

A national health crisis: **Maternal deaths in Papua New Guinea**

A report by ChildFund Australia

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Michael, age 4, in Central Province, Papua New Guinea.

About ChildFund Australia

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Foreword



Nigel Spence

Nigel Spence
CEO, ChildFund Australia

It is deeply unjust that in a country just 160 kilometres off Australia's coastline, women and their babies lose their lives during childbirth, in terrible conditions and from causes that are completely preventable.

Yet this is the daily reality in Papua New Guinea (PNG), particularly for the 85 per cent of the population that live in rural and remote areas.

No woman should die giving life. Nor should any woman see the child she has carried for nine months pass away because she could not get the help she needed while giving birth.

The conditions in which women in PNG give birth would shock many Australians. Rural health clinics, where they exist, are rudimentary and lack even the most basic equipment. Staff are often under-trained, and few in number – unable to cope with the vast health needs of impoverished communities.

Doctors are in scarce supply. For many women in Central Province, where ChildFund works, the closest doctor is a four-hour drive away.

Due to this lack in health infrastructure, most women have no choice but to give birth at home, and rely on traditional birth attendants to assist them. The latter are without resources, and use whatever tools they have available. These may include sharpened bamboo to cut the umbilical cord, a used produce sack for the mother to lie on, and plastic bags instead of gloves.

In these conditions, it is little wonder that PNG has some of the region's highest rates of maternal and newborn deaths. It is estimated that one in 120 women will lose their life due to a maternal cause, compared to Australia's one in every 8,700.

And unlike many other developing countries in the region where signs of progress in maternal and child health are evident, these rates are not improving.

Many factors have contributed to this continuing problem, most notably PNG's extreme shortage of doctors, nurses and midwives as well as the facilities, medicine and equipment that would prevent many of these tragedies.

However, there are also many people on the frontline who, every day, are committed to making sure childbirth is the safe, joyous event it should be. Commitments by the PNG Government, the National Health Plan and support from international aid donors are essential but clearly not enough, as the current statistics show. Much greater investment and sustained implementation are imperative.

There are few more pressing challenges than preventing the health crisis that is unfolding on our doorstep. ChildFund will continue to work with leaders, healthcare professionals and local communities to develop long-term improvements.

In the short-term we are equipping communities and frontline workers with the essentials they need to save the lives of mothers and their newborns in PNG.

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Due to this lack in health infrastructure, most women have no choice but to give birth at home.

Executive Summary

Almost half of all mothers in PNG give birth in their homes, a figure that hasn't changed in decades, and where unsafe conditions contribute to a high number of preventable deaths.

In some provinces, less than one in five women give birth in a facility with a skilled birth attendant present.¹ Women who give birth at home do so in dangerous conditions, using unsanitary equipment and without the assistance of a midwife, a nurse, a doctor or any trained health professional.

As a result, women are vulnerable to the common causes of maternal deaths: severe bleeding, infections, eclampsia and complications during delivery. These deaths are largely preventable.

It is estimated that one in 120 women in PNG will die from causes related to pregnancy.² However, the reality is likely to be much, much higher.³ Newborns are also extremely vulnerable in these conditions and neonatal deaths comprise one-third of all deaths of children under five in PNG.⁴

Women who reach a clinic in rural areas often find these facilities unstaffed or without electricity, running water, or essential medication and equipment.⁵

In response, the PNG Government has made improving healthcare a priority, especially in rural areas, where 85 per cent of the population lives.

The National Health Plan 2011–2020 set the ambitious targets of reducing the maternal mortality rate to fewer than 100 deaths for every 100,000 births and child deaths to fewer than 20 deaths for every 1,000 children under five by 2030.⁶

This represents more than half of the most recent estimated maternal mortality rate and half the under-five mortality rate.

However, a five-year review of the National Health Plan in 2016 showed the health sector had an “overall decline in performance over the last five years”.

“There are many health policies and strategies that have been developed emphasising the importance of primary healthcare, improving quality of care, disease prevention and improving human resources for health,” the review stated.

“However, successful implementation of these policies and strategies require appropriate technical and financial support, otherwise these cannot translate into improved health outcomes.”

The review found that initiatives to improve the health of pregnant women and their newborns had not made an impact.

“There is no evidence of improvements in most of the maternal and child health indicators, with the exception of child mortality from pneumonia and diarrhoeal disease amongst children under the age of five years.”

The extremely high rates of maternal and newborn deaths, and the ongoing lack of progress, reveals a need for greater support at the village level, where most women in PNG give birth.

Papua New Guinea's national health crisis

Central Province in PNG covers almost 30,000km² and is home to a population of more than 270,000 people. Most families live in small villages connected by dirt roads that are poorly maintained.

