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The need for comprehensive and integrated FP service delivery in PNG is real, large, growing, and continuous. With the largest cohort of young people in PNG’s history ever to enter their reproductive years, FP services will have to expand by more than 40 percent just to maintain current prevalence rates, which are already inadequate in PNG. Maintaining current prevalence rates will fall far short of protecting every man and woman who wishes to avert unintended pregnancies. Urbanization, which helps drive the desire for smaller families, is also continuing to proceed rapidly. Thus, the demand and need for effective family planning will be growing considerably for years to come.

High fertility, besides being recognized as a key population issue affecting socio-economic development and gender equity, and is a major obstacle to poverty reduction. The priority action in this regard therefore is to improve birth spacing and reduce fertility through providing and promoting improved family planning and reproductive health services within the context of relevant national policies. It is expected that this will have a direct impact on alleviating and reducing poverty by making family size smaller thereby contributing to the welfare of households. Fertility decline will also reduce population growth and lessen the young dependency ratios. It will also reduce maternal, infant and child mortality by improving the health of mothers and children.

In the formulation of this National Family Planning Policy, full recognition has been given to the sensitivities that would be involved in its implementation. As the success of the policy will be contingent upon changes in individual behaviour and attitudes towards the family and resource planning decision-making process, it is important to clarify at the outset, that the policy has been formulated keeping in view the essence of PNG cultural and traditional values.

This policy plans an important contribution to the development and future of Papua New Guinea and I commend it to all partners in the health sector, and to the other government sectors. It complements the Population Policy of PNG.

Hon. Michael Malabag, MP.
Minister for Health and HIV and AIDS
Acknowledgment

The National Department of Health owes its thanks to many individuals and organizations for their hard work toward the creation of this National Family Planning Policy. Only through the collaborative efforts of these partners could this document have come to fruition. This policy will provide clarity to the health sector and its partners on family planning services programs and activities in PNG.

I would like to acknowledge the NDoH Health Improvement Branch staff, National Reproductive Health Advisory Committee, the Ministerial Family Planning Committee for their commitment and contributions throughout the process of thinking and writing this document. Support from AusAID, UNFPA, UNICEF and WHO in providing the technical assistance and guidance in the preparation of this document. The staff of the National Department of Health and the national specialists and medical and nursing officers involved in family planning services and counselling in the government, church and NGO sectors are thanked for their invaluable insights and contributions.

The policy will be supported by the work of the Ministerial Taskforce on Maternal Health which recognizes the pivotal role family planning plays in saving women’s lives.

Finally, I look forward to the implementation of the Family Planning Policy in Papua New Guinea through the health sector of PNG for the benefit of our people, the majority of whom live in the rural areas.

Mr. Pasco Kase
Secretary of Health
Executive Summary

This document represents the first National Family Planning Policy for PNG. With the goal to induce changes in population trends ultimately to bring the size, composition and distribution of population in line with the needs of sustainable development for poverty alleviation, national development and improvement in the quality of life of all Papua New Guineans.

The document outlines four policy statements that will guide implementation of the family planning services throughout the country.

- Family planning options should be promoted to stabilize population growth rates by attaining replacement fertility levels for optimal population and sustainable national development.
- The PNG health sector must make appropriate, quality client-focused family planning services affordable and accessible to all who need and want them, while maintaining proper client confidentiality.
- The PNG health sector must support couples and individuals to decide freely and responsibly on the number and spacing of their children, providing them with access to accurate information education, and counseling.
- The Government of PNG must ensure the availability of well trained and supervised and motivated service providers for family planning.

Quality family planning service provision is a primary intervention to reduce the burden of maternal mortality and morbidity in PNG. Modern family planning prevalence of 65 percent by 2020 will be necessary to be reached in order to achieve a desired Total Fertility Rate of 2.2 percent by 2020.

This policy outlines the implementation plan on the different roles and responsibilities and the processes involved in securing resource support. For government agencies the normal planning and budgetary process will be followed. The private health sector and NGOs will implement using the own processes and in their own jurisdiction but will collaborate with government from time to time for the purposes of alignment to priorities set by government and reporting.

Monitoring and evaluation is an important process for the purpose of tracking progress. This policy outlines in the final chapter mechanisms in which this policy will be used for the purpose of monitoring and evaluation of results.
# ABBREVIATIONS

