Roller-coaster: The challenge of using teaching and learning as opportunity for teacher professional development

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Abstract

Aim and rationale: *Roller-coaster* is a Professional Doctor of Education thesis by publication. It describes the key steps I have taken as a lecturer in public health to use my teaching and learning activities as an opportunity to address my own research higher degree needs. As Acting Chairman of the Division of Public Health (DPH) at the UPNG School of Medicine and Health Sciences (SMHS) at the commencement of the study, I needed to address my own professional development needs to better support colleagues in similar situations as me to address their own needs. To achieve this aim, four main goals were set: to develop skills in literature searching and reviewing, to develop understanding and hands-on experience with qualitative thematic analysis, to develop skills in basic quantitative analysis and to strengthen my academic writing and publishing capacity by sharing and disseminating research findings through peer-reviewed journals, newsletters, conferences and other presentations. Instead of researching a single topic in-depth outside my routine teaching activities, as is usually the case with a conventional PhD, the professional doctorate allowed me to write for different kinds of audiences and to submit a portfolio of research outputs based on my day-to-day work.

Methods: The study was guided by two related research questions: a) what are the main challenges and opportunities involved in using teaching and learning activities to achieve my research higher degree goals and b) how can this experience help me to better support colleagues in similar situations. To answer these questions, a mixed methods approach, informed by a range of transformational and pragmatic world views including Problem-Based Learning, empowerment, participatory learning-by-doing and auto ethnography, was taken. To ensure the authenticity of the narrative, I have written significant sections of this doctoral study in the first person.

Results and discussion: Three peer-reviewed journal articles are presented as evidence that I achieved the professional development goals I set myself: a review of gender policies and programs in Papua New Guinea (PNG), an implementation of the Aboriginal Australian Family Wellbeing (FWB) empowerment program in the context of the University of Papua New Guinea (UPNG) public health teaching, and the feasibility of transferring the FWB program from the university to a PNG community

setting. Newsletter articles and other research outputs are also presented in the appendix as additional supporting evidence. The study has shown that it is possible for university teachers, including those from resource-poor countries such as PNG, to use teaching and learning activities as an opportunity to achieve their professional development goals. However, the journey I experienced was like a 'roller-coaster', with concomitant high and low moments. Key challenges included a steep learning curve, lack of money, time constraints, tiredness, sickness and family responsibilities. Despite the many challenges, the reflective learning-by-doing approach taken allowed me to use the challenges as opportunities to learn and grow. By routinely reflecting on what was working and not working and how to make things better, I was reminded of the often minor but significant incremental progress I was making along the way, especially during the difficult or low moments. Overall, insights gained from my study highlight the nature of empowerment and how this might be fostered or cultivated in the context of health workforce development in PNG. A range of study limitations and suggestions for future research are also highlighted. The keywords below have been used extensively in this study.

Keywords: Problem-Based Learning, professional development, family, wellbeing, empowerment, gender equity, program implementation, transferability, sustainability

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List of Abbreviations

ABS	Australian Bureau of Statistics
AIDS	Acquired Immune Deficiency Syndrome
AL	Action Learning
AusAID	Australian Aid Agency
AUWBIS	Australian Unity Well-Being Index Survey
CGA	Country Gender Assessment
CI	Confidence intervals
CIMC	Central Implementation and Monitoring Committee
CLC	Christian Life Centre
DCH	Diploma in Community Health
DNPM	Department of National Planning and Monitoring
DPM	Department of Personnel Management
DPH	Diploma of Public Health
DPH	Division of Public Health
FHI	Family Health International
FSVAC	Family and Sexual Violence Advisory Committee
FWB	Family Wellbeing (program)
GBV	Gender-Based Violence
GEM	Growth and Empowerment Measure
GESI	Gender Equity and Social Inclusion
GESIP	Gender Equity and Social Inclusion Policy
GoPNG	Government of Papua New Guinea
IJHSS	International Journal of Humanity and Social Science
HIV	Human Immune-Deficiency Virus
HSR	Health Systems Research
JCU	James Cook University
MDG	Millennium Development Goals
MPH	Master of Public Health
NACS	National AIDS Council Secretariat
NCD	National Capital District
NDH	National Department of Health

NGDP	National Goals and Directive Principles
NGO	Non-Government Organisation
NHGP	National Health Gender Policy
NHP	National Health Plan
NPWGE	National Policy for Women and Gender Policy
PAR	Participatory Action Research
PBL	Problem-Based Learning
PJMS	Pacific Journal of Medical Science
PMD	Prime Ministers Department
PNG	Papua New Guinea
PNGDSP	Papua New Guinea Development Strategic Plan
PSS	Personal Safety Survey
RPNGC	Royal Papua New Guinea Constabulary
SE	Standard error
SIC	Sister- In Charge
SHSS	School of Humanities and Social Sciences
SMHS	School of Medicine and Health Sciences
TOT	Training of Trainer
UNAIDS	The Joint United Nations Program on HIV/AIDS
UNFPA	United Nation Family Planning Association
UPNG	University of Papua New Guinea
WHO	World Health Organization

Chapter 1: Introduction

The aim of this chapter is to provide background on and introduce the context of the study, the challenges and opportunities involved in developing the study and the Problem-Based Learning (PBL) approach applied.

PBL is a learner-centred approach that empowers learners to conduct research, integrate theory and practice, and apply knowledge and skills to develop a viable solution to a defined problem (Savery 2006). This approach supports and empowers students to achieve their learning goals and differs to conventional or traditional approaches to learning. Instead of the lecturer 'knowing all' and passing on this knowledge to students in a one-way direction, the teacher instead becomes a facilitator, who helps students to research issues, consider solutions and implement and critically evaluate those solutions. In this way, teachers and students learn together.

PBL originated at the McMaster University Medical Faculty, Canada, in the mid-1960s. Since then it has been successfully adapted in medical curricula in many developed countries, including the Netherlands, Australia, Israel and the United States (Gewartz et al 2016; Savery 2006) and in Papua New Guinea (Itaki 2007; Kevau et al. 2004). The main components of the PBL approach are learning in small groups, the teacher as facilitator rather than lecturer, student self-directed learning, and the use of a written problem as stimulus (Itaki 2007; Kevau et al. 2004; Gewartz et al 2016).

In 2000, PBL was introduced to the School of Medicine and Health Sciences (SMHS) at the University of Papua New Guinea (UPNG) as an approach to medical and health worker training (Itaki 2007; Kevau et al. 2004). The approach has been very popular among health workforce students and their teachers because it addresses the limitations of a teacher-centred approach and enables a more learner-centred approach. However, there are challenges associated with the application of PBL at the UPNG, including high staff turnover and lack of resources to routinely train new staff, and the need to adapt to changes in technology, for example, supporting students to access information from the internet rather than relying on resource-intensive PBL hardcopy resources (Itaki 2007). However, what has become evident is that the PBL approach can potentially assist

academic staff to achieve their own professional development goals. My study is the first to apply PBL to teacher professional development.

1.1 Background to the Study

The study draws on PBL and associated participatory research and action learning activities, primarily through the lens of an Aboriginal Australian Family Wellbeing (FWB) empowerment program (Kitau et al. 2011; McCalman, Tsey, Kitau, & McGinty 2012) as an educational strategy to enable student and teacher professional development in UPNG. The FWB program was piloted as a community development and empowerment subject within the UPNG public health course. I was involved in this opportunity to support my own professional development as a Lecturer in Public Health Education. Specifically, the study was designed to improve my research skills regarding literature searches and reviews, qualitative and quantitative data analysis, writing for peer-reviewed journals, user-friendly knowledge sharing and using my experience to engage and support other academic public health colleagues to achieve their own professional development goals.

FWB is an evidence-informed group intervention developed by Aboriginal Australians to give people skills that empower them to build support networks, to self-reflect, to learn to heal from emotional pain and to solve problems using creativity and innovation no matter how difficult or challenging the situation (Tsey et al. 2005; Whiteside et al. 2014 cited in Kitau et al. 2016, 2017). It has four main components: (a) establish the setting, (b) create a safe space, (c) show participants how to think and communicate effectively and (d) help participants recognise their own experience and knowledge, their strengths and basic human needs (Tsey et al. 2005; Whiteside et al. 2014 cited in Kitau et al. 2016, 2017). In 2009, FWB was adapted as a PBL course by PNG researchers, and incorporated into public health training at the Division of Public Health (DPH) in 2010 (Kitau et al. 2011; McCalman, Tsey, Kitau, & McGinty 2012). In 2013, I taught the FWB subject to 20 DPH students in a 13-week semester-long course. I then took the students to the Bereina station community and conducted a one-day FWB introduction to local residents, to give them a ‘taste’ of the FWB topics. The focus of this doctoral study is this 2013 FWB implementation.

I was first introduced to Australian researchers and the FWB program in 2008. Many things happened within the UPNG public health program in this period. At the time, there were 20 enrolled students, 14 of whom were enrolled in the Diploma in Community Health (DCH) and six of whom were enrolled in the Masters in Public Health (MPH) training program. With the death of the Chair of Public Health in 2008, I became the acting chairman. At the same time, most teaching staff left for personal reasons or after their contracts with UPNG expired. Hence, I was forced to rely on AusAID-funded fly-in-fly-out Australian academics from Brisbane and Sydney to teach the public health program. Given UPNG's close proximity to Cairns, I decided to identify and build partnerships with JCU academics who could support me and my team to develop capacity to adapt and teach the James Cook University (JCU) subjects.

I visited JCU and spent a few days with Professor Komla Tsey, lead researcher of the Empowerment Research Program, and his team in Cairns, where I was introduced to the FWB empowerment program. Professor Komla Tsey also arranged for me to visit Yarrabah to see how men's and women's groups were using FWB. I had the privilege of spending another three days in Townsville with Professor Sue McGinty from the School of Indigenous Australian Studies, where I met Professor Yvonne Cadet-James and other academic staff. While there I was given the opportunity to experience courses that could be adapted to DCH training at UPNG. One course that stood out as very relevant and important for PNG was the 'Empowerment and Change' subject, based on the FWB program.

The report that convinced me that FWB may be relevant in the context of PNG was titled 'No More Bandaid Solution': Yaba Bimbie Indigenous Men's Support Group Evaluation Report: January 2004–June 2005 (McCalman et al. 2005). Reading this report inspired me to adapt the FWB program to our Community Health course and curriculum. I was inspired by the men's actions in forming a men's group and taking the initiative to address issues affecting their health and wellbeing, in particular, the high level of drug and alcohol abuse, violence and suicide in their community, with guidance from the JCU FWB empowerment team. In my view, the application of FWB in Yarrabah is a model of successful community empowerment and transformation, which PNG can learn from to tackle the same issues affecting the youth.

In PNG, the concept of empowerment is often promoted by the government and development partners (Papua New Guinea Department for Community Development 2011; Papua New Guinea Department of National Planning and Monitoring 2011; Papua New Guinea Department of Personnel Management 2013; Papua New Guinea National Strategic Plan Taskforce 2010; 2016; NDoH 2010; 2016; Rissel 1994); however, it has been hard to find well-evaluated empowerment programs in the literature. My vision of empowerment, based on my experience as a community health worker and public health educator, is that positive change cannot happen unless an individual person changes first, followed by the family, the clan, the tribe and then the community, out to districts, province and nation. This takes patience and time. Money alone cannot bring about long-term change and transformation. As a public health lecturer, I was interested in exploring the idea of empowerment through my PBL and research activities. FWB provided an opportunity to apply and examine empowerment through implementing and evaluating an intervention.

1.2 My Decision to Undertake Doctoral Study

The decision to use the FWB teaching and research as an opportunity for my doctoral study was based on two factors. First, it came in part from my difficulties in accessing a scholarship for research training. Although I had used the PBL public health teaching approach and related Participatory Action Research (PAR) and Action Learning (AL) to support a range of student learning activities within the Diploma of Public Health (DPH) and Masters of Public Health (MPH) programs, my attempts to obtain AusAID and other sponsorship to undertake PhD research failed. This was mainly because of my age and my lack of publication history. I was 'caught between a rock and a hard place'. So, as we say in PNG '*mipela brukim bush*', meaning just do it and try to learn along the way, I decided to base my training on my current work rather than rely on a scholarship. Though the policy not to award scholarships to people over 50 years is based on the reality of the relatively short life expectancy in PNG, which makes anybody over the age of 50 'high risk', the downside is that it denies professional development opportunities for university academic staff who have come from industry as mature age students, rather than through the conventional Bachelor and Honours degree academic pathways.

Second, the same difficulties in accessing research training are shared by other colleagues in PNG. Many lecturers and tutors at the UPNG, and particularly, at the School of Medicine and Health Sciences (SMHS) where I work, have skill limitations. For the same reasons as I have, they have never had the opportunity to develop themselves. This was revealed by Lahui-Ako's (2005) study, which identified many skills limitations among lecturers teaching at the SMHS. The study strongly recommended that they should use action research, and other methods of adult learning such as mentoring and experiential learning, to develop themselves and improve the quality of their teaching.

1.3 My Life Journey as a Lecturer

In the next part of this chapter, I share my life journey and experience as a lecturer, my career aspirations, the challenges and opportunities for further studies and how I came to do my Doctor of Education at JCU. The aim is to provide additional context for the study.

1.3.1 1977 – Early Education and Training

I was born and grew up on Manus Island, one of the 22 provinces in Papua New Guinea (PNG). After primary and secondary education on Manus Island, I trained as a Health Extension Officer for three years (1977–1979). After eight years of experience as a district and provincial health extension officer, I moved to the National Health Department to work in health policy and planning. To prepare for these responsibilities, I was sent to Kuala Lumpur, Malaysia, to do a two-week course on Health Systems Research (HSR). This course was part of the National Health Department and World Health Organization initiative for capacity building of health managers taking up senior posts in the department. The course planted the idea of research firmly in my mind.

The key focus of the HSR training was to enable me to promote its use as a health management tool for decision makers and managers (Gilson 2012, p. 21; Hoffman et al. 2012, p. 18). As a Health Manager, I was trained to apply HSR as part of the monitoring and evaluation of the National Health Plan at all levels of the health system (Papua New Guinea Department of Health 1986). The experience demystified research: I learned that research was for every health worker; not only for researchers and scientists in research institutes, but for ordinary health workers and health managers. To me, this was real

empowerment. I felt confident to discuss issues related to health policy and plans with academics and researchers. Before this, research was considered 'special', and felt inaccessible to me.

1.3.2 1989 – Employment in the National Health Department

In the early 1980s and 1990s, PNG was undergoing a period of rapid political and administrative changes and decentralisation of government services (Kolehmainen-Aitken 1992; Smith 1997, p. 408; World Health Organization 1990). Many of the roles and functions of the health department at the national level were decentralised to provinces and districts (Kolehmainen-Aitken & Newbrander 1997). However, there was little management capacity for these functions, as there were few qualified indigenous PNG doctors and managers to take over from expatriate counterparts following PNG's independence from Australia. In preparation for this transition, new systems and programs were created. The Diploma of Community Health (DCH) and the Master of Public Health (MPH) at UPNG were designed for public health professionals such as myself, with no university degree or postgraduate qualifications. I successfully completed the one-year Diploma in 1992.

1.3.3 1993–1996 – Appointment as National Health Planner and Post Graduate Training

When I returned to the Department after the DCH course, I was appointed to the position of National Health Planner. In the absence of qualified planners, the Department appointed people to roles that were well beyond their training and experience. In many developed countries, such as Australia and New Zealand, a person is employed as a National Health Planner if they have strong quantitative and planning qualifications and years of professional experience. In PNG, lack of expertise meant that people were appointed into roles for which they were not qualified. I was 'thrown into the deep end', so to speak. As National Health Planner, I quickly realised that I needed more training. Hence, I accepted the opportunity to travel to the University of New South Wales in Sydney for the two-year Masters by Coursework in Health Services Planning.

1.3.4 1995–1996 – After Post Graduate Training in Australia

On returning from UNSW after completing my Masters of Health Planning in 1996, I worked for four years in the National Health Department as the Project Coordinator and later as the Principal Advisor of Human Resource Planning. I applied several times to do my PhD at the University of New South Wales and the University of Queensland. Although I was accepted and made an offer to study there, I was not able to take these opportunities up because of a lack of sponsorship and because I was not an academic. Thus, I applied for a lecturer position at UPNG and was accepted; I then resigned from the National Health Department.

1.3.5 2002 – Joining the SMHS, UPNG

Although I had extensive community and health department experience and had completed a Master of Health Services Planning, I had never completed a research degree such as honours, a research masters or a doctorate, or conducted research in my own right. This was an obvious gap in my experience, as lecturers are expected to teach research methods and also supervise student research projects. To do this effectively, I would need to complete a research degree and undertake my own research projects. Many lecturers and tutors at the UPNG, and particularly at the School of Medicine and Health Sciences (SMHS) where I work, are in similar situations.

1.3.6 Since 2008 – Collaboration with JCU

My opportunity to undertake a doctoral degree came in 2008, when I collaborated with JCU. As the Acting Head of the Division of Public Health, I was constantly faced with an acute shortage of staff to teach and conduct research and publish papers in international journals. Through the JCU/UPNG Partnership, I built a good working relationship with the JCU Empowerment Research Program team. Through this collaboration, the Aboriginal Australian FWB empowerment program was identified and adapted into the Public Health course at UPNG. Transferring and sustaining the program was possible through the capacity-building support from Professor Komla Tsey and his empowerment research team at JCU between 2009 and 2011. Following my successful visit to JCU Cairns, Professor Tsey, Dr Janya McCalman and Dr Mary Whiteside became my main mentors. With AusAID support, they visited me in PNG

between 2009 and 2011 to train me and my staff to facilitate the FWB program (Kitau et al. 2011; McCalman, Tsey, Kitau, & McGinty 2012).

At about the same time I started collaborating with the JCU empowerment team, a co-tutelage agreement was signed between JCU and UPNG, under which UPNG staff could undertake joint degrees across the two universities without paying international student fees (JCU 2015). This JCU generosity was clearly the opportunity I had been looking for and at which I immediately jumped without hesitation.

1.4 Doctoral Study – What is my Main Goal?

My goal has always been to do my PhD, no matter what and how long it takes. However, I needed the right person to mentor me at the right time. Since I met Professor Komla Tsey in 2009, he has encouraged me to use my teaching activities with public health students as opportunities to critically reflect on my own skills needs, identify priority gaps and then use the more flexible JCU Doctor of Education, rather than the conventional PhD, to achieve my professional development goals.

1.5 Rationale for Undertaking a Professional Doctorate

The main rationale for undertaking the professional doctorate degree pertains to my professional development skills needs. I found that the professional doctorate is designed for people such as myself. Instead of researching a single topic in-depth outside my routine of teaching and research activities, the professional doctorate encourages writing for different kinds of audiences and submission of a portfolio of work based on the candidate's day-to-day work:

> This degree enables professionals to study several issues and encourages writing for different kinds of audiences (for example for work settings, for parents, for journals and newsletters and for academic publishers), instead of focusing on one issue culminating in one thesis (JCU 2015a, p. 1).

1.6 Identifying Basic Research Skills

Through discussions with my potential supervisors and my own constant reflections, I identified a set of basic research skills that could enhance my capacity to better facilitate public health teaching for my students. Some of the most frequent questions students

ask during public health teaching activities include how to do literature searches and reviews, what is qualitative research and how it is done, and how is it possible to undertake quantitative data analysis including sample size calculations. I decided that these were important research skill sets that I should further develop. I then selected related public health teaching activities as opportunities to further develop the priority skills sets as described in the next chapter. As the Acting Chair of Public Health at that time, addressing my research training needs would also place me in a better position to support my colleagues to work towards their own professional development goals.

This program has thus enabled professionals like me to study several issues and write several papers instead of writing one major thesis. Since 2014, I have completed all the tasks to achieve my Professional Doctorate academic outputs as described in the next chapter.

1.7 Structure of the Thesis

The thesis is structured into six chapters, as follows:

Chapter 1 of the thesis is the introduction. This chapter provides background on the PBL study, and the challenges and opportunities involved in developing the study. The aim is to provide context for the doctoral study.

Chapter 2 is the methodology chapter, and outlines and describes the key steps I have taken to produce the body of work comprising the Doctor of Education outputs.

Chapters 3–5 are mostly a presentation of published works. Chapter 3 provides the background and literature review on the challenges and opportunities in implementing the new PNG Health Gender Policy, including other related literatures on gender-based violence prevention.

Chapter 4 presents a case study on the effectiveness of the uptake and implementation of the Aboriginal Australian FWB empowerment program in the context of public health training at UPNG, while Chapter 5 explores the feasibility of transferring the Aboriginal FWB empowerment program from the UPNG setting to the community setting.

Chapter 6 is the final chapter, and discusses the key findings in the context of the relevant literature and the conclusions, recommendations and areas for future research and support.

Chapter 2: Methodology

2.1 Introduction

This chapter outlines and describes key steps I have taken to produce the body of work comprising the Doctor of Education outputs. This methodology chapter is different from a conventional PhD methodology chapter, for two main reasons.

First, each of the doctoral outputs reported in Chapters 3–5 of the thesis have already been published and therefore represent stand-alone pieces of work with their own detailed methods including data analysis sections. This makes this study a Professional Doctor of Education by publication. Hence, the purpose of this methodology chapter is to develop an understanding of the theories and world views that have informed my approach to the overall study, explain the broad steps that I took to achieve the research skills development goals I set myself and how these enabled me to then produce each of the academic outputs presented in the thesis, rather than the specific research methods and analytic techniques applied.

The second reason is to share with my colleagues that are planning to do similar professional doctorates the broad steps that they might take to achieve their professional development goals. Therefore, I deliberately approach this methodology chapter with my UPNG colleagues in mind by trying to explain, in a step-by-step fashion, the main learning activities I underwent to produce each of the academic outputs and the challenges and opportunities involved. This way, those embarking on similar journeys can learn from my experience and be better informed.

The chapter is divided into four main sections including this introduction. The next section describes the actual steps I took to identify my professional skills development needs described in the previous chapter, while the third section focuses on issues relating to my world view and how this has influenced the methods and analytic techniques applied in the study. The fourth section provides an overview of the main components of the doctoral study in the form of a logic model, including the specific skills development goals and the pathways through which they have been achieved and the evidence of achievement. A final section highlights the key Doctor of Education

milestones, including securing institutional ethics approval for the study, the confirmation seminar, the midterm candidature review and the exit seminar.

2.2 Applying the PBL Approach to my Doctoral Study Journey

Achieving the professional development goals I set myself has been like embarking on a long journey during which I was sometimes not sure when it would end or where it would take me. On numerous occasions, I questioned whether the journey was the right one and whether there was really a light at the end of the tunnel. An important part of the methodological journey is the process of developing conceptual and practical research skills and competencies to undertake the study. What are my research skills development needs and how do I prioritise them? How do I develop a research proposal? How do I conduct thematic analysis? How do I determine a sample size? How do I write an abstract to a paper? How do I write a discussion section of a paper? How do I write a newsletter article? How do I prepare a power point presentation? As someone who has been on a steep learning curve, grasping these and other research skills and techniques has not been easy.

Given the professional development focus of my study, my primary supervisor encouraged me from the outset to apply the UPNG PBL approach, with which I am familiar, to my own doctoral study. This would enable me to view the process as one in which as a student I take the lead in learning-by-doing with guidance and support from my advisors as co-learners. The approach evolved into a simple but effective formula starting with a brainstorm; for example, ‘what is thematic analysis?’ or ‘how to write an abstract?’ Next, I googled and, to my surprise, on any given topic, there were so many ‘how to do it steps’ in peer-reviewed journal papers, books and reports, from which I could develop draft steps and techniques for undertaking the specific task. I then discussed these draft steps and techniques first with my primary advisor and, after incorporating his initial feedback, circulated the work to other advisors for feedback. Once I secured agreement on how to approach the task, I was ready to start. Using the agreed steps, I undertook the relevant activities for producing the draft of the research output; for example, an abstract or literature review, whichever the case may be. Again, I sent the initial draft to my primary supervisor for feedback before circulating to the rest of the team. This to-and-fro process between my advisors and myself of drafting and refining versions of the relevant research outputs sometimes involved nearly a

dozen iterations before the material was finalised. With my advisors' encouragement, I kept diaries in which I tried to write about every two weeks, reflecting on the learning activities, aspects that worked, things that I needed to change and the lessons I had learnt and how to use them to inform future activities.

2.3 Research Skills Development Goals

I have already described the professional skills development goals I set myself in the previous chapter. The purpose of this brief section is to explain how I actually applied the PBL approach described above in identifying and prioritising my professional development needs. Once I decided to do the professional doctorate, I had to work out the specific skills I needed to acquire by the end of my study. It was difficult to know which skills were important. My primary advisor in a brainstorm session asked me, 'What skills development questions do your students frequently ask you?' and 'What type of research skills do your student ask you to help them with?' This prompted me to prioritise literature searches and reviews, basic qualitative and quantitative data analysis and academic writing for publication. Acquiring these skills, I believed, would prepare me to perform my role as a public health lecturer more effectively.

2.4 Underpinning Research Paradigm

Once my professional development priorities were clarified, I had to take a step back and reflect on my own social, educational, cultural and spiritual values and experiences and the extent to which these and other world views might inform my approach to the study. During the compulsory education research subject, I learned the important message that research does not occur in a vacuum. In other words, no researcher approaches their topic as an empty vessel. Our beliefs and attitudes, our values, our cultures and our views about the nature of reality all combine to influence the types of research we do and the methods we use. My primary advisor reinforced this understanding and prompted me to reflect deeply on whom I am, my beliefs and attitudes, how these affect the research I have chosen to do, and the steps I will take to ensure the research process is transparent and the results are reliable and trustworthy.

The more I reflected, the more I became aware that, as somebody who came from a modest PNG Manus Island family, what has helped me in life has been my ability to

embrace opportunities as they come my way and the many people who have supported and mentored me along the way. I discovered that I am somebody who has a deep empathy for people and a willingness to help people to help themselves. I discovered that these values came from my PNG cultural upbringing, which is strongly grounded in reciprocity; 'give and take' or '*yu halivim mi, mi halivim yu*'. They also come from my Christian upbringing and compassion to help those in need. Further, my public health training and philosophical approach to teaching and learning using PBL approaches is based on the premise or belief that the best way to help people is to help them in ways that enable them to help themselves. As the saying goes, 'If you give a person a fish, you feed them for a day, but if you teach a person how to fish, you feed the person for the rest of their life' (Chinese proverb). Through this process, the reasons I embraced the Aboriginal FWB empowerment approach after reading the Yabba Bimbi report (McCalman et al. 2005) and talking with Yarrabah men became obvious to me. Empowerment is the capacity for people to take steps with the support of others to achieve greater control and responsibility over their own affairs (Rissel 1994; Wallerstein 1992, 2006). Although there has been much discussion on empowerment in PNG in government and NGO policies and programs (Papua New Guinea National Strategic Plan Taskforce 2010; Government of Papua New Guinea Development – Partners Gender Forum 2012; GoPNG DFCD 2011; Rissel 1994), like my colleagues before me have found in the context of Aboriginal development in Australia (Tsey & Every 2000), it is hard to find well-evaluated empowerment programs and services in the context of PNG. Yet empowerment as a framework has the potential to help people in PNG address many challenges, not least in promoting health and wellbeing issues. Going through this brainstorming exercise convinced me that researching the feasibility of the Aboriginal FWB empowerment program in PNG is not only necessary but its empowerment focus appeals to my professional, cultural and religious values.

Having developed awareness and understanding of my beliefs and attitudes about the nature of reality and how these influence approaches to research, my primary supervisor directed me to the relevant texts with sets of questions to guide my reading. Specifically, he asked me to read and answer using my own words questions such as 'What is a world view?', 'What is a research paradigm?' and 'What is mixed methods?', and to explain how these relate to my study.

The literature confirmed and further clarified my emerging understanding of a world view as the ways in which we as researchers perceive the world based on our cultural, religious and socio-political values, belief systems and experiences and how these affect the topics we chose to research and the methods we use. Creswell (2013) used Guba's (1990, p. 17) definition of world view as basically 'a basic set of beliefs that guide action'; other writers define it as 'paradigms' (Lincoln, Lynham & Guba 2011; Mertens 2010), 'epistemologies and ontologies' (Crotty 1998), and 'research methodologies' (Neuman 2009). While different terms are used in this context, they all refer to similar things.

Given my interest in empowerment and helping people to help themselves, I found the transformational world view (Slife & Williams 1995 cited in Creswell 2013) appropriate as an underpinning paradigm for my study. The bottom line, transformational researchers argue, is that research must 'be a voice' for the less powerful in society (Slife & Williams 1995 cited in Creswell 2013). Researchers coming from this world view include critical theorists, participatory action researchers, Marxists, feminists, racial and ethnic minorities, persons with disabilities, indigenous and postcolonial peoples and members of the lesbian, gay, bisexual, transsexual and queer communities (Slife & Williams 1995 cited in Creswell 2013). Clearly, the empowerment focus of the Aboriginal FWB program and the UPNG PBL approaches to empowering students as co-learners with their teachers and the people and communities with whom they work sit comfortably within the transformational world view.

My research is also informed by the pragmatic world view (Creswell 2013), which refers to those researchers who are concerned about people's health and wellbeing and the use of qualitative and quantitative research or any type of research methodology to make a difference and improve people's lives. To address issues and solve problems, they take a pragmatic (practical) approach, choosing research methods, techniques and procedures as long as these work and help to achieve their goals and purpose (Creswell 2013). The pragmatic world view allowed me to apply a mixed methods approach to achieve my identified skills development needs to better support my students and colleagues. Mixed methods often combine qualitative and quantitative methods in a study design (Creswell 2013). In my study, I used convergent parallel mixed methods (Creswell 2013) in the sense that both qualitative and quantitative data were collected at about the same time to assess the process of the FWB delivery and the impact on the

participants. I also found auto ethnography as a research methodology highly relevant in this study. According to Ellis, Adams and Bochner (2011, p. 273), auto ethnography is 'an approach to research and writing that seeks to describe and systematically analyse personal experience to understand cultural experience'. It combines elements of the researcher's own experience and the science of analysing and describing peoples and cultures in conducting and writing up research findings (Ellis et al. 2011), usually using the first person 'I'. As a method, auto ethnography is therefore both a process and an outcome (Ellis et al. 2011). My interest in critically reflecting on my own professional development journey to better support colleagues in similar situations makes auto ethnography an appropriate research method. Hence, I have written significant sections of this doctoral study in the first person.

To summarise, informed by a combination of the transformational and pragmatic world views as well as auto ethnography, I was determined from the outset that the research outputs I produced in the process of achieving my professional doctorate goals should not just be for my own benefit alone; rather, they should have practical value for my students, colleagues and the communities with whom I work. This commitment influenced the projects I elected to pursue to achieve the skills development goals I set myself as outlined in the next section of this chapter.

2.5 Main Components of the Doctor of Education Study

Table 2-1 provides a broad overview of the main components of the Doctor of Education in the form of a logic model designed to explain my specific skills development needs, the research activity undertaken to address these needs, and the evidence on achieving the expected outcome. These included a literature review (Study 1), FWB evaluation in the context of UPNG public health training (Study 2) and feasibility of transferring the FWB program from a university to a community setting (Study 3). Underpinning these substantive studies are sets of mandatory course work and professional development courses as well as my efforts to develop capacity to write and disseminate information for different audiences including publishing in peer-reviewed journals.

2.5.1 Study 1 – Literature review

The first substantive skills development need is the capacity to undertake a literature review. My task was to conduct and publish a literature review. I used two main strategies to develop literature search and review skills. The first was one-to-one discussions with my advisors, who explained to me the key steps in doing literature scoping and reviews, the different types of reviews such as systematic literature reviews and narrative reviews and their advantages and disadvantages. They then gave me examples of different types of reviews conducted by their research teams including PhD students' theses, which I read to learn the key steps.

At about the same time I started developing an understanding of how to undertake a literature review, the PNG Minister of Health launched the new PNG Health Gender Policy (PNG Department of Health 2014). There was a role for universities to work with the Department of Health and other stakeholders to network and build partnerships via regular dialogue and participation to implement the policy. Specifically, the policy required universities to integrate gender equity into their curricula, and I was invited to sit on the gender curriculum committee. I attended several workshops and meetings in Madang and Port Moresby to write up the new curriculum and develop monitoring and evaluation tools.

Through these workshops and meetings, it became obvious to me that a systematic analysis and review that teased out the key strengths and limitations of the new health gender policy was highly relevant for the different agencies responsible for implementing the policy. Hence, I decided to focus my literature review on interpersonal violence, with a specific focus on health gender policy to both inform my study and serve as a resource for those tasked with implementing the policy.

I spent at least six months conducting a literature search and increasing my skills by reviewing the newly launched PNG Health Gender Policy. Although it took a long time, the tasks undertaken provided an opportunity for me to learn the basic skills from my advisors through support and supervision. They guided me to use thematic analysis to review and highlight the challenges and opportunities of implementing the new PNG Health Gender Policy as well as drawing on the broader literature to recommend strategies to overcome the potential pitfalls.

The main outcome was the sole author 2015 publication 'Implementing the new PNG Health Gender Policy: Challenges and opportunities', *International Review of Social Sciences and Humanities,* Vol. 9, No. 1, pp. 23–32 (retrievable from http://irssh.com/yahoo_site_admin/assets/docs/3_IRSSH-1017-V9N1.115110857.pdf). I presented the findings in Goroka, Eastern Highlands province, at the PNG Association of Public Health Specialty Meeting and Medical Symposium, the Port Moresby Science Conference as well as to the curriculum committee, with positive response.

2.5.2 Study 2 – Piloting of the FWB program in public health training at UPNG

As explained in the previous chapter, between 2009 and 2011, the JCU empowerment research team collaborated with me and my UPNG public health colleagues by piloting the Aboriginal FWB empowerment program in the context of public health training (Kitau et al. 2011; McCalman, Tsey, Kitau, & McGinty 2012). The aim of this pilot was to determine FWB's acceptability and appropriateness as a health promotion subject in the context of UPNG public health training. FWB was enthusiastically received, and qualitative course evaluations demonstrated the relevance of the approach to many of the social and health problems confronting PNG, including gender equity and interpersonal violence (McCalman, Tsey, Kitau, & McGinty 2012). In response to the positive feedback from students, the program was incorporated as a subject within the DPH course that I taught over 2011–2013. I used evaluation data collected during these deliveries as an opportunity to develop my qualitative and quantitative skills by analysing and publishing the data. For the quantitative data, I learned how to use Microsoft Excel software to analyse data. I also learned how to calculate effect size (Cohen 1992). Similarly, for the analysis of the qualitative data, l worked online with my co-advisor at La Trobe University using the six basic steps by Braun and Clarke (2006) for conducting thematic analysis. The main outcome is the following co-authored mixed methods publication: Kitau, Kinchin, Whiteside, Hane-Nou & Tsey 2016, 'Effectiveness of the uptake and implementation of the Aboriginal Australian FWB empowerment program in the context of public health training in PNG', *Pacific Journal of Medical Science*, vol. 16, no. 2, pp. 16–34.

2.5.3 Study 3 – Transferring the FWB program from university to community setting

Finally, in Study 3, I explored the feasibility of transferring the Australian FWB program from the UPNG public health training context to a community setting as an interpersonal violence prevention strategy. The skills I had acquired from the two previous publications enhanced my confidence and excitement, resulting in another co-authored mixed methods publication: Kitau, Whiteside, Kinchin, Hane-Nou & Tsey 2017, 'Transferring the Aboriginal Australian Family Wellbeing Empowerment Program from a Papua New Guinea university context to broader community settings: a feasibility study', *Pacific Journal of Medical Sciences*, vol. 17, no. 1, pp. 22–37.

2.6 Underpinning Course Work and Skills Training

Underpinning the Doctor of Education degree requirements are a set of compulsory course work and professional development skills training designed to enhance students' capacity and preparedness for the doctoral study. The coursework and professional skills development components of the Doctor of Education helped me gain skills to support the research activities and outputs submitted in my portfolio of work. The Introduction to Educational Research (JCU 2015b), for example, is an online course on the LearnJCU website. I completed eight modules: Module 1: Introduction to Educational and Social Research; Module 2: Tools You Need (EndNote Ref. APA6); Module 3: Reviewing the Published Literature and Discussion Board Readings; Module 4: Research Design – Explore principles of research design (this module included situating my research, identifying the research context and problem, formulating the research questions, approach and methods, and research methodology); Module 5: Choosing My Research Approach (on the strengths of qualitative and quantitative and mixed methods approaches to social research and data analysis); Module 6: Making Sense of Data – 'Data Driven World' (collecting, analysing and using data within educational and other institutions); Module 7: The Ethics of Education and Social Research – Ethics module; and Module 8: Contemporary Practices in Education and Social Research (which included researching via email and social media, using narrative methodologies, exploring auto ethnography, considering anthropocene using a classical research approach (JCU 2015a). My final assessment result was 75% (JCU 2015b).

Other professional development courses included (1) Intellectual Property & Copyright (19 October 2014 & 16 March 2015), (2) Data Storage & Management (10 October 2014 & 11 March 2015), (3) Effective Candidature Management (10 October 2014 & 11 March 2015), (4) Introduction to Professional Writing & Editing (11 March 2015), (5) Plagiarism & Safe Assign (8 October 2014 & 10 March 2015), (6) Research Integrity (8 October 2014 & 10 March 2015), (7) Preparing for Confirmation of Candidature (10 March 2015), and (8) HDR Induction Day (10 March 2015) (JCU 2015, 2017).

