour, it can mean a treacherous, twelve hour journey in an open boat to the nearest hospital.

Population and Poverty

Population :	**5.1 million**
Rural Population :	**85%**
Poverty :	**37%**
Rural Poor:	**41%**
Urban Poor:	**16%**

Based on an average national poverty line of 461 Kina ($136) per adult, about 37 percent of PNG's population must be considered as poor. The vast majority (93 %) of the poor live in rural areas, where over 41% of the population fall below the poverty line. Many of the poor have no cash income and thus derive their livelihoods almost entirely from subsistence agriculture. Of those who earn cash income, poverty is highest among those engaged in small-scale tree crop production, domestic agriculture and hunting ─ gathering. Over 40% of all households in Papua New Guinea derive their main income of export tree crops. Poverty is significantly more widespread among households whose head has not attended school.[3]

The national infant mortality rate is 77 per 1000 live births, one of the highest in the Pacific region. In urban areas the rate is 33 per 1000 live births, compared with about 114 per 1000 in the highlands. Overall, about 100 out of every 1000 children die before reaching their fifth birthday, but a child living in the highlands is three times more likely to die before age five than a child living in urban areas.

The primary causes of child death are pneumonia (33%), neonatal infection (17%), slow foetal growth/immaturity (11%), hypoxia /asphyxia (17%) and meningitis (7%). Pneumonia and malaria are prominent causes of death among older children.[4] All causes are exacerbated by poor nutritional status among children, almost 30 per cent of whom are underweight. Regional disparities in malnutrition show that about 12 per cent of children living in the national capital district of Port Moresby are underweight, compared with 42 per cent in Madang Province and 45 per cent in Milne Bay Province.[5]

Poor nutrition is the result of the late introduction of complementary food, the high rate of infections and diseases, especially malaria, and the poor quality of the food children consume. This is partly the result of food taboos. Many people believe that fish, meat, eggs, fruit and some vegetables are damaging to pregnant women and young children. Infrequent feeding is another major cause. Children are often unfed when they accompany their mothers to work in the family gardening plot.

[3] World Bank, 1999
[4] DOH 1998
[5] UNDP, 2000

Inequalities are evident in per capita health expenditures, estimated at 46 kina (about US$15) per capita in the capital, 32 kina (about US$11) per capita in Milne Bay and just 15 kina (about US$5) per capita in Madang.[6] Another indicator of unequal access to health care is the maternal mortality rate, estimated at 375 per 100,000 live births nationally, but at 625 per 100,000 in the highlands.[7] Nearly twice as many women in urban centres (87.4%) as in rural areas (42.9%) use a health facility to deliver their baby. Yet poor access to health services is only partly responsible. Traditionally, many highlands women wander off into the bush when their time comes, to deliver their babies by themselves. Approximately 40 per cent of all pregnant women are anaemic, but in some pockets it could be as high as 80 per cent. Anaemia was among the top ten causes of hospital admissions and deaths among children between 1990 and 1995.

A study of the impact of distance on attendance at a health facility showed that for patients with malaria and acute respiratory infections attendance dropped 50 per cent at a distance of 3.5kms.. Female patients showed less distance decay as adolescents and adults, but male infants had lower distance decay than female infants. (The research was conducted in East Sepik Province, Wosera Area, as part of the malaria vaccine research project (Muller et al., 1998))

About half the children in Papua New Guinea never enroll in primary school. In the next few years more than 14,000 elementary classes offering preparatory level and Grades 1 and 2 will be established in villages. In most cases, the teacher will be a young Grade 10 graduate from the community who volunteers for training. The preparatory, first and second grade classes will be taught in the vernacular which is an advantage for village children who do not speak English. Over the next couple of years many more children will matriculate but the potential for the current generation of poor rural children to obtain more than a limited basic education remains remote. About half the adult population is illiterate. The challenges for village development for the next several years therefore include working with a predominantly illiterate adult population.[8]

People-Centred Planning

The exclusion of rural children from health, education and other basic services is partly the result of geography, of difficult terrain, stormy seas and the high costs of transportation, but this is probably not the primary cause. Since gaining independence from Australia in 1975, Papua New Guinea has been beset by political turmoil and economic crises.

[6] DNPM/UNICEF, 2000
[7] DHS 1996
[8] DNPM/UNICEF 2000, Part IV Specific Actions

Governments have been vulnerable to the shifting tides of political re-allignment. Frequent votes of no-confidence undermine and often bring down the group in power. The economy, based on globally significant reserves of gold, gas and other resources, is vulnerable to fluctuations in market prices. More significantly, poor governance has meant that periods of economic growth have not translated into increased opportunities for people. Until recently, the health and development of the rural poor, especially children, was not a government priority.

In the early 1990s, the Bougainville crisis forced the closure of the rich Panguna mine. Drastic budget cuts followed that severely undermined the health system. Recovery began in 1995 with the introduction of the Organic Law, which commited all levels of government to people-centered development focussing on health, education, rural infrastructure and primary production. Progress was slow at first but by 2000, about 60 per cent of the wards had Aid Posts that were either staffed by minimally trained Aid Post Orderlies who usually had 6^{th} or 7^{th} grade education or by Community Health Workers who were high school graduates who had followed a two year training course. The National Health Plan for 2001-2010 further emphasised the need for more people centred approaches and set many important goals for reducing infant, child and maternal mortality through improvements in immunization, nutrition and treatment of illnesses in children, particularly diarrhoea and respiratory diseases.