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Full Form</th>
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<tbody>
<tr>
<td>AIDS</td>
<td>Acquired immune deficiency syndrome</td>
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<tr>
<td>ANC</td>
<td>Ante Natal Care</td>
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<tr>
<td>ART</td>
<td>Antiretroviral Therapy</td>
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<tr>
<td>ASRHS</td>
<td>Adolescent Sexual and Reproductive Health Services</td>
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<tr>
<td>BCC</td>
<td>Behaviour Change Communication</td>
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<tr>
<td>CBD</td>
<td>Community Based Distribution</td>
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<tr>
<td>CBOs</td>
<td>Community Based Organizations</td>
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<td>CCP</td>
<td>Comprehensive Condom Programming</td>
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<tr>
<td>CHWs</td>
<td>Community Health Workers</td>
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<tr>
<td>CYPs</td>
<td>Couple Years of Protection</td>
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<tr>
<td>DHS</td>
<td>Demographic and Health Surveys</td>
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<tr>
<td>DMPA</td>
<td>Depomedroxyprogesteroneacetate (DepoProvera)</td>
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<tr>
<td>DPs</td>
<td>Development Partners</td>
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<tr>
<td>EC</td>
<td>Emergency Contraception</td>
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<td>EmOC</td>
<td>Emergency Obstetric Care</td>
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<td>EOC</td>
<td>Essential Obstetric Care</td>
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<tr>
<td>DCE</td>
<td>Drugs, Commodities and Equipment</td>
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<tr>
<td>FBO</td>
<td>Faith Based Organizations</td>
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<tr>
<td>GoPNG</td>
<td>Government of Papua New Guinea</td>
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<tr>
<td>HIV/AIDS</td>
<td>Human Immuno-Deficiency Virus/Auto-Immune Deficiency Syndrome</td>
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<tr>
<td>HMIS</td>
<td>Health Management Information System</td>
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<tr>
<td>HRM</td>
<td>Human Resources Management</td>
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<td>ICPD</td>
<td>International Conference on Population and Development</td>
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<td>IEC</td>
<td>Information Education and Communication</td>
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<tr>
<td>IUD</td>
<td>Intra-Uterine Device</td>
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<tr>
<td>FP</td>
<td>Family Planning</td>
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<tr>
<td>IMR</td>
<td>Infant Mortality Rate</td>
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<tr>
<td>LAM</td>
<td>Lactational Amenorrhoea Method</td>
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<tr>
<td>LAPM</td>
<td>Long Acting and Permanent Methods</td>
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<td>LARC</td>
<td>Long Acting Reversible Contraception</td>
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<tr>
<td>LLG</td>
<td>Local Level Government</td>
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<tr>
<td>MCH</td>
<td>Maternal and Child Health</td>
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<tr>
<td>MDGs</td>
<td>Millennium Development Goals</td>
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<td>MMR</td>
<td>Maternal Mortality Ratio</td>
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<td>M&amp;E</td>
<td>Monitoring and Evaluation</td>
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<td>MOU</td>
<td>Memorandum of Understanding</td>
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<td>National Department of Health</td>
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<td>NGOs</td>
<td>Non-Governmental Organizations</td>
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<tr>
<td>OC</td>
<td>Oral Contraceptive</td>
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<tr>
<td>OPD</td>
<td>Out Patient Department</td>
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<tr>
<td>PAC</td>
<td>Post-abortion Care</td>
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<td>PICT</td>
<td>Provider initiated counselling and testing</td>
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<tr>
<td>PLHIV</td>
<td>People Living with HIV/AIDS</td>
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<tr>
<td>PNC</td>
<td>Post Natal Care</td>
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<tr>
<td>PPTCT</td>
<td>Prevention of Parent to Child Transmission</td>
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<td>RHCS</td>
<td>Reproductive Health Commodity Security</td>
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<tr>
<td>SRH</td>
<td>Sexual and Reproductive Health</td>
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<tr>
<td>STIs</td>
<td>Sexually Transmitted Infections</td>
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<tr>
<td>VCT</td>
<td>Voluntary Counselling and Testing</td>
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<tr>
<td>SDP</td>
<td>Service Delivery Point/s</td>
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<tr>
<td>TFR</td>
<td>Total Fertility Rate</td>
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<td>UNFPA</td>
<td>United Nations Fund for Population Activities</td>
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<tr>
<td>VHV</td>
<td>Village Health Volunteer</td>
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<tr>
<td>YAH</td>
<td>Youth and adolescent Health</td>
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CHAPTER ONE – BACKGROUND

1.1 Intent of Policy
The intent of this policy is:

1. To ensure, a clear understanding of family planning and its important role in family, community and national development amongst the population of Papua new Guinea, and its leadership.
2. To support PNG families and individuals to have the number of children they desire and they can care for.
3. To support the nation to attain and match the population size to the resources available within the country – natural, financial and social.

1.2 Historical Context
Through this National Family Planning Policy the Government reaffirms its respect and support for the right for all couples and individuals to decide freely and responsibly on the number and spacing of their children, and to have access to the information, education, services and means to do so. Since the implementation of the Policy will involve a variety of sectors as well as different sections of society, the Policy is consistent with and complements other national plans and policies (i.e., Medium Term Development Framework, The Health Sector National Strategic Plan (2006-2010), National Health Plan (2001-2010), Millennium Development Goals) and is not intended to be a substitute for them in any way.

