



The New Zealand All-Party Parliamentary Group

# **Study tour to Papua New Guinea: raising awareness of the Millennium Development Goals in the Pacific**

**7<sup>th</sup> – 15<sup>th</sup> April 2006**

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## 1.0 Introduction

### 1.1 About the study tour

From 7<sup>th</sup> – 15<sup>th</sup> April 2006, a delegation of MPs, journalists, and NGO and NZAID representatives visited Papua New Guinea on a study tour focusing on issues relating to poverty, including HIV/AIDS, gender inequality, maternal and child health, and the environment.

Funded by the Asia Pacific Alliance: Advancing the ICPD Agenda (see Appendix 2.0), the study tour was organised by New Zealand Family Planning's international development unit (FPAID) and the Development Resource Centre (DRC).

Headed by New Zealand Parliamentarians' Group on Population and Development (NZPPD) Chair Steve Chadwick, the delegation included NZPPD Vice-Chair Dr Paul Hutchison, and NZPPD member Tim Barnett, Australian Federal Labour MP Duncan Kerr, an Australian photographer, and journalists from TVNZ, the *New Zealand Herald* and the *Listener*, FPAID and DRC staff and NZAID representatives (see Appendix 1.0 for a full list of participants).

The overarching goal of the study tour to PNG was increased awareness and knowledge among the public and decision-makers in New Zealand of: the Millennium Development Goals (MDGs), and linkages between:

- the MDGs
- the International Conference on Population and Development (ICPD) goals and principles; and
- the declaration of commitment adopted at the 2001 United Nations General Assembly special session (UNGASS) on HIV/AIDS.

In particular, the study tour aimed to highlight the importance of good sexual and reproductive health in achieving the MDGs in the Pacific.

Journalists participating in the study tour committed to gathering stories and information in order to publish and broadcast compelling stories to New Zealanders back home (see Appendix 6.0) helping to generate a groundswell of support for increased development assistance and other policies that can contribute to improving lives and creating a supportive environment for achievement of the MDGs in our region.

Through collaboration between the Asia Pacific Alliance NGO members in New Zealand (FPAID and DRC) and Australia, Australian MP Duncan Kerr and photographer Steven Nowakowski were able to participate in the study tour. Steven captured powerful images that will be essential for awareness-raising activities in New Zealand and Australia.

Building on a collaborative relationship formed during the last APA-funded MP study tour to Asia in 2004, the MPs met with Dame Carol Kidu, Minister for Community Development and PNG's only women MP. The delegates also met with Dr Puka Temu, the Minister assisting the Prime Minister on HIV/AIDS, who has called for 100 per cent condom use to help halt the epidemic.

As well as meetings with MPs and officials, delegates went to the heart of the matter as they met and talked with sex workers, visited hospitals, schools, villages and non-government organisations (See Appendix 3.0 for a full programme outline).

## **1.2 Purpose of this report**

This report has been prepared as a record for the delegation and to share information about the study tour with parliamentarians, the media, and national and international networks. The report outlines themes that emerged from the study tour relating to the achievement of the MDGs in PNG and links with the goals and principles of the ICPD and UNGASS on HIV/AIDS Declaration of Commitment. From these themes, the NZPPD has developed recommendations for action. MPs who participated in the study tour have also committed to follow-up activities, including working with media, writing letters of support to key individuals in PNG including Dr Temu and Dame Carol Kidu, maintaining contact with civil society networks requesting this, and scheduling meetings with the PNG High Commissioner, NZAID and the Ministry of Foreign Affairs and Trade.

## 2.0 Background

### 2.1 International Conference on Population and Development (ICPD)

Held in Cairo in 1994, the ICPD was groundbreaking in that it considered population issues not from a demographic perspective, but from a human rights perspective, and advocated the empowerment of women, the education of girls and the involvement of men.

The New Zealand delegation, led by the Hon Katherine O'Regan, was central to the development of the ICPD Programme of Action (POA). The ICPD-POA endorses a new strategy that emphasises the integral linkages between population and development and focuses on meeting the needs of individuals, rather than on achieving demographic targets.

The key to this new approach is empowering women and providing them with more choices through expanded access to education and health services, skill development and employment, and through their full involvement in policy and decision-making processes at all levels. Indeed, one of the greatest achievements of the Cairo Conference has been the recognition of the need to empower women, both as a highly important end in itself and as a key to improving the quality of life for everyone.

One of the primary goals of the ICPD-POA is to make family planning universally available by 2015 as part of a broadened approach to reproductive health and rights. It also includes goals on education, especially for girls, as well as goals to further reduce levels of infant, child and maternal mortality. It addresses issues relating to: population, the environment and consumption patterns; the family; internal and international migration; prevention and control of HIV/AIDS; technology, research and development; and partnership with the NGO sector. The POA provides estimates of the levels of national resources and international assistance required, and calls on governments to make these resources available.

The POA builds upon the World Population Plan of Action, adopted at the World Population Conference held in Bucharest in 1974, and the recommendations adopted at the International Conference on Population, held in Mexico City in 1984. It also builds on the outcomes of the World Summit for Children (1990), the UN Conference on Environment and Development (1992), and the World Conference on Human Rights (1993). In turn, the ICPD's major emphases were reaffirmed at the World Summit for Social Development and the Fourth World Conference on Women (Beijing), both held in 1995.

#### **ICPD COMMITMENTS**

At the Cairo Conference, 179 governments agreed to a Programme of Action that:

- calls for sexual and reproductive health care to be available to all, including adolescents, by 2015.
- defines reproductive rights and applies human rights principles to population policies and programmes.
- states that gender equity and equality are essential for sustainable development, and calls for women and all other clients to be involved in the planning, implementation, management, and evaluation of sexual and reproductive health care programmes.
- encourages men to be full and responsible partners in sexual and reproductive health and family life.
- asserts that both stabilizing population growth and changing production and consumption patterns are central to reducing environmental degradation and poverty.

- calls for economic, social, and education policies that will help meet ICPD goals, including universal primary education, debt reduction, and women's access to economic resources.

A 1999 review of progress since the Cairo conference (ICPD+5) provided growing evidence that the ICPD agenda is practical and realistic, and that despite all obstacles, it is being put into practice. The review included reports on national implementation efforts, global expert meetings and an international forum at The Hague, organised by UNFPA. It culminated in a special session of the United Nations General Assembly, from 30 June to 2 July 1999, which identified key actions needed for further implementation of the ICPD Programme of Action and new benchmarks for measuring progress towards ICPD goals.

Throughout 2004, a 10-year review and assessment of the Cairo accord - ICPD+10 – took place. This mainly involved regional meetings of United Nations agencies and international non-governmental organisations (NGOs) to reaffirm commitment to the ICPD as a strategic framework, analyse lessons learned, exchange experiences of implementing the ICPD goals, and to plan how to more effectively work towards the 2015 target. More information can be found at [www.countdown2015.org](http://www.countdown2015.org)

## 2.2 Millennium Development Goals

In 2000, the Millennium Summit (New York) saw 189 world leaders agree to a set of time-bound and measurable goals and targets for combating poverty, hunger, disease, illiteracy, environmental degradation and discrimination against women. These Millennium Development Goals (MDGs) are now placed at the heart of the global development agenda.

The MDGs, to be achieved **by 2015**, are to:

1. eradicate extreme poverty and hunger
2. achieve universal primary education
3. promote gender equality and empower women
4. reduce child mortality
5. improve maternal health
6. combat HIV/AIDS, malaria and other diseases
7. ensure environmental sustainability.
8. develop a global partnership for development

In many ways the ICPD-POA anticipated the MDGs, and many of the goals are similar. Although reproductive health was omitted from the MDGs, enabling people to choose their family size will slow the rapid population growth that undermines poverty reduction efforts in the world's poorest countries and prevents environmental sustainability. Better reproductive health information and services are critical to reducing maternal and child mortality and halting HIV/AIDS. Smaller family sizes mean parents can better afford to send their children to school, and preventing unwanted pregnancies helps keep girls in school, advancing women's empowerment. Achieving the ICPD agenda is therefore critical if the MDGs are to be reached.

*"The Millennium Development Goals, particularly the eradication of extreme poverty and hunger, cannot be achieved if questions of population and reproductive health are not squarely addressed. And that means stronger efforts to promote*

*women's rights, and greater investment in education and health, including reproductive health and family planning."*

United Nations Secretary-General Kofi A. Annan, message to the Fifth Asian and Pacific Population Conference, Bangkok, 16 December 2002.

A UN review of the MDGs took place at the 2005 World Summit in September in New York. In a victory for the advocates involved, the outcome document adopted during the Summit makes a clear link between reproductive health, the ICPD and the MDGs. The 151 world leaders attending the Summit committed to:

*"Achieve universal access to reproductive health by 2015, as set out at the International Conference on Population and Development, integrating this goal in strategies to attain the internationally agreed development goals, including those contained in the Millennium Declaration aimed at reducing maternal mortality, improving maternal health, reducing child mortality, promoting gender equality, combating HIV/AIDS and eradicating poverty."*

World Summit Outcome Document, paragraph 57(g).

Critically, the outcome document links development, peace, security and human rights. It also includes linkages to the Beijing Platform for Action for women, and expands on the original primary education focus of MDG 3 ("promote gender equality and empower women") through a resolution to promote gender equality and eliminate pervasive gender discrimination through:

- An end to impunity for violence against women
- The goal of universal access to reproductive health
- The right to own and inherit property
- Equal access to labour protections
- Increased representation for women in government decision-making bodies
- Involvement of women in post-conflict decision-making.

### **2.3 UNGASS on HIV/AIDS**

The United Nations General Assembly held a special session (UNGASS) on HIV/AIDS in June 2001 in New York, to acknowledge the extent of the HIV/AIDS epidemic, not only as a global public health issue, but also as a looming development and security crisis that requires a complex strategy to combat. The session was attended by delegates from the highest level of national governments, as well as 900 members of civil society, made up of 450 NGOs and numerous people living with HIV/AIDS.

Specific aspects of the epidemic discussed include:

- prevention and care
- HIV/AIDS and human rights
- Social and economic impact and the strengthening of national capacities
- International funding and cooperation.

Member states adopted a declaration of commitment that covers a broad range of issues, with specific targets and time-frames to turn the tide of the epidemic. The declaration recognises:

- the links between poverty, underdevelopment and illiteracy to the spread and impact of HIV/AIDS

- that stigma, silence, discrimination, denial and a lack of confidentiality undermine prevention and care efforts
- gender equality and empowerment of women and girls are fundamental to reducing vulnerability
- access to medication in the context of pandemics such as HIV/AIDS is fundamental to the realisation of the right to health.