There are few cars in Central Province and almost all travel is done on foot or in crowded public motor vehicles – these are privately-operated buses which serve as the only form of transport for many rural communities, and connect them to the national capital.

Due to the lack of hospitals, people who need specialist medical care must travel to Port Moresby. This presents a serious concern for pregnant women, according to Dr Mary Rose Bagita, president of the Papua New Guinea Obstetrics and Gynaecology Society.

"If a woman needs to be referred to the nearest bigger health facility or hospital, that presents itself with another problem – transport issues, road issues, cost of transport," Dr Bagita said.

"A lot of these rural women, they don't have the money to be spending on transport and the cost of staying in a city while they give birth."

In 2016, only one in five women in Central Province gave birth at a medical facility with a skilled birth attendant.⁷

Across the country, the percentage of women giving birth in clinics has declined in recent years, despite laws and programs designed to encourage supervised births. In 2016, 40 per cent of women gave birth at a facility with a supervised birth attendant, down from 44 per cent in 2012.⁸

The percentage of pregnant women who attended at least one antenatal examination also declined in the same period, from 66 per cent to 54 per cent.⁹

The estimated number of women and children who die in childbirth each year in PNG varies drastically depending on the source. Despite the disparity in figures, no one disputes that the country has unacceptably high rates of maternal and newborn deaths.

PNG has yet to achieve its maternal and child health-related Millennium Development Goals (which were due to be met in 2015), and must overcome serious challenges if it is to reach targets within the Sustainable Development Goals.

According to a World Health Organisation study, the country would need an estimated 44.5 doctors, nurses or midwives for every 10,000 people to meet its Sustainable Development Goals¹⁰, major increase on its current health workforce.¹¹

This would require massive investment at a time when the country is facing serious economic pressures.¹²

Gender-based violence

PNG is a dangerous place for pregnant women and their newborns, not only because of widespread poverty but because of the extremely high incidence of domestic violence.

It is widely reported that violence occurs in more than two-thirds of families in PNG. Some studies estimate that one in two women will be forced to have sex in their lifetime.

There is no official data on violence against women and children, and pregnant women specifically, but experts believe the incidence is likely to be higher than two in three.

This is a view supported by ChildFund Australia's research

in Rigo District, Central Province.¹⁶ During this field study, not a single woman interviewed acknowledged having a husband who had never beaten them. Women also said their children were often present when their partners were violent towards them.

Violence starts before birth. One study found 86 per cent of women had been beaten during pregnancy.¹⁷

Another quantitative study¹⁸ with a sample of 415 women from the National Capital District, Western Highlands, Morobe and Western Province showed that 44.5 per cent of pregnant women surveyed reported sexual violence in their relationship, and 58 per cent reported physical violence.

"I think we are facing a health crisis in our country with mothers and their unborn children," Dr Bagita said.

"There's so many factors related to it because our priorities are not directed towards the rural facilities."

More than 85 per cent of babies born in PNG each year are born in rural areas¹³, where the lack of doctors and facilities are the most acute.

"The main challenge for women in rural areas is getting access to the care they need and, once they make that decision to get access, how to actually get there and, when they get there, whether the services are available or not," Dr Bagita said.

"That's the really big issue in our country."

Small villages have for decades been serviced by basic clinics, which make up almost two thirds of the country's health facilities.¹⁴

These aid posts are usually staffed by a community health worker with two years training, and are designed to service about 1,000 people.

Larger villages may have a health centre or a sub-centre that function as referral points between lower level facilities and district hospitals.

Combined, these rural health facilities comprise more than 95% of the facilities in PNG, but they struggle to keep up with the demands of a growing population.

In 2008, almost one fifth of all aid posts were closed because of shortages in funding, staff, and other resources¹⁵, putting even further pressure on under-resourced rural clinics already servicing large populations.

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I think we are facing a health crisis in our country with mothers and their unborn children.

A MOTHER'S GRIEF

Stella



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The little boy was Stella's seventh and last child. He was also her fourth baby to die.

It was just before dawn and the roosters had yet to crow when Stella, eight months pregnant, went into labour.

She was carrying her seventh child, and there were red flags early on. A month before, she had felt the baby tumbling around in her belly. But when the pain and contractions began, everything fell quiet.

"I felt something was wrong," Stella says. "I couldn't feel the baby moving and there was a bad smell coming from me.

"I told my husband, 'there's something wrong with me, you need to take me to the hospital'."

Stella waited for an hour in pain before she and husband Francis stumbled through the dark from their village in Kivori¹⁹, in remote PNG, and found a driver who would take them to the nearest health clinic, a 10km drive away in Waima.