Poverty strongly inhibits choices available to people. Consequently, an important objective of the Family Planning Policy is to contribute towards the alleviation of poverty. Population, poverty reduction and sustainable development are interrelated. Therefore, population issues should be part of PNG’s integrated system of development policies and programs. Increased wealth of the nation is not a necessary condition for improved health as exemplified by many other low-middle income countries. There is a need to concentrate not only upon the medical determinants of health (e.g. Public Health programs such as Child Health, Supervised Delivery etc.) but also upon the non-medical or Social Determinants of Health as education, nutrition, housing, employment, law and order, transport options and social cohesion. Other GoPNG departments and policies partner with NDoH in setting sound government policies with SMART (Simple, Measurable, Achievable, Reliable Time bound objectives) in their implementation plans. This requires clear political leadership and determination, and a Sector Wide Approach. Rather than see medical and non-medical determinants as competitive, PNG must go for both as vital complementarities.

There is a need to ensure that sexual and reproductive health, including population and family planning is appropriately reflected in other national health-sector plans, including those covering population, HIV/AIDS prevention and care, proposals to the Global Fund to fight AIDS, tuberculosis and malaria, strengthening the Health system and other relevant initiatives.

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Investments in family planning are economically sound and play an important role in economic development and poverty reduction. However, despite slight increases in the contraceptive prevalence rate due to the FP program, the unmet need in PNG remains high hindering achievement of related reproductive health goals.

There is no organized opposition in PNG to birth spacing programs or to introducing more comprehensive reproductive health and family planning services, nor are there legal barriers to the provision of contraceptives.

1.3 Audience
This policy is written for all human resources providing services in all the health facilities throughout PNG as well as for a range of audiences:

- Health Training institutions
- Health managers at all levels of the health system
- Provincial Authorities
- Districts Authorities
- Non-Government Organizations
- Research Institutions
- Private and Corporate Organizations
- Development partners
- Faith based organizations providing health services
- Leaders at community, provincial and national levels.

1.4 Policy Development Process
In the formulation of this policy, full recognition has been given to the sensitivities that would be involved in its implementation. As the success of the policy will be contingent upon changes in individual behaviour and attitudes towards the family and resource planning decision-making process, it is important to clarify at the outset, that the policy has been formulated keeping in view the essence of PNG cultural and traditional values.

This policy has been developed through an extensive process over 5 years. This process has included:

- Literature review of the evidence base in PNG and internationally on family planning and development and family planning services
- Stakeholder consultations
- Drafting by the National Reproductive Health Consultative Committee
- Support by specialist technical assistance – within PNG and internationally
- Guided by the Ministerial Family Planning Summit in April 2007 and the recommendations arising from the working group discussions.

All comments and views were incorporated and endorsed by both NDoH and National Health Board.
CHAPTER TWO - POLICY CONTEXT AND DIRECTIONS

2.1 Goal

The goal of this National Family Planning Policy is to induce changes in population trends in order to bring the size, composition and distribution of population in line with the needs of sustainable development for poverty alleviation, national development and improvement in the quality of life of all Papua New Guineans. It is intended to prevent unintended and unwanted pregnancies and thereby reduce the high pregnancy rates and the resulting morbidity and mortality in mothers, neonates and children. The policy and programs will be both population influencing and population responsive. In so doing, this National Family Planning Policy will help PNG couples and individuals to:

- make every child a resourced and wanted child;
- to fulfill the right of the individuals in achieving their reproductive goals (family size) when and if they decide to have children, safely and healthily;
- avoid illness, disease and disability related to reproduction

2.2 Vision and Mission

Vision

All Papua New Guinean couples and individuals to be able to achieve their reproductive goals safely and healthily.

Mission

The PNG government will ensure that all Papua Guinean couple and individuals have access to equitable affordable and quality FP services.

2.3 Objectives

The principal objectives that will contribute towards achieving the above overall goal are to:

- promote FP option to stabilize the population growth rate by attaining replacement fertility levels for optimal population and sustainable national development.
- make appropriate, quality family planning services affordable and accessible to all who need and want them, while maintaining proper client confidentiality.
- support couples and individuals to decide freely and responsibly on the number and spacing of their children, providing them with access to accurate information, education, and counselling.
- ensure the availability of well trained, supervised and motivated service providers.
2.4 Principles

The following principles should guide the planning and implementation of the National Family Planning Policy.

2.4.1 Rights based service provision where Sexual and reproductive rights are an integral component of basic human rights

2.4.2 Duty of care of FP service providers and informed freedom of choice where clients are counselled and informed on the different methods available, are guided and given freedom to make informed choices on their FP needs. Health workers have a duty to always respect the client’s right to freely choose, and must ensure that the information and advice given are technically accurate, free from service providers personal bias, client requests or needs addressed at all times, even by health workers who have ethical beliefs against family planning services.

2.4.3 Equitable access to quality family planning services where regardless of social status, cultural background, tribal ethnicity, geographical setting and urban or rural livelihood is given the same quality of health care services.

2.4.4 Holistic and integrated approach: where every person receives comprehensive FP services combining provisions of different SRH programs and health interventions at the same time when required. FP will build on existing programs and recognize the comparative advantages of the different partners in the planning, implementation and evaluation of FP programs.