Table 2-1: Doctor of Education Logic

Professional development learning needs	Associated learning tasks	Associated approaches, methods and tools	Evidence of completed tasks
<u>Literature search and review skills</u>			
Learn how to conduct a literature search and undertake a literature review	To undertake a purposeful literature review of the effectiveness of PNG gender-based violence prevention policies and programs	Purposeful literature searches and review	Kitau 2015, 'Implementing the new PNG Health Gender Policy: Challenges and opportunities', *International Review of Social Sciences and Humanities*, vol. 9, no. 1, pp. 23–32, viewed 17 August 2015, <https://researchonline.jcu.edu.au/38747/1/Implementing_the_new_PNG_NHGP.pdf>.
<u>Qualitative data analysis skills</u>			
Learn how to conduct qualitative data analysis	a) To review and describe the challenges and opportunities of implementing the new PNG Health Gender Policy, especially the proposed health gender curriculum b) To survey and analyse responses on uptake and implementation of the Aboriginal Australian (FWB) program as a public health training by the PNG partners at the (UPNG) c) To identify key themes related to the	Thematic analysis	1. Kitau, Kinchin, Whiteside, Hane-Nou & Tsey, 2016, 'Effectiveness of the uptake and implementation of the Aboriginal Australian FWB empowerment program in the context of public health training in PNG', *The Pacific Journal of Medical Science*, vol. 16, no. 2, pp. 16–34, viewed 7 December 2017, <http://www.pacjmedsci.com/R%20Kitau%20et%20al%20PJMS_Vol_16_No2_%20Nov_2016_16-34.pdf>. 2. Kitau, Whiteside, Kinchin, Hane-Nou & Tsey 2017, 'Transferring the Aboriginal Australian Family Wellbeing Empowerment Program from a Papua New Guinea university context to broader community settings: A feasibility study', *Pacific Journal of Medical Studies*, vol. 17, no. 1, pp. 22–37, viewed 7 December 2017, <http://www.pacjmedsci.com/R%20Kitau%20et%20al%20PJMS_Vol_16_No2_%20Nov_2016_16-34.pdf>.

	feasibility of transferring the FWB program from a PNG tertiary setting to broader community contexts to address the problem of endemic interpersonal violence and to generate pilot data to inform future community wellbeing interventions in PNG		
Quantitative data analysis skills			
Learn how to conduct quantitative data analysis	a) To determine the effectiveness of the Aboriginal Australian FWB program uptake and implementation as a public health training by PNG partners at the (UPNG) using a set of pre-post Likert scale surveys b) To assess the feasibility of transferring the FWB program from a PNG tertiary setting to broader community contexts using a set of pre-post Likert scale surveys	Survey pre-post data analysis using Excel	1. Kitau, Kinchin, Whiteside, Hane-Nou & Tsey 2016, 'Effectiveness of the uptake and implementation of the Aboriginal Australian FWB empowerment program in the context of public health training in PNG', *The Pacific Journal of Medical Science*, vol. 16, no. 2, pp. 16–34, viewed 7 December 2017, <http://www.pacjmedsci.com/R%20Kitau%20et%20al%20PJMS_Vol_16_No2_%20Nov_2016_16-34.pdf>. 2. Kitau, Whiteside, Kinchin, Hane-Nou & Tsey, 2017, 'Transferring the Aboriginal Australian Family Wellbeing Empowerment Program from a Papua New Guinea university context to broader community settings: A feasibility study', *Pacific Journal of Medical Studies*, vol. 17, no. 1, pp. 22–37, viewed 7 December 2017, <http://www.pacjmedsci.com/R%20Kitau%20et%20al%20PJMS_Vol_16_No2_%20Nov_2016_16-34.pdf>.
Academic writing for peer-reviewed journals			
Learn how to write an academic	a. To work with advisors to write, edit and proofread a paper before	Academic writing, self-editing and	1. Kitau 2015, 'Implementing the new PNG Health Gender Policy: Challenges and opportunities', *International Review of Social Sciences and Humanities*, vol. 9, no. 1, pp. 23–32, viewed 17 August 2015, <https://researchonline.jcu.edu.au/38747/1/Implementing_the_new_PNG_NHGP.pdf>.

paper for a peer-reviewed journal	submitting for publication b. To identify and select a suitable international journal to publish the monograph	proofreading of manuscript	2. Kitau, Kinchin, Whiteside, Hane-Nou & Tsey 2016, 'Effectiveness of the uptake and implementation of the Aboriginal Australian FWB empowerment program in the context of public health training in PNG', *The Pacific Journal of Medical Science*, vol. 16, no. 2, pp. 16–34, viewed 7 December 2017, <http://www.pacjmedsci.com/R%20Kitau%20et%20al%20PJMS_Vol_16_No2_%20Nov_2016_16-34.pdf>. 3. Kitau, Whiteside, Kinchin, Hane-Nou & Tsey 2017, 'Transferring the Aboriginal Australian Family Wellbeing Empowerment Program from a Papua New Guinea university context to broader community settings: A feasibility study', *Pacific Journal of Medical Studies*, vol. 17, no. 1, pp. 22–37, viewed 7 December 2017, <http://www.pacjmedsci.com/R%20Kitau%20et%20al%20PJMS_Vol_16_No2_%20Nov_2016_16-34.pdf>.
<u>User-friendly knowledge sharing</u>			
Learn how to best disseminate and share the knowledge gained	1. Share experience and knowledge as a way of engaging and supporting colleagues to develop their own professional development goals 2. Present paper in the Symposium and Conference in PNG and Australia	Critical reflective analysis Conference and other presentations	1. Kitau 2017b, 'My simple story: How FWB came to PNG', *National Centre for FWB (NCFWB) Newsletter*, April, no. 3, pp. 15–16, viewed 7 December 2017, <http://www.cairnsinstitute.jcu.edu.au/fwb-newsletter/>. 2. Kitau 2017a, 'My quest – Completing the Doctor of Education by end of 2017', *Cairns Institute Newsletter,* April, pp. 4–5. Newsletter stories at UPNG and NDH (PNG) 1. Kitau 2017, My simple story – How FWB came to PNG, to be published in the NDH/UPNG Newsletter, PNG. 2. Kitau, R 2017, My quest – Completing the Doctor of Education by end of 2017, to be published in the UPNG/NDH Newsletter, PNG. List of all conferences and other presentations I have done: 1. Presented the Gender Paper at the Annual Medical Symposium PNG APH Specialty Meeting in September 2014, Goroka, Eastern Highlands Province, PNG (Kitau 2014a). 2. Presented the Gender Paper at the Science Conference in November 2014 at UPNG, Port Moresby, PNG (Kitau 2014b) 3. Presented the Student Paper at the Inaugural Australian Mental Health Conference in July 2017, JCU Townsville (Kitau et al. 2017c) 4.Presented the Community Paper at the PNG Update Conference in August 2017, at UPNG (Kitau et al. 2017d) 5. Presented the Community Paper at the PNG Annual Medical Symposium in September 2017, at Stanley Hotel, Port Moresby (Kitau et al. 2017e) 6. Presented the Community Paper at the JCU/UPNG Impact Conference in December 2017, UPNG, Port Moresby (Kitau et al. 2017f)

7. Presented the 'Roller-Coaster' Paper at the PNG Update Conference in June 2018, UPNG, Port Moresby (Kitau 2018g)

Other Doctor of Education coursework – Online course JCU – Introduction to Educational Research

Professional Development Course

Intellectual Property & Copyright - 19/10/14 & 16/03/15 - Preparing for Confirmation of Candidature – 08/10/15 & 10/03/15

Data Storage & Management - 10/10/14 & 11/03/15 - HDR Induction Day (10/03/15)

Effective Candidature Management - 10/10/14 & 11/03/15 - Research Integrity- 08/10/14 & 10/03/15

Introduction to Professional Writing & Editing (11/03/15)

Plagiarism & Safe Assign - 08/10/14 & 10/03/15

2.7 Doctoral Study Milestones

An important part of the doctoral journey is to articulate critical milestones designed to keep students on track. Once enrolled as a student, I had to develop ethics applications for both the JCU Ethics Committee and UPNG Ethics Committee since the study was undertaken under the JCU–UPNG co-tutelage arrangement. These were approved promptly because I was basing the research on existing PBL teaching and learning data. Since I did not have to collect any new data and the existing data were collected under a previous JCU Ethics Approval (JCU Ethics Committee approval H3532: 2009), there were no major ethical issues for the research. Hence, approval was prompt (JCU Ethical Approval Number H6217, 23 June 2015; UPNG Ethical Clearance for Mr Russel Kitau, letter from Professor Subba-Rao, Pro-VC ASA, 21 October 2015).

The next important milestone was the confirmation seminar, which I passed in August 2015. Although the review of the health gender policy was the only publication I had achieved by the time of the confirmation seminar, the chair of the panel, Professor Brian Lewthwaite, commented that the doctoral research plan I presented in the logic model was one of the best he had seen and accordingly sought my permission to use it as exemplar for new Doctor of Education students. Such feedback from a leading education expert, combined with positive responses to presentations of the health gender policy review to colleagues in PNG, re-assured me that I was on the right track. Achievement of these milestones was facilitated by a La Trobe University $10,000 seed funding grant for this research, which supported my stay in Cairns for the first 12 months of the study, to write up the work. By the time I passed the confirmation seminar, the funding had run out and I had to return to UPNG to complete the rest of the doctoral deliverables, with on-site support from Dr Goru and email and intermittent visits for intensive supervision in Cairns.

Despite the obvious challenges of distance supervision, which clearly affected my progress, by the time of the mid-candidature review in October 2016, I had published the second paper, and so I did not have to present a seminar to the review panel. However, the panel identified gaps in my compulsory professional development, which required me to return to the JCU Cairns campus for six months in 2017 to attend the

outstanding face-to-face training sessions as well as complete the doctoral deliverables outlined in the study plan.

2.8 Summary

In summary, the professional doctorate journey is best described as a roller-coaster with concomitant high and low moments. As I had left my family at home and had limited resources to support my stay in Cairns, I was keen to finish the study as early as possible. Over time, I learned that there are no easy ways or short cuts to achieving professional development goals. I learned from my advisors and many others that patience and hard work are the only way to become a competent researcher. I found the application of the PBL approach to my own study in the forms of brainstorming, literature searches, coming up with steps as a guide to undertaking a given activity, the to-and-fro feedback and diary documentation of lessons learned for the future very useful in reminding me of the slow but incremental progress I was making throughout the course of the study.

Overview of Chapters 3, 4 and 5

Chapters 3, 4 and 5 provide publications accomplished as part of demonstrating my research output in relation to the achievement of my professional goals. The publication of these papers offers significant evidence of key tenets progressing the notion of empowerment in the community. For them to be accepted for publication in international journals highlights a central element of a desire to demonstrate that writing for different audiences is an integral part of the learning process to disseminate research findings and outputs. Their inclusion in this study is pivotal to a key part of a major signpost: to embed the process of research to inform practice as well as enhance its relationship to my professional trainer/trainee journey.

Chapter 3: Policy Review

3.1 Introduction

The following article was published in the *International Journal of Humanity and Social Science* (IJHSS). IJHSS is an open access peer-reviewed journal published by the Centre for Promoting Ideas in the US. The main objective of IJHSS is to provide an intellectual platform for international scholars. The journal has an impact factor of 0.22.

The paper was originally submitted and received by IJHSS on 13 September 2014. After review, it was revised and resubmitted on the 15 January 2015, and finally accepted and published in July 2015. It was deposited in Research Online @ JCU ISSN 2248-9010 on 13 July 2015.

The focus of the paper is a systematic scoping review of gender policies and programs in PNG. I conducted and published this paper to meet two specific goals regarding my Doctor of Education study. One is to demonstrate my capacity to undertake systematic literature searching and reviewing as described in Chapter 2. The other is to make a contribution to the development of gender-based curricula across universities in PNG. At the time I was learning to undertake systematic literature searching and reviewing, a new PNG Health Gender Policy (2014) was launched by the PNG government. The policy specifically required all university health courses to embed gender into their curricula. Hence, I conducted the scoping review of gender policies and programs to inform the work of the National Health Gender Curriculum Committee, of which I was a member.

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Implementing the New Papua New Guinea National Health Gender Policy - Some Challenges and Opportunities

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Abstract

Gender- Based Violence (GBV) is a major issue world-wide. Within last two decadesmany resources were invested into ending it in Papua New Guinea. In 2015, which incidentally coincides with the end of the Millennium Development Goals, PNG must reflect on and learn from the past in striving towards achieving gender equality. The purpose of this paperis to review the new National Health Gender Policy in the context of previous attempts by the governments and development partners to tackle gender inequality and gender violence. The aim was to highlight potential lessons which need to be taken into account to ensure successful implementation of the policy. The study was performed by conducting asummary of previous attempts to implement gender policies and programs in Papua New Guinea since Independence in 1975 was provided. This was followed by a review of the new National Health Gender Policy (2014) to identify challenges and opportunities in implementing the new policy. The opportunity to use evidence-based approach to provide practical guidance to all key stakeholders to translate the new policy into action is highlighted.

Keywords: Gender, health, policy, implementation, challenges, opportunities, behaviour, change.

Background

Gender Based Violence (GBV) is a major issue worldwide (WHO, 2005). In most countries,including Papua New Guinea (PNG), GBV, is now on the priority policy agenda. Within the last two decades, a lot of time, effort and resources have been invested into developing strategies to reduce GBV in line with two Millennium Development Goals (MDG), being MDG3 (promoting gender equality) and MDG6 (*Combating HIV/AIDS malaria and other diseases*). But time is running out. The deadline for achieving these MDGs is 2015 (which is less than 500 days away). Recent reports show that, some countries have done well, whilst others haven't (Pacific Islands Forum Report, 2011). Is Papua New Guinea on track? If yes, then there is a reason to celebrate, if not, then, it is time to critically assess some of these strategies and use this opportunity to make some changes for the next ten years.

Reports by WHO (2007) and UNAIDS (2010) concluded that violence against women by intimate partners and others and sexual abuse of children are both common in PNG, and that

these acts increase the risk of HIV transmission. Similarly, Bradley (2011) reported that violence against women in PNG is a barrier to the achievement of the MDGs. Furthermore, the lack of data and agreed methods and standards for measuring its various forms prevented the inclusion of an indicator of violence against women for the MDG3 target (Bradley, 2011). Bradley (2012) found that there was "very little cause for optimism that PNG will be able to meet the targets of MDG3 and MDG6 by the 2015 deadline." These reports strongly suggest that PNG is unlikely to achieve its MDG goals.

In 2014, the PNG National Department of Health (NDH) launched the National Health Gender Policy (NHGP), which aimed to help the country achieve its gender policy objectives. The new policy states: "Today, the policy environment in gender and health is ripe. The health sector provides opportunities for integrating a gender perspective both organizationally within the NDH and in health sector policies and plans" (PNG NHGP, 2014). While the policy environment may be ripe, the greatest challenge lies in implementing and evaluating such policies.

This paper reviews the new PNG NHGP within the context of previous attempts to develop and implement gender policy initiatives. The aim is to help those responsible for implementing the new policy to avoid repeating mistakes of the past. The paper is structured into four sections. Section one provides background on PNG and the place of gender in its independent constitution, while section two outlines previous attempts to implement gender policies. Section three reviews the new NDH Gender Policy, including its strengths and limitations. Section four highlights the importance of grounding the implementation of the NHGP in research and other experiential evidence, to avoid the pitfalls of previous attempts to foster gender equality in PNG.

Methods

Summary of previous attempts to implement gender policies and programs in PNG since Independence was provided. This was followed by a review of the new PNG National Health Gender Policy (2014) to identify challenges and opportunities in implementing the new policy. A draft review was presented to Health Policy makers at the PNG Association of Public Health Specialty Meeting in September 2014 in Goroka and feedback incorporated into the review.

PNG is an ethnically and culturally diverse country, with more than one thousand tribes and848 known languages/dialects being spoken. Each tribe or language group was highlyindependent, with little sense of national identity. Decades of colonial rule over disparategroups culminated in an independent PNG nation in 1975. As PNG celebrates its 40thanniversary of independence in 2015, which incidentally coincides with the end of the MDGs, it must reflect on and learn from the past in striving towards achieving gender equality.

The PNG Constitution has clear objectives to achieve integral human development, equality and participation, including gender equality (reference). The Constitution also promotes gender equality through its basic rights provisions, which include rights to freedom and life, as well as freedom from inhumane treatment. The PNG Constitution is the mother law and all other laws and policies enacted to support gender equality are consistent with it. The Constitution is also linked to several international laws, agreements and conventions, including key United Nations international human rights treaties and international legal instruments on gender equality and women's rights. These include:

- The Convention on the Elimination of All Forms of Racial Discrimination (1982).
- The Convention on the Rights of Children (CRC) (1993).

- The Convention on the Elimination of All Forms of Discrimination Against Women (1995).
- Millennium Development Goals (2000).
- The Revised Pacific Platform for Action on Advancement of Women and Gender Equality(2005-2010).
- The Commonwealth Plan of Action on Advancement of Women and Gender Equality(2005-2015).
- International Covenant on Economic Social and Cultural Rights (2008).
- Optional Protocol to the Convention on the Elimination of All Forms of Discriminationagainst Women (2000).
- Beijing Platform for Action (1995).
- Equal Remuneration Convention (1951).
- Discrimination (Employment and Occupation) Convention (1960).
- Convention on the Rights of Person with Disabilities (CRPD) (2012).

In response to the international commitments, the governments of PNG of all political persuasions have formulated national strategies to address gender issues. Some of these strategies are reflected in current policies, including the PNG Vision 2050, the PNG Development Strategic Plan 2012-2030, the National Health Plan 2011-2020, the National Policy for Women and Gender Equality 2011-2015, and the Gender Equity and Social Inclusion Policy 2013.

In 1980, the Department of the Prime Minister developed Vision 2050, in accordance with the National Goals and Directive Principles (NGDP). The concepts and strategic direction of Vision 2050were rigorously tested during a three-month comprehensive nationwide consultation program in the 89 districts. Papua New Guinean children, adolescents and adults were all asked to contribute to its development. The people's response was overwhelming, as men, women and children came forward to describe their hopes for PNG's future. Vision 2050 is based on the dreams and aspirations of the many Papua New Guineans who yearn to live in a country where all people are given a fair go in life. Vision 2050 is truly the people's vision.

In line with Vision 2050, the Department of National Planning and Monitoring developed the PNG Development Strategic Plan 2012-2030, which aims to deliver high quality of life for all Papua New Guineans. The broad objectives are guided by the directives and goals of theNational Constitution and the plan describes how PNG can become a prosperous, middle income country by 2030.

Next, the NDH developed the PNG National Health Plan 2011-2020, within the frame work provided by key GoPNG policy documents and Vision 2050. Its mission recognises theimportance of basic services: "We will be ranked among the top 50 countries in the UN Human Development Index by 2050, creating opportunities for personal and national advancement through economic growth, smart innovative ideas, quality service and ensuring a fair and equitable distribution of benefits in a safe and secure environment for all citizens."

The PNG Development Strategic Plan (PNG DSP) 2010–2030, developed by the Department of National Planning and Monitoring (DNPM) is also guided by Vision 2050. The DSP links theprinciples and focus areas of Vision 2050 and provides policy direction and sector interventions with clear objectives, quantitative targets, and baseline indicators. Both documents emphasise that long-term planning needs to be embraced to ensure fundamental improvements in service delivery.

The vision of the National Health Plan is for PNG to be a healthy and prosperous nation that upholds human rights and Christian/traditional values and ensures affordable, accessible,

equitable and quality health services for all citizens. The goal is to strengthen primary health care for all and improve service delivery for the rural majority and urban disadvantaged. The mission is to improve, transform and provide quality health services through innovative approaches, by supporting primary health care, health system development and good governance at all levels.

The NDH has also shown leadership in issues relating to gender and sex through the National Gender Policy and Plan on HIV and AIDS (NACS). This policy takes on responsibilities from the National AIDS Council Secretariat (NACS) for HIV and AIDS issues and has a strong focus on GBV. Other policies and guidelines have also been developed to complement this. Several trainings and workshops on gender and awareness activities have been conducted to sensitize health professionals to the role of gender and sex in health (as UNFPA and WHO gender mainstreaming for health managers).

Results

By far, the most extensive initiatives are the National Policy for Women and Gender Equality 2011-2015 (NPWGE) and the Gender Equity and Social Inclusion Policy 2013 (GESIP). The NPWGE was developed and is coordinated by the Department for Community Development. The policy outlines strategies for increasing advocacy against violence towards women and girls and providing services to affected victims. It also focuses on capacity building, by developing research and legislation to better address GBV issues. It defines gender equality as when the roles of women and men are valued equally. The definition has three aspects: equal opportunities, equal treatment and equal entitlements. As the policy explains, gender equality benefits everybody in terms of overcoming stereotypes, prejudices, and other barriers, so that women and men can contribute to and benefit from economic, social, cultural, and political developments in society at the same level (NPWGE, 2011).

The GESIP was developed and is coordinated by the Department of Personnel Management in accordance with the Public Service (Management) Act (Year 1995). It encourages all public servants and employees of the public service to "Rise up, step up, speak up" and create working environments that are respectful, courteous, inclusive, collaborative, equitable and productive. The GESIP identifies challenges facing the National Public Service and aims to develop a culture where public service officers and employees feel supported and confident in identifying and disclosing barriers to gender equality. It defines leadership, values and behaviours at individual, team and agency levels and assists agencies with mainstreaming their business processes and systems (egg. recruitment, induction, training, promotion and performance management). The policy also provides directions and guidelines to help transform workplaces and enhance the rights of workers, thus improving levels of health and wellbeing of staff.

Evaluations of all these policies have been conducted, finding that whilst some progress hasbeen made, significant challenges still remain. In 2011-2012, the World Bank conducted thePNG 2011-2012 Country Assessment in several PNG provinces to evaluate the NPWGE and the GESIP. The aim for this evaluation was to identify the gender-related barriers to shared efforts to reduce poverty and to stimulate inclusive development in PNG. The evaluation found persistent and growing gender inequalities across a wide range of health, education, economic and other social indicators.

In the health sector, for example, the evaluation reported a decline in services in rural areas,with women facing greater obstacles than men in terms of access. When women need to travel to health care centres, they face greater security risks and bear greater opportunity costs than men. Gender inequality at home, for example in decision-making and control over resources, also hinders women's health seeking behaviour, causing delays in seeking medical

help for pregnancy and family planning issues. Women's education has evident benefits in terms of health status and access to health services, particularly in rural areas. Improving secondary education for women is therefore critical for improving the health status of women and children.

The evaluation also found that gender relations and gender inequality are significant drivers of the HIV and AIDS epidemic in PNG. Women and girls are more vulnerable to HIV infection and other STIs. Women's lack of power and rights in sexual relations and the high risk of GBV both increase the likelihood of HIV transmission. Fear of violence, abandonment, stigma and discrimination hinder women's willingness to negotiate for safer sex and to seek HIV testing or treatment. The risk factor of transactional sex is linked to income inequality and uneven development, and is associated with male migration for employment in enclaves and women's financial hardship. Lower literacy and education among women reduces their opportunity to learn about prevention of HIV and AIDS.

The report clearly and comprehensively describes the challenges of lack of coordination, management, monitoring and evaluation of the implementation of the policy during 2011-2012, such challenges existing despite there being substantial investment input fromdevelopment partners. Many, if not all of the recommendations made have been incorporated into national and sector policies and proposed initiatives, but they have not been translated into funded programmes of action. Similarly, legislation exists that both upholds women's rights as citizens and protects women from illegal acts, but the justice system does not adequately apply and enforce the law. The consensus recommendation is that more robust attention to funding existing policies and enforcing existing laws would have a significant positive effect on gender equality in PNG.

The purpose of the NHGP is to achieve equality in health status and health development through legislation, policies and programs. The policy also strives to meet the NDH mission to improve primary health care for the rural majority and urban disadvantaged (p 4). The main goal is for policy makers and managers to integrate a strong gender perspective into the health sector and to promote the health and gender equality of the people of PNG in a just and equitable way (p 13). The absence of a health gender policy in previous years means that the health sector is yet to institutionalise planning, budgeting and implementation of gender-sensitized programs across the health system.

The PNG NDH led the process for developing this policy, with assistance from development partners. International conventions and agreements and existing policies in PNG relating tohuman rights, gender and health were reviewed and summarised with current health statistics (p 3). Broad consultation took place between members of the health sector, development partners and external experts. Stake holders who participated in these consultations included the NDH Policy Development Working Committee, NDH Family Health Services Branch, nongovernment organizations (NGOs), UN Agencies and partners. A reviewed version of the strategy was presented at consultative meetings with the support of the WHO Regional Advisor on Gender for final inputs and comments (p 3).

They were guided by six principles (ch 4, p 4-5), being: (1) Development approach; (2) Human Rights-Based Approach; (3) Informed Freedom of Choice; (4) Millennium Development Goals; (5) Gendered approach; and (6) Life course perspective. Brief explanations of each these principles are also stated below. A list of core Government Legislations and Policies relating to gender equality and women's rights was used to support the policy (ch 1, p 1, 6).

The text is clearly written and is easy for policy makers and managers to read and understand. Chapter 1 provides a short summary of the main intent of the policy, the historical context, the audience and the policy development process. It aims to actively promote equality

between women and men. To improve health outcomes, all health care providers must work from a gender perspective, which also includes the implementation of government obligations and relevant human rights conventions. From a historical context, Gender Equality Goals were enshrined in the PNG Constitution at Independence in 1975 (p 2).

There are four key priority areas of the policy, which are described in chapter 3 (p 9-14) asfollows:

(1) Policy 1: Integration of gender in NDH programs (p 9).A total of 4 strategies and 16activities are listed and described to help in developing a focus on gender-basedviolence andimplementing gender sensitive activities. The 4 strategies are: (1) Increaseawareness of the links between human rights (egg. reproductive rights) and gender andawareness of theimportance of gender–sensitive health programming for improvedhealth outcomes amongpolicymakers, providers and beneficiaries; (2) NDH programsare reviewed and revised toinclude a gender perspective; (3) NDH shall work with thehealth sector stakeholders to ensure that programs implement gender-sensitiveactivities according to health area program plans reviewed under SO 3.3.1.2; and (4) Allhealth sector program stake-holders' projectbudgets include funds to explicitly addressgender issues.

(2) Policy 2: NDH gender equitable administrative policies and procedures (p 11).This policy describes the promotion of gender equitable administrative policies and procedures of the NDH managers and health service delivery, using three strategies and 15 activities. The strategies are: (1) NDH to develop human resource policies that are gender sensitive and implemented; (2) NDH administrative policies to mandate a workplace free of sexual harassment and gender-based discrimination; and (3) Gender sensitized policies and procedures are developed.

(3) Policy 3: Equal Access to health information and health services (p 12): Priority Policy 3 promotes the importance of equal access for men/boys and women/girls to health information and health services that are free from discrimination. There are 4 strategies and 15 activities. The strategies are: (1) Enhance women's decision-making role in relation to health seeking practices; (2) Involve women and men in health seeking practices and in supporting their spouses and family members of either sex to seek care and (3) Improve gender integration in health services and right to health; and (4) Increase access to quality health services for all.

(4) Coordination and Partnership on Gender Based Violence (p 14): Priority Policy 4 (ch5, p 16) focuses on strengthening the coordination and partnership between NDH managers, stakeholders and partners by using 2 strategies and 4 activities. The strategies are: (1) Strengthen all existing links with partners and stakeholders and where necessary, develop new partnership ties amongst those holding primary responsibility for prevention of GBV and providing justice to those affected by GBV; and (2) NDoH will work closely with all partners and stakeholders to enhance and promote multidisciplinary approaches to address gender related issues and GBV and enhance effective coordination across the relevant sectors.

In terms of audience, everyone is included, it is for all public health agencies at different levels of the government, training institutions, all relevant partners as well as those accessing health services at all levels. The policy development process was based on broad consultation (p 2) between the health sector and partners, with external experts.

There are several challenges associated with implementation of the NHGP. Firstly, It says very little on the types of indicators that would be used to assess the impact of the policy. In this regard, Bradley's (2011) concerns about a lack of data and agreed methods and standards for measuring violence against women must be taken seriously. Secondly, implementation of the policy depends on properly trained, qualified and competent managers and the need to

adequately train managers who know how to apply information correctly, at the right time and place.

Thirdly, health is a labour-intensive sector and with the current shortage of trained workforce, implementation will be affected. To avoid further crises or overburdening the already overstretched and overworked health workforce, institutions need to increase their numbers of trained health workers to help implement the health gender policy. The implications of the policy on service delivery (p 14) depend on addressing the health workers needs. It should start from within and move out and all managers should take the lead role and be the champions and agents of change by being role models themselves. Fourthly, coordination is a major challenge. It is the fourth Priority Policy objective stated in the policy, but is not specific enough on how it will be done. This is a problem experienced by other sectors.

Discussion and Conclusion

This paper reviewed the new PNG NHGP in the context of previous attempts by the national governments and development partners to tackle gender inequality and violence against women. The aim was to highlight potential lessons that must to be taken into account to ensure successful implementation of the policy. The main lesson is that developing a policy isone thing, but implementing the policy successfully is another. The history of PNG as an independent nation is littered with well-intended gender informed policies, plans, programs and other initiatives. Unfortunately, the problem has been with implementation and evaluation to determine what works for whom and under what circumstances. The main barriers to implementation include: lack of baseline data, poor coordination, lack of expertise, and a cultural mindset among both men and women in PNG that gender is women's business and hence men feel uncomfortable to engage in such discussions.

While the barriers to successful implementation are many, for the sake of brevity, this conclusion highlights only one: the need to take a more robust evidence-based approach togender policy implementation in PNG. Bringing about gender equality involves major cultural changes and dramatic shifts in power relationships between men and women. It involves deep understanding of how new ideas, innovations and cultural changes are spread or disseminated, leading to changes in behaviours, attitudes and beliefs. The process involves not only changing individual mindsets, but also those of groups and communities of people, as well as the systems and institutions. Yet, the policy says very little about the nature of evidence informing the priority strategies and actions. Table 1 provides a summary of the strength of the available evidence regarding the spread of innovations.

The evidence summary highlights three issues, which are relevant to the PNG health gender policy implementation. First, individually, no single dissemination strategy is likely to affect significant cultural and behaviour changes. Second, dissemination approaches need to target individual, group and systems level changes. Third, combinations of dissemination approaches carefully targeted at the multiple levels of change are likely to be more effective. An evidence- based approach can provide practical guidance to all the key stakeholders responsible for translating the new health gender policy into action. For the universities and training institutions which are expected to produce a workforce that is sensitive and committed to gender equity, a useful starting point is to have reliable baseline information on the extent to which the current curricular are gender informed. This could be followed by incorporating appropriate gender-based learning into courses and evaluating its impact on students.

For NGOs facilitating gender workshops across the country, the starting point is perhaps to step back and ask: what are we trying to change, what is the evidence base for our activities, who else is trying to achieve the same objectives, how can we value add to each other and

evaluate the impact or benefits across multiple rather than individual programs? For the national health departmental policy makers charged with the overall responsibility for implementing the policy, the starting point is to collect relevant local, regional and national impact data such as the incidence of gender- based violence, the knowledge, attitudes and practices towards gender-based violence amongst health workforce and students as well as other indicators against which to monitor progress. Equally important is to consider the nature of the evidence underpinning the key elements of the policy and where possible to make changes in light of the strength of the available evidence.

Table 1: Summary of key findings about dissemination approaches examined in this scan

Dissemination approach	**Summary of key finding from the research**
1.Written materials	Written materials may increase awareness but is less likely to motivate behaviour change.
2.Conferences	Conference may spark awareness particularly in early adapters.
3.Social Media	Campaigns have the potential to spread ideas and increase uptake but evidence of longer term impacts is lacking.
4.Change Champions	Change champions of opinion leaders can influence uptake, especially among clinicians.
5.Training	Training can improve the knowledge and skills of participants but the impact depends on the format and may be short term.
6.Train-the – trainers	Train-the-trainers program can help to share skills but may not always improve uptake of new practices if sufficient resources are not dedicated to roll out.
7.Action Research	Action research has the potential to spread practice within wider teams, but the evidence base is lacking.
8.Collaborators	Evidence about the impact of collaborators is mixed. They can help to improve good practice but effects may not disseminate more widely than to those taking part.
9.Networks	Ideas are spread through social professional networks, but the exact mechanisms for this and how to harness networks effectively remain uncertain.

Source: Debra de Silva, Spreading improvement Tips from Empirical Research, Health Foundation inspiring improvement, No. 20, Evidence Centre, United Kingdom, 2014.

List of Abbreviations:

AIDS - Acquired Immune Deficiency Syndrome

GBV - Gender – Based Violence

GESIP - Gender Equity and Social Inclusion Policy 2013 (GESIP)

GoPNG - Government of Papua New Guinea

HIV - Human Immune Virus

MDG - Millennium Development Goal

NACS - National AIDS Council Secretariat

NDH	-	National Department of Health
NGO	-	Non- Government Organizations
NHGP	-	National Health Gender Policy
NHP	-	National Health Plan
NPWGE	-	National Policy for Women and Gender Equality
PNGDSP	-	Papua New Guinea Development Strategic Plan
UNAIDS	-	United Nations AIDS

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3.2 Conclusion

I learned two main lessons through the publication of this paper that helped to inform the next two published papers of this thesis. Although I had previously co-authored several publications, this systematic scoping review is the first paper I published in my own right. This gave me confidence to face the academic challenges associated with doctoral study. However, the experience of publishing this paper also taught me that there are no short cuts to academic writing. In my eagerness to complete the work as quickly as possible to return home to my job and family, I did not pay attention to issues such as referencing and quotations. A wake-up call came when my paper was put through plagiarism-checking software. It became clear to me I was lifting large sections of other people's work without referencing this properly. I learned to respect the rules of academic writing as taught through the professional development Research Skills Program course on Plagiarism and Safe Assign, which I attended, at JCU Cairns, on 8 October 2014.

The other lesson I learned from the scoping review is that PNG is full of policies and programs designed to address gender-related violence and to improve health and wellbeing. However, there is scant evidence on well-evaluated programs and services to show what works for whom and why. Hence, the next two publications in the thesis focused on the implementation and evaluation of the Aboriginal Australian Family Wellbeing program in the contexts of public health teaching and a community setting respectively, to gauge the program's relevance to PNG health and social priorities.

Chapter 4: Effectiveness of the Uptake and Implementation of an Aboriginal Australian Empowerment Program in the Context of Public Health Training in Papua New Guinea

4.1 Introduction

The *Pacific Journal of Medical Science* (PJMS) is widely read by health policy makers, practitioners, researchers and teachers in PNG—the people I seek to influence through my research. As this and the following paper complement one another in their examination of a particular intervention for the context of PNG, I decided to publish them in the same journal.

The paper that follows was submitted to the PJMS on 6 October 2016. Following feedback, it was revised and resubmitted on 21 October 2016. It was then accepted and subsequently published on 20 November 2016. The paper has been cited in at least two papers.

The focus of this paper is to show my capacity to implement an intervention as part of a PBL process, to evaluate the intervention using mixed methods approaches and to conduct quantitative and qualitative data analysis, as set out in Chapter 2. After learning and familiarising myself with basic thematic and statistical analysis, I took the lead in analysing each of the data sets under close supervision and support from my advisors and co-authors.

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EFFECTIVENESS OF THE UPTAKE AND IMPLEMENTATION OF AN ABORIGINAL AUSTRALIAN EMPOWERMENT PROGRAM IN THE CONTEXT OF PUBLIC HEALTH TRAINING IN PAPUA NEW GUINEA

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ABSTRACT:

An initial collaboration between Australian and Papua New Guinea (PNG) researchers established the suitability of the Aboriginal Australian Family Wellbeing empowerment program (FWB) in University of Papua New Guinea (UPNG) public health training. This study seeks to determine the effectiveness of program uptake and implementation by the PNG partners. A total of 30 students in the UPNG participated in 40 hours of FWB. Qualitative workshop evaluations were compared with those of the initial study. Quantitative pre and post surveys measured students' initial and subsequent sense of wellbeing in three areas. Local uptake and implementation were effective: UPNG partners from the initial pilot facilitated the FWB program in their own right and achieved similar results. Students found the FWB content and delivery highly relevant and empowering. They reported enhanced capacity to improve their own wellbeing and help others to do the same. Quantitative results showed minor improvements, or deterioration, in reported wellbeing, arguably because post-intervention data were not collected immediately after training but rather at different times. Despite this, the study highlights the need for appropriate and well-tested quantitative measures and dedicated research funding to improve the evidence-base for social health interventions such as FWB in the PNG context.

Keywords: Empowerment, Family Wellbeing program, interpersonal violence; program transfer; self-reported wellbeing measures; student/military confrontations

INTRODUCTION:

The transfer and implementation of acceptable and effective health services and programs across settings provides an important and potentially cost-effective strategy for promoting health and wellbeing, especially in resource-poor countries [1]. It is important when transferring programs and services from one context to another to monitor and evaluate their acceptability, effectiveness and sustainability over time. This paper builds on a partnership between Australian and Papua New Guinea researchers designed to explore the transfer and implementation of an Aboriginal Australian Family Wellbeing empowerment program to Papua New Guinea (PNG) settings [2,3].

The Family Wellbeing (FWB) program is an evidence-informed group intervention developed by Aboriginal Australians to enhance their collective capacity to negotiate a constantly-changing and uncertain world and the problems associated with being a minority population in their own country [4, 5]. The premise of the program is that there are no easy answers or readymade templates for dealing with complex, so-called 'wicked', problems such as the legacy of colonial dispossession, racism, discrimination, poverty, intergenerational trauma, interpersonal violence and substance abuse. The creators of FWB sought to give people skills that would empower them to build support networks, to self-reflect, to learn to heal from emotional pain and to solve problems using creativity and innovation no matter how difficult or challenging the situation [4,5].

The FWB approach to empowerment has four main components which often occur in parallel rather than sequentially. The first step is to establish the setting. People are brought together in small interactive participant groups and introduced to the premise that as individuals they are responsible for their own wellbeing; that they have the capacity to take control of their lives and make positive changes to improve their day-to-day situation, no matter how dire that may be. The second element involves the creation of a safe space where these ideas can be discussed and developed. This safe space is established through the development of negotiated group agreements and peer-support relationships based on confidentiality, respect, authenticity, empathy, sharing and trust. The third component shows participants, through experiential exercises, how to think and communicate effectively using human qualities such as creativity, innovation, perseverance, empathy, forgiveness, commitment and generosity. The fourth component aims to help participants recognize their own experience and knowledge, their strengths and basic human needs. Change is facilitated through exploring alternative ways of dealing with problems, difficult relationship patterns, violence and abuse, emotion, loss and grief, conflict and crisis. Participants are

also encouraged at this stage to open up and share their fears and their insights with others, to build support networks, practise problem and conflict resolution, identify change objectives and implement and monitor changes. The result of the process is that participants are not only able to exert greater influence and responsibility over their own situations, but they become agents for change in their family, workplace and community [4,5,6, 7].

On becoming aware of the Australian FWB research, researchers from the University of Papua New Guinea (UPNG) invited Australian researchers to participate in a collaborative project to explore the relevance and adaptability of the FWB program to the social, health and political challenges currently facing PNG. UPNG is the premier university for PNG and the Pacific, located in Port Moresby in the National Capital District (NCD). Its mission is to provide quality education, research, and service for nation-building and global advancement towards an innovative and empowered society [8]. Although PNG culture and society differs in many respects from the situation of Aboriginal Australians, the FWB's basic human – needs approach to empowerment was considered to be universal and hence potentially applicable to the "empowered society" vision of the UPNG.

It is believed that skills relating to core public health business such as disease surveillance, management and control tend to be adequately covered. However, public health students in the School of Medicine and Health Sciences (SMHS) UPNG had no access to practical social health tools to enable and empower communities to take greater control and responsibility for building safer and healthier social environments so that individuals can achieve better health and wellbeing. This situation led to interest in the potential of the Australian program to fill the social health gap within the UPNG public health teaching program.

Based on train-the-trainer principles, the Australian team facilitated the introduction of the FWB program to staff and students in post-graduate public health courses at UPNG. There were three separate deliveries between 2009 and 2011 to over 100 [2,3] students with the goal of preparing the PNG partners to facilitate the program in their own right.

FWB was well received, and qualitative course evaluations demonstrated the relevance of the approach to many of the social and health problems confronting PNG, including interpersonal violence [2, 3]. The findings also indicated that the approach was more likely to be sustained when integrated into existing education courses. UPNG saw the relevance of FWB for equipping health professionals to better enable and support family groups, communities and organisations to improve health and wellbeing at local levels, and officially incorporated the program as a core subject within its public health training [3].

Since 2012, some of those that participated in the FWB program have routinely facilitated FWB empowerment training with other public health students in their own right. This paper follows on from the previous research to examine the effectiveness with which the UPNG partners have adapted and facilitated the FWB course.

METHODS:

Study Design: Based on previous FWB empowerment evaluation in tertiary settings, a sequential exploratory mixed-methods design was adopted in which quantitative measures were piloted to test their sensitivity and complement qualitative workshop evaluation data [9]. The main question guiding the study was: how effective is the uptake and implementation of the Aboriginal FWB empowerment program in the context of UPNG public health training? Program uptake and implementation was considered effective if the FWB delivery by UPNG research partners achieved comparable results to those of the initial study.

Participants and Setting: Two groups of public health students participated in the study as part of their public health training at the Division of Public Health (DPH), SMHS UPNG. One group consisted of 10 part-time distance education students who attended a 1-week intensive FWB workshop during a six-week residential school. The second group consisted of 20 students who studied on campus full time.

Measures: To assess program uptake and implementation effectiveness, qualitative workshop evaluation outcomes were assessed and compared with those of the initial feasibility pilot study [2,3]. The aim was to determine the extent to which local UPNG researchers took up and implemented the program to achieve outcomes similar to the initial Australian partner-led feasibility pilot study. A standardised FWB workshop evaluation questionnaire was administered immediately after the end of the intervention. As well as collecting demographic data (age and gender), Part 1 of the qualitative questionnaire asked participants to provide feedback on what they liked and/or disliked about the program; the extent to which their expectations were met; how they intended to use FWB skills within family, workplace, and broader community settings and to suggest ways to improve the program. Part 2 of the questionnaire used a 10-item Likert scale to gauge the extent to which students perceived FWB as relevant to PNG, and their level of understanding and confidence in using the knowledge in their family and professional roles. Students were asked to what extent they agreed or disagreed with statements such as “family wellbeing is relevant to PNG” and “after doing this course I feel really competent to teach it”.

Quantitative pre and post surveys were used to: 1) understand the students' wellbeing prior to the intervention measured by levels of safety and violence in their social environments, psychosocial empowerment and subjective wellbeing; and 2) investigate changes in responses after the intervention measured by the Australian-developed surveys using effect size approach.

The first aspect is addressed using 5 questions taken from the Australian Bureau of Statistics (ABS) Personal Safety Survey (10,11). Three questions use a nominal scale (yes/no answers); two use an ordinal scale ranging from 1 (very unsafe) to 5 (very safe). A key objective of the Personal Safety Survey (PSS) is to measure perceived levels of violence in the participants' social environment. For the purposes of this survey, violence is defined as any incident involving the occurrence, attempt or threat of either physical or sexual assault experienced by a person during the 12 months prior to the survey.

Psychosocial empowerment is measured by the Growth and Empowerment Measure (GEM14) developed specifically to evaluate psychosocial empowerment among FWB participants [12]. This tool consists of 14 items, and has 3 subscales: the "Inner Peace" subscale (items 2, 3, 4, 10, 11, 12, 13, and 14); the "Self-Capacity" subscale (items 5, 6, 7, and 9); and "others" (items 1 and 8) which address strength, happiness, and connectedness. All items on the GEM14 are rated on a 5-point scale between two extremes. For example, for item 1, which asks about knowledge, the lowest point on the scale is "I feel like I don't know anything", while the highest is "I am knowledgeable about things important to me". The measure provided an overall score (maximum score =70), as well as scores for each of the three subscales. The final measure, the Australian Unity Well-Being Index, is a scientific measure of "subjective wellbeing" [13] which asks people to rate their satisfaction from 0 (completely dissatisfied) to 10 (completely satisfied), across eight aspects of their personal life: health, personal relationships, safety, standard of living, achieving in life, community connectedness, spirituality or religion and future security. An overall score was calculated for this index (maximum score = 80). The survey questionnaires are presented in Annex 1.

Data Collection: The study was approved by the Human Research Ethics Committee at James Cook University (JCU), Australia and the SMHS UPNG Research and Ethics Committee. The purpose of the questionnaires was explained to the student participants. They were also told that completion of the questionnaire represented their consent to participate in the study, that participation was voluntary and that participants are free to withdraw from the study at any time. Pre and post intervention questionnaires were administered to Diploma of Public Health

students before and after the FWB program. The qualitative workshop questionnaire was administered during the final session of the workshops while the quantitative questionnaire was administered at the outset of the FWB training and between two to five months after completion of the FWB training.

The FWB intervention: The two groups of students attended a total of 40 hours of the FWB program as part of their public health training. Key FWB topics covered included group agreement, human qualities, basic human needs, understanding relationships, life journey, conflict resolution, understanding emotions and crisis, loss and grief, beliefs and attitudes and understanding interpersonal violence. Both groups attended the course during the same semester: the 10 distance education students attended a six-week intensive residential block, while the 20 on-campus students attended weekly 3-hour workshops over the 13 week semester.

Data analysis:

Qualitative: Student responses to the evaluation questions after the final session of the FWB training were combined and thematically analysed. This process was based on the 6 steps recommended by Braun and Clarke [14]: 1) familiarize ourselves with the data; 2) search for codes; 3) create themes; 4) review themes; 5) name and define themes and 6) write the report. To ensure rigor and trustworthiness, the initial data coding and analysis was work shopped by three researchers through careful reading, independent coding and comparison of codes, and discussion and debate about preliminary themes. This collaborative work shopping also improved the effectiveness of the interpretive process [14]. Differences in interpretation were negotiated until consensus was reached. The data analysis workshop was intended to serve as a capacity-building exercise.