Stella clenched her teeth in agony as the car made its way on the dirt track filled with ruts and potholes.

When they finally arrived at the small health clinic – usually attended by two healthcare workers and visited by 6,000 people from the surrounding villages – it was empty.

In a panic, Stella and Francis looked for another vehicle that would take them to the next closest clinic, a 12km drive way in Beraina.

"I pushed and pushed and pushed for an hour at Beraina," Stella says. "But there was no sight of the baby, so I asked them to transfer me to Port Moresby General Hospital."

The trip to the capital, Port Moresby, was fraught with difficulties before it even started. An ambulance was available, but the driver was nowhere to be seen. "It took 20 minutes before we left," Stella says. "They had to walk all the way to his home to tell him to come.

"I went to the ambulance and got on and was lying down with a nurse, and just began pushing."

Stella, drenched in sweat and tears, arrived at Port Moresby General Hospital three hours later. A little boy wrapped in a blanket lay lifeless in her arms. "When my baby came, the umbilical cord was around his neck three times," Stella says.

"The nurse cut the cord off and hit the baby on the bottom, but there was no sign of life.

"The nurse took the baby, put him in my hands and said 'sorry, mother'." The little boy was Stella's seventh and last child. He was also her fourth baby to die.

"After I had my last child I had an operation to stop having babies," Stella says.

Her sixth child, also a little boy, died during childbirth after another traumatic journey to hospital. For two hours Stella lay in pain and agony on baggage, among dozens of strangers, in a packed public motor vehicle.

"We kept stopping at villages to pick up people," Stella says. "I was lying on coconut bags and cargo. One lady was with me and telling me not to push until we got to the hospital, because the passengers' cargo was there. I pushed anyway.

"When I got on the hospital bed, my baby just came out dead.

"The cord wasn't around his neck but he just didn't breathe."

The two babies were buried a few years ago in a little cemetery near their grandmother's home, along with their older brother and sister, who also died because of complications at childbirth.

The youngest boy's grave – unlike the cement graves of his brothers and sister – is marked with a small mound of sand and dirt.

"We are still trying to make cement for the latest baby who passed away," Stella says. A bouquet of pink flowers grows on top. "I come here once a week and talk to my babies, and say: 'Good morning, mummy loves you'."

There's an overwhelming sadness every time Stella visits the cemetery. It's her three surviving children – Olive, 15, Amy, 8, and Michael, 4 – who keep her going.

"I hate to tell my story," she says. "When you have a baby for nine months and then the baby dies, no one can understand that.

The experience of losing four children has also taken a toll on her husband, Francis.

The children's deaths could have been prevented if there was only better access to antenatal and healthcare services, he says.

"We don't have facilities here to cater for women who have complications in delivery," Francis says.

"I blame myself that I never made more of an attempt to bring Stella to a place where she would have delivered safely."

It's not right that a mother should have to bury her child, Stella says, and she only hopes the future will be different for her daughters and their families.

"I don't want other women to suffer what I have suffered," she says.



Stella regularly visits the graves of the four children she lost during childbirth.

Giving birth: Australia versus Papua New Guinea

The far north Queensland region of Cairns has a population of about 162,451 people. The main hospital in Cairns has nine birthing rooms, each with an ensuite, 24-hour obstetric support and a special care nursery.

Three of the rooms in the maternity unit have large baths where mothers can relax during labour or have a water birth. Mothers at Cairns Hospital can choose to have mood music, massage oil, aromatherapy burners, heat packs and a fridge in their room.²⁰

More than 2,800 people work in nursing roles in Cairns and the surrounding hospitals.²¹ Mothers who give birth in Cairns have access to extensive resources to prepare them for birth, as well as healthcare professionals to guide them through the process.

There are about 2,700 births at Cairns Hospital each year or about seven each day.²² Just an hour away by plane in Port Moresby, the capital of PNG, the conditions could not be more different.

Only 160km separates the Australian mainland from its closest neighbour, but in many ways the countries are worlds apart. According to recent estimates, the rate of maternal deaths in PNG²³ is more than five times higher than Australia's maternal mortality rate from 1964 to 1966²⁴. It is more than 35 times greater than Australia's current maternal mortality rate.²⁵

Dozens of babies are born each day in Port Moresby General Hospital's 24-bed labour ward. The ward is crowded, and patient turnover is high. The hospital struggles to keep up with the demand of a growing population, and there is a critical need for more doctors, nurses and midwives across the country.