Yet while the policy frame work for decentralization and "bottom-up" planning had been established, the practical tools to enable the process to go forward were missing. Several consultations were held to try to advance the concept, including a bottom-up planning session held in Esa'ala District, Milne Bay, in August 2000. During the workshop, local leaders were asked to name priorities for their communities and the list that emerged included electricity, roads, bridges and other projects demanding major investment.

Iba Luke, an administrative officer from Duau Local Level Government, was very disappointed in the outcome. "It was hopeless. There was nothing on the list that we could do for ourselves. We were left in exactly the same situation as before, just sitting around waiting for someone to come with the money and the expertise. It made us seem so powerless; as if we were incapable of doing anything for ourselves, when we are not. There is a lot we can do."

Iba Luke eventually emerged as one of the foremost local advocates of the Community Based Best Practices project which he, and other local leaders, saw as a strategy not only for improving child nutrition, which was its original purpose, but as a foundation for village development.

Project Structure

The Community Based Best Practices for Child Survival and Development project was part of the 1998-2002 Master Plan of Operations agreed by the Government of Papua New Guinea and UNICEF. The project partnered UNICEF with the Nutrition Section of the Department of Health, and was to be based in the two provinces that showed the worst nutrition indicators: Madang and Milne Bay. Political upheaval prevented progress for some time, but expansion in the recruitment of community health workers (CHW) in 1999 provided new opportunities. During that year, a manual on child health and nutrition was developed and used in the training of more than 40 CHWs assigned to work in the provinces of Madang and Milne Bay. In July 2000, UNICEF and the Department of Health jointly supported the appointment of an international consultant to be based in the Nutrition Section of DOH, who would oversee the next phase of project development

At the outset it was recognized that an exclusionary approach to health service delivery was a major obstacle to improvements in child healt and nutritionh. Community members were largely passive recipients of health care and were not normally involved in planning or monitoring processes. The health workers were also passively waiting in health facilities for sick patients to show up. Their role was curative, not preventive. The challenge for the Community-Based Best Practices project was to develop a tool that would help break down the barriers between health services and communities, and empower families to define, prioritise, satisfy and monitor their health needs.

The Colour My House tool, see pages 18-22

"The "house" sets a standard. It shows people what is necessary if they want to fulfill the rights of their children to a healthy start in life."
Florence Addo, UNV, Milne Bay Province

Between July and October 2000, the consultant and members of the Department of Health worked with local leaders and villagers in the districts of Esa'ala in Milne Bay and Middle Ramu in Madang District, developing and testing the "Colour My House" tool. The tool was based on the Triple A process adapted from a scheme previously used by health workers in the Philippines. In Papua New Guinea it was to be family-based, participatory and educational. The tool allowed families to assess their situation against 19 key indicators. Collectively, the coloured houses provided an assessment for the village, and became the basis for the Ward Plan. It defined community-based actions and overall goals that were officially submitted through political bodies and to administrative and health authorities. In this way the village plan became part of district and provincial plans.

An important dimension of the project was the establishment of a community team that included the Ward Member (the local political leader), the Community Health Worker and members of the community who were trained as trainers. They worked together, running the "Colour My House" assessment with all families participating, and guided the community through analysis, project planning and implementation.

A Plan for Early Childhood

The "Colour My House" strategy was initially designed to help improve child nutrition, but it will also be used to help parents learn about the management of childhood diseases (IMCI). The same methodology can be used to provoke discussion of how to create safe and stimulating environments for children during the critical early years.

As a result of the project, issues related to child health and nutrition began cropping up as political issues at the Ward, Local Level Government and District levels. According to Peter Lavidah, the District Administrator of Middle Ramu, "We never talked about these issues before. Never. We talked about the terrible transport situation, about how we needed roads and bridges. But now I see that we have a real crisis in immunization! In some of our more remote wards, there have been no mobile immunization teams for the last five years! Until we had this process, this simply was not clear to us."

John Christie, Team Leader with the Health Sector Support Programme of AusAID commented, "this is the first time I have ever heard of villagers in Papua New Guinea actually demanding immunizations and birth certificates to establish the citizenship of their children"

To date, 19 Wards in the two provinces have been trained in the Triple-A process and 9 of these have begun implementing projects based on the outcome of their assessments and analysis. In the coming year it is expected that half the Wards in each province will be trained in the process.

The expansion of the project occurs organically: every time a "Colour My House" activity is carried out, leaders and health workers from neighbouring communities are invited to observe, participate and learn "on the job." The chief expense involves the provision of basic materials – charts, coloured pens and a sheet with the house template for every family. UNICEF's role is to provide technical assistance and materials support during the pilot phase.

Project Costs:

Training trainers, families and supplying the materials to implement the Triple A Process costs about Kina 3,779 or about $1,115 for a Ward of 100 families.

See the detailed budget breakdown in Annex 1

The project is still in a pilot phase but has already been endorsed by the Department of Health as a strategy that should be adopted by other donor agencies and projects. In April 2001, a process began of expanding the strategy to the six provinces falling under the Health Sector Support Programme backed by AusAID. To date, selected staff from provincial and district-level health and nutrition services have been trained in the process. By the end of the year it is anticipated that at least one district in each of these provinces will be implementing the process and developing district and provincial plans based on the outcome.