Human rights issues are addressed throughout the declaration, in particular with regards to addressing factors which increase vulnerability to, and impact of, HIV infection, through the protection and promotion of all human rights. Governments pledged that by 2003 they would:

*“enact, strengthen or enforce as appropriate legislation, regulations and other measures to eliminate all forms of discrimination against, and to ensure the full enjoyment of all human rights and fundamental freedoms by, people living with HIV/AIDS and members of vulnerable groups; in particular to ensure their access to, inter alia, education, inheritance, employment, health care, social and health services, prevention, support, treatment, information and legal protection, while respecting their privacy and confidentiality; and develop strategies to combat stigma and social exclusion connected with the epidemic.”*

The Declaration also acknowledges a need for accountability, and to this end calls for the strengthening of national monitoring mechanisms for HIV/AIDS-related human rights. Success in the fight against AIDS is measured by the achievement of time-bound targets; the UN Secretary General issues annual progress reports identifying problems and constraints, and recommending action needed to accelerate realisation of these targets.

A review of the 2001 UNGASS on HIV/AIDS is being held from 31<sup>st</sup> May through to 2<sup>nd</sup> June 2006. Sexual and reproductive health advocates will be working to make sure that linkages are made between HIV/AIDS and sexual and reproductive health.

Globally, the overwhelming majority of HIV infection is sexually transmitted, or associated with pregnancy, childbirth or breastfeeding. Poor sexual and reproductive health and greater vulnerability to HIV infection also share common roots, including poverty and discrimination based on gender. Yet far too many policies and programmes for HIV and sexual and reproductive health do not take account of these commonalities.

- Almost half the 40 million people living with HIV/AIDS are women
- Young people aged 15-21 account for nearly half of all new cases of HIV worldwide – the majority of them young women.
- Physically women and girls are highly vulnerable to HIV. Inequality, poverty and violence increase this risk and limit their ability to negotiate condom use.

For most women, sexual and reproductive health services are the most familiar and accessible entry points for HIV/AIDS prevention, treatment and care.

## 2.4 PNG Country Profile

<b>2.4.1 QUICK FACTS ON PNG</b>	
Area:	462,840 sq km (178,704 sq miles)
Capital:	Port Moresby
Population:	5.7 million
Annual popn. growth rate:	2.7%
Popn under 15 years of age:	40%
Life expectancy:	56 years (women), 55 years (men)
HIV/AIDS prevalence:	1-3% of pregnant women test HIV positive and between 32,000 and 140,000 people are estimated to be living with the virus
Maternal mortality rate:	300 per 100,000 live births (2005)
Infant mortality rate:	69 per 1000 live births (2003)
Under five mortality:	93 per 1000 live births (2003)
Popn. living in absolute poverty:	37%
Access to potable water:	17%
Access to sanitation:	45%
Major language:	English (official), Pidgin, Motu, other languages specific to each of PNG's 700 tribes
Adult literacy rate:	49.2% (male: 59.2%; female: 43.9%)
Major religions:	Indigenous beliefs, Christianity
Monetary unit:	1 kina = 100 toea
GDP growth rate:	3.5% (2005)
Main exports:	Gold, petroleum, copper, coffee, palm oil, logs
GNI per capita:	US \$500 (World Bank, 2005)
Head of state:	Queen Elizabeth II, represented by Governor-General Paulias Matane
National government:	Prime Minister Rt Hon Sir Michael Somare heads the Government and National Alliance Party
National legislature:	Unicameral Parliament, 109 elective seats (89 open constituencies; 20 provincial constituencies)
Last election:	June 2002
Next election:	2007
(Sources: UNDP 2005 Human Development Report, BBC, NZAID, MFAT, UNDP PNG, National Statistical Office of PNG, UNICEF, Population Reference Bureau, MDG Progress Report for PNG (2004))	

### 2.4.2 Overview

Sharing a border with Indonesia, PNG is situated between Australia and the Solomon Islands. It is the largest and most populated of all the Pacific Island Countries. Despite being well endowed with natural resources, it is a country that is struggling to build a society where all its citizens can enjoy a decent quality of life. Recent achievements such as a government that has survived one full term, and steady economic growth, are over-shadowed by the explosion of HIV over the past years. PNG also has high rates of poverty and crime. According to

NZAID figures, almost 40 per cent of the country's 5.7 million people live in poverty. PNG is also the only Pacific nation with a generalised epidemic of HIV and AIDS.

### **2.4.3 Land**

PNG is an extremely diverse country, from coastal regions to rugged mountainous highlands, with an extraordinary range of ecosystems. PNG has vast natural resources, especially mineral, forest and marine resources. Mineral deposits are extensive, and there are reserves of petroleum and natural gas, but the difficult terrain and inadequate infrastructure make exploitation slow. The sector is a large source of revenue, but the success of such mining and petroleum projects has had a detrimental effect on other natural resources (such as fresh water and through soil erosion). The extent of overseas control of resource removal, including flow of profits since unprocessed material is exported, is a concern.

The environment is under threat due to mining, and also various agricultural practices such as land clearing for commercial as well as traditional agriculture, harvesting of timber and other extraction processes. Only around 1 per cent of PNG's land is suitable for growing cash crops, including coffee and cocoa.

Almost 97 per cent of land in PNG is customary-owned and governed by traditional land tenure systems; land is owned either by individuals or under some form of clan ownership. Most people meet their basic needs through subsistence agriculture. Only 3 per cent of land is owned by the state, which means the government has limited access to land for development purposes. Most forms of economic activity have been sustained through partnership with the traditional landowners, and land disputes are common.

Outside of the urban centres, infrastructure is very poor. Roads are either nonexistent or are not maintained, making access extremely difficult. Delegates on the PNG study tour were told that only 3 per cent of the population is linked by road, 20 per cent by sea and 50 per cent by air. Port Moresby is largely inaccessible by land from the rest of the country. In many regions, the only way to reach schools, health services, produce markets and other necessary services is by walking.

PNG is divided into four regions, comprising 19 provinces and the National Capital District:

- Southern Coastal (Papuan) Region: Western, Gulf, Central, National Capital District (NCD), Milne Bay and Northern (Oro)
- Northern Coastal (MOMASE) Region: Morobe, Madang, East Sepik, West Sepik

- Highlands Region: Southern Highlands, Enga, Western Highlands, Chimbu, Eastern Highlands
- New Guinea Islands Region: Manus, New Ireland, East New Britain, West New Britain, Bougainville.

#### **2.4.4 Population**

PNG's 5.7 million people live dispersed widely across the country, with a population growth rate of at least 2.3 per cent per year and an average life expectancy of 55.1 (UNDP Human Development Report, 2005). With the population doubling approximately every 30 years, and a fertility rate of 4.1 births per woman, pressure on the available natural and human resources has increased dramatically during the last few decades. The high population growth rate makes it increasingly difficult to achieve sustainable development.

There are over 700 ethnic groups, each with its own language. Linguistically, it is the world's most diverse country. Some 80 per cent of PNG's people live in rural areas with few or no facilities. Some clans in the isolated mountainous interior have little contact with each other, let alone with the outside world, and like the vast majority of rural dwellers, are dependent on subsistence agriculture.

International migration of the population is low but internal migration from rural to urban areas and from rural to rural-non-villages is substantial. However, PNG's urban sector remains relatively small.

#### **2.4.5 Governance**

PNG's governance system is a parliamentary democracy largely based on the Westminster model. As a member of the Commonwealth, the head of the Independent State of PNG is the Queen of England, represented by the Governor General who is elected by the National Parliament for a five-year term. The current parliament has 109 members comprised of one representative from each of the nineteen provinces and the National Capital District, and one representative from each of the 89 open constituencies. There are also provincial and local level governments. This makes it hard to develop coherent national policies and almost impossible to ensure accountability for program delivery where multiple levels of government overlap.

Every five years the political leaders are elected at the national and local level government. Though parties and party allegiances within the PNG parliamentary system are fluid, PNG has had an unbroken record of democratic continuity since independence. The independent judiciary and bodies like the office of the ombudsman are respected, the media has a free voice, and civil society is active. But instability is a feature of the PNG political landscape. No government has served out its full term in power, although the current one looks likely to do so. There is a very high turnover of Members of Parliament (in 2002 elections, 80 of

the 109 incumbents lost their seats). Political parties are weak and the formation of national governments has required coalition building. There are constitutional mechanisms which prevent motions of no confidence from constantly being moved but the long term policy agenda often appears to be secondary to the exigencies of political survival. Women are chronically under-represented, with Dame Carol Kidu currently PNG's only female MP. Elections can be violent.

The current government led by PM Sir Michael Somare began in 2002 as a ruling coalition involving 17 of the 18 political parties represented in parliament. Several Cabinet re-shuffles changed this, and the threat of a successful no-confidence motion dogged parliamentary sessions during 2004. But 2005 was a relatively stable year in PNG politics. The government will reach the constitutional threshold that prohibits further votes of no confidence from July 2006.

The next general election scheduled for 2007 will be held under a new 'limited preferential' voting system, designed to ensure that successful candidates enjoy more support within their electorates and to encourage more alliance building between parties.

As well as the formal system of governance, customary law and the informal sector remains important in the lives of many citizens of Papua New Guinea.

#### **2.4.6 Economy**

PNG has a dual economy – a formal, corporate-based economy, and a large informal economy where subsistence farming accounts for the bulk of economic activity. The formal sector provides a rather narrow employment base, consisting of workers engaged in mineral production, a relatively small manufacturing sector, public sector employees and service industries including finance, construction, transportation and utilities. The bulk of the population is engaged in the informal sector. Migration to major city centres in the past decade has contributed to urban unemployment and social problems.

External factors contributing to economic problems have included the recent worldwide economic depression, the negative development in commodity prices, unfavourable trade conditions and globalisation. Internal factors include a series of inappropriate policy regimes and fiscal failures, the civil war in Bougainville and a series of devastating natural disasters. As identified by the Government, poor governance and inadequate public sector management are the major development problems.

The large informal contribution of the subsistence sector is inadequately incorporated in the accounts of the national product. The growth in GDP for 2005 is estimated at 3.5 per cent compared to 2.8 per cent in 2004. This has been described as “the greatest economic recovery that PNG has had since Independence”. However, the economic growth rate needs to be significantly

higher to achieve real growth per capita given the high population growth rate. The growth of debt continues to be higher than economic growth.