Dr Mary Rose Bagita is president of the Papua New Guinea Obstetrics and Gynaecology Society and co-ordinator of gynaecology and obstetrics at Port Moresby General Hospital. Her team in the labour ward consists of three full-time doctors, one resident and two registrars.

Every eight-hour shift there are at least three midwives, sometimes as many as six. This small team is responsible for the births of about 15,000 babies each year, or about 41 babies a day.

"Here we have a good team of doctors and nurses so, I think, with a lot of teamwork, you feel that you're not bearing the burden alone, that you can share the load with other colleagues so that keeps us all going," Dr Bagita said.

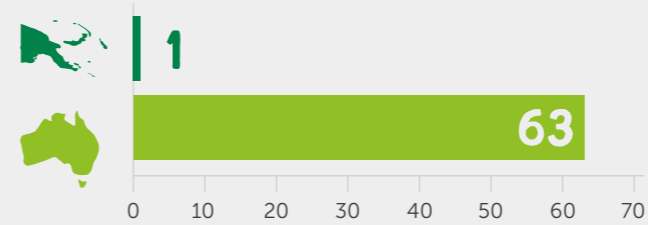
Despite the challenges, Port Moresby General Hospital is better resourced than the facilities in PNG's regional areas, where 85 per cent of the population live. Healthcare facilities in rural areas are rare, and the number is dwindling. Only 40 per cent of all pregnant women have a supervised birth at a health facility.²⁶

Women often go into labour under their homes or in a makeshift hut with only help from relatives and an untrained traditional birth attendant from their village.

Childbirth in PNG and Australia

Physicians per 18,000 people (2010)

In Papua New Guinea there is **only one doctor for every 18,000 people**. In Australia there is one doctor for every 350.



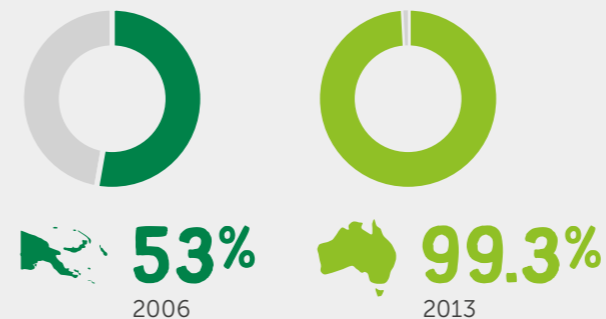
Nursing and midwifery personnel density

There are more than 24 midwives and nurses in Australia for **every single midwife or nurse in Papua New Guinea**.



Proportion of births attended by skilled health personnel

In Australia, almost all women give birth with a skilled birth attendant present. **In Papua New Guinea, it is around half.**



Maternal and child mortality in PNG and Australia

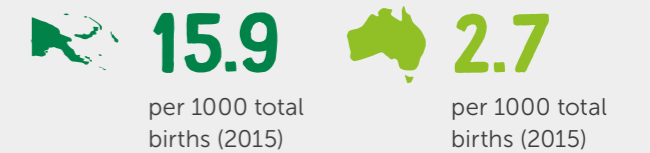
Neonatal mortality rate

A newborn in Papua New Guinea is **ten times more likely to die** in their first month of life.



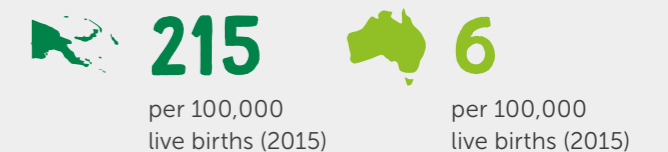
Stillbirth rate

Stillbirths are almost **six times more likely to occur** in Papua New Guinea.



Maternal mortality ratio

A woman in Papua New Guinea is **35 times more likely to die** during pregnancy.



Lifetime risk of maternal death

The lifetime **risk of dying during pregnancy is 1 in 120 in Papua New Guinea**. In Australia it is 1 in 8,700.



Sources: World Health Organization Global Health Workforce Statistics, OECD, UNICEF, State of the World's Children, Childinfo, and Demographic and Health Surveys, Estimates Developed by the UN Inter-agency Group for Child Mortality Estimation, WHO, UNICEF, UNFPA, World Bank Group, and the United Nations Population Division. Trends in Maternal Mortality: 1990 to 2015. Geneva, World Health Organization, 2015

How women give birth in the village

Jacinta Oa has been a frontline worker in PNG's rural health system for 30 years, including 15 years as the officer in charge at the health sub-centre in Waima, a small village in Central Province about four hours drive from the national capital.

Jacinta Oa's small clinic consists of a delivery room, a waiting room, an examination room, an office, a storeroom and a shaded outdoor waiting area.