Methodology and Constraints on the Case Study

The author spent six days in Papua New Guinea in constant company and dialogue with several members of the Department of Health which runs the project, and as well as Provincial and District Officials for Madang, Middle Ramu and Esa'ala. These included Clementine Yaman, Markus Kachau, Jennifer Simon, Peter Gaan, Paul Mabong, Gei Raga, Peter Lavidah and Henry Briones, a consultant and technical advisor with the Department of Health who is partially funded by UNICEF. Visits by the author to the villages of Atemble and Tsungribu included observation of the "Colour My House" process and provided opportunities for on-the-spot interviews with villagers, local leaders, health workers, district and provincial officials. There was insufficient time to visit Esa'ala District. However, more than twenty health workers, ward members, ward recorders, local level government representatives and the district administrator traveled from Esa'ala to Madang for a one day experience-sharing conference with their counterparts in Middle Ramu District. This valuable exchange was specifically arranged for the case study although it would have happened anyway eventually. Extensive interviews were conducted with Henry Briones, UNICEF Representative Richard Prado and many members of the Department of Health, including the Director of the Health Improvement Branch, Enoch Posanai. Documents related to the project were obtained from the Department of Health and UNICEF.

The chief constraint on the case study is the brevity of the project. The "Colour My House" process was tested in Begasi and Weyoko Wards in Esa'ala District, in October 2000, and in Atemble Ward in November. Only one Ward, Atemble, had completed a quarterly evaluation of progress. Yet the scheme was expanding rapidly and had gained its own momentum. Ward members who had not participated in the activities yet were asking to get it into their wards. District officials and the Department of Health laid strong and justified claims of ownership.

Colour My House Assessment

Preparation and Mobilization

The "Colour My House" process is introduced and guided by the Ward Development Committee and the local Community Health Worker.[9] The Ward Development Committee is headed by the Ward Member, who is the elected leader of the village. It is his/her responsibility to represent the Ward at the Local Level Government Assembly. It also includes the Ward Recorder, who is appointed by the Ward Member and the Local Level Government as an archivist responsible for recording basic statistics of the Ward. Ward Recorders know, for example, exactly how many people live in the village, how many babies have been born in the previous year and how many deaths have occurred. Interestingly, although every village in Papua New Guinea possesses an accurate record of child births, there is almost no official birth registration, and no existing channels through which parents or ward recorders can officially record births.

The Ward Recorder, Ward Member, and other active members of the village, and the Community Health Worker are trained in the "Colour My House" process by observing it in action in a neighbouring community. They often also receive follow-up support from other health workers who are experienced in using the strategy. In Esa'ala, Samwel Samwel, a health workers who was one of the first to take part in "Colour My House," often helps other communities to go through the process.

Every family has to be included in the process otherwise it is incomplete. Any families who are not present during the session are personally visited by the community health worker and taken through the process.

Harietta Yareki, Women's Association, Koruwea Ward, Esa'ala District, Milne Bay

We spent at least a month preparing people for the Colour My House process. A lot of us were involved including women's organizations and youth volunteers as well as the members of the Ward Development Committee. We went to the church and

[9] . In rural areas, the boundaries of a Ward usually coincide with the boundaries of a single village.

talked to people as they were leaving the Sunday service, because then most of them were in a good mood and had time to listen. We also went to peoples' houses and explained that this was going to be something that would help everyone in the community, so everyone had to be involved. We did a good job with this mobilization because when we did the Colour My House, every single family came.

The people were quiet and attentive as they coloured their houses but sometimes they had arguments. One husband and wife were arguing a lot because they didn't understand exactly how to read a growth chart. The record book for their three year old child showed a falling line which meant that the child's weight was going down. The husband still wanted to colour the window for malnutrition green but the wife wasn't sure what to do. Even they had been going to the health post to have their child weighed, they never understood what the growth chart really meant. We were able to help them understand.

After the houses were coloured, each family pinned their house onto the data board. When he looked at his house filled with all the colours, one man called David said, "We are looking at ourselves in the mirror."

Samwel Samwel
Community Health Worker, Taulu Ward, Esa'ala District, Milne Bay

I have been a community health worker for many years and have been very frustrated. I could see so many problems in the villages but I didn't know what to do. I was trained to sit in the health post to wait for people to come to me when they were sick. I was taught only how to dispense medicines. I knew something was wrong with this system but until we began using the Triple-A process I didn't understand what it was. Now I know that we have to work alongside the people, in their place, not just in the health post. We are the servants of the people. We have to go out and be with them.

Samwel Samwel and people in Weyoko Ward during the Colour My House process

The people in Taulu where I work have many problems. Many children are malnourished, especially because of food taboos. When a woman is pregnant she is forbidden to eat fruit and protein foods. People believe that if she eats these things she will bleed and the baby will not grow. They believe that a child will get sick if he drinks milk from a green coconut milk, that he will get boils if he eats

eggs. If a woman is nursing a child and gets pregnant, she will immediately stop breastfeeding.