Quantitative: Participants were requested to complete the FWB questionnaire before and after the intervention. Given the relatively small sample (n=30) and unmatched pre-post surveys the approach to the analysis of survey responses was largely descriptive. A Wilcoxon signed rank test was conducted to assess changes between the average pre-post scores across the GEM survey, the Australian Unity Well-Being Index survey and Part 2 of the PSS. Differences between pre-post yes/no responses from Part 1 of the PSS were examined using Fisher's exact test. $P<0.05$ was reported for significance of results. Effect sizes were calculated to indicate the sensitivity to change of the GEM Scale, the three subscales and the Australian Unity Well-Being Index (AUWBI). Effect sizes (r) were calculated using the methodology of Berry et al. [15]. Cohen [16] suggests that r values greater than 0.5 may be considered large, greater than

0.3 may be considered medium and greater than 0.1 may be considered small.

RESULTS:

Study population demographics: Gender distribution of the 30 students that participated indicated that 56.7% (17/30) were male and 43.3% (13/30) were female. Distribution of the students according to age-groups showed that 6.7% (2/30) were in the ≤34 years age-group, 83.3% (25/30) were in the 35 to 54 years and 10.0% (3/30) in the ≥55 years age group. Overall, 30 students completed the surveys, with all completing the pre, and 28 completing both pre and post surveys.

Qualitative: The participants were mostly very positive about both the content and process of the FWB program. They saw it as highly relevant to personal, family and community needs given its potential to enable empowerment at each of these levels. There were a number of recommendations as to how the program could be taken forward by gaining endorsement from national health leadership and being integrated into current health strategies and professional curricula. These results are presented as three broad themes, each theme comprising several sub-themes supported by quotes from students. To ensure anonymity, quotes are not identified by student names, but rather by numbers in brackets.

FWB content and process: Participants said FWB was very helpful and relevant to their personal, family and community health: for example, one student said "The program of FWB is very important and improve the standard of living within ourselves, family and community as a whole, for health and living condition" (7). They found the program content to be "clear and easy to understand" (1). Many participants said they liked all of the program topics: "Almost every topic covered and learned a lot of new information" (8). When asked what they didn't like about the program, all of those who answered this question said that there was nothing they didn't like and that everything was helpful.

Participants referred to specific topics they liked. One student said: "The thing that I like best or useful in the training was about the Life Journey and the support I get along the Life Journey" (21). Others mentioned the topics of conflict resolution, basic human needs, human qualities, emotions, grief and loss, the process of change and addressing family violence. The topic most frequently mentioned was-understanding relationships. Several students appreciated learning about research as part of the program: for example, one student said: "I find it useful and interesting in doing field trips, doing research and writing project proposals on Family Wellbeing" (19).

The process of FWB learning was highly valued, particularly the extent to which students participated in the learning process. They said

that they enjoyed class discussions and sharing their personal experiences. One student noted the learning associated with hearing about others' experiences and "…challenges they have conquered…" (14). They also enjoyed making class presentations: one student said that they "like the presentation- It involve us to take part" (22). There were some positive comments made about the quality of facilitation: one student said the program "was taught clearly" (4).

Whilst most students found the program process useful and helpful, a few participants found some aspects challenging. One student found it hard to talk about personal issues, feeling there was an expectation that they talk about "Some private issues that need not be exposed in public" (13). A number of students felt they needed better program resources, including handouts, videos and training modules. Other participants had ideas for improving the process of program delivery such as allowing more student involvement "…because the participants have a wealth of experience to share at present that would generate more discussion" (14). Several people noted the importance of facilitator training: "This course should be conducted by a proper Trainer who have attended the TOT (Training of Trainer)" (15); "A full two week Training of Trainers for family wellbeing must be conducted" (23). Another person suggested that if students are asked to run program sessions they need adequate time to prepare and "…more support from the facilitator" (22). Others suggested that more time be allocated to program delivery: "…we didn't have much time to go through all the topics."(15). Whilst one thought it would be better if the training ran for "two weeks"(8), another thought better use could be made of the time available, for example participant groups could undertake group homework before presenting "…so we really understand the topics." (11).

Personal and Community Empowerment: Participating in FWB led to some important outcomes for participants. Many referred to their own personal growth and empowerment. This helped them in their relationships with others and provided a vision of how problems could be addressed at the community level. At a personal level participants reported a number of elements relating to personal growth, including enhanced self-awareness. One person said of the program that "It equips me to see my own strength and weakness" (3). Another person became more in touch with their inner qualities: "discover my inner qualities and know myself…" (2).

FWB topics provided frameworks for understanding others and building relationships, for example: "I was able to …express my feelings openly with others" (2); "…able to listen to other people and understand the needs" (1). Participants applied these frameworks to their work situations, thereby enhancing their professional capacity.

One person provided an analysis of the problems facing the PNG health system and how such problems might be tackled: "I have experienced the broad ideas in the system of management in the problem areas of how the problem in the health system was discovered."(6)

All of these outcomes helped participants to feel more confident. They spoke of feeling empowered and motivated: "It really motivated me because it empower me and build my capacity in the line of my duty" (5); "I am a changed person, because this course helped me to evaluate myself and at the same time, has empowered me to do more for other people" (18); "It will help me to solve problems in the family and the community and also lead by example." (7).

Many participants called for the program to be taken to workplaces and to communities: "…to widen the program out to the community and workplace."(7); "This program needs to go out and reach other people or health workers who really need to change" (16). They could see the program's potential to enable community capacity: "…to create a behaviour change and empowering the community to be responsible for their own health, this would involve capacity building and capacity development within families and community approaches through problem solving" (20). They highlighted the programs relevance for the PNG contemporary social context; "Their ways of living can change and adjust in a healthy way of living and thinking" (7); and "This course is relevant for PNG and should be adopted and sustained" (10).

Taking the Program Forward: A range of measures for taking the program forward were identified. These included gaining National Department of Health (NDOH) support: "it must be communicated to the National Department of Health for sanctioning" (23). One participant suggested the program be delivered first in more stable communities: "I believe if FWB is to make any impact in the country, it has to start in the family or the particular village which is lawless free. When people start seeing some changes, it can expand". (21) Some suggested integrating the FWB program into existing village health education programs: "Problem solving by leaders, pastors and councilors and Village health worker in hygiene and health education." (6); "Can link with the Provincial health advisors- about the program so that this program can be implemented in the districts by each trainer." (22).

Participants also commented on some of the more practical issues associated with program delivery including training, funding and evaluation. One person suggested that "Training of Trainers should be conducted throughout the provinces" (15). Others thought the program could be integrated into existing training programs in public health, community health, nursing and education: "… be integrated into one course of the public health

course in Community Health or other subjects" (10); "….other schools like the nursing colleges as well."(14); "This course should be included in the Education, UPNG Training Curriculum for all students to learn as well" (15). One student highlighted the need for funding: "I for one, I will go and implement this program, but I need some kind of funding to run this program" (9). Finally, the need for ongoing research and evaluation was mentioned: "…we need to do a research on this FWB…to see how this will help community" (17). The results from the open-ended evaluation data were largely confirmed by analysis of the Likert scale data regarding FWB relevance to PNG and levels of understanding and confidence to use the knowledge. After completing the FWB training, 73% of students said they understood what FWB was about, while about one third of the students (27%) were not so sure. The majority of students (95%) were interested in doing more FWB courses delivered by UPNG/JCU in the future (Q8) and indicated that they felt competent to implement aspects of FWB themselves (Q9). 90% of students felt changed, empowered and confident to use the FWB knowledge and skills after the training. All students felt that they could carry out small projects to introduce FWB to local communities as part of their study assignments (Q10). The majority of students nominated Health Promotion/ Education (80%), Child Health (70%) and Community Health (70%) as the priority areas where they would like FWB to be incorporated.

Quantitative: Statistical analysis was conducted to examine the effects of the FWB intervention by comparing students' mean responses before and after participation in the FWB workshops. Results indicated no statistically significant variation for the three components of the FWB questionnaire (Table 1). All three survey results revealed non-statistically significant negative change in post vs pre-scores signifying deterioration in attitude from before the intervention to after.

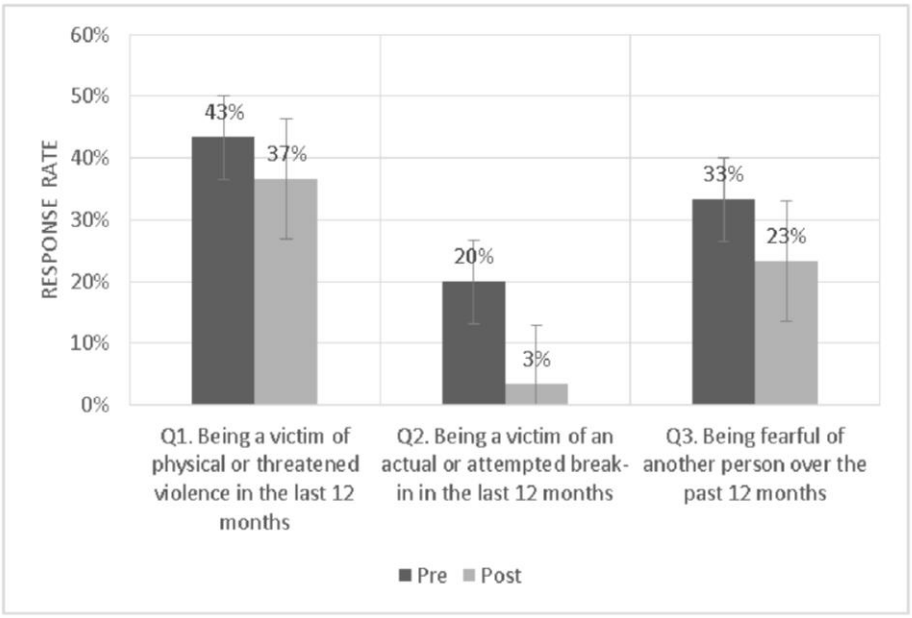
Personal Safety Survey (PSS): The PSS revealed staggering statistics. 43% of the students reported being the victim of actual or threatened violence in the previous 12 months; 33% reported being fearful of another person and 20% being a victim of an actual or attempted break-in (pre-survey scores). 92% of the victims knew the person who harmed or threatened them. 67% knew the person who broke in or attempted to break in. 90% knew the person who made them fearful (Fig 1). The students reported that they were less confident about personal safety at home during the day and night after the intervention, Fig 2.

Table 1: Summary of results from Wilcoxon Signed Ranks tests comparing scores (pre and post) and sensitivity to change

Measure	Pre		Post		N-ties	Z	p-value
	Mean	SD	Mean	SD			
GEM: Scale: 1 (feel least); 5 (feel most)	4.30	0.44	4.03	1.18	25	-0.108	0.912
Australian Unity Well-Being Index. Scale:1 (completely dissatisfied); 10 (completely satisfied)	7.97	1.22	7.88	1.13	28	-0.330	0.741
Personal safety (Part 2) Scale: 1 (very unsafe); 5 (very safe)	4.00	1.12	3.93	1.44	24	-0.029	0.976

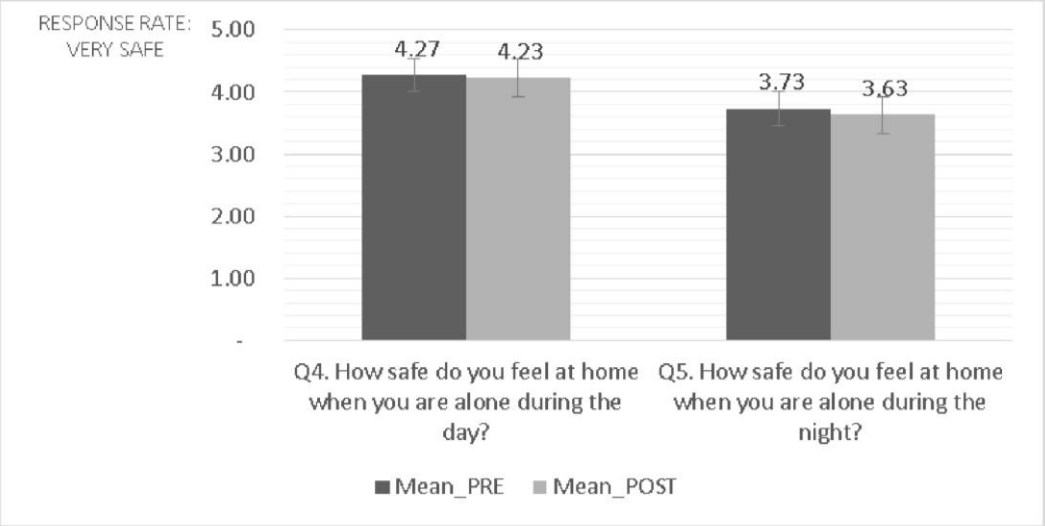
*The result is not significant at p> 0.05

Figure 1: Personal Safety Survey results. Part 1



{*Error bars represent standard errors (SE). When SE bars overlap, the difference between the two mean scores is not statistically significant (p>0.05)}

Figure 2: Personal Safety Survey results. Part 2



{*Error bars represent standard errors (SE). When SE bars overlap, the difference between the two mean scores is not statistically significant (p>0.05)}

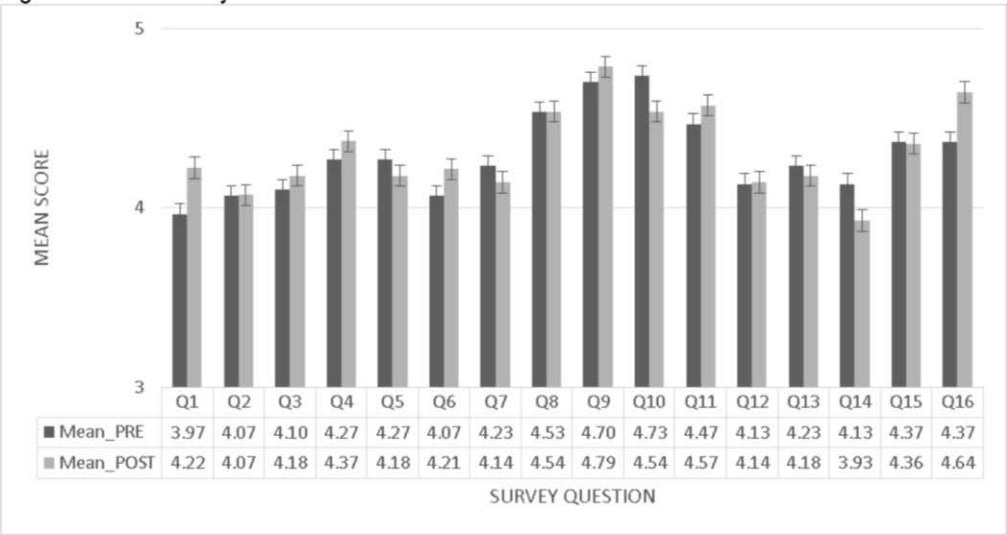
Growth and Empowerment Measure (GEM):

The intervention had the greatest positive effect on the students' perception about things that are important to them, (Q1) "I am knowledgeable about things that are important to me", and the ability to cope with threats, (Q16) "If I was threatened by someone I knew, I am confident I could take steps to avoid conflict" .On the other hand, the students scored negatively on their self-confidence after the intervention, (Q10) "Mostly I feel shame or embarrassed" (Figure 3).

Australian Unity Well-Being Index survey (AUWBIS):

The students scored the greatest satisfaction with being a part of their community (Q7) and spirituality (Q8), and the least satisfaction with standards of living (Q2), safety (Q6) and security (Q9), both prior to and after the FWB workshops (Figure 4). Intervention positively affected, though not statistically significant, students' views towards being part of the community (Q7), satisfaction with achievements in life (Q4) and life as a whole (Q1) (Figure 4).

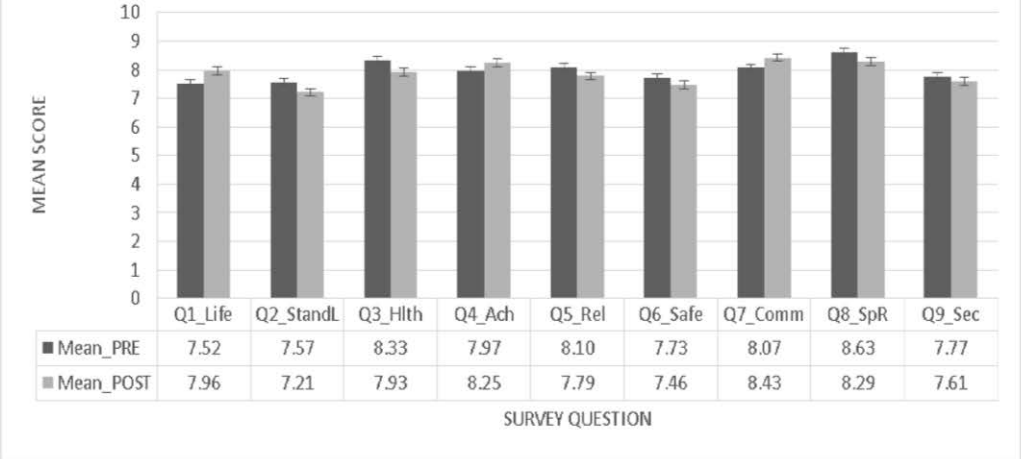
Figure 3: GEM survey results



	Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8	Q9	Q10	Q11	Q12	Q13	Q14	Q15	Q16
Mean_PRE	3.97	4.07	4.10	4.27	4.27	4.07	4.23	4.53	4.70	4.73	4.47	4.13	4.23	4.13	4.37	4.37
Mean_POST	4.22	4.07	4.18	4.37	4.18	4.21	4.14	4.54	4.79	4.54	4.57	4.14	4.18	3.93	4.36	4.64

{*Error bars represent standard errors (SE). When SE bars overlap, the difference between the two mean scores is not statistically significant (p>0.05)}

Figure 4: Australian Unity Well-Being Index survey results



	Q1_Life	Q2_StandL	Q3_Hlth	Q4_Ach	Q5_Rel	Q6_Safe	Q7_Comm	Q8_SpR	Q9_Sec
Mean_PRE	7.52	7.57	8.33	7.97	8.10	7.73	8.07	8.63	7.77
Mean_POST	7.96	7.21	7.93	8.25	7.79	7.46	8.43	8.29	7.61

{*Error bars represent standard errors (SE). When SE bars overlap, the difference between the two mean scores is not statistically significant (p>0.05)}

DISCUSSION:

The aim of the study was to determine the effectiveness of the Aboriginal Australian FWB program in the context of public health training at UPNG; specifically, the effectiveness of the uptake and implementation of the program by local UPNG partners.

The qualitative feedback from students regarding the effectiveness of the program uptake and implementation was overwhelmingly positive. Students found the FWB program content and the participatory learning-by-doing style highly relevant and empowering. Topics such as basic human needs, conflict resolution, relationships, beliefs and attitudes were identified as particularly useful tools for building healthier relationships and for helping to address high levels of interpersonal violence in PNG. Students felt that participating in the FWB gave them the skills, confidence, and motivation not only to improve their own health and wellbeing but also to help family members and their service clients do the same. Overall, participants saw themselves as potential role models and FWB champions in their respective communities and work settings and offered practical suggestions and recommendations as to how the benefits of FWB might be maximised and sustained in PNG.

These qualitative findings are similar to those of the initial train-the-trainer pilot study conducted in PNG by the Australian partners. Participants in that initial pilot perceived the FWB emphasis on participation, dialogue and routine questioning of one's cultural beliefs and attitudes as bringing them back to their origin to carefully consider and take what is good from their past, combine this with ideas from the outside world and thereby create authentic new ways of tackling complex health, social, economic and political challenges facing PNG [1]. These findings are moreover similar to numerous discrete qualitative evaluations conducted in a wide variety of settings across Australia over the years [4,5,16,17]. The fact that PNG partners were able to facilitate the FWB program in their own right and achieve results similar to other FWB deliveries clearly confirms the effectiveness of local uptake and implementation. Criticisms of the delivery were in the main constructive and focused largely on logistic issues such as the need for more time to do the training properly, appropriate learning resources tailored to PNG cultural contexts and that initiatives such as FWB must be recognised, supported and resourced within PNG health and other policies and programs in order for the program to be meaningfully implemented.

While the qualitative feedback revealed a positive impact of the FWB program on participants' sense of wellbeing, the same cannot be said for the quantitative findings. In contrast, quantitative results showed only minor improvements across the three self-reported

wellbeing measures after the intervention and in some areas the situation deteriorated. The intervention had the most positive effect on the students' perception of being knowledgeable about things that are important to them, their ability to cope with threats, and the confidence that they could take steps to avoid conflict if they were threatened by someone they knew. On the other hand, the students scored more negatively on their overall confidence after the intervention.

A possible explanation for the discrepancy between the qualitative and quantitative findings is the fact that the measures were developed and validated in Australian contexts so that language and other cultural nuances may have been problematic in the PNG context. The students were however health professionals undertaking tertiary studies and hence language was unlikely to be a major issue. A more plausible explanation, based on discussions with academic staff and students who undertook the FWB training, is the timing of data collection. The qualitative data were collected immediately after the students completed the FWB training and were full of enthusiasm for the course. The follow-up (post) quantitative data on the other hand were collected between two to five months after students completed the training. Whatever the reason for lack of improvement on the quantitative measures before and after the FWB intervention, the design of measures for programs of this nature, especially across cultural contexts, remains an issue that needs further exploration.

Despite the inconclusive quantitative results, the training in FWB did prepare staff and students to go through a crisis later that year when there was a major confrontation with the military. On that occasion (September 2013) armed soldiers entered the university campus following a previous altercation with some university students outside Port Moresby General Hospital. The university hospital campus where health and medical sciences students including the FWB participants studied was subsequently temporarily closed and students moved to the main university campus about 8.0 km across the city (from Taurama campus to Waigani campus). Many students and staff were traumatized by this experience. Even though students were traumatized, many of them expressed, through reflections, that FWB helped them to go through the crisis by effectively managing their feelings following the confrontations. Students found FWB topics such as crisis, emotions and conflicts particularly useful in coping with the crisis.

The frequency and nature of the violent confrontations between university students and the military in recent times, which in many ways reflects growing concerns regarding interpersonal violence in PNG in general [18,19], highlight both the possibilities and the limits of interventions such as FWB. On the one hand FWB gave students practical skills to build healthier relationships and with

interpersonal conflicts constructively. On the other hand, the levels of trauma, fear and anger experienced by students during the military confrontation clearly show the limitations of empowerment programs such as FWB as a one-off activity. These circumstances highlight the need to routinely reinforce such skills through support networks, refresher programs and other mentoring mechanisms.

This study has some limitations. The sample size was small and the study was conducted as part of routine public health training so the timing of program facilitation and data collection had to fit in with the requirements of the faculty teaching timetable. Not surprisingly, participants raised concerns about there not being enough time to cover all the topics. Further, the study had no funding support and was conducted as part of routine teaching, with remote academic support from Australian partners. Lack of resources combined with timetable constraints meant, for example, that the Australian Unity Well-Being Index measures were not piloted before being administered to the students. Many commentators including Crossley [21] Vullimay [22] and Bray [23] noted that when transferring social and educational programs especially in the realm of comparative education and models from other contexts and settings we should be cautious as they are fraught with threats and are bound to be incompatible. Therefore, it is encouraging that careful analysis has gone into compiling the results of both statistical data and thematic evidence and ensuring discussion, in particular the emphasis it places on the applicability of the FWB in PNG. Despite the limitations, the study is significant in the sense that it largely confirms the findings of previous PNG and Australian studies [2,3]. It shows the effectiveness of the uptake and implementation of the program by local PNG partners in the public health training context. The study also highlights the need for appropriate and well-tested quantitative measures as well as dedicated research funding support in order to improve the evidence-base of social health interventions such as FWB in the context of PNG.

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	Annex 1: SURVEY QUESTIONNAIRES: Table I: Growth and Empowerment Measure (GEM survey questions)
#	**QUESTIONS**
Q1	I feel like I don't know anything
Q2	I feel like I don't know how to do much of anything
Q3	I feel slack, like I can't be bothered to do things even when I want to
Q4	I feel unhappy with myself and my life
Q5	I am held back from what I could do, there are no opportunities for me
Q6	I feel that other people don't admire or value me
Q7	Have no voice. I can't express myself. Nobody listens to me
Q8	I feel isolated and alone, like I don't belong
Q9	I am not hopeful that anything will change for me
Q10	Mostly I feel shame or embarrassed
Q11	I do things for other people all the time. I am not looking after myself or my family well
Q12	I am always worrying and nervous. I can't relax or slow down
Q13	I live in fear of what's ahead
Q14	I feel a lot of anger about the way my life is
Q15	If I was threatened by another person, I have no-one close to me who would help and support me
Q16	If I was threatened by someone I knew, I would not know what to do

	Table II: Australian Unity Wellbeing Index survey questions
#	**QUESTIONS**
	Thinking about your own life and personal circumstances:
Q1	How satisfied are you with your life as a whole?
Q2	How satisfied are you with your standard of living?
Q3	How satisfied are you with your health?
Q4	How satisfied are you with what you are achieving in life?
Q5	How satisfied are you with your personal relationships?
Q6	How satisfied are you with how safe you feel?
Q7	How satisfied are you with feeling part of your community?
Q8	How satisfied are you with spirituality or religion?
Q9	How satisfied are you with your future security?

	Table III: Personal Safety survey (PSS) questions
#	**QUESTIONS**
Q1	Have you been a victim of physical or threatened violence in the last 12 months?
Q1a	IF YES to previous question, did you know the person who harmed or threatened you?
Q2	Have you been a victim of an actual or attempted break-in in the last 12 months?
Q2a	IF YES to previous question, did you know the person who broke-in or attempted to break-in?
Q3	Has another person made you fearful over the past 12 months?
Q3a	IF YES to previous question, did you know the person who made you fearful?
Q4	How safe do you feel at home when you are alone during the day?
Q5	How safe do you feel at home when you are alone during the night?

4.2 Conclusion

This paper provides evidence on the effectiveness of FWB in PNG. It demonstrates my capacity to implement an intervention as part of a PBL process, and to undertake quantitative and qualitative data analysis. There were limitations with the surveys used, as is also the case with the FWB study in a community setting, which follows. This became evident during my doctoral study.

Chapter 5: Transferring the Aboriginal Australian Family Wellbeing Empowerment Program from a Papua New Guinea University Context to Broader Community Settings: A Feasibility Study

5.1 Introduction

This paper builds on the previous study and tests the feasibility of the Aboriginal Australian Family Wellbeing program within a PNG community setting. It was submitted to the PJMS on 29 November 2016 and, following review, resubmitted with changes on the 13 December 2016. Following acceptance, it was published on 25 March 2017.

This paper provided me with a further opportunity to develop analytical skills. As with the previous paper, I took the lead in analysing and interpreting the different data sets, with support and input from my co-authors.

Transferring the Aboriginal Australian Family Wellbeing empowerment program from a Papua New Guinea university context to broader community settings: a feasibility study

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TRANSFERRING THE ABORIGINAL AUSTRALIAN FAMILY WELLBEING EMPOWERMENT PROGRAM FROM A PAPUA NEW GUINEA UNIVERSITY CONTEXT TO BROADER COMMUNITY SETTINGS: A FEASIBILITY STUDY

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ABSTRACT:
This study aims to assess the feasibility of transferring the Aboriginal Family Wellbeing empowerment program (FWB) from a Papua New Guinea (PNG) tertiary setting to broader community contexts to address the problem of endemic interpersonal violence and to generate pilot data to inform future community wellbeing interventions in PNG. Levels of wellbeing among a convenience sample of 100 participants recruited from Bereina station, Kairuku- Hiri District and other parts of the National Capital District and Central Province were assessed using a cross-sectional survey with an anonymous self-administered questionnaire. Follow-up FWB pilot workshops conducted in Bereina station for participants in the wellbeing survey used standardised FWB workshop evaluation questionnaires to obtain community feedback on the relevance of the program. Up to one in four females and over half of males who completed the survey reported being a victim of actual or threatened violence in the last 12 months. In terms of wellbeing, participants were least satisfied with their standards of living and most satisfied with spirituality. Workshop participants could see that FWB has the potential to address community concerns, including interpersonal violence, as it provides a process for identifying basic community needs and introduces skills to address conflict. The challenges and opportunities involved in sustaining such programs at community levels are highlighted.

Keywords: Feasibility, Transferring, Family wellbeing, Interventions, Interpersonal violence, Community, Sustainability

INTRODUCTION:

Interpersonal violence imposes a significant burden of health harm on both men and women in Papua New Guinea (PNG), including increased HIV risk, hospital admission and death [1,2]. Violence for men most often takes the form of criminal assault or tribal fights [2]. For women violence involves domestic and family violence and rape, and torture or even murder of women accused of sorcery [3]. The

United Nations Development Program (UNDP) [4] rates PNG 140 out of 146 countries in gender inequality; two-thirds of women in PNG have reported violence and domestic violence accounts for 90% of female trauma in women and girls [2,3, 5].

Interpersonal violence is aggravated by growing unemployment and associated alcohol and drug use among young adults. In PNG, youth unemployment is a major concern, especially for those who have completed primary, secondary or even tertiary education [6,7]. In urban settlements, towns and big villages across the country, there are growing numbers of youths who are unemployed and not engaged in economic or community activities. They are the so-called "drop outs" or "forgotten generation" and are often involved in excessive use of alcohol and drugs, including home brewing, which leads to disharmony within family and communities [6,7, 8]. These young people are also more susceptible or vulnerable to infectious diseases, including HIV, because of the risks associated with excessive alcohol and drug use [9].

Health practitioners, whose role is to provide help at the individual, family and community level, are also affected by interpersonal violence. The level of safety and security in the workplace has been shown to be a factor in health worker motivation [10].

Despite efforts including legislative change, public awareness campaigns and training the levels of interpersonal violence in PNG are worsening [11,12]. The history of PNG as an independent nation is littered with well-intended, gender-informed policies, plans, programs and other initiatives [11]. The problem has been the lack of a systematic approach to endemic interpersonal violence. Such an approach requires needs assessment, the selection of appropriate, evidence-based interventions in relation to those needs, pilot testing of the interventions and the assessment of their outcomes to establish their feasibility and acceptability, followed by the design of compelling trials to determine what will work in practice [11].

Previous pilot studies established the acceptability and feasibility of the Aboriginal Australian Family Wellbeing (FWB) program in the context of training University of Papua New Guinea (UPNG) public health students in community development [13,14,15]. The students, as well as community and church leaders who later became aware of the program, recommended the potential usefulness of FWB to tackle the high levels of interpersonal violence in PNG communities [13,15].

The present paper responds to the student recommendation and subsequent invitations by church and community leaders by testing the appropriateness of FWB as an interpersonal violence intervention in a community setting. The aim is to generate relevant baseline data to inform future FWB and other community interventions in PNG.

Overview of the FWB program:

This overview of the history, rationale and previous practical application of the FWB program provides a context for the methods and outcomes of the present study.

FWB is an evidence-informed group intervention developed by Aboriginal Australians in 1993 [16] to enhance their individual and collective capacity to negotiate a changing and uncertain world and manage problems associated with being a minority population in their own country [17,18,19].

The program recognises that there are no easy strategies to manage complex problems such as racism and discrimination, transition from traditional to modern lifestyles, poverty, intergenerational trauma, interpersonal violence and substance abuse. FWB seeks to impart communication, self-reflection and analysis skills to empower people to create support networks, develop resiliency and resolve apparently insurmountable problems using creativity and innovation [13,17,19,20].

The FWB approach to empowerment has four main components. First, people meet in small interactive groups and introduced to the premise that as individuals they have the capacity to take control of their lives and make positive changes to improve their day-to-day situation, however dire that may be. Second, a safe space where these ideas can be discussed and developed is established through the development of negotiated group agreements and peer-support relationships based on confidentiality, honesty, empathy and trust. Third, experiential exercises show participants how to think and communicate effectively emphasising human qualities such as creativity, perseverance, forgiveness, commitment and generosity. Fourth, participants are encouraged to recognise their own experience and knowledge, strengths and basic human needs. Alternative ways of dealing with emotional problems, difficult relationship patterns, violence and abuse, conflict and crisis are explored to suggest strategies for change. Participants are encouraged to share their fears and insights with others, to build support networks, practise problem and conflict resolution, identify change objectives and implement and monitor changes.

Underpinning the entire process is the teacher, as role model and guide, creating a supportive environment where students and teachers, as co-learners, to experience what Fullan and Scott [21] referred to as “deep learning” pedagogy. In consequence participants not only have greater influence and agency in their personal situation, but can become agents for change in their family, workplace and broader community [17,19,22,23].

METHODOLOGY:

Study Design:

Based on previous FWB pilots in the context of UPNG public health training [13], the study adopted an exploratory mixed-methods design in which quantitative measures were administered to complement qualitative workshop evaluation data. Two main research questions guided the present study: 1) What is the level of wellbeing in the communities identified as potential sites for the FWB feasibility study? 2) How feasible is the Australian FWB as an interpersonal violence intervention in a PNG community setting? Wellbeing among study participants was assessed using three measures: a) perceived levels of safety and violence in participants' social environments; b) psychosocial empowerment; and c) subjective wellbeing. FWB feasibility in the community setting was assessed using standardized FWB qualitative workshop evaluation questions.

Participants and Setting:

The study was part of the UPNG problem-based learning approach to public health education. The FWB Empowerment and Change course was designed to train students to assess community needs with regards to FWB and to facilitate and evaluate the program in a community setting. Two groups were selected for the quantitative wellbeing survey through a process of convenience sampling. Firstly, each of 10 public health students administered the wellbeing survey to 5 participants in their workplace, providing a group of 50 survey participants working in various health facilities in the National Capital District (NCD) and Central Province. Secondly, in response to invitations by community and church leaders interested in the FWB program, a research group made up of 14 public health students led by a lecturer in the Division of Public Health (DPH) in School of Medicine and Health Sciences (SMHS) UPNG administered the wellbeing survey to a total of 50 local participants at Bereina station, in the Kairuku-Hiri District of Central Province. The Bereina community survey was followed by FWB pilot workshops for community leaders and youth, facilitated by members of the DPH research group. A total of 50 people, 27 (54%) men and 22 (44%) women attended the FWB community workshop, while 1 (2%) was a missing data. Half the survey participants thus came from outside the community where the FWB pilot workshop was conducted.

Measures:

The quantitative component was a cross-sectional survey of the 100 participants. The sample size was calculated to allow for comparison of the prevalence of violence between females and males. After reviewing the literature by Ganster-Breidler [24] it was estimated that 65% of women and potentially 20% of men would have experienced physical violence. Using a sample size calculator for

80% power and alpha error of 0.05, the samples size of 44 participants was obtained to detect a statistically significant difference in the prevalence of violence between females and males with 95% confidence. However, the sample size was increased to 100 to cover for unexpected non-response rate and sample errors. Three quantitative measures of wellbeing were included in the survey. The first uses five questions taken from the Australian Bureau of Statistics (ABS) Personal Safety Survey (PSS), designed to measure perceived levels of violence in the participants' social environment. Three questions use a nominal scale (yes/no answers); two use an ordinal scale ranging from 1 (very unsafe) to 5 (very safe). For the purposes of this survey, violence was defined as any incident involving the occurrence, attempt or threat of either physical or sexual assault experienced by a person during the 12 months prior to the survey [13]. Psychosocial empowerment is measured by the Growth and Empowerment Measure (GEM14) developed specifically to evaluate psychosocial empowerment among FWB participants [25]. This tool consists of 14 items, and has three subscales: the 'Inner Peace' subscale (items 2, 3, 4, 10, 11, 12, 13, and 14); the 'Self-Capacity' subscale (items 5, 6, 7, and 9); and "other" (items 1 and 8) which address strength, happiness, and connectedness. All items on the GEM14 are rated on a 5-point scale between two extremes. For example, for item 1, which asks about knowledge, the lowest point on the scale is "I feel like I don't know anything", while the highest is "I am knowledgeable about things important to me". The measure provided an overall score (maximum score =70), as well as scores for each of the three subscales [13]. The final measure, the Australian Unity Well-Being Index, is a scientific measure of "subjective wellbeing" [26] which asks people to rate their satisfaction from 0 (completely dissatisfied) to 10 (completely satisfied), across eight aspects of their personal life: health, personal relationships, safety, standard of living, achieving in life, community connectedness, spirituality or religion and future security. An overall score was calculated for this index (maximum score = 80) [13]. Qualitative data to assess the feasibility of FWB in a PNG community setting were obtained using a workshop evaluation questionnaire administered to participants immediately after the 1-day FWB workshop. As well as collecting demographic data (age and gender), the qualitative questionnaire asked participants to provide feedback on what they liked and/or disliked about the program; the extent to which their expectations were met; how they intended to use FWB skills in family, workplace, and broader community settings; and to suggest ways to improve the program [13]. The workshop evaluation feedback was supplemented by the head of the DPH research team's diary reflections regarding his efforts to support the Bereina community leaders to

implement priority issues arising from the pilot workshop.

The FWB intervention:

Prior to the FWB community workshop, the DPH research team undertook several planning visits to the Bereina community and trained 10 community and church leaders in the FWB program. As well as building potential local facilitator capacity, the aim was to give opinion leaders the opportunity to provide judgements regarding the cultural appropriateness of FWB prior to piloting the program with the broader community. The 10 community and church leaders, in collaboration with members of the DPH research team, then facilitated a 1-day FWB workshop targeting the youth of the Bereina community. Key FWB topics covered in the workshop include group agreement, human qualities, basic human needs, understanding relationships, life journey and conflict resolution; understanding emotions and crisis, loss and grief, beliefs and attitudes and understanding interpersonal violence. Following the workshop, the DPH research team members supported the community over 5 months towards translating issues arising from the workshop discussions and evaluation into action.

Ethical approvals:

The study was approved by the Human Research Ethics Committee at James Cook University (JCU), Australia and the UPNG School of Medical and Health Sciences (SMHS) Research and Ethics Committee. Consent was also obtained from the community leaders. The purpose of the questionnaires was explained to the participants. They were also told that completion of the questionnaire represented their consent to participate in the study, that participation was voluntary and that participants were free to withdraw from the study at any time.

Data analysis:

The approach to the quantitative data analysis was largely descriptive. Answers to survey questions were cross tabulated according to the participants' gender, age-group (<24, 25-34 or 35-54 years) and socioeconomic status (employment and education). The statistical significance of differences in violence rates between females and males was assessed with 95% confidence intervals (CIs) and $\chi 2$ test. Rates, rate differences and the 95% CIs were calculated with continuity correction according to the Wilson [27] procedure using the online calculator vassarstats.net. Differences between females' and males' scores on continuous variable scales were tested by conducting a series of independent sample t-tests. $P<0.05$ was reported for significance of results.

Qualitative responses to the FWB workshop were analysed thematically. The analytic process was based on the six steps recommended by Braun & Clarke [28]: 1)

familiarize ourselves with the data; 2) search for codes; 3) create themes; 4) review themes; 5) name and define themes; and 6) write the report [16].

RESULTS:

Quantitative measures:

One hundred participants consented to the study but 98 completed questionnaires were returned; of these 54 were male and 44 female participants. Two questionnaires were not completed because the participants did not specify their gender, age or employment status. The gender distribution, age groups, employment status and educational level of the participants are presented in Table 1.

Of the 100 participants 46% reported being victims of physical violence or threats in the previous 12 months; 10% had been victims of actual or attempted break-in and 32% reported that another person had made them fearful. Of all episodes of abuse, the majority of the victims (73%) knew the person who harmed or threatened them or made them fearful and 60% knew the person who broke in or attempted to do so (Table 2). Physical violence or threats affected males more often than females ($\chi 2(1, N = 98) = 11.01$, $p < .001$), Table 2. 47.8% of the victims of physical violence or threats were aged 24 or younger.

