SOCIAL SUSTAINABILITY IN PAPUA NEW GUINEA
Social Sustainability in Papua New Guinea

by

Israel Sembajwe

NRI
The National Research Institute
First published in September 2013

Copyright © 2013 The National Research Institute

NRI Discussion Paper No. 131

The NRI is an independent statutory authority established by an Act of Parliament in 1988 and confirmed by the LASER (Amendment) Act 1993. NRI’s main aims are to undertake research into the social, political, economic, educational, legal, environmental, and cultural issues and problems of Papua New Guinea and to formulate practical solutions to these problems. Research results are published in the following NRI publication series:

- Research Reports;
- Discussion Papers;
- Issues Papers;
- Spotlight with NRI; and
- ‘other’ publications including newspaper commentaries, journal articles, chapters in books, books, conference proceedings, bibliographies, indexes and other compendiums.

Direct any inquiries regarding these publications to:

The Publications Sales Coordinator
National Research Institute
P.O. Box 5854
BOROKO, NCD. 111
Papua New Guinea

Tel: (675) 326 0300/326 0061
Fax: (675) 326 0213
E-mail:nri@nri.org.pg
Website: www.nri.org.pg

ISBN 9980 75 203 3
National Library Service of Papua New Guinea

ABCDE 20176543

The opinions expressed in this report are those of the authors and not necessarily those of the National Research Institute.

Cover photo, courtesy of NRI Communications Team
One of the principles of social sustainability is interconnectedness — promoting togetherness — as demonstrated by these NRI children.
CONTENTS

Acronyms iv
Executive Summary v
Introduction 1
Stunting and Wasting 4
Labour Force Participation and Unemployment 4
Illiteracy 5
School Attendance and Grade Completed 5
Sanitation 6
Access to Safe Water 6
Births Attended by Skilled Health Personnel 7
Access to Other Facilities and Services 7
Disease Prevalence 7
Other Social Issues 8
Women 9
The Elderly 10
People with Disabilities 11
Past Policy and Program Development 11
Conclusion 13
Summary of Indicators 13
The Way Forward 14
References 14
<table>
<thead>
<tr>
<th>Acronyms</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>AIDS</td>
<td>Acquired Immune Deficiency Syndrome</td>
</tr>
<tr>
<td>DPT</td>
<td>diphtheria, pertussis and tetanus</td>
</tr>
<tr>
<td>GDP</td>
<td>gross domestic product</td>
</tr>
<tr>
<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
</tr>
<tr>
<td>PNG</td>
<td>Papua New Guinea</td>
</tr>
<tr>
<td>TB</td>
<td>tuberculosis</td>
</tr>
</tbody>
</table>
Executive Summary

When a discussion of social sustainability focuses on community sustainability, a number of elements emerge that provide a simple and clear framework for a definition. Principles of social sustainability include equity, diversity, interconnectedness, quality of life, and democracy and governance. They promote inclusiveness and equal opportunity, building of viable social structures that facilitate good governance and togetherness, empowerment and good quality of life, and transparent institutions that facilitate access to knowledge and justice.

Issues relating to social sustainability in Papua New Guinea (PNG) include poverty, stunting and wasting, labour force participation and unemployment, illiteracy, school attendance and grade level completed, access to sanitation and safe water, immunization, births attended by skilled health personnel, disease prevalence (particularly of HIV/AIDS, malaria and tuberculosis), and issues confronting youth, women, the elderly, and people with disabilities.

Trends in PNG’s social sector since the 1980s sometimes reflect marginal improvement but often reveal stagnation or decline. Analysis of the limited data available suggest that the following indicators could be used to set baseline status for key social issues and measure future progress: the Human Development Index; the Human Poverty Index; per cent of population living on less than US$1.25 a day; labour force participation rate; illiteracy rate; per cent of population that has ever been to school; per cent of population currently attending school; per cent of population completing grade 10; per cent of population completing grade 12; access to improved sanitation; access to safe water, immunization rates; proportion of births attended by skilled health personnel; malaria, tuberculosis, and HIV/AIDS prevalence rates; and existence of policies on youth, gender, ageing, and disabilities.

The government of PNG did not begin to formulate an explicit population policy until the late 1980s. The first National Population Policy (1991–2000) focused on health, education, family planning, migration and urbanization, with reduction of the population growth rate as a central concern. Reflecting changes in the international community’s approach to population issues, the government began in the mid-1990s to take a broader approach to population that involved more attention to social and economic issues such as education, opportunities for women, support for the family and employment. These are reflected in the second National Population Policy (2000–2010), which was accompanied by policies on issues such as education, health and HIV/AIDS to encourage cooperation across sectors and facilitate the mainstreaming of population issues in social policy.

However, to be effective, this will require improvements in institutional capacity. Current constraints include staff turnover, lack of qualified staff and limited data availability. Some key agencies have been downsized or completely eliminated. These constraints, plus a lack of attention to population issues in wider development policies, have severely hampered implementation of population programs.