Because of the stagnation in economic growth as well as the deterioration in public services (especially in rural areas), it is a widely held view that living standards for a significant number of Papua New Guineans have declined since 1990. Furthermore, in spite of the increasing cost of living, salaries have changed very little over a long period, contributing to a static or possibly worsening poverty situation.

Employment rates in the rural sector are high, but only a small proportion of those employed are wage earners or have income from another source. Most economically active people are engaged in subsistence activities. In the urban sector, unemployment rates are very high, which contributes to the worsening law and order situation.

#### **2.4.7 Socio-cultural**

Throughout history, distinctive cultures and attitudes of self-sustenance have been developed and shaped by the high dependence Papua New Guineans have on the natural environment. In recent times, development pressures and globalisation have had an impact on the social life and traditional culture of Papua New Guineans.

While social organisation and culture have changed through the impact of missionary activity, education or more generally the spread of government control, population movement has created a landless class of migrants living in squatter settlements in and around urban areas, particularly the National Capital District.

Three key elements of PNG's social environment are the traditional land tenure system, the wantok system (clan relations), and the churches in combination with community based groups for women and youth. The wantok system is PNG's safety net, under which family and clan members are required to support each other; this can also become a large burden in modern day society when people from rural areas expect to be supported by wage earners. The pay-back system can also see tribal fighting and revenge measures inflict suffering on a widening band of victims, and in conjunction with increasing social breakdown, contributes to the high levels of crime.

The government relies heavily on churches and community groups for service provision. The extensive church/community group network provides around 50 per cent of all health and education services in the rural sector. The health system generally breaks down below the district level unless there is an external investor such as NZAID or particularly effective local voluntary organisations. Seventy per cent of rural populations lack access to even basic health services such as family planning supplies and immunisation, and only 12 per cent of births are supervised by a skilled birth attendant (compared to 40 per cent nationally in 2000, and 52

per cent in 1991). Total health spending is only 4.5 per cent of GDP. Other problems include workforce disputes, low salaries, infrastructure decay, poor human resources planning, and funded positions and buildings not existing on the ground. Recently, government has increased funding to churches and community groups to improve service delivery.

## 2.5 Millennium Development Goals in PNG

PNG's development record has been uneven and its social indicators remain extremely poor (ADB). Although classified as a middle income country, and despite vast natural resources, over nearly 40 per cent of the population is living in absolute poverty (UNICEF – PNG). The disparities among population demographics (female/male rural/urban) are alarmingly large, with much of the government's budget spent on debt repayments, leaving very little for public services such as health and education.

With an exceedingly high crime rate rampant violence against women, soaring numbers of people living with HIV and AIDS and the highest infant and maternal mortality rates in the Pacific, PNG ranks last among Pacific developing member countries on the human development index (HDI) and the poverty index (HPI) of the United Nations Development Programme (2005) (PNG is ranked 137 out of 177 rated countries on the HDI, and 78 out of 103 ranked countries on the HPI.)

PNG relies heavily on donors, with half of its national development budget currently made up of donor funds. The main bilateral donors are Australia, Japan, China, New Zealand and Germany, with Australia contributing 82.3 per cent of the combined development assistance contributions and New Zealand around 1.9 per cent (NZAID).

It should be noted that in the *Progress Report for Papua New Guinea 2004*, drafted by the PNG Government and the UNDP, the targets for each MDG have been identified as unattainable. Instead, the report refers to a Medium Term Development Strategy, which has “tailored” goals that are considered to be more realistic for the country.

### **MDG 1:** *Eradicate extreme poverty and hunger*

An estimated 40 per cent of the population lives on less than \$1 per day. The proportion of people under the national poverty line has not changed significantly during the last two decades of the 20th century, while the population of PNG has approximately doubled.

Disparities in income and in consumption are great, and the benefits of economic growth are distributed very unequally. Differences in poverty at the sub-national level are also large. Regional poverty lines and the percentage under that line in each region differ widely. The Northern Coastal Region has not only by far the

lowest poverty line but also by far the highest proportion of people below that line.

No direct information on differences in the level of poverty at the provincial level is available. However, the average life expectancy at birth can to some extent be considered as a proxy index of development and of poverty. The provincial distribution of this index suggests that differences in the degree of poverty between provinces are large, with the highest levels in the provinces of the Northern Coastal Region and in Gulf Province.

The level of malnutrition also provides an indirect indication of poverty and hunger in PNG. The level of malnutrition of children under age five is highest in those provinces that also have by far the highest level of child (as well as overall) mortality: West Sepik and Gulf, but also Milne Bay Province.

PNG needs a significantly higher economic growth rate to lift the population out of poverty. Dependency on donor assistance is high and foreign debt servicing absorbs a large part of the national income. There is also a need to ensure that economic policies, and particularly the implementation of these policies, are increasingly pro-poor.

There is a strong inverse correlation between education and poverty in PNG. Many people in a large part of the rural sector have only limited access or no access at all to basic educational services, and the same applies to basic health services. Furthermore, the limited empowerment of women and the high level of gender inequality contribute to poverty in PNG.

Last but not least, PNG faces the challenge of HIV and AIDS. This epidemic has already led to significant loss of productive capacity in the formal as well as non-formal sector. If PNG follows a low case scenario, by 2020 the working age population will be reduced by 13 percent than it otherwise would have been. If a medium case scenario is realised then the reduction in the workforce will be 34 percent, and if a high case scenario occurs then the reduction will be 34 percent (AusAID 2002). These estimations show just how large the impact HIV and AIDS will be on the ability of the country to maintain a workforce. The epidemic will most likely also lead to deterioration in food consumption and nutrition in affected households. HIV and AIDS is an increasingly important factor that will negatively affect the achievement of MDG 1.

The government has tailored the global targets concerning poverty and hunger and incorporated these into its development strategy. The national poverty target for 2015 is to decrease the proportion of people below the poverty line by 10 per cent.

## **MDG 2:** *Achieve universal primary education*

Only half of women aged 15 years and over and two-thirds of men 15 years and older have ever attended school (WHO). Nearly half of primary school age children in PNG do not attend school. Currently, only 56 per cent of children finish primary school. Less than 40 per cent of children start secondary school, and less than 5 per cent complete secondary school. Education disparities vary from region to region. While there is an enrolment rate of more than 80 per cent in the National Capital District, the rate in the Highlands is under 65 per cent.

PNG's gender gap in education is the highest in the entire Pacific region. For every 100 boys in primary school, there are 80 girls; for secondary school the figure for girls is 65. The main obstacles to preventing children (particularly girls) from enjoying their right to education are cultural, social, and economic. School fees, teacher absenteeism, poor infrastructure, safety, and keeping children out of school in order to help with subsistence crops are just some of the barriers. Where girls cannot afford to continue their education those pressures sometimes lead secondary and even primary students into the sex industry in order to meet fee payments.

While education reforms have been prioritised by the government, large resource challenges hamper the achievement of the global target for primary education (as well as other levels of education). It is extremely difficult – with currently available resources – to build all the new schools (especially the Elementary Schools) and train all the new teachers that are required under the reforms. However, of equal importance are the social and cultural constraints to achieving the education goals.

In PNG, there is a significant gap between the relatively high educational performance in matrilineal societies and the much lower performance in most patrilineal societies, particularly those in the Highlands Region. This applies in particular to girls' education. Education, while subsidised is, not free. Where there is only enough money in the family to educate one child, the boy will often be preferred. Girls are often kept at home because it is assumed they will become homemakers. Many girls, particularly in the Highlands Region, still marry at an early age. Sexual abuse, particularly rape, is also a major obstacle to girls' education.

Lack of formal education hinders the ability to get basic and consistent messages about HIV over to young people. Also, confusion over curriculum obligations in respect of HIV and other sexual and reproductive health matters means poor or no delivery of key sexual health messages even for young people who are accessing secondary education. ;

The level of literacy in PNG gradually improved in the 1980s and 1990s, but is still very low, particularly in the provinces of the Highlands Region, most notably Southern Highlands and Enga, in terms of enrolment (and staying in school).

The PNG government considers the global target of achieving close to 100 per cent universal primary education by 2015 as unrealistic. The global target has

therefore been tailored; the national target is to achieve a Gross Enrolment Rate of 85 per cent at the primary level by 2015, and a retention rate of 70 per cent. Youth literacy (15-24) should also increase to 70 per cent by that year.

**MDG 3:** *Promote gender equality and empower women*

*Rape and other forms of violence against girls and women, both single and married, is nothing short of a human rights crisis in the country; they are the greatest obstacle to community development and empowerment.*

Ume Wainetti  
Executive Officer of Family and Sexual Violence Action Committee  
(PNG)

PNG is a signatory to a number of international conventions that support gender equity and empowerment of women, particularly the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) and the Convention on the Rights of the Child (CRC). These international conventions have been translated into national policies, strategies and laws. PNG takes part in the global initiative “Acceleration of Girls’ Education” in six provinces. The implementation of the policies and strategies proves to be very difficult, not to mention costly. Resource implications, economic, social and cultural factors are obstacles that hamper the achievement of gender equality.

Labour force participation and employment rates for PNG females in the rural sector are very high by international standards, especially in the five provinces of the Highlands Region, but this is the result of the fact that most women (as well as men) in this sector are engaged in agriculture and/or fishing for subsistence (household consumption). However, in 2000, only 5.3 per cent of all employed women had a wage job (compared to 15.2 per cent for men).

Although there is a significant gender gap in education and literacy, recent evidence suggests young females are catching up with their male counterparts. However, this is at least partly due to a decrease in male literacy. Overall, males are performing better than females, particularly in the area of education and literacy. These gender differences are more profound in the Highlands Region. This also applies to many other key indices, such as health, morbidity, mortality and labour force participation.

A major issue impacting gender equality and women’s empowerment which is not specifically addressed in MDG 3 is the issue of violence against women. Violence against women in PNG is widespread, and has an enormous impact on all of the MDGs. In urban areas, it is estimated that 65 per cent of all women suffer gender violence. This rate can reach up to 95 per cent in some remote communities (UNICEF - PNG).

Violence against women is an endemic problem. In rural areas such as Kup, and in Simbu Province as a whole, many people, particularly women, are unaware of their basic human and legal rights. Women and girls are often targets of revenge for tribal fights and rape is common. The use of firearms and damage to property during tribal fighting also contribute to the silent suffering of women and children. Women suffer when their husbands and sons get killed, and they are the ones who have to run for fear of their lives, sometimes pregnant or with babies and taking what little property they are able to carry with them.

