CARE's Community Workshop Series

End of Project review of the Highlands Sexual, Reproductive and Maternal Health Project: Papua New Guinea

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It starts with equal

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The views in this paper are those of the author alone and do not necessarily represent those of the CARE or its programs, or the Australian Government/any other partners.

Cover page photo: Community Workshop series participants in Siaka along with CARE staff Elsie Monguru and Manase Sese.

Image: Patrick McCloskey

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Abbreviations

ANCP	Australian NGO Cooperation Program (DFAT funding mechanism)
BHM	Barola Haus Mama
CWS	Community Workshop Series
CSO	Civil Society Organisation
DFAT	Department of Foreign Affairs and Trade
EBC	Ecumenical Brotherhood Church
FBO	Faith-based organisation
FGD	Focus Group Discussions
FSC	Family Support Centre
FSV	Family and Sexual Violence
FSVU	Family and Sexual Violence Unit
GBV	Gender Based Violence
HSRMH	Highlands Sexual, Reproductive and Maternal Health project
IGD	Informal Guided Discussion
LLG	Local Level Government
M&E	Monitoring and Evaluation
MHV	Maternal Health Volunteer
MSC	Most Significant Change story
NGO	Non-Government Organisation
OIC	Officer in Charge
PNG	Papua New Guinea
SRMH	Sexual, Reproductive and Maternal Health
STI	Sexually Transmitted Infection
ToT	Training of Trainers
UDHR	Universal Declaration of Human Rights
VHV	Village Health Volunteer
WASH	Water Sanitation and Hygiene

Executive Summary

In February 2017, the Siaka Aid Post registered its first birth in 35 years. While Siaka has no road access and is only reachable by foot, it has had an operational aid post since 1982 and has a relatively new maternity ward. Still, for 35 years the women of Siaka would not come to deliver their babies.

In Siaka, it was customarily believed that men would contract asthma or tuberculosis if they saw a baby delivered or were around a woman who had recently given birth. They thought that if women started delivering at the health facility, men who went there for treatment would get sick or even die. Women were also ashamed to deliver in front of male health workers. So instead of delivering at the health centre, women delivered in bushes or 'birthing houses' away from men and without access to medical help. This put their lives and the lives of their babies at risk.

CARE came to Siaka in July 2016 to run their Community Workshop Series aimed at helping communities critically think about long-held social norms and attitudes. Participants from the community attended three workshops across one year that helped them explore how traditional customs and gender norms can negatively affect sexual, reproductive and maternal health by, for example, preventing use of family planning or care for women during pregnancy and birth. They learnt key leadership, communication and organisation skills to help them change the identified harmful attitudes and behaviours of their communities for the better.

After the second workshop, community leaders in Siaka who participated in the Community Workshop Series organised a public meeting to discuss community health concerns including the custom of women birthing in bushes and not at the health centre for fear of men getting sick. In this meeting, the community agreed that women should deliver at the health facility and agreed to overturn this harmful traditional belief.

With the support of the Ecumenical Brotherhood Church aid post, Community Health Workers (CHW) and Village/Maternal Health Volunteers (VHV) trained and supported by CARE, Siaka was able to change a long held custom and improve the health and wellbeing of women and babies in the community.

As of April 2017, five births have occurred in the Siaka clinic from a base of zero.

For CARE staff involved in the Highlands Sexual, Reproductive and Maternal Health (HSRMH) project – a project conducted in small communities in the very remote highlands of Papua New Guinea where health indicators are some of the worst in the world – this story demonstrates the significant changes possible from the Community Workshop Series and the project at large

About the Review

This internal, desk-based, end-of-project review for the HSRMH project evaluates the effectiveness of the Community Workshop Series in contributing to positive change in community and individual SRMH related attitudes and behaviours. It also explores how the CWS can better incorporate Family and Sexual Violence (FSV) and be taken to scale in the future.

The review analysed existing qualitative data (Most Significant Change stories, focus group discussions, informal guided discussions, action plans, and staff interviews) through participatory discussions and thematic analysis, and generated basic statistical analysis of quantitative pre/post CWS test data from Siaka.

Findings

The review found evidence that gender roles, norms and behaviours are changing following CWS:

- There is evidence that household workloads are being share more equally by partners. **Over half the MSCs thematically analysed mentioned sharing household workloads as a key change**, with gardening, household chores, and childcare most frequently mentioned. Women most often commented on men helping with childcare and household chores.
- Partners and families are overcoming long-held taboos around talking about sex and family planning. **12% more people are now receiving sexual health information from family members than at baseline.** Women are initiating these conversations, with 24% more women more confident to speak to their husband about family planning
- While there is evidence that inter-spousal communication is improving, and some decisions are being shared regarding family planning and budgeting, respondents in post-test still expressed attitudes that supported male dominance over a woman's movements and decisions.
- **A quarter of all MSCs mentioned engaging in consensual sex as a key change**, with both men and women reporting more respectful relations and nearly half of group CWS action plans aiming to reduce forced sex. This is a good start but given only a quarter of MSCs acknowledge this there is still a long road ahead.

The CWS has improved some SRMH outcomes highlighted as sectoral priorities, especially family planning

- Almost **half of MSCs mentioned uptake of family planning as a key change**. Estimate figures indicate that reported uptake of contraception following the CWS **has increased modern contraceptive use across the three project sites by 3-9%**. **95% of post-test respondents could name a modern contraceptive compared with 59% at baseline**.
- MSCs and action plans indicate that men are challenging traditional norms around not assisting pregnant women and are walking their wives to the health centre for antenatal check-ups since the CWS. **95% of respondents affirmed that pregnant women need to go to the health centre, compared to 51% at baseline.**
- **In Siaka, five supervised deliveries have occurred at the health facility as of April from a base of zero.** At baseline over 90% of births in Siaka occurred outside a health facility.
- Knowledge about the causes and prevention of STIs remains low as per post-test results in Siaka, and increased testing or knowledge was not mentioned in action plans or MSCs.

The CWS had a number of positive yet unexpected outcomes:

- **Improvements in shared household financial management.** Across the three sites, some men and women have reported that following CWS they have begun to share financial and budget

decisions more within their household despite this not being specifically addressed in CWS training.

- **Improvements in community governance.** Leadership training has improved the transparency and inclusivity of existing community leaders and helped community members take on diverse leadership roles outside of SRMH in institutions such as Law and Order Committees, Youth Groups and Elementary School Boards.
- **Communities are organising local governance structures for SRMH.** Participants are forming their own community groups dedicated to SRMH awareness and advocacy. In Siaka there is the 'CARE Training Group' and 'Komuniti Change Group,' in Umba/Hengiapa the 'Awareness Committee', and in Yamaya the 'SRMH Support Group.' These groups are establishing roles and responsibilities so they can effectively work with NGOs and government in the future.
- **CWS is promoting sustainable community governance structures.** One SRMH community group in Umba/Hengiapa has reportedly addressed youth drug and alcohol issues upon request from the community.

The CWS also had some unintended outcomes:

- There is evidence within the MSCs analysed that in some instances the teaching of the CWS, especially around respect and conflict resolution, is leading to **unintended interpretations that reinforce harmful gender norms that women, not men, need to change their behaviour to diffuse couple disputes** by being submissive, obedient and silent when they have grievances or want to refuse sex.
- Family violence remains endemic in project areas and CARE needs to ensure that the CWS is mitigating risks to women, especially those who attend the CWS without their husbands.
- To address these unintended outcomes CARE will prioritise incorporating FSV awareness and prevention into the CWS.

Incorporating FSV awareness and prevention into the CWS

- Structural changes to the CWS model should be considered including adding an additional FSV session between the current gender inequality and human rights sessions, creating a new gender pillar or extending the time given to work through the current sessions on gender and human rights.
- To better incorporate and link FSV more effectively to the SRMH outcomes, CARE should provide capacity building to staff implementing the CWS to improve their knowledge and facilitation skills regarding FSV, enabling them to better connect FSV to national laws, customs, faith, human rights and SRMH outcomes.
- Staff should be trained on how to respond appropriately to disclosure of FSV incidents and CARE PNG's mechanism for debriefing and self-care.
- Formal and informal referral pathways should be scoped out for relevant communities so CWS implementing staff, if approached, can provide survivors with more support options in alignment with the PNG National GBV strategy.

Taking the CWS to scale

- The CWS should/could be tested in other locations to further refine the tool and establish a more rigorous evidence base.
- A Training of Trainer model, with faith-based organisations would be the strongest and most sustainable form to take the CWS to scale in future. The CWS could be grafted onto existing VHV programs to leverage this capacity.
- Staff canvassed the idea of holding 'fast-track' CWS training for Government officials, focusing on only the advanced sessions to spread the training more widely without the intensive time in field.

Recommendations

Monitoring and evaluation

- Articulate a robust method for analysing MSCs adapted to this project.
- Ensure when transcribing stories and Focus Group Discussion to use the words of the beneficiary and not paraphrase to retain original meaning.
- If resources allow, it would be beneficial to build skills of health centre staff to collect, track and manage health data and undertake baselines aligned with Government health priorities to improve sustainability of CWS outcomes, and integration into existing Government health services reporting structures.

Achieving results

- Investigate ways to encourage communities to nominate more women and young people to participate in the CWS so the program is influencing those of childbearing age more and has more equal numbers of men and women.
- Provide training to staff on human rights-based approaches to strengthen their ability to facilitate these conversations in culturally appropriate ways, link human rights to SRMH and mitigate harm.
- Consider streamlining the number of action planning outputs to prevent 'planning fatigue'

Incorporating FSV into the CWS

- Investigate structural changes to the CWS to better incorporate FSV including adding an additional FSV session within the SRMH pillar.
- Increase CARE staff knowledge and facilitation skills in relation to FSV. Training could be provided internally or by an external expert. Staff should also be educated on how to identify participants, especially women, who have an increased risk of violence, and how to respond appropriately to disclosures of FSV within the community and how to debrief and access support within CARE PNG.
- Scope out referral pathways beyond the local health centre, including mapping informal resources including women's groups, community groups, and religious and community members, for CWS staff members to draw upon when required. Ensure these align with those contained within the PNG National GBV strategy.
- Ensure that the risk of family violence is included in the project risk matrix and is monitored. This could be done through an anonymous spreadsheet where staff record incidents of FSV they have heard about or seen in the community.

