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Addressing the Challenges

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FAMILY PLANNING IN PAPUA NEW GUINEA: CURRENT STATUS AND PROSPECTS FOR RE-POSITIONING FAMILY PLANNING IN THE DEVELOPMENT AGENDA

Geoffrey Hayes

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<th>Description</th>
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<tbody>
<tr>
<td>AAP</td>
<td>Annual Action Plan</td>
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<tr>
<td>ADB</td>
<td>Asian Development Bank</td>
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<tr>
<td>AMS</td>
<td>Area Medical Store</td>
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<td>ASRH</td>
<td>Adolescent and Youth Sexual and Reproductive Health</td>
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<td>AusAID</td>
<td>Australian Agency for International Development</td>
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<tr>
<td>CEDAW</td>
<td>Convention for the Elimination of All Forms of Discrimination Against Women</td>
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<td>CEO</td>
<td>Chief Executive Officer</td>
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<td>CHS</td>
<td>Church Health Service</td>
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<td>CHW</td>
<td>Community Health Worker</td>
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<td>CPR</td>
<td>Contraceptive Prevalence Rate</td>
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<td>CST</td>
<td>Country Services and Support Team</td>
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<td>DHS</td>
<td>Demographic Health Survey</td>
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<td>DP</td>
<td>Development Partners</td>
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<td>FC</td>
<td>Female Condom</td>
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<td>FP</td>
<td>Family Planning</td>
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<td>GBV</td>
<td>Gender Based Violence</td>
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<tr>
<td>GDP</td>
<td>Gross Domestic Product per capita</td>
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<td>GFATM</td>
<td>Global Fund Against AIDS, Tuberculosis and Malaria</td>
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<td>HC</td>
<td>Health Centre</td>
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<td>HEO</td>
<td>Health Extension Officer</td>
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<tr>
<td>HIV/AIDs</td>
<td>Human Immuno Deficiency Virus/Acquired Immuno Deficiency Syndrome</td>
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<td>HSIP</td>
<td>Health Sector Improvement Programme</td>
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<td>ICPD</td>
<td>International Conference on Population and Development</td>
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<td>IUCD</td>
<td>Intrauterine contraceptive device</td>
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<td>LMIS</td>
<td>Logistics Management Information System</td>
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<td>MDG</td>
<td>Millennium Development Goal</td>
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<td>MMR</td>
<td>Maternal Mortality Ratio</td>
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<td>NACS</td>
<td>National AIDS Council Secretariat</td>
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<td>National Department of Health</td>
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<td>NGOs</td>
<td>Non Governmental Organisations</td>
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<td>NCD</td>
<td>National Capital District</td>
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<td>NSV</td>
<td>Non Scalpel Vasectomy</td>
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<td>NZAID</td>
<td>New Zealand Agency for International Development</td>
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<tr>
<td>O&amp;G</td>
<td>Obstetrics and Gynaecology</td>
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<td>PMGH</td>
<td>Port Moresby General Hospital</td>
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<td>POM</td>
<td>Port Moresby</td>
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<td>PNG</td>
<td>Papua New Guinea</td>
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<tr>
<td>O&amp;G Society</td>
<td>Obstetrical and Gynaecological Society</td>
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<td>RH</td>
<td>Reproductive Health</td>
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<td>RHCS</td>
<td>Reproductive Health Commodity Security</td>
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<tr>
<td>Acronym</td>
<td>Full Form</td>
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<tr>
<td>SCF</td>
<td>Save the Children Fund</td>
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<td>SDPs</td>
<td>Service Delivery Points</td>
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<td>SPC</td>
<td>Secretariat of the Pacific Community</td>
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<tr>
<td>STI</td>
<td>Sexually Transmitted Infection</td>
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<tr>
<td>SWAp</td>
<td>Sector Wide Approach</td>
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<tr>
<td>UNAIDS</td>
<td>Joint United Nations Programme on HIV/AIDS</td>
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<td>UNFPA</td>
<td>United Nations Population Fund</td>
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<td>UNICEF</td>
<td>United Nations Children’ Fund</td>
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<td>UNCT</td>
<td>United Nations Country Team</td>
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<tr>
<td>UPNG</td>
<td>University of Papua New Guinea</td>
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<td>VHV</td>
<td>Village Health Volunteers</td>
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<td>WB</td>
<td>World Bank</td>
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<td>WHO</td>
<td>World Health Organisation</td>
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Map of Papua New Guinea
PNG’s fertility transition commenced in the 1970s but has proceeded at a slow and uneven pace. A slow-down in fertility decline was evident in the 1987-97 period when PNG was facing major development problems. Decentralization of health services has undermined health service delivery, including family planning. Given present trends it is unlikely that the TFR will reach replacement level for at least another 20 years, by which time the population will reach 10 million and still be growing.

Family planning in the sense of a set of institutions that served to limit or space-out the number of children has been a feature of Papua New Guinea’s traditional societies. But traditional herbal means of contraception were ineffective and, along with abortion, dangerous to women’s health. Today, traditional forms of family planning co-exist with the use of modern contraceptives, but raise similar fears within the community. Among those who have little understanding of how various contraceptives work, fears of the health consequences of contraception apply to both modern and traditional forms, with the possible exception of post-partum abstinence.

Modern family planning was first provided in a government clinic in 1961 on a very small scale under pressure from the local community. A formal national policy on family planning was introduced in 1973 and by 1978 a large scale programme was being put in place. The devolution of responsibility for family planning from the national level to the newly-created provinces resulted in a significant set-back for family planning from which, arguably, it has yet to fully recover. Political and religious opposition to modern family planning also undermined the programme.

A comprehensive assessment of family planning in 2002 revealed major problems in the delivery of family planning services to individuals, couple and communities in PNG. The assessment revealed that half of all the “health centres” (second- and third-tier of rural health services) were not providing any modern contraceptives at all. Excluding permanent methods, 50 percent of health facilities are providing 95 percent of couple-years of protection (CYP) using oral and injectible contraceptives.

The fact that churches operate nearly half of all rural health centres has major implications for family planning service delivery. The government operates 51 percent of health centres and provides nearly 80 percent of CYP. The Catholic Church operates 20 percent of all health centres and provides 2 percent of CYP for modern methods. While the ovulation method is taught, health staff report that it is difficult to teach to poorly educated or illiterate women.

The contraceptive prevalence rate for modern methods has increased steadily since the 1970s from about 6 percent in 1978 to 24 percent in 2006. The rate of increase in the use of modern family planning between the last two Demographic and Health Surveys (DHS) conducted in 1996 and 2006 has been very slow at about 2.4 percent annual growth. At this rate of increase, it would take more than 30 years to reach a contraceptive prevalence rate of 50 percent.

The proportion of women using “traditional” forms of contraception is rising in some regions of the country. At the national level, the proportion of all married women
using modern contraception is rising, but it is not rising as a proportion of women using any method of contraception.

The unmet need for family planning in 2006 was 44 percent of currently married women, which is a small decrease from 46 percent in 1996. However, because of growth in the population of women of child-bearing age over the decade, the absolute number of women with an unmet need has increased to 632,000 in 2006, a 30 percent increase since 1996. Thus, the “demand” for family planning is growing rapidly and will continue to do so. The unmet need for family planning is highest among women aged 40-49, among women with no education, and among rural women.

The barriers to expanding access to and use of family planning are many and various. They are also formidable and difficult to overcome. The deterioration in primary health care delivery in rural areas following decentralization is a major constraint because it will take many years to re-build this system. Family planning services cannot be improved unless all health care delivery systems improve because family planning is an integral part of primary health. There is no possibility of returning to vertically integrated family planning programmes within the public health system.

The 2002 assessment of family planning identified the following factors as impeding the use and delivery of family planning in rural areas:

- The “attitudes” of health staff as well as the community itself, particularly religious attitudes, constrain potential clients from seeking services and discourage health staff from delivering services. This applies particularly to the supply of services to adolescents.
- Fear and “lack of awareness” are two of the most important reasons for lack of community access.
- Unreliable and inconsistent supplies of contraception are a significant constraint that contributes to discontinuation of modern methods.
- The deteriorating conditions at health centres and district hospitals (both in terms of staff and infrastructure) has severely limited access to tubal-ligation for rural women. Travelling to a provincial hospital for this operation is costly and inconvenient.
- Service providers are either unaware that the family planning policy and the law allows contraceptives to be supplied to any person above 16 years of age regardless of marital status or are unwilling to follow the policy.
- Some family planning staff are asking for written consent from husbands or partners, even though this is neither a legal requirement nor a condition of health policy.
- Adolescents find it very difficult to access condoms or any form of family planning because many health providers self-identify as guardians of the perceived moral order. This moral order does not condone sexual activity among unmarried adolescents. The concept of reproductive rights is either unknown or not accepted.
- Some health centres still restrict family planning services to specific days and times.
- Imposition of consultation fees at the facility level.
• Low level of female education and high rates of illiteracy.

• Many health staff continue to believe that the free distribution of condoms encourages promiscuity and prostitution or they believe that the community itself holds this view..

• Very few women are accessing contraception at Mother and Child Clinics or from pharmacies and shops. The most rapidly growing source of contraception is the PNG Family Health Association (IPPF affiliate). Access from hospitals and health centres is declining but access at aid posts is increasing.

Some of the factors that do not constrain the use of family planning in PNG include the following:

• Preference for a large family. Family size preferences have declined significantly from the 1970s until today. The “wanted” TFR has dropped to 3.0 in 2006, a 23 percent reduction since 1996 and a 50 percent decline since the 1980s. The gap between wanted and actual fertility has been growing rapidly and as of 2006 was 1.4 children, a significant increase from 1996.

• The gap between wanted and actual fertility, as well as the large and growing unmet need for family planning, shows clearly that there is a high existing demand for family planning. It is not necessary to create further demand to justify the expansion and improvement of family planning programmes. Government and other observers have persistently understated the demand and need for family planning in the community over many decades.

• Unacceptability of vasectomy. Vasectomy appears to be an acceptable method of contraception in PNG. This has been suspected since the 1980s but is now proven by wide experience.

Recommendations

• The unwillingness of some churches to provide modern contraception at the health facilities under their management needs to be addressed in a sensitive, yet effective manner. A range of approaches have been suggested and need to be further explored, including the use of CBD, health volunteers, NGOs, mobile clinics and renegotiated service agreements with Church Health Services.

• Place increased emphasis on village aid posts as the primary service delivery point for contraception and family planning. This will require more reliable distribution of commodities to aid posts (commodity security), better training of Community Health Workers and extensive rehabilitation of premises.

• Produce a new, revised version of the family planning policy and service delivery technical guidelines and distribute to all aid posts, health centres and clinics. The revised guidelines needs to focus more on reproductive rights, maternal and child health and less on demographic issues.

• Continue to expand the use of vasectomy across the country.
• Intensified training of CHWs and other health staff to emphasize the adoption of appropriate attitudes toward clients, client rights and quality of care.

• All previous recommendations on how to improve family planning, including the 2003 and 2005 assessment reports, the National Population Policy 2000-2010, and the Report of the Ministerial Task Force on Maternal Health, should be reviewed and cross-check for consistency. Harmonize the recommendations and targets.

• The CPR and TFR targets in the Draft National Sexual and Reproductive Health Policy and the Maternal Health Task Force Report should be adjusted to realistic levels.

• Seek ways to eliminate consultation fees for family planning imposed at facility level.

• Further analysis of DHS data is needed, particularly to further assess the relationships between religion, contraceptive use and unmet need.

• Also re-check the DHS data on the low uptake of family planning in the context of MCH clinics.

• Stronger emphasis on reproductive rights in policy documents and materials used in the training of health workers. Efforts should be made to educate the population at large about rights to family planning services, regardless of who is managing the facility. Posters outlining client rights to be displayed in all service delivery points.

• The Family Health Association should be assisted to expand its operations given its apparent success in distributing 10 percent of all contraceptives, despite its small coverage.

• Encourage all provinces to appoint a family planning logistics manager.

• Review the implementation of the recommendations made in the 2003 and 2005 RHCS assessments by UNFPA.

• Plan for a follow-up family planning assessment in 2012 to review changes since the last comprehensive assessment by Burdon et al. in 2002.
1. **Introduction: Family planning and fertility decline**

(a) **Family planning and contraception: Traditional and Modern concepts**

According to the IPPF, family planning refers to

> the conscious effort of couples and individuals to plan for and attain their desired number of children and to regulate the spacing and timing of their births. Family planning is achieved through contraception and through the treatment of involuntary infertility.¹

Defined in this way, “family planning” is not a completely foreign introduction to Papua New Guinea (PNG) society and culture. Traditional methods of contraception have been identified throughout PNG’s many societies and cultures (Bulmer, 1973; McDowell 1988) and some of these continue to be practiced up to today (Jenkins et al.1994). In addition to deliberate and conscious attempts to prevent conception, many traditional practices had the effect of limiting the number or timing of births that a woman may experience in her lifetime, even though this was not the explicit purpose of the practice. Foremost among these was post-partum sexual abstinence, the practice of abstaining from sexual relations for some years after the birth of a child—often for as long as the child was breast-feeding. In traditional New Guinea cultures, this period could last up to five years (Heider 1973) but 2-3 years was probably more typical. Abstinence was practiced because of a belief that sexual relations before weaning could harm the child by contaminating the mother’s breast milk. As in other traditional cultures, abortion and infanticide were also used in PNG as measures of last resort when the birth of a child offended the moral order (as with an unmarried woman), threatened the survival of another child (as with the birth of twins), or was born with a deformity (McRae 1982).

But traditional forms of contraception and family limitation, however conscious they may have been, were generally not “parity-specific” in the sense encompassed by modern concepts of family planning. That is, in traditional times it is unlikely that women were in a position to formulate a preferred number of children and to apply the knowledge and technical means available to them to achieve exactly that number. More likely, women sought to space children to ensure their survival and to end childbearing when they were no longer capable, in their estimation, of caring for children. In some communities it was considered shameful for women to continue childbearing when their first child was grown up, but not necessarily to have many children (Townsend 1984).

Thus modern family planning is characterized as much by attitude and intention as by the use of specifically modern techniques of contraception. In fact, in modern PNG, traditional techniques coexist with modern attitudes and some attitudes towards contraception are derived from experience with or understanding of traditional techniques. Thus, when the oral contraceptive pill was introduced, some users understood it as

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analogous to the ingestion of traditional herbal medicines made from tree bark or the fruit of certain plants, as taught by the ancestors. Concerns about the side effects of modern methods of contraception also have their counterpart in the effects of traditional contraceptives, which are believed to cause vomiting, bleeding and physical weakness, as well as sterility (Jenkins et al. 1994). The implication is that contraception is not a major cultural innovation and that this should ease the way for the use of modern methods of proven effectiveness.