Table 1: Victims' profile by the type of abuse

Variable	Total n=100†	A victim of physical or threatened violence *n=46				A victim of an actual or attempted break-in*n=10				Been made fearful by another person* n=32			
		Female		Male		Female		Male		Female		Male	
		n	%	n	%	n	%	n	%	n	%	n	%
Female/Male	44/54	12	27.3	34	63.0	4	9.1	6	11.1	14	31.8	18	33.3
Age group													
≤ 24	42	6	13.6	16	29.6	2	4.5	2	3.7	8	18.2	14	25.9
25 to 34	36	4	9.1	14	25.9	0	0.0	4	7.4	4	9.1	4	7.4
35 to 54	20	2	4.5	4	7.4	2	4.5	0	0	2	4.5	0	0.0
Employment													
Employed (FT & PT)	16	4	9.1	4	7.4	0	0.0	0	0.0	0	0.0	2	3.7
Unemployed	56	8	18.2	20	37.0	2	4.5	2	3.7	8	18.2	10	18.5
Student	8	0	0.0	4	7.4	2	4.5	2	3.7	2	4.5	4	7.4
Retired	6	0	0.0	0	0.0	0	0.0	0	0.0	4	9.1	0	0.0
Other	12	0	0.0	6	11.1	0	0.0	2	3.7	0	0.0	2	3.7
Education													
Grades 1-6	22	4	9.1	10	18.5	0	0.0	4	7.4	2	4.5	4	7.4
Grades 7-10	58	4	9.1	20	37.0	2	4.5	2	3.7	8	18.2	12	22.2
Grades 11-12	2	2	4.5	0	0.0	2	4.5	0	0.0	2	4.5	0	0.0
Vocational	8	0	0.0	2	3.7	0	0.0	0	0.0	0	0.0	2	3.7
University	4	2	4.5	0	0.0	2	4.5	0	0.0	2	4.5	0	0.0

† - Two participants did not specify their gender, age and employment status; six participants did not specify their education; *In the last 12 months; ** The highest proportions were marked in bold for female and male independently, except for gender; FT – full time; PT – part time

Table 2: Prevalence of abuse by gender

	Female (n = 44) N (%)	95% CI*	Male (n = 54) N (%)	95% CI*	Rate difference %	95% CI**	p-value (χ2 male vs female)
A victim of physical or threatened violence in the last 12 months	12 (27.3)	15.4 to43.0	34 (63.0)	48.7 to 75.4	35.7	14.4 to 52.8	<0.001
A victim of an actual or attempted break-in in the last 12 months	4 (9.1)	2.9 to 22.6	6 (11.1)	4.6 to 23.3	2.1	-13.0 to 15.7	NS
Been made fearful by another person over the past 12 months	14 (31.8)	19.0 to47.7	18 (33.3)	21.5 to 47.6	1.5	-18.3 to 20.6	NS

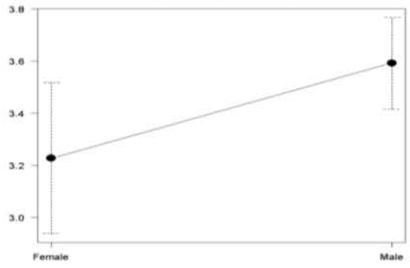
NS - Not statistically significant

*95% confidence interval of a proportion including continuity correction; **95% confidence interval for the difference between two independent proportions including continuity correction

Figure 1: Average Response Safety at Home

How safe do you feel at home when you are alone during the day? Response range: min 0 (very unsafe) to max 5 (very safe)
Mean ± SD: response (overall): 4.32 ± 1.13

How safe do you feel at home when you are alone during the night? Response range: min 0 (very unsafe) to max 5 (very safe)
Mean ± SD: response (overall): 3.46 ± 1.61



*Error bars represent standard errors (SE). When SE bars overlap, the difference between the two mean scores is not statistically significant (p>0.05); Y-axis represents average score ranging from 0 (very unsafe) to 5 (very safe); SD: standard deviation

Both genders felt less secure at home when alone during the night compared to during the day (Figure 1). Females tend to feel safer during the day when alone, compared to males, who reported feeling more secure during the night. These differences were not statistically significant.

The mean scores obtained for survey participants' wellbeing are presented in Table 3. The questionnaire used and the format of the response options are presented in Annex 1. Even though the differences between scores for the female and male participants were not statistically significant, some findings are worth highlighting. The level of overall satisfaction

and wellbeing appeared to be marginally higher among females compared to males (p> 0.05). Both men and women scored the least satisfaction with their standards of living (Q2) and the most satisfaction with spirituality (Q8) (p> 0.05). Women were less satisfied with personal relationships (Q6) and future security (Q9) when compared to men (p> 0.05). Men, on the other hand, were most unhappy about life as a whole, their achievements in life, safety, being a part of the community and health.

Table 3: Wellbeing survey results

	Q 1 Life	Q2 StandL	Q3 Hlth	Q4 Ach	Q5 Rel	Q6 Safe	Q7 Comm	Q8 SpR	Q9 Sec	Overall
Females, Mean(SD)	6.80 (2.52)	6.50 (2.95)	7.76 (2.54)	6.73 (2.37)	7.04 (3.64)	7.09 (2.87)	7.23 (2.69)	7.44 (2.90)	6.93 (3.03)	7.06 (2.72)
Males, Mean(SD)	6.67 (2.17)	6.18 (2.64)	7.00 (2.19)	6.85 (2.29)	7.15 (2.70)	6.95 (2.20)	6.98 (2.54)	7.53 (2.45)	6.96 (2.38)	6.92 (2.39)
p-value	0.778	0.573	0.140	0.796	0.851	0.774	0.638	0.875	0.951	0.416

*The result is not significant at p> 0.05

Table 4: GEM survey results

Questions	Female, Mean (SD)	Male, Mean (SD)	p-value
Q1. I feel like I don't know anything	4.27 (1.05)	4.09 (1.02)	0.401
Q2. I feel like I don't know how to do much of anything	4.09 (1.18)	4.02 (1.28)	0.774
Q3. I feel slack, like I can't be bothered to do things even when I want to	4.14 (1.15)	4.13 (1.10)	0.977
Q4. I feel unhappy with myself and my life	4.04 (1.38)	4.24 (1.10)	0.433
Q5. I am held back from what I could do, there are no opportunities for me	3.68 (1.57)	3.76 (1.33)	0.780
Q6. I feel that other people don't admire or value me	3.96 (1.26)	3.76 (1.17)	0.433
Q7. Have no voice. I can't express myself. Nobody listens to me	4.00 (1.19)	3.98 (1.16)	0.939
Q8. I feel isolated and alone, like I don't belong	4.16 (1.38)	4.49 (0.79)	0.131
Q9. I am not hopeful that anything will change for me	4.60 (0.86)	4.47 (0.79)	0.444
Q10. Mostly I feel shame or embarrassed	3.93 (1.47)	4.22 (1.18)	0.285
Q11. I do things for other people all the time. I am not looking after myself or my family well	4.51 (1.30)	4.24 (1.05)	0.654
Q12. I am always worrying and nervous. I can't relax or slow down	3.93 (1.13)	4.18 (1.00)	0.246
Q13. I live in fear of what's ahead	3.64 (1.49)	4.02 (1.15)	0.160
Q14. I feel a lot of anger about the way my life is	3.51 (1.46)	3.87 (1.16)	0.169
Q15. If I was threatened by another person, I have no-one close to me who would help and support me	4.00 (1.28)	4.15 (0.89)	0.506
Q16. If I was threatened by someone I knew, I would not know what to do	4.02 (1.37)	4.35 (0.93)	0.163
Overall	4.03 (1.28)	4.12 (1.07)	0.514

*The result is not significant at p> 0.05

The data in table 4 show the mean scores for the GEM survey. The questionnaire used and the format of the response options are presented in Annex 1. Difference between genders was not statistically significant. The lowest mean scores among women were received for Feeling anger about the way my life is (Q14) and for men Holding back from

what I could do (Q5). The highest mean scores for woman were Being unhopeful that anything will change for me (Q9) and for men Feeling isolated and alone (Q8).

Qualitative measures:

Four main themes emerged from the analysis of the data obtained from FWB pilot program participants. These themes are relevance of program content; acceptability of the delivery process; personal and community change; and sustainability. To ensure anonymity, quotes are not identified by the names of participants, but rather by numbers in brackets.

Relevance of Program content:

Community participants could see that the program content was relevant to the day-to-day issues they faced. Program topics such as basic human needs provided a framework for people to better understand the nature of their problems. For example, one person referred to the "importance of our basic needs in life" (4) while another said they learnt "many good things that will help me in my future life" (16). Community participants could see how program ideas were appropriate for healing and strengthening community relationships: comments such as "reunite families, youths- and the community", and "It will help me to solve problems in the family and the community" (7) were frequently found in program feedback. The topic of conflict resolution was seen as particularly valuable as it gave people ideas about how they could start to address family violence. For example, one person said: "Helping us to understand violence and help to resolve conflict… and bring up a better family" (12).

Acceptability of the Delivery Process:

Community participants clearly appreciated the process through which FWB was delivered. They liked having the opportunity to participate within a safe environment that encouraged openness. For example one person said "What I found was useful was doing group discussions and participating in the session" (19); while another said "Well actually the whole course was useful, but in particular was group discussion- openness in participants" (29). Several people commented on the quality of the program facilitators. One participant said "I think the training was just pleasant, and the facilities [facilitators] were just very active, and the way they present was just amazing" (17). However one person would have preferred external rather than local facilitators: "If ever there should be other courses why not other facilitator rather than our own people" (19). Despite this criticism this person was still very positive about their learning: "But otherwise, I really am happy with this course" (19).

Other criticisms of the delivery related to lack of time and program resources. Some felt that the one day wasn't long enough to cover all of the material: "We should learn more over two days" (24); "Every topic I find useful, but need more

time in presentations" (28). For one participant the program felt rushed: "Everything was alright but just that we need to really look into time management- we had to rush because time had caught up with us" (29). Another person suggested that "…more exercises be conducted so that we could understand better" (10). Community participants also recommended that more resources be provided and developed for the local context; for example they suggested: "… making some small booklets or hand sheets." (28), "… manuals and handouts of our own" (21).

Personal and Community Change:

Participation in FWB led to change in a number of ways. Some said that the program gave them a sense of hope that life could be better in the future. For example, one person said "I thank you for coming to our forgotten generation to help in building in them the hope for a better FAMILY LIFE in their community" (12). Community participants spoke of how the program had an important impact on their life: "I enjoyed and learned a lot of notes for physical and spiritual education. It's the great privilege for all of us as Bereina youths, have experienced how effective the programme" (19); "…it had a very big impact in my life, and also I have learnt a lot…" (19). One area of learning was self-care; for example one person said: "I learnt about how to look after myself and my family members" (20); Some people spoke of taking on leadership roles, including building skills in FWB program facilitation: "I'm looking forward to improve my skills in facilitating the given sessions." (14); "This is my first time to be a Facilitator. Thank God for your heart; to save the youths of Bereina district" (32).

Program Development and Sustainability:

The transfer and acceptance of FWB into this community was a first step; the next challenge is how to develop and sustain the program. Community participants clearly wanted more opportunities to participate in the program and to continue learning. They said, for example: "My suggestions is that we should have more of this course so that we could learn more and help our community to change to become a better people in our community" (5); "This is the first of its kind that we had in our District, to equip our youths in order to prevent them from involving themselves in doing wrong things. This training will help them in the Family Wellbeing." (28). Several community participants were keen to expose other groups, such as married couples, to the program ideas: "More participants especially young married youth." (27); "I suggested that if I am married; we should come as couples to attend this training course. Reason: So my partner will know and understand each other in this training." (7). Some community participants had suggestions for organizing the program: "We need to set up proper time for next training: - advise all other participants to attend;" (11).

There were ideas for integrating FWB into existing community programs such as the spiritual development activities run by the church. For example, one community participant said: "I suggest that the course could be improved by teaching the youth more of spiritual lessons and drama activities" (1). Others gave thought to how those who had done the training might sustain their learning and distract themselves from problems such as drug abuse. Several people suggested starting small farming projects, for example: "We should have some projects like farming looking after animals and projects like making gardens so that we the youths come together so we can do away with drugs and us to become good to the community and also to help in our needs and wants of our family." (5); "I should make good things after this course like projects farming making gardens, and help our community and work together" (6).

Leadership support was seen as critical to program sustainability. This could be achieved in a number of ways, such as encouraging village elders and chiefs to participate in the course or by training more people to be program facilitators. One participant said "If possible could you arrange for this course for village elders and chiefs. After this training for other community leaders would be very useful" (27); another suggested "Train the Facilitators…before training participants" (28).

The workshop feedback was largely confirmed by the leader of the DPH research team reflections on his follow up activities designed to support the community implement priority issues arising from the workshops. He observed workshop participants using the basic human-needs topic to identify the many difficulties they face, including poverty and access to health care, education, housing, clean water and vegetables. They found the solution-focused emphasis of the FWB program useful for planning how to address some of these difficulties and they wanted more sessions to be run. The community went to significant lengths to enable the program to continue, highlighting the community's perception of the relevance and importance of the program. The community lacked a training centre where the program could be delivered, so the young people were organised to build a shelter from local materials. FWB participants then contributed money and bought a brick-making machine to make bricks to build permanent homes and classrooms at the local school. Further, with the assistance of the DPH team leader, community leaders developed an activity plan to address some of the other local problems. This plan included small projects such as growing vegetables, cooking food for sale or sewing clothes and selling these at the local market.

DISCUSSION:

The study aims to assess the need for the Aboriginal Family Wellbeing empowerment program (FWB) and the feasibility of

transferring the program from a PNG university setting to broader community contexts to address the problem of endemic interpersonal violence and to generate pilot data to inform future community wellbeing interventions in PNG. The findings highlight the very real social challenges confronting PNG and the relevance and applicability of programs such as FWB at community levels. The fact that study participants experience their social environment as stressful and unsafe cannot be overstated. As many as one in four females and more than one in two males reported being a victim of physical or threatened violence in the last 12 months. Nearly half of the victims were aged 24 or younger, and knew their abusers. Both men and women were least satisfied with their standards of living and the most satisfied with spirituality. The extent to which spiritual beliefs and attitudes serve as internal resources for individuals and communities to cope with the day-to-day stresses of life requires further investigation. There is little doubt that the FWB program has much to offer the ubiquitous problem of interpersonal violence in PNG. Community members who participated in the workshops could all see the potential for FWB as a tool for addressing community concerns. Outcomes included providing a process for identifying basic community needs and offering skills for young people to better address needs such as food, shelter, education and interpersonal relationships that are based on respect. Engaging young people in meaningful activity will in the long run improve community safety and wellbeing [27]. Despite the clear relevance of the program and the calls for FWB to be continued and expanded, the reflections of the DPH team leader on the enthusiasm generated by the FWB workshop and his attempts to support the community channel such enthusiasm into action highlight a particular dilemma often confronted in community programs. When offered external support and new opportunities, community members are often keen to begin on a process of improving conditions in their community and it is by working with communities that researchers learn most and can help to bring about lasting change. However, this requires time that university staff and students do not usually have and they cannot always be there to support local initiatives. In Bereina, this problem can be overwhelming for the external facilitators as they question their capacity to meet community needs and expectations. How should an external community development facilitator balance raising hopes and aspirations with what can realistically be achieved? This conundrum highlights the need to tread carefully and take a strategic approach to change. Arguably, the most important and realistic role universities can play is to remain focused on their core business, in this case, the training of public health students. These students, as the health workforce and opinion leaders of the future, are the ones most suitable to take their new knowledge back to

the community. Opportunities for ongoing university support and mentoring, refresher training courses and the utilization of local or online communities of practice could also be explored (although internet infrastructure is very variable in PNG). As it is a pilot study, the results of this research cannot be generalised to other settings. Studies have demonstrated however that small pilot studies can contribute and provide information to national planning [29, 30]. The PNG government is committed to addressing interpersonal violence, and in 2014 the PNG National Department of Health (NDoH) launched a policy platform which incorporates a rights-based and empowerment approach. This policy, the National Health Gender Policy (NHGP) states "Today, the policy environment in gender and health is ripe. The health sector provides opportunities for integrating a gender perspective both organizationally within the NDoH and in health sector policies and plans" [12]; While the policy environment may be ripe, the greatest challenge lies in implementing and evaluating such policies [11]. Integrating practical interventions such as FWB in routinely available community education, health and other development programs and services provide a potentially valuable way forward.

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Annex 1: SURVEY QUESTIONNAIRES:

Table I: Growth and Empowerment Measure (GEM survey questions)

#	Question
Q1	I feel like I don't know anything
Q2	I feel like I don't know how to do much of anything
Q3	I feel slack, like I can't be bothered to do things even when I want to
Q4	I feel unhappy with myself and my life
Q5	I am held back from what I could do, there are no opportunities for me
Q6	I feel that other people don't admire or value me
Q7	Have no voice. I can't express myself. Nobody listens to me
Q8	I feel isolated and alone, like I don't belong
Q9	I am not hopeful that anything will change for me
Q10	Mostly I feel shame or embarrassed
Q11	I do things for other people all the time. I am not looking after myself or my family well
Q12	I am always worrying and nervous. I can't relax or slow down
Q13	I live in fear of what's ahead
Q14	I feel a lot of anger about the way my life is
Q15	If I was threatened by another person, I have no-one close to me who would help and support me
Q16	If I was threatened by someone I knew, I would not know what to do

Table II: Australian Unity Wellbeing Index survey questions

#	Question
	Thinking about your own life and personal circumstances:
Q1	How satisfied are you with your life as a whole?
Q2	How satisfied are you with your standard of living?
Q3	How satisfied are you with your health?
Q4	How satisfied are you with what you are achieving in life?
Q5	How satisfied are you with your personal relationships?
Q6	How satisfied are you with how safe you feel?
Q7	How satisfied are you with feeling part of your community?
Q8	How satisfied are you with spirituality or religion?
Q9	How satisfied are you with your future security?

Table III: Personal Safety survey (PSS) questions

#	Question
Q1	Have you been a victim of physical or threatened violence in the last 12 months?
Q1a	IF YES to previous question, did you know the person who harmed or threatened you?
Q2	Have you been a victim of an actual or attempted break-in in the last 12 months?
Q2a	IF YES to previous question, did you know the person who broke-in or attempted to break-in?
Q3	Has another person made you fearful over the past 12 months?
Q3a	IF YES to previous question, did you know the person who made you fearful?
Q4	How safe do you feel at home when you are alone during the day?
Q5	How safe do you feel at home when you are alone during the night?

5.2 Conclusion

Undertaking this study helped me to build my research skills and to build further evidence on the relevance of FWB to PNG. The Aboriginal Australian FWB program proved feasible for engaging a PNG community in examining issues of gender-based violence and ways to engage young people in meaningful activity. However, the study highlights the challenges associated with sustaining such programs when they are delivered by external university teachers and students. It is therefore important to find ways in which to integrate promising programs into existing services to avoid duplication as well as promote sustainability.

Chapter 6: Discussion

The objective of this study was to use PBL activities as an opportunity to meet my professional development needs. As Acting Chair of Public Health at UPNG at the beginning of this study, I needed to address my own professional development needs through the doctoral study to serve as a role model for colleagues in public health and other parts of the university who have similar needs. To achieve this goal, I identified four main areas of research skills I needed to develop, based on the research skills that the students themselves require to perform PBL tasks and activities. The first is how to conduct a literature search and review to synthesise evidence across a variety of academic papers and reports. The second is to improve my understanding of the nature of qualitative research and how to apply thematic analysis, a major form of qualitative research, in data analysis. My third objective is to similarly develop understanding of quantitative research and how to apply Microsoft Excel to calculate frequencies, sample sizes, median, average and effect size and to determine if a result is statistically significant. The fourth research skill is to develop writing, publication and knowledge translation skills including the dissemination of findings using a variety of mediums such as peer-reviewed journals, newsletters and power point presentations targeted to different audiences.

The study highlighted a range of important issues relevant to university teacher professional development, gender policy and community development in PNG. For the purposes of this discussion chapter, I focus mainly on a) the challenges and opportunities in using teaching and learning activities to achieve teacher professional development, b) the issue of gender equity and the relevance of the Aboriginal Australian FWB empowerment program as a potential tool for training teachers and health care workers to better enable and support communities to engage in respectful conversations and action regarding issues of gender and community wellbeing, and c) the nature of empowerment and ways to maximise its potential in the context of health workforce training at UPNG and beyond.

6.1 Teacher Professional Development

The study has shown that it is possible for university teachers, including in resource-poor countries such as PNG, to use teaching and learning activities as an opportunity to achieve their professional development goals. However, as reflected in Chapter 2 (Methods) of this thesis, the journey towards achieving my professional development goals has been no less than a roller-coaster, with concomitant high and low moments. Many times, I had to ask myself why am I doing this, what is the purpose, is there any end to this journey? This was especially so because I had left my family back in PNG with no scholarship to support myself properly in Cairns and hence I was anxious to find short cuts to complete the work as quickly as possible and return home.

Over time, I learned that there were no short cuts; rather, developing research skills and expertise requires hard work, patience and endurance. For example, the first doctoral output, the review of gender policy, was the first paper I wrote in my own right. I had previously co-published papers with others but had never published a paper in my own right. It was not easy. I wanted to do it as quickly as I could. However, I soon learned the hard lesson that there are no short cuts to publishing. When the first version of the paper was put through a plagiarism test, I realised that I needed to summarise other people's ideas using my own words, or, if I used other people's words, to put them in quotation marks. My supervisors pointed out that plagiarism is a serious academic crime; since then, I have been careful to write things in my own words. Now I can teach my students to do the same.

The auto ethnography-informed (Ellis et al. 2011) reflective PBL approach to the thesis, as described in Chapter 2, was very helpful in reminding me of the often minor but significant incremental progress I was making along the way, especially during the lengthy processes involved in grasping specific research and writing techniques, such as sample size and mean calculations and thematic analysis and reporting. The 'thesis by publication' approach to the professional doctorate was also useful in breaking down the study into discrete manageable pieces. This made the process less overwhelming than a conventional 100,000-word PhD thesis would have been.

Overall, my doctoral journey experience is, in many ways, similar to others using their teaching as the basis for research higher degree studies. Despite the many challenges

teachers encounter in using their teaching as an opportunity to achieve professional development, the most successful are those that appear to use such challenges as opportunities to learn and grow. Johnson (2001) used her teaching as the basis for a PhD study by exploring the relevance and usefulness of 'reflection in action and reflection on action to understand the situation, contain it-and to devise a way forward' (p. 5). Glaze (2002), a nurse educationist, employed the same reflective practice approach based on a hermeneutic phenomenology framework. Both studies found similar results relating to their experiences and reflections. Johnson (2001) found it challenging and argued a need for discipline and adherence to academic principles to succeed. This was not easy, to continue thinking and writing and presenting her findings in an 'omniscient and impersonal way' when faced with personal crises beyond her control. On the other hand, Glaze's (2002) study identified important issues related to the stages in a real-life PhD that are relevant to students and academics in similar situations. These included 'time constraints, need for stamina, fluctuation in feelings, consideration of wider social issues, taking stock, identification of learning, loss of artistry and the need for pragmatism' (Glaze 2002, p. 53). In trying to balance her PhD study with her other professional and family responsibilities, Glaze (2002) needed 'stamina' to overcome tiredness, referring to her PhD journey as a 'marathon process' (p. 157). I have experienced similar challenges and feelings, including time constraints, tiredness, sickness, family responsibilities and support. For example, at a critical stage in my study, two family members were sick at the same time and I had to take one of them overseas to the Philippines for eye surgery, without which doctors said she would go blind. Through a reflective process, I decided that the doctoral study could wait while the progression of the retinal detachment towards blindness could not wait. Hence, I took two months study leave to help deal with these health issues before returning to study. Similarly, I had to take time off when I was hospitalised for a month. Although such interruptions were unsettling, I was determined to achieve my goal. I agree with Glaze (2002) that a doctoral study is a marathon process, though mine was more like a roller-coaster (Kitau R, *My doctoral journey story*, https://youtu.be/scB9oM_ax1Y).

6.2 Review of PNG Health Gender Policy

The review of gender policies and programs in PNG, with a particular focus on the 2014 PNG Health Gender Policy (Kitau 2015; Papua New Guinea Department of Health

2014), provided the opportunity to develop literature search and review skills. The review found that since Independence, PNG governments have been willing to develop policies and programs designed to address gender equity; however, there has been a lack of implementation, let alone monitoring and evaluation. Barriers to implementation and monitoring include a lack of baseline data and lack of coordination among the multiplicity of players, including NGOs, resulting in duplication of efforts. Above all, there has been a lack of an evidence-based approach to developing and evaluating interventions, and a deep-seated cultural belief that gender is not men's business because of the traditional separation of male and female roles.

More recently, Lamprell and Braithwaite (2017), using content analysis, assessed the extent to which and how gender has been represented in eight key PNG health sector policy documents, to make recommendations for strengthening and mainstreaming gender equity across the health system. The study found that gender is mentioned mainly as part of programs such as maternity and childcare for women, confirming Kitau's (2015) finding that gender is mainly women's, and not men's, business. The content analysis found that 'All-in-all gender and gender mainstreaming do not have sufficient prominence in policy documentation to act as a platform for change' (Lamprell & Braithwaite 2017, p. 8). This, they argue, was contrary to the mandate between international donors and the PNG government that gender be considered in every stage of policy and its application. Lamprell and Braithwaite (2017, p. 8) suggest a need to move away from the current narrow treatment of gender to a 'more prominent, more inclusive and broad-based notion'. Importantly, the key to policy success depends on take-up, adoption and spread, and that civil society groups, the real change makers in PNG, should be involved since 'the Government is dragging along and not leading the way' (Lamprell & Braithwaite 2017, p. 9). Involving civil society groups and activists 'can overcome lack of political will and encourage citizen participation, awareness and empowerment using non-political approaches to enhance democracy' (Lamprell & Braithwaite 2017, p. 9).

6.3 Rationale

The implementation of the Aboriginal FWB empowerment program in PNG public health teaching as well as the community setting provided the opportunity not only to further develop my qualitative and quantitative analytic skills, but to make a

contribution to an understanding of empowerment as a generic tool that can potentially enable communities of people to engage in respectful but challenging conversations regarding community wellbeing.

When taking a health program from one setting to another, it is important to pilot and determine its acceptability before implementing on a wider scale (Kitau et al. 2011; McCalman, Tsey, Kitau, & McGinty 2012).). Two versions of the Aboriginal Australian FWB program were evaluated for the current study. UPNG lecturers implemented the one-week intensive FWB program within Diploma public health training. The students and lecturers then introduced the program in a one-day workshop in a community setting as part of PBL activities. The aim was to give the community a small taste of the FWB program, to determine its acceptability and potential feasibility in a community setting.

The students found the FWB program content and participatory learning approach very empowering and highly relevant to the PNG context. They found topics such as human qualities, setting ground rules through negotiated group agreements, basic human needs, conflict resolution, relationships, life journeys, beliefs and attitudes useful tools for having conversations about sensitive topics including gender equity. What the FWB evaluation has shown is that although issues such as gender equity are sensitive and the prevailing cultural belief is that men can't talk about it, the FWB empowerment approach creates a relatively safe space for both men and women to have such conversations. The program motivated the students to take steps towards improving their own wellbeing to become better role models for their families and the clients with whom they work in their professional roles as health care providers. This is particularly relevant because the students reported high levels of interpersonal violence in the 12 months prior to the study, confirming other research (Kitau et al. 2016) that interpersonal violence and safety are major concerns in PNG. The quantitative pre-post results did not show significant improvements because of a combination of timing and lack of opportunity to test the Australian measures prior to implementation in the PNG context.

Like the students, participants in the FWB program delivered in the community setting were enthusiastic about the potential of the program to help or enable them, especially young people, to take greater control and responsibility to address a range of priority

issues confronting the community, such as interpersonal violence, alcohol and drug misuse, unemployment and lack of housing. As with students, most of the community surveyed experienced life as generally stressful, with one in four females and more than one in two males reporting being victims of physical or threatened violence in the previous 12 months; nearly half of the victims were aged 24 or younger and knew their abusers. Not surprisingly, FWB participants in the community setting saw the program as potentially useful in helping to address a range of community issues including up-skilling young people to address their basic human needs, such as food, shelter and education, and building interrelationships based on respect. Evidence suggests that engaging young people in meaningful activity in the long run improves community safety and wellbeing (Whiteside et al. 2016). Follow-up support provided by UPNG lecturers and students resulted in the community taking initial steps towards addressing some of these challenges and needs. Nevertheless, a major finding from the community study is how to sustain community interventions such as the FWB program given a lack of dedicated resources for university teachers and students to implement and support such teaching and learning activities.

6.4 Problem-Based Learning and Empowerment

Insights gained from my study highlight two things concerning the nature of empowerment and how this might be strengthened in the context of health workforce development in PNG. First, the study confirmed that UPNG's emphasis on using PBL since 2000 to train the health and medical workforce is the right direction. At the core of PBL is the concept of empowerment, defined as a social action process that promotes the participation of people and communities towards the goals of increased individual and community control over health and wellbeing (Wallerstein 1992; Wallerstein 2006 cited in Whiteside et al. 2011, p. 115; Whiteside et al. 2011). PBL focuses on learner-centred teaching and learning designed to empower students and teachers as co-learners to conduct research, integrate theory and practice, and to apply knowledge and skills to develop viable solutions to complex problems (Savery 2000). Rooted in the traditions of Participatory Action Research (PAR) and related Action Learning (AL), PBL brings together teachers and students in small working groups to critically reflect on real-life problems, take action and evaluate the outcomes. It uses simple but effective reflective questions such as 'What did we do?' 'What worked well?' 'What didn't work well?'

'What have we learnt?' and 'How can we do better next time?' Through this cyclical process of plan-act-reflect, participants learn as individuals, as teams and as organisations, towards continuous quality improvement (Revans 1997).

Second, the Aboriginal FWB conceptualisation of empowerment in terms of basic human needs reveals a deeper, more fundamental understanding of empowerment, which teachers can potentially use to strengthen and support PBL activities. The premise is that all humans, regardless of age, class, ethnicity, gender or sexual orientation, have basic physical, emotional, mental and spiritual needs, without which we cannot flourish as individuals and/or communities of people. We have physical needs such as healthy food, exercise (moving the body), shelter, sexual expression and a good night's sleep. Emotionally, we need to feel safe and respected, to give and accept love, and be valued and cherished. Mentally, we have a need to be curious about the world, for the opportunity to learn throughout life and to be allowed to make mistakes and learn from them. Spiritually, we have a need to be connected to something bigger than ourselves. For some, this may be religion, but for others, it may be their culture, land, place of birth or a world view. Additionally, we need to have peace, tranquillity, creativity and beauty in our lives. FWB creates relatively safe learning environments based on negotiated group agreements for participants to ask critical questions, such as 'What are my basic human needs?' and 'Are they being met in ways that do not disadvantage others, and if not, what can I do to ensure that my needs are appropriately met?' In so doing, FWB has demonstrated its potential as a simple but universally effective tool to engage and enable people of diverse backgrounds to have challenging but respectful conversations about their rights and the responsibilities of all people, not only to themselves but to each other.

I hope to share this basic human needs approach to empowerment with my UPNG academic colleagues in the context of PBL. Beyond the university setting, I also hope to share the approach with frontline workers across health promotion, community development and other social health programs and services.

6.5 Limitations

There are limitations to the studies of FWB in the context of PNG. The main one is the limitations in the study instruments, which became apparent during my doctoral study.

Further, for the doctorate, I obtained ethics approval to analyse data previously collected in university and community pilot FWB deliveries. There proved to be gaps in these data. For example, because the project was undertaken as part of PBL activities, in many ways, the research was secondary to the need to support students to complete assignments and do exams within the semester, which did not always fit neatly to the intervention research design data collection time frames. Lack of expertise also meant that I did not appreciate at that time the importance of pre-testing the questionnaire, and keeping to a pre-post design data collection schedule.

A related gap in the study is that despite having embarked on a steep learning curve and clearly achieving the professional development goals I set myself, I am still not 100% sure that I will return to my university or to my job and be able to conduct and evaluate community interventions such as the FWB empowerment program, which I believe are critically important in challenging and changing community attitudes towards gender equity. It is reassuring that my advisors have always told me that doctoral study is an apprenticeship, in the sense that consolidating skills as an independent researcher really starts from the time the doctoral study is completed. This is why in Australia and other developed countries early research career development schemes are increasingly available to support new doctoral graduates to consolidate research capacity in collaborative partnerships with more experienced researchers and industry partners.

Despite these limitations, the results of the study have made an original contribution to the knowledge base in at least two important respects. First, the reflective approach to my doctoral journey informed by both auto ethnography and PBL principles as documented in Chapter 2 of these studies provides a practical framework for university lecturers embarking on similar professional development journeys. Second, the study shows the potential of the Aboriginal Australian FWB approach as a workforce development tool that health workers, teachers and civil society leaders can use to engage and enable local communities to dialogue in mutually respectful conversations regarding issues of priority concern including sensitive topics such as gender equity. Third, the significance of the Methodology Chapter is to reinforce the approach I used to collect my data. Hence the inclusion of the three published papers in the thesis, legitimises the empirical process and grounds the thesis as highly scholarly exercise.

6.6 Priority Areas for Future Research

Future research in PNG needs to focus on how best to support academic staff such as myself to achieve doctoral studies. Research also needs to examine ways in which newly graduated doctorates can be supported to become independent researchers and ultimately research leaders, so they can support the next generation of researchers in an ongoing capacity development cycle. Other priorities for future research include the integration of programs that are shown to work into the core business of government and NGO services and programs. In other words, when university teachers and researchers pilot a program that is shown to be promising, they need to work with government and NGO service providers to consider integrating such programs into their core business, and collaborate with them to monitor and evaluate outcomes.

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Appendices

Appendix A: FWB Questionnaire

Appendix Table 1: Growth and Empowerment Measure (GEM Survey questions)

#	Question
Q1	I feel like I don't know anything
Q2	I feel like I don't know how to do much of anything
Q3	I feel slack, like I can't be bothered to do things even when I want to
Q4	I feel unhappy with myself and my life
Q5	I am held back from what I could do, there are no opportunities for me
Q6	I feel that other people don't admire or value me
Q7	Have no voice. I can't express myself. Nobody listens to me
Q8	I feel isolated and alone, like I don't belong
Q9	I am not hopeful that anything will change for me
Q10	Mostly I feel shame or embarrassed
Q11	I do things for other people all the time. I am not looking after myself or my family well
Q12	I am always worrying and nervous. I can't relax or slow down
Q13	I live in fear of what's ahead
Q14	I feel a lot of anger about the way my life is
Q15	If I was threatened by another person, I have no-one close to me who would help and support me
Q16	If I was threatened by someone I knew, I would not know what to do

Appendix Table 2: Australian Unity Wellbeing Index Survey Questions

#	Question
	Thinking about your own life and personal circumstances:
Q1	How satisfied are you with your life as a whole?
Q2	How satisfied are you with your standard of living?
Q3	How satisfied are you with your health?
Q4	How satisfied are you with what you are achieving in life?
Q5	How satisfied are you with your personal relationships?
Q6	How satisfied are you with how safe you feel?
Q7	How satisfied are you with feeling part of your community?
Q8	How satisfied are you with spirituality or religion?
Q9	How satisfied are you with your future security?

Appendix Table 3: Personal Safety Survey (PSS) Questions

#	Question
Q1	Have you been a victim of physical or threatened violence in the last 12 months?
Q1a	IF YES to previous question, did you know the person who harmed or threatened you?
Q2	Have you been a victim of an actual or attempted break-in in the last 12 months?
Q2a	IF YES to previous question, did you know the person who broke-in or attempted to break-in?
Q3	Has another person made you fearful over the past 12 months?
Q3a	IF YES to previous question, did you know the person who made you fearful?
Q4	How safe do you feel at home when you are alone during the day?
Q5	How safe do you feel at home when you are alone during the night?

Appendix Table 4: PNG Family Wellbeing Questionnaire

Papua New Guinea Wellbeing Questionnaire

Why complete this survey?

The questionnaire is to help us understand a range of issues such as how you feel about your life, your ability to cope with unexpected events and your ability to have a say in how your community is run. The Family Wellbeing program aims to help people with these and other issues.

This survey is a pilot and we would very much appreciate your feedback on its contents. Please let one of our facilitators know if you would like to comment.

Instructions for completing the survey

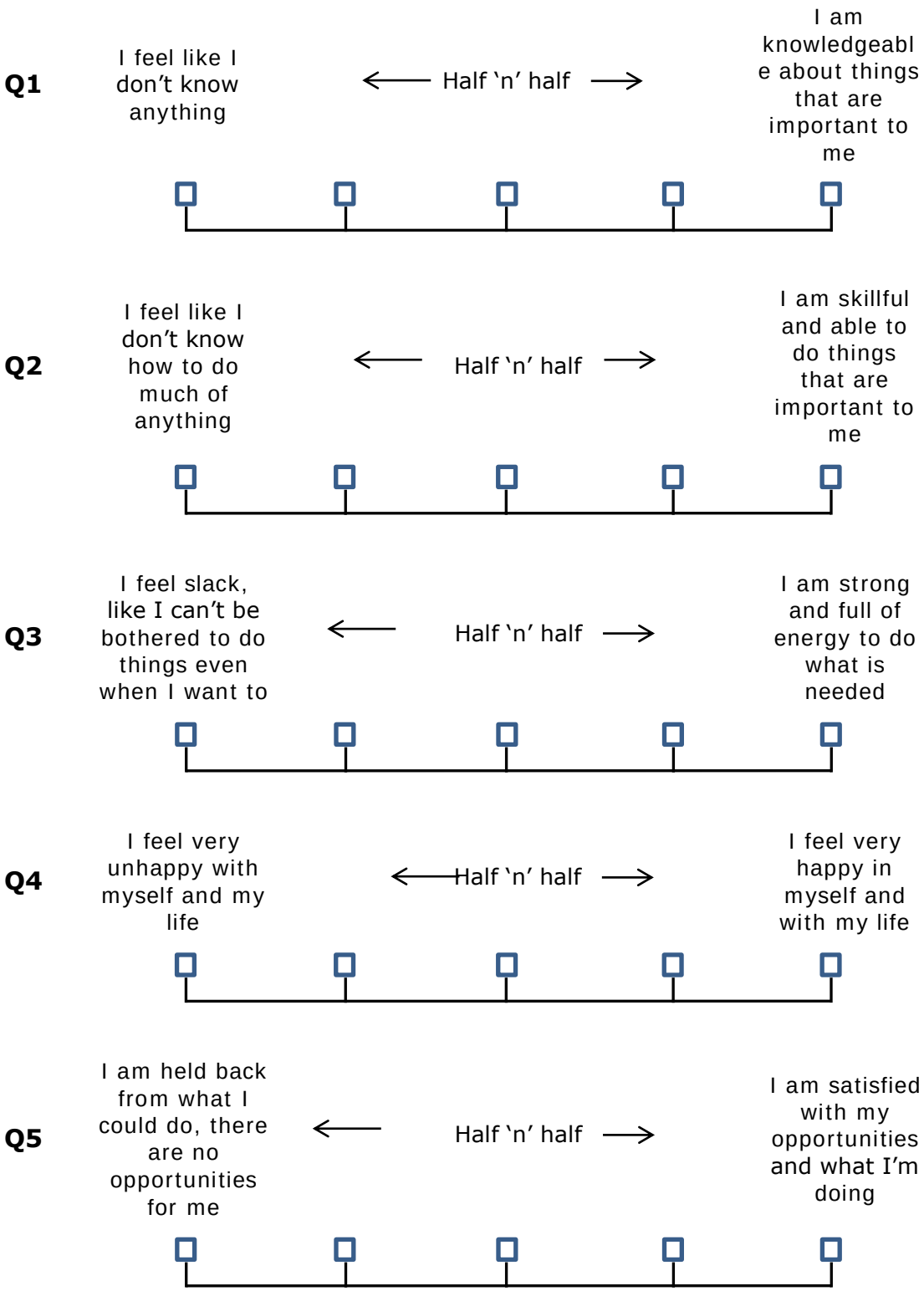
- You do not have to answer any question that makes you feel uncomfortable.
- If there are questions you are not sure about, ask someone with whom you are comfortable to help.
- Except for the questions specifically about you (your age group, your community, etc.), all questions ask for your *opinion*, there is no right or wrong answer.
- When you have completed your questionnaire, please pass it to one of our workshop facilitators.
- The reports that are developed from this survey will combine the answers from everyone. The answers from individuals will not be revealed – only the combined results will be reported.

What if I have a problem or question about the survey? Please seek help or advice from your peers or a facilitator. There are contacts you can phone – see the back page.

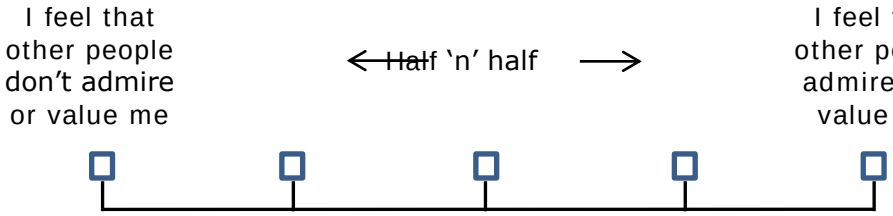
How do you feel about yourself?