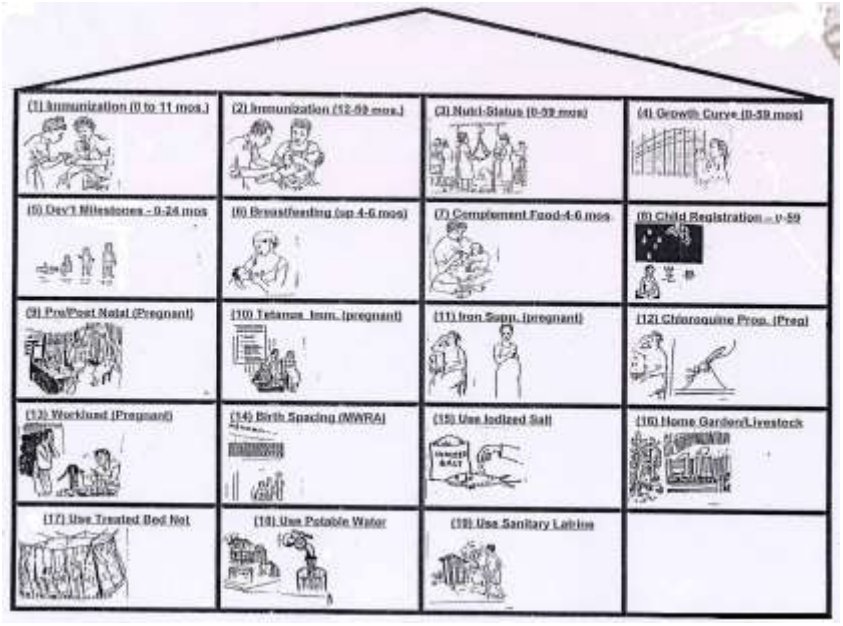
It is easier for me to explain the problem of food taboos when I am working out in the community. I can find a child whose parents do not care about the taboos and stand him alongside one whose parents do not give nutritious foods. I ask people to look at the children and tell me which is the strong and healthy one. They can see it right there with their own eyes.

The good thing about this process is that it lets people understand what is going on in their own homes. People get very surprised when they see the colour of their house. They want to make a change.

Community Health Worker as a Technical Advisor

During the "colour my house" process, the community health worker acts as a technical resource for the Ward Development Committee. This represents a significant departure from earlier practice in which the health service was regarded as largely responsible for delivering "good health" to the nation. It acknowledges that the promotion of a healthy life can only happen in partnership with families and communities. The very frequent transfer of all government employees, including community health workers, makes this particularly important for ensuring sustainability.

The Colour My House Template



The basic "Colour My House" template has 19 windows containing indicators that collectively define the beginnings of a healthy life. The indicators were selected based on analysis of causes and factors affecting child nutrition. The capacity of each family to respond to the problem was also considered in the selection of indicators.

The whole village participates in the "Colour My House" activity. Husband and wife sit together and following discussion of every window they begin to colour their own house: Green if the desired behaviour is being practiced, red if it is not and blue if the issue is irrelevant.

The 20th window is purposely left blank to stimulate the question of what else the community wants to monitor. In Esa'ala, one community health worker Samwel Samwel added "Children aged 5 to 10 years attending school" because he saw "many many children of that age in the villages who should have been in school."

Henry Briones, Consultant, Department of Health

In the beginning we wanted to include an indicator on domestic violence against women but the leaders said this was too culturally sensitive. "If we have that one the husband and wife will argue!"
So we removed it for now because we want first to build the level of confidence in the family and the community to make some changes in their lives.

Colour My House in Tsungribu

The village of Tsungribu, population 710, went through the "Colour My House" process in March 2001. Eleven families took part in the first session. Four others are scheduled so that eventually all families will be included.

Simon Bukare, the nursing officer from the mission health centre up-river at Anabeg, opened the meeting.

"You've all had the same trouble at the health post.," he said. "The nurse gives you an injection and never tells you why. She gives you medicine and doesn't say what it's for!" Everybody laughed.

He held up the picture of the house. "You've all got one of these. Today you are going to colour your house so that you can see if your family is healthy." He asked everyone to look at the first "window" of their house (dealing with immunization for infants up to one year old) and to describe what they saw.

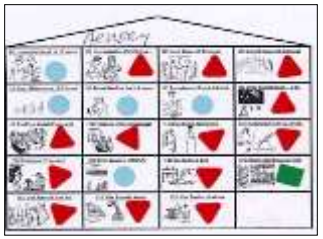
People were shy at first but some of the men spoke up. "The nurse is giving an injection," said one.

"Good," Simon said, "Anything else?"

"Mother is bringing baby to the clinic for an injection," said another.

"Very good!" shouted Simon, clapping his hands and everyone joined in. He spoke fast, kept moving, cracked jokes and tried to keep everyone involved. He asked why immunizations were given and what for. People said they were for *sut* (tuberculosis) and *pek pek wara* (diarrhoea) and other diseases. Simon explained the purpose of the immunizations and then asked how many times a baby had to receive them before they were one Christmas (year), and gave the answers if nobody knew. All important points he wrote on the blackboard. Most people in Tsungribu cannot read but writing their words was a way of showing they were valuable. He used the cue cards that are supplied to all the trainers. These have a large illustration on one side relating to one of the indicators and all the questions to be asked of the community and relevant factual information on the other. The cards helped to keep the discussion focussed, stimulated awareness and helped families to make informed choices.

After the discussion it was time to colour the first "window." This only applied to immunization in the first year so Simon asked everyone who had a baby less than one Christmas old to raise their hands. All those who didn't raise their hands had to colour that first window blue. The rest had to work out whether their infants were fully immunized or not. None of them were so they all had to colour that first window red. All the other windows were covered in the same way. Sometimes Simon spoke, sometimes the Ward Member, or the aid post worker, everyone helped until all the windows were coloured.



Desirable behaviour being practiced

Desirable behaviour not being practiced

Not relevant

A revision of the images used in the house template is underway. For example, the new version will show mother AND father bringing their child to the health post for immunization.