More broadly, CARE can investigate:

- Training frontline health workers in the five minimum standards of clinical care for FSV survivors and training VHVs in FSV awareness and prevention given their position as a first point of contact within communities.
- Aligning FSV reporting processes for CARE staff to those promoted by the Government in the National GBV strategy and promote these in communities.

Taking the CWS to scale

- Pilot further and establish an evidence base for the CWS model. Disseminate findings to donors and peers.
- Research potential partners, gage interest, capacity and fit of model and any required modifications.
- Investigate ways to graft the CWS to already existing community structures and programs, for example, VHV training programs, to leverage these capacities.
- Develop a training workshop/program to train trainers on the CWS model and approach. Ensure this includes training on facilitation skills and links the CWS to applicable broader project or program goals and outcomes.

Introduction

In May/June 2017, CARE International in PNG and CARE Australia commissioned an internal end of project desk review of the Highlands Sexual, Reproductive, Maternal Health project. This coincided with the cessation of donor funding in June 2017 (although project work will continue under a no-cost extension funded by Pacific Women Shaping Pacific Development until December 2017).

The purpose of this review is to position CARE for future health funding opportunities in PNG by providing an evidence base for project results and recommendations for future health programming. This review also satisfies end of project donor reporting requirements.

Given the 'light touch,' internal nature of this review, not all components of this project will be analysed and evaluated. CARE has identified its work in driving community demand for health services and challenging gender norms through the Community Workshop Series (CWS) as a key strength and point of difference when compared with other NGOs operating within the PNG health sector. As such, this review will focus on reviewing the first objective of the project – *Increase community support for gender equality in SRMH decisions making and demand for services through the Community Workshops Series*.

An internal in-country review of the CWS as a tool later in 2017 will complement this review.

The overarching question for this review is:

How effective is the Community Workshop Series in contributing to positive change in community and individual SRMH related attitudes and behaviours?

Underpinning this are a number of sub-questions including:

1. How has the CWS positively changed gender norms and attitudes as outlined in the HSRMH project log frame?
2. How has the CWS positively contribute to changed SRMH behaviours identified by the PNG Government as sectoral priorities[1] including antenatal care, family planning, and supervised deliveries in a health centre?
3. Did the CWS produce any unexpected or unintended outcomes?
4. Which aspects of the CWS resonated most with participants and why?
5. How can the CWS better incorporate awareness around Family Sexual Violence (FSV) and its connection to poor SRMH outcomes?
6. How can CARE take the CWS to scale?

Scope (Project and Context)

The HSRMH project began in 2015, with AUD$1.4 million funding provided jointly by the Department of Foreign Affairs and Trade's (DFAT) Australian NGO Cooperation Partnership (ANCP) program, and Pacific Women Shaping Pacific Development. The project built on the successes and learnings of the previous Maternal and Infant Health project implemented by CARE International in PNG in the Highlands region from 2012 – 2015. CARE implements the HSRMH project with key partners including the Provincial Department of Health, Church healthcare providers, and local NGO Barola Haus Mama who are subcontracted to train VHVs and co-deliver the CWS.

The HSRMH Project aims to meaningfully and sustainably improve the health and wellbeing of women, their families and communities in targeted rural disadvantaged areas of Papua New Guinea. To achieve this the project works across the following three objectives

1. Increase community support for gender equality in SRMH decision making and demand for health services through the Community Workshop Series (CWS) model (formerly Community Engagement Manual)

[1] As recognised in the PNG National Health Plan 2011-2020.

3. Give women, girls and communities the knowledge and tools they need to create healthy living environments by training and supporting Village Health Volunteers (VHV) and Maternal Health Volunteers (MHV)
4. Support health systems and staff to ensure they have the skills and infrastructure needed to deliver high quality SRMH services that are accessible and acceptable to the community.

Objectives 1 and 4 are funded by Pacific Women. Objective 3 is funded by ANCP. A second objective addressing governance and enabling environments was included at the outset of the program but was cut in 2016 following DFAT budget cuts. These cuts also substantially shortened the span of the project to conclude in June 2017 rather than June 2019.

The El Nino emergency drought response in 2015/16, which resulted in the secondment of HSRMH staff, further disrupted planned activities with implementation time cut from two years to ten months for all activities. Follow-up timeframes were shortened and long-term mentoring and follow-up was no longer possible.

The HSRMH project works in three sites – Siaka, Yamaya and Umba/Hengiapa – in Morobe province in the Highlands. All three sites are extremely remote and mountainous, with limited health services. In these areas, health indicators are some of the worst in the world. In PNG, the maternal mortality rate is high, estimated at 594 maternal deaths per 100,000 live births,2 with the rate higher in these remote regions. Across CARE's three sites, baseline data revealed that 24% of households had suffered at least one maternal death and 21% a neonatal death. Only 11% of respondents at baseline had given birth in a health facility, the rest gave birth at home, in a birthing house, or in a bush. Access to and knowledge of family planning is low across these three sites – more than a third of respondents at baseline claimed to have never received education or information about family planning and only 29% of couples were using a modern form of contraception. Gender and power issues in the household and community, such as masculinities that encourage men to dominate women, the conception of masculine sexuality as an uncontrollable force, and high acceptance of violence against women are major underlying conditions leading to poor SRMH outcomes.

Over the course of two years, the project has directly reached over 27,000 men, women and children through community mobilisation, VHV training and awareness raising, health centre staff training, as well as infrastructural support.

The CWS as a tool

The CWS is a participatory community mobilisation tool that draws on CARE's work in Social Analysis and Action3 to help communities challenge negative gender norms and behaviours related to poor health. CWS has been adapted specifically to the PNG context.

Communities select male and female participants for the workshop based on their roles as local leaders. CARE encourages the partners of those selected to attend. Participants attend three workshops over the course of 8-12 months.

The CWS has three teaching pillars:

- **Leadership**–includes topics like being a good leader, governance, transparency, accountability, conflict resolution.
- **SRMH** – includes topics like underlying determinants of health, sex and reproduction, gender, culture and belief, policy and laws.
- **Action** – includes topics on behaviour change process, influencing attitudes, identification and solving problems, prioritising actions.

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[2] Kassebaum, Nicholas J et al. "Global, Regional, and National Levels and Causes of Maternal Mortality during 1990–2013: A Systematic Analysis for the Global Burden of Disease Study 2013." *Lancet* 384.9947 (2014): 980–1004. *PMC*. Web. 22 May 2017.

[3] CARE's SAA is an approach for working with communities through regularly recurring dialogue to address how their social conditions perpetuate their health challenges. In this way, SAA seeks to enable communities to identify linkages between social factors and health and then determine how to address them

Through these pillars, participants explore how local customs and gender norms can be harmful to women's health, and identify norms and practices they can change within their communities. Participants learn key leadership, conflict resolution, communication and organisational skills that help them to convert these ideas into collective action plans at the end of each of the three workshop sessions. The HSRMH team follow up with communities three weeks after each workshop to track the progress of their action plans since their last visit and offer guidance.

At the end of the workshop, CWS participants draw up a collective role model agreement that outlines the actions they will take in the future to help increase SRMH knowledge and outcomes within their community going forward. CARE awards participants who complete all three CWS sessions and role model agreements with certificates of completion. Those who complete two sessions earn a certificate of participation.

Over the course of this project, nine cohorts across three sites completed the CWS. 427 participants (272 men and 155 women) enrolled in the CWS and completed at least one session. The average age of these participants was 36 years old. 333 women and men earned a certificate by completing two or more sessions. 134 men and 94 women completed all three workshop sessions (surpassing the project target of 60 for each gender) to earn a certificate of completion with a further 71 men and 34 women completing two of three sessions, earning a certificate of participation. Of those who earnt a certificate, 38% were women and 62% were men.

67 men and 27 women attended one session of the series. These participants did not earn a certificate but may still have made small changes to their attitudes and behaviours as a result of participating.

The retention rate for participants completing the entire course was 53%. This was depressed by lower completion levels in Umba/Hengiapa. Completion of two or more of workshops was 78%. For women this was higher at 83% and for men lower at 75%.

In Siaka, 92 participants (59 men, 33 women) commenced the CWS. Of these 69 (38 men, 31 women) received a certificate of completion (retention rate 75%) and 21 received a certificate of participation (19 men, 2 women). Two men dropped out.

In Yamaya 143 participants (91 men, 52 women) commenced the CWS. Of these 98 (65 men, 33 women) received a certificate of completion (retention rate 69%) and 32 received a certificate of participation (19 men, 13 women). 13 dropped out (6 women, 7 men)

In Umba/Hengiapa 192 participants (122 men, 70 women) commenced the CWS. Of these 61 (31 men, 30 women) received a certificate of completion (retention rate 32%) and 52 received a certificate of participation (33 men, 19 women). 79 (21 women, 58 men) dropped out. The team explained the lower completion rate in Umba/Hengiapa was related to strong religious beliefs that prevented many people attending the first training as they thought it was linked to sorcery. However, more people attended the second and third training once they understood what CARE was doing. Tribal fighting and community deaths contributed to lower attendance in the second and third sessions.

The CWS is not a standalone tool, and is supported by the VHV and Health System Strengthening components of the HSRMH project. MHVs and VHVs play a key coordinating role for the CWS – encouraging community participation, assisting with the coordination of the workshop and attending themselves. Through their health awareness and engagement work, VHVs and MHVs reinforce key messages from the CWS around sexual reproductive and maternal health attitudes and behaviours and provide a link between participants and health services and workers. Health worker training and health centre support improves the quality and appropriateness of healthcare to meet the demands of the community and improves the capacity of staff to monitor the uptake of health services.