In an atmosphere of endemic oppression of women and fear/ignorance around HIV, women with HIV are blamed for their situation even though male promiscuity and lack of condom use is the core of the problem.

Polygamous marriages are common in areas such as Kup. Young girls between the ages of thirteen and sixteen are enticed into believing they will have an easier life if they marry a person of wealth, power and status. Women in these relationships are expected to be strong and capable enough to make their own gardens and look after their own children. Women and children in these relationships suffer more now than in the past owing to the impact that socioeconomic change has had on women and children in rural areas (Garap, Kup Women for Peace).

#### **MDG 4: *Reduce Child Mortality*<sup>1</sup>**

In the 1960s, the national average life expectancy at birth was only about 40 years, and the child mortality rate 134 per 1000. However, a significant decrease in mortality started in the 1970s. In 2004, the national average life expectancy is around 55 years, which is still very low, especially by Pacific standards.

About 35 children under five years of age die every day – about 13,000 children per year. These death rates are the highest in the region. The major killers are preventable or at least treatable: low birth-weight, diarrhoea, pneumonia, measles, and malaria, along with conditions exacerbated by HIV and AIDS (UNICEF - PNG). Perinatal<sup>2</sup> conditions account for over 10 per cent of all recorded deaths. Overall, 27 per cent of children are considered moderately to severely malnourished, and 43 per cent of children aged 0–5 are stunted (WHO: Regional Office for the Western Pacific).

Differences in mortality at the provincial and lower level are extremely large. Since 1980, provincial differences in infant and child mortality have increased even further. Provinces like Gulf and West Sepik still have infant mortality rates of more than 100 per 1000 live births, whereas the NCD and most provinces in the Islands Region have a level of infant mortality which approaches the far more moderate level of countries in the central part of the Pacific.

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<sup>1</sup> Child mortality relates to the under-five mortality rate, which includes the infant mortality rate – another common measure of the health of a society.

<sup>2</sup> Perinatal refers to the period five months before birth and one month after.

Development programmes and projects in the past may actually have contributed to the large variations in mortality that exists between the high and low achievers amongst the provinces. It seems that for the last 30 years or so, provinces with a level of child mortality that is significantly below the national average have benefited far more from development interventions aimed at reducing the high level of child mortality (i.e. health services, mother and child healthcare (MCH), reproductive health, immunisation etc.) than provinces with much higher child mortality rates. Reasons include the safety and security situation and the lack of basic infrastructure in some provinces.

In view of the already stagnating mortality indices and the enormous new challenges PNG is facing, especially the threat of HIV and AIDS, it is unlikely the global target of reducing child mortality by two thirds can be achieved by 2015. However, the government's more modest tailored national targets of reducing the infant mortality rate to 44 per thousand, and the under five mortality rate to 72 per thousand by 2015 may be achievable if efforts to get the HIV/AIDS epidemic under control succeed, and efforts by government, NGOs, churches and the private sector as well as those of international organisations start focusing more on those provinces that have entirely or partly missed out in the improvement of the mortality situation: West Sepik and Gulf and more generally the provinces in the western part of the country.

**MDG 5: *Improve maternal health***

Although maternal mortality is a poor indicator of maternal health, along with the proportion of births attended by skilled personnel, they do provide some measurement of women's access to health services. PNG has a high maternal mortality ratio of 300 deaths per 100,000 live births (compared to 29 in Samoa in 2001). It must be noted that national averages obscure wide variations across the country: 1 in 18 rural women dying during pregnancy or childbirth (Save the Children New Zealand). The high cost of delivering health services to remote communities is partially responsible for the country's high maternal, infant and child mortality rates (World Vision New Zealand).

At least 500 women die each year from pregnancy/childbirth related causes; for each of these deaths, at least 30 others suffer complications such as severe anaemia, chronic pelvic infection, fistulae, prolapse of the womb and other problems. More than 90 per cent of these deaths occur at home, far beyond the reach of the formal health system. Most deaths occur because pregnant women or new mothers have trouble reaching a clinic, due to lack of roads or transport.

Clinics are scarce. Between 1995 and 2000, more than 300 health aid posts were closed down, and this number is on the increase. Antenatal care coverage declined from 80 per cent in 1991 to 67 per cent in 2000. The rate of supervised deliveries declined from 52 per cent in 1991 to 44 per cent in 2000. Supervised deliveries include not only births supervised in a health facility but also those supervised by

a trained village birth attendant. Only 13.4 per cent of all deliveries were in health facilities (UNICEF – PNG).

The goal of reduction of 75 per cent in maternal mortality by 2015 is generally considered as highly unlikely for PNG. The tailored target in the National Health Plan, which aims at reducing the maternal mortality rate to 274 per 100,000 live born children by 2015, has been adopted as the national target instead.

The level of fertility in PNG is high at 4.1 births per woman, and a decrease to a more moderate level will undoubtedly lead to improved maternal health and a decrease in maternal morbidity and mortality. Teenage pregnancy is also common, contributing to child and maternal morbidity and mortality.

Contraceptive use is low, with only around 26 per cent of women using any method of contraception (UNDP Human Development Report 2005). Women of all ages need greater access to sexual and reproductive health services if the levels of maternal and child mortality are to be decreased.

Furthermore, the level of education and literacy of women is closely associated with maternal health and mortality (as well as with mortality of their infants and children). Improvements in education will lead to less poverty, better nutrition, safer child rearing practices and therefore to a decrease in maternal and child morbidity and mortality. It goes without saying that any progress to date in improving maternal health will be threatened, if not regressed, by the HIV and AIDS epidemic.

#### **MDG 6:** *Combat HIV and AIDS, malaria and other diseases*

PNG has the highest rate of HIV and AIDS in the Pacific Region and the fourth highest in Asia and the Pacific after Thailand, Cambodia and Burma. The epidemic has been classified as generalised since 2003, and now threatens to be an HIV and AIDS epidemic of similar proportions to Sub-Saharan Africa.

The percentage of pregnant women visiting selected antenatal clinics who are diagnosed with HIV, or HIV and AIDS, has risen above 1 per cent in recent years and may now be approaching 3 per cent in some parts of the country. In patients with an STI at Port Moresby General Hospital (PMGH), 9 per cent are HIV positive. HIV is mainly heterosexually transmitted in PNG, and the most affected groups are females between the ages of 20-30, and males between the ages of 20-40. At particular risk are the wives of high-risk men such as men who travel frequently for work, who have sex with sexworkers, and who also have sex with men. High rates of transactional sex for goods or money also exacerbate the spread of STIs and HIV. Furthermore, it is difficult for women to negotiate sexual relations and condom use.

*In our culture it is difficult to tell a husband to use condoms. Some of the women say that they know their husbands are unfaithful but they are too frightened to ask them to use condoms because the husbands might leave them and get other wives or beat them up.*

**Julie Bambon, Nurse**

In PNG, high rates of STIs and violence against women – particularly sexual violence – increase women’s risk to HIV (WHO: Regional Office for the Western Pacific). It is estimated that between 1,500 - 4,500 pregnant women in the country were HIV positive in 2003, potentially passing the infection on to some 1,400 babies during birth or breastfeeding. (If an HIV positive women becomes pregnant there is a 35 percent chance she will transmit the virus to her child if no preventative action is taken.)

There are several factors that contribute to an ongoing lack of awareness around HIV and broader sexual and reproductive health, and this perpetuates the spread of STIs and HIV. These include: low levels of education and literacy, particularly in the rural sector; limited distribution of, and access to, condoms, especially in rural areas; the lack of empowerment of women and a high level of gender inequality; and high levels of complacency in relation to HIV and AIDS, particularly by those in positions of power and political influence. Another factor contributing to, and compounding, the spread of HIV are conservative moral and Christian beliefs which are repeatedly confounded with public health matters. Because churches provide about half of all health services, the importance of this cannot be overestimated.. All these factors together, particularly the lack of political leadership and commitment, makes an efficient multi-sectoral response to the epidemic difficult.

If the current annual rate of increase of recorded cases in PNG of approximately 33 per cent per year continues, the number of recorded cases would be close to half a million by 2015. This is about 7 per cent of the projected population for 2015. HIV and AIDS have become destabilising factors of the first order, and the single most important challenge for development in PNG as well as for the achievement of the MDGs. The government’s development strategy aims at controlling the spread of HIV and AIDS by 2015, and stabilising its spread by 2020.

However, the work against HIV and AIDS in PNG relies almost entirely (more than 95 per cent) on external funding, lessening the sense of domestic ownership of the problem. Improved donor coordination is an important factor that may lead to a more cost-effective and sustainable approach in the fight against HIV and AIDS. Enhanced capacity of the National AIDS Council (NAC) to undertake this coordinating role, as well as the responsibility for monitoring and evaluating on-going national programmes may not only improve national ownership and leadership for work against the epidemic, but would allow the NAC to take on the role for which it was originally envisioned.

The data base for HIV and AIDS incidence and prevalence in PNG is poor, and the need for more robust statistics is addressed in section 3.6 of this report. Using the WHO formula of multiplying the number of known cases (11,852 up to March 2005) by ten, the actual number of people living with HIV is estimated to be 118,520. This is supported by the general agreement that, due to very limited surveillance capacity and many other factors, the number of recorded cases represents only a small proportion of what is believed to be a much larger group. UNAIDS states that there are between 32,000 and 140,000 people living with HIV (2006).

MDG 6 also addresses other diseases that comprise a heavy burden of disease in PNG. This includes tuberculosis, or TB, (often closely associated with HIV) and malaria. Again, reported cases of these diseases are likely to be much lower than the actual incidence of disease in the general population. In 2003, 527 cases of TB were reported; 53 per cent of these were cured by DOTS (Directly Observable Treatment Short-course) (UNDP Human Development Report 2005). At present, about 19 per cent of TB patients in the PMGH are also HIV positive. Malaria is the countries largest contributor to the burden of disease, with a reported incidence rate of 1,688 cases per 100,000 people (UNDP Human Development Report 2005).

Along with these diseases, there are a growing number of non-communicable diseases in the urban centres. While these are small in comparison with the threats to health and economic sustainability that HIV, TB and Malaria pose, they are not insignificant and also need to be addressed.