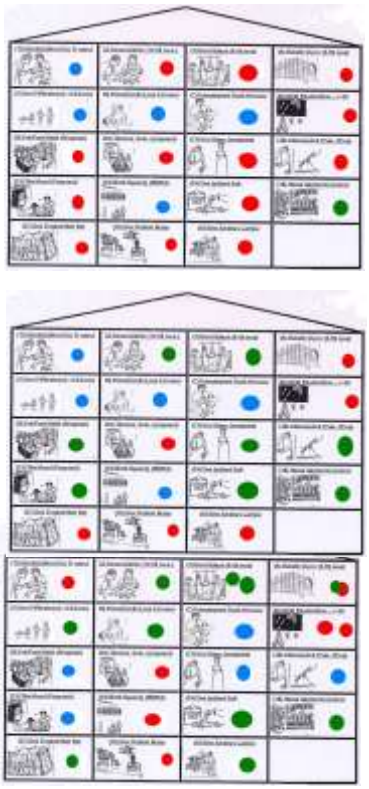
The Pikinini Skel Haus

One of the first acts of communities after completing the "colour my house" process, is the construction of the *pikinini skel haus* or "child-weighing house." It is a simple structure made of bush materials where children brought for weighing, where the coloured houses are displayed and immunizations given. It is a place for providing basic health and nutrition services, and will become the base for a *pikinini play skul*, as in Atemble where swings and a seesaw from locally made materials have already been installed. As a *Meri-man skoolim haus* ("Woman-Man Schooling House) it is also a place for village-based adult-education, where people can gather to "talk-talk" about helping their families. The construction of the *pikinini skel haus* is one of the first tangible signs of commitment by the community that they are going to work together to improve the health of their families. The decision to put up the structure comes out of the discussion of where parents will wait with their children when it is time for weighing, with other functions added later. To date 13 wards engaged in the process have erected pikinini skel houses. Several other communities not yet included have also put up the structures and are demanding from district authorities that they be covered by the Triple A process soon.

In Atemble, all the coloured houses of the village are pinned on the wall of the *pikinini skel haus*. Together, they present a portrait of the health and well-being of children throughout the community. As communities repeat the "colour my house" process, there is a visible change not only in the "colour" of their individual homes, but also in the "colour" of the village. The revised houses are pasted over the previous one, giving the families and villages an instant record of their achievements.

A Changing House: The Anton Family

Hendry Anton is the pastor in Atemble. In November 2000, when his family went through the first "Colour My House" exercise, his wife was pregnant and one of his four children was under-five.



Top, November 2000
Middle: January 2001
Bottom March 2001

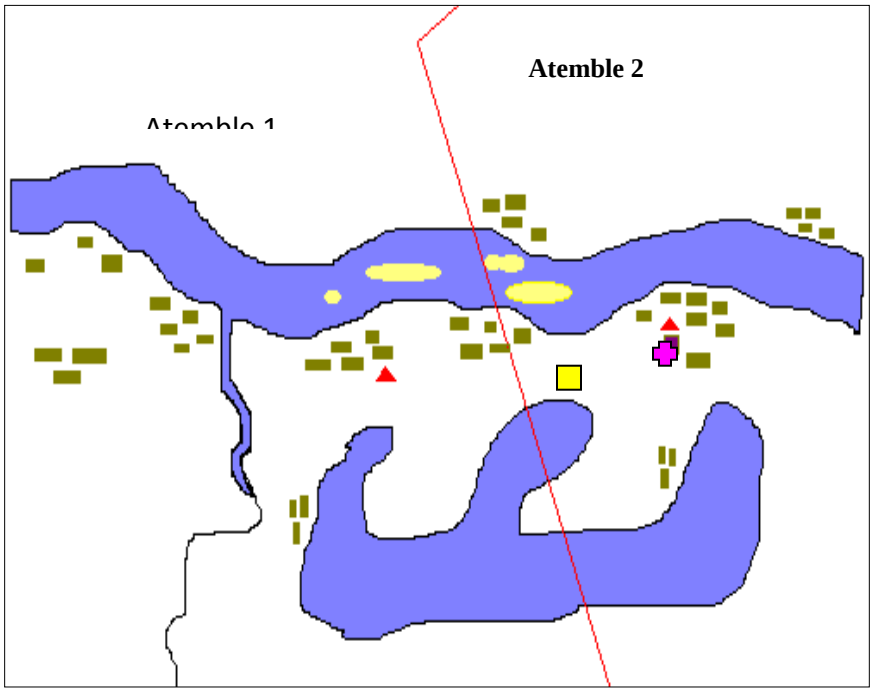
They had no Child Clinic book, the child was not fully immunized, his weight had not been plotted on a growth chart, and his birth had not been registered. Mrs. Anton was pregnant. She had no *Meri* (woman) H ealth Book, was not receiving ante-natal care, was not taking iron supplements or chloroquine, had not been immunized against tetanus and had a heavy workload. The family was not using iodized salt, not using treated bed nets, and had no access to potable drinking water or a sanitary latrine. The Antons did have a kitchen garden, however, so "window" 16 was coloured green.

By January 2001, the child under-five child had completed immunization, and had a Child Clinic Book but still needed to complete six consecutive monthly weighing session plotted on the growth chart. Mrs. Anton was enrolled in ante-natal care. She had a Meri Health Book and was now receiving iron supplements and chloroquine. She no longer had a heavy workload and had started a course of Tetanus Toxoid though had yet to complete the five doses.