Growth and Empowerment Measure (GEM14)

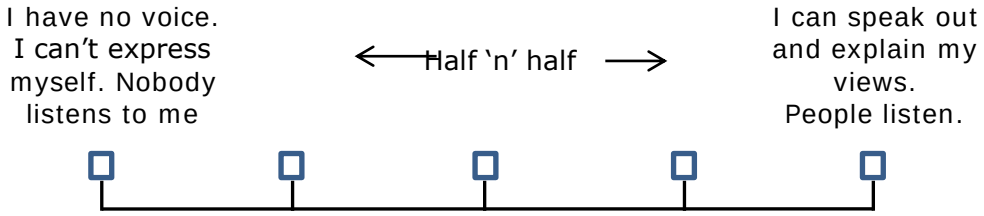
Please tick the box that matches how you feel <u>most of the time</u>



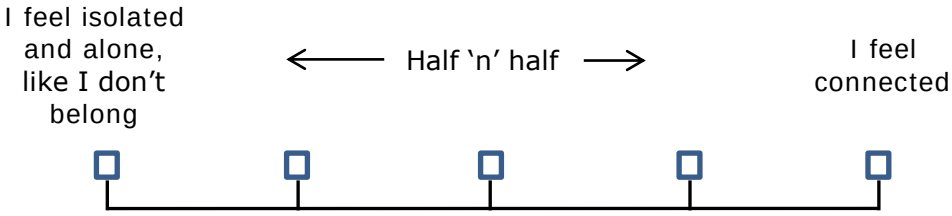
Q6



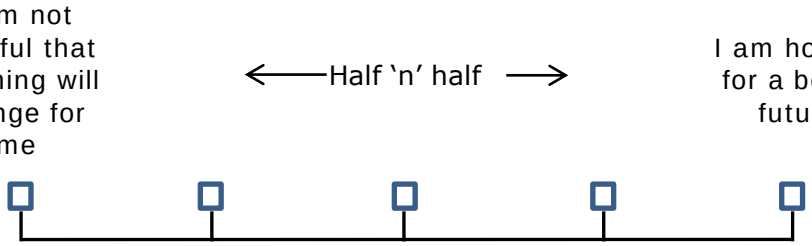
Q7



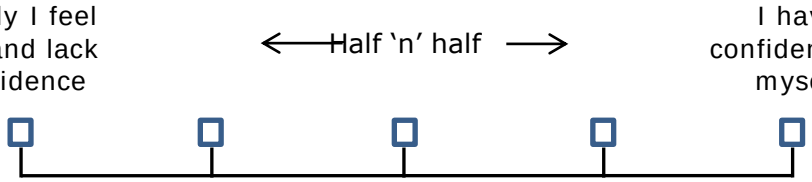
Q8



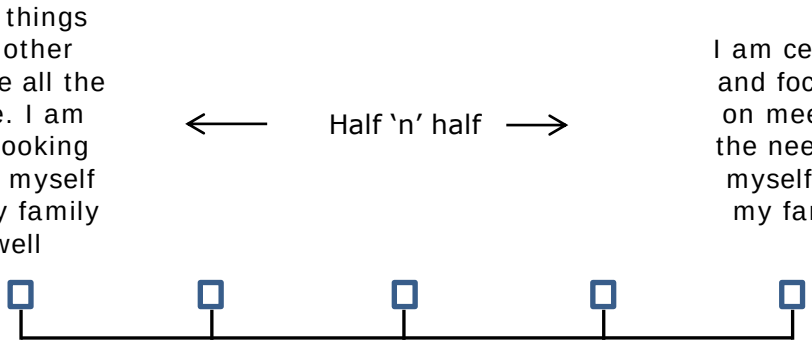
Q9



Q10



Q11

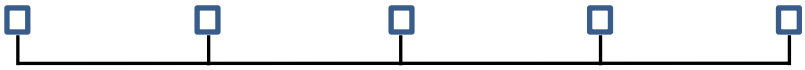


Q12

I am always worrying and nervous. I can't relax or slow down

← Half 'n' half →

I feel calm and relaxed, even when I'm busy

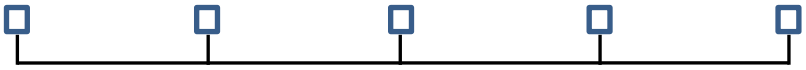


Q13

I live in fear of what's ahead

← Half 'n' half →

I feel safe and secure, I can face whatever is ahead

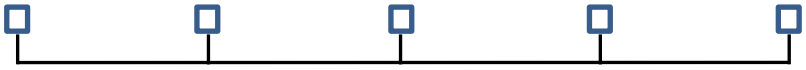


Q14

I feel a lot of anger about the way my life is

← Half 'n' half →

I don't hold anger inside of me about bad things in life

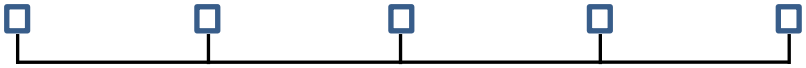


Q15

If I was threatened by another person, I have no one close to me who would help and support me

← Half 'n' half →

If I was threatened by another person, I would have help and support

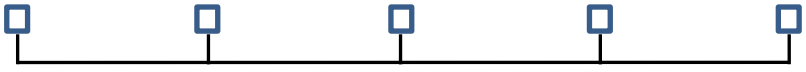


Q16

If I was threatened by someone I knew, I would not know what to do

← Half 'n' half →

If I was threatened by someone I knew, I am confident I could take steps to avoid conflict



Your recent experiences and how you feel about safety at home

Please tick the box that matches your emotions over the last four weeks

Over the last twelve months… (Please place a ✓ in the box that represents the best answer for you)	Yes	No	Neutral	Agree	Strongly agree
	1	2	3	4	5
Q1 Have you been a victim of physical or threatened violence in the last 12 months?	☐	☐	☐	☐	☐
Q1a IF YES to previous question, did you know the person who harmed or threatened you?	☐	☐	☐	☐	☐
Q2 Have you been a victim of an actual or attempted break-in in the last 12 months?	☐	☐	☐	☐	☐
Q2a IF YES to previous question, did you know the person who broke-in or attempted to break-in?	☐	☐	☐	☐	☐
Q3 Has another person made you fearful over the past 12 months?	☐	☐	☐	☐	☐
Q3a IF YES to previous question, did you know the person who made you fearful?	☐	☐	☐	☐	☐
Q4 How safe do you feel at home when you are alone during the day?	☐	☐	☐	☐	☐
Q5 How safe do you feel at home when you are alone during the night?	☐	☐	☐	☐	☐

Wellbeing (Please place a ✓ in the box that represents the best answer for you)

Q1. Thinking about your own life and personal circumstances, how satisfied are you with your life as a whole?

Completely dissatisfied					Neutral					Completely satisfied
0	1	2	3	4	5	6	7	8	9	10
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Q2. How satisfied are you with your standard of living?

Completely dissatisfied					Neutral					Completely satisfied
0	1	2	3	4	5	6	7	8	9	10
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Q3. How satisfied are you with your health?

Completely dissatisfied					Neutral					Completely satisfied
0	1	2	3	4	5	6	7	8	9	10
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Q4. How satisfied are you with what you are achieving in life?

Completely dissatisfied					Neutral					Completely satisfied
0	1	2	3	4	5	6	7	8	9	10
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Q5. How satisfied are you with your personal relationships?

Completely dissatisfied					Neutral					Completely satisfied
0	1	2	3	4	5	6	7	8	9	10
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Q6. How satisfied are you with how safe you feel?

Completely dissatisfied					Neutral					Completely satisfied
0	1	2	3	4	5	6	7	8	9	10
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Wellbeing (continued) (Please place a ✓ in the box that represents the best answer for you)

Q7. How satisfied are you with feeling part of your community?

Completely dissatisfied					Neutral					Completely satisfied
0	1	2	3	4	5	6	7	8	9	10
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Q8. How satisfied are you with your spirituality or religion?

Completely dissatisfied					Neutral					Completely satisfied
0	1	2	3	4	5	6	7	8	9	10
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Q9. How satisfied are you with your future security?

Completely dissatisfied					Neutral					Completely satisfied
0	1	2	3	4	5	6	7	8	9	10
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Demographics

D1 Your age group is... (Please place a ✓ in the box next to your answer)	☐ Under 24 ☐ 25 to 34 ☐ 35 to 44 ☐ 45 to 54 ☐ 55 to 64 ☐ 65 and over
D2 Are you... (Please place a ✓ in the box next to your answer)	☐ Employed full-time and part-time ☐ Unemployed ☐ Student ☐ Retired ☐ Other
D3 You are... (Please place a ✓ in the box next to your answer)	☐ Male ☐ Female

D4 How far did you go in school (Highest grade completed) … (Please write your answer in the box)	Grade
D5 Have you completed any technical training like TAFE? (Please place a ✓ in the box next to your answer)	☐ Yes ☐ No
D8 Have you completed any university study? (Please place a ✓ in the box next to your answer)	☐ Yes ☐ No

Thank you!

Appendix B: FWB Workshop Evaluation Form

Appendix B1: Guideline for DPH Lahara Students Evaluation Report

1. How is FWB relevant, adaptable and sustainable in your life, community and workplace?

2. How will you integrate FWB into your research project and seek for funding?

3. How will you apply FWB to address the interpersonal violence in families, workplace and community you live in?

4. What is the Plan of Action and your budget and source of funding?

5. What are your conclusion and recommendations?

Appendix B2: FWB Evaluation Form

Each facilitators and participants are asked to evaluate this program. The report should be divided in the following order:

1. Introduction

2. What is your real purpose?

3. Your main reason, role and responsibility for facilitating or participating in this course.

4. What is FWB and how has the topic you taught or learnt in this course empowered you at all?

5. How you first heard about FWB empowerment, your initial feelings and reactions, why did you decide to try it?

6. What are some of the challenges you have faced during, after the course or in the future and will you address them?

7. How did you apply what you taught or learnt in your family, workplace and community?

8. Any results (positive or negative) of how you successfully /unsuccessfully integrated the FWB concept and approach personally, in your family, community or workplace/or your research project and 5 year strategic plan to address public health issues and interpersonal violence?

9. The FWB partnership between JCU, UPNG and Bereina to date: (1) How did we do it? (2) Why did we do it? (3) What were the hard thing about what we tried to do? (4) What were some of the highlights and achievements to date? (5) What have we learnt from the experience?

10. How did FWB TOT idea come about? What has happened to date in PNG (UPNG, Bereina) since the program was introduced, what kinds of preparations have you been doing? What has worked well? What hasn't worked well to date? When do you think it will be delivered in your community, etc.…?

11. What is your future plan of action: Personal, Family, Workplace, Community? If you have any plan (what does it state?)

12. Conclusion and recommendations.

Appendix B3: FWB Training – Lahara Students

To be filled in at the end of the workshop. Please take note that the information you provide will be treated as confidential and will be used to improve the program.

Facilitators name……..

Date…….

Now that you have finished this workshop we would like you to think about the following questions.

1. In what ways were your expectations about the program met or not met?

2. What did you like about the program?

3. What did you not like about the program?

4. Write down some of the ways you can use the family wellbeing skills and knowledge: a) in your family? b) in your workplace? c) in your community life?

5. Any other comments/thoughts on the FWB approach?

Appendix B4: Workshop Evaluation Community

1. What in particular did you like or find useful in the training course?

2. Did you enjoy the presentation of the material? Were the exercises used in each session helpful?

3. Was there anything you didn't like or didn't find useful?

4. Do you have any suggestions as to how the course could be improved?

5. Any other comments you would like to make?

Appendix B5: Participants Information Sheet and Consent Form

I, Russel Kitau, am a lecturer and researcher at the Division of Public Health, School of Medicine & Health Sciences, University of Papua New Guinea, am coordinating and teaching the Lahara course on Research design project on Family Wellbeing Community education and Empowerment program.

As part of the course I am asking you to participate in this survey by filling in this questionnaire.

The questionnaire is to help us understand a range of issues such as how you feel about your life, your ability to cope with unexpected events and your ability to have a say in how your community is run. The Family Wellbeing program aims to help you, your colleagues and other people with these and other issues.

Should you have any queries or questions regarding this survey then do not hesitate to contact me on Ph.: or Email me on:

Consent Form

I,……. (Please Print Name) agree to participate in this survey and I fully understand that the information that I provide will be kept confidential and only used for developing new policies for the improvement of the health services in my health facility, district and province. Therefore, I voluntarily give my consent to participate in the survey.

Signature…….. Date…….

Witness…….. Date……

Appendix C: Letter to Executive Dean SMHS UPNG for Ethics Committee Approval

This administrative form
has been removed

Appendix D: Letter for Ethics Approval JCU Research Ethics Committee

This administrative form has been removed

Appendix E: Ethics Approval from University of Papua New Guinea

Appendix F: Candidate Confirmation Seminar PowerPoint, 2015

PROBLEM BASED LEARNING AS A TOOL FOR TEACHER DEVELOPMENT- A CASE FROM UNIVERSITY OF PAPUA NEW GUINEA SCHOOL OF MEDICINE & HEALTH SCIENCES

RUSSEL KITAU
DOCTOR OF EDUCATION CANDIDATE

PRINCIPAL ADVISOR: PROFESSOR KOMLA TSEY
CO-ADVISOR: DR IRINA KINCHIN

ACKNOWLEDGEMENT

At James Cook University we acknowledge the Australian Aboriginal and Torres Strait Islander peoples as the Traditional Owners of the lands and waters where we operate our business. We pay our respects to ancestors and Elders, past, present and future.

OUTLINE OF PRESENTATION

1. Introduction
2. Background and Rationale
3. Aims and objectives
4. Methodology
5. Project Plan & Budget
6. Dissertation Outline
7. Publications Plan
8. Risk Management Plan
9. Summary
10. References

1. WHAT IS PROBLEM BASED LEARNING?

"Learner-centred approach that empowers learners to conduct research, integrate theory and practice, and apply knowledge and skills to develop a viable solution to a defined problem" (Savery, 2000)

PBL focuses mostly on students' learning and emotional needs.

However, professional and skills development needs of the academic staff are not supported.

2. BRIEF BACKGROUND OF PNG

MAP OF PNG

BACKGROUND

PNG is an Island nation in Pacific

Population 7.5 million (2010)

80% live in rural areas

Gained independence in 1975

22 provinces / 89 districts

6 universities

WHAT IS THE PURPOSE OF MY DOCTOR OF EDUCATION STUDY?

1. To draw on Problem Based Learning activities to support my own professional development ;

2. To engage and support other public health colleagues to achieve their own professional development goals; and

3. To develop strategies to support the new health gender curriculum.

MY STORY: PROBLEMS AND CHALLENGES THAT I FACE AS A PUBLIC HEALTH ACADEMIC

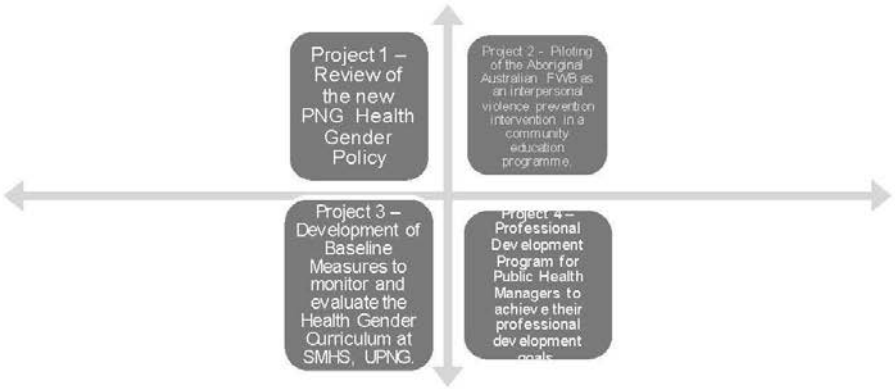
- Teaching
- Conducting Research
- Publishing of paper in Journals
- Professional Development
- Problem Based Learning and my work
- With Professor Komla Tsey

Set of basic research skills → 4 projects designed to improve my research skills

TABLE 1: DOCTOR OF EDUCATION STUDY LOGIC.

Teacher Development Need	PBL Opportunity	Development Outcome
Literature searches and reviews	• Review the new PNG Gender Policy • Identify potential baseline indicators for proposed health gender curriculum	• Published review of new Gender Policy • Collate and workshop potential indicators with health gender curriculum development committee
Qualitative data analysis	DPH Empowerment and Change Subject: train and support DPH students to pilot feasibility of Aboriginal Australian Family Wellbeing (FWB) as interpersonal violence prevention program in PNG	• Qualitative process and outcome paper
Quantitative data analysis	Pilot the feasibility of FWB evaluation questionnaire in PNG context	Quantitative baseline data feasibility paper
• Engage with and support colleagues' development goals • Produce a dissertation	• Routine feedback from discrete projects to current efforts to embed gender into all public health curriculum as prescribed by new gender policy • Seminars on my professional development experience • Synthesis of learnings from discrete projects and activities	A 50,000 word dissertation

4 DISCRETE PROJECTS



3 THINGS IN COMMON:

1. Relate to a PBL activity
2. Meet professional development needs for teachers
3. Raise awareness about Gender based violence

4. METHODOLOGY-
PROJECT 1: REVIEW OF THE NEW PNG HEALTH GENDER POLICY

Research Questions	Research Objectives	Approaches	Reasons for selecting methodology	Data collection	Data analysis
What are the challenges and opportunities in implementing the new PNG Health Gender Policy?	*To thematically analyse and describe the challenges and opportunities of implementing the new PNG Health Gender Policy, especially the proposed health gender curriculum.*	Qualitative thematic analysis	As new to qualitative analysis, I found Clarks et al 6 steps useful: 1- Familiarize with data 2. Generate initial coding 3. Searching for themes 4. Review themes 5. Define and naming themes 6. Producing the report	Access gender policy and other relevant reports and evaluations	Combine all found documents into 1 dataset. Read through and identify key themes relating to the challenges and opportunities of implementing the new PNG Health Gender Policy

PROJECT 2: PILOT STUDY OF ACCEPTABILITY AND FEASIBILITY OF THE ABORIGINAL AUSTRALIAN FAMILY WELLBEING PROGRAM AS INTERPERSONAL (GBV) INTERVENTION STRATEGY

Research Questions	Research Objectives	Approaches	Reasons for selecting methodology	Data collection	Data Analysis
a) Is the FWB acceptable as an interpersonal violence prevention intervention in a community education programme? b) Is the FWB evaluation measures appropriate in the context of PNG ?	*a) To pilot the FWB to determine if it is appropriate as interpersonal violence intervention in community setting;* *b) To pilot and test the appropriateness of the FWB evaluation questionnaire in the context of PNG community setting.*	a) Pilot study b) Qualitative methods (Braun & Clarke, 2006) c) Quantitative methods pre-post-test questionnaire	Need to learn skills. Effective method	a) Students reports, Russel' s journals b) Surveys	a) Thematic analysis b) Descriptive statistics, T-test using Excel: 1. Create an excel database 2. Code the data 3. Enter the data 4. Clean the data 5. Analyze the data 6. Presentation of the results

PROJECT 3: BASELINE MEASURES FOR M & E OF NEW GENDER – BASED HEALTH CURRICULUM

Research Questions	Research Objectives	Approaches	Reasons for selecting Methodology	Data collection	Data Analysis
Which existing measures regarding attitudes and beliefs about gender based violence that can be used to monitor and evaluate the new PNG Health Gender Curriculum?	*To undertake purposeful literature review to identify appropriate baseline indicators of attitudes and beliefs about gender-based violence that can be used to monitor and evaluate the new National Health Gender Curriculum.*	Purposeful literature review, Google Search; Used 5 criteria to select articles and select the IMAGE Questionnaire	Need to learn literature review and searches skills.	Consulted Librarian. Identified key search strategies including key words "gender based violence" "belief" "attitudes" "PNG" "Pacific"	Review of titles, abstracts to identify indicators relevant to PNG gender curriculum..

PROJECT 4: PROFESSIONAL DEVELOPMENT PROGRAM

Research Questions	Research Objectives	Approaches	Reasons for selecting Methodology	Data collection	Data Analysis
What are the opportunities and challenges for UPNG public health academics staff using PBL and associated PAR and Action Learning approaches to achieving their professional development goals?	*To provide an opportunity for me to share my experience as a way of engaging and supporting my colleagues to develop their own professional development goals.*	Feedback of results of Project 1, 2, 3. Reflective Practice on experience.	Reflective practice is central to PBL. Constant reflecting.	Use field notes with Reflective Practice questions: 1. What are my Professional Development activities? 2. What is working? 3. What is challenging? 4. How to makes things better?	Thematic analysis of my reflective practice.

5.(A) PROJECT WORK PLAN
WORK PLAN FOR THE DR EDUCATION STUDY: (2014-2018)

Task	Responsible	Where	Time Frame	Indicator of achievement
1. Complete the Introduction to Educational Research course.	R.Kitau	JCU	October 2014	Final report
2. Complete the GRS Development Program.	R.Kitau	JCU	June 2015	Final report
3. Write paper and submit for publishing.	R.Kitau	JCU	April 2015	Paper published
4. Submit Ethics Approval Application.	R.Kitau	JCU	May 2015	Ethical approval
5. Develop Research Project Proposal	R.Kitau	JCU	May 2015	Proposal completed
6. Confirmation Seminar	R.Kitau	JCU	August 2015	Seminar completed
7. Project 2- Publish Paper on Acceptability and Feasibility of FWB program	R.Kitau	UPNG	January 2016	Paper submitted
8. Project 3- Publish paper on Indicators for measuring gender curriculum	R.Kitau	UPNG	July 2016	Paper submitted
9. Project 4- Engage public health colleagues	R.Kitau	UPNG	July 2016	Seminars conducted

5.(A) PROJECT WORK PLAN
WORK PLAN FOR THE DR EDUCATION STUDY: (2014-2018)

Task	Responsible	Where	Time Frame	Indicator of achievement
10. Mid Candidature Review	R.Kitau	JCU	July 2016	Review done
11. Writing of Dissertation	R.Kitau	UPNG	July 2016	Draft completed
12. Exit Seminar	R.Kitau	UPNG	December 2016	Seminar completed
13. Revise and submit to Examiners	R.Kitau	UPNG	May 2017	Final submitted to examiners
14. Review and incorporate examiners comments	R.Kitau	JCU	July 2017	Final dissertation completed
15. Dissemination	R.Kitau	JCU	July 2017	Presentation at UPNG
16. Publish Dissertation into a Springer Brief Book	R.Kitau	JCU	August 2017	Manuscript submitted
17. Graduation	R.Kitau	JCU	April 2018	Graduated.

5 (B) PROJECT BUDGET

ITEM	Year 1	Year 2	Year 3	Total
Income	$AUD 9,000.00	$AUD 2,000.00	$AUD 2,500.00	$AUD 13,500.00
Expenditure:				
1. Living expenses in Cairns	$ AUD 6,000.00	-	-	$AUD 6,000.00
2. Publishing	$ AUD 500.00	$ AUD 1,000.00	$ AUD 1,000.00	$AUD 2,500.00
3. Return airfares	$ AUD 1,000.00	$ AUD 1,000.00	$ AUD 1,000.00	$ AUD 3,000.00
4. Attend Conference	$ AUD 1,500.00	-	$ AUD 500.00	$ AUD 2,000.00
Total	**$ AUD 9,000.00**	**$AUD 2,000.00**	**$AUD 2,500.00**	**$AUD13 ,500.00**

6. DISSERTATION OUTLINE

Chapter No.	Tentative Chapter Title
One	Introduction
Two	Background (Literature Review)
Three	Methodology
Four	Results – Main Findings
Five	Discussion
Six	Conclusion and Recommendations

7. PUBLICATIONS PLAN

Tentative title of publication / creative work	Target Journal / Conference / Exhibition	Proposed Authors	Remarks
1. Implementing the new PNG Health Gender Policy: Challenges and Opportunities.	International Journal of Social Sciences and Humanities	Russel Kitau (2015)	Completed
2. Acceptability and Feasibility of the Aboriginal Australian FWB Empowerment program as an intervention for gender based violence in PNG.	TBA	Russel Kitau, Mary Whiteside, Komla Tsey, Irina Kinchin	
3. A Purposive review of measurement scales for baseline survey and monitoring and evaluation new gender based curriculum.	TBA	Russel Kitau, Komla Tsey (2017)	

8. RISK MANAGEMENT PLAN

Risk	Likelihood	Impact	Plan B or Strategy
1. Unable to secure additional funding support to extend my stay here for another 18 months.	Medium	High	I will save from my salary to visit Cairns each year for at least 2 weeks for intensive supervision and support.
2. Quality of supervision from UPNG.	Medium	High	Visit supervisors at JCU once a year. Regular email contact.
3. Not able to write papers and submit on time.	Low	High	Attend writing workshops at UPNG Centre for Research and regular email contact with advisors.
4. Delay in ethics approval from SMHS, UPNG, NDoH, MRAC	Low	High	Regular follow- up

9. SUMMARY:

(1) Research capacity building quantitative and qualitative data analysis and publishing;

(2) Support other public health colleagues to achieve their own professional development goals; and

(3) Greater attention to evidence-based approaches to evaluate new PNG Gender Health Curriculum

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Let's take the opportunity to talk about it .....PBL- PROFESSIONAL DEVELOPMENT & GENDER HEALTH

THANK YOU

Appendix G: Cairns Institute Newsletter Publication

Welcome!

The Cairns Institute undertakes research in the humanities and social sciences that addresses critical points of social and environmental transformation in the tropics. Our research is visionary, multidisciplinary, and driven by principles of social justice and reciprocity.

Tropical societies are undergoing profound changes associated with economic modernisation, cultural globalisation, transnational mobility and environmental change. Governments and communities face an interconnected set of issues including uneven growth, poverty, urbanisation, exposure to natural hazards, degradation of natural resources, and so on. Social transformation in the tropics is a given.

If the humanities and social sciences are to both understand and support transformation, questions of how we undertake research are as important as questions of what we research. This is not about fundamental versus applied research. Instead, it is about fostering strong partnerships with community, industry and government institutions. It is about the co-production of knowledge with these stakeholders. It is about supporting the aspirations of community groups to be involved in or to direct research agendas. It is about experimentation with novel methodological and theoretical frameworks. It is about collaborating where needed across disciplinary boundaries. And it is about ensuring research results are communicated to multiple audiences.

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JAMES COOK UNIVERSITY AUSTRALIA

Cairns
Singapore
Townsville

Contents

From the Director

Last week the Cairns Institute was buzzing with visitors from Papua New Guinea (PNG). And as I write this I'm just back from meetings in Port Moresby. Without checking my passport, I honestly couldn't tell you how many times I've travelled between Cairns and Port Moresby over the last few years. Many times!

As possibly the world's most culturally and linguistically diverse country, it makes sense that social scientists take quite an interest in PNG. Rich in biological diversity it makes just as much sense to our colleagues in the environmental sciences who also take an interest. Then there are the challenges for food security and public health, the transitioning economy, the shifting geopolitics of the Pacific, and all sorts of other factors that draw researchers to PNG. As a place to do research, there is a lot going on.

Take a look at major scholarly publication databases and a very clear pattern emerges. PNG is a place scientists go to do research on local communities and environments. It is not a place, on the whole, scientists go to do research with local communities, or with domestic researchers and institutions. Of course there are exceptions to this generalisation. And it is the exceptions I want to focus on here as it is the exceptions, in my view, that will contribute most to a brighter future for the citizens of PNG.

Regular readers of the Cairns Institute newsletter will have noted several stories about the University of Papua New Guinea/James Cook University Twinning Project. Through this project we have been able to involve nearly a hundred staff, to date, across both universities. Most have been involved in capacity building activities focused on teaching and learning, research skills and academic quality—all important areas of activity. But the most enduring legacy of this project, I believe, will be the relationships that have been established—peer-to-peer and institution-to-institution—which will, in turn, support long-term collaboration and co-learning.

It's all very well for Australian universities to profess their respective commitments to serving the public good. The question is how? A question we can answer in myriad ways but none of the answers sound convincing when they continue to involve travelling to other countries (or to remote communities, or to disadvantaged postcodes) simply to do research on people.

From December 12 to 13 this year, UPNG and JCU will be co-hosting PNG IMPACT, a two day conference intended both to showcase research that is already making a real difference in PNG and to encourage network building and collaboration between researchers, government agencies, NGOs, industry and other stakeholders. I'll have more details about this conference to share with you shortly. Meanwhile, if you have an interest in how research can support sustainable and inclusive development in PNG, do reserve the dates.

Distinguished Professor Stewart Lockie
Director
The Cairns Institute

Monitoring the human dimension

Professor Allan Dale is leading a National Environmental Science Programme (NESP) project that will develop cost-effective indicators and metrics for monitoring human dimension outcomes, objectives and targets identified in the *Reef 2050 Long-Term Sustainability Plan* (Reef 2050 Plan). Dr Margaret Gooch is taking a break from her usual role with the Great Barrier Reef Marine Park Authority (GBRMPA) to work at the Institute as a Senior Researcher on the project. Other contributors include Dr Nadine Marshall (CSIRO) and Dr Karen Vella (Queensland University of Technology).

Four of the seven themes of the Reef 2050 Plan address human dimensions and establish targets and actions for: 1) governance; 2) heritage; 3) community; and 4) economic outcomes. However, as a result of limited socio-economic research coordination, there is no agreed framework to benchmark these human dimensions to help monitor progress, refine strategies and progress actions identified in the Reef 2050 Plan.

The project, titled *The IMS 2050 Human Dimensions Project: Cost-effective indicators and metrics for key GBRWHA human dimensions* (NESP Project 3.2.2), will add value to and ensure continuity with information collected through the Social and Economic Long-Term Monitoring Program for the Great Barrier Reef by:

- determining potential and extant indicator sets
- evaluating data collection cost-effectiveness
- determining thresholds (where appropriate)
- providing guidelines for a collaborative approach via expert panel discussions, for developing grading scores based on multiple lines of evidence to rate progress towards relevant Reef 2050 Plan targets, objectives and outcomes.

Allan said: "This project for the first time sees communities and people in the GBR catchment being considered as part of the wider Reef ecosystem. It will start to consider looking after the resilience of GBR communities as being just as important as looking after the biophysical health of the reef itself."

Unfortunately, due to Cyclone Debbie, the first expert panel workshop scheduled for 27 March 2017 in Cairns was postponed, and has been re-scheduled to 2 May 2017.

The Reef 2050 Plan is available at www.environment.gov.au/marine/gbr/long-term-sustainability-plan


Allan Dale


Margaret Gooch

My quest - Completing the Doctor of Education by end of 2017

My name is Russel Kitau and I am a lecturer at the University of Papua New Guinea (UPNG) and a Doctor of Education student. My quest toward completing the Doctor of Education degree commenced three years ago under the co-tutelage program which is the formal arrangement or contract between JCU and UPNG. This program has enabled me, as a Higher Degree Research (HDR) candidate, to be enrolled in a higher degree by research at both institutions concurrently. I enrolled at JCU and UPNG in 2014 and spent 13 months at JCU and the last 18 months at UPNG.

It has been an exciting time for me. As a pioneer, my desire has been that my area of study on transplanting an educational and community intervention program from the Australian Aboriginal experience is implemented in the rural areas of Papua New Guinea (PNG), and to utilise educational avenues in tertiary education to disseminate the program. I don't think anyone has done this—I am the first person to do this study! I would like to recommend others to do the same.

My story describes the strategy I used to achieve the object of the study, the main goal and focus, the methods used, the main findings, the main themes which link the three key papers (posted for possible publication by the *Pacific Journal of Medical Science*), the lessons learnt, and how we can sustain it.

The main goals of my proposed Doctor of Education study are:

1. To develop and implement professional development strategies in order to improve the capacity in research as a lecturer in Public Health
2. To explore issues relating to gender violence preventative policies and programs in PNG.

My method of data collection and analysis involved using a literature review to review the new PNG Health Gender Policy, undertake quantitative and qualitative analysis, and writing and publishing three papers which will form the basis and content of a required 50,000 word dissertation. The three papers are:

- Implementing the new PNG Health Gender Policy: Some challenges and opportunities
- Effectiveness of the uptake and implementation of the Aboriginal Australian Family Wellbeing empowerment program in the context of public health training in Papua New Guinea
- Transferring the Aboriginal Australian Family Wellbeing program from a PNG university to broader community settings: A feasibility study.

After successfully publishing the three papers, the next step was to compile the papers into a plausible thesis write up. The key findings identified four main themes:

1. Interpersonal violence prevention
2. Wellbeing interventions
3. Transferring programs from one setting to another
4. Difficulties evaluating community empowerment/ wellbeing interventions.

Firstly, interpersonal violence prevention is the main theme described in the three papers and it is a major public health issue. The new PNG Health Gender Policy provides strategies to address it, but there are several challenges and opportunities which help or hinder the implementation of the policy. Secondly, although wellbeing interventions to

(Continued on page 5)

My quest cont.

(Continued from page 4)

address interpersonal violence are available internationally, these need to be tested as part of the pilot study before it can be widely implemented.

The effectiveness of the uptake and implementation of the Aboriginal Australian Family Wellbeing empowerment program in the context of public health training in a university setting paper was the pilot study. The main findings were overwhelmingly positive as most participants reported that the program was effective in empowering and supporting them during their course. If it worked well as part of their training to achieve their professional development goals, it can do the same for their colleagues and at the community level. Hence, the third paper explores the feasibility of transferring the program from the UPNG public health setting to a broader community context.

However, when transferring from one setting to another we have to be cautious, as they are fraught with threats and may not be culturally compatible.

Finally, the difficulty of evaluating community empowerment wellbeing interventions is one of the main concerns—so much time and resources are spent on programs which are yet to produce positive results because they are hard to measure due to lack of appropriate tools to measure the interventions. Furthermore, there are very few evaluation studies of interventions in developing countries, including PNG.

In summary, the main lessons learnt so far from my study are that transferring educational programs from one setting to another cannot be effective or sustainable unless integrated into the university curriculum and community development programs. The uptake and a measure of successful implementation of the interventions such as in the above, suggest that their effectiveness is dependent on how well the community, and other major stakeholders, especially the tertiary teaching and learning programs, integrate and adapt the programs for implementation.

My plan is to spend the next 6-8 months with my Principal Advisor, Professor Komla Tsey, at The Cairns Institute to complete writing up my thesis. I hope to graduate in 2018. I would like to take this opportunity to thank my Advisors for supporting me during the past 2–3 years to undertake my Doctor of Education program. Thank you for allowing my story to be published in the newsletter.

Russel Kitau
PhD student
UPNG lecturer

Inspired architecture with a purpose

Cairns Institute Adjunct Associate Professor Shaneen Fantin has been involved in creating an important new facility in Cairns. POD (People Oriented Design), which has Shaneen Fantin and Belinda Allwood as directors, recently collaborated with Synapse (Acquired Brain Injury Association of Qld), and other architects (including TEDxJCUCairns speaker, Andrew Lane), Indigenous consultants and design companies to create Australia's first culturally appropriate supported accommodation facility. Shaneen said that the units were inspired by traditional Aboriginal rainforest architecture and designed to foster connection with the natural environment.

The project, which is the accumulation of nine years of dreaming, has been designed to be appropriate for Indigenous people who have suffered a brain injury, stroke or profound disability. It is also available for non-Indigenous people with disabilities and will support everyone who lives at the centre during recovery.

"Working on the Synapse project has been a remarkable experience for POD. We feel very honoured to work with so many passionate and talented people to bring this project to fruition. However, the project has shown us how immense the need is for well designed supported accommodation for people with disabilities" said Shaneen Fantin.

The centre is located in Warner Street, Cairns, and was built with funding from the Australian Government, and the Queensland Government will cover the centre's ongoing costs. Synapse expects that the first residents will begin living in the centre in July 2017.

Shaneen has also been conducting a sustainable design workshop as part of the Asia Pacific Architecture Forum in Brisbane. The workshop titled *The Least House Necessary*™ challenges participants on low energy design and what they need to live comfortably in the tropics. To learn more about *The Least House Necessary*™ watch Shaneen's TEDx talk.

THE CAIRNS INSTITUTE NEWS

THE CAIRNS INSTITUTE
Research in tropical societies


Pond apple fruit

Fulbright scholar Sean Riley

Maynard looked at me, grinning, as Victor wrapped the fish he had caught that morning in bark peeled from a nearby tree and placed it over the fire. "So, are you going to eat some?" another of the Australian Djunbunji Aboriginal rangers asked me. I eyed the fish dubiously, unsure if I wanted to break my vegetarian diet. When I later helped myself to a heaped plate of seconds, the rangers burst into hearty laughter, bragging they had "broken" the silly American. Little did I expect that Victor would remember this exchange when I returned two and a half years later, though in his retelling I eventually went back for fifths.

I have traveled back to Australia through a Fulbright Scholarship because the rangers of the Djunbunji Land and Sea Program have a pond apple problem. The root of the issue is simple; the pond apple produces edible fruit. Consequently, the Mandingalbay Yidinji (MY) people, the traditional owners of the lands managed by Djunbunji, have come to value this Americas native. Unfortunately, the pond apple, a formidable bioinvader, is wiping out native ecosystems on their lands. Some members of the MY community understandably oppose eradication due to the resulting loss of resources but something must be done to contrain its spread.


Sean Riley in the field

Sean Riley at the Fulbright Gala Presentation Dinner at Parliament House in Canberra

Under the mentorship of Professor Komla Tsey at The Cairns Institute and with assistance from the network of scholars at JCU, I will spend the next ten months conducting research to advance our understanding of the severity of the pond apple threat on Djunbunji's lands and the effectiveness of pond apple eradication techniques. The rangers and I will use this information to develop management options that address both the resource and invasion potentials of the pond apple so the area's impressive biodiversity and plentiful bushtucker can be maintained for the enjoyment of future generations.

Sean Riley
BSc Environmental Science & Biology (2016)
Santa Clara University, California

THE CAIRNS INSTITUTE NEWS

THE CAIRNS INSTITUTE
Research in tropical societies


Kasia Wojtylak with Flor Ángel Lassimo in the Tercera India community, Caraparaná, Colombia, 2016

Can we talk about a Caquetá-Putumayo linguistic area?

In February 2017, PhD student Kasia Wojtylak visited Bogotá, Colombia. Together with Youlin Avila and Felipe Sarmiento they have been preparing a workshop that will take place at the Instituto Caro y Cuervo (Bogotá, Columbia) in September later this year. The workshop will be part of the Seminar on Indigenous Languages held every year to discuss the state of indigenous languages in Colombia.

The workshop organisers: Kasia is currently in the final stages of finishing her PhD in Anthropological Linguistics at the Language & Culture Research Centre (The Cairns Institute) and she will submit her thesis in May 2017. Her work, supervised by Distinguished Professor Alexandra Aikhenvald, Professor R.W.M. Dixon, and Dr Elena Mihas, is the first detailed description of Murui, a Witotoan language spoken in the Colombian and Peruvian parts of the Amazon basin.

Youlin is finishing her Masters in Linguistics at Instituto Caro y Cuervo in Colombia. Her thesis describes the vowels in Minika, (Witotoan), used by speakers living in Bogotá, and she is supervised by Professor Camilo Díaz. Youlin started her work with indigenous communities as part of her MA degree, when she documented the use of Minika in Bogotá, and she has also worked documenting oral tradition from the Totoró people, a Barbacoan group located in southwest Colombia. She currently teaches at two main universities in Bogotá.

Felipe is an undergraduate linguistics student at the National University of Colombia. He is working with the Murui-speaking teachers in the boarding school of the Puerto Refugio community (Putumayo) in southern Colombia. The work is a part of a joint initiative with anthropology and biology students, members of Yauda Estudios Amazónicos, a multidisciplinary undergraduate student group.


Youlin Avila by the Amazon river, Leticia, Colombia

The Caquetá and Putumayo groups: Traditionally, eight indigenous groups inhabited the part of Northwest Amazonia known as the Caquetá and Putumayo (C-P) river basins. The C-P groups form part of a cultural complex called the 'People of the Centre'. The C-P languages belong to three language families (Witotoan, Boran, and Arawak) plus one isolate, Andoque. At the beginning of the 20th century, the C-P


Felipe Sarmiento in the Puerto Refugio community, Putumayo, Colombia

(Continued on page 9)

A pair of Mika wooden signal drums in the Muruí community of San José, Caraparaná, Colombia (Photo: Kasia Wojtylak, 2016)

Can we talk about a Caquetá-Putumayo linguistic area?

(Continued from page 8)

population might have been as much as 46,000. Today it numbers about 10,200 people.

Traditionally, the C-P groups lived next to each other, and shared relative cultural homogeneity, including trade specifications, intermarriage, multilingualism and common ritual activities that relate to the consumption of pounded coca and liquid tobacco.

The location of the Caquetá and Putumayo river basins in Northwest Amazonia

An example of a cultural trait shared by the C-P people is the *manguaré* instrument, a pair of hollowed-out wooden drums (see photo at top of page). Traditionally, communal roundhouses would relay messages across the entire tribe by using the drums. The *manguaré* was used to summon kinsmen or clans, to report danger or progress in preparation for a celebration, to announce a hunt, war, arrival of an important person or death.

Curiously, the C-P languages share common linguistic traits. Those traits are seen mainly in their grammatical structures, rather than in lexicon. An example of such a grammatical trait is the category of 'the reported evidential'. In C-P languages, one will commonly say 'He reportedly left the house', instead of the usual: 'He left the house'. The speaker usually will specifiy how they know that the event took place. With the reported evidential, they signal that the knowledge was acquired through other people by 'hearsay'. It is an efficient way to avoid potential misunderstandings.

With all the information that has become available on the languages of the C-P area in the recent years, we still know very little about the extent of shared cultural and linguistic traits among the C-P groups and languages. The main idea behind the workshop is to try to fill in that gap.

The Workshop: The workshop will bring together researchers who work with the C-P people and languages, to corroborate the idea of the C-P region being a linguistic area. A linguistic area is defined as a geographically limited region where, due to the speakers' long-term contact, unrelated languages converge towards a similar prototype.

Each day of the workshop will be divided into themes relating to language contact in the C-P area, sociolinguistics, as well as those issues dealing with anthropological and historical questions about the C-P peoples and their languages. This will allow the workshop organisers to review the state of art of the C-P research, and awaken interest in C-P research in Colombia. An integrated volume of papers will be published after the workshop.

Kasia Wojtylak, Youlín Avila & Felipe Sarmiento

Judith Herrmann, a PhD Student at The Cairns Institute, presented on her PhD research at the Soroptimist

Empowering women in many ways

International NQ "Empowering Women Conference". Judith's research focuses on the analysis of the needs and experiences of Rwandan women who survived sexual violence during the genocide against the Tutsi and who raised their case at a local community court. As part of her research, Judith conducted interviews with over 20 Rwandan women. In line with the theme of the Soroptimist conference, Judith focused her presentation on those aspects of her research that highlighted four moments of empowerment for the women she interviewed.

Firstly, the women were empowered through justice. The majority of interview participants saw their perpetrators punished by the jury of their community court, which seemed to some validation of the harm experienced.

Secondly, the women were empowered through forgiveness, as some of them decided to forgive, despite never having received an apology from their perpetrators.

Thirdly the women were empowered by being a member of a support group, which gave them a safe platform to share their stories and feel that they were not alone.

Finally, participating in research provided another opportunity of empowerment for the women. By participating in Judith's interviews, the women could actively contribute to education about what had happened in Rwanda and what they experienced during the justice process following the genocide. Furthermore, women were empowered in the interviews because they experienced that their individual story mattered.