Methodology

Existing qualitative and quantitative data was used as the basis to answer the guiding questions of this review.

Available data included:

- 81 Most Significant Change stories (MSCs) from CWS participants collected by the HSRMH team in early 2017 across the three project sites.
- Three Focus Group Discussions (FGD) with CWS participants collected in 2017 in Siaka (one combined group, one all-male and one all-female group)
- Seven Informal Guided Discussions (IGD) with community members who did not participate in the CWS collected in 2017 in Siaka (four men, three women)
- Action plans from the nine CWS cohorts including follow up analysis and participant reported data.
- Pre/post test data collected from 22 participants in Siaka before and after CWS in mid-2016 and again in early-mid 2017 (although the same individuals were not surveyed). This data will be amalgamated with post-test data from the other sites when available.

Project literature including recent donor reports, project design documents, the M&E framework and the 2015 baseline study were reviewed to contextually situate this review.

A thematic analysis of 81 MSCs (35 male, 46 female) was undertaken with input and feedback from the HSRMH team to track emergent themes, and patterns in relation to the changes participants were experiencing. Within these stories, changes experienced were organised within categories to give an overview of what changes respondents were reporting and how often these were being reported, with consideration taken for differences between gender, sites and ages. FGDs and IGDs were also analysed within this matrix. The team alluded to their own participatory methods for analysing MSCs although the detail of this process and how change was documented was not clear nor were the findings available at the time of writing.

Action plans were similarly analysed thematically to understand what issues were deemed most and least important for communities based on number of action plans that addressed this issue. Action plans also gave an indicative score of how communities were progressing against the action.

Pre/post data was analysed using Microsoft Excel to generate basic statistics. For reasons discussed below, post-test results were compared to the baseline where possible, but given the small sample size only give a rough indication of the direction of change.

To supplement these already existing data sources, the author interviewed key members of the Healthy Women team who deliver the CWS, the HSRMH M&E coordinator, and staff members from implementing partner Barola House Mama to delve further into the effectiveness, scalability and impact of the CWS approach.[4] The Program Manager and Program Director in PNG were also consulted.

[4] Interview conducted on the 17 May 2017 for 1.5 hours with Noah Fumi, Manase Sese, Leah Warisan, Collin Esoke, Eva Inamuka. Interview conducted on 31 May 2017 for 1 hour with Takeso Totaya from Barola Haus Mama.

Limitations

Given the internal nature of this review there are some limitations to the methodology and findings.

- **Data specific to the research question was not collected.** The review relied on already existing data and as a result there are gaps in the data – while, for example, for Siaka there is existing FGD and IGD as well as pre/post data, this has not yet been collected for other sites, meaning the data and hence findings from these sources are not representative but indicative only.
- **Changes cannot be solely attributed to the CWS.** The changes described within the MSCs, FGDs, IGDs, and post-test data are likely influenced by a combination of interventions within the HSRMH project (including VHV training and health system strengthening) and possibly interventions beyond the HSRMH project, despite the data being specifically taken from CWS participants only.
- **CARE staff collected and interpreted the data.** CARE staff gathered all the data utilised in this review meaning respondents might have answered questions with a positive bias towards CARE's programs given staff presence. The data has been interpreted and the review written by a CARE Australia staff member supporting this project.
- **Meaning was lost in transcription.** Some Focus Group Discussions were paraphrased/summarised rather than written out in the exact words (or as close as possible to) of the participants, meaning that the original thoughts and interpretations of participants could be obscured. This was particularly the case for the all-female FGD.
- **Pre/post test data is incomplete.** Instead of pre and post testing the same participants, the HSRMH team has decided to do a representative pre and post-test survey across the three sites. Currently only Siaka data is available. Given that only 22 surveys were completed in this site from a pool of 69, we do not have a representative sample to compare pre and post-tests. Once all the pre and post-tests are completed and amalgamated across all sites, comparison will be possible. In the interim Siaka post-test data, where possible given the different questions, has been compared to baseline data. Any changes are **indicative only** as the post-test sample size is small, not representative and only from Siaka.
- **Health facility data on key sectoral priorities including antenatal care visits, family planning uptake, STI tests, and supervised births was often unavailable.** Apart from Siaka, health facilities within the target areas were unable to provide data on these key outcomes that could be used to verify evidence gathered from MSC and CWS action plans. In the future it would be beneficial to align monitoring processes to Government health priorities and indicators by completing baselines with all health centres on sectoral priorities like family planning, antenatal care and supervised births then tracking these throughout the life of the project. To do this would also require building the capacities of health centre staff to collect, track and manage this data by facilitating OICs and LLG Health Managers to provide training to improve health facility assessments and management.

Findings and analysis

Before beginning, it is important to emphasise that the behavioural and attitudinal changes the CWS is aiming towards represent substantive changes for the communities participating and will take time. Many of the supportive behaviours and attitudes the HSRMH team aims to achieve require changing entrenched traditional customs, confronting persistent myths and fears, and shifting gender and power relations between couples, within families and for the community as a whole. The communities CARE is working in are remote, often many hours from the nearest road with lack of basic services, and with some of the worst SRMH indicators in the country and indeed the world. Outwardly, some changes may seem small, so it is important to understand these changes within the remote context in which they are taking place to better understand their significance.

How has the CWS positively changed gender norms, attitudes and behaviours?

Partners sharing household workloads

Over half the MSCs thematically analysed mentioned the sharing of household workloads as a key change resultant from their participation in the HSRMH project and, in particular, the CWS. This was the most common change mentioned. Four out of nine CWS cohorts incorporated action items around sharing workloads into their action plans.

However, it must be noted that at baseline nearly all married participants reported that their husband helped them with at least some of the household home and garden chores, so perhaps these changes should be understood more in the degree or type of support now being given.

For men particularly, sharing more of women's workloads demanded a shift in thinking away from traditional customs that classify almost all household chores and childcare as 'women's work'

> *I didn't help her with looking after the children. I always tell her that our customs do not allow me to hold the children or to take care of them…Unlike before, I am now starting to help my wife in looking after the children.* Man, 50, Umba/Hengiapa

In addition, men also described other changes to customary practices contributing to a more equitable home. Men reportedly now allow women and children to access parts of the house previously deemed exclusively the 'man's area', and allow women and children to eat using the same utensils as men.

While some participants only vaguely described how workloads were shared, when details were given the most common chores shared were gardening, followed by household chores (which could include various chores like cleaning, laundry or cooking as defined by each participant) and childcare.

> *'[My husband] didn't help me in looking after the children when I do gardening and he didn't help me with any loads that I carry from the garden. I would usually carry food, firewood and on top of that I would carry my younger child on my head…after the training…my husband began to help me with gardening and other household chores. He began to look after the children when I went gardening and he started to share the workload with me.'* – Woman, 45, Yamaya

In the 2015 baseline, the most commonly reported chores shared were gardening followed by breaking firewood, tasks which are often seen as more acceptable for males to do. It is positive then to see participants often mentioning that husbands are sharing traditionally more female chores like household work and childcare. As with the baseline, male MSCs more often mentioned sharing workloads than MSCs from women, but women most often commented specifically on men helping with childcare and household chores.

There was also increased recognition of assisting women with their workloads when they are pregnant. **100% of post-test respondents believed pregnant women need to do less work compared to 47% at baseline.** This was evident too in MSCs:

> *'I am seeing myself to be gradually changing in terms of cleaning around my house, helping my wife with gardening activities, doing wife's activity when she is pregnant, cooking for the family'* – Man, 31, Umba/Hengiapa

Some women and men in the MSCs explicitly connected the sharing of workloads to more rest for women. They explained this reduced women's body aches and pains, enabled them to put on weight, and gave

them sufficient time to bathe and wash properly, linking shared workloads with improved female health outcomes:

> *I started to make time to rest. Making time to rest is the most significant to me because now I am able to have baths and take care of my personal hygiene.* - Woman, 19, Siaka

One issue that emerged through analysing MSCs and action plans was that some men are asking women to lessen their workloads but not offering to take on some of their work in return, meaning women are fearful that important work will not get done. One man in action plan feedback stated that he

> *'…tried to communicate with his wife to lessen her workload but she opposed that their children will go hungry if she tried to rest from gardening.'* Action plan, Yamaya (Hangini)

It is important to emphasise to CWS participants that while women cutting down on their workloads is important, especially when pregnant, men need to share these workloads to ensure that key household tasks are completed.

Partners discussing family planning

Almost half of the MSCs analysed mentioned uptake of family planning as a significant change, and of these almost all mentioned discussing family planning with their spouse as key to making this decision (only a minority of men spoke about 'sending' their wife for family planning with no discussion).

> *'I am communicating a lot with my wife now about family planning and we have agreed to go on family planning after our child is born' – Male, 27, Umba/Hengiapa*

Discussion of family planning and sex in general has long been considered taboo in highland culture but it seems the CWS has helped men and women challenge these taboos and opened communication channels:

> *'I am empowered by the training and I am able to challenge my custom. Customarily I am not allowed to talk openly and publically about family planning.'* - Man, 25, Hengiapa.

In post-test, 28% of people reported receiving advice about sex from their family compared to 16% at baseline. This increased proportion could support qualitative evidence and staff observations that couples and families are discussing family planning more than before. Discussions are not restricted to spouses; parents too are beginning to take a greater role in the educating their children:

> *'I told my married sons that there are risks associated with having too many children too close together. Please go and get on family planning.'* - Woman, 51, Siaka

Thematic analysis of MSCs revealed that men more often spoke about influencing and educating members of their family and community when it came to family planning. However women too, who have traditionally been marginalised from these conversations, were initiating conversations with their spouse and family. **73% of women surveyed in post-test felt 'completely sure' they could speak to their husband about family planning compared to 49% at baseline,** perhaps indicating that women's confidence to broach this traditionally difficult topic with their husbands has improved through the CWS process.