By March 2001, the new baby had been born and was being exclusively breastfed. The family was using treated bed nets and had built a latrine. Anaton said " I am very happy. My wife and I tried our best to change our color from red to green – there are still many reds but we will work hard to really achieve all green in our house"

The Aid Post, School, and "Pikinini Skel Hauses" in Atemble Ward, Middle Ramu District

(Based on map drawn by community members)



Pikinini Skel Haus Constructed by villagers in November 2000. (page XX)

Aid Post Constructed by villagers in April/May 2000. The Aid Post and a house for a Community Health Worker were erected after three women in the community of 370 died in childbirth in less than 3 years. After the buildings were constructed the Ward Representative (village leader) applied for and obtained a community health worker for the village.

The village school, Grades 1 and 2 only, built by villagers who then applied for and obtained a teacher. The nearest other school is in Aiome, 2 hours walk through the bush and too far for the children. But what happens after Grade 2? At present only 3 adults in the community are literate.

Houses with palm woven walls, thatched roofs, up on stilts to avoid the floods, lie in several distinct clusters along the River Ramu and beside the lagoon formed by the old river bed

The river and the district border pass through the middle of the village but the villagers of Atemble 2 still consider themselves to belong to Middle Ramu because the district HQ, Aiome, is much closer (2 hours walk).

Village Analysis, Planning and Action

The coloured houses are pinned on a wall or board, and then the problems are counted and discussed. People are encouraged to find their own answers. Often they say that they didn't take their child for an immunization because they were too busy in the garden, or because they didn't know when the nurse was coming.

Family colouring their house in Atemble

Sometimes people are critical of health workers and the service: "They are never there when they are supposed to be," one will say. "They never have the vaccines anyway," says another. This stage of the process can be difficult for health workers who may become defensive. Instead they are encouraged to ask the villagers why the vaccines are not available. The discussion will often turn towards the high costs of transportation and the difficult communications, and the community health worker often explains the problem of the cold chain, and the need to keep vaccines at a certain temperature.

> The discussion then turns from the cause of the problem to what will happen if nothing is done about it. "The child may die" someone often says. Whenever anyone dies in the village, everything stops. For a whole week no one does anything. It is therefore not only tragic to lose someone, it can have a very negative economic impact on the community as a whole.

Sometimes we have a camera during the colour my house process and we photograph families afterwards with their coloured house. At the end of the day, everyone seems proud of what they have done.

Florence Addo,
United Nations Volunteer,
Milne Bay Province

And so the question of action arises. What can we do about this? Do we just accept this as the way things are? Among the points that often emerge is the idea that children living in the village have as much right to immunization as children living in the city, and parents, health workers and community leaders have a duty to demand immunization on their behalf.

The health worker explains the power of having a list of all the children and women in the village who need immunization. The Ward Member promises to raise the issue of the poor supply of vaccines at the next meeting of the Local Level Government.

So the process continues, until every "window" of the house has been analysed and discussed. When the process is finished everyone is asked to sign a paper promising that they will help to improve the situation. There is never any hesitation about this. Those who cannot write, they make their mark.

Albert Simon
Ward Recorder, Yo'o Ward, Esa'ala District, Milne Bay Province

We went through the "Colour My House" exercise in January 2001. When they saw the colour of their houses everyone was shocked. They said, "I thought everything was fine in my house, but look! My house is red!"

We posted all the results on a board and counted our problems:

28 out of 81	**children under five were not fully immunized.**
58 out of 81	**children under five were not growing well**
9 out of 34	**children under two were not developing well**
5 out of 9	**children up to 4 months old were not exclusively breastfeeding.**
14 out of 17	**pregnant women were not attending either pre-natal or post natal clinics**
60 out of 65	**women of reproductive age (15 to 45 years) had not been fully immunized with tetanus toxoid.**

None of our children under 5 years (or any children!) had birth certificates and no one was using iodized salt, or treated bed nets, or safe drinking water or sanitary latrines.

We analysed these problems and developed several projects. For example, we created a master-list of all the children and women in the Ward who needed immunizations and took this to our local health centre. All the families began using iodized salt. No one in Yo'o understood before why this was so important. All the pregnant women and new mothers began attending pre-natal or post-natal clinics.

Many children were malnourished. One boy was very badly affected but his mother didn't see it. During the "colour my house" process, she had marked the window for healthy growth with green. We talked with her and discovered that she had adopted a one month old girl when her son was still only four months old. There was competition for her breastmilk and attention, and while the adopted girl thrived, her son had become malnourished, especially because he did not receive complementary foods at the right time. By the age of one he was listless, unable to stand and had not uttered a single syllable. Yet the mother didn't notice. She thought that it was something inside the child that made him this way.

We tried to help the family and urged them to give more nutritious food to the child, to give him mashed sweet potato cooked in coconut milk with the leaves. But it was hard to find the words that would help the parents understand and also discouraging to see the child becoming weaker.

We take some steps forward and some steps back. We need education in the village to help families understand about many issues including nutrition and sanitation, but not everyone can go at the same pace. Just because we see the problem does not mean we can fix it immediately.

Noah Gibson
Ward Member, Weyoko Ward, Duau Local Level Government, Esa'ala District

We are rich in many things in Weyoko. It is a place of sea and land, of many fish and good crops, but it is also a place of mosquitos, of sorcery and of traditional taboos and restrictions. Because of these things we have many problems in our community. Some of these we can solve by ourselves but with some we need help. When we went through the Colour My House activity, among other problems we found that 38 children in our community were malnourished. We talked about what kind of action we should take. Several families planted kitchen gardens so that they would have good food closer to their homes. But we met with resistance from some people when we tried to confront the food taboos. The old people said, "We brought you up this way so who are you to tell us what to do." We keep on trying but it takes time to change the way things have always been.