Judith's speech at the conference was received with great interest by the audience, and was followed by half an hour of questions and answers. After the conference, Judith was invited to speak at various future events organised by Soroptimist International

Judith made reference to a TEDx talk she gave in September 2016 at TEDxJCUCairns. The talk, titled "When sorry seems to be the hardest word ... but I don't care!", that focused on the power of forgiveness when feeling wronged by someone who was unwilling to apologise.

See Judith's profile in the April 2016 issue and her 2016 TEDx talk

Judith speaking at the conference

ALTAR opened its 2017 film screenings on 15 March with the documentary *Anthropocene* (2015). It was great to see so many people in the audience and the interest in the rather global and important theme. The Director of The Cairns Institute, Professor Stewart Lockie, opened the film series and introduced our first guest speaker, Distinguished Research Professor William F. Laurance, Director of the Centre for Tropical Environmental and Sustainability Science and ALERT-conservation at JCU. Professor Laurance introduced us to the theme of the Anthropocene and the film greatly expanded on his talk. We learned how it all started and where to trace the beginnings of the new geological epoch.

The second film of the Anthropocene film series is *Canning Paradise* (2012). We will screen it on Wednesday 12 April 2017 at 6:30pm in The Cairns Institute main lecture theatre. We will welcome our second guest speaker, Dr Simon Foale, JCU lecturer and researcher at the College of Arts, Society & Education, and the Centre for Tropical Biodiversity and Climate Change. Dr Foale will talk about ecological, economic and political aspects of the increasing importance of pelagic fisheries for food security and livelihoods in Papua New Guinea and Solomon Islands. The film, *Canning Paradise*, is a feature-length documentary about the global tuna industry and the world's biggest export markets. Set in the north-eastern part of Papua New Guinea, the film follows the struggle of local communities to protect their fishing grounds and future livelihood. After the screening, we plan to Skype with the director of the film Olivier Pollet. All are welcome!

All the screenings are free to public. We hope to inspire the viewers with all the films of this year and give a reason for a constructive dialogue. Please see the poster for further details and the facebook page.

www.facebook.com/groups/AltarFilms

www.anthropocenethemovie.com

alert-conservation.org

www.canningparadise.com

espaces.edu.au/altar/film-screenings/2017

THE CAIRNS INSTITUTE NEWS


Aerial view of Kerema Town (Gulf Provincial capital)

THE CAIRNS INSTITUTE
Research in tropical societies

A reflection of life on the Station – A field note from the desk

Comfortably sitting back at my desk, it is a little bittersweet to think that it has been a year to the day that I first started field work in Baimuru, a remote station in the Gulf Province of Papua New Guinea (PNG). Major field work has now been completed (December 2016), and as days turn into months, the task of analysis and writing has begun.

A number of truths become evident as the writing process of the PhD is underway. Firstly, the field work portion of this entire process, as integral, has also been an enriching one (professionally and personally). Secondly, writing can be as much fun as you allow it to be. For someone (and I imagine I'm not alone) who can be easily distracted when a major piece of writing is underway, I have found that in this instance, as much as the temptation of distraction exists, I have also been thoroughly engaged. A nice surprise.

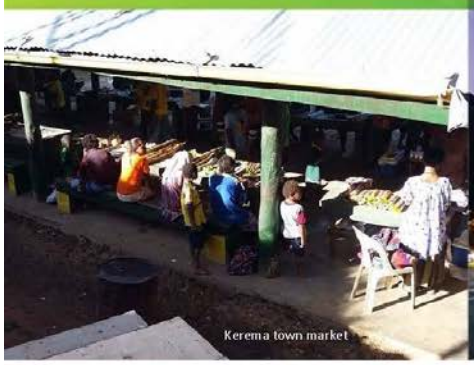
Generally, collating the data engages you in reflection, of what has been done, but also what can become. The last few months of field work came with it, as one would hope, a level of comfortability and integration into a community that welcomed me, not just as a PNG woman, or a researcher, but as a part of the community. Now at this point, I acknowledge these sentiments are etched with nostalgia, but I also need to add that as an anthropologist, the study that I conducted would otherwise not have been possible, if not for the inclusion (as much as it was), into the community.

Baimuru Station is a place in transition, much like the rest of PNG. Sadly, much like many remote centres in PNG, it is also an area in decline. Basic essential services are limited due to lack of infrastructure, under staffing, lack of resources and indifferent governance. Further access to essential services is determined by money. Local economy exists in large part informally, through market sales (goods; fresh produce; money—informal loans or 'moni maket'). The main industry of the sawmill closed (August 2016), and along with it, jobs were lost and the main formal business entity became non-existent. Foreign owned trade stores capitalise on selling out of date food products and poorly manufactured disposable products to an otherwise captive clientele.


The now disused sawmill in Baimuru

Despite these specific developmental challenges, the desire of people in the community to engage in modernity is still high. Economic development, or at least engagement toward stronger economic status, is the hope that many in the community see as being able to strengthen not only their own positions, but the position of the community within the region, province and even nationally.

(Continued on page 13)


Kerema town market

A reflection of life on the Station cont.

(Continued from page 12)

Many enterprising individuals who can raise funds to travel have begun to look to centres such as Kikori (Western Gulf) and Kerema (Eastern Gulf, provincial capital), to seek employment, sell their produce and goods and buy goods to sell back in Baimuru—this stimulates the local economy somewhat, still informally.

These developmental challenges (along with many others) and the notion that economic viability is the priority for individuals and families is important to the conversation on issues of gender inequalities and violence in small communities in PNG. In striving for economic viability and development, certain facets of gender inequality and violence can be compounded and perpetuated. This is one of many topics that will be explored further in my dissertation. Issues concerning cultural structures and social interactions that develop and support concepts of gender inequality and violence within this local community will also be discussed. These and other important themes that will emerge through data analysis, identify a specific local narrative of gender and violence in PNG that can further inform broader discussions, particularly those on responding to gender violence in PNG.


Market at Kikori station (main centre in the Kikori District of Gulf Province)

Nalisa Neuendorf
PhD candidate, Anthropology
College of Arts, Society & Education

See Nalisa's previous newsletter stories from July 2016 and April 2016

Allan Dale appointed to new water panel

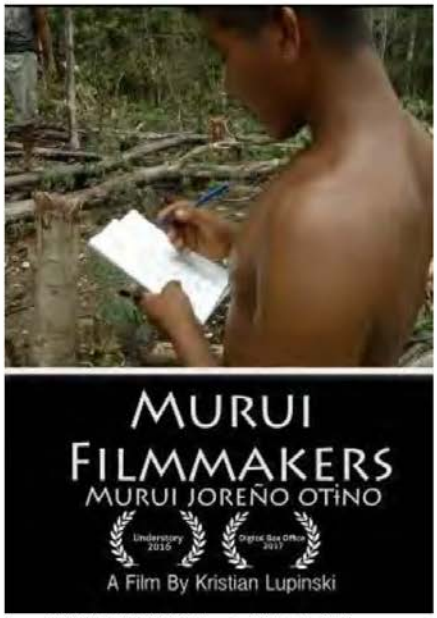
Every three years new members are appointed to the Queensland Government Water Act Referral Panel to provide independent advice to the Minister for State Development and Minister for Natural Resources and Mines, Dr Anthony Lynham, on water resources management matters. This year Professor Allan Dale is one of the 12 appointees who will provide advice on changes to water entitlements held by water users, rules for the operation of a water supply scheme, applications to relocate a water licence, and whether water entitlements are to be granted, amended or refused.

See the membership announcement at the Australian Water Association website.

Murui filmmakers

Recently, Anthropological Laboratory for Tropical Audiovisual Research (ALTAR) members, filmmaker Kristian Lupinski and PhD student at Language & Culture Research Centre, Kasia Wojtylak, released *Murui Filmmakers - Murui Joreño Otino*, a short documentary made entirely in Murui, a language spoken in northwestern parts of the Amazon by about 1,000 people (in southern Colombia and northern Peru).

Murui Filmmakers features Lucio 'Choma' Agga Botyay, one of the Murui film students from a Murui village, Tercera India, in Colombia. In the film, Lucio discusses the importance of documenting his people's disappearing traditions, language, and the traditional way of life.



MURUI FILMMAKERS 2016 poster (Kristian Lupinski)

The film was made possible by a 2015 grant Kasia and Kristian received from the Firebird Foundation for Anthropological Research. Between October 2015 and February 2016, not only have members of the Tercera India community learnt how to make their own films, they also lead the production of a full feature documentary *Our Murui words - Kaí Murui Uai.*


Murui woman, Sandriela Agga, dressed to take part in one of the film classes, 2016, Tercera India, Colombia (Photo: Kasia Wojtylak)

The full feature is currently being edited and is due to be released mid-2017.

Murui Filmmakers: https://youtu.be/SJT68R4QUw0

For more information on the project, email: muruifilm@gmail.com

Kristian Lupinski
ALTAR

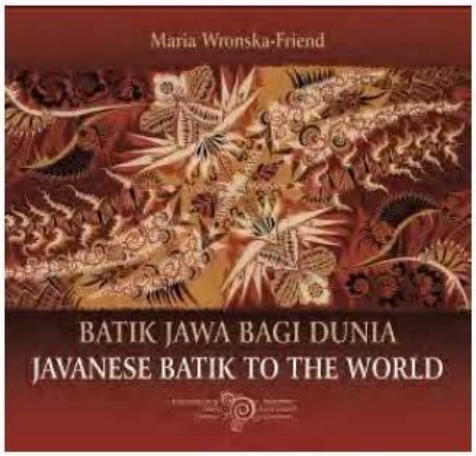
The book was launched in Jakarta at the University of Indonesia by the Dean of the Faculty of Humanities, Dr Adrianus Waluyo Untu Rahmat

Javanese batik to the world

In Indonesia, from time immemorial, cloth has been a highly revered material, produced and decorated in a number of highly creative ways. One of those is the batik of Java: the method of resist-dyeing in which molten wax is used to draw patterns and cover those parts of the cloth that are not to be dyed. In some cases this process is so complex that it may require up to ten months to produce one piece of sarong, worn as a wrap-around skirt.

The best examples of batik fabrics are not only unique products of artistic endeavour, but are valued also for their transcendental qualities: imbued with complex symbolic meanings, they act as a visual expression of the Javanese worldview and philosophy. In 2009 batik of Indonesia received world-wide recognition by being inscribed on the UNESCO List of Intangible Cultural Heritage of Humanity.

However, the cultural significance of Javanese batik extends far beyond the borders of Indonesia. Dr Maria Wronska-Friend, Adjunct Senior Research Fellow at the College of Arts, Society & Education, has for more than thirty years been investigating various aspects of Southeast Asian textiles and costumes. Her latest research focused on the global impact of the technique and aesthetics of Javanese batik which from the end of the 19th century became a source of inspiration for textile producers, designers and artists in countries as diverse as the Netherlands, India, Australia and Ghana. In its early stage, this process was a direct outcome of colonial encounters and globalisation. For example, the Javanese technique was introduced around 1890 to Europe by a group of young artists from Amsterdam who, searching for a new source of inspiration, turned their attention to the arts of the largest colony of the Netherlands, at that time known as the Dutch East Indies. Soon after, batik was practised in all parts of Europe and became a distinctive feature of the Art Nouveau and Art Deco movements. At approximately the same time, Javanese batik iconography was introduced to mass-produced, industrial textiles printed in the Netherlands, UK and Switzerland that were destined for West African markets. Javanese motifs have been enthusiastically received by African people and, following a process of intensive adaptation, have become an integral part of the African textile tradition and identity. One may find them even in Cairns, on fabrics worn by members of the African community.



Book cover

To India, the Javanese technique was introduced in the late 1920s, following the visit of Rabindranath Tagore to Java and Bali. The great Indian poet and philosopher became fascinated with the cultural traditions of Indonesia. He organised an extensive collection of Javanese textiles that

(Continued on page 16)

Batik studio at Ernabella Art Centre, 2008 | Photo: M. Wronska-Friend

Javanese batik to the world cont.

(Continued from page 15)

was used as a reference to create a Bengali version of batik. Tagore's Indonesian collection is kept at the Visva Bharati University at Santiniketan where last year Dr Wronska-Friend was invited to study this significant group of objects.

The most recent cross-cultural encounters took place in the 1970s with the introduction of the batik technique to Aboriginal communities of the central desert of Australia. Here, especially at Ernabella, Fregon and Utopia, wax-resist dyeing became a new form of artistic expression. In the following years several collaborative projects took place, in which Australian and Indonesian artists worked side by side. At times, Javanese batik motifs entered not only fabrics but also drawings and acrylic paintings of Aboriginal artists.

The outcome of Dr Wronska-Friend's research is a bilingual book (in Indonesian and English) *Batik Jawa bagi Dunia*.

The book was endorsed by Dr Hilmar Farid, Director General of Culture at the Ministry of Education and Culture (right). On the left is the publisher, Dr Irwan Julianto

Javanese batik to the world, published in 2016 in Jakarta. The publisher and sponsor is Komunitas Lintas Budaya Indonesia (Indonesian Cross-Cultural Community), an organisation that promotes social integration by fostering inter-ethnic communication. The book has been endorsed by Dr Hilmar Farid, Director General of Culture at the Ministry of Education and Culture and was launched in November 2016 at the University of Indonesia in Jakarta by Dr Adrianus Waworuntu, the Dean of the Faculty of Humanities. A day later a similar event took place at the Gajah Mada University in Yogyakarta, in the city that is recognised as the cultural capital of Java and the heartland of batik.

The book received a very warm reception and good media coverage, including major broadcasting services of the country as well as ABC Australia in the Indonesian language. Much appreciated was not only the content of the book but also the fact that the author, as an expression of her gratitude to the Indonesian people who for almost twenty years provided support for her research, decided to publish this book in Jakarta and in the Indonesian language.

In Indonesia the book is sold by Gramedia—the country's largest network of bookshops, while the Australian distributor is the Asia Bookroom in Canberra.

Queue for autographs at the launch of the book

Creating Futures 2017 Conference

The Cairns Institute's Adjunct Professor Ernest Hunter and Institute event manger Jennifer McHugh recently travelled to Suva, Fiji, to meet with colleagues and plan for the 2017 Creating Futures Conference (CF17). While in Suva they conducted a workshop with the Fijian Conference presenters and staff from the Fijian Ministry of Health (MoH).

The conference will be the largest gathering of practitioners, policy makers, consumers and carers with a focus on mental health in the Western Pacific. **Creating Futures 2017: Fiji**, will be supported by the Fijian MoH, the Fiji Alliance for Mental Health (FAMH) and a range of international organisations including the Royal Australian and New Zealand College of Psychiatrists, James Cook University, the University of Queensland, Central Queensland University, Canterbury University (NZ) and Sangath, an Indian NGO located in Goa that has become a world leader in research and interventions to address unmet needs in mental health across low and middle income countries.

Additionally, over 40 health practitioners from Australia and New Zealand have volunteered their time and covered their own expenses to conduct 32 workshops in areas identified by practitioners and mental health planners in Fiji. The MoH will fund over 80 staff to attend, and other departments, NGOs and interested parties will also be invited to attend.

Ernest Hunter, who is conference convener, is an Australian medical graduate who trained in adult, child and cross-cultural psychiatry, and public health in the United States before returning to Australia in the mid-1980s. He has worked most of the last three decades in remote Indigenous populations, and for the last 25 years in Cape York and the Torres Strait. He is an Adjunct Professor with The Cairns Institute, and the School of Population Health at the University of Queensland

"By comparison to our neighbor states, Australia is privileged beyond measure in terms of economic circumstances and access to social and health services. This is particularly the case in terms of mental health. To make a difference in those less-privileged settings demands commitment for the long term and a significant degree of humility—while we have advantages we do not necessarily have answers. If there are answers out there that we can contribute to, it is through cooperation and co-creation—that's been and remains the driving principle of Creating Futures." Ernest Hunter, 2017.

Coinciding with the conference will be a *Leadership in Mental Health: Island Nations Course*. The is based on the groundbreaking course run by Sangath, which is now a WHO Collaborative Centre in Mental Health. In collaboration with the London School of Hygiene and Tropical Medicine, the course has been running for nearly two decades and is designed for mental health workers from settings in which resources are scarce and who are committed to improving care for people experiencing mental health disorders at a population level. A key driver of the course has been Professor Vikram Patel, nominated by *TIME* as one of the 100 most influential people on the planet for his work in this field. Professor Patel has participated in the last two Creating Futures conferences.

(Continued on page 18)

Developing Northern Australia Conference

Professor Allan Dale will chair the Developing Northern Australia Conference for the third year in 2017. The conference, which will be held in Cairns at the Pullman International Hotel on 19 and 20 June, will focus on initiatives to drive progress, growth and investment in the development of northern Australia.

Previous conferences held in Townsville and Darwin have been hugely successful and this year is also shaping up to be an important event.

Featured speakers include:

- Professor Hurriyet Babacan, CEO, Tablelands Regional Council
- Mr Mark Coffey, Head, Office of Northern Australia
- Mr Philip Davies, CEO, Infrastructure Australia
- Ms Tracey Hayes, CEO, Northern Territory Cattlemans Association
- Professor Sandra Harding, Vice Chancellor and President, James Cook University
- Fiona Jose, Executive General Manager, Cape Operations, Cape York Partnership
- Mr Bernard Salt, AM, Partner, KPMG
- Ms Sharon Warburton, Chair, Northern Australia Infrastructure Facility
- Mr Peter Yu, CEO, Nyamba Buru Yawuru

For more information or to register please visit northaust.org.au/

Creating Futures 2017 cont.

(Continued from page 17)

"Global mental health is the discipline that seeks to address one of the most neglected global health issues of our time. It is also one of the most exciting and dynamic disciplines of global health, with a growing legion of advocates, donors, commitments, and initiatives. While we must celebrate this 'coming of age,' the field still has a long road ahead—one strewn with challenges." Vikram Patel, 2014.

The *Leadership in Mental Health: Island Nations Course* will be run in Suva with the support of FAMH and will be facilitated by two of the course tutors from Sangath, a number of Australian experts in relevant fields, with the support of past Fijian participants from the course. It is anticipated the course will accommodate some 25 delegates, the majority of whom will be from Fiji, with the remainder from neighbour states.

For more information please visit the website www.cairnsinstitute.jcu.edu.au/dialogue/conferences/cf17/

CREATING FUTURES CF17: FIJI

TEDxJCUCairns in 2017

TEDxJCUCairns will return in 2017 with the theme of **Tropovation**. This year we want to celebrate and highlight tropical innovation. We have already started speaking with a number of potential speakers and it looks like we will have another exciting line-up. JCU Creative Media students have already begun work on design aspects of the event. The date is still to be confirmed but it will be at the beginning of September. Keep an eye on the facebook page and website for details.

The talks from 2016 have been well received with some gaining international media attention. All of the speakers have been busy and continue to do great work in our region. Terri Janke's story was the subject of an NITV Living Black documentary. Paul Giacomin, whose talk was titled *Worming your way to good heath* has recently been awarded the Emerging Science Leader by the Queensland Government. The Cairns Regional Council awarded TEDxJCUCairns 2016 speaker Kate Fern the title of Cairns Region Woman of the Year , with Cairns Mayor Bob Manning saying:

"Kate is a shining example of a woman who has the drive and determination to set her own path. This is matched by her tremendous compassion for others, demonstrated by her support of many charities. She is truly a wonderful role model and an asset to our region." (see Cairns Regional Council)

Curator and Designer Grace Lillian Lee has been named as one of the Deadly Indigenous people to watch in 2017 by NITV. Grace, whose talk was titled *Culture to Catwalk* is continuing her work in Indigenous communities and will again curate the Cairns Indigenous Arts Fair Fashion show.

Both Cairns Institute Adjunct Professorial Research Fellow Bill Liley and Jesse Martin (2015) were recently interviewed for a Department of Communities documentary on community initiatives involving domestic violence. Bill's talk, *Gentle hands won't hurt: Our last chance to prevent domestic violence*, outlined some techniques to prevent domestic violence, and Jesse is starting to implement some of the strategies in the work his organisation, The Streets Movement, is doing in jails.

Speakers from previous years have also been busy: 2015 speaker Tulsa Gautam is a semifinalist in the 2017 Queensland Young Achiever Awards, and 2014 speaker David Hudson has been traveling in China with Tourism Australia to promote tourism.

Behind the camera TEDx people have also been active with Tai Inoue, our technical guru, recently working on a couple of documentaries with National Geographic following on from his footage being used in a David Attenborough *Life that Glows* documentary.

Elizabeth Woolley, who has been involved in our integrated student learning program for the past two years, has graduated and been accepted to do Honors. Her Honors will focus on the impact of TEDx talks.

These are just a few examples of what the amazing 44 TEDxJCUCairns speakers from the past three years have been doing. We are so lucky in our region to have such a rich pool of dedicated, talented and inspiring people to work with us to develop TEDxJCUCairns.

You can view talks from 2014, 2015 and 2016 on our website under VIDEOS tedxjcucairns.com/

Hackathon & Myriad

The Institute's Professor Allan Dale was one of the facilitators at the recent "Hack the Reef", a northern part of the state's Myriad Festival. Originating from Silicon Valley, hackathons inspire teams from across many disciplines to join forces to innovate to solve complex problems.

An incredible list of experts and a diverse group of participants were involved in the first ever creative hackathon dedicated to finding solutions to problems facing the Great Barrier Reef on 25 March 2017 in Townsville. Small teams presented their ideas to Hackathon Facilitators after working in groups to come up with creative solutions to a complex problem. A group dealing with the removal of superfine sediments (The Superfines) from catchments won the Hackathon and were given free tickets to attend Myriad.

Following on from "Hack the Reef" Allan coordinated JCU's interface with Myriad. Myriad is the landmark tech and innovation event in Queensland. Despite challenges from the remnants of Cyclone Debbie, Myriad's event program offered an action packed exploration of the Future of Culture; Future of Health; Future of Money; Future of Cities; and the Future of Work and Play.

JCU had a total of 20 students and 9 staff attending the Myriad conference, representing a fantastic range of disciplines including creative arts, Internet of Things, engineering, town planning, politics, occupational therapy, psychology, IT, business and more.

Myriad attracted over 2,000 attendees and 100 speakers. JCU was deeply engaged with the conference as a sponsor, providing a keynote speaker (Professor Alex Loukas), and a Northern Economy workshop (Professor Ian Atkinson). Myriad was also supported by The Space and Innovation NQ.

The AudioVisual Lab offers a unique range of audiovisual services to the University and wider community. With expertise developed from various research situations—from small-scale community projects, to on-campus workshops and documentary production—**The AudioVisual Lab** provides an array of skills and services necessary for the production of audiovisual research outputs.

Bringing high quality production values to projects, small and large, we aim to make audiovisual presentations come alive with clear sound, multiple camera angles and framing, and dynamic editing. The AudioVisual Lab services include: participatory/community based research consultancy; photography; online services.

Packages can be put together according to the scope of events and the requirements of specific clients.

For more details please contact:
Dr Daniela Vávrová | Daniela.Vavrova@jcu.edu.au | Mobile: 0420 593 462 | Studio: 07 4232 1882
Bard Aaberge | Bard.Aaberge1@my.jcu.edu.au | Mobile: 0448 711 975

See examples of our work at espaces.edu.au/av-lab (Linxs)

Native Title Workshop for Mid-Career Anthropologists

September 18th to 22nd 2017
Cairns, QLD

This unique five day Native Title Workshop for Mid-Career Anthropologists is being held at JCU's Cairns campus in beautiful Tropical North Queensland.

Facilitated by The Cairns Institute (JCU) and the Centre for Native Title Anthropology (ANU), this workshop will enhance your professional skills in the Native Title arena. The workshop will cover data management, communication strategies and writing skills, PBC management and governance, and developing skills for engaging with legal culture.

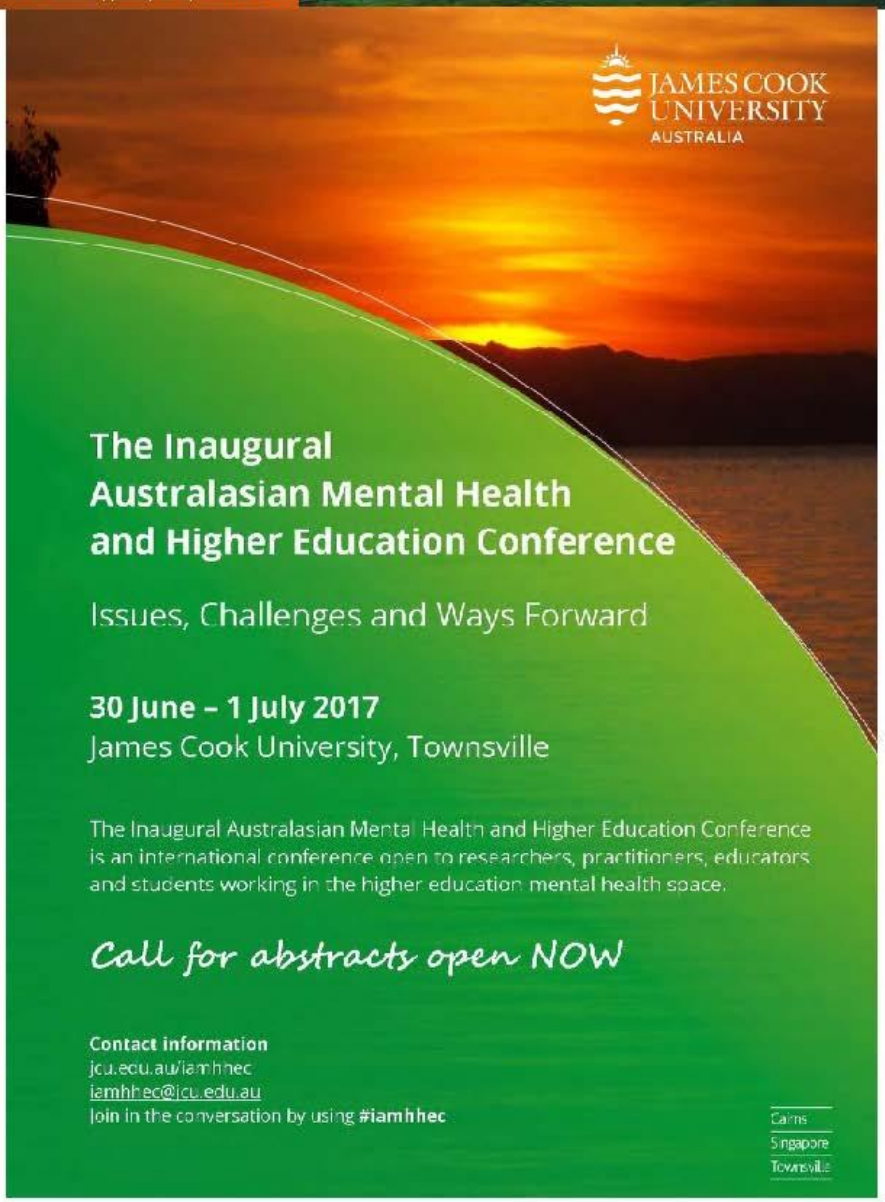
Generous scholarship grants, including fee waiver, food and accommodation for the 5 days are available to mid-career anthropologists on application.

Places are strictly limited

Please pre-register your interest NOW by replying to jennifer.gabriel@jcu.edu.au

We will keep you updated on workshop details.


THE CAIRNS INSTITUTE NEWS
THE CAIRNS INSTITUTE
Research in tropical societies
Kevin John Maurício | pixabay.com/photo-1880440/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Port Moresby | 12-13 December 2017

PRELIMINARY CONFERENCE ANNOUNCEMENT

Research and education across all disciplines are essential to realizing global and national commitments to sustainable development. Knowledge, design and innovation are as important to governance, peace, safety, health and environmental integrity as they are to economic growth and poverty alleviation. As ICT, energy and bio- technologies transform the ways in which people interact, move and work, worldwide, new opportunities are emerging, both to utilize and to protect, PNG's unique human and natural endowments.

Capitalizing on these opportunities will require more though than simply doing more research. At **PNG IMPACT**, speakers and delegates will consider how research can be designed, coordinated and communicated to deliver more societal benefit. Recognizing that no one approach is relevant across all disciplines and issues, case studies will be presented from a diversity of perspectives, with ample time dedicated to dialogue and networking.

PNG IMPACT will:

- Showcase a cross-selection of active research projects, across the sciences, social sciences and humanities, delivering significant societal benefit for PNG.
- Promote dialogue over how research and research policy can best support aspirations for a safe, inclusive and sustainable society.
- Provide a platform for network-building among researchers, research institutions and research stakeholders active in PNG.

PROGRAM

Day 1. Research Showcase - brings all delegates together in a single plenary format for a mixture of:

Keynote presentations to showcase best-practice examples of research providing significant societal impact in PNG.

Panel discussions addressing governance, policy and institutional frameworks for high impact research and innovation.

Day 2. Research Innovation Lab -An interactive and participatory opportunity for researchers active or interested in PNG to share their work, network with colleagues, and explore new collaborations.

The program for the day will include a mix of research presentations, facilitated dialogue and open networking.

A call for papers and detailed program information including speakers will be released as details are confirmed. More information will be posted on the project website https://www.jcu.edu.au/learning-and-teaching/directorate-of-learning-teaching-and-student-engagement/twinning-project

THE CAIRNS INSTITUTE
Research in tropical societies

What is happening in the institute?

Details for these upcoming events can be found at: jcu.edu.au/cairnsinstitute/events/index.htm

Event name	Date & location
ALTAR film screening: Canning Paradise (90 mins) by Olivier Pollet (2012) With an introduction by Dr Simon Foale who will talk about ecological, economic and political aspects of food security and livelihoods in PNG and Solomon Islands	12 April 2017 The Cairns Institute, D3.054
LCRC seminar by Richard Lansdown Berlioz' Memoirs and Delacroix's Journal: Context, Personality, Ethos	12 April 2017 The Cairns Institute, D3.150
LCRC workshop by Distinguished Professor Alexandra Aikhenvald Reflexive and reciprocal constructions in Manambu	19 April 2017 The Cairns Institute, D3.150
LCRC seminar by Nathan White Non-spatial setting in White Hmong	26 April 2017 The Cairns Institute, D3.150
LCRC workshop by Bob Dixon Reflexive and reciprocal constructions in Jarawara	3 May 2017 The Cairns Institute, D3.150
LCRC workshop by Hiroko Sato Reflexive and reciprocal constructions in Kove	10 May 2017 The Cairns Institute, D3.150
Community forum presented by Helen Boon and David King followed by a discussion on resilience in the tropics Disasters and social resilience: A bioecological approach	11 May 2017 Townsville City Campus room 406 & videolink to Cairns D3.054
ALTAR film screening: Salero (76 mins) by Mike Plunkett (2015) A film about salt harvesters in Bolivia	17 May 2017 The Cairns Institute, D3.054
LCRC workshop by Kasia Wojtylak Reflexive and reciprocal constructions in Murui	17 May 2017 The Cairns Institute, D3.150
Book launch and community forum by Distinguished Professor Alexandra Y Aikhenvald How Gender Shapes the World & The Cambridge Handbook of Linguistic Typology & the official opening of TropDoc Project	8 June 2017 The Cairns Institute D3.054 & link to Townsville City Campus room 407
Community forum presented by Liz Tynan Atomic thunder: The Maralinga story	6 July 2017 Townsville City Campus & link to Cairns D3.054
TEDxJCUCairns	2 September 2017 (TBC) The Cairns Institute, D3.054
Tropics of the Imagination Conference Hosted by James Cook University in Singapore	6-9 September 2017 Singapore
Native Title Workshop for Mid-Career Anthropologists	18-22 September 2017 The Cairns Institute
International Day of the tropics lecture—details to come	29 September 2017 JCUS streamed to The Cairns Institute
Fourteenth International Conference on Environmental, Cultural, Economic & Social Sustainability—Open now for proposal submission and registration.	17-19 January 2018

Appendix H: Family Wellbeing Newsletter Publication

My simple story—how FWB came into PNG

My name is Russel Kitau and I am a lecturer at the Division of Public Health School of Medicine and Health Sciences at University of Papua New Guinea. I am currently doing my Doctor of Education program at James Cook University (JCU) under the Conjoint MOU agreement between JCU and UPNG.

It is indeed a great honour and privilege to share a simple story in your newsletter about how FWB came into PNG and why I got involved in it. For me it will be one way I can share my knowledge and experience with the Australian FWB community on why I chose this program. Before I got involved with FWB, many things happened at that time between 2008/2009. It was a period of change and shift in public health program and curriculum from block to integrated teaching approach at the SMHS, UPNG. At that time there were 20 students, 14 were doing the Diploma in Community Health (DCH), and 6 doing Masters in Public Health (MPH). Most of the teaching staff left and with the passing on of the chairman in 2008, I become the acting chairman. Personally, I think everything worked out for the good, in fact a blessing in disguise, which I failed to recognise at that time.

I never realised how relevant and important FWB was until I met Professor Sue McGinty who connected us with Professor Komla Tsey and the Research Empowerment team at JCU Cairns. She was invited to come to UPNG and teach the Qualitative Research Methods course from 2007- 2010. Since JCU was very close to Port Moresby, she suggested that I visit and meet Professor Komla Tsey and the Research Empowerment Team. So I came to JCU to see courses which could be adapted to DCH training at UPNG. One course which was identified as a gap and stood out as important was the support- empowerment change based on the Aboriginal developed Family Wellbeing program. So I visited JCU and spent few days with Professor Komla Tsey and the Research team in Cairns where I was introduced to the FWB Empowerment program. They also arranged a trip for me to visit Yarrabah to see how men's and women's groups were using FWB. I also had the privilege to spend another 3 days in Townsville with Professor Sue McGinty from the School of Indigenous Studies where I met Professor Yvonne Cadet-James and other academic staff.

A report which I read which convinced me that FWB may be relevant in the context of PNG was the report on "No More Bandaid Solution": Yaba Bimbie Indigenous Men's Support Group Evaluation Report: January 2004-June 2005. James Cook University, Cairns, QLD, Australia (McCalman et al, 2005) This inspired me to adapt the FWB program into our Community Health course and curriculum.

Following this successful visit to JCU Cairns, Professor Komla Tsey, Dr Janya McCalman and Dr Mary Whiteside became my main mentors who took a couple trips between 2009 –2011 to facilitate and train me and my staff to facilitate the program.

In May 2009, I invited Professor Komla Tsey and Dr Janya McCalman to come to UPNG and run a one- week FWB empowerment workshop at the School of Medicine and Health Sciences and a paper was published ("Bringing us back to our origin": adapting and transferring an Indigenous Australian values-based leadership capacity-building course for community development in Papua New Guinea, McCalman et al, 2012).

On 25 November 2009, the JCU Human Research Ethics Committee approved the research project from the School of Indigenous Australian Studies on Empowerment and wellbeing program. Our project was *UPNG: Students in the Masters of Public Health, Diploma of Community Health and Diploma of Community Nursing programs completed FWB/ Empowerment & Change course as a compulsory subject within our academic programs.*

The following year, 2010, I assisted Professor Komla Tsey to conduct the second workshop for over 50 participants and evaluated it and wrote and published a paper (Kitau et al, 2012). Between January and February 2010 we conducted FWB as part of the 6 week Summer School course for 20 students at the School of Medicine and Health Sciences. During this time our students assisted me as co-facilitators to conduct FWB Community Health course. The third workshop for the students was conducted in 2011 by Professor Komla Tsey and assisted by Dr Mary Whiteside from La Trobe University.

For the practical field work I took the students to Bereina Government station where we conducted awareness and training on FWB for to the community leaders. This resulted in the church leaders inviting us to conduct research and training for the youths to address the issue of unemployment, drug and substance abuse, interpersonal violence and start a rehabilitation program.

Between 2012 – 2013, we did the training on our own without the support from our Australian counterparts. We trained 28 DPH students as co-researchers and facilitators of FWB who then supported us teach FWB in the Division of Public Health. At the same time I used this opportunity to pilot FWB as a public health education intervention strategy for students in

(Continued on page 16)

My simple story—how FWB came into PNG

(Continued from page 15)

university and youths in community setting. You can see in the photos some of my students whom I trained as facilitators who assisted me in the one-day FWB workshop in Bereina.

Finally, I have found positive results in adapting the data from PNG situation to the transfer and implementation of the Indigenous Australian FWB program from the university to community settings in PNG. My findings highlight the real social challenges confronting PNG and the relevance and applicability of FWB at community levels.

Four themes have emerged from the data analysis: (1) Interpersonal violence prevention; (2) Wellbeing interventions; (3) Transferring programs from one setting to another; and (4) difficulties evaluating community empowerment/wellbeing interventions. I have already published three papers on the results and lessons learnt in international journals (see below).

The next step is to compile these three papers into a plausible thesis write-up for my Doctor of Education. I will be spending the next 5 months at JCU Cairns to write up and submit my thesis and graduate in 2018.

In closing, I'd like to thank Professor Komla and co-advisors for their support and contribution to ensuring FWB was successfully brought to PNG. I also acknowledge JCU who run the FWB program the Australian Aboriginal and Torres Strait Islander peoples as the Traditional Owners of the lands and waters where we operate our business. We pay our respects to ancestors and Elders, past, present and future for sharing with us the FWB program in PNG and beyond their borders.

Russel Kitau
PhD student
UPNG lecturer

FWB workshop conducted in Bereina Government station in Kairuku-Hiri District Central Province in 2013

Kitau, Russel, Whiteside, Mary, Kinchin, Irina, Hane-Nou, Goru, and Tsey, Komla (2017). Transferring the Aboriginal Australian Family Wellbeing Empowerment Program from a Papua New Guinea university context to broader community settings: a feasibility study. *Pacific Journal of Medical Sciences, 17*(1). pp. 22-37.

Kitau, Russel, Samiak, Louis, Guldan, Georgia S., and Machine, Edwin (2016). The public health challenge of dengue fever in Papua New Guinea. *Pacific Journal of Medical Sciences, 16*(1). pp. 20-26.

Kitau, Russel (2015). Implementing the New Papua New Guinea National Health Gender Policy - some challenges and opportunities. *International Review of Social Sciences and Humanities, 9*(1). pp. 23-32.

Appendix I: PowerPoint Presentation of the Gender Paper in the PNG Association of Public Health Conference in Goroka EHP

Implementing the New Papua New Guinea National Health Gender Policy - Some Challenges and Opportunities

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Presented at the PNG Association of Public Health, Goroka, Eastern Highlands, September 2014

Abstract

- Gender equality and gender- based Violence (GBV) are major issues world-wide. Within last two decades many resources were invested in addressing these problems in Papua New Guinea (PNG). With the Millennium Development Goals to end in 2015, PNG must reflect on and learn from the past in striving towards achieving gender equality and reducing GBV. The purpose of this paper is to review the new National Health Gender Policy in the context of previous attempts by the governments and development partners to tackle gender inequality and gender violence. The aim is to highlight potential lessons should be taken into account to ensure successful implementation of the new policy. The study was performed by conducting a thematic analysis and summary of previous attempts to implement gender policies and programs in Papua New Guinea since Independence in 1975. This was followed by a thematic review of the new National Health Gender Policy (2014) to identify challenges and opportunities in implementing the new policy. The opportunity to use an evidence-based approach to provide practical guidance to all key stakeholders to translate the new policy into action is highlighted.
- **Keywords:** Gender, equity, violence, policy, health, policy, implementation, behaviour, change.

Background

- Gender inequality and related gender- based violence (GBV) are major issues worldwide (WHO 2005). Like most countries, Papua New Guinea (PNG), now includes equity on the priority policy agenda. In the last two decades considerable time, effort and resources have been invested in developing strategies to reduce GBV in line with two Millennium Development Goals (MDGs): MDG3, *promoting gender equality* and MDG6, *Combating HIV/AIDS malaria and other diseases* (UN Millennium Project 2005). But time is running out. The deadline for achieving these MDGs is 2015, less than 500 days away. Recent reports show that, some countries have done well, whilst others have not (Pacific Islands Forum Secretariat 2011). Is PNG on track? If so, there is a reason to celebrate; if not, it is time to critically reassess some of these strategies and take the opportunity to make some changes for the coming ten years.

Background

- PNG is an ethnically and culturally diverse country; with more than one thousand tribes and 850 known languages/dialects being spoken (National Statistical Office (NSO) 1997, p. 17). Historically, each tribe or language group was highly independent, with little sense of national identity. Decades of colonial rule over disparate groups culminated in an independent PNG nation in 1975. The PNG Constitution (GoPNG, 1975) contains clear objectives for achieving integral human development and equality and participation, including gender equality (GoPNG, 1975). The Constitution also promotes gender equality through its basic rights provisions, which include rights to freedom and life, and freedom from inhumane treatment. The PNG Constitution is the mother law and all other laws and policies enacted to support gender equality are consistent with it. The Constitution is also linked to several international laws, agreements and conventions, including key United Nations international human rights treaties and international legal instruments on gender equality and women's rights.

These include:

- The Convention on the Elimination of All Forms of Racial Discrimination (1982).
- The Convention on the Rights of Children (CRC) (1993).
- The Convention on the Elimination of All Forms of Discrimination Against Women (1995).
- Millennium Development Goals (2000).
- The Revised Pacific Platform for Action on Advancement of Women and Gender Equality (2005-2010).
- The Commonwealth Plan of Action on Advancement of Women and Gender Equality (2005-2015).
- International Covenant on Economic Social and Cultural Rights (2008).
- Optional Protocol to the Convention on the Elimination of All Forms of Discrimination against Women (2000).
- Beijing Platform for Action (1995).
- Equal Remuneration Convention (1951).
- Discrimination (Employment and Occupation) Convention (1960).
- Convention on the Rights of Person with Disabilities (CRPD) (2012).