In the future, PNG’s decision makers should adopt a collaborative approach in formulating, implementing, monitoring and evaluating national development programs in the social, economic and environmental sectors. Increased coordination and efficient management are imperative. These will require institution building and staff capacity building. The key recent planning documents Vision 2050 and the Long-Term Development Plan 2010–2020 provide an ideal foundation for such efforts.
Introduction

Although it may be argued that there is no standard definition of social sustainability, research and discussion reflect that when we focus on community sustainability, a number of elements emerge that provide a simple and clear framework for a definition. In such a framework, important principles of social sustainability are highlighted, including equity, diversity, interconnectedness, quality of life, and democracy and governance (Barron and Gauntlett 2002; see Table 1). These characteristics promote inclusiveness and equal opportunity, social structures that facilitate good governance and togetherness, empowerment and good quality of life, and transparent institutions that facilitate access to knowledge and justice.

This paper will concentrate on a few characteristics that can help identify some minimum indicators of social sustainability in Papua New Guinea (PNG), to provide a baseline for setting future targets and measuring progress. The indicators and targets will be valuable inputs in the process of monitoring and evaluating the country’s progress towards social and overall sustainability. Quality of life indicators will be given preference.

Table 1: Characteristics of socially sustainable communities

<table>
<thead>
<tr>
<th>Principles</th>
<th>Characteristics</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Equity</strong>—the community provides equitable opportunities and outcomes for all its members, particularly the poorest and most vulnerable members of the community.</td>
<td>There is equal opportunity for all members. There is equity for indigenous people. There is equity in relation to human rights. There is equity in relation to disadvantaged members.</td>
</tr>
<tr>
<td><strong>2. Diversity</strong>—the community promotes and encourages diversity.</td>
<td>The community is inclusive of diverse groups. The community values difference.</td>
</tr>
<tr>
<td><strong>3. Interconnectedness</strong>—the community provides processes, systems and structures that promote connectedness within and outside the community at the formal, informal and institutional level.</td>
<td>The quantity of social processes promotes connectedness. The quality of social processes promotes connectedness. The structures governing social processes promote connectedness. Public and civic institutions promote connectedness. Community services promote connectedness. Planning and physical infrastructure promote connectedness. Media and communications promote connectedness. Recreation and sports promote connectedness. Transport promotes connectedness.</td>
</tr>
</tbody>
</table>
Table 1 (Cont’d)

<table>
<thead>
<tr>
<th>4. Quality of life—the community ensures that basic needs are met and fosters a good quality of life for all members at the individual, group and community level.</th>
<th>Community members have a sense of belonging. Community members have a sense of place. Community members have a sense of self-worth. Community members have a sense of safety. Community members have a sense of connection with nature. Community members have a sense of empowerment and responsibility. Community members have a sense of self-reliance. Community members have a good quality of life in relation to education. Community members have a good quality of life in relation to health. Community members have a good quality of life in relation to employment. Community members have a good quality of life in relation to income and standard of living. Community members have a good quality of life in relation to housing. Community members have a good quality of life in relation to clean air, soil and water. Community members have opportunities for personal and social development.</th>
</tr>
</thead>
<tbody>
<tr>
<td>5. Democracy and governance—the community provides democratic processes and open and accountable governance structures.</td>
<td>Community members have access to information, knowledge and expertise. Participation processes are open and accountable. Democratic processes and governance structures are effective. There is integrity of democratic processes and governance structures. Democratic processes and governance structures are accountable. Democratic processes and governance structures incorporate justice and legal rights.</td>
</tr>
</tbody>
</table>


Barron and Gauntlett (2002:ix) argued that social interactions affect what happens in the economic and environmental sectors, and promote social and overall sustainability. Consequently, equitable social values (including diversity and interconnectedness) potentially lead to good “sustainable economic and environmental relations” and reduce, or eliminate altogether, “unjust, competitive and divisive social principles which allow one group alone to set the agenda” (ibid:ix). Socially sustainable communities have substantial economic and environmental ingredients, especially those representing quality of life and interconnectedness.

Beginning from this platform, this paper reviews trends in social sustainability indicators. The focus is on the social issues of poverty, stunting and wasting, labour force participation and unemployment, illiteracy, school attendance and grade level completed, access to sanitation and safe water, immunization, births attended by skilled health personnel, access to
other facilities and services, disease prevalence (HIV/AIDS,1 malaria and tuberculosis [TB]), youth, women, the elderly, and people with disabilities. Indicators are suggested that can easily be measured to establish a baseline against which future progress can be measured.

Poverty

Poverty is a constant threat to the welfare of people in developing countries. It is well recognized by the international community as a key factor constraining the development potential of a large proportion of the global population. This is illustrated by the weight the international community put on poverty reduction when it was identified as the first of the Millennium Development Goals (UN 2000).

