

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

**Russel Kitau**

PhD Student, Division of Public Health  
School of Medicine and Health Sciences, University of Papua New Guinea  
Port Moresby, P.O. Box- 5623, NCD, Papua New Guinea  
E-mail: rkitau25@gmail.com

(Received: 30-9-14 / Accepted: 15-1-15)

## **Abstract**

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

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

## **Background**

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

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

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

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

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

## Methods

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

PNG is an ethnically and culturally diverse country, with more than one thousand tribes and 848 known languages/dialects being spoken. Each tribe or language group was highly independent, with little sense of national identity. Decades of colonial rule over disparate groups culminated in an independent PNG nation in 1975. As PNG celebrates its 40<sup>th</sup> anniversary of independence in 2015, which incidentally coincides with the end of the MDGs, it must reflect on and learn from the past in striving towards achieving gender equality.

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

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

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

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

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

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

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

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

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

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

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

## **Results**

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

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

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

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

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

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

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

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

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

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

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

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

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

**(1) Policy 1:** Integration of gender in NDH programs (p 9). A total of 4 strategies and 16 activities are listed and described to help in developing a focus on gender-based violence and implementing gender sensitive activities. The 4 strategies are: (1) Increase awareness of the links between human rights (eg. reproductive rights) and gender and awareness of the importance of gender-sensitive health programming for improved health outcomes among policymakers, providers and beneficiaries; (2) NDH programs are reviewed and revised to include a gender perspective; (3) NDH shall work with the health sector stakeholders to ensure that programs implement gender-sensitive activities according to health area program plans reviewed under SO 3.3.1.2; and (4) All health sector program stakeholders' project budgets include funds to explicitly address gender issues.

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

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

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

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

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

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

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

## **Discussion and Conclusion**

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

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

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

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

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

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

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

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

### **List of Abbreviations:**

<b>AIDS</b>	-	Acquired Immune Deficiency Syndrome
<b>GBV</b>	-	Gender – Based Violence
<b>GESIP</b>	-	Gender Equity and Social Inclusion Policy 2013 (GESIP)
<b>GoPNG</b>	-	Government of Papua New Guinea
<b>HIV</b>	-	Human Immune Virus
<b>MDG</b>	-	Millennium Development Goal
<b>NACS</b>	-	National AIDS Council Secretariat

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

## Acknowledgements

The author acknowledges the support and contribution from Professor Komla Tsey, Cairns Institute, James Cook University for his guidance and assistance in reviewing this manuscript. A very special acknowledgement goes to James Cook University for providing scholarship and allowing the author to use its' study facility at the Cairns Institute under the MOU Co-tutelle arrangement between JCU and UPNG. Without this arrangement this would not have been possible.

## References

- [1] Global and regional estimates of violence against women: Prevalence and health effects of intimate partner violence and non-partner sexual violence, Geneva, (2013b), Accessed on 28 March (2014), [http://apps.who.int/iris/bitstream/10665/85239/1/9789241564625\\_eng.pdf](http://apps.who.int/iris/bitstream/10665/85239/1/9789241564625_eng.pdf).
- [2] AusAID, HIV/AIDS in Papua New Guinea, (2011), Retrieved 10 October (2011) from <http://www.ausaid.gov.au/country/png/hivaids.cfm>.
- [3] C. Bradley and J. Kesno, Family and sexual violence in Papua New Guinea: An integrated long-term strategy, *Discussion Paper No. 84*, (2001), Port Moresby: Institute of National Affairs.
- [4] C. Bradley, Strengthening a gendered approach to HIV/AIDS in Papua New Guinea: Some issues for donors and development partners, *National HIV/AIDS Support Project (Unpublished Report)*, (2006).
- [5] C. Bradley, Capacity building in counselling on gender-based violence, *Papua New Guinea – Australia HIV & AIDS Program (Unpublished Report)*, (2009).
- [6] C. Bradley, Discussion notes on addressing violence against women and HIV and AIDS, with examples from Papua New Guinea, *Paper Prepared for UN Women's Expert Group Meeting on National Action Plans on Violence against Women*, (2010), Retrieved from <http://www.un.org/womenwatch/daw/vaw/v-egms-nap2010.htm>.
- [7] Country Assessment Report 2011-2012, World Bank, Port Moresby, (2011).
- [8] D. de Silva, Spreading improvement ideas: Tips from empirical research, (2014), Retrieved from: <http://www.health.org.uk/publications/spreading-improvement-ideas/>.
- [9] National Department of Health, *Health Sector Gender Policy, National Health Board*, (2013), Port Moresby, Papua New Guinea (In Draft).
- [10] Gender Equity and Social Inclusion Policy, Department of Personnel Management, Port Moresby, (2013), Retrieved from: <http://www.epsp.os-dev.com.au/our-activities/monitoring-and-evaluation.php>.

- [11] UN Millennium Project, *Investing in Development: A Practical Plan to Achieve the Millennium Development Goals*, (2005), New York, America. Retrieved from: <http://www.unmillenniumproject.org/documents/MainReportComplete-lowres.pdf>.
- [12] Papua New Guinea National HIV and AIDS Strategy 2011-2015, Implementation Framework, National AIDS Council, Port Moresby, PNG, Retrieved from: [http://www.adi.org.au/wp\\_content/uploads/2013/07/2010\\_AidsCouncilPNG\\_NatHIV\\_AIDSStrategy.implementation.pdf](http://www.adi.org.au/wp_content/uploads/2013/07/2010_AidsCouncilPNG_NatHIV_AIDSStrategy.implementation.pdf).
- [13] PNG Development Strategic Plan 2012-2030, Department of the National Planning & Implementation, Port Moresby, PNG, (2012).
- [14] PNG Country Gender Assessment 2011-2012, Department for Community Development, Port Moresby, PNG, (2012).
- [15] PNG Vision 2050, Department of Prime Minister, Port Moresby, PNG, (2001).
- [16] PNG Country Report by AusAID, launched 24 November (2008), Port Moresby, PNG.
- [17] Public Service Management Act, Department of Personnel Management, Port Moresby, PNG, (2013).