2.4.5 Gender Equality: where every persons regardless of sex as well as gender and sex of their caregivers, has equal access to quality family planning services

2.4.6 Evidence based services: where every persons receiving family planning information and interventions that are proved to be effective, documented and internationally recognized.

2.4.7 Friendly services where all persons receive FP services in supportive and hospitable environment.

2.4.8 Confidentiality is maintained by high standards of privacy, confidentiality, and professional non-judgmental attitude by service providers to client.

2.4.9 Millennium Development Goals and the Cairo Program of Action: The national FP program aims to fulfil the Millennium Development Goals and the Cairo Program of Action in an effort to ultimately reduce poverty, improve health, and promote peace, human rights, gender equality, and environmental sustainability

2.4.10 Partnership: NDOH as the steward of the health system promotes coordination and joint programming among stakeholders including the private sector, academia, professional councils, civil society organizations, development partners, NGOs, FBOs and communities at all levels in order to improve collaboration, maximize resources, and avoid duplication.
2.5 Core Government Legislations and Policies

This policy is in line with the following core Government laws and National Policies and Strategies:

Laws and Acts
- Papua New Guinea Constitution; 1975
- Public Hospital Act 1994
- National Health Administration Act; 1997
- Organic Law for Provincial and Local Level Governments; 1998
- HIV Management and Prevention Act; 2003
- Provincial Health Authority Act 2007
- Criminal Law (Compensation) Act
- National Council of Women Act
- Sorcery Act
- Equality and Participation Bill
- Family Sexual Violence Act (2012)
- Public Service General Order (2012)
- Lukautim Pikinini Act (2011)

Policies and Standards
- Vision 2050, 2009
- National Health Plan 2011-2020; 2010
- Minimum Standards for Village Health Volunteers in Papua New Guinea; 2003
- National Policy on Health Promotion; 2003
- National Policy on Partnerships in Health Sector for Papua New Guinea; 2002
- National Tobacco Control Policy; 2003
- National Policy for Expanded Program on Immunization; 2004
- National Policy on Medical Equipment for Papua New Guinea; 2004
- Child Health Policy; 2010
- National Population Policy 2001-2010; 1999
- National Disability Policy (2012)
- Medical and Dental Stores Catalogue; 2002
- Minimum Standards for District Health Services in Papua New Guinea; 2003
- National Family Planning Standards Policy for Papua New Guinea; 1995
- Health Sector Human Resource Policy -2012
- National Youth Policy 2008-2012
- Child Health Policy 2009
- National Women and Gender Policy (2011)
- Mental Health Policy (2011)
- National Disability Policy (2012)
- Youth and Adolescent Health Policy (2014)
- National Health Sector Gender Policy (2014)
- National Sexual and Reproductive Health Policy (2014)
- Health Sector Partnership Policy (2014)
- Infant and Young Child Feeding Policy 2014
- National Medicine Policy 2014
CHAPTER THREE - POLICIES AND STRATEGIES

3.1 Current Situation
The total fertility rate (TFR) has remained high in PNG. The TFR fell from between 4.8 percent in 1996 to 4.4 percent in 2006 (an 8% decline); to 4.0 percent in 2010 (a further 9% decline). Women in urban areas have a lower TFR (3.6%) than women in rural areas (4.5%), and there are marked differences by region – ranging from 3.9 percent in the highlands to 4.6 percent in the Islands. In addition, the adolescent birth rate is high. Women aged 15–19 have an estimated birth rate of 70 births per 1000; 22 percent of 19 year olds have at least one child and 6 percent have two or more children.

It is recognized that women who have more frequent births, and women who deliver at very young and older ages, are at higher risk of dying. Longer birth intervals improve the health of the fetus, young children, and of the mother. Avoiding unplanned and unintended pregnancies and lowering overall fertility is crucial to reducing maternal, newborn and child deaths.

Low contraceptive use: In 2006, the contraceptive prevalence rate (CPR) – for any modern method - was estimated to be 26 percent. Women in rural areas were less likely to use modern contraceptive methods than women living in urban areas (24% and 35%, respectively). Contraceptive use was lowest in the lowest two wealth quintiles. Routine facility data show substantial differences in contraceptive use between geographic area, with use very low in SHP and Enga provinces, and in the Highlands region. In 2006, injectables were the most commonly used modern method (9.1%), followed by female sterilization (8.6%) and the pill (4.6%). Unmet need for contraception was estimated to be 36 percent in 2006. Differences were noted between women with no education (34%) compared to women with grade 7 and above (22%).

Distribution of contraceptive methods is still a problem in many areas for a number of reasons – including stock management and ordering practices, and logistics problems (distribution and transportation)

Lack of knowledge of contraception: A very high proportion of women (28%) cited lack of knowledge as a reason for not intending to use contraception in 2006; 26 percent cited wanting more children as a reason. Other reasons for not using contraception included: opposition by husband or religious beliefs (9%), and health concerns or fear of side effects (9%). Only 5 percent of women mentioned lack of availability of contraceptives as a reason for not using them. Lack of knowledge of women and their families remains an important barrier to use.