#### **MDG 7: *Ensure environmental sustainability***

*Now, when I see my bush, I cry. In the past we had sago, pigs, cassowary, big trees everywhere. We used traditional paint from the bush. Now it is very different, I cry for my village*

**Aiambak villager, Western Province, PNG**

PNG is very rich in natural resources, but degradation has occurred at a rapid pace. According to the most recent estimates, a very significant part of the total land area is, in spite of large-scale deforestation, still covered with natural forest. At 26 million hectares, PNG has the largest intact rainforest in the Asia Pacific region – the third largest in the world (PNG Forests: A Rough Guide).

The country also has vast swampy plains, wide rivers and high mountain ranges, which all present unique challenges. PNG's geographical location makes it vulnerable to natural disasters such as volcanic eruptions, tidal waves, floods caused by monsoon rain and prolonged dry spells. A large part of the total land area undergoes strong or severe erosion, is permanently inundated or regularly flooded.

PNG is signatory to a large number of multilateral environmental agreements, but despite this, implementation of effective resource management proves to be extremely difficult due to lack of knowledge and skilled personnel, and funding constraints and protection.

PNG forests are home to the majority of PNG's population, providing the essentials necessary for rural livelihoods. In addition, the forests are home to approximately 10,000 refugees from West Papua (PNG Forests: A Rough Guide).

Since customary landowners hold an estimated 97 per cent of the total land area, a large proportion of the population has access to the resources that meet their basic needs. Most Papua New Guineans are directly dependent on these resources provided by their physical environment. It provides them with food and shelter and, for the rural population, the utilisation of their natural resources is often the only way to earn a cash income. However, the reverse side of the coin is the continuing degradation of the environment by total or partial removal of natural forest, which is considered by many as a serious threat.

Forestry is a major industry in PNG, but governance of this sector has been poor and marred by corruption.. Logging companies, which cannot buy communal land must rely on temporary logging rights and have had little incentive to reduce environmental damage (World Vision New Zealand).

Up to 45 per cent of the forest has been allocated as concessions for logging, and about 60 per cent of this has already been consumed. Over the last two decades, foreign logging companies have eaten into large tracts of rainforest. Logs from these old-growth forests are exported with an appallingly low return to local communities, while leaving behind horrendous social and environmental problems (Australian Conservation Foundation).

Logging often occurs with little regard for sustainable management or environmental standards. For example, while logging is meant to be on a 40 year cycle, most areas are logged within 12 years. A 2002 World Bank-funded government review revealed that all major logging permits and extensions granted during that year were illegal and that the logging companies were "roaming the countryside like robber barons, encouraged by persons whose proper role is to exercise control" (PNG Forests: A Rough Guide).

*Union officials have taken dozens of statements from women and girls working in the remote logging camps, far from home, who say they are routinely threatened with guns or gunshots to scare them into having sex with company officials or the police who work for them.*

*Loggers have grown increasingly aggressive in their quest for high-value timber. According to a civil rights lawyer, traditional landowners in remote areas were forced to*

*sign papers with the barrel of a gun at their back. In the presence of police and company officials, without proper legal advice, with guns pointed to them.*

**Source quoted by Lee Tan  
Asia-Pacific Unit Coordinator for the Australian Conservation Foundation**

The opening of the PNG economy to foreign penetration has promoted the exploitation of natural resources at a level that has sometimes seriously damaged the environment. One of the most conflictive activities is that of mining, which generates much of the revenue that PNG needs to fund its budget but which can also cause major land degradation, flooding and soil erosion, pollute water sources and render people homeless. The mines of Bougainville and Ok Tedi boast the largest copper deposits in the world but their history has been marked by conflict with local communities and allegations of environmental vandalism.

There are also concerns that future threats include clearing for agricultural use, due to the high population growth rate and the very large proportion of the population dependent for their livelihood on subsistence farming. Forests continue to be cleared for activities such as commercial farming, infrastructure and urban development. This will almost certainly mean that land clearing will be extended to areas that are more vulnerable to erosion of the topsoil and the rapid depletion of soil nutrients. It may also be expected that soil degradation will increasingly threaten the livelihood of rural people.

Some information is available on energy generation and use but it provides a rather patchy picture. For instance, the dated information on the annual sales of petroleum products indicates that the annual increase has not kept up with the annual population growth rate. Information on petroleum imports is also limited and dated. The only information regarding Green House Gas (GHG) emission dates from 1994. At that time, GHG emissions per capita were still insignificant.

Very little is known about energy use in the rural area. However, survey results indicate that rural households use firewood, kerosene, batteries and fuel for transportation. Other energy sources are close to irrelevant for rural households. The majority of rural households use firewood as the primary energy source. Since far more than 80 per cent of the total population resides in the rural sector, the proportion of PNG households using wood as the primary energy source could be at least 80 per cent.

The total renewable water resources available per person are high compared to most countries in the world. The sources for drinking water are different for rural and urban areas. In rural areas only about 9 per cent of the households have access to piped water. About 70 per cent of rural households use raw and untreated drinking water from a spring, river, stream, pond, lake or dam. On the other hand, more than 70 per cent of the urban households have access to piped water. Regarding sanitation, about 76 per cent of the rural households still have a traditional pit toilet. Only 2.5 per cent have their own or a shared flush toilet and

16 per cent have no toilet facility at all. On the other hand, 58 per cent of the urban households have their own or a shared flush toilet, and 32 per cent use a traditional pit toilet. Virtually all these latter households are found in the squatter settlements within the urban areas.

The government's medium term development strategy aims to implement the principles of sustainable development through sector specific programs by 2010 and no later than 2015. Another goal includes increasing the commercial use of land and natural resources through improvements in environmentally friendly technologies and methods of production by 2020. The government also aims to increase to 60 per cent the number of households with access to safe water. In the urban sector, this target has already been reached, but the rural sector (about 87 per cent of the population) seems unattainable by 2015.

**MDG 8: *Partnership for global development***

Official Development Assistance (ODA) or foreign aid is of great importance for the achievement of the MDGs in PNG. PNG's largest funding agency is Australia, which provides about A\$330 million each year in direct development assistance. Japan is also a significant source of bilateral assistance. The World Bank and European Union are the major multilateral financiers, together with ADB. NZAID's 2004/2005 allocation is NZ\$9.6 million (ADB and NZAID).

Aid constitutes a large proportion of all public financial resources available for the support and facilitation of the PNG government's internal revenue and development agenda. The crucial role of external financing becomes particularly clear when funding for HIV/AIDS, malaria, and other diseases is considered. Activities are almost entirely (96 per cent) externally funded. If donors decide to withdraw support, all efforts being made will collapse. Government contribution towards achieving MDG 7 (Environmental sustainability) is also limited. Excessive donor dependency may undermine the achievement of the MDGs.

In many cases, several donors are involved in closely related activities. There are, however, systemic weaknesses at the policy as well as operational level in the management and coordination of ODA. There are of course many reasons why efforts undertaken so far have not always been effective. In order to optimise foreign aid, the government has embarked on a sector wide approach to donor coordination. It is hoped this will lead to more effective management of all forms of foreign assistance

Another crucial area for PNG is that of debt. Since 1990, growth of debt has been significantly higher than economic growth. Debt for 2004 is projected to be 70.9 per cent of GDP. The large government debt burden implies that debt service absorbs much of the limited public budget. Many consider this to be the most important impediment to development, and it certainly has a profound impact on the achievement of all MDGs since relatively few resources are left to improve health, education and other services and to halt environmental degradation.

PNG is a signatory to a large number of international trade agreements, and a member of several trade organisations, including the World Trade Organisation, the Economic Partnership Agreement with the European Union, the Asia Pacific Economic Cooperation and various bilateral and multilateral agreements within the Pacific Region. PNG's membership of these organisations may have an impact on its ability to achieve the MDGs. For instance, theoretically, the opening up of trade barriers should create growth. However, in order for this growth to occur, PNG industries must be internationally competitive at the time of liberalisation. This means that the necessary infrastructure to improve efficiency must have already been put in place before trade liberalisation occurs. If this is not the case, and liberalisation occurs before PNG industries are able to compete on the world market, it is possible membership of these trade organisations and agreements could have a negative impact on the ability of PNG to achieve the MDGs.

### **3.0 Study tour thematic areas**

The following themes emerged through a combination of meetings and discussions with parliamentarians and officials, and field visits to villages, schools, hospitals and community projects. Through these interactions, delegates saw firsthand just how high PNG's need is in relation to the wider Pacific region, and the important role New Zealand and Australia can play in increasing the wellbeing of people in our home region. The agreed themes encapsulate the delegates' impressions of what needs to occur in PNG in order to achieve the MDGs, and have been developed into recommendations in section 4.0 of this report.

#### **3.1 Make grassroots projects flourish**

While PNG faces many challenges, all is not bleak. During their visit the delegation saw much good work being done at a community level. An example of how a small NGO/community-run project can make a difference to people who face significant challenges was a Save the Children "Poro Sapot" (peer support) project that provides a refuge and training place for Port Moresby's sex workers (see box 1). Similarly, PNG's Family Health Association in Lae, funded mainly by the International Planned Parenthood Federation (with no government funding) has a team committed to improving people's lives through better sexual and reproductive health.

The delegation agreed it is important to build on what is working, including building capacity of the indigenous NGOs, strengthening their management capacity and expanding the services that are working.

However, in order to do this there is a need for systems strengthening, better accountability, and improved coordination and communication both within and across sectors – additional themes that emerged during the study tour.

*Box 1*

#### **Poro Sapot – Port Moresby**

Save The Children's Poro Sapot (peer support) project in Port Moresby focuses on providing information and training to sex-workers, and covers a range of topics including HIV/AIDS, safer sex and self defence. Around 800 people use the centre each month. Many are the victims of violence, and have also faced discrimination from the police and other groups. Poro Sapot is helping build the relationship between sex-workers and the police, and volunteers from the project conduct patrols of the areas known to be hot-spots, to keep an eye on the workers and monitor the numbers in each area. The delegation spent time with the project's committed and compassionate staff, as well as workers using the facilities. Many had stories about violence, living on the streets, and friends who had died from AIDS.

### 3.2 Systems strengthening

Delegates on the study tour agreed that there is urgent need in PNG for system strengthening. A disconnect between policy and delivery was apparent, as well as a lack of accountability. Decision makers at the national level had few or no means of ensuring outcomes and accountability at the provincial and local levels.

When meeting with UN agencies and the WHO, delegates were given details of corruption and structural issues. Examples were given of cases where the national government allocated funding so that money is (or should be) in the system, but the funds were not getting through to the regional and provincial levels.