Note, however, the comment by Townsend (1984) referring particularly to the situation in the Goroka District in the late 1970s:

_The existence of traditional magical or herbal methods of family limitation is not necessarily favourable to the acceptance of modern family planning if shame, secrecy or disapproval surround their use._

Until today, however, the use of modern forms of contraception in PNG, such as condoms, oral contraceptives, injections, tubal ligation, etc. co-exists widely with traditional forms, such as sexual abstinence, withdrawal, the use of herbal medicines, anal sex and other sex acts. Induced abortion by traditional means is another option practiced today to avoid an unwanted birth. The choice of contraceptive method may be determined by circumstances such as lack of access to modern contraceptives in remote rural areas or a preference for traditional ways of managing family life. Similarly, among those who have little understanding of how various contraceptives work, fears of the health consequences apply to both modern and traditional forms. Cost may also be a consideration, but it is not necessarily the case that modern methods are expensive while traditional methods are not. Traditional methods may be more costly than modern ones because only older men or women (or persons skilled in sorcery) have the knowledge of how to prepare traditional medicines and they expect to be paid either in cash or kind. Traditional methods are normally accompanied by rituals that give an impression of witchcraft and may be shunned by those who adhere to Christian beliefs. Health policies prohibit the use of “witchcraft” or “sorcery” in public health provision.

While modern contraception may in principle be free at the distribution point, reaching a Service Delivery Point (most often a health centre rather than a village-based aid post)\(^2\) involves not only the cost of transport but also the opportunity costs arising from the neglect of gardens or the care of children. In the more remote areas, a health centre or District Hospital may only be accessible on foot and after several days walk in some cases. Where there is a high probability that the Health centre will not have a supply of contraceptives, such arduous journeys may not be undertaken and reversion to traditional methods may occur. It is also well understood that the health centre may charge fees for the consultation, even if the contraceptives are free.

\(^2\) In PNG, the lowest level of rural health care provision is the “aid post”, which usually services one or more rural villages or hamlets. The next step up the hierarchy of service provision is the “health sub-centre” which serves a larger cluster of villages. A “health centre” is one step up from a health sub-centre and services a district. In larger districts the health centre has been up-graded to a district hospital. Reference to “health centre” in this document refers to either a health sub-centre or a health centre, i.e., step 2 or three up the hierarchy of services.
The complexity of current practices that show evidence of intermingling of traditional and modern forms of contraception needs to be taken into account when considering the relationship between the contraceptive prevalence rate (CPR) and fertility levels and trends. To some extent this is the case in all Pacific societies, but nowhere more so than in PNG.

(b) The slow fertility transition in Papua New Guinea

There is no evidence to suggest that average completed fertility per woman in Papua New Guinea at the national level reached the heights of other Pacific Island countries in the 1960s and 1970s, where TFRs peaked at 7 or 8 (Hayes and Robertson 2010). PNG’s TFR reached a historical peak at 6.3 in the 1960-65 period (Figure 1), after which it commenced a slow decline to its most recently-measured level of 4.4 in the 2001-2006 period (DHS 2006). However, the fertility transition has not proceeded at a consistent pace since fertility first began to decline in the early 1970s. Compared with the pace of the fertility transition in Less Developed Countries (LDCs) as a group, the rate of fertility decline in PNG has been slow, as can be seen in Figure 1. Furthermore, PNG experienced a distinctive slow-down in the rate of its fertility decline in the period 1985-90 to 1995-00. For the 10 years centred on 1987-1997, the PNG’s TFR dropped by only 0.33, compared with a decline of 0.79 in the LDCs as a group. As of the 2000-05 period, PNG’s TFR was about 1.5 children per woman above the TFR for all LDCs—a difference of 51 percent.

Figure 1: The fertility transition in PNG and LDCs compared, 1950-2005

![Figure 1: The fertility transition in PNG and LDCs compared, 1950-2005](source: UNDESA (2009))
As Figure 2 shows, PNG’s reduced rate of fertility decline in the late 1980s and early 1990s opened a gap between PNG and other LDCs that will probably take a long time to close. The UN “Medium” projections for PNG and the LDCs suggest that PNG would reach a TFR of 2.5 about 20 years after the other LDCs and that it would take until 2045 before “replacement” fertility of 2.2 was reached. Had PNG’s fertility transition not “stalled” prematurely, replacement fertility might have been reached much earlier, and the impact of population “momentum” that much less. As it is, the UN “Medium” population projections suggest that PNG’s total population would reach 12.9 million by 2050 while the “low” projection based on a faster rate of fertility decline would produce a 2050 population of 11.1 million, or 1.8 million fewer people.\(^3\)

![Figure 2: Actual and projected fertility change in PNG and LDCs 1950-2050](image)

Source: UNDESA (2009)

(e) **Research issues**

The relatively slow pace of the fertility transition in PNG relative to the LDCs as a group, and also relative to other Pacific Island countries, is the primary issue in need of explanation. However, an explanation that aimed to be complete, or at least comprehensive, is certainly beyond the scope of this paper as it would require a review of a large number of development indicators and an effort to link these indicators to a general theory of fertility change. What this paper aims to do is to consider the specific relationship between fertility decline and the use of family planning, or more precisely, contraception. For example, is there evidence to demonstrate that the pace of fertility decline has been constrained by various types of barriers or impediments to the use of effective forms of contraception? Even this much reduced question presents analytical

\[^3\] Other projections indicate a population of 13.3 million by 2050 (see SPC 2010).
problems arising from the difficulty of adequately measuring the demand for and the supply of family planning services. As in all analysis using the economic concepts of “supply” and “demand”, supply and demand interact in complex ways. An increase in supply can create its own demand, as when the diffusion of family planning services raises knowledge and awareness of the possibility of effectively controlling fertility among populations that previously had little awareness of this, hence increasing the demand for it. Conversely, a belief among authorities that demand for family planning is low and therefore there is no point in supplying services will almost certainly be self-reinforcing as the best indicator of a demand for family planning is the actual use of it.

In spite of these analytical difficulties, it is possible to gain some indication of supply and demand in the PNG case by the use of Demographic and Health Survey data along with other data sources to shed light on the issue of whether family planning services, or the lack of them, have played a role in PNG’s slow, and occasionally, “stalled” fertility transition. Should it be established that there is a link between slow fertility decline and the shortcomings of family planning services, either because health policies have not placed sufficient emphasis on family planning, or because service delivery has been ineffective, then the issue is what can be done to strengthen family planning within the present paradigm of sexual and reproductive health.

(d) Explanatory framework

This paper does not embrace or test a specific theory of fertility change but simply employs the variables and indicators available from DHS conducted in PNG in 1996 and 2006, supplemented by other data sources. Published DHS tables, however, contain a very limited range of variables and these are generally presented in two-way cross-tabulations. Although sampling errors are published in both the 1996 and 2006 DHS reports, the relationships discussed in this paper have not been tested for statistical significance. Until such tests are done the suggested relationships between variables remain tentative.

(e) Demographic context

The demographic situation in Papua New Guinea, particularly its population growth rate, has long been a subject of controversy. This has arisen from the fact that PNG has a short history of census-taking. The first censuses in 1996 and 1971 were done on a sample basis and were therefore not full enumerations. A belief developed that the 1971 population was under-estimated so it was adjusted upwards, thereby elevating the growth rate. It was later found that the 1971 estimates had been over-adjusted. In the meantime it became widely believed that PNG’s growth rate fell between 2.7 and 3.5 percent, a high rate of growth relative to other developing countries. During the period when the first efforts were being made to formulate a population policy in PNG many politicians believed that the growth rate was 3.5 percent per annum and thus a serious problem was looming (Sharpless 1992). The first census that sought to enumeration the entire population did not take place until 1980 and the second occurred in 1990. The latter census was considered to have suffered from a larger undercount than either the 1980 census or the next census in 2000 thus creating the problem of which census
interval should be used to calculate the growth rate. Again, population growth rates of 2.7 percent per annum were being suggested using the intercensal period 1980-2000.

Allowing for various adjustments to the census counts, it is likely that PNG’s population growth rate peaked at around 2.6 percent annual growth in the 1966-71 period and subsequently declined to somewhere in the range 2.3-2.4 percent by the mid 1990s. Population growth rates based on indirect estimation of birth and death rates from census and surveys generally resulted in lower rates than census counts as they are unaffected by under-enumeration. Based on estimates from the 1996 DHS, population growth around that time would have been about 2.3 percent per annum—a rapid enough rate of growth but somewhat short of “explosive” (Department of Planning and Monitoring 1999).

The best estimate of the present rate of growth is 2.1 percent annually. This is exactly the rate of growth anticipated for the 2005-10 period by the National Population Policy 2000-2010 based on the “medium” population projection. However, the estimated 2010 population of 6.7 million (SPC 2010) is well above the projections contained in the population policy. The most likely reason for this is that the base population for the projections was too low, given that the projections were done before the 2000 census results were available.

Although all projections are uncertain, the HIV epidemic in PNG adds even greater uncertainty. Even in the context of a generalized HIV and AIDS epidemic, however, the population of PNG will continue to grow, but the rate of population growth will be lower given the elevated mortality of AIDS than it would otherwise have been (Hayes 2007). Given that the base population used in the population policy projections was too low, the projections used in the national population policy are no longer valid. Revised projections suggest that PNG’s population will almost certainly reach 10 million but for the population to level-off at around 10 million the rate of fertility decline would need to be considerably faster than it has historically been and faster than assumed under the “low” UN projections.

2. Family planning services

(a) Government family planning services

The first family planning clinic in PNG was established in Port Moresby in 1961 by the Maternal and Child Health Division of the Department of Public Health (Bowler 1968). The initiative came from the community itself, not from the Administration (Bower, 1968; O’Collins 1979). Women in the villages surrounding Port Moresby requested the Administration to provide them with the same “medicine” that allowed the wives of colonial officers to limit their family size to three children. The availability of the service was not publicized but became known through word of mouth. Initially oral contraceptives were offered free. When the IUCD was introduced, the free supply of the contraceptive pill was withdrawn and IUDs were offered free instead.

In the early stages the programme was completely “passive”, providing services to those who requested them but not actively promoting contraception. But the programme spread to other centres in the country on demand. The programme did not
aim to limit family size as such but to assist women who wished to space their children. Nevertheless, tubal ligation was offered to women who wished to stop childbearing, and it was the woman herself who decided when she should stop—usually when she felt too old to take care of children. Tubal ligation was popular among rural women but as its use spread there was opposition from the Catholic Church, which opposed any form of surgery that was not required to cure a disease. The Church distributed pamphlets warning people of the dangers of tubal ligation and husbands came to believe that the operation would be harmful to their wife’s health (Muirden 1976). Quite likely the belief that men were opposed to their wives using family planning originated in this period. For some men at least, their opposition to modern family planning arose from the same fears about the consequences for women’s health as women themselves experienced. Research in the PNG Highlands shows that men are well aware that childbirth is dangerous but they are also concerned that whatever contraception method their wives use it is safe (Pataki-Schweitzer 1993).

In later years, when medical officers travelled to rural areas with the necessary medical equipment to perform tubal-ligations, the response was spontaneous. Burdon, et al. (2002) reported that village women would walk up to 5 days to obtain a tubal ligation. The use of tubal ligation increased rapidly at first but then levelled-off in the mid-1970s, possibly in response to Church opposition. The IUD and tubal-ligation were particularly popular among rural women but were the hardest to obtain because the medical skills necessary to provide these methods were rare.

The issue of whether PNG should adopt a large-scale family planning programme was discussed by demographers in a 1970 meeting sponsored by the Australian National University before independence. The consensus reached was that a massive family planning programme was “not desirable” at that time but may become imperative “within a decade” (Caldwell 1971). Three reasons were given for not embarking on a large-scale family planning programme: (1) PNG still had low population density; (2) a large-scale programme was not politically acceptable; (3) a family planning programme would not attract enough clients to justify it. There was, however, a consensus that a programme would be necessary eventually and that the administration should ensure that the existing level of demand was met so that the experience gained from a “limited” family planning programme could be applied when the time came to initiate a larger scheme. A budget allocation was estimated and a programme of training and research was proposed (Caldwell 1971). It is notable that the health benefits of family planning were not among the criteria used to justify a family planning programme.  

A nation-wide family planning programme was in fact established shortly after by a Cabinet decision in 1973 under the self-governing administration that preceded full independence. After independence, however, political opposition to family planning grew, confirming earlier concerns that a large programme would not find political support. The first Governor-General opposed family planning on the grounds that PNG needed a population of 20 million to protect its land from invasion (D’Sa 1988). Some post-

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4 The question of whether a focussed family planning programme was needed in PNG was still being discussed 30 years later (Burdon et al. 2002) but the justification had shifted to maternal and infant health.
independence politicians saw family planning as a “colonial” imposition. A lively debate in the newspapers on the issue continued for many years. By 1978 posts and training programmes had nevertheless been created, including the establishment of an IEC unit.

By the late 1970s, an active government family planning programme was in operation supported by a specific allocation in the total health budget. The programme focussed on mother and child health. Women were motivated during the antenatal period, at the time of delivery and post-partum to adopt family planning. Women who did not deliver at a health centre were motivated during child health clinics (Muirden 1982). Training of medical officers, aid-post orderlies, nurses, nursing supervisors and other health staff accelerated during the late 1970s. Family planning services, including injectibles, IUDs, condoms, tubal ligation and vasectomy were available at various levels of health care service delivery. A range of other activities supporting family planning had also been undertaken, including the development of IEC materials, radio programmes, family life education in schools (including the use of students to give family planning education in their home villages during vacations) and various seminars for government officers on population and family planning topics. By 1978 it was estimated that 6 percent of women of reproductive age were using family planning (Muirden 1982).

The establishment of provincial governments after independence was followed by decentralization of health service provision. Training of family planning workers devolved gradually to the provinces. In 1982, the responsibility for family planning was transferred to provincial governments and funds for family planning were withdrawn from the national budget (Townsend 1984). The Family Planning Division of the Department of Health was abolished. Decentralization of health services had a negative impact on the national family planning programme, resulting in a decline in the number of contraceptive users (Burdon et al. 2002), and its effects are still evident up to today.

(b) Church health services

An important feature of PNG’s health care delivery system is that a large proportion of rural health centres are operated by churches, primarily the Catholic Church but also including Anglican and other denominations. This has arisen because mission stations normally included a health centre or hospital. These health facilities now receive subsidies from the government to support the provision of primary health care, including family planning.

In 1974, shortly after a government family planning programme was established, the Catholic Church established a Catholic Family Planning Office and later a Family Life Association that commenced teaching the ovulation method of family planning. This method is still taught in Catholic-run health centres and other methods are discouraged. In the early 1980s the Catholic Church distributed a pamphlet against tubal ligation (Ayers-Counts 1981) and pamphlets warning against the use of modern contraception are allegedly still distributed today. The Anglican Church has similarly voiced its opposition to tubal ligation as well as the provision of contraceptives to young or unmarried people.

5 Personal communication with NGO operating in Port Moresby.
The latter policy has caused anguish in some rural communities where a majority of the population feel that the Church should relax its restrictions (Maibani-Miche 1998).

The Health Department presently distributes “kits” of medicines (funded by AusAID) containing a supply of contraceptives to all health centres, including those operated by Churches. It is reported that some Church-operated Health centres remove the contraceptives from the kits and destroy them, a practice that is at the least wasteful (Midire et al. 2005).