Village health volunteers (VHVs), who conduct home visits and health education meetings, are often not active. Other community leaders such as religious leaders and traditional healers are often not used to deliver family planning messages and counselling. A school-based health promotion strategy shows promise – especially in a setting in which adolescent pregnancies remain common - but has not yet been implemented widely.

Female education and status of women: Female literacy for women 15 and older is estimated to be 56 percent. Higher rates of female education are associated with higher rates of contraceptive use.
3.2 Analysis of Issues

Available data suggest that there are a number of factors that have contributed to the slow fertility decline, including:

There is a need to increase the availability of facilities offering services and staff able to provide services at peripheral facilities. Community aid posts need to be re-opened and staffed. Mobile outreach clinics should include family planning services, especially for long acting permanent methods and long acting reversible contraception. At the community level, village health volunteers (VHVs) need to be used more widely and effectively to distribute methods. All of these efforts require further investments in peripheral health systems at the district and sub-district levels. The improvement of the logistic management system should be a priority.

For a number of reasons health workers at first level health facilities (Community Health Post and Health Centres) do not provide counselling in the area of family planning and reproductive health. Common reasons include: lack of training and awareness; lack of time; cultural sensitivity/religious beliefs; and a lack of counselling skills. Training and supervision of health workers needs to emphasize counselling in this area and would be supported by the development of counselling materials.

Improve knowledge and awareness of contraception and family planning at home and community levels. In many areas cultural norms and traditions regarding family planning need to be changed; and knowledge of methods improved. A systematic health promotion and behavior change strategy that uses multiple channels to improve knowledge of family planning at the home and community levels is urgent. Improved family planning counseling skills of health workers – by improving training and supervision has to be implemented.

Mass media strategies – such as print, radio or television – have also not been used widely. A comprehensive health promotion and behaviour change strategy is needed, using multiple channels. Messages and materials need to be developed and tested locally to ensure that they are appropriate. Messages should target men and key family decision-makers, as well as women of reproductive age.

Women’s status in society remains traditional in many areas, which limits their ability to make reproductive decisions. Adolescents, who have a relatively high birth rate, are less likely to be able to make informed decisions and to have decision-making power in the home. A high proportion of adolescent births not only increases the risk of death for mother and baby, but also limits the ability of the mother to obtain education and employment in the longer term.

Improved education tends to increase contraceptive use rates and reduce unmet need. In addition, improved education increases female decision-making power and tends to reduce overall fertility. On-going investments in female education are an important priority.
3.3 Policy Response and Strategies

Objective 1: To promote Family Planning for sustainable national development

Family planning options should be promoted to stabilize population growth rates by attaining replacement fertility levels for optimal population and sustainable national development.

Strategies

1. Provide advocacy for and support to political commitment, strong leadership and good management of the implementation of National Family Planning Policy, its related programs and services at all levels of society.

2. Advocate for consideration of family planning and population resource matching issues into all Government policies and plans, at national, provincial and local levels.

3. Ensure adequate resourcing for the implementation of the National Family Planning Policy

Objective 2: To provide client focused quality family planning services

Appropriate, quality client-focused family planning services shall be made accessible and free of charge to all who need and want them, while maintaining proper client confidentiality.

Strategies

1. All government health service providers and those funded by government are to ensure that all clients who request or need family planning services, including various age groups (e.g. adolescents) disable, gender, marital status, ethnicity, literacy levels, language, religion, income levels, and other criteria shall have access to quality free of charge Family Planning services;

2. All FP service providers encourage and support clients and communities to be actively engaged in the planning and evaluation of family planning services;

3. All health service providers ensure client-focused and youth friendly care and services are at all service delivery points;

4. All FP service providers, Provinces, Public Hospitals and PHAs are to ensure appropriate environment for effective and confidential client counselling is available at all family planning service delivery points;

5. The Government of PNG and other non-government providers are to ensure the supply of contraceptives and related consultations and procedures as per PNG standards are provided free of charge every working day in an integrated manner;
6. NDoH to advocate for review of current PNG legislation that relates to termination of pregnancy in order to increase access to safe legal abortion services when a woman's physical, mental and social health is at risk;

7. NDoH, Provinces, PHAs, Public Hospitals and other partners work together to develop and maintain strong logistics systems related to family planning commodities and supplies;

8. NDoH works with all government and non-government service providers and ensure family planning information and services are easily available by getting them as close as possible to potential users and through an expanded range of service delivery points;

9. NDoH works with all government and non-government service providers in ensuring voluntary sterilization for both men and women is widely available without unnecessary restrictions;

10. NDoH works with all government and non-government service providers and expand and adequately resource quality voluntary no-scalpel vasectomy services nationwide;