> *'I went home and told my husband about it [information on contraception received in the training] and we agreed and went to receive family planning. It will help me to space my children and take a break from child bearing.'* - Woman, Siaka.

However only 9% of women from post-test felt comfortable going on family planning without their husband's permission compared to a higher 17% at baseline. This pattern is evident in the MSC analysis too, with women always seeking their partner's agreeance before going on contraception. It is important to note that CWS facilitation is aimed at doing no harm and if a women felt that getting contraceptives without her

husband's consent might result in her facing violence, the team would actively encourage her to get permission.

> *'I learnt about family planning which really helped me. I plan to get family planning but since my husband is not here, I'm waiting for him. I plan to discuss, agree and go for family planning.* '- Woman, 38 Umba/Hengiapa.

However while women may not yet be comfortable taking contraception without their husband's permission, it is important not to underestimate the significance of husbands agreeing to use contraception in the first place. In the areas where the project works, many men fear that the use of contraceptives will encourage their wife to become promiscuous and so will not let their wife take contraception. Ceding some of this control by allowing their wives to access family planning (even if they generally control the final decision) is still a significant change.

Aside from the cultural taboos surrounding the discussion of family planning and myths around family planning including female promiscuity, links to sorcery and beliefs that it will make women infertile, couples planning on taking contraception also have to confront cultural norms that value large families and sons. This is exacerbated by the practice of 'bride price'[5], which reinforces the custom of women as property whose utility is governed by her husband and his family, and is often defined by bearing many children. This can put couples, and especially women, under pressure to forego contraception. The CWS, through its right-based approach and discussions around leadership and SRMH decision-making, is helping couples and women respond to this pressure and continue with family planning as suggested below:

> *'This has prompted our families to be angry with us for going on family planning. They said we were too young and should not stop from having children but we told them that we have the right to make that decision because the cost of living is too high these days. This training has …helped me to be confident and speak up' - Woman*, 34 Umba/Hengiapa.

It is also empowering communities to respond – one CWS group listed an action item to 'remove the belief that paying bride price gives him [husband] the right to do whatever he wants with the wife' including prevent her from accessing contraception and health services. The same group also had an action item addressing cultural norms associated with big families, stating 'Men/husbands must remove the belief that the land needs to be populated with a lot of children.'

Staff also drew links between family planning and decreases in family sexual violence and arguments as women can become more open to having sex with their husbands once on contraception as the risk of pregnancy is decreased. This was supported by some MSCs:

> *'After my husband went for vasectomy, I am more relaxed with him when he wants to have sex because I am no longer afraid of having unwanted pregnancies. I feel free and I am a lot happier with my husband.'* Woman, 34, Umba/Hengiapa

> *'We do not fight and argue about sex anymore because I am on family planning as a result of this training.'* Woman, 20, Umba/Hengiapa

This, however, does not change the important fact that it is always a woman's right to refuse sex regardless of her contraceptive status and violence is never the fault of women refusing sex, regardless of the reason.

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[5] The function of a bride price was to provide compensation to the family of the bride, who would typically move in with her new husband's family. In more recent times, it has also been described as providing a disincentive for divorce, since the husband would have to pay another bride price when seeking a new wife.

Bride price reinforces a custom that women are property who's utility is governed by men and ultimately negates their rights to 'self determination'.

There is some qualitative and quantitative evidence to suggest that partners and families are breaking down customary barriers and discussing family planning after engaging in the CWS. While women may still not feel comfortable to access family planning on their own accord, their husband's agreeance for them to access family planning is a significant step within the contextual environment.

Inter-spousal communication and decision-making

Aside from reported increased communication between spouses around family planning, participants of the CWS also report improved couple communication and decision-making in other areas of family life. This includes shared decision-making around household budgets:

> *I'm beginning to include my wife in decision-making. Whatever we earn from peanut sales is shared between the two of us. We do budget on what to get for the family.'* Man, Siaka

However when women in post-test were asked about who makes decisions about their healthcare there was virtually no change to baseline figures with most women reporting they and their husband make the decision together (45%), followed by women themselves (27%). As previously discussed, women in MSCs and in post-test revealed they are reluctant to go on family planning without their husband's approval.

Post tests also revealed that 91% of all respondents thought a woman should not question a man (100% men, 82% women) compared to 53% of men at baseline and 77% of all respondents, (73% men, 82% women) agreed that a man has a right to control his wife's movements, on par with the baseline reading. Although these conclusions are being drawn from a small sample, it could indicate that attitudes that support male dominance are still widely held.

Family and Sexual Violence (FSV)

Family violence is a broad term that refers to violence between family members, as well as violence between intimate partners and is a term often used in PNG to recognise the extended family and community relations in which violence can occur. Family violence can take many forms including physical, sexual, emotional, psychological and economic.

Sexual violence can occur within intimate partner and family contexts and can include sexual harassment, sexual pressure and coercion, and sexual assault (rape). Within the context of this report, sexual violence is manifested in the form of forced sex within marriage perpetrated by men.

The HSRMH project had initially planned to pilot the Sasa! Model[6] with VHVs to address violence against women, and provide training to staff to assist in the development of FSV materials and staff facilitation skills. Unfortunately, the El Nino drought emergency response in 2016 resulted in the secondment of HSRMH staff, delaying and eventually inhibiting the roll out of Sasa! As will be discussed later, this also meant that staff did not receive specific FSV training and facilitation skills.

Despite the lack of concerted focus on FSV, activities and discussions embedded within the CWS especially around gender roles, inequality and human rights encouraged communities to consider the impact of FSV on women's health. When it came to talking about FSV, the CWS manual and facilitators placed more emphasis on elements of sexual violence particularly forced sex within marriage.

A quarter of all MSCs mentioned no longer forcing/being forced to have sex as a key change. This was the third most cited change as per analysis of MSCs followed by reduction in physical violence and

[6] Sasa! is a methodology for addressing the link between violence against women and HIV/AIDS. Sasa! is meant to inspire, enable and structure effective community mobilization to prevent violence against women and HIV/AIDS

verbal arguments. While this is a good start, given only a quarter of MSCs acknowledge this there is still a long road ahead.

Traditional highland customs give men control over their wives, with sex often perceived as a 'man's right' given he is the head of the household and he and his family have paid bride price. Men would often report coercing their spouse to have sex, sometimes using physical force. While the CWS training did not strongly focus on FSV, staff attest that in action planning and discussion on harmful gender norms women and men began to discuss these issues. Following the CWS, some men reported more empathy and respect for their wives, with some even apologising for their prior behaviour forcing their wives to have sex and beginning to modify their customary beliefs:

> *In terms of sexual relationship, I would honestly say I forced my wife to have sex and did not respect her wishes in bed. I disturbed her often when she wants to rest from too much work wanting to have sex…After attending the second CWS training, I apologized to my wife and cried for her…I love my wife and promised not to repeat my bad behaviours.* Male, 42, Siaka.

Women, more often, commented about no longer being forced or argued with over declining to have sex, although for some men this was the most significant change they reported.

> *This is very significant to me; the respect I am experiencing in the bedroom, my husband's respect for me when I refuse sex.* – Woman, 50, Yamaya

Participants did mention decreasing other forms of family violence including physical and verbal, although not as often as sexual violence. Men more often remarked on decreasing physical violence within the home sometimes linking this to forced sex, other times not.

> *I respect my wife on sex side of life. Of those changes, the most significant change to me is that I am now able to communicate with my wife regarding sex, and we agree before having sex. To date, I have not yet beaten my wife over sex. Previously it used to be a daily habit.* – Male, 41, Yamaya

> *I used to be very violent towards my wives but I have stopped fighting with them after I was involved in the training.* Man, 43, Umba/Hengiapa

At baseline, it was noted that family violence is not only perpetrated by men, and that women are not the only victims. Children, men and other family members can also experience violence and women too can be perpetrators. Women in MSCs (although to a lesser extent than men), also spoke about changing their abusive behaviours:

> *I stopped swearing at my husband and stopped hitting my children as well…. I even stopped arguing and fighting with my husband over little things.* Woman, 28, Umba/Hengiapa

Four out of nine CWS cohorts had an action item relating to husbands respecting women's decisions and not forcing their wives to have sex, although no cohorts had specific action items around decreasing physical violence, verbal abuse or other forms of FSV.

While both male and female participants contributed to action plans, actions around decreasing forced sex were hard for female participants to act on outside of advocating to their husbands and male relatives. For female participants, this meant that sometimes the changes they were hoping to see as a result of the training did not occur as their husbands were unwilling to modify their behaviour:

> *However, my husband still needs to change in the bedroom; he is having power over me - over sex." – Woman, 40 Yamaya*

As will be discussed below, there were also instances of backlash against women who were trying to encourage their husbands to change, especially when their husbands were not CWS participants. Staff

observed that women in these situations were still motivated to advocate for change, potentially putting them at increased risk.

While it is encouraging to hear these stories of behaviour change related to FSV, especially around forced sex, they also raise questions surrounding sustainability. Without wider change within the community, especially amongst community leaders, a lack of enforcement on the part of authorities and suitable services made available for women and others experiencing violence it is hard to know if these reported changes will last.

How has the CWS positively changed SRMH behaviours identified by the PNG Government as sectoral priorities[7] including antenatal care, family planning, supervised deliveries in a health centre?

Within the HSRMH project logframe, influencing individual health behaviours and increasing health knowledge is described as the role of VHVs and MHVs (Objective 3) through their community awareness sessions, advice and health service referrals. While the aim of the CWS is to change communal attitudes and harmful gender norms so they are more supportive of women's health, it is important to try ascertain whether these attitudinal changes are leading to SRMH behavioural changes like increased supervised deliveries or antenatal care by analysing MSCs and CWS post-test data.