There are inadequate data to assess the true status of poverty in each nation. Therefore, discussions of poverty must be based on proxy poverty indicators. For example, the Human Development Report (UNDP 2009), produced annually by the United Nations Development Programme, ranks countries using the Human Development Index, which measures life expectancy, adult literacy, gross enrolment, and GDP (gross domestic product) per capita. The higher a country’s exposure to poverty, the lower its index value.

In 2007, PNG, which received a rank near the middle of the index, was almost at the bottom among countries in the Pacific for which data were available, such as Fiji and Vanuatu. Worldwide rankings ranged from a high of 0.971 for Norway to a low of 0.340 for Niger (UNDP 2009:169). PNG, with an index of 0.541, was ranked 148th out of 182 nations—two places lower than in 2006, when it was ranked 146th. This suggests that despite its relatively favourable GDP ranking (which places it in the lower echelon of middle-income countries), the country has not invested adequately in human development programs and faces the risk of gradually sliding down to join the group of low-income countries.

Another measure, the Human Poverty Index, measures the probability of not surviving to age 40, adult illiteracy, the proportion of the population not using an improved water source, and the proportion of children who are underweight for their age. This index yielded a score of 39.6 per cent and a rank of 121 for PNG in 2007, again the worst in the Pacific for countries with data available (UNDP 2009:178). The probability of not surviving to age 40 was 15.9 per cent; adult illiteracy was 42.2 per cent; 60 per cent of the population were not using an improved water source; 35 per cent of children were underweight for their age; and 35.8 and 57.4 per cent of the population were below the poverty levels of US$1.25 and US$2 respectively. These indicators underscore the need for broadened and deepened human development programs in PNG. Given these levels of poverty, the Millennium Development Goal of halving the prevalence of poverty by 2015 will be difficult to meet.

In 1996, Gibson and Rozelle (2001:26) produced a head count poverty index of 30.2 for PNG. A comparison of this with later data suggests that poverty in PNG remained constant or worsened somewhat between 1996 and 2007. It was less prevalent in urban areas (11.4) than in rural areas (33.5), and was highest in Momase and the northeast of the country (38.8) and lowest in the National Capital District (16.3) (ibid:26).

As the quote in Box 1 shows, rural areas experienced and still experience deeper poverty than urban areas. Rural areas are always at a disadvantage in any development paradigm, 

---

1 Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome.
especially in situations of unbalanced planning and implementation of development programs.

**Box 1. Poverty in rural areas**

“Our results show that poverty in Papua New Guinea is primarily rural and is associated with those in communities with poor access to services, markets, and transportation. Our simulations illustrate that improving access to schools leads to high declines in poverty.”

Gibson and Rozelle 2001:1

**Stunting and Wasting**

Infants and children are especially vulnerable to malnutrition and under-nutrition. It weakens their immune system and makes them susceptible to illnesses that may sometimes result in death. This is a major contributing factor to infant and child mortality.

Data on malnutrition and under-nutrition have been collected in PNG during National Nutrition Surveys. The last such survey was conducted in 1982–83 (Heywood, Singleton, and Ross 1988). Up-to-date national data on nutritional status are not available. Based on the old data, Hanson et al. (2001:13) pointed out that in 1982–83, serious malnutrition existed in 19 of 86 districts in terms of both weight for age (wasting) and height for age (stunting). At the upper end, in districts such as Ambunti-Drekikir (East Sepik), Usino-Bundi (Madang), and Kabwum and Menyamya (Morobe), at least 70 per cent of children were stunted; while at the lower end, in districts such as Ramu (Madang) and Middle Fly (Western), at least 15 per cent of children were stunted.

Over 10 years later (1996–98), in a limited number of rural communities, it was observed that there was no improvement; in fact, the proportion of malnutrition had increased (*ibid*:323–26). Hanson et al. (2001) stated that high levels of malnutrition in the country were complex in origin and not just a matter of inadequate food supply, suggesting that these health challenges required careful study and analysis. Both inadequate food supplies and lack of knowledge about using available supplies in a balanced manner contribute substantially to malnutrition.

**Labour Force Participation and Unemployment**

Low labour force participation rates and high unemployment and underemployment rates exacerbate poverty and increase the dependence of those who don’t work on the few who do.

A young age structure and a high rate of population growth, which are primarily the consequence of high fertility rates, lead to increasing numbers of youth entering the working age. This creates a major challenge for workforce planning because the economy is not expanding quickly enough to accommodate a rapidly growing number of new entries to the labour market as well as those who are already unemployed or underemployed.

In the analysis of the 2000 Census, the National Statistical Office showed that labour force participation rates for the population aged 10 years and over were 63.8, 68.8 and 67.5 per cent in 1980, 1990 and 2000 respectively for the country as a whole (NSO 2003:54). The rates were 65.5, 76.7 and 68.4 per cent for males and 62.0, 60.1 and 66.7 per cent for females
(ibid:54). Discounting the fluctuations, males had marginally higher participation rates than females, and changes over time were small and inconsistent.