11. NDoH works with all government and non-government service providers to integrate family planning services at every opportunity at all levels and all programs of the health service;

12. Monitor and evaluate the family planning program at all levels of implementation

13. All partners implementing this policy ensures that individuals and couples are provided with advice on the prevention of infertility related to STIs and appropriate referral for assessment of infertility;

14. All publicly funded health care providers and programs must implement this national policy so that all PNG citizens have access to all methods of family planning. In cases where this conflicts with an individual’s or institution’s values, ways to manage the conflict but maintain access for all clients must be mutually negotiated between the government and the provider/institution;

15. All Family Planning service providers ensures family planning are discussed and offered by all health workers in all non-emergency client and patient consultations;

16. NDoH liaises with Training Institutions and Office of High Education to ensure Family Planning is properly taught in the pre-service training curriculum of primary care providers in PNG;

17. NDoH to work with respective management of health facilities to plan and budget for Sexual Reproductive Health service providers to have access to regular Family Planning in-service training.
Objective 3: To provide freedom of choice for responsible Family Planning

The PNG health sector shall support couples and individuals to decide freely and responsibly on the number and spacing of their children, providing them with access to accurate information education, and counselling.

Strategies

1. NDoH work with all partners develop effective communication strategies for various target audiences to promote the informed and voluntary adoption and continuity of use of effective family planning methods.

2. Government health institutions work with all partners to increased social awareness on reproductive rights amongst all PNGs

3. Government health institutions work with all other partners to support social mobilization and advocacy programs for family planning.

4. Government health institutions work with all other partners to support the involvement of men and ensure availability, accessibility and sustained reproductive health services for men, including information and services related to male and female methods of family planning and contraception.

5. Government health institutions work with all other partners and promote the involvement of adolescents and ensure access to information on and access to reproductive health services, including services related to male and female methods of family planning and contraception.

Objective 4: To have adequate distribution of competent motivated service providers

Availability of well trained, supervised and motivated service providers for Family Planning programs and services shall be promoted and encouraged at all levels to provide quality Family Planning services.

Strategies

1. NDoH Human Resource workforce planning takes into account the need to provide quality accessible family planning services, both as standalone and integrated services.

2. All partners implementing this policy ensure that all health service providers are competent in providing quality comprehensive family planning services according to their level of care.

3. All partners implementing this policy ensure there is strong and accountable management of family planning programs at all levels of the health system.

4. All provinces, PHAs and hospitals ensure there is quality service delivery through regular supportive supervision by appropriately trained supervisors.
5. NDoH to evaluate the impact of improved human resource management on access to and quality of care of family planning services and use the results to continue to strengthen human resources for family planning.

3.4 Resource, staffing and service implications
The successful implementation of the policy and strategies has implications on service delivery, in turn contributes to the nation’s development.

Financial Implications:
Financial implications in implementing this policy are captured as part of the 2011-2020 National Health Plan and the Ministerial Task Force budget estimates. Implementation at the Provincial levels are allocated through the Health Functional Grants in particular funding of activities related to Maternal Child Health (MCH) integrated outreach, Facility operations and Medical Supplies distribution. It has to be understood that any decrease in funding will have implications in staffing and Family Planning service provision.

Human Resource Implications:
Current data on Human Resources for Family Planning services shows that:

- There are inadequate numbers of all categories of health workers, in particular midwives
- The distribution of staff varies considerably by province, with some provinces being less well staffed than others
- A high proportion of staff works in urban areas although 87 percent (%) of the population is rural with one third of Community Health Workers (CHW) who are trained to work in the rural settings, end up working in public hospitals.
- 54 percent (%) of current workforce is at retirement age or will retire in the next decade. These workers are not being replaced.
- There are a number of limitations to existing training institutions for all cadres of health worker- including lack of resources, limited teaching quality and clinical practices especially in midwifery skills.

Adequate level of funding to support human resources training and up skilling to be competent, with appropriate level of compensation will be able to retain committed workers.

Other resources and service implications:
Other resources such as appropriate facilities and services meeting standards are all important to ensure quality services are provided at all times when needed or expected.

Support for resource materials, especially for awareness and education on prevention and informed decision making will impact PNG’s development situation as stated in the current situation.
CHAPTER FOUR - IMPLEMENTATION PLAN

This policy requires effective coordination and collaboration from all relevant stakeholders including the users of the FP services. Because FP directly impacts development status of PNG, this policy will be implemented by the different levels of government collaborating with all health service partners in the following manner:

The DoH is the steward for the health sector will coordinate the implementation of this policy based on the Sexual Reproductive Health Strategic Plan 2013-2020 which will be operationalized at the central level through the Corporate Plan and the Annual Implementation Planning process.

The Public Health Division of the DoH will be responsible for coordination and developing overarching partnerships agreements between the state and other relevant partners in implementation FP services in PNG. Specific requirements of individual partnerships with provinces and districts will be modified, within the framework of overall government policies and legislative requirements.