We were informed of examples of funds being paid out for salaries to staff in rural health centres which no longer operated.

We were told that the structural weaknesses were causing havoc with basic service delivery in health.

This was confirmed in our field visits with graphic examples of massive health management issues where we heard that money remained in the central health department, while provincial hospitals and community health centres had run out of equipment, medicine and staff, despite the availability of qualified people. There are many more doctors and nurses than the positions funded for them – according to the WHO only 10 per cent of nursing graduates get jobs.

For example Angau Hospital, visited by the delegation in Lae, is literally collapsing due to termites – reducing it from a 500 bed hospital to 300 beds - and is in desperate need of basic equipment and supplies. The national cancer unit there has been without a part for the radiography machine for several years, and in obstetrics, the hospital has been without an ultrasound scanner since April 2005. In the labour ward women are forced to use mattresses on the floor because of a lack of beds. These are just some of the problems – in the words of the hospital's CEO: "We desperately need help."

In other examples of health system problems, WHO also says there is a lack of leadership, coordination and supervision, resulting in problems such as absences from work not being followed up.

### **Port Moresby Hospital**

Media members of the delegation were taken to Port Moresby Hospital by MP Dame Carol Kidu during an afternoon where the MP members of the delegation were in meetings with PNG officials and parliamentarians (which media were not allowed to attend). The difficulties in the health sector and the burden HIV and AIDS are placing on an already dysfunctional system was more than obvious at a general ward at Port Moresby General. For 63 very ill patients – many at various stages of HIV-related illness – there were two junior doctors and two nurses. The nurses generally work 24 hour shifts and many simply run away when they cannot cope with the hours and conditions. The hospital gets just half the money it needs. On a stifling day, the ceiling fans were not operating because the hospital cannot afford to pay the power bill.

It was evident that in PNG, the primary health care system needs to be strengthened and have an increased focus on health education and providing people with the tools to manage their own health. Preventive and primary health care has to be Papua New Guinea's priority. In an environment where people usually have to take control of their own health care, there needs to be an availability of things like mosquito nets, male and female condoms and other low cost items. While the hospital system is in crisis and needs attention the Delegation is also well aware of the limited budget capacity of the national government. Health service delivery needs to adopt a more holistic approach in order to be effective.

Of note, the Sector Wide Approach (SWAP) in PNG – the coordination of which is being led by New Zealand - is working to strengthen the ability of the National Department of Health (NDOH) to meet the health needs of PNG. Importantly, it also ensures that funds from various donors are channelled through the NDOH in a coordinated way that enables the NDOH greater control and enhances better management of funds.

### **3.3 Coordination and communication**

Throughout the study tour, delegates saw examples of grassroots initiatives that are working extremely well. But there was an obvious disconnect through lack of coordination and communication about what various organisations are doing. For example, recently a large multilateral donor that was establishing a peer education network on HIV and AIDS approached neither the Provincial AIDS Council, nor the PNG Family Health Association, whose 300 community based distributors who work in isolated communities would have been an obvious resource and network to tap into.

Coordinated programme delivery could also be achieved through improved relationships between the formal government sector and NGO sector. This would depend on the NGOs and government agreeing common aims in certain areas. Government needs to be able to fund NGOs and work with them so they are aware of policy, and in a way that harnesses the capacity of NGOs to deliver services on behalf of government.

There is also a disconnect and lack of communication between centralised government and district/local governments that provide services. For example, delegates were concerned to observe an absence of education about sexual and reproductive health, including HIV and AIDS, in schools. PNG is a conservative country and these are not topics that are easily discussed, especially in a school setting. At Bugandi Secondary School in Lae, the head teacher mentioned his desire to introduce teaching around these areas, but felt it was unlikely this would be supported by parents. He said there are no coordinated sexual and reproductive health modules in the national curriculum which the school teaches. This contrasted with the understanding of the provincial National AIDS Council HIV/AIDS coordinator that HIV/AIDS information was already being delivered through the curriculum although he may have been thinking of work that is being done by the PNG Family Health Association, who work with secondary school teachers to try and get sexual and reproductive health taught in schools (and in nursing schools).

Hon Dr Puka Temu, the Minister with special responsibility for HIV/AIDS, told the Delegation he recognised the need for a culture shift in schools and that he saw them as a key to making sure the safe sex message got out to the community. He said he was talking to the Minister of Education regarding delivering information through the curriculum. The Delegation hopes that outcome can be achieved.

### **3.4 Consistent and coordinated funding**

The delegation noted that large donors frequently bypass the national government to directly fund the voluntary and private sectors to deliver aid outcomes. Whilst this is understandable, it also creates problems, such as increased suspicion of NGOs by PNG's leaders, and with regard to sensitivities about legitimacy and sovereignty. Whatever the merits of those arguments, it seems a foregone conclusion that for the foreseeable future much aid funding will be channelled outside of the PNG government. The delegation agreed that there is a need for donor countries, multilateral agencies, international NGOs and faith based organisations to consider recurrent funding in core programme areas, so that staff can be hired on an ongoing basis and agencies properly resourced. Donor money currently doesn't provide for maintenance. Ongoing funding for core areas could include not only staff but also supply of condoms, drugs and HIV/AIDS testing supplies - recognising the that if there are problems with these supply chains the services are of little or no value. In getting funding agencies to rethink some of

their priorities, it would be important to look in particular at the continuation of funding strands, longer terms, and making sure there is better accountability through mechanisms such as the SWAP.

### **3.5 Balanced development**

Historically, development in PNG has been focussed on large-scale infrastructure and centralised development interventions. While this is important, it is often at the detriment to local, rural development initiatives. This lack of focus on rural areas is one of the contributing factors to urban drift which results in the expansion of informal, unservices, settlements. Infrastructure development such as roads, water, sanitation and communications, is vital, but must be balanced by a focus on supporting rural agricultural production and access to markets, as well as other local, decentralised sustainable livelihood interventions. As 80 per cent of PNG's population lives rurally, and with the high productivity of the land, this is essential if PNG is to capitalise on its strengths.

### **3.6 Need for better data and statistics**

In a country as vast as PNG, with no roading network, remote rural areas and 800 different languages, accurate and timely data collection is a major challenge. Nor is basic technology such as computers widely available.

Using HIV/AIDS statistics as an example, UN agencies say the prevalence is 2 per cent, meaning somewhere between 0.8 per cent and 3.2 per cent (or 60,000 – 95,000 people). This is based on loose indicators, because surveillance in rural areas in particular is so poor. The same applies to other indicators such as literacy. Statistics around HIV and AIDS are even more difficult to gather due to social stigma.

Data and strategic choices go hand in hand. Accurate data is also needed to measure and monitor actions and outcomes in the fight against HIV/AIDS and other issues the country faces, and for evidence-based advocacy.

### **3.7 Political leadership**

A key message that participating MPs developed during the study tour is that political leadership is critical if the MDGs are to be achieved in PNG.

While in Port Moresby, the delegation met with Dame Carol Kidu, PNG's only woman MP and Minister of Community Development, and Dr Puka Temu, the Minister assisting the Prime Minister on HIV/AIDS. Dame Kidu works actively on issues of gender inequality, violence against women and HIV/AIDS, while Dr Temu has made a controversial call for 100 per cent condom use to help halt the spread of HIV/AIDS.

PNG has a parliamentary AIDS Committee with 18 members. The establishment of this group is to be celebrated. However, all 18 members need to be able to speak openly and with conviction before positive impact can be realised. Secretariat support may enhance the opportunity presented by the group.

Strong political leadership is needed, as well as unified government policy coordination on stopping the spread of HIV/AIDS. Political leaders need to openly recognise there is a crisis, and take action that reflects this. It was evident during the visit that poor administration, lack of systems of accountability, and even corruption at all levels of government, from central to local, is hindering HIV/AIDS prevention and other efforts to improve the lives of PNG's people. With the HIV/AIDS epidemic now well entrenched and fast escalating, the window of opportunity for effective action on stemming the epidemic is limited.

Political leadership is also needed to combat the stigma and discrimination around HIV/AIDS that is helping fuel the epidemic. The Delegation was pleased to learn that the Prime Minister had recently made strong statements about HIV/AIDS but the Delegates noted that this was still an exception among political leaders, rather than the rule.

*Box 3*

### **The shame and stigma of HIV/AIDS**

At Port Moresby General Hospital, staff run a sexually transmitted infection clinic where most people go to be tested and treated for HIV. The clinic has no labelling, and is known simply as the building at the back. The clinic has funding from the Global Fund to provide antiretroviral drug treatment for those who fulfil the WHO criteria for treatment. Supply of drugs is often raised as an issue in PNG, but at this clinic funding of ARVs isn't the problem. The problem is finding people to treat – there is so much shame and stigma attached to HIV and AIDS that only a third of the available drugs are being used.

If the looming humanitarian crisis facing PNG is to be lessened shame and stigma needs to be overcome. This means a human face is needed for the campaign and this requires political champions who take ownership of the issues and strategies to deal with them. Indeed, champions at all levels and sectors of leadership are needed.

In particular, more male MPs need to be educated and supported to speak out against violence against women, and to discuss openly issues around HIV and AIDS. Other leaders across the spectrum of society are also key, including community, business, and religious and youth leaders.

Sadly PNG MPs were not sufficiently involved in the study tour. Fifteen members of the national parliament were invited to a New Zealand High Commission reception on the second night in Port Moresby, but only one attended. We thank him for his interest, as we thank the Governor of Morobe Province, Luther Wenge, for attending a dinner with the delegation. Personal leadership from the top will be critical to attitude changes. There is plainly not enough such leadership. The services and communities that the delegation visited told us they were honoured and excited to see international parliamentarians but complained that their own MPs had never visited them. If peoples ideas are going to change more local commitment from MPs is needed. Local MPs need to speak openly about the issues and engage more with the quality work carried out by NGOs.

The need for political leadership interlocks very much with issues around how the public sector is run.

### **3.8 Raising awareness of issues and breaking down taboos**

The delegation noted an absence of social marketing around issues such as condom availability, HIV/AIDS stigma and discrimination, and violence against women.

In talking with people in the community, it was evident that many had very little knowledge of HIV/AIDS, and that a massive HIV/AIDS educative programme is needed, including campaigning from the grass roots upwards.