There is no electricity, no running water, and no ambulance. There are no mattresses on the consulting beds. The clinic is open from 8am to 6pm on weekdays, manned by Jacinta and another community health worker.

This is the only health clinic within walking distance of the estimated 6,000 people who live in Waima and its surrounding villages. An aid post in Kivori, about 10km away, used to provide healthcare services to some of the surrounding villages, but a lack of funding, and staff, has resulted in its closure.

"We only have two staff here but we encourage all mothers to deliver their babies at the clinic," Jacinta said. "But in Kivori, most mothers deliver at home because they have no transport to reach here."

The walk from Kivori takes around two hours, but can be much longer if someone is sick or heavily pregnant. Women who go into labour when the clinic is closed, or have complications during labour, are in a dire situation.

The next closest health clinic is a 45-minute drive up an extremely bad road that can become completely impassable during the rainy season. The closest hospital is in Port Moresby.

There are few cars in the villages surrounding Waima and patients looking to get an ambulance to Port Moresby must bear the cost.

These barriers to healthcare mean that many women choose to give birth at home, in unsanitary conditions. In cases where women cannot make it to the clinic, Jacinta often travels to their home to assist with delivery.

The risks of rural childbirth

The condition of our community health facilities, even the district hospitals, is very poor. A lot of them are really in disrepair. If you have a facility but the water tank is broken and the sinks are not functioning, and the toilets don't work, then it's a health and hygiene risk when mothers come in to deliver.

Dr Bagita, president of the Papua New Guinea Obstetrics and Gynaecology Society and co-ordinator of gynaecology and obstetrics at Port Moresby General Hospital

My two children delivered in Port Moresby Hospital were normal with less pain. I got medicine and that was good. The delivery at home in the village was difficult and I didn't like it. Sometimes accidents can happen; babies can die during delivery. I felt bad, like I was going to die. Now I do not want to have any more children.

Judy, rural mother of three children

We don't have a hospital here so people like me are needed at the time of delivery. In the village, we make a place under the house and we put old bags on the ground, or plastic bags. This is where the mother delivers.

Jullian, village health volunteer

Our services could be improved with a better ward, more staff, better equipment like oxygen and forceps, and a better maternity ward. We don't have a toilet or shower or any running water. And we need an ambulance.

Jacinta, community health worker

Women in rural areas face a lot of problems. They may have bleeding after childbirth, or have a prolonged or obstructed labour. They might have a medical condition like anaemia or malaria during pregnancy which makes delivery more complicated. And most of them will have to deliver without a skilled health worker.

Olive Oa, head of ChildFund PNG's health programs

The place of birth

In many rural communities, a temporary hut is built for expectant mothers. In Kivori, this is called the Koroaonai, meaning 'place for birth'.

Where there is limited space for a temporary hut, a special room under the family house is created for the mother and baby.

The hut is covered with coconut leaves or bags and is built next to the woman's family home. Once labour pains are constant, the woman will enter the hut where she sits in a squatting position, sometimes resting on coconut husks.

The woman will pull a rope that is tied above her head each time she experiences a contraction. The woman's mother often sits behind her, putting her arms around her daughter's abdomen, with a birth attendant kneeling in front of the woman to support the mother and deliver the baby.

In some communities, mothers are not encouraged to give the baby colostrum and this is thrown away.

After the child is born, the placenta is buried under a tree, the roots of which are used as a means of family planning.

Post natal care in rural areas

In Kivori, it is customary for a mother and her newborn stay in the birthing place for up to two months following childbirth.

Inside the designated hut or room, the mother sits with her back to the flames of a fire. It is believed this will encourage the uterus to return to its normal size, and works as a cleansing process for the mother and her reproductive organs.

Her lower abdomen is tied with a rope made from banana trees, to reshape her stomach post pregnancy and childbirth.

Women cannot comb their hair, as this is believed to be unhealthy, and must use a special stick to scratch an itch.

The mother is not allowed to handle or prepare food for the first two weeks after childbirth, and her eating utensils are kept separate from other family members.

Traditional customs also apply to the mother's diet during this time, which consists largely of carbohydrates, such as banana, boiled in water. She will partake of very little fat or protein, and will be forbidden from eating crabs.



Jacinta Oa is the head of a small, under-resourced clinic in Central Province.



Jullian has been a traditional birth attendant in her village for almost three decades.



ChildFund PNG's Olive Oa is working with Jacinta to improve health interventions for mothers and their newborns.

The traditional birth attendant

Almost three decades ago, traditional birth attendant Jullian delivered her first baby.