The Medical Standards Division and Public Health Divisions of the DoH will be responsible for monitoring compliance with the National Health Service Standards and the registration and accreditation of health facilities. The Medical Board of PNG will be responsible for licensing of facilities and health workers. Both the Public Health and Medical Standards will outline referral mechanisms and pathways within the health sector.

The implementation of this policy will be informed and guided by other complementary and subsidiary policies for specific strategies implementation such as the Health Sector Human Resources Policy and the Health Sector Workforce Development Plan.

Provinces and the various partners operating in specific provinces will implement this policy through the Province, Provincial Health Authority and Public Hospitals Service Planning process. Annual Implementation Planning and Budgeting will guide and resource implementation on an annual basis. This will maximize the utilization of limited resources for optimum outcomes.

The total cost of implementing this policy is captured in the Sexual and Reproductive Health Strategic Implementation 2013-2020 and supports the costing of National Health Plan and Maternal Task Force activities relating to Family Planning.
CHAPTER FIVE - MONITORING AND EVALUATION

Monitoring and evaluation are central components of all programs. Firstly, clear targets and benchmarks for FP activities and coverage need to be set at National and Sub-national levels. Secondly, service delivery plans must be based on a clear plan of what is to be achieved, how and by when, with a clear set of indicators and strong baseline data.

In order to implement and maintain quality family planning services, health planners and managers at all levels need timely information on:

- the strengths and weaknesses of the service delivery system, which may affect access to and quality of family planning services;
- the knowledge and attitudes of family planning clients and the larger community, which may affect clients' contraceptive decision-making; and
- the policy environment, which may affect both of the above.

This information serves to assess the process of implementation and the success or failure of programs. They also inform priority-setting exercises and modification of policies and elements of programs where required.

Progress on the implementation of strategies and attainment of objectives needs to be assessed on a regular basis. The NDoH will ensure processes are in place to monitor and evaluate the impact, process, outcomes and responsiveness of the reproductive health system in order to know whether the strategies adopted are producing the expected outcomes and impact.

At each level of the system a set of indicators will be developed with, data collected and analysed on a periodic basis. This monitoring and evaluation will take place at the service delivery level with simple data sets providing information for health workers to plan response service delivery and interventions. Basic data sets will be included in the NHIS routine data gathering system from activity registers of the health posts, health centres and hospitals. At the district and provincial level, data will be gathered to inform district support, including supervision, for service interventions. Further data will be required by PHO and NDOH. These data will be a consolidation of district reporting in conjunction with specific data collection, periodic reviews and ad hoc field research. Central services will use this specific and consolidated data to assess the effectiveness of the overall NRHS and issues that may emerge in the implementation.

Methods to monitor compliance with Policy must be chosen and could include:

- Self assessment (with checklist) and reporting from facility level
- Supportive supervision and follow-up
- Training records including competency levels
- Peer review processes
- NHIS data reports
- Patient and health facility record reviews
- Client and facility surveys
- Community surveys and qualitative research
- Census and Demographic Health Survey data
- Other household level studies
- Operational research
### ANNEX ONE: Glossary

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
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<tr>
<td>Abortion</td>
<td><em>abortion</em> is the termination of pregnancy by the removal or expulsion from the uterus of a fetus or embryo prior to viability. An <em>abortion</em> can occur spontaneously, or can be induced in which case it is usually called a <em>miscarriage</em>, or it can be purposely <em>induced</em>.</td>
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<td>Community health post</td>
<td>CHP are a platform for the delivery of comprehensive primary health care. They operate from a public health model of health and will provide MCH services, public health services and health promotion services for the community. The CHP will be manned by a Public Health Manager, Midwife and a Health Promotion Officer.</td>
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<tr>
<td>Couple Year Protection</td>
<td>CYP is an indicator used to monitor the progress of family planning programs and to estimate family planning coverage. CYP refers to the estimated protection provided by contraceptive methods during a one-year period, based on the volume of all contraceptives sold or dispensed free of charge to clients during that period. In essence, CYP indicates the amount of time a couple will be protected against an unwanted pregnancy based on the contraceptive method used.</td>
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<tr>
<td>Contraceptive Prevalence Rate</td>
<td>Contraceptive prevalence rate is the percentage of women who are practicing, or whose sexual partners are practicing, any form of contraception. It is usually measured for married women ages between 15-49 only.</td>
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<tr>
<td>Total Fertility Rate</td>
<td>Total Fertility Rate is the average number of children that would be born per woman if all women lived to the end of their childbearing years and bore children according to a given fertility rate at each age. The total fertility rate (TFR) is a more direct measure of the level of fertility than the crude birth rate, since it refers to births per woman.</td>
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<tr>
<td>Unmet need</td>
<td>The percent with an unmet need for family planning is the number of women with unmet need for family planning expressed as a percentage of women of reproductive age who are married or in a union. Women with unmet need are those who are fecund and sexually active but are not using any method of contraception, and report not wanting any more children or wanting to delay the birth of their next child.</td>
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Long term methods

Several medicines and devices are now available to provide long-term contraception for women. These options offer from 1 month to 10 years of contraceptive protection, depending on which one is selected.