Background

- As PNG celebrates its 40th anniversary of independence in 2015, coinciding with the deadline of the MDGs, it must reflect on and learn from the past in striving towards achieving gender equality. Various reports strongly suggests that PNG is unlikely to achieve its MDG goals. Reports by WHO (2007) and United Nations AIDS (2010) concluded that violence against women by intimate partners and others and sexual abuse of children are both common in PNG, and that these behaviours increase the risk of HIV transmission. Bradley (2011) reported that violence against women in PNG is a barrier to the achievement of the MDGs. Furthermore, it was not possible to provide an indicator of violence against women for the MDG 3 target because of lack of data and agreed methods and standards for measuring its various forms (Bradley, 2011). Bradley (2013) found that there was "very little cause for optimism that PNG will be able to meet the targets of MDG3 and MDG6 by the 2015 deadline.

Background

- In 2014, the PNG National Department of Health (NDH) launched the National Health Gender Policy (NHGP) (National Department of Health (NDH) 2014), which aimed to help the country achieve its gender policy objectives. The new policy states: "Today, the policy environment in gender and health is ripe. The health sector provides opportunities for integrating a gender perspective both organizationally within the NDH and in health sector policies and plans" (NDH 2014). While the policy environment may be ripe, the greatest challenge lies in implementing and evaluating such policies. This paper reviews the new PNG NHGP 2014 within the context of previous attempts to develop and implement gender policy initiatives. The aim is to help those responsible for implementing the new policy to avoid repeating mistakes of the past. Two questions guide the review: What are the challenges and opportunities in implementing gender policies in PNG? How can those responsible for implementing the new Gender Health Policy avoid the pitfalls of the past?

Methods

- A systematic literature search of gender equity and GBV prevention policies in PNG was conducted with the assistance of a James Cook University (JCU) librarian using Ovid-Online and Google Search to identify relevant studies. A study was to be selected if it was a PNG national government policy or program focusing primarily or in part on gender equity and or GBV prevention.
- The search strategy was developed to identify all publicly available reports of policies and programs that met the eligibility criteria, using relevant databases. The databases included were: MEDLINE; National Library of Medicine; SAGE Journals Violence Against Women; PEDIATRICS; and WHO Reports. In addition, all PNG national government departmental websites were searched for relevant gender equity and GBV prevention policies and programs. The search terms used were: PNG* OR Pacific*; Gender Equity* or Gender Equality* or Gender- Based Violence*; Prevention* OR Policy* OR Program* OR Practice*.
- Abstracts were screened to determine inclusion or exclusion and where abstracts met the eligibility criteria the papers were read in full. The policies and programs were analysed using qualitative thematic approach (Braun and Clarke 2006). The author read carefully through the relevant policy and program documents to become familiar with the data. He then coded the data line by line and discussed with the primary supervisor how the codes might be grouped into analytic categories and considered their relationship to the review questions.
- The results of the review were then discussed in the context of the broader implementation science literature (de Silva 2014) in order to highlight the need for evidence-based approaches to implementing and evaluating the new Health Gender policy. A draft review was presented to Health Policy makers at the PNG Association of Public Health Specialty Meeting in September 2014 in Goroka and feedback incorporated into the final review.

Results

- Of the six policies that met the inclusion criteria (Table 2), three focused primarily on women and/or gender equity, including the new Health Gender policy (Department for Community Development (DFCD) 2011; Department of Personnel Management (DPM) 2013, NDH 2014). Of the remaining three, two were focused broadly on holistic and inclusive human development (Department of National Planning & Monitoring (DNPM) 2012; PMD 2010) while one focused on health equity for all, including – women and children (NDH 2011).

Table 2. Table 1: PNG Gender Equality informed policies and programs

Author, year	Short title	Responsible Department	Primary Focus	Reported outcomes/challenges
National Strategic Plan Task Force 2010	PNG Vision 2050	Prime Ministers Department	Holistic and inclusive human development	Despite policy prescriptions very little actual movement in terms of recognizable shift towards sustainable modalities of growth had taken place. (Bololoi 2016, p. 9)
DNPM 2010	PNG Development Strategic Plan 2012- 2030	Department of National Planning & Monitoring	Holistic and inclusive human development	Basic services cannot be delivered everywhere but must be strategically located because of resource limitations (DNPM 2015, p. 39)
NHP Task Force, NDH 2011	National Health Plan 2011-2020	Department of Health	Improved access to health for all women and children included	NHP Mid Term Review found shortage of frontline service workers remains and weak monitoring and reporting systems (NDH 2011, p. 7,8)
DFCD 2011	National Policy for Women and Gender Equality (NPWGE) 2011-2015	Department for Community Development	Women and gender equality	Relationships based on gender equality can prevent HIV, lack of coordination, management, monitoring and evaluation; national/departmental annual budgets need to reflect gender equity; need for the justice system to enforce laws (GoPNG 2012)
DPM 2013	Gender Equity and Social Inclusion Policy 2013	Department of Personnel Management	Gender equity and social inclusion	Some movement and changes happening but need to consolidate implementation (Glen Davies, Update, 2015, p 10).
NDH 2014	National Health Gender Policy 2014	Department of Health	Health as vehicle to achieve gender equity	Challenges includes lack of baseline data, lack of coordination, and lack of expertise and gender as women's business.

Summary of previous and current gender-related policies and programs

- A summary of the previous and current gender-related policies and programs is provided. This is followed by an overview of key implementation challenges as a basis or highlighting potential pitfalls associated with the new Health Gender policy.

Previous and current gender equity related policies

- In response to the international commitments, the governments of PNG of all political persuasions have formulated national strategies to address gender issues. As Table 1 shows, some of these strategies are reflected in current policies, including the PNG Vision 2050, the PNG Development Strategic Plan 2012-2030, the National Health Plan (NHP) 2011-2020, the National Policy for Women and Gender Equality (NPWGE) 2011-2015, and the Gender Equity and Social Inclusion Policy (GESIP) 2013.
- Vision 2050, for example, was developed and coordinated by the Prime Minister's Department. After extensive consultation across the country, the plan was finalised and launched by the Government on 16th September 2009 (Bailoloi 2016, p. 9). The vision focuses on making PNG a "smart, wise, fair and happy society" (National Strategic Plan Taskforce 2010, p. 2). Key pillars of the vision are Human Capital Development, Gender, Youth and People Empowerment. The vision includes over twenty quantifiable development indicators and markers designed to monitor and evaluate progress.
- The mission of the PNG Vision 2050 is: "We will be ranked among the top 50 countries in the UN Human Development Index by 2050, creating opportunities for personal and national advancement through economic growth, smart innovative ideas, quality service and ensuring a fair and equitable distribution of benefits in a safe and secure environment for all citizens."(National Strategic Plan Taskforce 2010, p. 2).
- In line with Vision 2050, the Department of National Planning and Monitoring (DNPM) developed the PNG Development Strategic Plan (PNG DSP), 2012-2030, which aims to deliver high quality of life for all Papua New Guineans. The broad objectives are guided by the directives and goals of the PNG National Constitution (GoPNG 1975) and the plan describes how PNG can become a prosperous, middle income country by 2030. The DSP links the principles and focus areas of Vision 2050 and provides policy direction and sector interventions with clear objectives, quantitative targets, and baseline indicators. Both documents emphasise that long-term planning needs to be embraced to ensure fundamental improvements in service delivery.

Previous and current gender equity related policies

- In 2011, the NDH developed the PNG National Health Plan 2011-2020, within the framework provided by key Government of PNG policy documents and National Strategic Plan Taskforce Vision 2050. The plan recognises the importance of basic services.
- The vision is "for PNG to be a healthy and prosperous nation that upholds human rights and Christian/traditional values and ensures affordable, accessible, equitable and quality health services for all citizens." The goal is "to strengthen primary health care for all and improve service delivery for the rural majority and urban disadvantaged." The mission is "to improve, transform and provide quality health services through innovative approaches, by supporting primary health care, health system development and good governance at all levels" (NDH 2011).
- The NDH has also shown leadership in issues relating to gender and sex through the National Gender Policy 2014 (NDH 2014) and Plan on HIV and AIDS (National AIDS Council of Papua New Guinea (NAC) 2010, p. 2). This policy takes on HIV and AIDS issues from the National AIDS Council Secretariat (NACS) and has a strong focus on GBV (NAC 2010, p. 2). Other policies and guidelines have also been developed to complement this such as Child Health Policy (2009), Family Planning Policy (2014), National Youth and Adolescent Health Policy (2014), School Health Policy (2014), National Sexual and Reproductive Health Policy (2014). Several training workshops on gender and awareness activities have been conducted to sensitize health professionals to the place of gender and sexuality in health issues (for example UNFPA and WHO gender mainstreaming for health managers).
- By far, the most extensive initiatives are the National Policy for Women and Gender Equality 2011-2015 (NPWGE) and the Gender Equity and Social Inclusion Policy 2013 (GESIP).

Previous and current gender equity related policies

- The NPWGE was developed and is coordinated by the Department for Community Development.
- The policy provides a framework and strategies for actions in promoting gender equality and preventing violence against women and providing assistance for victims. The policy suggests that two important things must happen to achieve these objectives. Firstly, steps must be taken to promote awareness and understanding that gender equality is about valuing and rewarding the roles and contributions of men and women in society equally. Secondly, progress towards gender equality must be routinely monitored in terms of the extent to which local, provincial and national policies, programs and services provide equal opportunities, treatment and entitlements for both men and women. The Department for Community Development closely monitors and evaluate this policy on a regular basis. (PNG Department for Community Development 2011 2011).
- GESIP was developed by the National Government, through the Department of Personnel Management, because it was recognised that a- national public service workforce that is gender conscious and committed to change was a critical first step in achieving the Government's equality goals. Although the policy is coordinated by the Department of Personnel Management, all departments in the public service are responsible for ensuring that their own recruitment, induction, training, promotion and performance management protocols provide quantifiable indicators of equal treatment of men and women (GESIP 2013).

Implementation challenges

- These policies have all been evaluated and while some progress can be seen, significant challenges still remain. In 2011-2012, the Country Gender Assessment Team conducted the PNG 2011 – 2012 Country Assessment in several PNG provinces to evaluate the NPWGE and the GESIP. The aim of this evaluation was to identify the gender-related barriers to development and provide new directions to enhance development that values and rewards the roles and contributions of men and women equally (GoPNG 2012, p. xvi).

- While recording many achievements, the CGA report also highlighted many barriers remaining to gender equality in PNG. Access to health services, especially for rural women and children, was identified as a major obstacle. Rural women lack the transport and other resources to enable them to access services for themselves and their children when needed. The fact that men rather than women often decide how the household resources are prioritised and utilised contributes to this problem. Another related factor is the lack of education for women. The report points out the need for gender equality in education so that women are empowered and become better able to take action and assert themselves relative to men within both the family setting and in the broader society (GoPNG 2012, p. xvi).

- The report highlights the potential benefits of relationships based on gender equality in the prevention of HIV/AIDS. Many women and girls are still vulnerable to the disease and to reduce the transmission they need to be assisted and empowered to better negotiate sexual relationships. Although economic development across the country has created job opportunities and support for families, it has also exposed women and girls to many vulnerabilities, especially when men migrate to find work and leave their wives to care for children as single parents (GoPNG 2012, p, xvii).

- Overall, the report identifies the lack of coordination, management, monitoring and evaluation of the implementation of the policy during 2011-2012, failing which prevail despite substantial investment input from development partners. It highlighted and recognized the government's efforts incorporating gender recommendations into existing programs and plans. Nevertheless, the report notes with concern that very little effort has been made to ensure gender equality is reflected in national and departmental annual budgetary and resource allocations. The justice system was singled out for its failures to enforce the gender equality law (p xvii). The report emphasises the need for increased funding to implement gender policies as a critical factor for the success of gender equality initiatives (p xvii).

The new National Health Gender Policy

- The purpose of the NHGP is to achieve equality in health status and health development through legislation, policies and programs. The policy also strives to meet the NDH mission to improve primary health care for the rural majority and urban disadvantaged (NDH 2014, p. 4). The main goal is for policy makers and managers to integrate a strong gender perspective into health sector attitudes and to promote the health and gender equality of the people of PNG in a just and equitable way (p 13). The absence of a health gender policy in previous years means that the health sector is yet to institutionalise planning, budgeting and implementation of gender- sensitized programs across the health system.

- The PNG NDH led the process for developing this policy, with assistance from development partners. International conventions and agreements and existing policies in PNG relating to human rights, gender and health were reviewed and summarised with current health statistics (p 3). Broad consultation took place between members of the health sector, development partners and external experts. Stakeholders who participated in these consultations included the NDH Policy Development Working Committee, NDH Family Health Services Branch, non- government organizations (NGOs) such as UNFPA, FHI, PDCJP, RPNGC, CIMC/FSVAC and UN Agencies and other partners. A reviewed version of the strategy was presented at consultative meetings with the support of the WHO Regional Advisor on Gender for final inputs and comments (p 3). The review was guided by six principles (ch 4, p 4-5), Development approach; Human Rights-Based Approach; Informed Freedom of Choice; Millennium Development Goals; Gendered approach; and Life Course perspective. A list of core Government Legislations and Policies relating to gender equality and women's rights was used to support the policy (ch 1, p 1, 6).

The new National Health Gender Policy

- The text is clearly written and is easy for policy makers and managers to read and understand. Chapter 1 provides a short summary of the main intent of the policy, the historical context, the audience and the policy development process. The policy aims to actively promote equality between women and men. To improve health outcomes, all health care providers must work from a gender perspective, which also includes the implementation of government obligations and relevant human rights conventions. From a historical context, Gender Equality Goals were enshrined in the PNG Constitution at Independence in 1975 (p. 2). In terms of audience, all public health agencies at any level of government, training institutions, relevant partners and those accessing health services at all levels are included. The policy development process was based on broad consultation (p2) between the health sector and partners with external experts.

- There are several challenges associated with implementation of the NHGP. Firstly, it says very little on the types of indicators that would be used to assess the impact of the policy. In this regard, Bradley's (2011) concerns about a lack of data and agreed methods and standards for measuring violence against women must be taken seriously. Secondly, implementation of the policy depends on properly trained, qualified and competent managers and the need to adequately train managers who know how to apply information correctly.

- Thirdly, health is a labour-intensive sector and implementation will be impacted by the current shortage of trained workers. To avoid further overburdening the existing strained resources of health workforce, institutions need an increased numbers of trained health workers to help implement the new policy. The implications for service delivery (p 14) depend on addressing the health workers needs. This process should start from within; managers should act as agents of change and take the lead as role models. Finally, as in other sectors, coordination is a major challenge. The policy does address coordination as the fourth policy, but is not specific enough on how this will be done.

Discussion and Conclusion

- This paper reviewed the new PNG NHGP in the context of previous attempts by the and development partners to tackle gender inequality and violence against women. The aim was to highlight potential lessons that should be taken into account to ensure successful implementation of the policy. The main lesson is that developing a policy is one thing, but implementing the policy successfully is another. The history of PNG as an independent nation is littered with well-intentioned gender-informed policies, plans, programs and other initiatives. Unfortunately, there have been problems with implementation and with proper evaluation of what works for whom and under what circumstances. The main barriers to successful implementation include: lack of baseline data, poor coordination, lack of expertise and a cultural mindset among both men and women in PNG that gender is women's business.

- The barriers to successful implementation are many, but for the sake of brevity, this conclusion highlights only one: the need to take a more robust evidence-based approach to gender policy implementation in PNG. Bringing about gender equality involves major cultural changes and dramatic shifts in power relationships between men and women. It requires a proper understanding of how new ideas, innovations and cultural changes can be disseminated to lead to changes in behaviours, attitudes and beliefs. The process involves not only changing individual mindsets, but also those of groups and communities of people, as well as the systems and institutions. Yet, the NHG policy says very little about the nature of evidence informing the priority strategies and actions.

- Table 3 provides a summary of the available evidence for the effectiveness of various approaches to the spread of innovations (de Silva 2014). This evidence summary highlights three issues, which are relevant to the PNG NHGP policy implementation. Firstly, no single dissemination strategy is likely to effect significant cultural and behaviour changes on its own. Secondly, dissemination approaches need to target individual, group and systems level changes. Thirdly, combinations of dissemination approaches carefully targeted at the multiple levels of change are likely to be more effective. An evidence- based approach can provide practical guidance to all the key stakeholders responsible for translating the new health gender policy into action.

Discussion and Conclusion

- For the universities and training institutions which are expected to produce a workforce that is sensitive and committed to gender equity, a useful starting point is to have reliable baseline information on the extent to which the current curricular are gender informed then follow this by incorporating appropriate gender-based learning into courses and evaluating its impact on students. For NGOs facilitating gender workshops across the country, the starting point is perhaps to step back and ask: what are we trying to how can we add value to each other's approach and evaluate the impact or benefits across multiple rather than individual programs? For the NHD policy makers charged with the overall responsibility for implementing the policy, the starting point would be to collect relevant local, regional and national monitoring and evaluation data such as the knowledge, attitudes and practices towards gender equality and the incidence of GBV against which to monitor progress. It would be equally important is to consider the nature of the evidence underpinning the key elements of the policy to make changes in light of the strength of the available evidence.

Table 3. Summary of key findings about dissemination approaches examined in this table

Dissemination approach	Summary of key finding from the research
1. Written materials	Written materials may increase awareness but is less likely to motivate behaviour change.
2. Conferences	Conference may spark awareness particularly in early adopters.
3. Social Media	Campaigns have the potential to spread ideas and increase uptake but evidence of longer term impacts is lacking
4. Change Champions	Change champions of opinion leaders can influence uptake, especially among clinicians.
5. Training	Training can improve the knowledge and skills of participants but the impact depends on the format and may be short term.
6. Train-the – trainers	Train-the-trainers program can help to share skills but may not always improve uptake of new practices if sufficient resources are not dedicated to roll out
7. Action Research	Action research has the potential to spread practice within wider teams, but the evidence base is lacking
8. Collaborators	Evidence about the impact of collaborators is mixed. They can help to improve good practice but effects may not disseminate more widely than to those taking part.
9. Networks	Ideas are spread through social professional networks, but the exact mechanisms for this and how to harness networks effectively remain uncertain.
	Source: Debra de Silva, *Spreading improvement: Tips from empirical research*, Health Foundation inspiring improvement, No. 20, Evidence Centre, United Kingdom, 2014.

List of Abbreviations:

- **AIDS** Acquired Immune Deficiency Syndrome
- **CIMC** Central Implementation and Monitoring Committee
- **FHI** Family Health International
- **FSVAC** Family Sexual Violence Action Committee
- **GBV** Gender – Based Violence
- **GESIP** Gender Equity and Social Inclusion Policy 2013 (GESIP)
- **GoPNG** Government of Papua New Guinea
- **HIV** Human Immuno- Deficiency Virus
- **MDG** Millennium Development Goal
- **NACS** National AIDS Council Secretariat
- **NDH** National Department of Health
- **NGO** Non- Government Organizations
- **NHGP** National Health Gender Policy
- **NHP** National Health Plan
- **NPWGE** National Policy for Women and Gender Equality
- **PDCIP**
- **PNGDSP** Papua New Guinea Development Strategic Plan
- **RPNGC** Royal Papua New Guinea Constabulary
- **UNAIDS** The Joint United Nations Programme on HIV/AIDS
- **UNFPA** United Nations Family Planning Association

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Appendix J: PowerPoint Presentation of the Gender Paper in the Science Conference at UPNG

Implementing the New Papua New Guinea National Health Gender Policy - Some Challenges and Opportunities

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Abstract

- Gender equality and gender- based Violence (GBV) are major issues world-wide. Within last two decades many resources were invested in addressing these problems in Papua New Guinea (PNG). With the Millennium Development Goals to end in 2015, PNG must reflect on and learn from the past in striving towards achieving gender equality and reducing GBV. The purpose of this paper is to review the new National Health Gender Policy in the context of previous attempts by the governments and development partners to tackle gender inequality and gender violence. The aim is to highlight potential lessons should be taken into account to ensure successful implementation of the new policy. The study was performed by conducting a thematic analysis and summary of previous attempts to implement gender policies and programs in Papua New Guinea since Independence in 1975. This was followed by a thematic review of the new National Health Gender Policy (2014) to identify challenges and opportunities in implementing the new policy. The opportunity to use an evidence-based approach to provide practical guidance to all key stakeholders to translate the new policy into action is highlighted.
- **Keywords:** Gender, equity, violence, policy, health, policy, implementation, behaviour, change.

Background

- Gender inequality and related gender- based violence (GBV) are major issues worldwide (WHO 2005). Like most countries, Papua New Guinea (PNG), now includes equity on the priority policy agenda. In the last two decades considerable time, effort and resources have been invested in developing strategies to reduce GBV in line with two Millennium Development Goals (MDGs): MDG3, *promoting gender equality* and MDG6, *Combating HIV/AIDS malaria and other diseases* (UN Millennium Project 2005). But time is running out. The deadline for achieving these MDGs is 2015, less than 500 days away. Recent reports show that, some countries have done well, whilst others have not (Pacific Islands Forum Secretariat 2011). Is PNG on track? If so, there is a reason to celebrate; if not, it is time to critically reassess some of these strategies and take the opportunity to make some changes for the coming ten years.

Background

- PNG is an ethnically and culturally diverse country; with more than one thousand tribes and 850 known languages/dialects being spoken (National Statistical Office (NSO) 1997, p. 17). Historically, each tribe or language group was highly independent, with little sense of national identity. Decades of colonial rule over disparate groups culminated in an independent PNG nation in 1975. The PNG Constitution (GoPNG, 1975) contains clear objectives for achieving integral human development and equality and participation, including gender equality (GoPNG, 1975). The Constitution also promotes gender equality through its basic rights provisions, which include rights to freedom and life, and freedom from inhumane treatment. The PNG Constitution is the mother law and all other laws and policies enacted to support gender equality are consistent with it. The Constitution is also linked to several international laws, agreements and conventions, including key United Nations international human rights treaties and international legal instruments on gender equality and women's rights.

These include:

- The Convention on the Elimination of All Forms of Racial Discrimination (1982).
- The Convention on the Rights of Children (CRC) (1993).
- The Convention on the Elimination of All Forms of Discrimination Against Women (1995).
- Millennium Development Goals (2000).
- The Revised Pacific Platform for Action on Advancement of Women and Gender Equality (2005-2010).
- The Commonwealth Plan of Action on Advancement of Women and Gender Equality (2005-2015).
- International Covenant on Economic Social and Cultural Rights (2008).
- Optional Protocol to the Convention on the Elimination of All Forms of Discrimination against Women (2000).
- Beijing Platform for Action (1995).
- Equal Remuneration Convention (1951).
- Discrimination (Employment and Occupation) Convention (1960).
- Convention on the Rights of Person with Disabilities (CRPD) (2012).

Background

- As PNG celebrates its 40thanniversary of independence in 2015, coinciding with the deadline of the MDGs, it must reflect on and learn from the past in striving towards achieving gender equality. Various reports strongly suggests that PNG is unlikely to achieve its MDG goals. Reports by WHO (2007) and United Nations AIDS (2010) concluded that violence against women by intimate partners and others and sexual abuse of children are both common in PNG, and that these behaviours increase the risk of HIV transmission. Bradley (2011) reported that violence against women in PNG is a barrier to the achievement of the MDGs. Furthermore, it was not possible to provide an indicator of violence against women for the MDG 3 target because of lack of data and agreed methods and standards for measuring its various forms (Bradley, 2011). Bradley (2013) found that there was "very little cause for optimism that PNG will be able to meet the targets of MDG3 and MDG6 by the 2015 deadline.

Background

- In 2014, the PNG National Department of Health (NDH) launched the National Health Gender Policy (NHGP) (National Department of Health (NDH) 2014), which aimed to help the country achieve its gender policy objectives. The new policy states: "Today, the policy environment in gender and health is ripe. The health sector provides opportunities for integrating a gender perspective both organizationally within the NDH and in health sector policies and plans" (NDH 2014). While the policy environment may be ripe, the greatest challenge lies in implementing and evaluating such policies. This paper reviews the new PNG NHGP 2014 within the context of previous attempts to develop and implement gender policy initiatives. The aim is to help those responsible for implementing the new policy to avoid repeating mistakes of the past. Two questions guide the review: What are the challenges and opportunities in implementing gender policies in PNG? How can those responsible for implementing the new Gender Health Policy avoid the pitfalls of the past?

Methods

- A systematic literature search of gender equity and GBV prevention policies in PNG was conducted with the assistance of a James Cook University (JCU) librarian using Ovid-Online and Google Search to identify relevant studies. A study was to be selected if it was a PNG national government policy or program focusing primarily or in part on gender equity and or GBV prevention.
- The search strategy was developed to identify all publicly available reports of policies and programs that met the eligibility criteria, using relevant databases. The databases included were: MEDLINE; National Library of Medicine; SAGE Journals Violence Against Women; PEDIATRICS; and WHO Reports. In addition, all PNG national government departmental websites were searched for relevant gender equity and GBV prevention policies and programs. The search terms used were: PNG* OR Pacific*; Gender Equity* or Gender Equality* or Gender- Based Violence*; Prevention* OR Policy* OR Program* OR Practice*.
- Abstracts were screened to determine inclusion or exclusion and where abstracts met the eligibility criteria the papers were read in full. The policies and programs were analysed using qualitative thematic approach (Braun and Clarke 2006). The author read carefully through the relevant policy and program documents to become familiar with the data. He then coded the data line by line and discussed with the primary supervisor how the codes might be grouped into analytic categories and considered their relationship to the review questions.
- The results of the review were then discussed in the context of the broader implementation science literature (de Silva 2014) in order to highlight the need for evidence-based approaches to implementing and evaluating the new Health Gender policy. A draft review was presented to Health Policy makers at the PNG Association of Public Health Specialty Meeting in September 2014 in Goroka and feedback incorporated into the final review.

Results

- Of the six policies that met the inclusion criteria (Table 2), three focused primarily on women and/or gender equity, including the new Health Gender policy (Department for Community Development (DFCD) 2011; Department of Personnel Management (DPM) 2013, NDH 2014). Of the remaining three, two were focused broadly on holistic and inclusive human development (Department of National Planning & Monitoring (DNPM) 2012; PMD 2010) while one focused on health equity for all, including – women and children (NDH 2011).

Table 2. Table 1: PNG Gender Equality informed policies and programs

Author, year	Short title	Responsible Department	Primary Focus	Reported outcomes/challenges
National Strategic Plan Task Force 2010	PNG Vision 2050	Prime Ministers Department	Holistic and inclusive human development	Despite policy prescriptions very little actual movement in terms of recognizable shift towards sustainable modalities of growth had taken place. (Bololoi 2016, p. 9)
DNPM 2010	PNG Development Strategic Plan 2012- 2030	Department of National Planning & Monitoring	Holistic and inclusive human development	Basic services cannot be delivered everywhere but must be strategically located because of resource limitations (DNPM 2015, p. 39)
NHP Task Force, NDH 2011	National Health Plan 2011-2020	Department of Health	Improved access to health for all women and children included	NHP Mid Term Review found shortage of frontline service workers remains and weak monitoring and reporting systems (NDH 2011, p. 7,8)
DFCD 2011	National Policy for Women and Gender Equality (NPWGE) 2011-2015	Department for Community Development	Women and gender equality	Relationships based on gender equality can prevent HIV, lack of coordination, management, monitoring and evaluation; national/departmental annual budgets need to reflect gender equity; need for the justice system to enforce laws (GoPNG 2012)
DPM 2013	Gender Equity and Social Inclusion Policy 2013	Department of Personnel Management	Gender equity and social inclusion	Some movement and changes happening but need to consolidate implementation (Glen Davies, Update, 2015, p 10).
NDH 2014	National Health Gender Policy 2014	Department of Health	Health as vehicle to achieve gender equity	Challenges includes lack of baseline data, lack of coordination, and lack of expertise and gender as women's business.

Summary of previous and current gender-related policies and programs

- A summary of the previous and current gender-related policies and programs is provided. This is followed by an overview of key implementation challenges as a basis or highlighting potential pitfalls associated with the new Health Gender policy.

Previous and current gender equity related policies

- In response to the international commitments, the governments of PNG of all political persuasions have formulated national strategies to address gender issues. As Table 1 shows, some of these strategies are reflected in current policies, including the PNG Vision 2050, the PNG Development Strategic Plan 2012-2030, the National Health Plan (NHP) 2011-2020, the National Policy for Women and Gender Equality (NPWGE) 2011-2015, and the Gender Equity and Social Inclusion Policy (GESIP) 2013.
- Vision 2050, for example, was developed and coordinated by the Prime Minister's Department. After extensive consultation across the country, the plan was finalised and launched by the Government on 16th September 2009 (Bailoloi 2016, p. 9). The vision focuses on making PNG a "smart, wise, fair and happy society" (National Strategic Plan Taskforce 2010, p. 2). Key pillars of the vision are Human Capital Development, Gender, Youth and People Empowerment. The vision includes over twenty quantifiable development indicators and markers designed to monitor and evaluate progress.
- The mission of the PNG Vision 2050 is: "We will be ranked among the top 50 countries in the UN Human Development Index by 2050, creating opportunities for personal and national advancement through economic growth, smart innovative ideas, quality service and ensuring a fair and equitable distribution of benefits in a safe and secure environment for all citizens."(National Strategic Plan Taskforce 2010, p. 2).
- In line with Vision 2050, the Department of National Planning and Monitoring (DNPM) developed the PNG Development Strategic Plan (PNG DSP), 2012-2030, which aims to deliver high quality of life for all Papua New Guineans. The broad objectives are guided by the directives and goals of the PNG National Constitution (GoPNG 1975) and the plan describes how PNG can become a prosperous, middle income country by 2030. The DSP links the principles and focus areas of Vision 2050 and provides policy direction and sector interventions with clear objectives, quantitative targets, and baseline indicators. Both documents emphasise that long-term planning needs to be embraced to ensure fundamental improvements in service delivery.

Previous and current gender equity related policies

- In 2011, the NDH developed the PNG National Health Plan 2011-2020, within the framework provided by key Government of PNG policy documents and National Strategic Plan Taskforce Vision 2050. The plan recognises the importance of basic services.
- The vision is "for PNG to be a healthy and prosperous nation that upholds human rights and Christian/traditional values and ensures affordable, accessible, equitable and quality health services for all citizens." The goal is "to strengthen primary health care for all and improve service delivery for the rural majority and urban disadvantaged." The mission is "to improve, transform and provide quality health services through innovative approaches, by supporting primary health care, health system development and good governance at all levels" (NDH 2011).
- The NDH has also shown leadership in issues relating to gender and sex through the National Gender Policy 2014 (NDH 2014) and Plan on HIV and AIDS (National AIDS Council of Papua New Guinea (NAC) 2010, p. 2). This policy takes on HIV and AIDS issues from the National AIDS Council Secretariat (NACS) and has a strong focus on GBV (NAC 2010, p. 2). Other policies and guidelines have also been developed to complement this such as Child Health Policy (2009), Family Planning Policy (2014), National Youth and Adolescent Health Policy (2014), School Health Policy (2014), National Sexual and Reproductive Health Policy (2014). Several training workshops on gender and awareness activities have been conducted to sensitize health professionals to the place of gender and sexuality in health issues (for example UNFPA and WHO gender mainstreaming for health managers).
- By far, the most extensive initiatives are the National Policy for Women and Gender Equality 2011-2015 (NPWGE) and the Gender Equity and Social Inclusion Policy 2013 (GESIP).

Previous and current gender equity related policies

- The NPWGE was developed and is coordinated by the Department for Community Development.
- The policy provides a framework and strategies for actions in promoting gender equality and preventing violence against women and providing assistance for victims. The policy suggests that two important things must happen to achieve these objectives. Firstly, steps must be taken to promote awareness and understanding that gender equality is about valuing and rewarding the roles and contributions of men and women in society equally. Secondly, progress towards gender equality must be routinely monitored in terms of the extent to which local, provincial and national policies, programs and services provide equal opportunities, treatment and entitlements for both men and women. The Department for Community Development closely monitors and evaluate this policy on a regular basis. (PNG Department for Community Development 2011 2011).
- GESIP was developed by the National Government, through the Department of Personnel Management, because it was recognised that a- national public service workforce that is gender conscious and committed to change was a critical first step in achieving the Government's equality goals. Although the policy is coordinated by the Department of Personnel Management, all departments in the public service are responsible for ensuring that their own recruitment, induction, training, promotion and performance management protocols provide quantifiable indicators of equal treatment of men and women (GESIP 2013).

Implementation challenges

- These policies have all been evaluated and while some progress can be seen, significant challenges still remain. In 2011-2012, the Country Gender Assessment Team conducted the PNG 2011 – 2012 Country Assessment in several PNG provinces to evaluate the NPWGE and the GESIP. The aim of this evaluation was to identify the gender-related barriers to development and provide new directions to enhance development that values and rewards the roles and contributions of men and women equally (GoPNG 2012, p. xvi).

- While recording many achievements, the CGA report also highlighted many barriers remaining to gender equality in PNG. Access to health services, especially for rural women and children, was identified as a major obstacle. Rural women lack the transport and other resources to enable them to access services for themselves and their children when needed. The fact that men rather than women often decide how the household resources are prioritised and utilised contributes to this problem. Another related factor is the lack of education for women. The report points out the need for gender equality in education so that women are empowered and become better able to take action and assert themselves relative to men within both the family setting and in the broader society (GoPNG 2012, p. xvi).

- The report highlights the potential benefits of relationships based on gender equality in the prevention of HIV/AIDS. Many women and girls are still vulnerable to the disease and to reduce the transmission they need to be assisted and empowered to better negotiate sexual relationships. Although economic development across the country has created job opportunities and support for families, it has also exposed women and girls to many vulnerabilities, especially when men migrate to find work and leave their wives to care for children as single parents (GoPNG 2012, p, xvii).

- Overall, the report identifies the lack of coordination, management, monitoring and evaluation of the implementation of the policy during 2011-2012, failing which prevail despite substantial investment input from development partners. It highlighted and recognized the government's efforts incorporating gender recommendations into existing programs and plans. Nevertheless, the report notes with concern that very little effort has been made to ensure gender equality is reflected in national and departmental annual budgetary and resource allocations. The justice system was singled out for its failures to enforce the gender equality law (p xvii). The report emphasises the need for increased funding to implement gender policies as a critical factor for the success of gender equality initiatives (p xvii).

The new National Health Gender Policy

- The purpose of the NHGP is to achieve equality in health status and health development through legislation, policies and programs. The policy also strives to meet the NDH mission to improve primary health care for the rural majority and urban disadvantaged (NDH 2014, p. 4). The main goal is for policy makers and managers to integrate a strong gender perspective into health sector attitudes and to promote the health and gender equality of the people of PNG in a just and equitable way (p 13). The absence of a health gender policy in previous years means that the health sector is yet to institutionalise planning, budgeting and implementation of gender- sensitized programs across the health system.

- The PNG NDH led the process for developing this policy, with assistance from development partners. International conventions and agreements and existing policies in PNG relating to human rights, gender and health were reviewed and summarised with current health statistics (p 3). Broad consultation took place between members of the health sector, development partners and external experts. Stakeholders who participated in these consultations included the NDH Policy Development Working Committee, NDH Family Health Services Branch, non- government organizations (NGOs) such as UNFPA, FHI, PDCJP, RPNGC, CIMC/FSVAC and UN Agencies and other partners. A reviewed version of the strategy was presented at consultative meetings with the support of the WHO Regional Advisor on Gender for final inputs and comments (p 3). The review was guided by six principles (ch 4, p 4-5), Development approach; Human Rights-Based Approach; Informed Freedom of Choice; Millennium Development Goals; Gendered approach; and Life Course perspective. A list of core Government Legislations and Policies relating to gender equality and women's rights was used to support the policy (ch 1, p 1, 6).

The new National Health Gender Policy

- The text is clearly written and is easy for policy makers and managers to read and understand. Chapter 1 provides a short summary of the main intent of the policy, the historical context, the audience and the policy development process. The policy aims to actively promote equality between women and men. To improve health outcomes, all health care providers must work from a gender perspective, which also includes the implementation of government obligations and relevant human rights conventions. From a historical context, Gender Equality Goals were enshrined in the PNG Constitution at Independence in 1975 (p. 2). In terms of audience, all public health agencies at any level of government, training institutions, relevant partners and those accessing health services at all levels are included. The policy development process was based on broad consultation (p2) between the health sector and partners with external experts.

- There are several challenges associated with implementation of the NHGP. Firstly, it says very little on the types of indicators that would be used to assess the impact of the policy. In this regard, Bradley's (2011) concerns about a lack of data and agreed methods and standards for measuring violence against women must be taken seriously. Secondly, implementation of the policy depends on properly trained, qualified and competent managers and the need to adequately train managers who know how to apply information correctly.

- Thirdly, health is a labour-intensive sector and implementation will be impacted by the current shortage of trained workers. To avoid further overburdening the existing strained resources of health workforce, institutions need an increased numbers of trained health workers to help implement the new policy. The implications for service delivery (p 14) depend on addressing the health workers needs. This process should start from within; managers should act as agents of change and take the lead as role models. Finally, as in other sectors, coordination is a major challenge. The policy does address coordination as the fourth policy, but is not specific enough on how this will be done.

Discussion and Conclusion

- This paper reviewed the new PNG NHGP in the context of previous attempts by the and development partners to tackle gender inequality and violence against women. The aim was to highlight potential lessons that should be taken into account to ensure successful implementation of the policy. The main lesson is that developing a policy is one thing, but implementing the policy successfully is another. The history of PNG as an independent nation is littered with well-intentioned gender-informed policies, plans, programs and other initiatives. Unfortunately, there have been problems with implementation and with proper evaluation of what works for whom and under what circumstances. The main barriers to successful implementation include: lack of baseline data, poor coordination, lack of expertise and a cultural mindset among both men and women in PNG that gender is women's business.

- The barriers to successful implementation are many, but for the sake of brevity, this conclusion highlights only one: the need to take a more robust evidence-based approach to gender policy implementation in PNG. Bringing about gender equality involves major cultural changes and dramatic shifts in power relationships between men and women. It requires a proper understanding of how new ideas, innovations and cultural changes can be disseminated to lead to changes in behaviours, attitudes and beliefs. The process involves not only changing individual mindsets, but also those of groups and communities of people, as well as the systems and institutions. Yet, the NHG policy says very little about the nature of evidence informing the priority strategies and actions.

- Table 3 provides a summary of the available evidence for the effectiveness of various approaches to the spread of innovations (de Silva 2014). This evidence summary highlights three issues, which are relevant to the PNG NHGP policy implementation. Firstly, no single dissemination strategy is likely to effect significant cultural and behaviour changes on its own. Secondly, dissemination approaches need to target individual, group and systems level changes. Thirdly, combinations of dissemination approaches carefully targeted at the multiple levels of change are likely to be more effective. An evidence- based approach can provide practical guidance to all the key stakeholders responsible for translating the new health gender policy into action.

Discussion and Conclusion

- For the universities and training institutions which are expected to produce a workforce that is sensitive and committed to gender equity, a useful starting point is to have reliable baseline information on the extent to which the current curricular are gender informed then follow this by incorporating appropriate gender-based learning into courses and evaluating its impact on students. For NGOs facilitating gender workshops across the country, the starting point is perhaps to step back and ask: what are we trying to how can we add value to each other's approach and evaluate the impact or benefits across multiple rather than individual programs? For the NHD policy makers charged with the overall responsibility for implementing the policy, the starting point would be to collect relevant local, regional and national monitoring and evaluation data such as the knowledge, attitudes and practices towards gender equality and the incidence of GBV against which to monitor progress. It would be equally important is to consider the nature of the evidence underpinning the key elements of the policy to make changes in light of the strength of the available evidence.

Table 3. Summary of key findings about dissemination approaches examined in this table

Dissemination approach	Summary of key finding from the research
1. Written materials	Written materials may increase awareness but is less likely to motivate behaviour change.
2. Conferences	Conference may spark awareness particularly in early adopters.
3. Social Media	Campaigns have the potential to spread ideas and increase uptake but evidence of longer term impacts is lacking
4. Change Champions	Change champions of opinion leaders can influence uptake, especially among clinicians.
5. Training	Training can improve the knowledge and skills of participants but the impact depends on the format and may be short term.
6. Train-the – trainers	Train-the-trainers program can help to share skills but may not always improve uptake of new practices if sufficient resources are not dedicated to roll out
7. Action Research	Action research has the potential to spread practice within wider teams, but the evidence base is lacking
8. Collaborators	Evidence about the impact of collaborators is mixed. They can help to improve good practice but effects may not disseminate more widely than to those taking part.
9. Networks	Ideas are spread through social professional networks, but the exact mechanisms for this and how to harness networks effectively remain uncertain.
	Source: Debra de Silva, *Spreading improvement: Tips from empirical research*, Health Foundation inspiring improvement, No. 20, Evidence Centre, United Kingdom, 2014.

List of Abbreviations:

- **AIDS** Acquired Immune Deficiency Syndrome
- **CIMC** Central Implementation and Monitoring Committee
- **FHI** Family Health International
- **FSVAC** Family Sexual Violence Action Committee
- **GBV** Gender – Based Violence
- **GESIP** Gender Equity and Social Inclusion Policy 2013 (GESIP)
- **GoPNG** Government of Papua New Guinea
- **HIV** Human Immuno- Deficiency Virus
- **MDG** Millennium Development Goal
- **NACS** National AIDS Council Secretariat
- **NDH** National Department of Health
- **NGO** Non- Government Organizations
- **NHGP** National Health Gender Policy
- **NHP** National Health Plan
- **NPWGE** National Policy for Women and Gender Equality
- **PDCIP**
- **PNGDSP** Papua New Guinea Development Strategic Plan
- **RPNGC** Royal Papua New Guinea Constabulary
- **UNAIDS** The Joint United Nations Programme on HIV/AIDS
- **UNFPA** United Nations Family Planning Association

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- The author acknowledges the support and contribution from Professor Komla Tsey, Cairns Institute, James Cook University for his guidance and assistance in reviewing this manuscript.