Unemployment rates were 2.9, 7.7 and 2.8 per cent in 1980, 1990 and 2000 respectively for the whole country, 3.9, 9.1 and 4.3 per cent for males, and 1.7, 5.9 and 1.3 per cent for females (ibid:54). The reason for the spike in unemployment in 1990, especially for males, is not known.

As expected, labour participation rates for the same points in time were higher in rural than urban areas: 66.0, 71.1 and 70.4 per cent in rural areas, and 48.0, 56.2 and 48.4 in urban areas. This is attributed to the availability of subsistence employment in agriculture in rural areas as opposed to the limited nature of both wage and subsistence employment in urban areas. Females are generally dominant in subsistence activities, while males dominate in jobs for wages.

Illiteracy

Illiteracy rates indicate the proportion of citizens unable to acquire and utilize information through reading and writing. It is normally assessed as a percentage of people 10 years and older who are unable to read and write. This percentage was assessed to be 42.2 per cent for PNG in 2007 (UNDP 2009), a marginal improvement over the 44 per cent recorded in 2000 by the census (NSO 2003:52). The rates were higher for females than for males (38 per cent for females compared to 20 for males in urban areas, and 70 per cent for females compared to 60 per cent for males in rural areas).

On a regional level, Gibson and Rozelle (2001:27) reported illiteracy rates ranging from 22 per cent in the New Guinea Islands to 65 per cent in the Highlands in 1996. This suggests that all rural areas are not at the same level of disadvantage.

School Attendance and Grade Completed

The system of education in PNG is going through a number of changes. For example, it is changing from putting emphasis on universal primary education (which used to be 6 years) to emphasising basic education (which is expected to cover 8 years) and reorganising the number of years spent at different levels of education (elementary, primary, secondary and tertiary). For more details, see the paper on education by Patricia Paraide (forthcoming).

Consequently, information on the different levels of education is disjointed and disorganized. Therefore, this analysis uses information from the censuses on school attendance and grade completion. School attendance focuses on the population aged 5 to 29 years, and the population that has been to school or completed a specified grade is taken from those aged 5 years and over.

The percentage of the population attending school in 1980 was 20.6 for both sexes, 23.1 for males and 17.8 for females (NSO 2003:42). Corresponding percentages were 20.3, 21.9 and 18.4 for 1990 and 26.4, 28.1 and 24.7 for 2000. What is consistent in all these series is the persistent disadvantage for girls in access to education. It would therefore be interesting to know to what extent PNG has progressed in closing the gender gap and promoting girls’ rights since it adopted the Millennium Development Goals (UN 2000).
Information on having ever been to school and grade completed reflects the same disadvantages for girls. For example, in 2000, the percentages having ever been to school were 50.9 for both sexes, 55.4 for males and 46.2 for females (NSO 2003:42). The corresponding percentages for those who completed Grade 10 were 17.7, 20.0 and 14.8; for Grade 12, they were 2.4, 3.2 and 1.4. In all cases, the percentages were higher in urban than rural areas; this is to be expected due to the greater existence of school facilities and services in urban areas.

Sanitation

The percentage of the population with access to improved sanitation for PNG as a whole remained constant at 44 per cent in 1990, 1995 and 2000, with just a slight increase to 45 per cent in 2006. Within the same period, the rates remained constant at 41 per cent in rural areas and 67 per cent in urban areas (UNESCAP 2009a:77). These rates were among the lowest in the Pacific region, with only Kiribati, Micronesia FS and Solomon Islands recording lower rates than PNG.

As expected, urban areas enjoy better sanitation than rural areas.

Access to Safe Water

PNG has experienced stagnation in regards to access to safe water as well. Overall, the rates were constant at 39 per cent in 1990, 1995 and 2000, with a slight increase to 40 per cent in 2006. They were constant at 32 per cent for rural areas and 68 per cent for urban areas (UNESCAP 2009a: 76). Overall for the Pacific region, the population with access to improved drinking water increased from 74 per cent in 1990 to 88 per cent in 2006 (ibid:73).

As expected, access to safe water was more widespread in urban areas than in rural areas.

Immunization

Closely related to the weight-for-age indicator for children is the relative effort the government of PNG has made to immunize its children, especially those under one year old. Rates for immunization against measles, for example, were 67, 42, 62, 60, and 58 per cent respectively in 1990, 1995, 2000, 2005 and 2007 (UNESCAP 2009a:28). These low immunization rates did not improve over time; if anything, they declined. PNG recorded the lowest rates within the Pacific region, with regional neighbours recording rates in the range of 63 per cent (Vanuatu) to 99 per cent (Federated States of Micronesia) in 2007 (ibid: 28). In the case of the DPT3 vaccine, PNG recorded rates of 68, 62, 59, 61 and 60 per cent in 1990, 1995, 2000, 2005 and 2007, again the lowest in the region, with other countries recording rates of 71 to 99 per cent (ibid:28). This is a further demonstration of possible social deprivation in PNG, especially in rural areas, and the stagnation or deterioration of service delivery in general.