In terms of primary health care promotion, the delegation saw many missed opportunities. For example, organisations were promoting ABC (Abstinence, Be Faithful, Correct and Consistent Condom use) but experience in other countries which have suffered HIV/AIDS epidemics show that this strategy often is followed for ideological reasons such as a focus on abstinence and fidelity, rather than promoting safer sex. Abstinence and fidelity may be desirable social objectives in their own right, but putting those precepts ahead of health outcomes is a recipe for disaster. For example, working with men is important to address issues around violence and gender equality, because ABC is of no use in situations where women do not have the power to negotiate when or whether to they have sex or the use of condoms, or to stop their husbands from being unfaithful.

### **Missed opportunity to target young men as agents of change**

In Port Moresby, the City Mission runs a 50 acre remedial farm for around 90 boys and young men aged 14 to 21 years. The programme offers an alternative to boys tired of living on the streets and ending up in prison. They come either voluntarily or through the justice system and learn skills such as building, gardening (with produce sold to restaurants and hotels) and cooking. Order is well maintained, with a roster system among the boys for security, and an understanding that if they don't comply with the rules they may need to leave until they are willing to change – although those that don't settle are supported to help them work through their issues before they reach the point where they need to leave. Many boys get jobs through the programme as companies trial them for work such as unloading shipping containers and putting in shelves in supermarkets. The delegation saw fantastic potential to develop programmes with the residents at the farm, for example around sexual and reproductive health and gender equality.

Social marketing must be directed at, prostitutes and MSM as a way of breaking down taboos around these issues. However that may be the easiest task because those audiences are discrete and identifiable—harder will be social marketing into rural communities and remote parts of the country. Unfortunately HIV and AIDS has arrived in those communities well before the social and health messages needed to minimise its spread.

Any social marketing will need to take into account the unique challenges posed by PNG's topography and many remote areas, as well as be embedded in the unique cultural context of PNG.

With low levels of literacy and education, and a strong cultural tradition of performance, drama groups and community conversations hold great potential in educating people. Sensitive and difficult subjects can often be gently and appropriately broached through drama in a non-confrontational manner. Success has been seen in other countries such as Cambodia and Senegal using drama. Also across the Pacific the power of performance as an effective means of education is widely recognised. Men also often find it less confrontational and more fun, enabling a supportive learning environment to be established. There are many opportunities to build on this method in PNG. For example, the Anglicare Stop AIDS project in Port Moresby, which the delegation visited, has an education component that includes drama groups that perform in communities. A drama group performed "Market Scene" for the delegation, with messages on HIV's mode of transmission (mainly heterosexual sex) and ABC (Abstinence, Be Faithful, Correct and Consistent Condom use).

### **3.9 Strengthen and support civil society**

Civil society in PNG has a unique and difficult role. The most effective and inspiring activities that the delegation visited were being implemented by NGOs and faith-based organisations. Despite their good work, they endure a lack of resources and staff. Civil society requires continual and increased governmental and international support and capacity building to ensure the people of PNG have improved access to the services provided by NGOs and FBOs.

The Prime Minister of PNG recently labelled NGOs as “enemies of the government”. In an environment of such mistrust and adversity, it is difficult for NGOs to continue implementing services, let alone take on civil society’s traditional role as government “watchdog”. However PNG will not enjoy a robust, functioning society until this important role of civil society is valued and respected. NGOs and FBOs must be supported and strengthened to ensure they can take on this role with some degree of security. This will require dedicated commitment from the international community. At the same time international donors need to be educating and encouraging the government to respect, value and support civil society in PNG.

#### 4.0 Areas for focus and recommendations for action

The table below outlines recommendations within the thematic areas outlined in the previous section. Suggestions for who needs to take action are indicated with a tick.

<b>Focus area 1: Make grassroots projects flourish</b>			
<b>Recommendation for action</b>	<b>NZ/Aus MPs</b>	<b>PNG MPs</b>	<b>International donor community</b>
1.1 Urge aid providers to give sustainable, predictable funding for core service delivery	√		√
<b>Focus area 2: Systems strengthening</b>			
<b>Recommendations for action</b>	<b>NZ/Aus MPs</b>	<b>PNG MPs</b>	<b>International donor community</b>
2.1 Promote increased coordination and collaboration around a country plan for PNG between UN agencies, PNG Government and donors, and to include in National Development Strategies and Plans where PNG has come from and where it is going, what kind of development PNG wants, and to promote consideration of structural reforms needed to move the country forward	√	√	√
2.2 Rebuild Angau Hospital – develop a locally appropriate, eco-design health centre for replacement, such as a building designed to use locally appropriate materials and structure that will endure.		√	√
2.3 Develop clinics and testing facilities that are linked, community and hospital based, low cost, accessible and that maintain the dignity and privacy of individuals.		√	√
2.4 Build accountability and transparency so that funding reaches the provincial level, particularly in relation to the Provincial AIDS Councils.		√	√

<b>Focus area 3: Coordination and communication</b>			
<b>Recommendations for action</b>	<b>NZ/Aus MPs</b>	<b>PNG MPs</b>	<b>International donor community</b>
3.1 Ascertain, through evidence, that the National AIDS Committee and the responsible minister have a cooperative and productive working relationship		√	
3.2 Examine and improve procurement, storage and distribution systems for medical supplies to ensure continuity of supply.		√	√
3.3 Re-examine policy to ensure that all those who need ARV treatment, receive it, and if required are given the necessary support and nutrition to enable them to take the medication effectively and safely.		√	√
3.4 Establish health clinics at schools.		√	√
3.5 Develop a standardised, consistent and compulsory sexual and reproductive health component of the school curriculum, and ensure that teachers are given the training and support to deliver it.		√	√
<b>Focus area 4: Consistent and coordinated funding</b>			
<b>Recommendation for action</b>	<b>NZ/Aus MPs</b>	<b>PNG MPs</b>	<b>International donor community</b>
4.1 Provide sustainable and predictable funding in core programme areas			√
<b>Focus area 5: Balanced development</b>			
<b>Recommendation for action</b>	<b>NZ/Aus MPs</b>	<b>PNG MPs</b>	<b>International donor community</b>
5.1 Increase the focus on informal (ie: community-based, outside of educational institutions) as well as formal education systems and methods of delivery.		√	√

<b>Focus area 6: Need for better data and statistics</b>			
<b>Recommendation for action</b>	<b>NZ/Aus MPs</b>	<b>PNG MPs</b>	<b>International donor community</b>
6.1 Improve the collection, analysis and distribution of data and statistics on sexual and reproductive health, including HIV and AIDS.	√	√	√
<b>Focus area 7: Political leadership</b>			
<b>Recommendations for action</b>	<b>NZ/Aus MPs</b>	<b>PNG MPs</b>	<b>International donor community</b>
7.1 Establish mentoring partnerships between parliamentarians in New Zealand and Australia with parliamentarians in PNG to foster accountability and build political leadership.	√	√	
7.2 Resource the Parliamentary AIDS Committee with secretarial support, and establish an exchange programme to assist establishment of secretariat support for the committee (through Commonwealth Parliamentary Association).	√	√	√
7.3 Develop workshops for parliamentarians specifically around country commitments to international agreements, including the ICPD Programme of Action, Beijing Platform for Action, the MDGs and human rights treaties.	√	√	√
7.4 The Prime Minister should take a specific role in speaking out as leader of the battle against HIV and AIDS, and violence against women.		√	
7.5 The Prime Minister, key ministers and the Parliamentary Committee on AIDS need to take advantage of funds offered by donors (and refused to date) to visit relevant African countries to learn from experiences there		√	√
7.6 Consider legislative reform to protect			

the safety and rights of sexworkers.		√	
7.7 Decriminalise consensual adult male-male sexual contact.		√	
7.8 Consider a follow-up visit in three to four years, to monitor progress.	√		√
<b>Focus area 8: Raising awareness and breaking down taboos</b>			
<b>Recommendations for action</b>	<b>NZ/Aus MPs</b>	<b>PNG MPs</b>	<b>International donor community</b>
8.1 Urge aid providers to assist with researching and implementing more effective social marketing of messages around sexual and reproductive health.	√		√
8.2 Scale up effective, evidence-based programmes such as the Anglicare drama programme - looking at African models and developing a national network of theatre groups to build on strong cultural traditions already present.		√	√
8.3 Establish men's programmes to counteract risk factors such as violence and multiple partners		√	√
8.4 Establish a "Champions" community leaders scheme in all sectors	√	√	√
<b>Focus area 9: Strengthen and support civil society</b>			
<b>Recommendations for action</b>	<b>NZ/Aus MPs</b>	<b>PNG MPs</b>	<b>International donor community</b>
9.1 Explore the use of advocacy workshops for civil society in PNG focussed on building constructive relationships between civil society and government.	√	√	√
9.2 Don't start more programmes until there is evidence showing they are working		√	√

## Appendix 1.0 Study Tour Participants

Members of the study tour delegation to PNG (7<sup>th</sup> – 15<sup>th</sup> April 2006) were:

- Steve Chadwick (MP), Chair of the New Zealand Parliamentarians' Group on Population and Development (NZPPD), and head of the delegation
- Tim Barnett (MP), NZPPD member
- Dr Paul Hutchison (MP), NZPPD member
- Duncan Kerr (Australian Labour MP)
- Julie Middleton, journalist, New Zealand Herald
- Sarah Barnett, journalist, New Zealand Listener
- Barbara Dreaver, journalist, TVNZ One News
- Mike Fitzgerald, cameraman, TVNZ One News
- Steven Nowakowski, photographer based in Australia – will join the delegation in Brisbane on the way to Port Moresby.
- Frances Bird, New Zealand Family Planning Association (NZFPA) Director Health Promotion & Professional Development
- Chris Te'o, FPAID programme coordinator
- Karyn Ammundsen, FPAID communications manager
- Bonnie Flaws, DRC information officer
- Catrina McDiamard, New Zealand Agency for International Development (NZAID) Communications Manager
- Andrea Fairbairn, Development Programme Manager PNG, NZAID.

Accompanying the delegation at their own expense were:

- John Chadwick, accompanying Steve Chadwick
- Ramon Maniapoto, accompanying Tim Barnett.