Behavioural change is complex, and is likely promoted by the CWS, VHV/MHV interventions as well as other factors. Acknowledging these complexities, this section aims to connect changes in attitudes and gender norms promoted by the CWS to the practice of positive health behaviours.

Uptake of family planning

Almost half of the MSCs thematically analysed mentioned uptake and knowledge of family planning as a significant change resultant from the CWS workshops, with men mentioning this slightly more often than women. This was the second most common change mentioned behind sharing of workloads.

For some respondents, the CWS represented the first time they had received education about family planning:

> *My husband and I did not know about family planning… but as a result of this training, my husband agreed for me to go on family planning …I got family planning implant in my arm in October 2016'* - Female, 20, Umba

For others, it was the first time they had been convinced of the benefits of family planning:

> *'I never allowed my wife to go on family planning before but after this training, I have agreed for her to access family planning health services… I don't want my wife to face difficulties during child birth after giving birth close together.'* - Male, 33, Yamaya

Participants gave many reasons for adopting family planning including the following (ordered from most to least common):

- Desire for themselves or their wife to gain strength and put on weight before their next pregnancy and to space children
- Couples were aware and fearful of the danger to women and babies' health during pregnancy and childbirth – for some they had already come close to death.

[7] As recognised in the PNG National Health Plan 2011-2020.

- The higher cost of living meant they could not support more children.
- The couple had decided they already had enough children.
- Desire to retain physical appearance and healthy body
- Smaller families are easier to manage and allow for the pursuit of other causes (for example 'God's work')
- There is not enough land for children to inherit

CWS training and VHV sessions helped educate and steer participants towards modern contraceptive options instead of traditional methods like herbs and leaves, and helped some couples make the switch to longer-term contraceptives like vasectomies instead of the pill or three monthly Depo Provera injections

> *'We both have discussed about family planning after learning from it during the trainings. We both have decided to go on medical family planning and quit traditional family planning after my wife gives birth.*' - Male, 20, Umba.

This increase in awareness of modern contraceptives is also borne out in post-tests. Of those post-tested after CWS **95% could name a modern contraception method**, with the most common methods named injections (32%), implant (22%) and the pill (10%). In the baseline, only 59% of respondents were able to identify a modern contraceptive method (including traditional methods) with the methods most commonly named injections, followed by the pill then male condom. This could indicate that CWS and other HSRMH interventions are increasing knowledge of modern contraception methods including methods previously little known like the contraceptive implant.

Participants also demonstrated a greater reproductive knowledge. 36% of participants post-test compared to 7% at baseline could correctly identify when a woman is most fertile during her cycle.

Participants are sharing their increased knowledge of contraception with their families and communities, with all nine CWS cohorts including an action item on increasing family planning and birth spacing within their communities. Participants have conducted shared their knowledge at church, within community meetings and amongst peer groups and have reported their own contraception uptake figures back to project staff during action plan reviews.[8]

In Siaka, CWS participants reported 37 couples adopted family planning (15 participants) following CWS activities including participation in workshops and advocacy to family, friends and community. A further 18 individuals wanted to adopt family planning at the time of the follow up. These figures were confirmed by data from implementing service provider partner Marie Stopes International.

These additional 37 couples taking up family planning represent an estimated **5% increase on baseline modern contraceptive use in Siaka from 30-35%.**[9]

When Siaka CWS participants reported on their own contraceptive use in post-test, 32% reported using a modern contraceptive (compared to the baseline of 30%) and 14% reported using a traditional method.

[8] Please note that participant reported figures have, where possible tried to be verified with health centre data but in most cases this isn't possible. Even health centre data is a questionable quality. The author acknowledges that these figures are unverifiable and are to be used as a guide only.

[9] Calculated using census 2011 ward figures for households using the same wards as stipulated in baseline (adding Segiapa ward to give a more realistic reading for Umba/Hengiapa which drew from two not one ward.) Household figures were used as all cases of contraception uptake reported by participants were between couples and there are no disaggregated figures from which to draw women of reproductive age. The number of households was multiplied by the baseline for modern contraception use (30% Siaka, 20% Yamaya, 37% Umba/Hengiapa) to give an estimated number of households using contraception at baseline and then the number of new users as reported by participants was added to this. This figure was then divided by the total number of households in the selected wards to give an estimated percentage for modern contraception use after CWS. By subtracting the first baseline percentage from the second for after CWS use you can get a **rough indication** of the percentage increase in modern contraception use following CWS (although not necessarily because of CWS). Please note this is a rough calculation that assumes the baseline sample was representative and generalizable and assumes that households contain only one (if any) married couple.

54% reported using no contraception. However of those not using contraception, 75% reported they or their partner were not at risk of getting pregnant (post-menopausal or pregnant) or were not sexually active.

In Yamaya, CWS participants reported they had reached 511 people through their own family planning awareness initiatives with 30 new couples (13 participants) taking up family planning, **representing an estimated 3% increase on baseline modern contraception use in Yamaya from 20-23%.**

In Umba/Hengiapa participants reportedly reached 529 people (including children) for family planning awareness raising after the first workshop and 227 women and 265 men after the second workshop. 62 new couples (15 participants) began using contraception representing an estimated **9% increase on baseline levels of modern contraception use from 37-46%.**

In Yamaya and Umba/Hengiapa it was not possible to validate community reports with data from the health centre or implementing service providers. However taken together with the thematic analysis, these figures suggest that the CWS may have contributed to increased family planning uptake amongst households in targeted wards and has increased awareness and understanding of the benefits of modern, medical contraception methods.

However, this uptake has concentrated on married couples. It appears through MSCs, FGDs and IGDs that unmarried young people are still reluctant to access family planning, given cultural taboos around sex outside of marriage:

> *'The women leaders have spoken to my daughter about family planning but she is reluctant to get any as she is not married.' Woman, Siaka, non-CWS participant IGD*

Including these young people in CWS is still important though as it will influence their habits later in life to practice family planning as one participant explains:

> *Though I am still young and single, the information I've learnt from family planning is very significant to me. This world is changing, people are changing and the cost of living is increasing. Therefore, I want to have less number of children and I am looking forward to it when I marry.* Man, 20, Umba/Hengiapa

Participants from the CWS report that knowledge and uptake of modern contraceptives has improved because of their experience. Some couples are using contraception for the first time, leading to small increases across sites from baseline contraceptive use, while others are switching from unreliable traditional methods of herbs and leaves to medical methods or moving to more permanent contraceptive options.

Antenatal care

Awareness of the importance of antenatal care is increasing. In post-test, **95% of respondents affirmed that pregnant women need to go to the health centre,** compared to 51% at baseline.

However, few MSCs mentioned women attending antenatal care accompanied by their husbands as a significant change. This could be because this was only seen as a significant change if a couple were pregnant at the time of CWS. Many of the CWS participants were older and beyond childbearing age with an average participant age of 36. In Yamaya, where the average age was 38, the community themselves recognised the need to include younger people in similar training in the future so it can benefit most those who are in the stage of life where the training is most applicable.

Traditionally, men have been reticent to accompany their wives to the health centre for antenatal checks as this is seen to diminish their masculinity. Men not accompanying women to health centres can decrease the likelihood women will attend their checks as women are afraid to walk the often long distances to the

health centre alone. At baseline 68.6% of women reported attending antenatal care visits. Only 45% of women reported their husbands accompanied them, whereas 85.5% of men reported that they accompanied their wives.

It is interesting to note that in MSC analysis almost all who mentioned accompanying women to antenatal care were men, and in FGDs it was only in the men's group that this shift was mentioned. While baseline and community feedback indicate that norms around accompanying women to antenatal care visits were already slowly changing, CWS training for some participants seems to have further pushed this change.

> *'After the CWS training I assisted my wife to the clinic four times for antenatal check when she was pregnant with our fourth child. I did not assist my wife in the first three pregnancies which were before the training because I was ashamed of what the other men in the village might think and say about me.'* – Male, 42, Siaka

> *'He came with me for two visits to the antenatal clinic this pregnancy. I think it is a good practice. It shows that he [husband] is happy with the pregnancy and cares about me.'* Female, Siaka.

Six of the nine CWS cohorts identified assisting expectant mothers to antenatal care as a community action. In the follow up of these action plans, seven participants (5 women, 2 men) reported that they had supported/had been supported by their partner to attend antenatal care visits. Participants had also reported that they communicated these messages to the community. In Yamaya, community leaders reported doing awareness and promotion for better support for women during pregnancy to 114 people.

While not widely reported in MSCs, antenatal care actions plans and follow-up across six cohorts demonstrate that there is determination within communities to change norms around women accessing and being accompanied to antenatal care. Stories that demonstrate this change evidence considerable behavioural shifts.

Supervised deliveries at a health centre

As outlined in the Executive Summary, since the CWS training in Siaka, **five births have occurred at the health centre as of April 2017 from a base of zero. This is a significant achievement considering at baseline over 90% of all births in Siaka occurred outside a health facility and 88% proceeded without supervision of a CHW or VHV.**

Participants and staff attribute the CWS to changing harmful cultural norms that were preventing women accessing the health facility and its relatively new maternity wing. Men and women believed that if men saw women giving birth or were around women soon after giving birth they could contract asthma or tuberculosis and so discouraged women from birthing in the health centre. After the second CWS workshop, participants held a community meeting in which they discussed and agreed to challenge these harmful cultural beliefs and allow women to birth in the health facility.

While supervised deliveries were hardly mentioned in MSC stories (probably for similar reasons as mentioned for antenatal care), those that did mention this noticed a considerable behavioural shift:

> *'When I went into labour he took me to Okinawa Health Centre for me to deliver and he was there to support me through my labour to delivery. It was something he never had done before.'* Female, 38, Yamaya.