(c) NGOs and CBDs

The principal NGO providing family planning in PNG, as in other Pacific countries, is the Family Health Association (FHA). Affiliated with the IPPF, the Family Health Association (originally the Family Planning Association) was established in Port Moresby in 1967. Management difficulties resulted in the FHA withdrawing operations from Port Moresby in the mid-1990s and re-establishing itself in Lae. The FHA currently operates clinics in Lae, Goroka and Rabaul. It also supports Community-based distribution of contraceptives in six rural districts in Morobe Province and provides female condoms to the “Save the Children Fund”, which has a project for sex workers. The 2006 DHS showed that 18 percent of respondents obtained oral contraceptives from FHA, 15 percent obtained injections and 13 percent received condoms through FHA. Thus FHA is a significant provider of contraceptives in the country.

Other NGOs have become active in recent years, in part to address the HIV epidemic. The Marie Stopes organization operates clinics in Port Moresby and three other cities as well as providing outreach support to peri-urban villages near Port Moresby. VCT, contraception, including tubal ligation and vasectomy, STI treatment are available in Marie Stopes clinics. This organization is also operating a trial project on norplant in collaboration with the Department of Health.

Family Health International (FHI) operates in Port Moresby, addressing HIV prevention in particular, including palliative care for terminally ill AIDS patients. FHI provides outreach support for clinics in peri-urban Port Moresby and also operates in Madang and Eastern Highlands. Population Services International (PSI) based in Port Moresby has programmes focussed on HIV prevention, including condom distribution. Pathfinder International operates a community based family planning project centred in Madang. A particular focus of this programme is the provision of water supplies to clinics offering family planning.

(d) The private sector

Oral contraceptives and condoms have been approved for sale in pharmacies for many years in PNG. Overall, however, the purchase of contraceptives at pharmacies or through a private physician is negligible in PNG and accounts for less that 5 percent of oral contraceptives, injectibles and condoms (NSO 2009). Only 4.4 percent of males in the 2006 DHS reported obtaining condoms from a pharmacy and another 4.9 percent obtained them from a shop. A Community-based distributor was a source of condoms for
7 percent of condom users which makes CBD a more important source of condoms than pharmacies or doctors.

(e) The current status of family planning services

Baravilala (2006) has described the structure of the public health system in PNG in the following terms:

Delivery of services through the PNG public health system is based on a network of 2400 aid posts (up to 50% of these are or have been closed because of staff and supply shortages), 500 health centres, 18 provincial hospitals, a national hospital, and 45 urban clinics. The numbers of facilities that are open or closed varies according to different provinces. In addition to staff and supply shortages some facilities have had to close because of disagreements with landowners and security concerns. Over the last decade the number of closures has continued to increase. Private health care is delivered mainly in the larger urban centres with most of the larger facilities located in Port Moresby.

While the government is the largest provider of health care, the Church Health Service operates approximately half of the rural health centres and sub-centres. The churches also train and educate many of PNG's health workers, including nurses and community health workers. Government does not provide any basic training programmes for CHWs. The Pacific Adventist University has a school of health sciences, and the Divine Word University (DWU) runs a health administration programme.

It is within the context of this system that the government provides family planning services to the public.

A comprehensive review of family planning services was undertaken in 2002 (Burdon et al. 2002). Most of the findings of this review probably remain valid today and few of its recommendations appear to have been implemented. The main points of this review are summarized below, generally referring to the period 1997-2001 and drawing specifically upon data from the Health Information System:

- The distribution of contraception is highly uneven. Excluding permanent methods, half of all health facilities are providing 95 percent of oral contraceptives and injections (as measured by “couple-years of protection”, or CYP).
- Half of the health centres in PNG are not providing any modern contraceptives at all.
- The Government operates 51 percent of health centres and provides nearly 80 percent of CYP. The Catholic Church operates 20 percent of all health centres and provides 2 percent of CYP for modern methods.
- Provinces that have been the focus of projects funded by international agencies (including UNFPA, World Bank, ADB and AusAID, individually or in
collaboration) have not markedly increased the use of contraception in those provinces, relative to the changes observed in provinces that have not been the focus of such projects.

- In provinces supported by UNFPA projects, contraceptive use increased for a while but then declined, suggesting that the improvements gained were not sustainable.

The review also employed a questionnaire to gather information on the beliefs and perceptions of health workers with regard to the delivery of family planning services. The results of this survey were report according to three groups of provinces: (1) Those provinces that had been included in the large-scale Population and Family Planning Project that operated from 1993 to 1998; (2) focus provinces that were included in the UNFPA’s Country Programme (1996-2002); (3) provinces that had not received any support from an externally-funded family planning project.

The results of the survey of health workers are summarized in Table 1, which shows the two most important reasons given by health workers as to (1) why health workers do not provide family planning services and (2) why communities don’t access family planning services.

In all three groups of provinces, staff attitudes are mentioned as a reason why health staff don’t dispense contraceptives. In the non-project and UNFPA focus provinces the most important factor is the religious beliefs of staff, whereas in the PFPP provinces lack of supply is the primary reason.

So far as why communities do not access contraceptives is concerned, lack of supply is again mentioned as the main reason in the PFPP provinces whereas community religious beliefs are the main reasons given in the other groups of provinces.

In Tables 2 and 3, the responses have been pooled, without consideration for the particular province. Table 2 shows that the attitudes of health providers is perceived by health staff themselves as the main reason why health staff do not supply contraceptives, followed by the lack of supply and IEC materials. Table 3 indicates that “fear” is perceived by health workers to be the main reason why the community does not seek access to family planning services, followed by lack of awareness and religious beliefs.

Although the selection of respondents in this survey was not based on scientific sampling methods, the health workers consulted were all well-informed and experienced in the provision of family planning services. Aside from those coming from provinces that had never participated in a major family planning project, most of these respondents had been involved in the implementation of projects aimed at improving access to family planning and other reproductive health services. It should not be concluded from these data that the various family planning projects had not made positive contributions toward improved access. For example, the vasectomy training provided under the UNFPA project provided a foundation for a much wider vasectomy training programme throughout the country that has been quite successful.
Table 1: Why health workers don’t provide services and why communities don’t access services.

<table>
<thead>
<tr>
<th>Two most important reasons why health workers don’t provide FP services (% of responses)</th>
<th>Two main reason why communities don’t access FP services (% of responses)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>A. PFPP focus provinces</strong></td>
<td></td>
</tr>
<tr>
<td>Lack of contraceptive supply 82.0</td>
<td>Lack of contraceptive supply 53.0</td>
</tr>
<tr>
<td>Staff attitudes 53.0</td>
<td>Lack of awareness 53.0</td>
</tr>
<tr>
<td><strong>B. UNFPA focus provinces</strong></td>
<td></td>
</tr>
<tr>
<td>Staff religious belief 85.0</td>
<td>Community religious belief 85.0</td>
</tr>
<tr>
<td>Staff attitudes 69.0</td>
<td>Fear 77.0</td>
</tr>
<tr>
<td><strong>C. Non project provinces</strong></td>
<td></td>
</tr>
<tr>
<td>Staff religious beliefs 55.0</td>
<td>Community religious belief 55.0</td>
</tr>
<tr>
<td>Staff attitudes 38.0</td>
<td>Fear 42.0</td>
</tr>
</tbody>
</table>

Table 2: Why don’t health workers supply contraception to a community?

<table>
<thead>
<tr>
<th>Reasons</th>
<th>Number of responses</th>
<th>Percent of all responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attitudes of health staff</td>
<td>50</td>
<td>46.7</td>
</tr>
<tr>
<td>Lack of contraceptive supplies</td>
<td>33</td>
<td>30.8</td>
</tr>
<tr>
<td>No IEC materials</td>
<td>28</td>
<td>26.2</td>
</tr>
<tr>
<td>Lack of training</td>
<td>15</td>
<td>14.0</td>
</tr>
<tr>
<td>Staff religion</td>
<td>11</td>
<td>10.3</td>
</tr>
<tr>
<td>Total responses*</td>
<td>137</td>
<td>100.0</td>
</tr>
<tr>
<td>Total respondents</td>
<td>107</td>
<td>--</td>
</tr>
</tbody>
</table>

*More than one response per respondent was permitted
Source: Burdon et al. (2002)

Table 3: Why don’t communities access family planning services?

<table>
<thead>
<tr>
<th>Reasons</th>
<th>Number of responses</th>
<th>Percent of all responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fear</td>
<td>50</td>
<td>46.7</td>
</tr>
<tr>
<td>Lack of awareness</td>
<td>48</td>
<td>44.9</td>
</tr>
<tr>
<td>Community religious beliefs</td>
<td>44</td>
<td>41.1</td>
</tr>
<tr>
<td>Attitudes of health staff</td>
<td>37</td>
<td>34.6</td>
</tr>
<tr>
<td>Lack of contraceptive supplies</td>
<td>18</td>
<td>16.8</td>
</tr>
<tr>
<td>Male attitudes</td>
<td>7</td>
<td>6.5</td>
</tr>
<tr>
<td>Total responses*</td>
<td>204</td>
<td>100.0</td>
</tr>
<tr>
<td>Total respondents</td>
<td>107</td>
<td>--</td>
</tr>
</tbody>
</table>

*More than one response per respondent was permitted
Source: Burdon et al. (2002)
Similarly, the PFPP project contributed substantially to the renovation of clinics, providing confidential, private space in which nurses were able to discuss issues and dispense advice. The PFPP project also changed procedures to ensure that clients could access services at any time and on all suitable opportunities, rather than FP clinics only being open at certain hours.

The interpretation of the data in Tables 1-3 presents a challenge as the questions were not designed to test a particular approach to service delivery. It is apparent, however, that “attitudes” of health staff themselves play a significant role in limiting access. Conversely, the attitudes of the community, particularly religious views constrain potential clients from seeking services. Male attitudes do not feature significantly among the most important reasons given for clients not seeking access, but they are mentioned. The large number of health staff who mentioned “fear” and “lack of awareness” as the two most important reasons for lack of community access is consistent with the results of the two DHS that have been conducted (see section 3).

The significance of attitudes and religious beliefs from both the supply and demand side raises issues concerning the role of Church-based health facilities in restricting access to family planning. The survey reported that nurses in Catholic run health centres were frustrated and angered by their inability to offer modern family planning. The fact that so many village aid posts had closed or were unable to offer services meant that more women were going to Church-operated health centres. The nursing staff were unable to provide tubal ligation even to high risk multiparous mothers in areas where maternal mortality was high. They had also found that the ovulation method that they were teaching was unsuitable and unreliable for illiterate village women. Some nurses secretly distributed contraceptives that came in the health kits and did not record dispensing them. On the other hand, supervisors ensured that no order for contraceptives was added to medical requisitions. Other nurses working in Catholic health centres reported that they would “get sacked” if they secretly distributed family planning (Burdon et al. 2002).

Government policy is to encourage Church-operated health centres to continue offering ovulation method as an acceptable alternative where religious precepts prohibited the use of modern contraception. This somewhat passive approach is questionable when viewed from a human rights perspective. One practical solution that has been achieved in at least one province is for Church-run health centres to refer potential clients to a nearby aid post where they know that FP services are available. This solution can only work where the Church is at least willing to cooperate and where aid posts are actually functioning and are supplied with commodities.

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6 One nurse reported: “I even wrote a letter to the Bishop asking permission to give FP to the high risk mothers who have had 5, 6 or 7 children as they are dying like flies up here—and they told me no” (Burdon et al. 2002).
A number of other issues to do with the barriers to access to contraception were highlighted by the 2002 review, and still need to be addressed, including:

- Service providers are unaware that the family planning policy and the law allows contraceptives to be supplied to any person above 16 years of age regardless of marital status.
- Some family planning staff are still asking for written consent from husbands, even though this is neither a legal requirement nor a condition of policy.
- Adolescents find it very difficult to access condoms or any form of family planning.
- Many health staff still hold the view that the free distribution of condoms encourages promiscuity and prostitution.
- Some health centres still restrict family planning services to specific days and times.
- Because health infrastructure is collapsing, tubal ligation cannot be conducted at health centres and clients have to travel to a provincial hospital, which they cannot afford to do if they are poor or if the roads are impassable.

(f) **Sources of supply of family planning services**

The DHS of 1996 and 2006 asked respondents where they last obtained a form of contraception. The results for both years are shown in Figure 3. The broad general pattern has not changed between the two surveys but there are some significant shifts in the use of some service delivery points. It is clear that in both years health centres and hospitals are the main sources of contraception, but they are all declining as a proportion of all sources. On the other hand, the Family Planning Association and aid posts have been increasing as a source of supply, with both increasing to about 10 percent.

Private doctors, pharmacies and shops are relatively unimportant sources of contraception, which is surprising. Also unexpected is the small and declining proportion of women who received their last supply of contraceptives from an MCH clinic. This is surprising given that family planning has been for many years and still is to some extent centred around Mother and Child health services. Mother and child clinics are considered to be the ideal time to raise the issue of family planning, particularly before intensive breast feeding ceases and women lose the protection provided by lactational amenorrhea. It may be that these results are a result of the way in which the question was asked in the DHS. It is possible that MCH clinics were a source of advice while supply was provided by a family planning clinic in a hospital. This issue needs further clarification.

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7 The family planning review noted that “[M]ost health workers would not dream of giving any family planning methods to anyone over the age of 16 who is unmarried. In fact, most family planning appears to be distributed only to women who already have a child (Burdon et al. 2002).
3. Current patterns of contraceptive use and unmet need

(a) Contraceptive knowledge and use

An assessment of national level trends in knowledge and use of family planning in PNG has only become possible since the second DHS was conducted in 2006. Health Information Systems are insufficiently reliable to give accurate figures on contraceptive prevalence at the national level. Even so, DHS data are only available for two points in time: 1996 and 2006, thus long-term trends cannot be examined. Furthermore, there are some methodological differences between the 1996 and 2006 DHS. The sample size in 2006 was much larger than in 1996 thus sample errors are smaller. Other things being equal, the 2006 DHS data should be of higher quality (more accurate) than the 1996 data. The analysis in this section takes the data from these surveys at face value without consideration of confidence intervals and statistical significance.

As indicated in Table 4, 81 percent of married women knew of a modern method of contraception in 2006 compared with 72 percent in 1996. While this is an improvement in the right direction, it is a very modest rate of improvement for a 10-year period—less than 1 percent increase per year. A somewhat faster rate of increase in contraceptive awareness is evident among women with some primary education (19 percent of the sample)—increasing from 70 to 80 percent over the decade. By contrast, among women with no education, knowledge of contraception increased at a much
slower rate: in 2006, 70 percent of women with no education had knowledge of a modern method of contraception, but only 62 percent of women with no education knew of a source compared to 87 percent of women who had reached grade 7 or higher. The lack of education clearly remains an important impediment to knowledge of modern contraception and its sources.