In her village in Central Province, the closest health centre is a two-hour walk so, with the woman already experiencing severe labour pains, Jullian had been summoned to help the expectant mother give birth at home.

More than 24 hours later, the baby was born healthy, the mother had survived an agonizing ordeal, and Jullian could breathe a sigh of relief. It was an intense and emotionally overwhelming introduction to her new role as a traditional birth attendant, one which she began with no formal training.

In those early days, Jullian's arsenal of midwifery equipment was rudimentary at best. "There were no hand gloves, so I would put on plastic bags on my hands. To cut the cord I would use a type of bamboo as a knife. I used whatever I could find."

Nor was her working environment any better. "It's a long walk to the clinic, and sometimes women can't wait, especially in times of emergency. Women worry that they might give birth on the road, so they decide to stay at home instead.

"I would spread old clothes or 50kg produce bags underneath the women during their labour. The string from the bags could also be used to tie the umbilical cord."

For the approximately 3,000 women who live in Kivori, the delivery options are extremely limited, if non-existent. A basic clinic can only be reached by a long journey on foot, and the district health centre is over an hour's drive on a poorly maintained road.

Public motor vehicles – the only form of transport available and equivalent to travelling on a large and overcrowded produce truck – do not travel this road on a daily basis. The cost of using this service is also prohibitive.

There are no doctors available in Central province, so to reach a hospital for more specialist care means a four-hour journey to Port Moresby.

For these reasons, women like Jullian perform a vital and sometimes life-saving service. For the majority of pregnant women, they are the only childbirth support available.

During the early years of her work, Jullian was fortunate to learn some additional midwifery skills by shadowing the Community Health Worker – the equivalent of a nursing assistant in Australia in terms of qualifications.

Jullian would assist him by setting up the delivery room and handing him any medical equipment during the delivery process. Jullian is illiterate, but through observation she learnt many basic procedures.

In 2015, ChildFund PNG gave Jullian the opportunity to take part in a new intensive training program for Village Health Volunteers (VHVs). This six-week course covered a broad range of healthcare issues, while also giving Jullian more in-depth knowledge in safe motherhood and early childhood care and development.

"The training was in simple terms and easy to understand. I learnt many new things on maternal health and general health, but more importantly the proper steps to take before, during and after delivery in those cases when a mother cannot get to the clinic."

And she has already had to put this training into practice.

Jullian says: "When my first-born daughter gave birth to her fourth baby, the umbilical cord broke in the womb. The baby was not breathing when she was born but I was able to resuscitate the baby, and she's six months old now.

"I went through all that training, and now I can save the life of a baby."

Head of ChildFund PNG's health program, Olive Oa, says ChildFund strongly encourages women to deliver at the nearest health facility where possible.

But she adds: "Due to issues of inaccessibility, and the hardships of reaching a clinic in many villages, women will continue to rely on traditional birth attendants.

"So it's extremely important that we make sure they have up-to-date skills, and some basic equipment. We also provide VHVs with birthing and newborn kits to ensure better safety and hygiene for women and their newborns."

Olive adds: "Being able to recognise signs of danger is also vital for a VHV. Knowing when to refer a woman to more specialist care can mean the difference between life and death."

Today, Jullian estimates that she has delivered around 180 babies. She encourages women to give birth at the clinic, but is always there to help when she is needed.

"Many times, I have walked long distances and in the night to reach women. Even when it rains, I find my way to them. It is tiring but I love what I do.

"I believe God gave me a gift to save lives so I will continue to help women until the day when my legs can no longer carry me."

A WOMAN'S FEAR

Elizabeth

Elizabeth doesn't know what feels worse: the intense pain in her lower belly or the throbbing headaches.

The two-hour walk from her home in Kivori in rural PNG, to the nearest health clinic, in Waima, probably didn't help. But there were no cars around to catch a ride.

Elizabeth is nine months pregnant with her fourth child, and she's worried the pain in her stomach and the headaches could be something serious. She's been here before, after all.

After giving birth to her second child in her village, she had severe abdominal pains and ended up travelling to the health clinic at Beraina – a rough and gruelling drive that took more than an hour – so she could get treatment.

"I stayed there for two weeks," Elizabeth says. "I was given amoxicillin and put on a drip."

There used to be an aid post near Kivori, but it's now an abandoned house surrounded by overgrown grass.

The only option for women now is to give birth at home without medical assistance, or travel the long distance to reach a health clinic at Waima or Beraina. But even then, Elizabeth knows that may not be possible, or there might not be anyone at the clinics to help.

"I am hoping to deliver here in Waima," Elizabeth says, "but if my labour starts in the night there will be no way for me to come here, so I will definitely have to have the baby in the village.