Bernard Jorimbi
Ward Member, Atemble Ward, Middle Ramu District,

No one in Atemble had a latrine. After we went through the Colour My House process we wanted to do something about this. As the Ward Member and Vice President of Arabaca Local Level Government I was able to go an see the demonstration latrine that was put up for the Pacific Islands meeting on "Healthy Islands." The latrine had a cement or fibre-glass top that cost more than 200 Kina (about $70) and could only be purchased in Moresby or Lae or some other big town. There was no possibility that people in our village could afford such a latrine cover or find ways of transporting it to their homes. In Atemble, we came up with our own solution. Using a piece of a canoe, we constructed a cover with a close fitting lid. It wasn't as high quality as the "Healthy Islands" latrine but it was affordable, it was made of bush materials and it was something the people could do by themselves without any help.

But we had other problems because when we dug our first latrine, the soft riverbank soil kept falling in to the hole. We solved this by lining the hole with bamboo poles lashed together in a cone shape. We also raised the latrine so that it would be less vulnerable to the floods which are very common.

We constructed two *pikinini skel hauses*, started regular weighing of all children, enrolled all women in ante-natal care and are now able to test salt for iodine right in the village. We had some problems with the treated bed nets because people thought that the nets would actually kill the

mosquitos. In the morning, they expected to find the floor covered with them and when this didn't happen the rumour spread that the treated nets are no good. We are now watching and counting how many children get sick with malaria in the homes that do have the treated nets and in the homes that don't.

Rising Demands

When the villages come forward with increasing demands, the pressure on district authorities to respond can become intense. For example, the Ward Member for Atemble has submitted to district, provincial and national health authorities a demand that all the children in the Ward receive immunizations. The process helped villagers to quickly define their priorities and to shape these into a plan. The District Administrators for both Middle Ramu and Esa'ala pointed out that the villages that had been through the "Colour My House" process were much further ahead in developing their Ward plans. Some aspects of the plan require action by the villagers themselves but others rely on responses by government. Strengthening the capacity of government to respond to these demands is therefore critical.

Peter Lavidah
District Administrator, Middle Ramu District, Madang Province

We don't need roads to change the lives of people. This programme is leading us in a new direction. No one wasted any money with this project. People used their own hands and the materials that were lying around them. It is up to the District to give them support but our problem is getting in the supplies. For example, we are very short of vaccines and now people are coming to us and asking for them. Now they know that vaccines can save lives and we have to make sure we provide them. It is difficult for us but actually this pressure from the people is very good because it will make the people in Port Moresby wake up.

Gei Raga
District Administrator, Esa'ala District, Milne Bay Province

Our country has been independent for 25 years. What have we been doing all this time? Mothers were dying. Children were dying and we were worried about building a highway, about putting up a bridge and laying an airstrip. We forgot about the mothers and children in the villages, forgot about the lives of people in the community.

There is no reason for malnutrition in Papua New Guinea. We have the best food here. With good preparation of food, a clean environment and clean water to drink you can have a healthy family. These are the basics. We were not even meeting these basics but with this "Colour My House" approach and with the support of everyone at the district and provincial level we can make big changes happen. This is not only about health. We need to get the fisheries officers involved and the agriculture extension officers involved. If people are having trouble growing their kitchen gardens, we have people in the district who can help. I can see this project as a way for us to really respond to the people, but we at the district level have to take responsibility. District Administrators

like myself need to be involved from start to finish, so that we are prepared to respond to the rising demand.

This is not a UNICEF project. This belongs to Papua New Guinea and it is up to people here to make it work.

"The people of Papua New Guinea must not merely be passive recipients of government services, but active participants. They must be empowered to take greater responsibility for their own health and to play a greater role in the design and implementation of programs that effect them".[10]

[10] DOH 2000-2001

Constraints

The response of most people to the Colour My House process has been positive, but the pace of learning and the commitment to action varies widely. In at least one village, following training, relations between the Ward Member and other community members broke down. While the community was able to go forward with the process and to carry out several projects, without the Ward Member it was impossible for their Ward plan to be submitted through the Local Level Government assembly. The participation of the Ward Member is critical since he is the only legally mandated person who can take the process forward to the next political level.

Elizabeth, Atemble Village, Middle Ramu District, Madang Province

I had four children but my third child died from malaria when she was a few weeks old. The first two are 6 and 5 Christmasses and the youngest, Audrina, is sixteen months.

I went with my husband and children to the health meeting. We coloured our house and we had a lot of red marks. Audrina wasn't fully immunized. She had no growth chart. After we weighed her Woss, the community health worker, said she was underweight. I wasn't surprised. Audrina is weak. I thought she wanted to die. But I followed the advice of I was given. I gave her banana, fish and fruit to eat, and fed her several times each day. Gradually her weight began to go up. Now I think that Audrina does not want to die anymore. I think she will live. I told my husband. He is happy about it.

David,
Young Man's House, Atemble, Middle Ramu District, Madang

I live in the young man's house. All the boys move in there when they are about 12 years old and stay until they get married. We went along to the community health meeting and coloured the man's house just like any other. We do not have children in the man's house but I suppose it was useful to be at the meeting because one day I will be a father. The man's house doesn't have a latrine. We haven't built one yet and I don't know if we will. We haven't talked about it.

Noah Gibson
Ward Member, Weyoko Ward

Most people in the community are behind the project but some are opposed. These are usually more educated people who have been to the capital but have come home because they are unemployed.

They are very critical of everything. They want to show off their smartness and to challenge our political leaders. They tell the people that the activity is a waste of time and that nothing will ever change. We have to try and include these people because the project cannot work unless everyone is involved but it is a struggle to convince them.