Table 4: Knowledge of contraception by education level: 1996 and 2006, currently married women

<table>
<thead>
<tr>
<th>Education</th>
<th>Knowledge of any method (%)</th>
<th>Knowledge of a modern method</th>
<th>Knowledge of a source of a modern method</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1996</td>
<td>2006</td>
<td>1996</td>
</tr>
<tr>
<td>No education</td>
<td>68.6</td>
<td>72.9</td>
<td>63.3</td>
</tr>
<tr>
<td>Grade 1-5</td>
<td>74.5</td>
<td>82.2</td>
<td>69.7</td>
</tr>
<tr>
<td>Grade 6</td>
<td>82.8</td>
<td>87.2</td>
<td>78.4</td>
</tr>
<tr>
<td>Grade 7+</td>
<td>92.7</td>
<td>94.8</td>
<td>90.9</td>
</tr>
<tr>
<td>Total</td>
<td>76.4</td>
<td>82.8</td>
<td>71.9</td>
</tr>
</tbody>
</table>


An unexpected result of the comparative analysis is that the proportion of women reaching grade 7 and over that knew of a source of modern methods was lower (87 percent) in 2006 than in 1996 (90 percent). It is possible that the larger sampling error in 1996 is responsible for this anomaly.

As evident from the data in Table 5, the use of contraception is positively associated with education. Whether all methods or modern methods alone are considered, contraceptive use among currently married women has increased, by 20 and 24 percent, respectively, over the decade. Among the most educated group, however, there has been little change. Furthermore, the proportion of those using any method of contraception that is using a modern method is no different in 2006 than in 1996 (about 75 percent). This is an unexpected finding, as one would normally expect that contraceptive use among more educated women would increase through time. This is not evident in PNG. On the contrary, larger increases in the use of contraception are evident among women with no education at all or some primary education.

At 24.4 percent, the overall contraceptive prevalence rate (CPR) in PNG in 2006 must be considered as low relative to other less developed countries, in which the average CPR for modern methods is 45 percent (PRB 2008). PNG’s current CPR puts it on a par with Haiti, one of the poorest countries in the world. However, compared with other Pacific Island countries (Figure 4), PNG’s CPR does not look unreasonably low when account is taken of the very great logistical difficulties of delivering health services to PNG’s large, widely scattered population with low levels of formal education, low

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8 The Population Reference Bureau (2008) reports Haiti’s CPR as 24.8 for modern methods.
income and poor transport and communications. PNG’s CPR is currently higher than that of Tuvalu or Kiribati while similar to Nauru’s. Although all of these countries face logistical problems in the delivery of health services, none of them face obstacles comparable to those facing PNG’s health-care system. Furthermore, these countries have an active NGO sector which provides alternative sources of family planning advice and supplies, a situation that is much rarer in PNG.

Table 5: Currently using contraception by education level: 1996 and 2006, currently married women

<table>
<thead>
<tr>
<th>Education</th>
<th>Using any method (%)</th>
<th>Using a modern method (%)</th>
<th>Percentage using a modern method</th>
</tr>
</thead>
<tbody>
<tr>
<td>No education</td>
<td>18.6</td>
<td>23.0</td>
<td>14.6</td>
</tr>
<tr>
<td>Grade 1-5</td>
<td>25.0</td>
<td>32.0</td>
<td>18.7</td>
</tr>
<tr>
<td>Grade 6</td>
<td>29.3</td>
<td>37.0</td>
<td>21.5</td>
</tr>
<tr>
<td>Grade 7+</td>
<td>44.6</td>
<td>43.2</td>
<td>33.5</td>
</tr>
<tr>
<td>Total</td>
<td>25.9</td>
<td>32.4</td>
<td>19.6</td>
</tr>
</tbody>
</table>

Source: DHS reports 1996 and 2006

Figure 4: Contraceptive prevalence rates in seven Pacific Island countries

Source: DHS Reports, respective countries.

(b) Geographical variations

Papua New Guinea is a country of contrasting regions, each with somewhat distinctive culture, geography and history. Colonial history combined with resource endowments has had a particular impact on the levels of development within regions and
patterns of unequal development between regions and provinces have persisted into the present. A comparison of regions provides some clue as to the impact of economic development on knowledge and use of family planning.

As might be expected, contraceptive knowledge and use is highest in the Islands region (Table 6), which generally has better social indicators than other regions due to its strong plantation sector and long history of educational development. Although the region suffered from development set-backs in 1980s and 1990s in the form of civil insurrection and natural disasters, knowledge of modern methods of contraception is the highest of all regions, with 93 percent of women expressing awareness of a modern method. However, the most rapid increase in knowledge between 1996 and 2006 has been in the Momase area (the North coast provinces) where knowledge of a modern method has increased from only 58 percent in 1996 to 75 percent in 2006. It is still the lowest of any region but much closer to the national average than it was a decade earlier.

Table 6: Knowledge of contraception by region: 1996 and 2006, currently married women

<table>
<thead>
<tr>
<th>Region</th>
<th>Knowledge of any method (%)</th>
<th>Knowledge of a modern method</th>
<th>Knowledge of a source of a modern method</th>
</tr>
</thead>
<tbody>
<tr>
<td>Islands</td>
<td>86.8</td>
<td>95.5</td>
<td>85.6</td>
</tr>
<tr>
<td>Momase</td>
<td>65.0</td>
<td>78.9</td>
<td>58.4</td>
</tr>
<tr>
<td>Highlands</td>
<td>76.8</td>
<td>80.4</td>
<td>73.9</td>
</tr>
<tr>
<td>Southern</td>
<td>84.1</td>
<td>83.9</td>
<td>77.6</td>
</tr>
<tr>
<td>Total</td>
<td>76.4</td>
<td>82.8</td>
<td>71.9</td>
</tr>
</tbody>
</table>

Source: DHS reports 1996 and 2006

It is striking that in 1996 only 55 percent of married women knew of a source of modern contraception in the Momase region. Although this proportion had increased to about two-thirds of married women by 2006, the other side of the coin is that one third of married women in this region professed to not knowing where to find a modern method of contraception in 2006.

The other spatial dimension of family planning knowledge and use is the rural-urban one. As could be expected, knowledge of contraception is higher in urban than rural areas both in 1996 and 2006 (Table 7) but the gap appears to be widening somewhat. That is, knowledge of any method has been rising faster in urban areas than in rural areas. This is also true of knowledge of modern methods and of the percentage of women who know of any method knowing a modern method. This proportion has risen faster in urban than rural areas, but is quite high in both. Essentially 100 percent of the women in urban areas who have knowledge of any method are aware of at least one modern method and 94 percent of rural women also fall into this category.
Table 7: Knowledge of contraception by urban-rural residence: 1996 and 2006, currently married women

<table>
<thead>
<tr>
<th>Area</th>
<th>Knowledge of any method (%)</th>
<th>Knowledge of a modern method (%)</th>
<th>Percentage knowing a modern method</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rural</td>
<td>74.2</td>
<td>80.9</td>
<td>69.3</td>
</tr>
<tr>
<td>Urban</td>
<td>85.7</td>
<td>94.1</td>
<td>82.5</td>
</tr>
<tr>
<td>Total</td>
<td>76.4</td>
<td>82.8</td>
<td>71.9</td>
</tr>
</tbody>
</table>

Source: DHS reports, 1996 and 2006

So far as the use of any method of contraception is concerned, the Islands region had the highest overall prevalence rate both in 1996 while the Highlands had the lowest rate with the other regions in between (Table 8). In 2006 this pattern remained the same, although the CPR rose in all regions. So far as modern methods are concerned, the Southern region (within which is located the nation’s capital city) had the highest prevalence rate in both 1996 and 2006. Between 1996 and 2006, the prevalence rate for modern methods has risen at the national level (from 19.6 percent to 24.4 percent) and in all regions other than the Islands (Table 8). In the Islands region, however, the CPR for modern methods essentially remained static between 1996 and 2006 (a decline from 27 to 26 percent would not be statistically significant) and the proportion of all users who were using modern methods fell from 68 percent to only 57 percent. The proportion of married women in the Islands region using “traditional” methods, particularly periodic abstinence, was highest of all regions in 1996 but was even higher in 2006. It is likely that this pattern is associated with religion as the “rhythm” method can also be described as a form of periodic abstinence and the use of this method is highest in the Islands region.⁹

Table 8: Use of contraception by region: 1996 and 2006, currently married women

<table>
<thead>
<tr>
<th>Region</th>
<th>Use of any method (%)</th>
<th>Use of a modern method (%)</th>
<th>Percent using a modern method</th>
</tr>
</thead>
<tbody>
<tr>
<td>Islands</td>
<td>40.0</td>
<td>45.3</td>
<td>27.1</td>
</tr>
<tr>
<td>Momase</td>
<td>24.5</td>
<td>32.9</td>
<td>17.8</td>
</tr>
<tr>
<td>Highlands</td>
<td>15.9</td>
<td>22.9</td>
<td>12.9</td>
</tr>
<tr>
<td>Southern</td>
<td>37.2</td>
<td>42.5</td>
<td>29.3</td>
</tr>
<tr>
<td>Total</td>
<td>25.9</td>
<td>32.4</td>
<td>19.6</td>
</tr>
</tbody>
</table>

Source: DHS reports 1996 and 2006

⁹ The “ovulation” method is taught by family health workers associated with the Catholic Church, but this is not a “traditional” method of birth control in PNG, even though the DHS classifies it as such.
It is possible that the decline in the CPR for modern methods of contraception in the Islands, accompanied by a rise in the use of any method, is a function of a religious revival over the period. Although 26 percent of the 2006 DHS sample population identified themselves as Roman Catholic, published DHS tables do not provide any evidence on contraceptive use by different religious groups that could be cross-classified by region.

The use of contraception, like knowledge, is higher in urban than rural areas with the proportion of currently married women using any form of contraception reaching 44 percent in 2006 compared with 36 percent in 2006 (Table 9). The use of modern family planning has increased in both rural and urban areas between 1996 and 2006 but the rate of increase has been higher in rural areas. The CPR for modern methods in rural areas increased by 32 percent between 1996 and 2006 compared with only a 19 percent increase in urban areas.

Table 9: Use of contraception by urban-rural residence: 1996 and 2006, currently married women

<table>
<thead>
<tr>
<th>Area</th>
<th>Using any method (%)</th>
<th>Using a modern method (%)</th>
<th>Percentage using a modern method</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rural</td>
<td>23.5 30.5</td>
<td>16.9 22.3</td>
<td>71.9 73.1</td>
</tr>
<tr>
<td>Urban</td>
<td>35.8 44.1</td>
<td>30.9 36.7</td>
<td>86.1 83.2</td>
</tr>
<tr>
<td>Total</td>
<td>25.9 32.4</td>
<td>19.9 24.4</td>
<td>76.8 75.3</td>
</tr>
</tbody>
</table>

Source: DHS reports 1996 and 2006

The proportion of all currently married urban women using contraception who are using a modern method has declined between the last two DHS (from 86 to 83 percent) suggesting that more urban women were using “traditional” methods in 2006 relative to a decade earlier. This is an unexpected result that may be associated with a more active campaign against modern contraception by the Catholic Church. In rural areas the use of modern contraception among those using any form of family planning has increased, but not by much. In 2006, 27 percent of all rural women using any form of contraception were using a “traditional” method.

(c) Age patterns

In PNG, knowledge of modern contraception tends to be relatively low among young people (65 percent of 15-19 year old females know of a modern method) rises with age to a maximum of 85 percent age 30-34 and then falls away among older women aged 35 and over (70 percent). The actual use of contraception shows a similar pattern but reaches its maximum (30.4 percent) among women aged 40-44 (Table 10). Trends over the 1996-2006 decade show increasing contraceptive use among younger women with somewhat slower increases among women aged 35 and over.
Table 10: Contraceptive use by age, education and parity, currently married women (%)

<table>
<thead>
<tr>
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<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>15-19</td>
<td>9.0</td>
<td>18.4</td>
<td>3.6</td>
<td>6.3</td>
<td>5.4</td>
<td>12.1</td>
</tr>
<tr>
<td>20-24</td>
<td>20.2</td>
<td>25.3</td>
<td>6.6</td>
<td>6.8</td>
<td>13.6</td>
<td>18.5</td>
</tr>
<tr>
<td>25-29</td>
<td>23.4</td>
<td>29.6</td>
<td>6.6</td>
<td>7.6</td>
<td>16.8</td>
<td>22.0</td>
</tr>
<tr>
<td>30-34</td>
<td>27.8</td>
<td>35.8</td>
<td>6.6</td>
<td>9.8</td>
<td>21.2</td>
<td>26.0</td>
</tr>
<tr>
<td>35-39</td>
<td>34.3</td>
<td>38.3</td>
<td>7.0</td>
<td>8.1</td>
<td>27.3</td>
<td>30.2</td>
</tr>
<tr>
<td>40-44</td>
<td>35.0</td>
<td>40.6</td>
<td>6.3</td>
<td>10.2</td>
<td>28.7</td>
<td>30.4</td>
</tr>
<tr>
<td>45-49</td>
<td>22.2</td>
<td>29.8</td>
<td>4.5</td>
<td>5.6</td>
<td>17.7</td>
<td>24.2</td>
</tr>
<tr>
<td>Total 15-49</td>
<td>25.9</td>
<td>32.4</td>
<td>6.3</td>
<td>8.1</td>
<td>19.6</td>
<td>24.4</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>No education</td>
<td>23.3</td>
<td>23.0</td>
<td>8.7</td>
<td>8.5</td>
<td>14.6</td>
<td>14.5</td>
</tr>
<tr>
<td>Grades 1-5</td>
<td>34.2</td>
<td>32.0</td>
<td>15.5</td>
<td>9.8</td>
<td>18.7</td>
<td>22.2</td>
</tr>
<tr>
<td>Grade 6</td>
<td>40.1</td>
<td>37.0</td>
<td>18.5</td>
<td>8.9</td>
<td>21.5</td>
<td>28.1</td>
</tr>
<tr>
<td>Grade 7+</td>
<td>49.0</td>
<td>43.2</td>
<td>15.5</td>
<td>11.0</td>
<td>33.5</td>
<td>32.2</td>
</tr>
<tr>
<td>na</td>
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<td></td>
<td></td>
<td></td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>6.3</td>
<td>7.8</td>
<td>3.6</td>
<td>4.0</td>
<td>2.7</td>
<td>3.8</td>
</tr>
<tr>
<td>1</td>
<td>15.5</td>
<td>23.1</td>
<td>7.2</td>
<td>7.6</td>
<td>8.3</td>
<td>15.5</td>
</tr>
<tr>
<td>2</td>
<td>25.0</td>
<td>34.1</td>
<td>7.4</td>
<td>9.0</td>
<td>17.6</td>
<td>25.1</td>
</tr>
<tr>
<td>3</td>
<td>28.6</td>
<td>34.2</td>
<td>6.3</td>
<td>7.6</td>
<td>22.3</td>
<td>26.6</td>
</tr>
<tr>
<td>4+</td>
<td>36.4</td>
<td>43.7</td>
<td>6.3</td>
<td>9.5</td>
<td>30.1</td>
<td>34.2</td>
</tr>
</tbody>
</table>

Source: DHS reports 1996 and 2006

Parity is also a significant determinant of contraceptive use, with higher parity women more likely to use contraception. But even among women of parity 4 and over, modern contraceptive use is only 34 percent (Table 10). The use of any form of contraception (traditional and Modern) reaches a peak (41 percent) among women aged 40-44, and 10 percent of this group was using a traditional method in 2006.