"I am worried about whether I will deliver properly."

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The only option for women now is to give birth at home without medical assistance...

Finding solutions for safe delivery

In May 2009, a Ministerial Taskforce on Maternal Health in PNG produced a series of recommendations to address the alarmingly high rate of maternal deaths in the country.

"The sheer absence of adequately trained, maintained and supervised staff and facilities is the most substantial barrier to progress when discussing maternal death and disability in PNG," the taskforce report stated.²⁷

Recommendations from that report helped form part of the National Health Plan 2011–2020, where the government set itself ambitious targets of reducing the maternal mortality rate to fewer than 100 deaths for every 100,000 births, and child deaths to fewer than 20 deaths for every 1,000 children under five by 2030.²⁸

"The priority strategy of the plan is 'back to basics', with rehabilitation of the foundations of our primary health care system, focusing on improving maternal health and child survival, and reducing the burden of communicable diseases," the National Health Plan stated.

Decreasing newborn deaths was highlighted as a priority because newborn deaths comprise around one-third of all child deaths.²⁹

Reducing neonatal deaths requires improved access to skilled birth attendants, access to obstetric care and early essential newborn care, according to the PNG Department of Health's Child Health Advisory Committee.³⁰

The results so far have been mixed. PNG did not meet its maternal and child health-related targets for the Millennium Development Goals in 2015, and the overall performance of the health system has declined in the last five years.³¹

One of the most troubling trends is the decline in women having supervised births in clinics, especially in rural areas. Unsupervised births contribute to the highest numbers of maternal and newborn deaths.

Olive Oa, head of ChildFund PNG's health program, said people in rural communities needed to be central to the effort to decrease deaths in childbirth.

"If we want to improve the statistics for the country as a whole, the first thing we have to do is improve and strengthen the services in the rural areas, the rural villages," she said.

ChildFund PNG runs health programs in two districts in Central Province. The programs are aimed at increasing the capacity of clinics, local volunteers and health workers. "In my opinion, the rural areas should be strengthened with better basic health services, with good equipment, resources," Ms Oa said.

"There should be upskilling of healthcare workers. Each facility should have at least a nursing officer. They need someone more skilled to attend to complications, especially if there are mothers experiencing difficulties during childbirth."



Elizabeth visiting a clinic in her village for a check-up with a community health worker.

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Over the course of the project, the number of midwives in PNG increased from less than 300 to more than 750.³⁶

The State of the World's Midwifery report in 2011 found PNG had one midwife for every 1,000 births per year and needed to quadruple its midwifery workforce to meet needs.³²

Since then, the number of midwives has been increasing and the PNG Government has introduced new midwifery schools, a one-year Bachelor of Midwifery curriculum for nurses and opened up more spots for midwifery students.

The Australian Government has also helped address the shortage of quality midwives through a five-year PNG Maternal and Child Health Initiative (MCHI) to improve the country's midwifery education and increase the number of graduates.

In the first two years of the initiative, more midwives graduated than in the previous decade. Over the course of the project, the number of midwives in PNG increased from less than 300 to more than 750.³³

The Australian Government's Australian Awards scholarships played a key role in this increase. A minimum of 95 per cent of students surveyed in Phase II of the project (2014 and 2015) were receiving scholarships and 80 per cent of all students surveyed felt they would not be able to study midwifery without the financial support of a scholarship.³⁴

Projects like MCHI and scholarships are critical to addressing the country's extreme shortage midwives, but training healthcare professionals takes time.

Dr Mary Rose Bagita believes immediate needs and the long-term national plan need to work together, with rural women at the centre.

"You don't need to have a specialist right at the district level; that would probably be a waste of training," she said.

"But if you have a specialist at the major hospitals and are able to train the larger cadre of health workers who are the community health workers and the nurses, and upskill their maternal and neonatal resuscitation skills, that would go a long way.

"While that is happening you could be training midwives and obstetrics and gynaecology specialists, which takes much longer than upskilling community health workers."

Dr Bagita said all women needed to be able to give birth at a quality facility under the guidance of someone who could treat the most common causes of death in childbirth.

"If you have a rural woman giving birth at either at home or in a rural health facility, if she has a massive bleed then it depends where she is," she said.

"If she's going to bleed at home and, you know, there's no way she can reach a health centre in time then the end result is terrible.

"If a woman delivers at the health facility and she has a PPH, a postpartum haemorrhage, and a health worker is trained on how to deal with that situation, then of course the outcome can be better."



Village health volunteers play a key role in rural health services.

Village health volunteers

Due to the remote locations of many villages in PNG, local health initiatives are essential to improve the outcomes of women and their children. Even basic training and simple medical supplies can be enough to save a life in places where many families can expect to lose a mother, sister, aunt or daughter to childbirth.