Only one CWS group in Umba/Hengiapa specifically mentioned mothers going to the health centre for delivery as an action item (although none had yet had the opportunity to complete this action) – another five plans contained more general actions around supporting pregnant women. However this lack of specific actions surrounding birthing in a health facility could be due to factors beyond the communities'

control – for example it might not be a realistic action if the health centre is far away, understaffed or under-resourced.

Overall one male participant in Yamaya reported he walked his wife to deliver at Baiyung health centre, five male participants reported helping their wife through birth (two in Yamaya, three in Umba) and two participants (one male, one female) reported being assisted by a Village Health Volunteer to deliver their baby.

Men helping their wives in labour is a significant shift. MSCs and the baseline explain that it is customarily forbidden in the highlands for a man to see a woman giving birth or be around a woman who has recently given birth (sometimes up to two months after birth). Indeed any assistance for women in labour is significant, even from VHVs, given that at baseline a quarter of women reported giving birth alone, and only 12% were assisted by a CHW or VHV, the rest relying on support from friends and family.

It is also interesting to note that MSCs and staff observed changed birth customs around forbidden foods during and immediately after pregnancy, with both men and women now eating certain foods previously prohibited, with potential positive consequences for the nutritional status of pregnant women.

In Siaka, significant progress has been made in increasing the number of women birthing at the aid post in part due to conversations started by the CWS. In Yamaya, there are a couple of reports through MSCs and participant follow-up of women delivering in a health facility. While birthing at a health facility is the end goal, it is positive to see through MSCs and action plan feedback that even if women are not getting to health facilities they are at least being helped by their husbands or a VHV/MHV to deliver.

Sexually Transmitted Infections

While STIs are only mentioned three times within the CWS manual, 'individuals seeking care for STI symptoms' is listed as an indicative SRMH supportive behaviour as per the project M&E framework for the Healthy Women objective.

No MSC stories mentioned changes in STI testing or understanding, and STI awareness or testing did not feature in any action plans. Post-test data, while it does not indicate how many participants were STI tested, does give an indication of knowledge of STIs. At baseline, less than quarter of respondents could identify that wearing a condom prevents STI infection, but **in post-test *no* respondents could identify this**. The most common answers were being faithful (32%) and abstinence (17%). In post-test 43% of respondents could identify that having sex with an infected person caused STI compared to 48% at baseline but the responses were very dependent on gender – **only 9% of women could identify this compare to 100% of men.**

Again, the post-test data is drawn from a small, non-representative sample, but it may give some indication that CWS participants do not have increased knowledge about STIs, especially given the absence STI mentions in action plans and MSC stories.

The HSRMH team indicated that information and behaviour change related to STIs was targeted in the VHV component of the HSRMH project as it is seen as more of an individual level change in behaviour rather than a community level change as is encouraged by CWS. As such these findings from CWS participants should be interrogated with data from the VHV component to understand these low levels of knowledge.

Going forward it is recommended that 'individuals' seeking care for STIs' be removed as an indicative SRMH supportive behaviour from the Healthy Women component given this is not addressed in depth within CWS workshops.

Did the CWS produce any unexpected or unintended outcomes?

Unexpected outcomes

The CWS operates in conjunction with other HSRMH project components including VHV training and Health System Strengthening activities. In some instances, it also operates in the same space as other interventions by other actors which can make discerning contribution of CWS to unexpected outcomes difficult.

For example in Siaka, EBC (who runs the health facility), ran a hygiene training shortly before the CWS. In addition, VHVs in these areas carry out awareness training in relation to Healthy Islands[10] criteria under objective two. While the CWS likely helped reinforce these learnings, it is probable that these interventions in Siaka, rather than the CWS, contributed to the high number of mentions in Siaka MSCs around improved village cleanliness (by fencing pigs and planting flowers) and improved personal hygiene (like bathing regularly, washing bedding, clothes and cooking utensils, and building toilets).

These changes, while not likely driven by the CWS, have positively contributed to reducing women's workloads and improving their health. For example when pigs are left unfenced, families establish their gardens far from the village (up to one day's walk away) to ensure they are not destroyed by the pigs. When pigs are fenced, gardens can be established closer to the village meaning women do not have to walk as far with heavy loads, thus lessening their workload.

Analysis of MSCs, FGDs, IGDs and interviews with HSRMH staff revealed other positive yet unexpected results from the CWS. These unexpected results were not formally tracked within the project M&E framework and surprised staff implementing the CWS.

Improvements in shared household financial management. While the CWS does discuss gender roles, communication, leadership and decision-making, it does not explicitly discuss financial management or sharing financial decisions between partners as some other training modules used by CARE do. However from across the three sites a few men and women have commented that as a result of CWS they have begun to share financial decisions more within their household, with men especially beginning to let women contribute to or even manage finances:

> '*Moreover as a result of the leadership training, he [husband] is also allowing me to manage the finance of the family unlike before where I get to cultivate the soil to plant food…and pick coffee beans but I never get to feel and touch the money made from my sweat'* – Woman, 40, Umba/Hengiapa

Improvements in inclusive governance. The leadership component of the CWS taught participants foundational public speaking, communication, problem solving and conflict resolution skills so that they could become role models and change agents in relation to SRMH. However, this leadership training has had flow on effects for other community governance institutions, with participants taking their skills and applying them to contexts outside of SRMH. For some participants this training helped them become community leaders in diverse areas including Law and Order Committees, Youth Groups and Elementary School Boards.

> *Prior to the CARE training I lived a very careless life. I lived according to my own will and I controlled everything. I would always raise my voice aggressively and caused a lot of troubles within my community…The leadership training has built up my capacity especially on the topic of resolving conflicts. After I began to change from my old ways the community has appointed*

[10] Healthy islands is a nationally endorsed approach that encourages communities to meet their self-care responsibilities by having a healthy living environment and leading health-promoting lives. Communities working towards becoming Healthy Islands are measured against Healthy Home and Healthy Family Criteria which include MCH clinic visits, family planning, building household VIP latrines, disposing of rubbish in covered pits, ensuring drinking water is clean, using mosquito nets.

me to be in the Law and Order Committee. Therefore this topic was very helpful to me especially to make decisions in a Win-Win, Win-Lose or Lose-Lose situation. – Man, 33, Yamaya

Existing community leaders are also reporting more inclusive, accountable governance practices:

With the Leadership Pillar, I tried not to make self centered decisions about issues or money relating to the community any more. I always used power over the community but now I am beginning to get views from the community and work together with them in regards to our community projects. I am beginning to accept criticism from my community but I accept it and try to work together with them. – Man, 46, Yamaya

Communities are organising their own local governance structures. The CWS encourages participants to influence their family and those around them through advocacy and awareness, but does not directly support the formation of community groups. HSRMH staff report that across the sites participants are taking the initiative to form their own community groups dedicated to SRMH awareness and advocacy. In Siaka there is the 'CARE training group' and 'Komuniti Change Group,' in Umba/Hengiapa the 'Awareness Committee' and in Yamaya the 'SRMH support group.' In Yamaya, the SRMH support group was established to work with NGOs, and Government around SRMH and has reportedly appointed roles and responsibilities including a chairperson and Board.

Some of these groups have gone beyond addressing SRMH issues and are becoming mechanisms within communities to address other health issues. In one village in Umba/Hengiapa a staff member recounted how an 'Awareness Committee' was established to increase knowledge about family planning and other SRMH issues. However, it has also recently tackled additional identified community issues including drug taking and alcohol consumption by a particular group of young men. The group engaged these men and explained issues around drug and alcohol consumption, and subsequently the youths changed their behaviour. The staff member noted that he witnessed this behaviour change firsthand. This demonstrates that the leadership skills and civic mechanisms being established by participants following the CWS have the propensity to work as mechanisms to address issues outside of SRMH within their communities.

Increased attendance as the CWS progressed. Often with workshop series, attrition as the series progresses is expected as the excitement wears off and other commitments arise, but in the case of the CWS, the staff observed that the number of participants following the initial workshop would often rise as word spread amongst villagers. HSRMH staff told anecdotes of participants walking from outlying areas for up to a day just to attend CWS training, demonstrating the interest generated by this training and the perceived value participants placed on what they would learn.

Word also spread regionally of the benefits of the CWS. Two villages in the Siaka region that had initially rejected CARE's offer to work there, predicated on fears that the training was linked to sorcery, asked CARE if they could deliver the training in their areas after hearing of the results of the CWS in surrounding areas. Unfortunately, given time and funding constraints, this was not possible.

Unintended outcomes

As well as some unexpected positive outcomes, analysis of MSCs, FGDs, IGDS and interviews with project staff revealed some unintended, negative outcomes.

There is evidence within the MSCs analysed that in some instances the teaching of the CWS, especially around respect and conflict resolution, is leading to unintended interpretations that reinforce harmful gender norms that women, not men, need to change their behaviour to reduce couple disputes by being submissive, obedient and silent when they have grievances or want to refuse sex.

One woman living in difficult circumstances with a violent husband reports that the violence has stopped because she, the woman, has stopped arguing with her husband echoing notions of victim blaming:

> *I fight a lot with my husband because he has gotten himself a second wife and neglected my children and me. My husband had never supported my children and me with money, clothes or soap for our daily needs. I struggle to make ends meet by selling little food from my garden but it is never enough. My house is already rotten and my children and I get wet during rainy nights…After the first training…I stopped arguing and fighting with my husband and children. When he comes by I do not start up fights with him but talk nicely to him….I realised that after doing that he has stopped beating me up and we now have peace and happiness in our home though he is with another wife…My husband has stopped beating me up after I started to change my negative attitudes.* Woman, 36, Umba/Hengiapa

Another woman now consents to sex with her husband even though her story suggests that she does not want to out of 'respect' for him:

> *Prior to this training…I would say no to my husband when I am tired and did not want have sex and he wanted to have sex… I now respect my husband when he wants to have sex. – Woman, 37, Umba/Hengiapa*

A husband also notes that his wife used to refuse to have sex with him that would result in fights but she now complies much more readily following the training.