The quality of the Triple-A process in any community depends to a great extent on the quality of the trainers. Ward members, health workers and other trainers receive five days training in the Triple A process. In general the Ward Members and Community Health Workers seemed well qualified and capable, but when the training fell on the shoulders of less qualified Aid Post Orderlies, the outcome was less certain. There are difficulties at times with the non-formal, interactive style that is essential for the full participation of families. Support for the trainers is provided by district and provincial health officials.

Sustaining the enthusiasm of communities for the process can present difficulties. In the initial stages, change comes very quickly but then the pace slows and communities are more likely to run into problems. The solution is to seek additional indicators that are manageable by the community themselves. Among these is the introduction of ECCD indicators and related activities.

Conclusion

The project strengths include that it is participatory, including all families with husband and wife working together. It is educational as it guides the family through a triple-A process of assessment, analysis and action, then re-assessment, fresh analysis and renewed action. It focusses attention on the kind of behaviour change that is necessary to promote positive change. It promotes awareness of child rights, by encouraging awareness of the causes of exclusion and the obligations of all adults.

In particular, the process breaks down into manageable components the obligations that parents need to fulfill to ensure the rights of their children to a healthy life – by ensuring that they are immunized, that their children receive nourishing food, that the water they drink and the environment they live in is safe and clean, that mothers are cared for during pregnancy, and so on. It is holistic because it looks at the health of the individual child in the context of her home and family, and it generates measurable achievements.

More detailed indicators related to early childhood development are gradually being introduced to the process, including inputs related to appropriate psycho-social stimulation during the critical early years.

The strategy operationalizes a key government policy objective by producing a tool that potentially places bottom-up planning within reach of communities throughout Papua New Guinea. The scheme has already been endorsed by the Department of Health as a strategy that should be adopted by other agencies. The six provinces that fall under the major AusAID Health Sector Support Programme have already begun implementation. The process is inexpensive and shows real potential for going to scale.

By teaming up health workers with local political leaders, the strategy is injecting a sense of health as a basis for development into the political process. The establishment of the community-based team also helps to overcome some of the problems generated by the frequent transfer of government officials. Health workers may come and go but the community members continue the process.

The project is already being recognized by local and district officials as possessing application potential outside the sphere of health and nutrition.

The project is inexpensive and costs will fall further once the support of the consultant is no longer necessary. All UNICEF funding is from regular resources, which was useful during the early stages when the project was moving very slowly. Yet now implementation is happening very quickly because the project answers policy objectives of government, institutional challenges of the health sector and local political bodies, and the priorities of families and children.

Annex 1 : Budget

Cost of the Triple A Process Per Ward of 100 Families/Households
(US$1.00 = Kina 3.389)

Training Cost	=	K2,350.00
(direct cost for five-day training for 5 participants per ward composed of Ward Member, Ward Recorder, Community Health Worker, Youth and Women representatives)		
Food at Kina 60/person/for five days	=	K 300.00
Accommodation at Kina 30/day/person	=	K 750.00
Transport @ kina 100/pax	=	K 500.00
Training supplies at Kina 10/pax	=	K 50.00
Incidentals at Kina 20/day/person	=	K 500.00
Training Manuals at Kina 50/pax (Field Guide, Cue Cards, Masterlist, Poster-size House)	=	K 250.00
Proportionate Cost for Trainers per Ward	=	K1,260.00
(Two trainers for five days covering cost of DSA and transport divided by 5 Wards for seven days)		
DSA @ Kina 400/day X 7 days X 1 pax = K2,800.00 divided by 5 wards	=	K 560.00
Salary of 1 NDOH Staff at Kina 100/day X 7 Days = Kina 700 divided by 5 wards	=	K 140.00
Salary of 2 local staff @ Kina 50/day X 7 days = Kina 700 divided by 5 wards	=	K 140.00
Implementing Triple-A (for a Ward of about 100 households)	=	K 169.00
House Template	=	K 10.00
Colored Stickers	=	K 15.00
Flip Chart (writing)	=	K 60.00
Marking Pen (pentel)	=	K 74.00
Masking Tape	=	K 10.00
TOTAL		K3,779.00
Cost per Family		K 37.79
(Cost per family with services of consultant		K 48.37)

Cost per Output of the Triple-A Process
(Estimated based on percent of time spent to produce the output)

Output	% Time Spent	Est. Cost	
		With Consultant (k4,837.40)	Without consultant (k3,779.00)
General family education on selected health & nutrition programs *(100 families – both husband and wife made aware of the programs – 19 indicators)*	25	1,209.35 = 12.09/family	944.75 = 9.45/family
Family assessment *(color-my-house showing the family health & nutrition status based on 19 indicators)*	25	1,209.35 = 12.09/family	944.75 = 9.45/family
Cluster/Ward Assessment *(Community-Based Information System – Data Board)*	10	483.74/ ward	377.90/ ward
Family Action Plan (*Commitment of every family to change for 100 families)*	10	483.74 = 4.8/family	377.90 = 3.78/family
Ward Action Plan	20	967.48/ ward	755.80/ ward
Masterlist *(Target Client List for Various Groups == four groups: 0-11 months, 12-59 months, women of reproductive age, and households)*	10	483.74 = 120.94/ group	377.90 = 94.48/ group
TOTAL	100	K 4,837.40	K 3,779.00

Note: Not costed is the commitment of every family and the community as a whole to change their condition.

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Maarkus Kachau – Provincial Health Advisor
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