Full immunization (BCG, DPT, hepatitis and measles) was 38.7 per cent in 1996 and 52.1 in 2006 (NSO 1997:106; NSO 2009:124). At both points in time the rate was highest in the Southern region and lowest in the Highlands or Mamose, and in urban than in rural areas. As

---

2 DPT3 involves three doses of a vaccine against diphtheria, pertussis and tetanus. It is commonly used as a measure of the availability of health services.
expected, the rates were highest for children whose mothers had a grade seven or more education, and lowest for those whose mothers had no education at all.

**Births Attended by Skilled Health Personnel**

Another indicator of provision of services is the proportion of births attended by skilled health personnel. For PNG, the proportion was 53 per cent in 1996 and 41 per cent in 2000 (UNESCAP 2009a:32)—another picture of stagnation and deterioration. PNG was again at the bottom of the list in the Pacific region, with other countries recording rates from 85 to 100 per cent (*ibid:*32). In addition, according to the PNG Demographic Health Survey (NSO 1997:103; NSO 2009:122), the percentage of births attended by a doctor, nurse or trained midwife was 51.3 in 1996 compared to 53.0 in 2006. Comparing the rates from all sources over time reveals that there was at least some improvement in this area, although it was minimal.

**Access to Other Facilities and Services**

In 1996, Gibson and Rozelle (2001:28) observed that in the majority of regions, most people had to travel on average at least an hour to essential services and infrastructure elements such as aid posts, schools and transportation points (roads, airports and boat docks). The New Guinea Islands, as is frequently the case, were better off than other regions (see Table 2). Improvement of infrastructure, communication and delivery of various services (including health and education) remains a major cornerstone of the country’s progress, not only in the social sector, but in all sectors that affect human welfare.

**Table 2: Travel times (in minutes) to nearest roads, schools, and health services in rural PNG, 1996**

<table>
<thead>
<tr>
<th></th>
<th>Road</th>
<th>Transportation pointa</th>
<th>Aid postb</th>
<th>Community or elementary school</th>
<th>High school</th>
</tr>
</thead>
<tbody>
<tr>
<td>Papua/South Coast</td>
<td>93</td>
<td>57</td>
<td>67</td>
<td>75</td>
<td>213</td>
</tr>
<tr>
<td>Highlands</td>
<td>254</td>
<td>53</td>
<td>66</td>
<td>58</td>
<td>134</td>
</tr>
<tr>
<td>Momase/North Coast</td>
<td>95</td>
<td>76</td>
<td>76</td>
<td>70</td>
<td>297</td>
</tr>
<tr>
<td>New Guinea Islands</td>
<td>67</td>
<td>21</td>
<td>28</td>
<td>19</td>
<td>98</td>
</tr>
</tbody>
</table>


a Road, airport, or dock.

b Includes stations and clinics.

**Disease Prevalence**

Malaria is endemic in PNG as in most tropical and subtropical regions of the world (especially in Africa, Asia and the Pacific, and Latin America and the Caribbean). The upper range of the prevalence rate is estimated to have been 41 per cent in both 2005 and 2009 (Pantumari, forthcoming). This reflects a stagnant situation which requires concerted effort to change for the better.
In recent years, malaria prevention campaigns, in particular the promotion of treated mosquito nets, have increased the awareness of the population on the need for and availability of preventive measures. In 2006, 51 per cent of households had mosquito nets, and 32.9 per cent had treated mosquito nets (NSO 2009:28). Usage was higher in urban areas (62.5 per cent) than in rural areas (49.6 per cent), with the highest usage recorded in the Islands, and the lowest (18.8 per cent) in the Highlands. The low rate for the Highlands may be partly explained by the fact that until recently, higher-altitude areas were free from mosquito infestation. But as global warming increases, the mosquito is extending its range to higher altitudes.

The TB prevalence rate for 2007 was recorded as very high at 475 per 1000 (ibid). Scarcity of data limits the presentation of prevalence trends. But the cited rate clearly shows that the rates are likely to grow even higher and TB is likely to continue to be a major burden for the country unless a serious effort is made to prevent its spread, increase its early detection, and provide universal access to its treatment.

HIV and AIDS present a development challenge to PNG, affecting the welfare of its citizens and generating constraints in all areas of sustainable development. The number of HIV/AIDS cases in the general population was estimated at 98 757 in 2009, leading to a prevalence rate of 2.56 per cent (ibid). The rate is expected to increase to 5.07 per cent in 2012 if no concerted effort is made to prevent the disease from spreading (ibid). In 2006, the national prevalence rate was reported to be 1.61 per cent (IPPF 2006). However, in contrast to the national projection and estimation report, the 2008 annual surveillance report gave a prevalence rate of 0.8 per cent for the year (ibid). But whatever the exact prevalence rate of HIV/AIDS may be in the country, it is clear that the disease, together with TB and malaria, affects the development process and worsens poverty.