The Village Health Volunteer (VHV) program trains dedicated volunteers to offer basic health support to pregnant women in their community. The program aims to bridge the gap between remote villages and health clinics in major centres by ensuring a safe birth for women and their newborns.

Jacinta Oa, the officer in charge at the Waima clinic in Central Province, said VHVs in her local community were encouraging women to attend antenatal clinics at the clinic.

"We have noticed an increase," Jacinta said. "The VHVs let the women and their husbands know when we are providing antenatal services and they let them know it is important that they get check-ups."

Based on a National Training Curriculum, the six-week VHV course combines theoretical knowledge with practical skills in the community, covering safe motherhood, children's health and self-help healthcare.

Volunteers receive training in birth delivery, monitoring and advising pregnant mothers, and family planning.

Their training helps them educate fellow community members about safe practices before and after childbirth to help reduce the affect of harmful customs.



The delivery room at the Waima sub-centre health clinic.

Improving health infrastructure

The report *A lost decade? Service delivery and reforms in Papua New Guinea 2002-2012*, which surveyed 142 rural health clinics, painted a bleak picture of the country's rural health facilities.

Although that survey pre-dated the government's recent attempts to improve healthcare throughout the country, Dr Bagita said the conditions in rural clinics are still below standard.

"The condition of our health facilities: our community health facilities, aid post, even the district hospitals – a lot of them are really in disrepair," Dr Bagita said. "They need ongoing maintenance."

People in rural areas are often sceptical about the service they will receive at a rural clinic, according to Jacinta Oa. Her clinic in Waima was recently upgraded by ChildFund and now has a birthing room.

ChildFund also assists the clinic with outreach programs, which help educate the community about safe practices.

"More people have been coming," Jacinta said. "They think that it's safe to come here because the health worker is here and they won't have as many worries when giving birth."

Upgrades to clinics and more outreach services will decrease the number of women giving birth at home and the number of deaths in childbirth, Olive Oa believes.

"We need to improve and strengthen those services so they can provide outreach services for women to access during the antenatal period, to identify if they have any medical problems during pregnancy," she said.

"Women need to be confident that the clinic will be open, that someone will be there to assist them, and that person is well trained."

Upskilling rural health workers

Mothers attending clinics in rural communities need to know that the healthcare worker will be able to help them deliver and provide early essential newborn care.

The rural workforce is under-staffed and, in many cases, has healthcare workers are not receiving ongoing training.³⁵

ChildFund PNG trains healthcare workers on integrated maternal and childhood healthcare. It is also working in partnership with rural clinics to develop outreach patrols, and improve healthcare infrastructure.

Olive Oa said ongoing training was essential in rural communities, where many healthcare workers have been in the same position for decades.

"There are simple solutions that can save lives and the healthcare workers are willing to learn," she said.

"But they do not always have training or they cannot make the training. If they have the training and they can help the mother when there is a complications, that would save a lot of lives."

A RURAL VOLUNTEER

Patricia



Patricia found Judy bleeding early in the morning. Pregnant with her third child, Judy had gone into labour at home in Kivori, in remote PNG.

She was a four-hour drive away from the nearest hospital, in the capital of Port Moresby.

Her mother-in-law, terrified, sent for the nearest available help, and Patricia and Raymond, Village Health Volunteers trained to identify and assist mothers during pregnancy and childbirth, arrived soon after.

"I stayed for some time," Patricia says. "Judy's water did not break until 3pm and then her contractions started and she delivered the baby, but not the placenta."

Recognising Judy had a retained placenta and therefore was at risk of developing an infection, Patricia and Raymond immediately called for a public motor vehicle to take Judy to Beraina health clinic.

"The main childbirth complications that we see are babies being born with the cord around their necks, the cord coming first, haemorrhaging, or retained placentas," Patricia says.

"After we were trained, almost all the mothers in this area ask for our assistance. Before, some mothers were alone during childbirth."

If Judy had given birth after dark, she may have never had made it to the clinic.

"Many women give birth at night so it is too hard to get to the clinic," Patricia says. "Some might start pains in the afternoon, but labour will begin later in the evening when it is too late to travel."

Judy is grateful to have had Patricia and Raymond by her side. She now has a beautiful 18-month-old girl, Joylyn.

"I was so lucky I went to Beraina. At the clinic the nurse helped deliver the placenta [using oxytocin], then she gave me some medicine and I stayed overnight," Judy says.

"I was so worried and I thought I would be finished."

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Many women give birth at night so it is too hard to get to the clinic.

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