(d) Unmet need for family planning

The ICPD Plan of Action (POA) recommends that “Government goals for family planning should be defined in terms of unmet need for information and services”. Subsequently, ICPD+5 recommended that the “Where there is a gap between contraceptive use and the proportion of individuals expressing a desire to space or limit their families, countries should attempt to close this gap by at least 50 percent by 2005, 75 percent by 2010 and 100 percent by 2015” (UNFPA 2004). The concept of “gap” comes from early generation KAP (Knowledge, Attitude and Practice) studies from which was coined the “KAP-gap” to refer to a situation whereby a woman expressed a desire to limit or space births but was not using any form of contraception. Closing this gap by 2015 would be an extremely ambitious goal in the case of Papua New Guinea.
The concept of “unmet need” has undergone further refinement in recent years with increasingly encompassing definitions of the categories of women who can be considered as having an unmet need. The current definition of unmet need according to the UN Population Division is:

Unmet need for family planning is the number of women with unmet need for family planning expressed as a percentage of women of reproductive age who are married or in union. Women with an unmet need are those who are fecund and sexually active but are not using any method of contraception, and report not wanting any more children or wanting to delay the birth of their next child (UNDESA 2009).

This definition is identical to that used in Demographic and Health Surveys. The method of computation requires that surveys identify women who are married or in a sexual union in various statuses requiring a complex branching process based upon answers to questions appearing at various points of the DHS questionnaire.

Women who are excluded from the numerator include those who:
1. Are using contraception to delay their next birth;
2. Are using contraception to stop childbearing;
3. Are currently pregnant or amenorrheic and the pregnancy was:
   a. Intended, or
   b. Due to a method failure;
4. Infecund (according to an objective set of criteria);
5. Want a child within the next two years.

By a process of elimination, a residual is obtained that includes women who:
1. Are not using contraception;
2. Are not pregnant or amenorrheic;
3. Do not want another child or do not want it within the next two years;
4. Are pregnant or amenorrheic and,
   a. Did not want the child
   b. Wanted the child but at a later date;
5. Unsure about wanting the child at a later date.

The denominator is all women who are married or in a sexual union.

The definition of unmet need employed by various analysts is not always consistent with the DHS definition, either in terms of the numerator or the denominator or both. For example, women who are unsure or “don’t know” whether they want another child can be considered by some analysts to have an unmet need whereas others would

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10 Unmet need can also be calculated, and increasingly is, for all women of reproductive age regardless of their marital status. In this paper only currently married women are included in the numerator and denominator. If all women of reproductive age are included, some method of excluding women who are not sexually active must be applied. Otherwise, unmet need will tend to be overstated.
exclude them. Burdon, et al. (2002) reported that unmet need for family planning based on the 1996 DHS was 62 percent for currently married women. But this percentage was not calculated using the international standard formula and is therefore not comparable with unmet need in other countries.11

Papua New Guinea is the only Pacific Island country to have two comparable measures of unmet need (1996 and 2006), thus allowing the analysis of trends over time. However, PNG’s DHS tables do not show the unmet need for spacing separately from the unmet need for stopping. Women are considered to have an unmet need if they say that they want no more children (or are not sure or undecided) and are not using contraception. It is possible that total unmet need as measured by the DHS would be higher if the unmet need for spacing were to be calculated separately and included in the total.

Table 11 shows that while a decline in unmet need is evident at the national level (from 45.9 percent to 43.9 percent) over the decade 1996-2006, the rate of decline is quite slow and unmet need remained quite high. In the Islands region, however, unmet need has actually increased over the period while in the Highlands region it has remained at the same level. In 2006 the Southern Region had the lowest level of unmet need, as was also the case in 1996.

Table 11: Unmet need for contraception by region: 1996 and 2006, currently married women (% of women 15-49)*

<table>
<thead>
<tr>
<th>Region</th>
<th>1996</th>
<th>2006</th>
</tr>
</thead>
<tbody>
<tr>
<td>Islands</td>
<td>38.3</td>
<td>42.7</td>
</tr>
<tr>
<td>Momase</td>
<td>48.0</td>
<td>41.3</td>
</tr>
<tr>
<td>Highlands</td>
<td>51.0</td>
<td>51.4</td>
</tr>
<tr>
<td>Southern</td>
<td>42.4</td>
<td>40.6</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>45.9</strong></td>
<td><strong>43.9</strong></td>
</tr>
</tbody>
</table>


*Refers to women who are not using contraception but who want no more children or are undecided or “don’t know” if they want another child as a percentage of all women of reproductive age.

(e) Explaining patterns of unmet need

Geographical variations in unmet need are predominantly reflections of socio-economic, socio-cultural and historical factors. As previously noted, the Islands region has a large proportion of Catholics and this probably explains the declining trend in the use of modern methods of family planning in that region. It is notable that it is only in the

11 The method used was to calculate the proportion of women not using contraception who did not want to have another child. Although this is not an unreasonable calculation, the standard formula uses all women of reproductive age as the denominator. The latter calculation gives a lower figure.
Islands region that unmet need increased between 1996 and 2006 (Table 11) and it is likely that this is due to efforts by the Catholic Church to discourage the use of modern contraception (Burdon et al. 2002).

A valid explanation of the socio-economic and socio-cultural determinants of unmet need would require a multivariate analysis that allowed for some variables (such as education and labour force status) to be controlled. Published tables do not permit such analysis in the PNG case and only two-way descriptive analysis is possible. The only variables available aside from region and rural/urban residence are age and education.

As is evident from Table 12, unmet need rises with age and falls with educational achievement. This pattern was evident in both 1996 and 2006. The highest level of unmet need is found in women aged 45-49 in both years, although it is very likely that many women in this age group believe themselves to be at low risk of conceiving a child. Among women aged 40-49, unmet need increased somewhat between the two surveys, whereas in all age groups 15-39 it has declined, although not by much. In the case of education, unmet need has fallen among those with less than grade 6 education but increased among women with grade 6 or more, but in both years women with no education have the highest unmet need—over 50 percent in both years—while women with grade 7 or above have the lowest.

Table 12: Unmet need for family planning by age and education

<table>
<thead>
<tr>
<th>Age-group</th>
<th>1996</th>
<th>2006</th>
</tr>
</thead>
<tbody>
<tr>
<td>15-19</td>
<td>33.1</td>
<td>29.5</td>
</tr>
<tr>
<td>20-24</td>
<td>30.3</td>
<td>29.8</td>
</tr>
<tr>
<td>25-29</td>
<td>40.1</td>
<td>37.1</td>
</tr>
<tr>
<td>30-34</td>
<td>45.5</td>
<td>42.2</td>
</tr>
<tr>
<td>35-39</td>
<td>50.5</td>
<td>48.0</td>
</tr>
<tr>
<td>40-44</td>
<td>56.7</td>
<td>61.5</td>
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<tr>
<td>45-49</td>
<td>73.4</td>
<td>76.8</td>
</tr>
<tr>
<td>Total 15-49</td>
<td>45.9</td>
<td>43.9</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Education</th>
<th>1996</th>
<th>2006</th>
</tr>
</thead>
<tbody>
<tr>
<td>No education</td>
<td>53.5</td>
<td>51.4</td>
</tr>
<tr>
<td>Grades 1-5</td>
<td>45.6</td>
<td>43.1</td>
</tr>
<tr>
<td>Grade 6</td>
<td>42.1</td>
<td>45.0</td>
</tr>
<tr>
<td>Grade 7+</td>
<td>28.6</td>
<td>30.8</td>
</tr>
</tbody>
</table>


Although the proportion of women aged 15-49 having an unmet need for family planning declined between 1996 and 2006, the decline was not sufficient to offset the growth in the population of women in the reproductive age range. Consequently, the actual number of women with an unmet need has risen significantly over the decade (Table 13 and Figure 5). The number of women with an unmet need for FP has risen from
an estimated 480,000 in 1996 to 632,000 in 2006, an increase of about 30 percent. As Figure 5 makes clear, the increase in the number of women with an unmet need is particularly large among women aged 40 years and older. Both the rate of unmet need and the number of women in this age group increased, leading to a significant increase in the number of older women having an unmet need for contraception.

Table 13: Total number of women with unmet need by age 1996 and 2006

<table>
<thead>
<tr>
<th>Age-group</th>
<th>1996</th>
<th>Female Population</th>
<th>Number with Unmet need for FP</th>
<th>2006</th>
<th>Female Population</th>
<th>Number with Unmet need for FP</th>
</tr>
</thead>
<tbody>
<tr>
<td>15-19</td>
<td>248,774</td>
<td>82,344</td>
<td>296,870</td>
<td>87,577</td>
<td></td>
<td></td>
</tr>
<tr>
<td>20-24</td>
<td>214,537</td>
<td>65,005</td>
<td>262,991</td>
<td>78,371</td>
<td></td>
<td></td>
</tr>
<tr>
<td>25-29</td>
<td>179,974</td>
<td>72,170</td>
<td>237,708</td>
<td>88,190</td>
<td></td>
<td></td>
</tr>
<tr>
<td>30-34</td>
<td>162,629</td>
<td>74,159</td>
<td>219,989</td>
<td>92,667</td>
<td></td>
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</tr>
<tr>
<td>35-39</td>
<td>133,253</td>
<td>67,293</td>
<td>194,114</td>
<td>93,175</td>
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</tr>
<tr>
<td>40-44</td>
<td>109,529</td>
<td>62,103</td>
<td>159,300</td>
<td>97,970</td>
<td></td>
<td></td>
</tr>
<tr>
<td>45-49</td>
<td>81,423</td>
<td>59,764</td>
<td>122,890</td>
<td>94,380</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total 15-49</td>
<td>1,130,119</td>
<td>482,837</td>
<td>1,493,462</td>
<td>632,328</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Source: Population: author’s projections. Number with unmet need based on rates given in Table 12.

Figure 5: Number of women with unmet need for family planning, 1996 and 2006

Source: Table 13.

Another measure of the extent to which women are able to access family planning is the percent of the total demand for family planning that is actually satisfied. Total demand is calculated by adding together the number of women who are using contraception and the number with an unmet need. The percentage of demand satisfied is...
the proportion of this total that is using contraception. Table 14 compares the percent of demand satisfied in PNG with 6 other Pacific Island countries that have had a DHS in recent years. It will be seen that the percent of demand satisfied in PNG is the lowest of all these countries. Particularly striking is the patterns by age. The percentage of demand satisfied in PNG for women aged 35 and above is very much lower than in other Pacific countries, especially Marshall Islands, Solomon Islands and Tuvalu.

Table 14: Percent of the total demand for family planning that is satisfied in selected Pacific Island countries by socio-economic characteristics (currently married women)*

<table>
<thead>
<tr>
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<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Age-group</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15-19</td>
<td>--</td>
<td>--</td>
<td>43.0</td>
<td>56.6</td>
<td>--</td>
<td>5.0</td>
<td>37.0</td>
</tr>
<tr>
<td>20-24</td>
<td>46.3</td>
<td>42.5</td>
<td>68.8</td>
<td>62.9</td>
<td>35.2</td>
<td>37.6</td>
<td>44.2</td>
</tr>
<tr>
<td>25-29</td>
<td>54.7</td>
<td>51.6</td>
<td>81.7</td>
<td>62.8</td>
<td>37.4</td>
<td>47.0</td>
<td>41.8</td>
</tr>
<tr>
<td>30-34</td>
<td>49.8</td>
<td>62.7</td>
<td>86.4</td>
<td>71.0</td>
<td>45.4</td>
<td>45.3</td>
<td>41.4</td>
</tr>
<tr>
<td>35-39</td>
<td>61.2</td>
<td>68.7</td>
<td>95.4</td>
<td>84.0</td>
<td>42.7</td>
<td>51.8</td>
<td>36.2</td>
</tr>
<tr>
<td>40-44</td>
<td>62.0</td>
<td>--</td>
<td>97.6</td>
<td>94.6</td>
<td>41.4</td>
<td>46.9</td>
<td>29.4</td>
</tr>
<tr>
<td>45-49</td>
<td>58.8</td>
<td>--</td>
<td>100.0</td>
<td>98.5</td>
<td>30.7</td>
<td>41.5</td>
<td>16.3</td>
</tr>
<tr>
<td>15-49</td>
<td><strong>55.8</strong></td>
<td><strong>60.3</strong></td>
<td><strong>84.6</strong></td>
<td><strong>75.6</strong></td>
<td><strong>38.6</strong></td>
<td><strong>44.2</strong></td>
<td><strong>36.5</strong></td>
</tr>
<tr>
<td>Residence</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urban</td>
<td>54.5</td>
<td>na</td>
<td>85.4</td>
<td>78.1</td>
<td>39.9</td>
<td>38.0</td>
<td>42.8</td>
</tr>
<tr>
<td>Rural</td>
<td>56.8</td>
<td>na</td>
<td>83.4</td>
<td>75.3</td>
<td>38.4</td>
<td>50.0</td>
<td>35.7</td>
</tr>
<tr>
<td>Education</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No education</td>
<td>na</td>
<td>na</td>
<td>--</td>
<td>71.0</td>
<td>Na</td>
<td>100.0</td>
<td>23.9</td>
</tr>
<tr>
<td>Primary or less</td>
<td>62.2</td>
<td>na</td>
<td>84.8</td>
<td>75.7</td>
<td>27.2</td>
<td>49.4</td>
<td>37.2</td>
</tr>
<tr>
<td>Secondary</td>
<td>50.1</td>
<td>61.0</td>
<td>85.1</td>
<td>75.9</td>
<td>39.5</td>
<td>41.1</td>
<td>39.7</td>
</tr>
<tr>
<td>More than secondary+</td>
<td>57.7</td>
<td>--</td>
<td>81.8</td>
<td>93.8</td>
<td>39.5</td>
<td>39.3</td>
<td>54.0</td>
</tr>
</tbody>
</table>

Source: DHS reports for specified countries. -- = number in sample too small. *In PNG, women who want more children are excluded from the calculation.

Demographic and Health surveys normally ask women who are not using contraception whether they intend to use it in the future. This gives some indication of why women with an unmet need are not using contraception, assuming that women with an unmet need have similar reasons for not using contraception as all women not using contraception, some of whom do not have an unmet need. Table 15 shows the responses to this question in 7 Pacific Island countries organized in terms of the “Ready, Willing and Able” framework developed by Lesthaeghe and Vanderhoeft (2001). Women who are ready, willing and able are those who are already using family planning and are
excluded from the table. The remaining women can be classified as either “unable” or “unwilling” to use contraception.

