Maternal Health in Papua New Guinea
Reality, challenges, and possible solutions

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Introduction

This paper focuses on Goal 5 of the Millennium Development Goals (MDGs) – improve maternal health by reducing maternal mortality by three-quarters by 2015. I discuss maternal health in Papua New Guinea, the reality, challenges, and possible solutions, in a general context, because I am not from the medical profession.

Maternal health in Papua New Guinea: The reality

Women of Papua New Guinea face all the general health issues that their male counterparts face: communicable diseases (infections), chronic diseases (especially those associated with urbanisation, including obesity, diabetes, and heart disease), accidents, and cancers. Mental and emotional health problems also appear to have increased as a result of the processes of ‘modernisation’. For women, if they survive pregnancy and childbirth, they have a good chance of outliving the men: the life expectancy at birth in Papua New Guinea is 64 years for women and 60 years for men (data for 2006 from WHO, 2009) – both the lowest amongst the Pacific Island nations. However, for a variety of reasons far too many women never reach their potential life expectancy.

Malaria is too common, representing about one-third of all hospital admissions and deaths of all hospitals. Tuberculosis remains a major cause of mortality and morbidity, and common viruses and bacterial infections responsible for chest infections and gastroenteritis (both big killers in Papua New Guinea) continue to be a challenge. Sexually transmitted infections account for an enormous burden of illness, with
recent statistics showing the prevalence of syphilis to be 3–12% (highest in the highlands), gonorrhoea and chlamydia to be about 25%, and trichomoniasis about 24–70%. The national prevalence of HIV is officially about 1.7% of the population (about 2% in all women screened at the antenatal clinic at Port Moresby General Hospital) but it is higher in certain areas. Gender-based violence (domestic and sexual) appears to be increasing but the exact prevalence is not known. The most common cancer in women in Papua New Guinea is cervical cancer (closely followed by oral cancer and then breast cancer), and we have close to the highest incidence in the world. A comprehensive Pap smear and mammogram screening programme is simply not feasible in Papua New Guinea, and there is no radiotherapy.

To add to these realities is the fact that Papua New Guinea has an appalling maternal mortality rate of 731 deaths per 100,000 live births (data from 2006 Demographic Health Survey (National Statistical Office, forthcoming). The total fertility rate is 4.3. This means that each girl in Papua New Guinea has a lifetime risk of dying of a pregnancy-related cause of 1 in 16; in the more remote areas of Papua New Guinea these numbers could be doubled and about 1,460 women die each year, about four each day. This is comparable to Sub-Saharan Africa, and is clearly the worst in the Pacific, if not the whole of Asia–Oceania (with the exception of Afghanistan).

Modern family planning prevalence is about 20% with a large family planning ‘gap’ – the perceived ‘ideal’ family size is shrinking, but there are inadequate family planning services to satisfy this ‘ideal’. The 2006 Demographic Health Survey shows that the percentage of men who want their partner to use family planning is 87% – a pleasing statistic, but at present it is not matched by access to family planning services. (This information was not gathered in previous Demographic Health Surveys.)

Statistics on birth spacing indicates that 25% women space their children less than 24 months apart and the median interval is 32 months (Demographic Health Survey, 2006). The median age for women at first birth is 20–21 years, and teenage pregnancy has increased to about 13%
and is more common in girls with no formal education. About 80% of women get at least one antenatal visit, but only about 36% receive adequately supervised delivery and this figure has been decreasing. It is one of the lowest rates in the world. Maternal death reporting is poor (as are all statistics).

Medical causes of maternal death in Papua New Guinea are known (haemorrhage; infections following childbirth, miscarriage, abortion, tubal pregnancy; anaemia and poor nutrition; acute infections; malaria; tuberculosis; gender-based violence and so on) and cheap to prevent, but a major issue is a lack of access to services.

In addition, various international reports estimate that, for every woman who dies in pregnancy or childbirth, another 30 sustain significant disability. The death or chronic ill health of a mother increases the probability of death and poor growth and development of her children. Therefore, improving financial and geographical access to good quality intrapartum care based in health centres is important in any poverty eradication strategy, as well as a means of reaching Goal 5.

What is clear from the evidence is that poverty undermines the effectiveness of current skilled attendance strategies. Failure to tackle the inequities in access to skilled care is arguably the biggest obstacle that could prevent us from reaching [Goal 5’s] target – a 75% reduction in maternal mortality by 2015. (Professor Wendy Graham, Immpact, interview with Population Reference Bureau, 2007)

Of all the human development indicators, the greatest discrepancy between developed and developing countries is in the risk of maternal death. We need to establish maternal health as an essential contributor to economic and social development not just the responsibility of health policy-makers, medical professionals, and public health experts, but also those working on education, human rights, micro-enterprise, HIV, child health, community development, and a range of other development sectors.
The reality and the challenge

Papua New Guinea has been challenged by the above scenario and faces the reality that it will almost certainly fail to meet the 2015 MDGs, with the possible exception of Goal 2 (achieve universal primary education).

For Goal 5 (improve maternal health) things appear to be going backwards. And the reality of maternal health in general, as outlined above, compounds the grim reality.

The two most cost-effective interventions in terms of decreasing maternal mortality are modern methods of family planning and adequately supervised delivery. Neither programme is doing well in Papua New Guinea at present.

Challenge of making pregnancy safer in Papua New Guinea

Effective interventions for making pregnancy safer are relatively cheap and certainly well known, but they are not reaching those in need in Papua New Guinea. In Papua New Guinea, the medical causes of maternal deaths are usually multi-factorial (as listed earlier). In addition, social and cultural determinants of health also contribute to maternal mortality and these have probably not been highlighted enough other than the issue of gender-based violence.