Long-acting reversible contraception (LARC) are methods of birth control that provide effective contraception for an extended period of time without requiring user action. They include intrauterine devices (IUDs) and subdermal implants. They are the most effective reversible methods of contraception because they do not depend on patient compliance.

Tubal ligation

Tubal ligation or tubectomy (also known as having one's "tubes tied" (ligation)) is a surgical procedure for sterilization in which a woman's fallopian tubes are clamped and blocked, or severed and sealed, either method of which prevents eggs from reaching the uterus for fertilization. Tubal ligation is considered a permanent method of sterilization and birth control.

Vasectomy

Vasectomy is a surgical procedure for male sterilization and/or permanent birth control. During the procedure, the vasa deferentia of a man are severed, and then tied/sealed in a manner such to prevent sperm from entering into the seminal stream (ejaculate). Vasectomies are usually performed in a physician's office or medical clinic.

Competence

Sufficient knowledge, psychomotor, communication and decision-making skills and attitudes to enable the performance of actions and specific tasks to a define level of proficiency.

Equitable

Characterized by equity or fairness; just and right; fair; reasonable: equitable treatment of all citizens.

Births interval

Birth interval is the length of time between two successive live births. Beginning with a live birth, the birth interval can be divided into the period of postpartum amenorrhea, the menstruating interval, and the following period of gestation.

Affordable

Affordable that can be afforded believed to be within one's financial means or affordable for everyone: Inexpensive; reasonably priced, available and accessible. Something that you are financially capable of purchasing or something that is possible for you to accept.

Counselling

refers to a process of interaction, a two way communication between a skilled provider, bounded by a code of ethics and practice, and a client/s. It aims to create awareness of and to facilitate or confirm informed and voluntary sexual and reproductive health decision-making by the client it requires empathy, genuineness and the absence of any moral or personal judgment.

Essential medicine and equipment:

Emergency medical devices are essential for safe and effective prevention, diagnosis, treatment and rehabilitation of illness and disease.
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<tr>
<th>Family Planning:</th>
<th>Family planning allows people to attain their desired number of children and determine the spacing of pregnancies. It is achieved through use of contraceptive methods and the treatment of infertility.</th>
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<tbody>
<tr>
<td>Long term family planning methods</td>
<td>Long-term methods (intrauterine devices, implants and sterilization), usually used to limit childbearing, and short-term methods (pills, condoms, spermicides, injectables, other modern methods and all traditional methods), better suited for women who want to delay but not forfeit having a child.</td>
</tr>
<tr>
<td>Permanent family planning methods</td>
<td>Vasectomy, and tubal ligation. Female sterilization is the most commonly used permanent method of family planning. Though vasectomy, the permanent sterilization method of men is safe, more reliable and easier method, female sterilization is four times commonly performed throughout the world.</td>
</tr>
<tr>
<td>Gender:</td>
<td>the social constructed roles, behaviours, activities and attributes that are considered by a society to be appropriate for its men and women. People are born female or male but learn to be girls or boys who grow into women and men. This learned, socially reinforced, and often legally enforced behaviour delineates gender roles and relationships.</td>
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<tr>
<td>Maternal death:</td>
<td>the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and the site of pregnancy, from any causes related to or aggravated by the pregnancy or its management but not from accidental or incidental causes</td>
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<tr>
<td>Maternal mortality ratio</td>
<td>number of maternal deaths during a given period per 100,000 live births during the same time period.</td>
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<td>Policy:</td>
<td>a written statement used to guide and determine present and future decision about standards of care</td>
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<tr>
<td>SRH care</td>
<td>the provision and access to quality sexual and reproductive health care services including; adolescence health services, family planning, safe motherhood, PPTCT, STI &amp; HIV, cancer screening services for cervical and breast cancer and prostate screening services and gender-based violence.</td>
</tr>
<tr>
<td>Standard of care:</td>
<td>professionally developed detailed written statements used to guide procedures</td>
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<td>Unsafe abortion</td>
<td>An unsafe abortion is the termination of an unwanted pregnancy by persons lacking the necessary skills, or in an environment lacking minimal medical standards or both.</td>
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<tr>
<td>Women of reproductive age</td>
<td>usually refers to all women aged 15-49 years. In PNG we have reported maternal deaths from the age of 12.</td>
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<tr>
<td>Stakeholders</td>
<td>those who may be interested in, potentially affected by, or influence the implementation of the SRH policy. In the context of this policy it applies to human resources for health, development partners, the partner government ministries, NGOs and civil society</td>
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<tr>
<td>Person with disabilities</td>
<td>persons with disabilities have the same sexual and reproductive health (SRH) needs as other people. Yet they often face barriers to information and services including; family planning, maternal health, HIV and AIDS, adolescence, and gender-based violence.</td>
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