Table 15: Reasons for lack of intention to use contraception in the future among currently married women who are not using contraception, selected Pacific countries (%) ca 2006-2009

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Unable (a)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lack of knowledge/knows no method</td>
<td>0.5</td>
<td>10.1</td>
<td>0.5</td>
<td>8.7</td>
<td>1.4</td>
<td>3.7</td>
<td>43.4</td>
</tr>
<tr>
<td>Access difficult/knows no source</td>
<td>0.0</td>
<td>2.5</td>
<td>0.0</td>
<td>4.2</td>
<td>0.2</td>
<td>0.2</td>
<td>6.9</td>
</tr>
<tr>
<td>Too expensive/costs too much</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>0.6</td>
<td>0.5</td>
<td>0.0</td>
<td>0.6</td>
</tr>
<tr>
<td>Total (a)</td>
<td>0.5</td>
<td>12.7</td>
<td>0.5</td>
<td>13.5</td>
<td>2.1</td>
<td>4.0</td>
<td>50.9</td>
</tr>
<tr>
<td>Unwilling (w)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Religious opposition</td>
<td>1.6</td>
<td>22.8</td>
<td>0.0</td>
<td>6.1</td>
<td>0.5</td>
<td>37.1</td>
<td>9.6</td>
</tr>
<tr>
<td>Husband/partner opposed</td>
<td>5.5</td>
<td>1.3</td>
<td>1.4</td>
<td>3.9</td>
<td>2.1</td>
<td>5.3</td>
<td>4.8</td>
</tr>
<tr>
<td>Others opposed</td>
<td>0.0</td>
<td>0.0</td>
<td>0.9</td>
<td>1.2</td>
<td>0.0</td>
<td>0.5</td>
<td>0.0</td>
</tr>
<tr>
<td>Respondent opposed</td>
<td>7.7</td>
<td>25.3</td>
<td>10.3</td>
<td>7.5</td>
<td>70.2</td>
<td>6.9</td>
<td>0.0</td>
</tr>
<tr>
<td>Health concerns</td>
<td>5.5</td>
<td>5.1</td>
<td>15.5</td>
<td>7.1</td>
<td>17.5</td>
<td>9.0</td>
<td>0.0</td>
</tr>
<tr>
<td>Fear of side effects</td>
<td>62.1</td>
<td>19.0</td>
<td>42.7</td>
<td>46.4</td>
<td>2.1</td>
<td>14.6</td>
<td>13.8</td>
</tr>
<tr>
<td>Inconvenient to use</td>
<td>0.5</td>
<td>2.5</td>
<td>8.9</td>
<td>0.3</td>
<td>0.0</td>
<td>0.5</td>
<td>0.0</td>
</tr>
<tr>
<td>Interferes with body’s normal process</td>
<td>9.3</td>
<td>6.3</td>
<td>3.3</td>
<td>3.6</td>
<td>3.7</td>
<td>3.2</td>
<td>0.0</td>
</tr>
<tr>
<td>Total (w)</td>
<td>92.3</td>
<td>82.3</td>
<td>83.1</td>
<td>76.1</td>
<td>96.3</td>
<td>51.9</td>
<td>28.2</td>
</tr>
<tr>
<td>Not specified</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other reasons</td>
<td>3.3</td>
<td>1.3</td>
<td>12.7</td>
<td>2.8</td>
<td>0.5</td>
<td>15.6</td>
<td>16.1</td>
</tr>
<tr>
<td>Don’t know</td>
<td>3.8</td>
<td>2.5</td>
<td>1.9</td>
<td>7.0</td>
<td>1.1</td>
<td>1.6</td>
<td>4.9</td>
</tr>
<tr>
<td>Missing/ non response</td>
<td>0.0</td>
<td>1.3</td>
<td>1.9</td>
<td>0.6</td>
<td>0.0</td>
<td>1.6</td>
<td>0.0</td>
</tr>
<tr>
<td>Total not specified</td>
<td>7.1</td>
<td>5.1</td>
<td>16.4</td>
<td>10.4</td>
<td>1.6</td>
<td>17.2</td>
<td>21.0</td>
</tr>
<tr>
<td>TOTAL</td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
</tr>
<tr>
<td>(N)</td>
<td>(182)</td>
<td>(79)</td>
<td>(213)</td>
<td>(644)</td>
<td>(561)</td>
<td>(377)</td>
<td>(1,030)</td>
</tr>
<tr>
<td>a/w ratio</td>
<td>0.01</td>
<td>0.15</td>
<td>0.01</td>
<td>0.18</td>
<td>0.02</td>
<td>0.07</td>
<td>1.80</td>
</tr>
</tbody>
</table>

Source: DHS reports for specified countries.

Note: Excludes women who are past menopause or have had a hysterectomy, have infrequent sex, are infecund or sub-fecund, or want as many children as possible. The group of women included in the table is not the same as those who currently have an unmet need for contraception because some of the women who currently have an unmet need may intend to use contraception in the future in which case they would be excluded from this table. Women with an unmet need who do not intend to use contraception in the future would be included in this table.
Although 83 percent of women of reproductive age in the 2006 DHS sample indicated that they knew about a method of family planning, lack of knowledge is the primary reason given by women who say that they do not intend to use contraception in the future. When lack of knowledge is combined with difficulty of access and cost, about 51 percent of women in PNG who do not intend to use contraception in the future indicate that they are unable to do so. This contrasts very sharply with the situation in other Pacific Island countries where a much smaller percentage of women cite lack of knowledge and lack of access as the reason for their lack of intention to use contraception. In other Pacific countries, the vast majority of women who do not intend to use contraception in the future have access to family planning but are not willing to use contraception. This is not the case in PNG, where only 28 percent indicated an unwillingness to use contraception.

The principle factor underlying an unwillingness to use contraception in future in Pacific Island countries is the “fear of side effects”, although personal and religious opposition is more important in some countries. In PNG about 10 percent of women not intending to use contraception mention “religious opposition” and about 14 percent cite fear of side effects. There is also a significant number of respondents to this question in PNG who have “other reasons” for not intending to use contraception, although what these reasons might be is not stated. Given the opposition to the use of modern contraception among some churches in PNG, it is possible that some of the respondents who mention “other reasons” are deterred by the attitude of the Church but do not wish to say so openly.

Relative to women in other Pacific countries, women in PNG express a strong willingness to use contraception, but lack of knowledge of contraceptive methods, lack of access to services, and a range of socio-cultural barriers is preventing them from doing so. By contrast, lack of knowledge and poor access are not major impediments to the use of contraception in other Pacific Island countries, whereas opposition on religious, health and other grounds are the main impediments.

4. Health, family planning, RH and population policies

(a) National Health Plan

PNG has had five national health plans since independence. In addition, government policy and strategies are reflected in a range of other documents. Most important among these is the RH Policy, the Family Planning Policy, and the National Population Policy. An important recent addition to the array of policy documents is the Report of the Ministerial Task Force on Maternal Health, which contains a number of proposals and recommendations that are relevant to the issue of family planning. In addition to health plans and policies there are several strategic documents that address implementation issues in greater detail.
The immediate past National Health Plan (NHP) covered the period 2001-2010. (A new National Health plan has been formulated for the period 2011-2020). Volume I of the 2001-2010 plan outlines the overall policy direction and priorities that the government has pursued over the past decade. These are the policies underlying the patterns and trends discussed in this paper.

The 2001-2010 National Health plan places family planning under the general heading of “Family Health, with a focus on Women’s and Children’s Health”, and the sub-heading “Reproductive Health”. The key statements are:

- All couples and individuals shall have access to information needed to decide freely and responsibly the number, spacing and timing of their children.
- All adolescents shall have access to information and advice on sexual health and family planning.
- All health facilities shall provide high quality family planning services that emphasize client needs, sensitive counselling, choice of methods and comprehensive information.
- All family planning clinics shall make available sexually transmitted infection treatment and cancer screening services.
- Women and adolescents shall be involved in the design and implementation of family planning and sexual health programs.

It is difficult to assess the significance of the wording of these statements. For example, the reference to adolescents refers to their having access to information and advice, but services are not mentioned. Certainly the statement could be interpreted to mean that health facilities were only obliged to provide information and “advice”, not to provide contraceptives.

The Implementation Plan for the Strategic Directions in Safe Motherhood, Neonatal and Reproductive Health provides more details of the strategies selected to achieve the objectives stated in the National Health Plan. The strategies include “…a special focus on adolescents to encourage responsible sexual behaviour, family planning and the prevention of sexually transmitted infections including HIV/AIDS.” It is likely that some health staff paid more attention to the expression “encourage responsible sexual behaviour” than the provision of family planning.

On a positive note, one objective of the implementation plan was to increase the contraceptive prevalence rate for modern methods to 25 percent—a target that may well have been achieved given that the 2006 DHS reported a CPR of 24.4 percent. Perhaps the target was on the low side.

The current National Health Plan (2011-2020) remains in draft at the time of writing, but it is clearly focussing on the restructure of the health services in an effort to recover from the consequences of the revisions to the organic law on provincial governments that resulted in the disintegration of health service delivery in Papua New
Guinea. The plan aims to rebuild primary health services in rural areas through the creation of a new first line institution to replace the aid post and the health sub-centre, to be known as a “Community Health Post”. Another change is the creation of regional specialist hospitals. All health care delivery points up to the regional specialist hospitals will come under the management of a “Provincial Health Authority”. The challenge of this restructure at the primary health level will be to ensure that the new Community Health Post is capable of supplying services more effectively than the aid post was.

The objectives of the NHP (2011-2020) include “increase family planning coverage”, with the primary strategy being to “Ensure every health facility has the capacity to offer family planning services at all times”. A related objective is to “improve sexual and reproductive health for adolescents, with the primary strategy being to “Increase the knowledge of adolescents about sexual and reproductive health.”

(b) Reproductive Health Policy

A comprehensive National Sexual and Reproductive Health Policy was developed in 2009 (National Department of Health 2009). One of the stated justifications for developing an RH policy is that “reproductive health services have concentrated on family planning to the detriment of other components”. The situational analysis also notes that “On the whole, the total demand for family planning is still relatively low as only 35.7 percent of women demanded for family planning according to the 2006 DHS report”\(^\text{12}\). Despite this, the policy expresses an intention to:

*Promote access to information on family planning and provide wide choices of contraceptive methods including surgical methods and encourage the development of new initiatives for identifying and solving logistical problems at all levels to ensure reproductive health commodity security.*

The primary policy objective that relates to family planning is to reduce unwanted pregnancies with a target of a 50 percent reduction by 2012. To achieve this it is proposed to increase the contraceptive prevalence rate from 20 percent to 60 percent over the same period. Needless to say, this is a highly unrealistic target, given that based on recent trends the use of modern contraception is only increasing at the rate of about 2.4 percent per year.

(c) Family Planning policy

A second edition of the National Family Planning Policy, Implementation Strategy and Technical Standards was issued in 2007 (National Department of Health 2007). This document covers family planning policy in detail and provides guidance to health staff in the application of the policy. The policy notes that access and use of family planning has been stagnant over the period 1996-2003 as measured by the “couple years of protection”. It also points out that the “new acceptor rate” over the period 2001-2005

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\(^{12}\) The actual “demand” for family planning in 2006 was 69.8 percent. Only 36.8 percent of demand was satisfied.
has also been stagnant and that 95 percent of women are not being reached by the present family planning services”.

The policy reiterates that the consent of a partner is not legally required before providing any contraceptive method. This includes tubal ligation and vasectomy. However, the family planning policy suggests that health workers should encourage couples to discuss the merits of adopting a permanent method of contraception before doing so. Similarly, a person aged over 16 years does not require parental consent to be provided with contraception.

National policy is for contraceptives to be provided free of charge at a public health facility; however, Provincial health authorities may charge a consultation fee for the provision of clinical services up to a maximum allowed by national policy. It is these fees that discourage would-be users of family planning from seeking the service, especially low-income rural women.

The policy goes on to identify a wide range of strategies to implement the measures intended to achieve its objectives, including management systems and monitoring and evaluation of the services provided. Detailed service delivery and technical guidelines are provided for the use of family planning nurses and other health staff. Included in the recommendations is that condoms should be made available in such a way that people can access them without having to ask a health worker directly or to formally register a request. Detailed guidelines are also provided on the standards of privacy, hygiene and cleanliness that facilities should meet for the dispensation of family planning services. Minimal equipment lists are described along with the educational materials that should be available for client use.

In general, the National Family Planning Policy (of 2007), especially its service delivery technical guidelines and its specification of the standards required at family planning clinics, hospitals and aid posts, is a very useful document for health workers, administrators and supervisors. As noted by Burdon et al. (2002) the problem in the past has been that very few health workers are aware of the policy or have a copy of it on hand. The other issue is that while the standards specified for facilities are reasonable and correct, very few family planning SDPs are able to achieve them.

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13 McRae (1982) has pointed out that the PNG Criminal Code allows a person to perform a surgical operation on a person that is for his benefit, but a medical practitioner who performs a sterilization knowing that the consent of the patient has not been obtained will be considered guilty of assault and subject to civil action by the patient. There is no law that requires the consent of a spouse before sterilization can be carried out, but until recently this was the general practice in PNG. At least one NGO that carries out tubal ligations in Papua New Guinea still requires the written consent of both the woman and her husband if she is married. This practice is to protect the facility against any risk of law suits or violence against the facility or its staff. McRae further notes that any attempt to restrict access to contraception may violate the right to privacy guaranteed by the Constitution. It is unlikely that this right has been tested in the courts.

This is the most important document of relevance to family planning produced by the National Department of Health in recent years.\textsuperscript{14} It documents the maternal health situation in some detail, highlighting in particular the impact that a deteriorating health infrastructure and an inadequate health budget have had on maternal health. The report notes, for example, that health expenditure as a proportion of GDP is only 0.6 percent in PNG compared with 2.1 percent in Indonesia, 4.1 percent in Fiji and 4.9 percent in Samoa. Declining real expenditure on health has contributed to the closure of 200 aid posts and a decline in ANC coverage over the period 1997-2004 (NDOH 2009). Among the key circumstances contributing to maternal mortality in PNG, the report places strong emphasis on the poor access to family planning information, services and supplies.

Accordingly, among the 7 Taskforce Recommendations, number four concerns family planning. The recommendation is reproduced in full below:

\textit{That quality of voluntary family planning service provision be immediately strengthened in the areas of access and coverage for all Papua Niugineans as a primary intervention to reduce the burden of maternal mortality and morbidity in PNG. The target should be modern family planning prevalence of 65\% by 2020 in order to achieve a desired Total Fertility Rate of 2.2 by 2020.}

The recommendation is compromised only by the unrealistic 2020 target for the contraceptive prevalence rate and the TFR. It has taken 30 years for the CPR to increase from around 6\% in 1978 to 24\% in 2006, and 40 years for the TFR to decline from 6 to 4.4. Although it is certainly possible to increase the speed with which women and couples are adopting reliable contraception, it is highly unlikely that a CPR of 65\% and a TFR of 2.2 could be achieved within 10 years, even with an accelerated programme.