> *'My wife would never agree to have sex with me easily. She usually refuses sex with me often. This provokes more disagreements and fights between us… she now agrees to have sex with me easily unlike the past.'* Male, 21, Umba/Hengiapa

Even the best-intentioned interventions can unintentionally reinforce harmful gender stereotypes and norms, especially in a highly patriarchal society like PNG where for women, showing 'respect' is traditionally equated to obedience and submissiveness.

It is recommended that this issue be addressed in detail in the upcoming review of the CWS as a tool to see if any modifications are required and tracked as a project risk.

Family violence is endemic in the project areas where CARE is working, and CARE recognises that there is a risk of exacerbating violence against women (and sometimes men) with programs like CWS that seek to change entrenched behaviours and norms. This is especially so for women whose husbands are not part of the CWS.

> *He once threatened to kill me at the church and said, "CARE training has spoilt your mindset and I am affected as well. I [interviewee] am being challenged and have no positive change in me as yet." – Woman, 31, Umba/Hengiapa*

> *I want to change but my husband beats me up when I want to change* – Action plan feedback Umba/Hengiapa

Instances where women want to change but cannot due to violence can be profoundly disempowering and discouraging. Yet despite the threat of violence many women remain determined, a fact that HSRMH staff confirm:

> *I really wanted the training and the change in me, I have a desire to continue with the change and influence change into my children. No matter what bad my husband might do to me, I want to patiently live the change.* – Woman, 39, Yamaya

While the risk of family violence is unfortunately unavoidable in this context, it can be managed through risk management processes and ongoing monitoring. The CWS manual urges facilitators to consider personal safety risks when selecting participants, encouraging them to 'avoid choosing people who are unsupported or highly vulnerable unless there is a plan in place to ensure their safety.' **Staff may require**

further training to identify participants who could face personal safety risks, especially women participants, to reduce the risk of exposure to violence. CARE also needs to ensure that once the CWS process begins that women attending without their husbands are given additional advice and support so they can be better placed to gain their husband's support and achieve change.

The 2015 HSRMH project design risk matrix did not include the risk of increasing violence, especially towards women, following the CWS and other program activities. **Going forward this is a risk that should be included, assessed and monitored.**

Monitoring could include informal, anonymous documentation of FSV incidents and backlash within the community by staff in a notebook or spreadsheet. It could also involve factoring in gender analysis and incidents of backlash when analysing program attrition rates.[11]

There are no quick solutions to these complex problems. This review recommends further exploration of these issues in the CWS model review in the coming months.

Which aspects of the CWS resonated most with participants and why?

To understand what resonated most with participants it is worth looking at what they spoke most about in MSCs, what they prioritised in action plans, and what staff observed.

Through analysis of MSCs sharing workloads, family planning, and consensual sex were the three most mentioned changes resulting from the CWS. Within the action plans, the most number of action items related to family planning, then supporting pregnant mothers (only one specifically mentioned supervised births), and equal third sharing workloads and not forcing women to have sex. HSRMH staff noted that the SRMH pillar was most popular, noting family planning in particular. Together these sources represent a common pattern with family planning consistently highly rated followed by supporting pregnant women, sharing workloads and consensual sex.

Men and women who were already leaders in the community were enthused by the leadership sessions, with many commenting that they were able to apply the skills they learnt to their various leadership roles:

> *Another thing it helped with was to be a better leader within the School Board of Papatea Elementary School which I am a part off - calling meetings and talking in the meetings and with parents. It gave me confidence and strength to talk in public.* Woman, 37, Yamaya

As previously discussed in the section above, it was also highly valued by non-leaders too, some of whom went on to earn leadership positions as a result of their new skills. From analysis of the MSCs, men more often than women commented on improved leadership skills as a significant change.

When staff were asked if different topics resonated with different genders, they responded that women were really inspired by the CWS sections on human rights, especially learning they had rights to healthcare and to refuse sex. Despite staff accounts that women were energised by this knowledge, men and women almost never framed their MSCs through the language of human rights – perhaps reflecting the negative consequences that can occur from women especially claiming their rights. Staff discussed how facilitators need to be better prepared to facilitate this rights-based approach to SRMH given that for many participants this is a new and challenging concept and because of the propensity for harm. This would also include reflecting on the most culturally appropriate ways to frame human rights and link them to customary norms and laws.

[11] CARE International, Guidance for Gender Based Violence (GBV) Monitoring and Mitigation within Non-GBV Focused Sectoral Programming, 2014, <http://www.care.org/sites/default/files/documents/CARE%20GBV%20M%26E%20Guidance_0.pdf>

Staff noted there was generally no difference between old and young when it came to what resonated most, although as has been discussed previously, some communities themselves acknowledged that future training would benefit from more young people who were at a reproductive stage and less older people beyond childbearing age.

It was suggested by staff that the socialisation process could be changed to frame the CWS in a way that does not represent it as a training only for leaders, but also for 'influencers' in the wider, younger community at large.

When discussing what resonated least one staff member noted that participants tend to disengage during the action-planning pillar. Participants within the CWS are expected to complete a variety of plans – action plans, role model agreements, future planning, and goal setting. This can lead to 'action planning fatigue' for the participants who sometimes feel they are repeatedly stating the same ideas.

The CWS tool review could investigate if the planning pillar and the planning outputs demanded of participants needs to be streamlined to ensure better engagement.

How can the CWS better incorporate awareness around Family and Sexual Violence and its connection to poor SRMH outcomes?

As previously mentioned, due to the secondment of HSRMH staff for the 2016 El Nino response, the Sasa! Model for behaviour change relating to violence against women was unable to proceed for VHVs in the three project sites. FSV training to develop materials and train staff also did not happen.

While the CWS does not substantially address FSV, it does take participants through sessions on gender awareness, gender roles, gender inequality and human rights that often raise issues around FSV. Within the CWS, the most common form of FSV mentioned is forced sex. This is addressed mostly within the sessions around sexual health and human rights. Other forms of FSV including physical and verbal abuse are mentioned only once within the CWS – in the qualities of an SRMH leader discussion and maternal health session. Staff note that FSV often comes out in participant problem trees.

However, there is recognition within the HSRMH team and CARE PNG that the CWS going forward needs to better link discussions around FSV with the SRMH pillar and improving outcomes around antenatal care, supervised births and family planning. The CWS would primarily focus on FSV awareness and prevention through challenging gender norms and inequalities.

This is important because the baseline found strong links between FSV and poor SRMH outcomes. Women who reported that their husband beats them were significantly less likely to report using modern contraception,and were much less likely to say that they felt confident that they could ask to use family planning or that their husband would agree to use it than women who said that their husband does not beat them. Furthermore the more freqently women were beaten, the less confidence they reported to feel in relation to these issues for 'confidence to ask to use family planning', and for 'confidence that their husband would agree to use family planning if asked.'

Women who reported that they were beaten by their husbands were were also more likely to report having been subject to forced sex and to say that their last pregnancy had resulted in miscarriage, stillbirth or death of the baby. These results imply strong associations between rates of domestic violence and other important aspects of SRMH.

Structural changes to the CWS

When HSRMH staff were asked how the CWS could better incorporate FSV there were a variety of responses. In terms of structural changes, it was suggested that more time could be given to discussing human rights, gender and FSV from the current workshop duration of three days to one week to give the team more time to explain these complex, interrelated concepts. Another suggestion was to create a new fourth 'gender pillar' that would include in-depth discussions concerning gender, human rights and FSV.

However, the most tenable solution suggested considering workshop time constraints is to add **a new FSV session within the existing SRMH pillar** to encourage deeper discussion of the forms, causes, consequences and interconnections of FSV. While the current CWS has a section on gender inequality within the SRMH pillar, this section is more focused on unequal roles and responsibilities within the home and not on unequal power relations. By expanding this section to address power inequalities a connection could be created to an additional FSV session between the gender inequality and human rights sessions that would link this imbalance of power to FSV. This session could explore some or all of the following:

- What is FSV?
- What are the forms of FSV
- Who experiences and perpetrates FSV?
- What causes FSV?
- What are the consequences of FSV (with links to SRMH)
- Understanding FSV from a human rights perspective[12]

Following on from this session a link could be made to human rights, given that it is through a human rights-based approach that CWS participants are guided to understand why FSV and other inequalities are unjust.

Adding another session would increase the time taken to complete the CWS training and it is questionable if all the above information on FSV could be squeezed into a participatory 60-90 minute session. However, to link gender inequality to FSV, poor SRMH outcomes and human rights demands a more in-depth understanding of the drivers, forms and consequences of FSV as well as the legal frameworks and services available, than is currently included within the CWS.

If the team designs an additional FSV session, it is important to harmonise this in terms of reporting and referral with the PNG National Strategy to Prevent and Respond to GBV 2016-2025. As part of this strategy, the Government has committed to establishing 100% of required government entities including police-based Family and Sexual Violence Units (FSVUs), hospital-based Family Support Centres (FSC) and legal aid; creating a national, coordinated GBV reporting database; and developing an inclusive GBV monitoring and evaluation framework.

While the National GBV strategy is a positive step, much work remains to ensure appropriate law enforcement responses and comprehensive access to services are available for survivors of family violence, with the Family Protection Act (2013) still yet to be implemented.

Capacity building

In addition to these structural suggestions, the team also suggested capacity building to improve FSV knowledge and facilitation skills. It was acknowledged that the HSRMH team were not prepared as well as they could have been to discuss FSV and its relationship to SRMH outcomes given the disruptions to the

[12] A useful resource to consult is the UN Women, *How to Design projects to end violence against women and girls,* 2015, https://unwomen.org.au/wp-content/uploads/2015/10/EVAW-Toolkit-UNWomen.pdf. This has an in-depth section on analysing violence against women that could be adapted.

training and roll-out schedule caused by the El Nino response, staff turnover, and very short implementation timeframe.