Nevertheless, as a result of intensified campaigns and programs about HIV/AIDS, knowledge about the disease is increasing. While it was 64.6 per cent among women included in the 1996 PNG Demographic Health Survey, it had risen to 87.2 per cent among the same group in 2006 (NSO 1997:119; NSO 2009:145). It was highest for women with grade seven or more education and lowest for those with no education; it was higher in urban areas. Overall, however, this knowledge is yet to be translated into reductions in infections and prevalence rates.

Other Social Issues

In dealing with a wide range of social issues that affect the population, care should be taken to focus on excluded groups so that plans for inclusion can be made. Groups that are often excluded or neglected include youth; the elderly; women; and people who are disabled or physically challenged. In PNG there is a strong belief that the wantok system (the traditional social network that takes care of the needs of members of the extended family) is still working. But in reality, it has been weakened by the changes in the traditional system necessitated by contact with other cultures from in and outside PNG, especially through education, urbanization, participation in the global economy, and migration. The changing economic environment increasingly forces families to give members of the nuclear family priority over those of the extended family.

Another social issue is the position given to women in social, economic and political settings. Women usually have less access to resources, services and decision-making opportunities.
They are subjected to a high degree of violence and bear an unfair share of subsistence agriculture and household chores.

The youth, women, elderly people, and people with disabilities deserve further discussion in the context of PNG's social sustainability.

Youth

Youths and children form the largest segment of populations in developing countries (over 60 per cent of the population under 35 years of age). They are the country's most promising human resource because they are the prospective leaders, thinkers and workers of subsequent generations. Yet because of the high demand on services like education and health in overburdened development systems, youth often suffer a high degree of exclusion from accessing these services. They face the same unfavourable environment when they seek employment and meaningful sources of livelihood.

In a search for better opportunities, young people form a large proportion of the migrant population, especially in urban areas. Due to overburdened systems, their expectations are usually not met when they arrive at their destination. Consequently, they fall victim to a variety of vices such as crime, drugs, alcohol, sex, and unwanted pregnancies. They become extremely susceptible to HIV and AIDS as well as violence. In this way, tomorrow's community and national leaders are becoming a frustrated and lost generation.

Yet in many countries affected by HIV and AIDS, young people are at the forefront of the revolution of behavioural change as they increasingly move from early and irresponsible sex to sex later in life, to fewer partners, use of condoms, lower pregnancy rates, and greater knowledge of reproductive and sexual health and awareness of sexually transmitted diseases. These outcomes are the fruit of adolescent and youth reproductive and health programs; information, education and communication programs; and government policies that promote the rights of adolescents and youth, such as equal access to education by girls.

Some of these elements were incorporated into past population and development programs. But it is difficult to determine how effectively they were implemented due to lack of data.

Women

Women are the pillars of families, communities and entire nations. They nourish us inside their bodies, take care of us in our infancy and childhood and give wonderful companionship in our adult life. That is why such sayings as "educate a man and educate an individual, but educate a woman and educate a community" find value and relevance in today's world. Thus it is particularly tragic when we fail to respect and honour our grandmothers, mothers, aunts, sisters, wives and daughters and subject them to violence in our homes and workplaces, deny them access to decision-making and leadership positions, and provide limited services to them.

In PNG, women's low status in society is widely acknowledged. This prevents women from making decisions about their health, accessing care and enjoying equal development opportunities such as education, employment and access to credit (NDOH 2009). As a result, they are exposed to higher risks of maternal mortality, and physical insecurity in the form of gender-based violence, including rape (Siebert 2009).
Nevertheless, there is a growing awareness in the country that women should be given access to decision-making as, for example, reflected by the proposal for a bill for reserved seats for women in parliament; the promotion of gender balance in institutions; the increasing condemnation of violence against women in the media; the call for increased opportunities to access employment and income by women; and the recognition of women’s special reproductive health care needs. In the past, PNG joined the rest of the international community to ratify the Convention on the Elimination of All Forms of Discrimination against Women (see UN 1979). But the recent Beijing +15 review revealed the persistence of high rates of violence against women in the Pacific (including PNG), low proportions of women at all levels of decision-making, and significant under-representation of women in the formal sector (UNESCAP 2009b; Asian NGO Forum 2009; Siebert 2009).

The Elderly

The elderly population of PNG is increasing. For example, the proportion of people aged 65 years and over was recorded as 1.6 per cent (1.6 for males and 1.5 for females) in 1980, 2.4 per cent (2.6 for males and 2.1 for females) in 1990, and 2.4 per cent (2.6 for males and 2.2 for females) in 2000. This implies that the degree of needs of elderly people in the country is also increasing, which requires the government to formulate and implement policies and programs to address them. In particular, with increasing poverty and the spread of diseases such as HIV/AIDS, the elderly are increasingly taking on responsibility for the care of children and grandchildren and sometimes frail spouses (for example, elderly women looking after their elderly husbands). This is especially true in urban areas, where social networks such as the wantok system are increasingly being weakened by modern behavioural habits, economic pressures, cultural mixing, and loose social relations.