In any case, it is worth noting the strategies that have been proposed to achieve this target. These include:

(a) Development and resourcing of a national family planning strategic plan to support the national family planning policy.

(b) Increasing access to a range of permanent and temporary contraception (long and short term acting) methods, for males and females.

(c) Sustained community mobilization and health promotion efforts to normalize community attitudes towards family planning as a way to match family and community resources to family size and spacing needs.

(d) Integration of family planning effectively into all health service delivery points independent of agency managing the service. Full funding to these services

\textsuperscript{14} Unfortunately the report misses an opportunity to explain the possibility that the apparent doubling of the maternal mortality ratio between the last two DHS is a consequence of statistical problems rather than a real change.
should be linked to provision of the package of full sexual and reproductive health services, with incremental funding arrangements if full services are not provided.

(e) Supporting men as partners and adolescent health services in sexual and reproductive health programs.

(f) Improvement in the quality of all health professional training programmes to ensure that graduates have the required competencies in quality voluntary clinic focused family planning service provision.

(g) Develop formal post basic courses in sexual and reproductive health.

(h) Strong monitoring implementation to ensure that national policy on free services for sexual and reproductive health is implemented at all health service delivery points.

Recommendation (d) carries the most serious implications as it would appear to be aimed at restricting funding to those health care institutions that do not support the same range of services that are supported by the government’s family planning and reproductive health policies. The only such institutions are those operated by churches.

(e) National Population Policy 2000-2010

The present policy, which expires this year, is the second national population policy adopted by the PNG Government since independence. The first was launched in 1991 and had a stronger population control approach than the current policy. The current policy was prepared in the light of the recommendations of the ICPD Programme of action and therefore placed particular emphasis on the cross-sector nature of population issues, including human rights, gender, education, environment, STIs and HIV, maternal and child health and urbanization.

The 2000-2010 policy was very cautious in the area of contraceptive prevalence. The policy pointed out that there was no clear relationship between the CPR and the total fertility rate at the provincial level. It was also noted that fertility decline was evident in provinces in which family planning delivery was poor or where no specific projects to support family planning had been implement. This observation was subsequently confirmed by the 2002 review of family planning (Burdon et al. 2002).

Nevertheless, the policy set objectives that would achieve the goal of “accelerating the demographic transition”. These included reducing the total fertility rate to 3.8 by 2010 and to 3.0 by 2020. These were realistic targets. To achieve these targets the policy proposed that the coverage and quality of family planning services should be improved starting with a specific focus on those provinces that had high fertility rates or low contraceptive prevalence rates. It was expected that these and other measures might increase the contraceptive prevalence rate to at least 40 percent by 2015. If all forms of contraception are included, it is not impossible that this target could in fact be reached as the CPR for all methods reached 32.4 percent; but the use of modern methods only reached 24.4 percent by 2006.
Specific objectives and strategies for family planning were placed within the broad category of reproductive health. The basic objective was that: “All health facilities to provide high quality family planning services that emphasize client needs, sensitive counselling, choice of methods and comprehensive information by 2010.

The strategies that it was felt could achieve this objective included”

- **Strengthen and expand family planning training programs for health workers at all levels.**
- **Improve the supply and distribution of modern contraceptives by strengthening the management and procurement and distribution systems.**
- **Review the user fee policy to ensure provision of “low cost or free” family planning services.**
- **Integrate family planning awareness, including the benefits of modern contraceptives for reducing maternal and infant mortality through MCH outreach programs.**

The principal difficulty associated with the National Population Policy 2000-2010 was not its formulation but its implementation. Like other health-related programmes, the implementation of the policy came to a virtual halt because the main responsibility for implementation was given to provincial governments. But provincial governments preferred to have a full-blown policy of their own rather than just implement the policy of the national government. Most provinces did prepare an implementation plan but it took many years to do so and in the meantime the leadership at the national level weaken significantly. Many of the strategies identified in the population policy subsequently reappeared in the Report of the Ministerial Taskforce on Maternal Health in Papua New Guinea of 2009.

5. **Commodity security**

(a) **Supply chain and logistics management**

The status of Reproductive Health Commodity Security (RHCS) in PNG must be considered poor. Although it would be extremely difficult to survey every Service Delivery Point in the country the evidence from several partial assessments and many local studies suggests that supplies of contraceptives are unreliable and inconsistent across the full range of health facilities from aid posts to hospitals. At the same time, the unavailability of contraceptives in the rural health facilities that actually deliver services may co-exist with large surpluses of commodities in Area Medical Stores or Provincial transit stores. The problem is not that the country cannot afford supplies; the primary reason for inconsistent supplies is poor distribution resulting from weak logistics management. This is indicated by the fact that the government budget allocation for medical supplies was under-spent by K11.3 million in 2004 (Midire et al. 2005).
The insecurity of supply of contraceptives at various levels of the health services delivery system is a major impediment to the continuous use of modern contraception in PNG. Village-level studies such as that undertaken by Maibani-Michie (1998) show that lack of or inconsistency in supply, along with difficulty of access, are the primary reasons for discontinuation of family planning methods in rural areas. This arises in part because the system of village aid posts—the lowest level of facility in the PNG system of rural health care—has been collapsing over the past 20 years. It is estimated that in 2000, 37 percent of aid posts in the country had ceased operating (NDOH Ministerial Task Force 2009). In some provinces the proportion of aid posts still functioning is less than this. Midire et al (2005) found that only 59 percent of aid posts in Morobe Province were operational.

Even if the village has a functioning aid post, the delivery of contraceptives, as with other medicines and supplies, is generally erratic and unreliable. A conscientious staff member of an aid post (an “Aid Post Orderly” (APO) or Community Health Worker—CHW) would need to be highly creative and energetic to ensure continuity of supply by seeking emergency supplies from a health centre or a district hospital when stock-outs occur.

In any case, aid posts are normally able to provide only condoms, injections and pills; but stock-outs of these commodities are common, frequently lasting several months. Some aid posts had never provided any family planning services because staff were not trained or interested. The unreliability of supply at the rural village level encourages women to go directly to a health centre, District or Provincial Hospital where the chances of finding the service or commodity wanted are higher. But even at these levels stock-outs can occur (Midire et al. 2005), although less frequently than at aid post level.

The closure of an aid post or the unavailability of contraceptives there can have dire consequences for women who wish to avoid pregnancy and have to seek services at the next highest SDP. Maibani-Michie (1989) cites the case of a woman from a remote part of Milne Bay Province, who said:

_I had discontinued depo not by choice but was forced to by natural circumstances. When my depo injection was due it was during the wet season and the rivers had flooded so I could not go to the health centre because to get there I had to go through 20 or more river crossings. As a consequence of that I fell pregnant to my 7th child…_

Comprehensive reviews of Reproductive Health Commodity Security (RHCS) in PNG were conducted in 2003 and 2005. The most recent of these (Midire, et al. 2005) describes the situation that would have prevailed around the time of the 2006 DHS. Major problems identified in 2005 include:

15 Midire et al. (2005) report visiting an Aid post that had been out of stock of condoms for four months, even though a plentiful supply was available in the Area Medical Stores. Baravilala (2006) reported that many health centres in provinces supported by a UNFPA project ran out of condoms within two weeks of receiving a supply. Supply is clearly not demand-driven.
**Forecasting.** The methods used for forecasting future requirements are inadequate. Ordering is done annually based on previous years but no account is taken of the “stock-outs” that have occurred during the year, resulting in a chronic under-supply of contraceptives. Deliveries to village aid posts are not based upon an assessment of demand or needs in the catchment area. Rather, a fixed quantity of contraceptives is included in medicine kits that are supposed to be delivered every six months.

**Procurement.** Government procedures for procuring contraceptives are complex, time-consuming and poorly implemented. While part of the problem is that the procedures are cumbersome, the main reason for delays is weak management, exacerbated by shortages of staff and inadequate training.

**Pipeline management.** Surpluses of stock in Area Medical Stores co-exist with shortages in District Hospitals, Health centres and aid posts. The over-stocking of supplies at one stage of the distribution chain accompanied by the under-stocking of supplies at Service Delivery Points is indicative of poor logistics management.

(b) **Funding sources**

It is not possible to provide a definitive accounting of all expenditure on RH commodities. It is clear, however, that the The Government of Papua New Guinea provides the bulk of the funds to finance the purchase of contraceptives. The purchase of contraceptives is carried out through mandated procurement systems that require the calling of tenders with the final decision on the supplier being made by various bodies up to the Executive Council, depending on the amount. In 2004, the PNG Government spent K1.97 million on contraceptives and a further K1.3 million was provided by AusAID under the Health Sector Improvement Programme (HSIP). These figures suggest that the Government provided 60 percent of the costs of contraceptives. However, if the private sector and NGOs are included that the Government share would decline to around 50 percent.

The contraceptives included in medical kits supplied to health centres and aid posts are purchased by AusAID and Asian Development Bank, respectively. The Health Sector support Programme (HSSP) spent K928,500 in 2005 on condoms included in these kits. AusAID provided an additional K9.5 million for condoms and other medical supplies through the National HIV/AIDS Project (Midire et al. 2005).

It is estimated that less than 5 percent of contraceptives are purchased directly by individuals from pharmacies or provided by private doctors. However, there are instances when hospitals that have run out of supplies send patients to pharmacies to purchase their requirements. The Papua New Guinea Family Health Association (an IPPF affiliate), which provides contraception free, obtains commodities from IPPF Headquarters in London. Other NGOs now operating in PNG, including Population Services International, Marie Stopes and Family Health International, purchase contraceptives locally or from abroad.
There is little or no coordination between these agencies in terms of the purchase of contraceptives. It is not possible to estimate the total expenditure, but it is likely that the Government’s share of the total is declining in relative terms.

(c) Commodity security Plan

A wide range of recommendations have followed from the recent RHCS reviews, but the extent to which these have been implemented over the past few years is not presently known. Foremost among these are:

- Establishment of a National RHCS Coordinating Committee/Working Group
- Development of a National RHCS Strategy
- Strengthening Logistics Management System (new procedures, equipment)
- Capacity building (appointing logistics manager, training in forecasting, etc.)
- Procurement of additional commodities not currently available (e.g., vasectomy kits)
- Improved mechanisms to ensure sustainability of RHCS (policy dialogue, resource mobilization, CBD)
- Preparation of an essential drugs list.

The status of implementation of these recommendations is unclear at this point but the 2005 report reviewed the status of the recommendations of the 2003 RHCS assessment, some of which reappear in 2005. Implementation appeared to be limited over the two-year period following the 2003 review. Importantly, progress had been slow in establishing an RHCS coordinating body.16

6. Adolescents, youth and older persons

(b) Adolescents and youth

At 65 per 1,000, the teenage fertility rate in Papua New Guinea is at the high end of the range for Pacific countries, providing you leave some obvious outliers as Marshall Islands (127) and Nauru (78) out of the comparison. Essentially, PNG, Vanuatu and Solomon Islands all have the same teenage fertility rate. Teenage fertility patterns are largely determined by cultural-behavioural conditions and are not closely related to overall fertility (Hayes and Robertson 2010). Teenage fertility does not necessarily follow the overall TFR down if it is declining.

Although very strong socio-cultural pressure can bring teenage fertility down to significantly lower levels, as the special case of Tonga suggests, most Pacific cultures are either unwilling or unable to practice the necessary degree of social control of teenage girls (less so of boys) that Tonga is able to achieve. In PNG and other Pacific cultures, teenage births generally occur outside marriage—even if marriage eventually occurs between mother and father in the fullness of time. Herein lies the problem for adolescents

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16 The National Sexual and Reproductive Health Policy (2009) does not refer to any of these recommendations or the activities associated with them.
in accessing family planning prior to becoming parents. Although both the law and government policy in PNG allows any person above the age of 16 to obtain contraceptives from government clinics, or any other source, the practice is rather different. Many health workers in family planning clinics regard themselves as guardians of the moral order rather that a service provider. As Burdon et al. (2002) noted, “...most health workers would not dream of giving any family planning methods to anyone over the age of 16 who is unmarried” (p.56). While this attitude may not be universal, it is probably quite common.

One of the limitations of the MCH approach to family planning is that young unmarried people without children have no access to the services. This was part of the rationale for broadening the approach to family planning and placing it within a rights-based reproductive health strategy. In practice, this approach is still insufficient for young people. Consequently, adolescents have to seek services from NGOs, or STI clinics, community based distributors, or private pharmacies. But these sources are difficult for rural youth to access as most NGOs operate in urban areas or at best in peri-urban villages. Similarly, peer educators and university-based clinics serving students are by definition urban and not of much assistance to rural youth, who have to fall back on an aid post or a health centre, where there access to services depends on the attitude of the Community Health Worker or Aid post Orderly. Where a health centre is Church-operated, it will be difficult for unmarried adolescents to access contraception, even if supplies are available.

The recent increase in the number of NGOs addressing reproductive health needs in Port Moresby is of assistance to youth and adolescents as these organizations are not concerned with upholding the moral order, as many government staff seem to be. The expansion of the PNG Family Health Association’s operations beyond its current three clinics would be of great assistance in improving access to family planning for young, unmarried people.

(b) Older persons

Older persons face barriers of a different type to those faced by adolescents. In this context, “older persons” refers to women who wish to stop child-bearing before they would naturally do so. Even in traditional times, women sought ways to cease child-bearing long before they lost the biological capacity to conceive. It is important to recall that unmet need for family planning in 2006 was 61.5 percent among women aged 40-44 and 76.8 percent among women 45-49. These are the women who, generally, would like to stop child-bearing but may still be at risk of conceiving if they are not using some form of family planning. Rural women are particularly at risk of an unwanted pregnancy in older age.

As Townsend (1984) pointed out, tubal ligation is the ideal contraceptive method for rural women who have had the children they wish to have. When T-L was introduced in the 1970s it was taken up rapidly by rural women. In the Goroka area the average age of women seeking tubal ligation in the 1970s was 34 years and average parity was 5.5 (Townsend 1984). When health centres were functioning well (i.e., fully supplied with
running water and maintained in a hygienic condition) T-L could be conducted there. Increasingly T-L is only available in a provincial hospital. For poor, rural women living in remote areas, travel to a provincial hospital is very difficult due to the cost and difficulties of transport.

In health centres operated by the Catholic Church, T-L is in any case not available and this is also true in some health centres operated by the Anglican Church. However, vasectomy is an increasingly popular permanent means of stopping child-birth and training in non-scalpel vasectomy is being provided across PNG with UNFPA support.

7. Linkages to other Reproductive Health issues

(a) HIV and AIDS

The advent of the HIV epidemic in PNG has had consequences for family planning in the sense that there is no shortage of condoms in the country, even if specific service providers (particular rural aid posts or health centres) have intermittent or unreliable supply. Female condoms are also being distributed in increasing quantities, particularly by NGOs addressing the needs of CSWs.

Government policy is that condoms should be made freely available to anyone who wants them without having to register in a clinic. There is evidence that health workers resist this policy. Despite the urgency of the HIV and AIDS crisis, some health workers continue to believe that the free distribution of condoms encourages promiscuity or prostitution.