Improved knowledge and skills would enable the team to better bridge the different pillars and connect FSV to SRMH outcomes as well as to human rights, local policies, national laws, local customs and faith.

A key recommendation going forward is to provide capacity building training to the HSRMH team to improve FSV knowledge and facilitation skills. This could be provided by an FSV expert within CARE or externally.

It is also important that CARE staff receive training and support to respond effectively to disclosures of FSV by project participants and community members, and are made aware of support within CARE PNG for their own debrief and self-care when dealing with traumatic disclosures.

Another key aspect of FSV discussions and linkages to SRMH outcomes was referral pathways for survivors of FSV. As one team member noted currently there is only one referral pathway suggested by the CWS team to participants and that is through the health centre. **Going forward, the team could scope out other referral services available including counselling and safe houses.** This is important given the services being rolled out as part of the PNG National Strategy to Prevent and Respond to GBV including Family Sexual Violence Unit in every province, Family Support Centres, and a national hotline.

In areas where formal referral services are limited, the team could **compile a referral list of informal FSV resources** including social networks; community groups (especially existing women's groups); trusted individuals (people who have been champions to speak out about positive male norms, and the unacceptability of GBV); religious leaders and community leaders.[13] This would provide CWS facilitators with more options if/when a survivor discloses their FSV experience. More broadly, **training frontline health workers on the five minimum standards of clinical care**[14] for FSV, and training VHVs in FSV awareness and prevention is important in this context as in remote communities they are often the first (and sometimes only) point of contact and care.

Another key action that CWS implementing staff could take to better inform themselves of the interactions between FSV and SRMH outcomes is to incorporate FSV monitoring systems into the project framework.

This could be as simple as monitoring FSV incidents using a simple tracking system like a notebook or spreadsheet to anonymously document events staff hear about and observe and when these occur. This could help staff pinpoint any parts of the CWS or broader intervention that may be causing harm, and may help elicit connections between FSV and poor SRMH outcomes.[15]

FSV monitoring systems should feed into government GBV reporting formats and structures once these become clearer with the introduction of national, provincial and district level databases for GBV.

How can CARE take the CWS to scale?

CARE is still developing the CWS through a flexible and iterative process. Continued funding will allow additional opportunities to test the tool in more communities over a longer period of time and build the evidence base for the different components, some of which may be developed further or not.

HSRMH staff believe it is important to take the CWS to scale in the future as they consider it a highly effective tool at instigating attitudinal and behavioural change. Staff in both CARE PNG and CARE Australia

[13] CARE International, Guidance for Gender Based Violence (GBV) Monitoring and Mitigation within Non-GBV Focused Sectoral Programming, 2014, <http://www.care.org/sites/default/files/documents/CARE%20GBV%20M%26E%20Guidance_0.pdf>
[14] The five essential services include: medical first aid; psychological first aid; prevention of HIV and other STIs ; vaccination against hepatitis B and tetanus, and emergency contraception to prevent unwanted pregnancies that are the result of rape.
[15] *Ibid.*

recognise that community engagement and mobilisation, especially around changing gender norms, is one of CARE's key strengths in comparison to other NGOs in PNG. CARE PNG want to use a strengths-based approach to build their programming portfolio in country.

Staff were asked how the CWS could be taken to scale and whether this would be through vertical scaling (through institutionalisation or policy change) or horizontal scaling through:

- Expansion of the CWS
- Replication of the CWS through ToT by grafting it onto other programs run by other organisation.
- Collaboration with other partners to combine the CWS with other program components or otherwise modify it to create a hybridised approach

Staff were also encouraged to think beyond and outside these concepts.

Staff recognised that funding constraints and the time and resource intensive nature of the CWS means that straightforward expansion of the current program would not be scalable.

Training of Trainers (ToTs) was identified as an effective way of replicating the model with other organisations. The difficulty identified with this strategy is that in PNG there are very few Civil Society Organisations (CSOs) that have expertise and experience in attitudinal/behavioural change and facilitation skills. Most CSOs specialise in in-service delivery. Even those CSOs that do have relevant experience would require considerable support from CARE creating extra logistical costs and challenges.

Faith-based organisations (FBOs) represent the best partners for ToT roll out according to staff because they are established and sustainable with their own and government channels of funding and a long-term presence in communities. **Aligning the CWS with existing VHV programs run by these organisations could be key** to scaling the CWS given the key coordination role VHVs play in bringing the CWS into communities and encouraging attendance, and the future role they could have in ultimately facilitating components.

If the team is interested in scaling through ToTs to other NGOs for replication of the CWS they need to consider the following questions:

1. What evidence do they need to convince potential new implementers that the CWS is an effective tool that complements their existing work and is better than other behaviour change tools?
2. If FBOs are suggested as the best partner for ToT rollout, will they be able to implement the CWS as it stands or will it require modification for their operational and project requirements?
3. What aspects of the CWS cannot be changed during scaling to preserve the tool's integrity and which aspects are flexible and can be moulded to suit different communities/implementers?

It was interesting to note that BHM staff were less confident about ToT as a model for CWS expansion. They expressed concerns that trained partners, even faith-based organisations, would be slow to implement independently without CARE driving this and would not be able to sustain the program long-term. They noted the need for CARE to ensure that any organisation undertaking ToT training was adequately trained in facilitation skills and clearly understood how their rollout of the CWS was linking to broader project or program goals.

Collaborating with other partners to create a hybrid approach was also canvassed. One possibility could be coordinating with District Level Government to run an abridged CWS training, facilitating the 'advanced' modules rather than the whole suite to make the training more accessible to time-poor government officials.

To take the CWS to scale through a ToT model requires the following preparations:

1. Establish an evidence base for the CWS and disseminate these findings to donors, partners and other interested agencies. This review as well as the CWS tool review can feed into this evidence base. This requires further project work in more pilot sites and a plan for generating evidence.
2. Research potential implementing partners and begin initial discussions to gage interest, capacity and fit of the tool to other projects and if further modifications would be required. Investigate ways

to graft the CWS to already existing community structures and programs, for example, VHV training programs to leverage these capacities.

3. Develop a training workshop designed to train trainers on the CWS tool and approach, keeping in mind what elements must be fixed and what can be flexible.

Lessons learnt and Recommendations

This section highlight the most important findings and lessons drawn from the analysis above, and presents specific recommendations for CARE to strengthen the CWS

Monitoring and Evaluation

- Ensure when transcribing Focus Group Discussions to use the words of the beneficiary and not paraphrase to retain original meaning.
- Articulate a robust method for analysing MSCs. While the team alluded to a participatory process to analyse MSCs this process did not follow the MSC methodology. Documenting this process would be useful to understanding how the team are analysing and distilling key findings from MSCs. The present categories used for grouping MSCs are not specific to the project, but rather are generic categories. Making these categories more specific would help link the changes documented in these stories to the desired outcomes.
- If resources allow, it would be beneficial to build the capacities of health centre staff to collect, track and manage data to improve sustainability of CWS outcomes and integration into existing Government health services reporting structures. This would provide much needed quantitative data to demonstrate the impact of the CWS and triangulate qualitative data.

Achieving results

- Investigate ways to encourage communities to nominate more women and young people to participate in the CWS so the program is influencing those of childbearing age more, and more equal numbers of men and women.
- Provide training to staff on human rights-based approaches to strengthen their ability to facilitate these conversations in communities in a culturally appropriate way.
- Investigate the unintended consequences of the CWS reinforcing negative gender stereotypes that demand women be submissive and obedient when it comes to resolving couple disputes and see if there are changes that can be made to the model or facilitation to avoid this.
- Consider streamlining the number of action planning outputs within the action planning pillar to prevent ‘planning fatigue’

Incorporating FSV

- Investigate structural changes to the CWS to better incorporate FSV. This could include elongating the time for the gender and human rights sessions, adding an additional FSV session within the SRMH pillar or creating a new gender pillar.
- Increase knowledge and facilitation skills of CARE staff that implement CWS in relation to FSV. Training could be provided internally or by an external expert. Staff should also be educated on how to respond appropriately to disclosures of FSV within the community and how to debrief themselves and access support within CARE PNG.
- Provide further training and guidance to CWS staff on how to identify participants, especially women, who may be placed at increased risk of violence.
- Scope out referral pathways beyond the local health centre, including mapping informal resources including women’s groups, community groups, and religious and community members, for CWS implementing staff to refer to when required. Ensure these align with those contained within the PNG National GBV strategy.

- Investigate training frontline health workers in the five minimum standards of clinical care for FSV survivors and training VHVs on FSV prevention and awareness given their key position as a first point of contact within communities.
- Align FSV reporting processes for CARE staff implementing CWS (and more broadly) to those promoted by the Government in the National GBV strategy and promote these in communities.
- Ensure that the risk of violence is included in the project risk matrix and is monitored. This could be done through a spreadsheet where staff anonymously record incidents of FSV they have heard about or seen in the community to track any patterns of violence.

Taking the CWS to scale

- Establish an evidence base for the CWS and disseminate these findings to donors, partners and other interested agencies. This review as well as the CWS tool review can feed into this evidence base. This requires further project work in more pilot sites and a plan for generating evidence.
- Research potential implementing partners and begin initial discussions to gage interest, capacity and fit of the tool to other projects and if further modifications would be required. Investigate ways to graft the CWS to already existing community structures and programs, for example, VHV training programs to leverage these capacities.
- Develop a training workshop designed to train trainers on the CWS tool and approach, keeping in mind what elements must be fixed and what can be flexible.

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About CARE

CARE works with poor communities in developing countries to end extreme poverty and injustice.

Our long-term aid programs provide food, clean water,basic healthcare and education and create opportunities for people to build a better future for themselves.

We also deliver emergency aid to survivors of natural disasters and conflict, and help people rebuild their lives.

We have 70 years' experience in successfully fighting poverty, and last year we helped change the lives of 72 million people around the world.