This section examines the extent to which the government of PNG has (1) tried to raise awareness among policy-makers and planners on aging and the needs of the elderly and (2) formulated and adopted policies and programs targeted at meeting their needs. PNG, as a member of the United Nations, which passed General Assembly Resolution 58/134, adopted the Madrid Plan of Action on Aging and is committed to addressing aging in all development policies and setting policy priorities for meeting the needs of the elderly (UN 2002). It has a responsibility to achieve a society for all age groups, among other things by promoting sustainable livelihoods for the elderly. It should mainstream aging issues in areas such as (1) data collection and analysis; (2) awareness raising, advocacy and education; (3) identification of performance indicators; (4) inclusion of aging in the social budget; (5) evaluation of laws, including mainstreaming of gender concerns into new legislation and policies; and (6) promotion of national coordination and international cooperation (Venne 2004; UN 2008).

National data collection on population and housing record adequate details on each member of the household. Hence, the aged population is generally identified and changes in its size can be tracked. However, when it comes to other areas like policies and programs, PNG has fallen behind. This is most likely due to the belief that in PNG elders are cared for by their children or other immediate relatives through the wantok system, which influences the government to argue that it is unnecessary to adopt policies and programs in support of the elderly, or to allocate scarce national resources for their care. Yet the reality, supported by

---

3 Beijing +15 refers to the evaluation of the implementation of the Beijing Platform for Action after 15 years. The Platform for Action was one of the outcomes of the Fourth World Conference on Women, held in Beijing in 1995.
Social Sustainability in Papua New Guinea  

Evidence from many other developing nations, is that intergenerational support for the elderly has broken down, leading to difficult living conditions for the aged population, and indicating that the need for official government support for the elderly exists and is growing (Sykes 2006). Migration, changing family structures, hunger and disease are some of the factors contributing to this change. Overall declining family resources force people to spend their limited resources on their children rather than on the elderly, and in broken family structures the norms for regulating intergenerational exchanges break down.

Thus, the needs of the elderly and the need for government interventions to support them are only expected to increase in PNG. The burden on the elderly is likely to increase as time passes due to the growing population, increasing mortality among working-age adults as a result of HIV/AIDS, the increasing disintegration of traditional family structures, and the increasing role of the elderly in family support and care-giving, especially in taking care of orphaned grandchildren, sick children and frail spouses.

People with Disabilities

PNG recognizes the existence and needs of people living with physical and other challenges or disabilities. This recognition is demonstrated by the vibrant National Board for People with Disabilities, which mobilizes civil society and lobbies the legislature to promote development policies and programs that take into account the needs of the disabled for inclusiveness in decision making as well as access to user-friendly facilities and services.

Despite this recognition of their needs, the government has yet to adopt policies that give disabled people access to decision-making processes such as representation in parliament, or to user-friendly facilities and services, especially in health and education. The limited services provided to disabled people in the country include those provided by Cheshire Disability Services of PNG, the Red Cross, Special Education, and St. John Blind Centre.

There is no national database that can be relied upon to inform policy and program formulation, implementation, and monitoring and evaluation. This suggests the need for national data collection exercises, such as the census and specialized surveys, to include enough questions to provide data for at least one or two indicators on disability. The availability of data will facilitate meaningful planning for the entire population, including people with disabilities; more meaningful drafting of strategies to, among other things, reduce inequality and eradicate poverty; and the tapping of the different abilities and potentials of people living with disabilities.

Past Policy and Program Development

Until the late 1980s it was assumed in PNG that if you take care of economic development, population needs would automatically be accommodated. It was not until then that the government recognized the need for an explicit population policy. The Expert Committee on Population Policy was set up in 1987 and became the National Advisory Committee on Population Policy later the same year. It was tasked with preparing for and formulating the first National Population Policy, which was adopted in 1991 to last until 2000. The policy focused mainly on health, education, family planning, migration and urbanization. The reduction of the population growth rate became a central concern, leading to projects on population and family planning, a national demographic survey with emphasis on family
planning and related reproductive issues, integration of population factors into development planning, and workforce planning and development.\(^4\)

With the International Conference on Population and Development and its Program of Action in 1994, the government began to embrace a broader range of population, social and economic issues. This expanded the range of operational areas from traditional population and demographic factors (fertility, mortality, migration, and population growth rates) to additional areas such as education, opportunities for women, support for the family, and employment. These are the main ingredients of the second National Population Policy, 2000–2010.

The institutional framework for addressing population issues also continued to evolve. Apart from the National Advisory Committee on Population Policy, set up in 1987, the adoption of the first National Population Policy (1991–2000) was accompanied by the establishment in the same year of a National Population Council as the highest body dealing with population policy and programs and coordination of national population activities; a Population Planning Unit to serve as a secretariat to the National Population Council; a Technical Advisory Committee to provide technical advisory services to the National Population Council; and, at a later date, a Population and Human Resources Branch in the Department of National Planning.