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Appendix K: PowerPoint Presentation at the Inaugural Australian Mental Health Conference

The transfer of an Aboriginal Australian Family Wellbeing empowerment program to Papua New Guinea university and community contexts: A feasibility study

Russel Kitau, Lecturer Division of Public Health,
School of Medicine and Health Sciences, University of Papua New Guinea,
Doctor of Education Student, James Cook University, 13th December 2017

Collaborators/Advisors: Professor Komla Tsey (JCU), Dr. Mary Whiteside (La Trobe University),
Dr. Irina Kinchin (Central Queensland University), Dr. Goru Hane- Nou (UPNG).

Acknowledgment

At James Cook University and UPNG we acknowledge the Australian Aboriginal and Torres Strait Islander peoples and indigenous people from NCD and Central Province as the Traditional Owners of the lands and waters where we operate our business. We pay our respects to ancestors and Elders, past, present and future

Map of Papua New Guinea & Australia

Outline of Presentation

1. Aim of the presentation;
2. What is the Aboriginal Australian Family Wellbeing (FWB) empowerment program?
3. Why I decided to pilot it in PNG?
4. What were the key steps in doing the pilot?
5. What were the main outcomes?
6. What were the main lessons for promoting teacher professional development on a sustainable basis?
7. What is the Way Forward?

1. Aim of the presentation:

- To share with you my story on the process of transferring an Aboriginal Australian FWB empowerment program in the context of public health training and Create Opportunity to achieve my professional development goal- To complete My Doctoral Degree in Education at JCU/UPNG. Related to this is - To use my experience to help my colleagues achieve their own professional development goal.

- **Research question- Is it possible for university teachers in resource-poor countries such as UPNG to use routine teaching and learning to achieve their professional development goals?**

2. What is the Aboriginal Australian Family Wellbeing (FWB) empowerment program?

- The Aboriginal Australian Family Wellbeing (FWB) empowerment program is an evidence-informed group intervention developed by Aboriginal Australians in 1993 to enhance their collective capacity to negotiate a constantly-changing and uncertain world and the problems associated with being a minority population in their country. The FWB approach to empowerment has four main components which often occur in parallel rather than sequentially (Aboriginal Education Development Branch, South Australian Department of Education Training and Employment, 1993, cited in Kitau et al, 2016).

3. Why I decided to pilot it in PNG?

- -as Acting Chair of public health we were faced with lack of staff and none with doctorate or PhD;
- -with AUSAID support we were relying on Australian academics flying-in flying-out from Canberra, Sydney, Brisbane to teach students but not necessarily building local capacity;
- - we decided to take advantage of Cairns close proximity to build partnerships with JCU specifically to build local research and teaching capacity;
- -the FWB focus on empowerment appealed to us because public health is about helping individuals, communities and societies to help themselves;
- **" If you give a person a fish you feed them for a day but if you teach them how to fish they feed themselves for life" (Chinese Proverb).**

4. What were the key steps in implementing the FWB pilot in PNG?

- Previous MOU between JCU and UPNG (2009) Co-tutel Agreement;
- An initial train-the-trainer by JCU colleagues (McCalman et al 2012; Kitau et al 2011);
- Senate decision to make FWB core subject in the public health training (Kitau et al 2011);
- Local PNG staff taught and evaluated the course(Kitau et al 2016; Kitau et al 2017);

Qualitative Results: University students (n= 30)

- "The program of FWB is very important and improve the standard of living within ourselves, family and standard of living as a whole, for health and living condition" (7).
- "It really motivated me because it empower me and build my capacity in the line of my duty" (5).
- "I am a changed person. Because this course helped me to evaluate myself and at the same time has empowered me to do more for other people" (18).
- "This program needs to go out and reach other people or health workers who really need to change" (16)
- "This program should be included in the Education, UPNG Training Curriculum for all students to learn as well" (15).
- "I for one. I will go and implement this program, but I need some form of funding to run this program" (9).

Quantitative Analysis Results (n=20)

Response	%
1.I understood what FWB was about	73%
2. I am not sure what FWB was about	27%
3. I am interested in doing more JCU/UPNG FWB courses	95%
4. I feel competent to implement aspects of FWB myself	90%
5. I feel changed, empowered and confident to use FWB knowledge and skills	90%
6. I feel I can carry out small projects to introduce FWB to local communities as part of my assignments	100%
7.FWB incorporated into existing courses: 7.1 Nominated Health Promotion 7.2 Child Health 7.3 Community Health	 80% 70% 70%

Community Participants (n=50)

- "reunite families, youths and the community" " and "it will help me to solve problems in the family and community" (7).
- "Help us to understand violence and help to resolve conflict... and bring up a better family" (12).
- "I thank you for coming to our forgotten generation to help in building in them the hope for a better FAMILY LIFE in their community" (12).
- "This is my first time to be a Facilitator. Thank God for your heart; to save the youths of Bereina district" (32).
- "We should have some projects like farming looking after animals and projects like making gardens so that we the youths come together so we can do away with drugs and us to become good to the community and also help in our needs and wants of our family." (5).

5. What were the main outcomes?

- - review of the new PNG Health gender policy found several challenges and opportunities in implementation 'gender as women's business' (Kitau 2015).
- -collaboration with NDoH, other stakeholders to develop and pilot new gender based curriculum for health workers in PNG;
- -students found the course empowering (Kitau et al, 2016); -students also found it relevant to PNG context and both men and women can openly discuss gender based violence which is a major challenge for PNG (Kitau et al 2016);
- -with student support we piloted the program in community setting which was enthusiastically received, but there were serious issues about sustainability (Kitau et al 2017);
- -I used data from the student and community pilot studies to undertake a professional doctorate in education- Thesis: "Roller- Coaster: the challenge of using teaching and learning as opportunity for teacher professional development."

6. What are the main lessons for promoting professional development for teachers on a sustainable basis?

- -this pilot study, has shown that **YES it is possible for university teachers including in resource-poor countries such as my situation at UPNG to use routine teaching and learning to achieve their professional development goals.**

- - however, lecturers are already overloaded with teaching so it doesn't help adding more courses as additional work load;

- - therefore, integrating research and empowerment in normal teaching and learning activities is the most feasible way forward.

7. What Is The Way Forward?

1. Future research in PNG needs to focus on how best to support academic staff to achieve doctoral studies.

2. Research also needs to examine ways in which newly-graduated doctorates can then be supported to become independent researchers in an on-going capacity development and enhancement cycle.

3. Other priorities for future research include integration of programs that are shown to work into core business of governments and NGOs services and programs.

4. When university teachers and researchers pilot a program that is shown to be promising then they need to work with government and NGOs service providers to consider integrating such programs into their core business and collaborating with them to monitor and evaluate outcomes.

ACKNOWLEDGEMENT

DPH- LAHARA STUDENTS

COMMUNITY PARTICIPANTS

Thank you.

- Any questions?
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Appendix L: PowerPoint Presentation at UPNG UPDATE Conference

19/02/2018

Transferring the Aboriginal Australian Family Wellbeing empowerment program from a Papua New Guinea university context to broader community settings: a feasibility study

PNG Update Conference at UPNG, 11th of August, 2017

Russel Kitau, Mary Whiteside, Irina Kinchin,
Dr Goru Hane- Nou, Komla Tsey

Outline of presentation

1. Abstract
2. Introduction
3. Aim & Objectives
4. Methodology
5. Results
6. Discussions and Way forward

INTRODUCTION

- Interpersonal violence imposes a significant burden of health harm on both men and women in Papua New Guinea (PNG), including increased HIV risk, hospital admission and death [1,2,3,4,5,6,7].
- Interpersonal violence is aggravated by growing unemployment and associated alcohol and drug use among young adults. (8,9,10,11).
- Health practitioners are also affected by interpersonal violence. The level of safety and security in the workplace has been shown to be a factor in health worker motivation [13].
- Despite efforts including legislative change, public awareness campaigns and training the levels of interpersonal violence in PNG are worsening [14,15].
- Previous pilot studies established acceptability feasibility of the AA (FWB) program in the context of training UPNG (UPNG) public health students in community development [16,17,18].
- Students, community and church leaders program, recommended the potential usefulness of FWB to tackle the high levels of interpersonal violence in PNG communities[16, 18].
- The present paper responds to the student recommendation and subsequent invitations by church and community leaders by testing the appropriateness of FWB as an interpersonal violence intervention in a community setting. The aim is to generate relevant baseline data to inform future FWB and other community interventions in PNG.

Methods

a) **Study Design:** Pilot study cross-sectional descriptive mixed methods

b) **Study site:** NCD, Bereina, Kairuku- Hiri District, Central Province, (2012- 2013)

c) **Participants:** 100 community participants participated 54 men and 44 women.(2 unspecified)

d) **Variables:** Demographic profile, safety, wellbeing, attitude

e) **Ethical Clearance:** JCU Ethics Committee & UPNG SMHS Ethics Committee and verbal consent

f) **Intervention:** 7 hours of FWB.

g) **Reasons for selecting methodology-** Need to learn skills. **Data collection-** Personal journals / Surveys Open –ended questions, workshop evaluations, pre survey questionnaire

h) **Data Analysis-** a) Qualitative Data- Thematic analysis (Braun & Clarke, 2006)

- b) Quantitative Data- Descriptive statistics, Microsoft Excel (Cohen, 1992).

RESULTS (QUANTITATIVE)

- One hundred participants consented to the study and returned completed questionnaires, of whom 54 were male and 44 female, while two participants did not specify their gender, age or employment status. The majority were unemployed (56.0%), aged 24 or younger (42.0 %) or between 25 and 54 (56.0%). High school, i.e. grades 7-10, was the most prevalent level of education (58.0%)

- Overall, nearly half (46.0%) of the participants reported being a victim of physical violence or threats in the previous12 months:34 (63.0%) males and 12 (27.3%) females. One-third (32%) reported that another person had made them fearful:18 (33.3%) males and 14 (31.8%) females. 10 participants had been a victim of an actual or attempted break-in: six (11.1%) males and four (9.1%) females. Physical violence or threats affected males more often than females ($\chi^2(1, N = 98) = 11.01$, $p < .001$), Table 2. 47.8% of the victims of physical violence or threats were aged 24 or younger, Table 1.Of all episodes of abuse, the majority of the victims (73.9%) knew the person who harmed or threatened them or made them fearful. 60.0% knew the person who broke in or attempted to do so.

- Both genders felt less secure at home when alone during the night compared to during the day. Females tend to feel safer during the day when alone, compared to males, who reported feeling more secure during the night. These differences were not statistically significant.

Table 1: Victims' profile by the type of abuse

Variable	Total n=100#	A victim of physical or threatened violence * n=46				A victim of a actual or attempted break-in* n=10				Been made fearful by another person* n=32			
		Female		Male		Female		Male		Female		Male	
		N	%	N	%	n	%	N	%	N	%	N	%
Female/Male	44/54	12	27.3	34	63.0	4	9.1	6	11.1	14	31.8	18	33.3
Age group													
≤ 24	40	6	13.6	14	25.9	3	4.5	2	3.7	8	18.2	14	25.9
25 to 34	26	4	9.1	14	25.9	0	0.0	4	7.4	4	9.1	4	7.4
35 to 54	20	2	4.5	4	7.4	2	4.5	0	0	2	4.5	0	0.0
Employment													
Employed (FT & PT)	16	4	9.1	4	7.4	0	0.0	0	0.0	0	0.0	2	3.7
Unemployed	56	8	18.2	20	37.0	3	4.5	2	3.7	8	18.2	10	18.5
Student	8	0	0.0	4	7.4	2	4.5	2	3.7	2	4.5	4	7.4
Retired	6	0	0.0	0	0.0	0	0.0	0	0.0	4	9.1	0	0.0
Other	12	0	0.0	6	11.1	0	0.0	2	3.7	0	0.0	2	3.7
Education													
Grades 1 to 6	22	4	9.1	10	18.5	0	0.0	4	7.4	2	4.5	4	7.4
Grades 7 to 10	58	4	9.1	20	37.0	2	4.5	2	3.7	8	18.2	12	22.2
Grades 11 to 12	2	2	4.5	0	0.0	2	4.5	0	0.0	2	4.5	0	0.0
Vocational	0	0	0.0	2	3.7	0	0.0	0	0.0	0	0.0	2	3.7
University	4	2	4.5	0	0.0	2	4.5	0	0.0	2	4.5	0	0.0

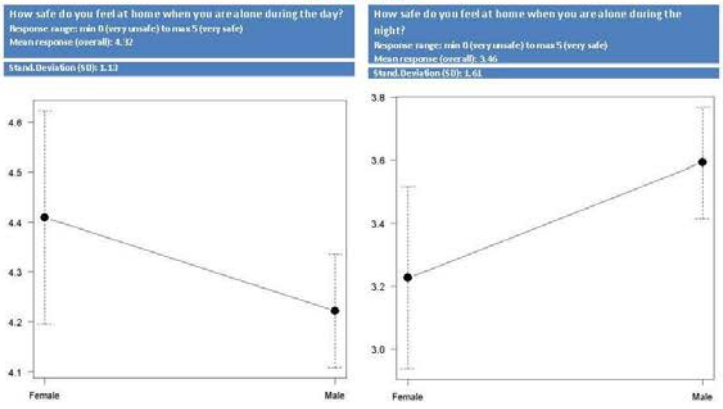
- Two participants did not specify their gender, age and employment status; ## participants did not specify their education; *In the last 12 months; ** The highest proportion were marked in bold for female and male independently, except for gender, FT - full time, PT- part time.

Table 2: Prevalence of abuse by gender

	Female (n = 44)		Male (n = 54)		Rate difference		
	N (%)	95% CI*	N (%)	95% CI*	%	95% CI**	p-value (χ2 male vs female)
A victim of physical or threatened violence in the last 12 months	12 (27.3)	15.4 to 43.0	34 (63.0)	48.7 to 75.4	35.7	14.4 to 52.8	<0.001
A victim of an actual or attempted break in in the last 12 months	4 (9.1)	2.9 to 22.6	6 (11.1)	4.6 to 23.3	2.1	-13.0 to 15.7	NS
Been made fearful by another person over the past 12 months	14 (31.8)	19.0 to 47.7	18 (33.3)	21.5 to 47.6	1.5	-18.3 to 20.6	NS

NS - Not statistically significant
95% confidence interval of a proportion including continuity correction; **95% confidence interval for the difference between two independent proportions including continuity correction.

Figure 1: Average Response Safety at Home



*Error bars represent standard errors (SE). When SE bars overlap, the difference between the two mean scores is not statistically significant (p>0.05): Y-axis represents average score ranging from 0 (very unsafe) to 5 (very safe); SD: standard deviation.

Figure 2: Wellbeing survey results

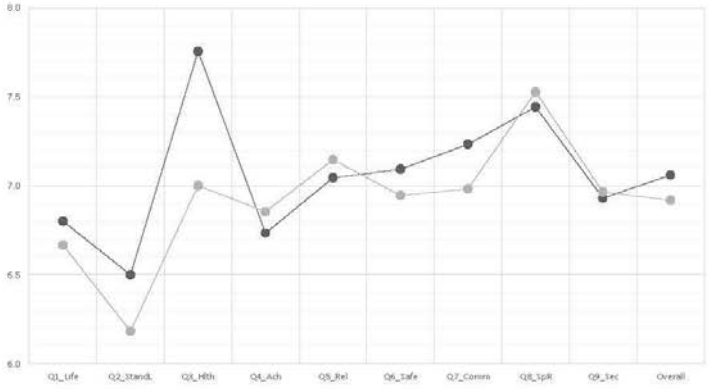
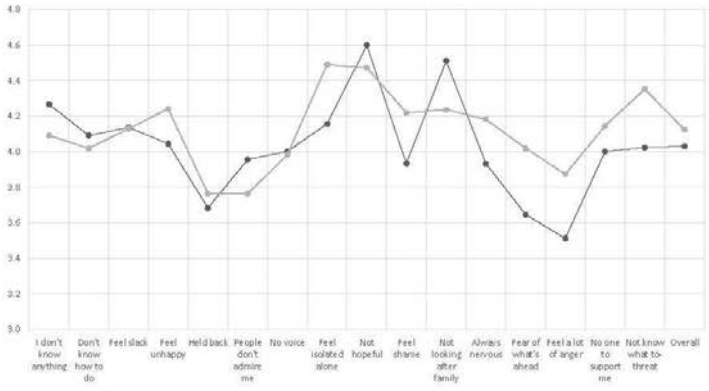


Figure 3 presented the mean scores for GEM survey.



Qualitative measures

- Four main themes emerged from the analysis of the data:
- Community participants could see that the **program content** was relevant to the day-to-day issues they faced and clearly **appreciated the process** through which FWB was delivered.
- Liked opportunity to participate within a safe environment that encouraged openness.
- Other criticisms of the delivery related to lack of time and program resources.
- Participation in FWB led to **change** in a number of ways; a sense of hope that life could be better in the future.
- Next challenge is how to **develop and sustain the program**.
- More opportunities to participate in the program and to continue learning.
- Integrating FWB into existing community programs spiritual development activities run by the church.
- Training might sustain their learning and distract themselves from problems such as drug abuse.
- Several people suggested starting small farming projects,
- Leadership support was seen as critical to program sustainability, village elders /chiefs to participate in course by training more program facilitators.
- Public health lecturer's reflections on his follow up activities designed to support the community implement priority issues arising from the workshops.

DISCUSSION 1

- The need for feasibility of transferring the FWB program from a PNG university setting to broader community contexts to address the problem of endemic interpersonal violence and to generate pilot data to inform future community wellbeing interventions in PNG.
- Findings highlight the very real social challenges confronting - experience their social environment as stressful and unsafe
- As many as 1 in 4 females and more than 1 in 2 males reported being a victim of physical or threatened violence in the last 12 months. Nearly half of the victims were aged 24 or younger, and knew their abusers.
- Both men and women were least satisfied with their standards of living and the most satisfied with spirituality.

DISCUSSION 2

- The extent to which spiritual beliefs and attitudes serve as internal resources for individuals and communities to cope with the day-to-day stresses of life requires further investigation.
- Outcomes included providing a process for identifying basic community needs and offering skills for young people to better address needs.
- Engaging young people in meaningful activity will in the long run improve community safety and wellbeing
- Opportunities for ongoing university support and mentoring, refresher training courses and the utilization of local or online communities of practice could also be explored (although internet infrastructure is very variable in PNG).
- Integrating practical interventions such as FWB in routinely available community education, health and other development programs and services provide a potentially valuable way forward.

ACKNOWLEDGEMENT AND APPRECIATION

Diploma Public Health Students (Facilitators)

Community Facilitators & Participants

Tanikiu bada- herea.

- Any questions?
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Appendix M: PowerPoint Presentation at PNG Medical Symposium

19/02/2018

Transferring the Aboriginal Australian Family Wellbeing empowerment program from a Papua New Guinea university context to broader community settings: a feasibility study

PNG Update Conference at UPNG, 6th of September, 2017

Russel Kitau, Mary Whiteside, Irina Kinchin, Dr Goru Hane- Nou, Komla Tsey

Outline of presentation

1. Abstract
2. Introduction
3. Aim & Objectives
4. Methodology
5. Results
6. Discussions and Way forward

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- Previous pilot studies established acceptability feasibility of the AA (FWB) program in the context of training UPNG (UPNG) public health students in community development [16,17,18].
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g) **Reasons for selecting methodology-** Need to learn skills. **Data collection-** Personal journals / Surveys Open –ended questions, workshop evaluations, pre survey questionnaire

h) **Data Analysis-** a) Qualitative Data- Thematic analysis (Braun & Clarke, 2006)

- b) Quantitative Data- Descriptive statistics, Microsoft Excel (Cohen, 1992).

RESULTS (QUANTITATIVE)

- One hundred participants consented to the study and returned completed questionnaires, of whom 54 were male and 44 female, while two participants did not specify their gender, age or employment status. The majority were unemployed (56.0%), aged 24 or younger (42.0 %) or between 25 and 54 (56.0%). High school, i.e. grades 7-10, was the most prevalent level of education (58.0%)

- Overall, nearly half (46.0%) of the participants reported being a victim of physical violence or threats in the previous12 months:34 (63.0%) males and 12 (27.3%) females. One-third (32%) reported that another person had made them fearful:18 (33.3%) males and 14 (31.8%) females. 10 participants had been a victim of an actual or attempted break-in: six (11.1%) males and four (9.1%) females. Physical violence or threats affected males more often than females ($\chi^2(1, N = 98) = 11.01$, $p < .001$), Table 2. 47.8% of the victims of physical violence or threats were aged 24 or younger, Table 1.Of all episodes of abuse, the majority of the victims (73.9%) knew the person who harmed or threatened them or made them fearful. 60.0% knew the person who broke in or attempted to do so.

- Both genders felt less secure at home when alone during the night compared to during the day. Females tend to feel safer during the day when alone, compared to males, who reported feeling more secure during the night. These differences were not statistically significant.

Table 1: Victims' profile by the type of abuse

Variable	Total n=100#	A victim of physical or threatened violence * n=46				A victim of a actual or attempted break-in* n=10				Been made fearful by another person* n=32			
		Female		Male		Female		Male		Female		Male	
		N	%	N	%	n	%	N	%	N	%	N	%
Female/Male	44/54	12	27.3	34	63.0	4	9.1	6	11.1	14	31.8	18	33.3
Age group													
≤ 24	40	6	13.6	14	25.9	2	4.5	2	3.7	8	18.2	14	25.9
25 to 34	26	4	9.1	14	25.9	0	0.0	4	7.4	4	9.1	4	7.4
35 to 54	20	2	4.5	4	7.4	2	4.5	0	0	2	4.5	0	0.0
Employment													
Employed (FT & PT)	16	4	9.1	4	7.4	0	0.0	0	0.0	0	0.0	2	3.7
Unemployed	56	8	18.2	20	37.0	2	4.5	2	3.7	8	18.2	10	18.5
Student	8	0	0.0	4	7.4	2	4.5	2	3.7	2	4.5	4	7.4
Retired	6	0	0.0	0	0.0	0	0.0	0	0.0	4	9.1	0	0.0
Other	12	0	0.0	6	11.1	0	0.0	2	3.7	0	0.0	2	3.7
Education													
Grades 1 to 6	22	4	9.1	10	18.5	0	0.0	4	7.4	2	4.5	4	7.4
Grades 7 to 10	58	4	9.1	20	37.0	2	4.5	2	3.7	8	18.2	12	22.2
Grades 11 to 12	2	2	4.5	0	0.0	2	4.5	0	0.0	2	4.5	0	0.0
Vocational	0	0	0.0	2	3.7	0	0.0	0	0.0	0	0.0	2	3.7
University	4	2	4.5	0	0.0	2	4.5	0	0.0	2	4.5	0	0.0

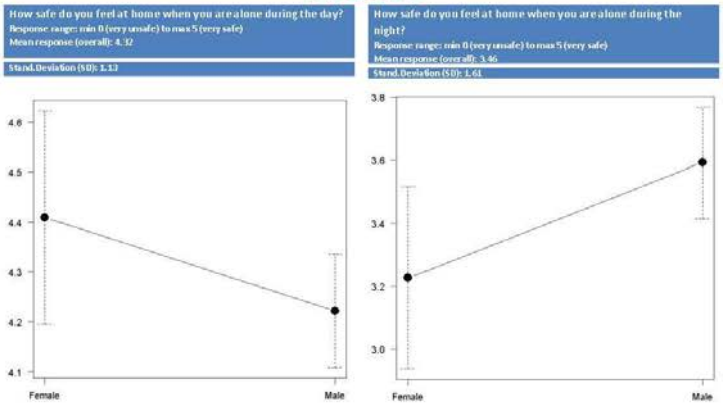
1 – Two participants did not specify their gender, age and employment status; six participants did not specify their education, *In the last 12 months, ** The highest proportion were marked in bold for female and male independently, except for gender, FT – full time, PT- part time.

Table 2: Prevalence of abuse by gender

	Female (n = 44)		Male (n = 54)		Rate difference		
	N (%)	95% CI*	N (%)	95% CI*	%	95% CI**	p-value (χ2 male vs female)
A victim of physical or threatened violence in the last 12 months	12 (27.3)	15.4 to 43.0	34 (63.0)	48.7 to 75.4	35.7	14.4 to 52.8	<0.001
A victim of an actual or attempted break in in the last 12 months	4 (9.1)	2.9 to 22.6	6 (11.1)	4.6 to 23.3	2.1	-13.0 to 15.7	NS
Been made fearful by another person over the past 12 months	14 (31.8)	19.0 to 47.7	18 (33.3)	21.5 to 47.6	1.5	-18.3 to 20.6	NS

NS - Not statistically significant
95% confidence interval of a proportion including continuity correction; **95% confidence interval for the difference between two independent proportions including continuity correction.

Figure 1: Average Response Safety at Home



*Error bars represent standard errors (SE). When SE bars overlap, the difference between the two mean scores is not statistically significant (p>0.05): Y-axis represents average score ranging from 0 (very unsafe) to 5 (very safe); SD: standard deviation.

Figure 2: Wellbeing survey results

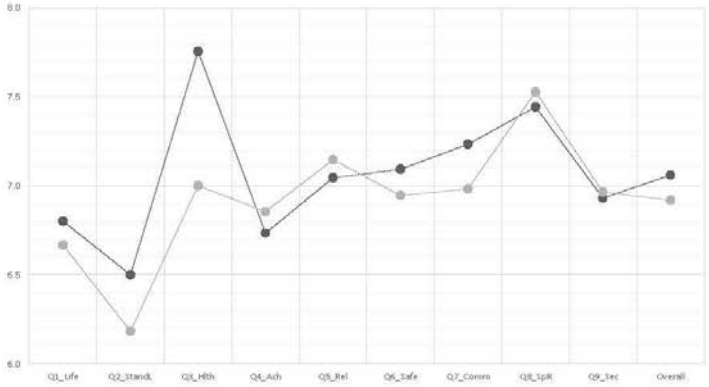
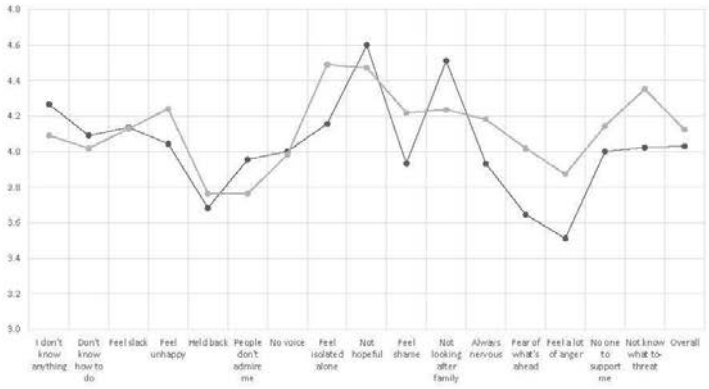


Figure 3 presented the mean scores for GEM survey.



Qualitative measures

- Four main themes emerged from the analysis of the data:
- Community participants could see that the **program content** was relevant to the day-to-day issues they faced and clearly **appreciated the process** through which FWB was delivered.
- Liked opportunity to participate within a safe environment that encouraged openness.
- Other criticisms of the delivery related to lack of time and program resources.
- Participation in FWB led to **change** in a number of ways; a sense of hope that life could be better in the future.
- Next challenge is how to **develop and sustain the program**.
- More opportunities to participate in the program and to continue learning.
- Integrating FWB into existing community programs spiritual development activities run by the church.
- Training might sustain their learning and distract themselves from problems such as drug abuse.
- Several people suggested starting small farming projects,
- Leadership support was seen as critical to program sustainability, village elders /chiefs to participate in course by training more program facilitators.
- Public health lecturer's reflections on his follow up activities designed to support the community implement priority issues arising from the workshops.

DISCUSSION 1

- The need for feasibility of transferring the FWB program from a PNG university setting to broader community contexts to address the problem of endemic interpersonal violence and to generate pilot data to inform future community wellbeing interventions in PNG.
- Findings highlight the very real social challenges confronting - experience their social environment as stressful and unsafe
- As many as 1 in 4 females and more than 1 in 2 males reported being a victim of physical or threatened violence in the last 12 months. Nearly half of the victims were aged 24 or younger, and knew their abusers.
- Both men and women were least satisfied with their standards of living and the most satisfied with spirituality.

DISCUSSION 2

- The extent to which spiritual beliefs and attitudes serve as internal resources for individuals and communities to cope with the day-to-day stresses of life requires further investigation.
- Outcomes included providing a process for identifying basic community needs and offering skills for young people to better address needs.
- Engaging young people in meaningful activity will in the long run improve community safety and wellbeing
- Opportunities for ongoing university support and mentoring, refresher training courses and the utilization of local or online communities of practice could also be explored (although internet infrastructure is very variable in PNG).
- Integrating practical interventions such as FWB in routinely available community education, health and other development programs and services provide a potentially valuable way forward.

ACKNOWLEDGEMENT AND APPRECIATION

Diploma Public Health Students (Facilitators)

Community Facilitators & Participants

Tanikiu bada- herea.

- Any questions?
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Appendix N: PowerPoint Presentation at JCU/UPNG Impact Conference

19/02/2018

The transfer of an Aboriginal Australian Family Wellbeing empowerment program to Papua New Guinea university and community contexts: A feasibility study

Russel Kitau, Lecturer Division of Public Health,
School of Medicine and Health Sciences, University of Papua New Guinea,
Doctor of Education Student, James Cook University, 13th December 2017

Collaborators/Advisors: Professor Komla Tsey (JCU), Dr. Mary Whiteside (La Trobe University),
Dr. Irina Kinchin (Central Queensland University), Dr. Goru Hane- Nou (UPNG).

Acknowledgment

At James Cook University and UPNG we acknowledge the Australian Aboriginal and Torres Strait Islander peoples and indigenous people from NCD and Central Province as the Traditional Owners of the lands and waters where we operate our business. We pay our respects to ancestors and Elders, past, present and future

Map of Papua New Guinea & Australia

Outline of Presentation

1. Aim of the presentation;
2. What is the Aboriginal Australian Family Wellbeing (FWB) empowerment program?
3. Why I decided to pilot it in PNG?
4. What were the key steps in doing the pilot?
5. What were the main outcomes?
6. What were the main lessons for promoting teacher professional development on a sustainable basis?
7. What is the Way Forward?

1. Aim of the presentation:

- To share with you my story on the process of transferring an Aboriginal Australian FWB empowerment program in the context of public health training and Create Opportunity to achieve my professional development goal- To complete My Doctoral Degree in Education at JCU/UPNG. Related to this is - To use my experience to help my colleagues achieve their own professional development goal.

- **Research question- Is it possible for university teachers in resource-poor countries such as UPNG to use routine teaching and learning to achieve their professional development goals?**

2. What is the Aboriginal Australian Family Wellbeing (FWB) empowerment program?

- The Aboriginal Australian Family Wellbeing (FWB) empowerment program is an evidence-informed group intervention developed by Aboriginal Australians in 1993 to enhance their collective capacity to negotiate a constantly-changing and uncertain world and the problems associated with being a minority population in their country. The FWB approach to empowerment has four main components which often occur in parallel rather than sequentially (Aboriginal Education Development Branch, South Australian Department of Education Training and Employment, 1993, cited in Kitau et al, 2016).

3. Why I decided to pilot it in PNG?

- -as Acting Chair of public health we were faced with lack of staff and none with doctorate or PhD;
- -with AUSAID support we were relying on Australian academics flying-in flying-out from Canberra, Sydney, Brisbane to teach students but not necessarily building local capacity;
- - we decided to take advantage of Cairns close proximity to build partnerships with JCU specifically to build local research and teaching capacity;
- -the FWB focus on empowerment appealed to us because public health is about helping individuals, communities and societies to help themselves;
- **" If you give a person a fish you feed them for a day but if you teach them how to fish they feed themselves for life" (Chinese Proverb).**

4. What were the key steps in implementing the FWB pilot in PNG?

- Previous MOU between JCU and UPNG (2009) Co-tutel Agreement;
- An initial train-the-trainer by JCU colleagues (McCalman et al 2012; Kitau et al 2011);
- Senate decision to make FWB core subject in the public health training (Kitau et al 2011);
- Local PNG staff taught and evaluated the course(Kitau et al 2016; Kitau et al 2017);

Qualitative Results: University students (n= 30)

- "The program of FWB is very important and improve the standard of living within ourselves, family and standard of living as a whole, for health and living condition" (7).
- "It really motivated me because it empower me and build my capacity in the line of my duty" (5).
- "I am a changed person. Because this course helped me to evaluate myself and at the same time has empowered me to do more for other people" (18).
- "This program needs to go out and reach other people or health workers who really need to change" (16)
- "This program should be included in the Education, UPNG Training Curriculum for all students to learn as well" (15).
- "I for one. I will go and implement this program, but I need some form of funding to run this program" (9).

Quantitative Analysis Results (n=20)

Response	%
1.I understood what FWB was about	73%
2. I am not sure what FWB was about	27%
3. I am interested in doing more JCU/UPNG FWB courses	95%
4. I feel competent to implement aspects of FWB myself	90%
5. I feel changed, empowered and confident to use FWB knowledge and skills	90%
6. I feel I can carry out small projects to introduce FWB to local communities as part of my assignments	100%
7.FWB incorporated into existing courses: 7.1 Nominated Health Promotion 7.2 Child Health 7.3 Community Health	 80% 70% 70%

Community Participants (n=50)

- "reunite families, youths and the community" " and "it will help me to solve problems in the family and community" (7).
- "Help us to understand violence and help to resolve conflict... and bring up a better family" (12).
- "I thank you for coming to our forgotten generation to help in building in them the hope for a better FAMILY LIFE in their community" (12).
- "This is my first time to be a Facilitator. Thank God for your heart; to save the youths of Bereina district" (32).
- "We should have some projects like farming looking after animals and projects like making gardens so that we the youths come together so we can do away with drugs and us to become good to the community and also help in our needs and wants of our family." (5).

5. What were the main outcomes?

- - review of the new PNG Health gender policy found several challenges and opportunities in implementation 'gender as women's business' (Kitau 2015).
- -collaboration with NDoH, other stakeholders to develop and pilot new gender based curriculum for health workers in PNG;
- -students found the course empowering (Kitau et al, 2016); -students also found it relevant to PNG context and both men and women can openly discuss gender based violence which is a major challenge for PNG (Kitau et al 2016);
- -with student support we piloted the program in community setting which was enthusiastically received, but there were serious issues about sustainability (Kitau et al 2017);
- -I used data from the student and community pilot studies to undertake a professional doctorate in education- Thesis: "Roller- Coaster: the challenge of using teaching and learning as opportunity for teacher professional development."

6. What are the main lessons for promoting professional development for teachers on a sustainable basis?

- -this pilot study, has shown that **YES it is possible for university teachers including in resource-poor countries such as my situation at UPNG to use routine teaching and learning to achieve their professional development goals.**

- - however, lecturers are already overloaded with teaching so it doesn't help adding more courses as additional work load;

- - therefore, integrating research and empowerment in normal teaching and learning activities is the most feasible way forward.

7. What Is The Way Forward?

1. Future research in PNG needs to focus on how best to support academic staff to achieve doctoral studies.

2. Research also needs to examine ways in which newly-graduated doctorates can then be supported to become independent researchers in an on-going capacity development and enhancement cycle.

3. Other priorities for future research include integration of programs that are shown to work into core business of governments and NGOs services and programs.

4. When university teachers and researchers pilot a program that is shown to be promising then they need to work with government and NGOs service providers to consider integrating such programs into their core business and collaborating with them to monitor and evaluate outcomes.

ACKNOWLEDGEMENT

DPH- LAHARA STUDENTS

COMMUNITY PARTICIPANTS

Thank you.

- Any questions?
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Appendix O: PowerPoint Presentation at the UPNG Update Conference: Year of the APEC

"The Challenge of Using Teaching and Learning as opportunity for Teacher Professional Development at the Update Conference: Year of the APEC, UPNG, Waigani, Port Moresby, 15th June 2018

UPDATE CONFERENCE: YEAR OF THE APEC, UPNG, WAIGANI: ROLLER-COASTER:

"THE CHALLENGE OF USING TEACHING AND LEARNING AS OPPORTUNITY FOR TEACHER PROFESSIONAL DEVELOPMENT"

- Russel Kitau, Division of Public Health, School of Medicine and Health Sciences, University of Papua New Guinea, Doctor of Education Student, James Cook University, 15th June 2018

2. BACKGROUND CONTEXT

MY BACKGROUND

- Background about myself RK,
- Early education and professional experience,
- Research challenges I faced as university lecturer,
- Why I decided to do the professional doctorate?

STUDY SITE

3. AIM AND RATIONALE

- ***Roller-coaster*** **is a Professional Doctor of Education thesis by publication. It describes the key steps I have taken as lecturer in public health to use my teaching and learning activities as opportunity to address my own research higher degree needs.**
- **As Acting Chairman of the Division of Public Health (DPH) at the UPNG School of Medicine and Health Sciences (SMHS) at the commencement of the study, I needed to address my own professional development needs in order to better support colleagues in similar situations as me to address their own needs.**
- **To achieve this aim four main goals were set: to develop skills in literature search and reviews; develop understanding and hands-on-experience with qualitative thematic analysis; develop skills in basic quantitative analysis; and strengthen my academic writing and publishing capacity by sharing and disseminating research findings through peer reviewed journals, newsletters, conferences and other presentations.**
- **Instead of researching a single topic in-depth outside my routine teaching activities as is usually the case with conventional PhD, the professional doctorate allowed me to write for different kinds of audiences and to submit a portfolio of research outputs based on my day to day work.**

4. METHODOLOGY

- **IS IT POSSIBLE FOR UNIVERSITY TEACHERS INCLUDING IN RESOURCE – POOR COUNTRIES TO USE TEACHING AND LEADING ACTIVITIES AS OPPORTUNITY TO ACHIEVE THEIR PROFESSIONAL DEVELOPMENT GOALS?**
- **The study was guided by two related research questions: a) what were the main challenges and opportunities involved in using teaching and learning activities to achieve my research higher degree goals; and b) how can this experience help me to better support colleagues in similar situations.**
- **To answer these questions, a mixed methods approach, informed by a range of transformational and pragmatic world views including problem-based learning, empowerment, participatory learning-by-doing, and auto ethnography, was taken.**
- **To ensure the authenticity of the narrative, I have written significant sections of this doctoral study in the first person.**

5. RESULTS AND DISCUSSION

- **IS IT POSSIBLE FOR UNIVERSITY TEACHERS INCLUDING IN RESOURCE – POOR COUNTRIES TO USE TEACHING AND LEADING ACTIVITIES AS OPPORTUNITY TO ACHIEVE THEIR PROFESSIONAL DEVELOPMENT GOALS?**
- **EVIDENCE: Three peer reviewed journal articles are presented as evidence that I achieved the professional development goals I set myself: review of gender policies and programs in Papua New Guinea (PNG); implementation of the Aboriginal Australian Family (FWB) empowerment program in the context of University of Papua New Guinea (UPNG) public health teaching; and the feasibility of transferring the FWB from university to PNG community setting. Newsletter articles and other research outputs are also presented in the appendix as additional supporting evidence.**
- **YES. THE STUDY HAS SHOWN THAT IT IS POSSIBLE FOR UNIVERSITY TEACHERS INCLUDING IN RESOURCE – POOR COUNTRIES TO USE TEACHING AND LEADING ACTIVITIES AS OPPORTUNITY TO ACHIEVE THEIR PROFESSIONAL DEVELOPMENT GOALS. HOWEVER, THE JOURNEY, AS I HAVE EXPERIENCED IT, WAS LIKE A 'ROLLER-COASTER' WITH HIGH AND LOW MOMENTS.**

6. KEY CHALLENGES

- **Key challenges include a steep learning curve, lack of money, time constraints, tiredness, sickness, and family responsibilities.**
- **Despite the many challenges, the reflective learning-by doing approach taken allowed me to use the challenges as opportunities to learn and grow. By routinely reflecting on what was working and not working and how to make things better, I was reminded of the often little but significant incremental progress I was making along the way, especially during the difficult or low moments.**
- **Overall, insights gained from my study highlight the nature of empowerment and how this might be fostered or cultivated in the context of health workforce development in PNG. A range of study limitations and suggestions for future research are highlighted.**

7. STUDY LIMITATIONS

- **Study based on data collected through previous FWB pilot study and research training and fieldwork activities for which ethics approval was obtained.**

- **Lack of experience. Even though I had support from JCU at the time of collecting the data, there was a gap.**

8. RECOMMENDATIONS

GOAL	STUDY SIGNIFICANCE?	FUTURE RESEARCH?
1,2,3,4	The reflective approach to my doctoral journey informed by both auto-ethnography and PBL principles provides a practical framework for university lecturers embarking on similar professional development journeys.	Examine ways to support new doctorates to become independent researchers and research leaders so they in turn can support next generation of researchers in an on-going capacity development cycle.

9. ACKNOWLEDGEMENTS

- Grateful Acknowledgement is made of Professor Komla Tsey, Principal Advisor, JCU
- Professor Komla Tsey was ably assisted by:
- Dr. Mary Whiteside, La Trobe University
- Dr. Irina Kinchin, Central Queensland University
- Dr. Goru Hane-Nou, University of Papua New Guinea
- My colleagues, students
- My Family (wife and son Junior)

9. ACKNOWLEDGEMENTS

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- My colleagues, students
- My Family (wife and son Junior)