(b) STIs

Increasing rates of other STIs is having an impact on the provision of some forms of contraception, such as the IUD. A considerable proportion of women seeking the IUD from Marie Stopes clinic in Port Moresby, for example, cannot be fitted with an IUD because they have an STI, which has to be treated before the clinic an IUD can be fitted. And an IUD alone provides no protection from an STI so is not suitable for women who are not in an exclusively monogamous relationship. At the same time, the expansion of NGO services has made it much more likely that young people will seek advice and treatment as the services provided at NGO clinics are more likely to follow a rights-based approach and maintain confidentiality.

8. Socio-cultural challenges to Family Planning

(a) Demand and supply of children

It is normally assumed that in traditional or under-developed societies, family size preferences are either high or that individuals do not perceive the size of their family as something that is within their control. There is ample evidence, however, that many
traditional societies in the Pacific did not aim at high fertility and took steps to limit the number of children (particularly in Melanesia) however ineffective these means may have been. With increasing “modernization”, women in particular come to believe that they can effectively limited their family size, at which point it becomes reasonable to ask how many children they would prefer to have. Agyei (1988) was probably the first researcher to put this question to a sample of PNG women in the late 1970s, finding that the majority of women wanted at least six children. At that time the Total Fertility Rate was 5.4, thus “wanted” fertility appeared to be higher than “actual” fertility.

Village-based research in a variety of settings throughout PNG a decade later did not confirm this finding. McDowell summarized this research by concluding that “four or five” children would be a sufficient number to meet the genuine needs of rural families (McDowell 1988), with the implication that there would be broad acceptance of any population policy that aimed to limit the average number of births to between 4 and 5.

Qualitative assessments by a number of researchers and informed observers from the 1970s onwards have suggested that most Papua New Guinea women would prefer to have four children. However, the actual number is less important than the balance of male and female children. As Townsend (1984) notes, women need boys for old age support and girls in order to receive bride-price when they marry (and child-price when they have children). This observation highlights the cultural fact that decisions about the number of children that a woman will bear are not necessarily for her alone to make (or even for her and her husband to make jointly) but belong to the social group. In fact, negotiations over bride-price may also involve an agreement between the respective clans being linked by marriage regarding the number of children of each sex that the woman would have.

In traditional times, and in some areas probably up until today, a married woman who aborted a child or committed infanticide could be depriving her own kin-group of the payments or gifts that the father’s kin-group is obliged to pay on the birth of a child, depending on how many children she already had. Abortion could be grounds for divorce at which point the woman’s kin-group would have to re-pay all or part of the bride-price they had received from the husband’s kin (O’Collins 1979). Thus, so long as such institutions as bride-price and child-price are culturally supported, a woman is not completely free to choose the number of children she will have. Nevertheless, it is possible to negotiate such issues when marriage is being arranged, and it is highly likely that nowadays male kin-groups will be satisfied with fewer children as the value of children’s labour declines and the cost of raising children increases.

The first reliable data on family size preferences in a nationally representative sample was obtained from the 1996 DHS. With a second DHS conducted in 2006 it is

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17 Pirie (1971) noted that “Melanesian societies show a notable restrained attitude toward fertility compared with Polynesian and there is every reason to believe that an effective means of limiting family size would be welcomed”.

18 The elimination of clan fighting has reduced the incentive to have many boys to increase the strength of the clan.
possible to measure changes in family size preferences. Table 16 shows ideal family size in 1996 and 2006 cross-classified by age. It is clear that the ideal number of children among women has not changed significantly between 1996 and 2006. (The small changes between the two surveys in some age groups are unlikely to be statistically significant).

Table 16: Ideal number of children by age, 1996 and 2006 (all women)

<table>
<thead>
<tr>
<th>Year</th>
<th>15-19</th>
<th>20-24</th>
<th>25-29</th>
<th>30-34</th>
<th>35-39</th>
<th>40-44</th>
<th>45-49</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>1996</td>
<td>2.7</td>
<td>3.0</td>
<td>3.4</td>
<td>3.9</td>
<td>4.2</td>
<td>4.3</td>
<td>4.7</td>
<td>3.5</td>
</tr>
<tr>
<td>2006</td>
<td>2.9</td>
<td>3.0</td>
<td>3.4</td>
<td>3.8</td>
<td>4.0</td>
<td>4.4</td>
<td>4.6</td>
<td>3.6</td>
</tr>
</tbody>
</table>

Source: DHS reports 1996 and 2006

The data suggests that women approaching the end of their reproductive years (age 35-39) still wish to have four children. However, when a comparison is made between the “wanted” TFR and the “actual” TFR in 1996 and 2006 it is apparent that the gap between wanted and actual fertility is widening. This is evident from the data in Table 17, which shows that the gap between actual and wanted TFR has increased from 0.9 to 1.4 between the two DHS. This widening gap implies that women are less able to achieve their family size goals in 2006 than they were a decade earlier—yet another indication that family planning services are not meeting the needs of women.

Table 17: Difference between “wanted” and “actual” TFRs by education, 1996 and 2006 (all women)

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Wanted TFR</th>
<th>Actual TFR</th>
<th>Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Education</td>
<td></td>
<td></td>
<td>1996</td>
</tr>
<tr>
<td>None</td>
<td>4.1</td>
<td>2.9</td>
<td>5.0</td>
</tr>
<tr>
<td>Grade 1-5</td>
<td>3.8</td>
<td>3.3</td>
<td>4.7</td>
</tr>
<tr>
<td>Grade 6</td>
<td>3.9</td>
<td>3.1</td>
<td>5.1</td>
</tr>
<tr>
<td>Grade 7+</td>
<td>3.3</td>
<td>2.8</td>
<td>3.8</td>
</tr>
<tr>
<td>Total</td>
<td>3.9</td>
<td>3.0</td>
<td>4.8</td>
</tr>
</tbody>
</table>

Source: DHS reports 1996 and 2006

It is noteworthy that the gap between wanted and actual TFR is smallest in both years for women who have been educated to Grade 7 and over; but the percentage increase in the gap is the highest for educated women. In this group, the difference between wanted TFR and actual TFR increased by 100 percent (from 0.5 to 1.0), whereas in other groups the increase ranged from 66 percent (for women with no education) to 33 percent (for women educated to grade 6). The implication of these figures is that
education is finally beginning to have a clear impact on desired family size, something that was not so evident in the past (Townsend 1984).

In sum, family size preferences should not present a socio-cultural challenge to family planning programmes in PNG. It is not the case that women generally want a large family and therefore that the demand for family planning needs to be generated before family planning will be taken up. This may well have been the situation in the 1970s, and possibly up to the early 1980s, but it is not the case today. Women want fewer children than they are likely to have given their present access to and utilization of family planning services. This is evident from Figure 6, which is based on data from a special DHS (based on the 1996 model) conducted in 2002-03 in the four provinces in which UNFPA has concentrated its activities since 1997.

Figure 6: Relationship between ideal number of children and children ever born and surviving, 2002 DHS of selected provinces

The figure shows that if this group of women were members of the same cohort, they would have reached their preferred or ideal family size (about 3.8 children) by age 35-39. But the mean children ever-born, and the mean number of surviving children continue to increase beyond that age reaching about 5.5 by age 40-44. This is not, of course a real cohort in the same sense that the TFR is not calculated on the basis of a real cohort but rather a synthetic cohort. But the data give an indication that the “supply” of children exceeds “demand” even when allowing for the mortality of children. The motive to have more births than needed to achieve a preferred number of children is significantly
weakened as the infant mortality rate declines, as it has been doing in PNG in recent decades. “Excess” births to compensate for the mortality of children are no longer required in the PNG context, although individual women in high mortality areas may be in this situation.

(c) Gender and family relations

Gender inequality makes a major contribution to maternal health problems in PNG. Violence against women is endemic and common, include sexual violence, rape and gang rape. Women and girls have unequal access to health care. Boy children are more likely to receive urgent health care than girl children. When life expectancy has been calculated using data obtained on deaths among adult women, male life expectancy has been shown to be higher than female.  

So far as family planning is concerned, the opposition of husband’s is not among the main reasons that women give for not using family planning; but it is generally understood that men have a major influence on a woman’s decision to use family planning and what kind to use. Men certainly wish to be more involved in family planning matters than they presently are and efforts to facilitate “men as partners” are certainly necessary. The success of the vasectomy programme pioneered in the

9. Conclusions and recommendations

(a) Conclusions

The fertility transition

- Fertility decline has occurred slowly in PNG compared with other less developed countries and virtually came to a stop in the early 1990s. The most likely reason for this is that mortality was also declining slowly and this was in turn linked to a general slow down in the pace of economic development. Decentralization of health services, including family planning, may also have played a part in the slow fertility decline.

- Given present trends it is unlikely that the TFR will reach replacement level for at least another 20 years, by which time the population will reach 10 million and still be growing.

Knowledge and use of family planning and unmet need

- Knowledge of modern family planning methods is increasing. In 2006 81 percent of married women knew a modern method and 73 percent knew a source of a modern method.

- Knowledge of a modern family planning method is growing fastest among women with no education or only primary education and slowest among educated women.

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19 This was only possible in 1991 when the DHS asked questions designed to determine male and female mortality separately. See (Hayes 1993).
• Of women educated to Grade 7 and over, 94 percent know a modern method compared to 70 percent of women with no education.

• Knowledge of contraception is growing fastest in urban areas. Virtually 100 percent of urban women who are aware of any method are aware of a modern method of family planning.

• Use of modern contraception is growing at a very slow pace of 2.4 percent per year in PNG, reaching only 24.4 percent of currently married women in 2006. At this rate it will take about 32 years to reach 50 percent.

• The use of contraception is highest among women educated to grade 7 or over.

• The proportion of women using “traditional” forms of contraception is rising in some regions of the country. Of all women in the Islands region who are using any form of contraception only 60 percent are using a modern method. Although the proportion of all married women using modern contraception is rising, it is not rising as a proportion of women using any method of contraception.

• The highest contraceptive prevalence rate is among women who have had four or more children followed by women educated to grade 7 and over followed by women aged between 35 and 44. Women aged 40-44 are most likely to use a traditional method.

• The unmet need for family planning is 44 percent of currently married women, which is a small decrease from 46 percent in 1996.

• The absolute number of women with an unmet need has increased to 632,000 in 2006, a 30 percent increase since 1996. This has occurred because the number of women of child-bearing age has increased substantially over the decade.

• The unmet need for family planning is highest among women aged 40-49 and among women with no education.

• Only 36.5 percent of the total demand for family planning (current users + unmet need) is satisfied.

• Older and uneducated women have the lowest percentage of total demand satisfied.

• The gap between desired or preferred family size (wanted TFR) and actual family size (actual TFR) is widening.

• Very few women access contraception at Mother and Child Clinics or from pharmacies and shops. The most rapidly growing source of contraception is the PNG Family Health Association (IPPF affiliate). Access from hospitals and health centres is declining but access at aid posts is increasing.

**Barriers to the access and use of family planning services**

• The general deterioration of rural (primary) health services, including: closure of aid posts, withdrawal of doctors, lack of maintenance and repair, lack of vehicles and fuel.
• Unwillingness of some church-operated health centres to provide modern contraception.
• Imposition of consultation fees at the facility level.
• Low level of female education and high rates of illiteracy.
• Lack of awareness and lack of access among less educated women.
• Unreliable and inconsistent supplies of contraceptives arising from poor management.
• Negative attitudes of health staff toward poorer patients.
• Reluctance of health staff to provide contraception to single people.
• Belief that contraception promotes promiscuity and prostitution.
• Religious prohibitions against modern contraception on the part of health staff and within the community.
• Fear of side effects or health concerns.

Commodity security
• RH commodity security is poor, mainly as a result of poor logistics management rather than the lack of funds to purchase supplies.
• There is little coordination between agencies in terms of purchase of supplies.
• Status of previous recommendations to improve RHCS is not clear.

Policies and strategies
• PNG has many policies, strategies and implementation plans in health and several concern reproductive health and family planning.
• The main problem with these plans is that while they are formulated by the national government, their implementation is the responsibility of provincial and district governments.
• Another problem is that policies and plans set unrealistic targets and do not address the constraints blocking their achievement. Many plans are poorly formulated (confusion between ends and means) but even well-formulated plans are not necessarily implemented.
• It is not helpful to characterize the demand for family planning in PNG as “low”, as is suggested in the current draft National Sexual and Reproductive Health Policy. This perception needs to be corrected. Demand for family planning in PNG is high and only 37 percent of current demand is being met.
• The review of family planning in 2002 states that the shift to a reproductive health approach has diluted the focus on family planning. The National Sexual and Reproductive Health Policy says that concentration on family planning has diluted reproductive health.
• Policies do not focus sufficiently on reproductive rights.

• The Family Planning Policy is clear and the guidelines for service provision are good. However, it is possible that the policy is not widely distributed or well known among health staff.

• Some health staff do not follow the family planning policy on condom distribution, the legal right of adolescents to be provided with contraception if they are over 16 years of age, and the right of individuals to receive contraception (including permanent methods) without the consent of a spouse.

(b) Recommendations

• Address the issue of the unwillingness of some churches to provide modern contraception, by:
  o Providing alternative government- or NGO-operated health services in the catchment area of church health services.
  o Promote CBDs and health volunteers in districts that are only served by church health services.
  o Mobile Family planning clinics.
  o Negotiate service agreements that permit church health services to refer clients to alternative services.
  o Church health services to be made aware of health and family planning policies and guidelines.

• Place increased emphasis on aid posts as the primary service delivery point for contraception and family planning, by:
  o More reliable distribution of commodities to aid posts (commodity security).
  o Produce a new, revised version of the family planning policy and service delivery technical guidelines and distribute to all aid posts, health centres and clinics.
  o The introduction to the guidelines needs to be revised to focus on reproductive rights, maternal and child health and not demographic issues
  o Training of CHWs and other health staff to emphasize the adoption of appropriate attitudes toward clients, client rights and quality of care.


• Specifically review the recommendations of the Burdon et al. report and the Maternal Health Task Force on the management of the family planning programme.
• In particular, review the CPR and TFR targets in the Draft National Sexual and Reproductive Health Policy and the Maternal Health Task Force Report and adjust them to realistic levels.

• Seek ways to eliminate consultation fees for family planning imposed at facility level.

• Further analysis of DHS data is needed, particularly to further assess the relationships between religion, contraceptive use and unmet need.

• Also re-check the DHS data on the low uptake of family planning in the context of MCH clinics.

• Stronger emphasis on reproductive rights in policy documents and materials used in the training of health workers. Efforts should be made to educate the population at large about rights to family planning services, regardless of who is managing the facility. Posters outlining client rights to be displayed in all service delivery points.

• Encourage all provinces to appoint a family planning logistics manager.

• Review the implementation of the recommendations made in the 2003 and 2005 RHCS assessments by UNFPA.

• Plan for a follow-up family planning assessment in 2012 to review changes since the last comprehensive assessment by Burdon et al. in 2002.
References cited