## Appendix 2.0 – Study Tour Programme, PNG, 7<sup>th</sup> – 15<sup>th</sup> April 2006

<p><b>FRIDAY</b> 7<sup>TH</sup> APRIL</p>	<p><b>Briefing session</b></p> <ul style="list-style-type: none"> <li>▪ 6pm – 7pm: delegation meets at Hotel Grand Chancellor Auckland Airport, Corner Kirkbride and Ascot Roads, for briefing. A briefing programme will be sent to all participants beforehand.</li> </ul>
<p><b>SATURDAY</b> 8<sup>TH</sup> APRIL</p>	<p><b>Depart for Port Moresby</b></p> <ul style="list-style-type: none"> <li>▪ 4.15am: delegation meets at Auckland International Airport check-in counters</li> <li>▪ 4.30am: check in for QF116 to Brisbane</li> <li>▪ 6.30am: QF116 to Brisbane departs</li> <li>▪ 8.05am (local time): arrive Brisbane airport. The delegation will be joined by Australian photographer Steven Nowakowski and Australian MP Duncan Kerr. Transit time of 1 hour 55 minutes.</li> <li>▪ 10am: QF351 departs to Port Moresby</li> <li>▪ 1pm (local time): arrive Port Moresby. The delegation will be met by New Zealand High Commission staff and taken to a VIP lounge while luggage is collected. The delegation will then proceed directly to the Holiday Inn to check in.</li> <li>▪ 5pm: Delegation briefing at Holiday Inn by New Zealand High Commissioner Laurie Markes and High Commission staff, and representatives from the World Health Organisation (WHO) and United Nations Population Fund (UNFPA). Australian High Commissioner Michael Potts will also attend. Drinks will follow from 6pm – 6.45pm</li> <li>▪ Dinner: Delegates’ own arrangements at hotel</li> </ul> <p>Please note that although the evenings are free, we strongly recommend that you stay within the hotel for your own safety.</p>
<p><b>SUNDAY</b> 9<sup>TH</sup> APRIL</p>	<p><b>Field visits within Port Moresby</b></p> <ul style="list-style-type: none"> <li>▪ 9.40am: Assemble in hotel lobby for 9.50am bus departure</li> <li>▪ 10am: Anglicare Stop AIDS Project (NZ funded)</li> <li>▪ 11.15am – 12.15pm: Poro Sapot Project (PSP). PSP involves peer education around HIV/AIDS for sex workers and men who have sex with men. The project trains volunteers who then distribute condoms, do demonstrations and teach negotiation skills.</li> </ul>

	<ul style="list-style-type: none"> <li>▪ 12.30pm – 2.15pm: Lunch at Ela Beach Brasserie (delegates’ own cost)</li> <li>▪ 2.30pm – 3.15pm: “Haus Ruth” – Port Moresby City Mission young women’s refuge and hostel</li> <li>▪ 3.45pm: Port Moresby City Mission remedial farm for young men</li> <li>▪ 5.30pm: Arrival back at hotel</li> <li>▪ Debrief: at the end of each day the delegation will meet for a debrief and to confirm the next day’s arrangements</li> <li>▪ Dinner: delegates’ own arrangements at hotel</li> </ul>
<p><b>MONDAY 10<sup>TH</sup> APRIL</b></p>	<p><b>Port Moresby programme continues</b></p> <p>The delegation will be split into two groups: media and MPs</p>

	<p><b>Media</b></p> <ul style="list-style-type: none"> <li>▪ 10am: assemble in hotel lobby for 10.15am departure</li> <li>▪ 11.am: UN agency interviews</li> <li>▪ Noon: Interview Hon Puka Temu while remainder of delegation has lunch</li> <li>▪ 1pm: Lunch</li> <li>▪ 2pm: Visit with Dame Carol Kidu to Port Moresby Hospital, and possibly electorate District AIDS Committee meeting or a community</li> <li>▪ 4pm: interviews with Dr Bun and Dr Mann</li> </ul>	<p><b>MPs</b></p> <ul style="list-style-type: none"> <li>▪ 9am: assemble in hotel lobby for 9.10am departure</li> <li>▪ 11 am: Hon Puka Temu, Minister with special responsibility for HIV/AIDS</li> <li>▪ 12.10 – 2pm: Lunch at Parliament House hosted by Dame Carol Kidu MP for Port Moresby South and Minister for Community</li> <li>▪ 2.15pm: Governor General Paulias Matane (Government House)</li> <li>▪ 3.15pm: Dr Bahanare Bun, Chairman of the Parliamentary AIDS Committee, and Dr Nicholas Mann, Chairman of the National AIDS Council (Parliament House)</li> </ul>
	<ul style="list-style-type: none"> <li>▪ The delegation will come together at the end of the day for a debrief</li> <li>▪ 6pm: Assemble in the hotel lobby for a 6.10pm departure</li> <li>▪ 6.30pm – 8.30pm: Reception at High Commission residence; please dress tropical informal.</li> </ul> <p>Note: Please settle room accounts this evening in preparation for early departure in the morning</p>	
<p><b>TUESDAY 11<sup>TH</sup> APRIL</b></p>	<p><b>Depart for Lae (flight details and programme times to be confirmed)</b></p> <ul style="list-style-type: none"> <li>▪ 4.15am: Meet in hotel lobby for 4.30am departure to airport.</li> <li>▪ 6am: Flight departs for Lae</li> <li>▪ 6.45am: Arrive in Lae. The delegation will be met by PNGFHA and NZAID staff. Provincial Administrator Manasupe Zurenuoc may also greet the delegation. There will then be a 45 minute trip to the Lae International Hotel for check-in as rooms</li> </ul>	

	<p>become available. On arrival at the hotel, the delegation will be welcomed by a sing-sing group.</p> <ul style="list-style-type: none"> <li>▪ Remainder of morning: free time at hotel.</li> </ul> <p><b>Programme for the day</b></p> <ul style="list-style-type: none"> <li>▪ 12.40pm: meet in hotel lobby for 12.50pm departure.</li> <li>▪ 1pm: Bugandi Secondary School</li> <li>▪ 2.30pm – 4pm: Angau Hospital - Chief Executive Officer/Maternal Ward/Well Women’s Clinic/HIV/AIDS Day Care Centre/Women &amp; Children Support Centre/Friends Clinic</li> <li>▪ Daily debrief</li> <li>▪ 7.30pm – 9.30pm: Dinner with Morobe Provincial Government officials (delegates’ own expense). Joining the delegation for dinner will be: <ul style="list-style-type: none"> <li>* Governor Honorable Luther Wenge</li> <li>* Provincial Administrator Manasupe Zurenuoc</li> <li>* Provincial Program Advisor (Education) Murika Bihoro</li> <li>* Provincial Program Advisor (Health) Dr Theo Likei</li> <li>* PNGFHA President Nellie McLay</li> <li>* PNGFHA Acting Executive Director Rhona Yabri</li> <li>* PNGFHA Program Officer Kingston [surame]</li> </ul> </li> </ul>
<p><b>WEDNESDAY 12<sup>TH</sup> APRIL</b></p>	<p><b>Lae programme continues</b></p> <ul style="list-style-type: none"> <li>▪ 6.45am: delegation meets in hotel lobby</li> <li>▪ 7am – 9.30am: Travel from Lae to Markham. Please note: bathroom facilities along the way are limited. We also recommend you bring a small, collapsible umbrella</li> <li>▪ 9.30am – 10.30am: Zumara Primary School – 18 years ago the four villages that send their children to this school were struck by a landslide that forced the communities and the school to move. They currently have just over 300 children and have no electricity or running water.</li> <li>▪ 11am: Mutzing District Hospital – Family Planning Section/maternal ward. This small medical centre services about 51,000 people with very limited resources.</li> <li>▪ Noon: lunch – a cut lunch has been organised (delegates’ own expense)</li> <li>▪ 1pm: Travel to Naramingke</li> <li>▪ 2.30pm: Adventist Development Relief Agency (ADRA) water and sanitation project at Naramingke Village near Lae</li> </ul>

	<ul style="list-style-type: none"> <li>▪ Daily debrief</li> <li>▪ Evening: free time at hotel.</li> </ul>
<p><b>THURSDAY 13<sup>TH</sup> APRIL</b></p>	<p><b>Lae Programme continues</b></p> <ul style="list-style-type: none"> <li>▪ 8.10am: meet in hotel lobby for 8.20am departure</li> <li>▪ 8.30am: PNG Family Health Association – clinic and youth centre</li> <li>▪ 10am – 11am: Adventist Development Relief Agency (ADRA) economic development project for women (in Bumange settlement)</li> <li>▪ 11.30am – 12.30pm: YWCA adult literacy programme</li> <li>▪ 1pm: Lunch at hotel (delegates’ own cost)</li> <li>▪ Presentations at hotel: <ul style="list-style-type: none"> <li>▪ 1.45pm – 2.30pm: Provincial AIDS Council – Ms Joanne Ganoka, Provincial HIV/AIDS Response Coordinator</li> <li>▪ 2.40pm – 3pm: Village Development Trust – Mr Jimmy Kosi, Eco-Forestry Officer</li> <li>▪ 3pm – 3.30pm: Save the Children – Mr Carlos Baraka, Poro Sapot Coordinator (Lae); Bob Humphries, East Sepik Women and Children’s Health Project</li> <li>▪ 3.30pm – 3.45pm: Afternoon tea</li> <li>▪ 3.45 – 4.30pm: Bris Kanda Project – Mr O’soso Ewa, Program Development Officer</li> <li>▪ 4.30pm – 5pm: Question and answer session</li> </ul> </li> <li>▪ Daily debrief</li> <li>▪ Dinner: delegates’ own arrangements at hotel</li> </ul> <p>Note: Please settle room accounts this evening in preparation for early departure in the morning</p>
<p><b>FRIDAY 14<sup>TH</sup> APRIL</b></p>	<ul style="list-style-type: none"> <li>▪ <b>Travel to Sydney via Port Moresby</b></li> <li>▪ 5.30am: delegation meets in hotel lobby for 5.45am departure to airport.</li> <li>▪ 6.15am: check-in for PX101 to Port Moresby.</li> <li>▪ 7.15am: PX101 departs for Port Moresby.</li> <li>▪ 8am: arrive Port Moresby. We will be in transit for 7 hours 10 minutes. Day rooms have been booked at the Airways Hotel nearby.</li> <li>▪ 3.10pm: QF352 departs for Sydney</li> </ul>

	<ul style="list-style-type: none"> <li>▪ 8.25pm (local time): QF 352 arrives Sydney. Check in to Mercure Hotel.</li> </ul> <p>Please note that you will be given an evaluation form to fill out on the flight from Port Moresby to Sydney.</p>
<p><b>SATURDAY 15<sup>th</sup> APRIL</b></p>	<p><b>Return home</b></p> <p>The group will be departing at different times for Auckland, Wellington and Christchurch.</p>