Papua New Guinea has always been an extraordinarily challenging place to provide services because of its geography, small and scattered populations, and cultural diversity. Unless people move to urban areas, the reality is that it is physically impossible to adequately service a significant proportion of the population – perhaps as much as 40%. But urban migration is not a solution – it creates other problems. We must, therefore, seek more creative solutions.
Strategic pathways and partnerships for delivery of knowledge and services

‘Traditional’ society in Papua New Guinea is based on relationships, responsibilities, and reciprocity – the extended family and clan. ‘Modern’ society is based on structures, systems, and procedures – both government and church hierarchies. There is a need to link and partner the modern with the traditional in our response to health service delivery. The government’s capacity to connect and engage at the community level has been limited. Partnerships are needed to make it happen, with strategies that target the community as meaningful participants in the process. These partnerships would build on and strengthen what is already happening with some churches and non-governmental organisations working at community level.

A multi-pronged approach is clearly needed to address the medical, social, and cultural issues related to maternal health and maternal mortality in an holistic manner using a whole-of-government and whole-of-society response.

A whole-of-government response includes health, education, community development, agriculture, and other government agencies as required from time to time. A whole-of-society response includes churches, non-governmental organisations, community-based organisations, clans, and women’s organisations. There is a need for a paradigm shift in attitudes at all levels, so our families and communities have opportunities to take ownership of development and build healthy communities from the inside out.

To achieve the MDGs, the issue of sustainability must always be paramount, knowing that sustainability of development is a social process that requires collaborative effort – money alone is not enough. Sustainability of socioeconomic change relies on cultural acceptance and social relevance. Progressing from ‘doing projects’ to being agents for transformational change in the daily lives of people is a real challenge. A ‘project mentality’ can become disempowering. It must be kept in mind that ‘development’ has a history of mismatched expectations and priorities often with disappointing outcomes, labelled
‘failures’. All efforts to achieve Goal 5 (improve maternal health) must be underpinned by improving women’s health status in general.

To conclude, I will highlight first some bad news and then some good news on improving the maternal health status of women in Papua New Guinea.

The bad news is that the health system is struggling and in some areas failing. The population is expected to double within 25 years, and we cannot stabilise the population at less than 24 million (in 50 years) unless we start right now to achieve a family planning prevalence of 80% of couples, and aim for a total fertility rate of about 2.3. If we do not rapidly reduce and stabilise our population growth rate, there is limited hope of addressing our maternal health crisis.

The bad news is also that morale amongst government workers is very low (eg, as seen in the recent nurses’ strike). Government workers’ living and working conditions are of a poor standard and Aid Posts are closing. Governance and performance management is challenged (for both good and poor performances).

Deeply entrenched cultural attitudes to the status of women and fatalism about death are also barriers to achieving Goal 5. Bad outcomes become normalised.

All of these issues are likely to be compounded by the current contraction of the global economy, which could reduce donor assistance on which the health sector is too heavily dependent.

On the other hand, there is good news. The health-related MDGs are not the job of the health sector alone. As stated before, they require a whole-of-government/whole-of-society approach through public–private community partnerships.

There is an increased government policy and planning response with a Ministerial Task Force on Maternal Health and a Ministerial Task Force on Family Planning (both taking a whole-of-government/whole-of-society approach). In terms of new policies, work is progressing on the National Family Planning Policy and an inaugural National Sexual and Reproductive Health Policy. The next National Population Policy is due in 2010. The new integrated family and community development
policy framework for all aspects of social development can become an additional vehicle for primary health awareness.

More good news is that there has been an improved response to domestic and sexual violence, with amendments to legislation on rape and sexual abuse and ongoing work on domestic violence to simplify court processes for women in violent situations. Sadly, maternal mortality sometimes relates to domestic violence situations.

There are also strong signs of increasing political will with the establishment of the Papua New Guinea Parliamentary Group on Population and Development in 2008. It is good news also that some individual members of parliament are establishing family planning and HIV management models to share with other members. There are also signs of increased community interest and focus on population planning and resource matching, resulting from land issues, school fee expenses, lack of jobs, poverty, and social unrest.

Over the last 11 years, AusAID guidelines related to family planning saw funding for Papua New Guinea family planning contracted by 84%. In view of this, Australia’s announcement (on 10 March 2009) of considerable changes to AusAID’s Family Planning Guidelines is very good news and has the potential to save thousands of women’s lives in childbirth and from related complications. There is the hope of funds to back this up, and relationships with development partners has improved in response to the improved focus on policy and legislative reform. In addition, the United States of America’s ‘global gag’ was recently lifted. This international support is essential but can never replace the need for Papua New Guinea to continue taking ownership of the issue of maternal health and our commitments to Goal 5.

And perhaps the good news with the most potential long-term impact is that there is increased determination to achieve Goal 2 (achieve universal primary education) combined with access to learning for all. It is hoped the new partnership being forged between formal education and flexible community learning can be a vehicle for change, giving the marginalised masses of our people access to knowledge and skills that will equip them to be the agents for change in their own
communities. Access to learning for all – young and old; female and male; able-bodied and disabled – is fundamental to the achievement of all of the MDGs.

With the potential of a massive economic boom from mineral, oil, and natural gas development projects, Papua New Guinea will have the financial means to address the targets of the MDGs. It is imperative that we also have appropriate policies and programmes and political and bureaucratic commitment to transform the future with our people, using the MDGs as the benchmarks for social development.

References