The second National Population Policy (2000–2010) was accompanied by sectoral policies on such areas as education, health, and HIV/AIDS to ensure that there was inter-sectoral cross-fertilization in program formulation and implementation to facilitate the mainstreaming of population issues in social policy. But this was to depend on available institutional capacity, especially in human resources, to ensure the effective implementation, monitoring and evaluation of any program.

Did this happen? The immediate answer seems to be: no. For example, in 2001, the government stated a number of constraints that confounded the implementation of the first national population policy (GoPNG 2001:6–7). These included lack of trained staff, frequent staff turnover, and limited data availability. Some of the institutions that were set up earlier were downsized or completely eliminated. This was the fate of the Population and Human Resources Branch, which was disbanded in 2000 as a victim of one of the Structural Adjustment Programs. These constraints created management shortcomings and significant shortfalls in the implementation of planned activities.

While these constraints were perpetuated in the 2000–2010 period, the situation was compounded by lack of a comprehensive approach that coordinates population policies, health and family planning programs, and other priority programs with wider national development policies. As in the past, much reliance was put on the National Department of Health to implement components of the population policy related to maternal and child health, without much coordination with other sectors such as education and community development. In addition, there was limited effort to advocate for and create awareness of population issues among the national leadership (including those in civil society and religious

\(^4\) These activities were financed by the Government of Papua New Guinea in collaboration with development partners, including Asian Development Bank, AusAID (the Australian Government Overseas Aid Program), the International Labour Organization, United Nations Development Programme, United Nations Population Fund and World Bank.
organizations), resulting in lack of integration of population issues in overarching national strategies and plans. It is therefore not surprising that most of the indicators reviewed in this paper remained stagnant or deteriorated.

But with the dawn of new development strategies such as Vision 2050, and plans like the Long-Term Development Plan 2010–2020, a new environment for future development has been created.

Conclusion

Marginal improvements have been made in PNG’s social sector since the 1980s. But in the majority of cases, available information reveals stagnation and even decline. In addition, available information is dated and often forces the analysis of trends to fall back on estimates made by international organizations. But despite these constraints, it is possible to identify some indicators that can be used to set baseline indicators for current status on a number of social issues. This will facilitate the measuring of future progress.

Summary of Indicators

Based on the discussion carried out in this paper, the suggested indicators and their values are as follows:

1. PNG’s Human Development Index was 0.541 in 2007, giving it a rank of 148 out of 182 nations.
2. PNG’s Human Poverty Index was 39.6 per cent in 2007, giving it a rank of 121.
3. In 2007, 35.8 per cent of the population lived on less than US$1.25 a day.
4. The labour force participation rate in the population aged 10 years and over was 67.5 per cent for both sexes, 68.4 per cent for males and 66.7 per cent for females in 2000.
5. The illiteracy rate was 42.2 per cent of the population aged 10 years and over in 2000.
6. The proportion of the population aged five years and over that had ever been to school was 50.9 per cent for both sexes, 55.4 per cent for males and 46.2 per cent for females in 2000.
7. The proportion of the population aged 5 to 29 years attending school in 2000 was 26.4 per cent overall, 28.1 per cent for males and 24.7 per cent for females.
8. The proportion of the population aged five and over that had completed Grade 10 in 2000 was 17.7 per cent overall, 20.0 per cent for males and 14.8 per cent for females.
9. The proportion of the population aged five years and over that had completed Grade 12 in 2000 was 2.4 per cent for both sexes, 3.2 per cent for males and 1.4 per cent for females.
10. In 2006, 45 per cent of the population had access to improved sanitation.
11. In 2006, 40 per cent of the population had access to safe water.
12. In 2007, the immunization rate was 58 per cent for measles and 60 per cent for DPT.
13. In 2006, the rate for full immunization was 56 per cent. This is the percentage of children given BCG, DPT, and measles vaccination before 12 months of age.
14. In 2006, 53 per cent of births were attended by skilled health personnel.
15. The malaria prevalence rate was 41 per cent in 2009.
18. Policy on ageing: As of 2010, there was no policy on ageing.
19. Policy on disabilities: The PNG Policy on Disability was established in 2009.
The Way Forward

PNG should increase the coordination of national sectoral policies and adopt a collaborative program approach in formulating, implementing, monitoring and evaluating all national development programs in the social, economic and environmental sectors. Intensified coordination and efficient program management are imperative. This will require institution building and capacity building, particularly in the area of human resources.

Integration of approaches in each of the pillars makes it easier to think and act in a holistic manner when it comes to coordination and harmonization of policies and programs touching on a wide range of sustainable development issues. The timely dissemination of Vision 2050 and the Long-Term Development Plan 2010–2020 provide an ideal platform from which to intensify integrated policy making and program formulation, implementation, and monitoring and evaluation.

References


