

RETURN TO ABUSER

**GAPS IN SERVICES AND A
FAILURE TO PROTECT SURVIVORS
OF FAMILY AND SEXUAL VIOLENCE
IN PAPUA NEW GUINEA**

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ABOUT MSF

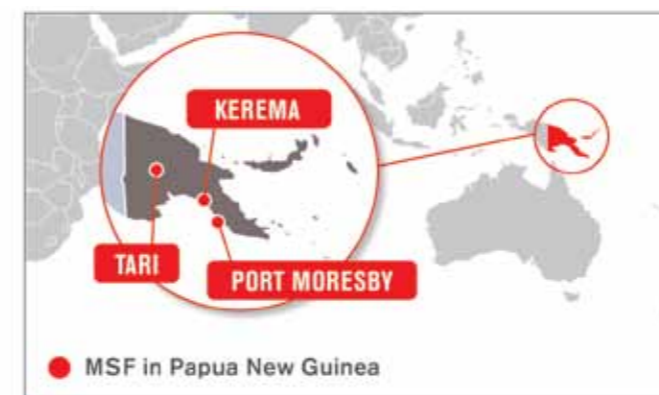
Médecins Sans Frontières/Doctors Without Borders (MSF) is an international, independent, medical humanitarian organisation that delivers emergency aid to people affected by armed conflict, epidemics, natural disasters and exclusion from healthcare.

Founded in 1971, MSF offers assistance to people based on need, irrespective of race, religion, gender or political affiliation.

A private, international, non-profit association, MSF observes strict neutrality and impartiality in the name of universal medical ethics and the right to humanitarian assistance, and is not affiliated to any government or political, religious or economic power.

MSF was awarded the Nobel Peace Prize in 1999 and today provides medical and humanitarian assistance in more than 65 countries across the globe.

For more information about MSF's work, visit www.msf.org.



MSF IN PAPUA NEW GUINEA

MSF first started working in Papua New Guinea (PNG) in 1992. Currently its teams provide medical and humanitarian assistance to survivors of sexual, domestic, social and general violence in Tari in Hela province, in addition to helping to improve detection, diagnosis and treatment of tuberculosis (TB) in the National Capital District and Kerema in Gulf province.

Since 2007, MSF has provided free, quality, confidential and integrated medical and psychosocial care to survivors of family and sexual violence in different parts of the country, including Morobe province, Hela province, Port Moresby in the National Capital District, Milne Bay province and East Sepik province. Since 2009, MSF has treated 27,993 survivors of family and sexual violence in the country, often in collaboration with the National Department of Health, and carried out 68,840 major and minor surgeries, one-third of which were for violence-related injuries.

MSF teams have also run trainings in some 50 health centres across the country, and trained other service providers – including police units for family and sexual violence, and community leaders – in the importance of providing survivors with timely medical and psychosocial care. In 2016, MSF will hand over responsibility for the final Family Support Centre it runs in the country to the Provincial Health Authority.



What is child sexual abuse?

A child at a play therapy session run by a counsellor who has been trained to assist young survivors of family and sexual violence at the Family Support Centre in Port Moresby's General Hospital.

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EXECUTIVE SUMMARY

In Papua New Guinea, women and children endure shockingly high levels of family and sexual violence, with rates of abuse estimated to be some of the highest in the world outside a conflict zone.

This is backed up by the experience of Médecins Sans Frontières/Doctors Without Borders (MSF), which has treated 27,993 survivors of family and sexual violence in the country since 2007.

In 2014 and 2015, some 3,056 people sought care for the first time in MSF-run Family Support Centres in the capital, Port Moresby, and in Tari, in the Highlands region. Their accounts provide important insights into the patterns of intimate partner violence, family violence and sexual violence in these areas. Their experiences suggest that large numbers of people are suffering grave physical and psychological wounds in the very place they should feel the safest – within their homes and families.

The overwhelming majority – 94 percent – of these patients were female. Most had been injured by their partners, family or community members, and in more than a quarter of all incidents involving intimate partners, the women had been threatened with death. Nearly all – 97 percent – of those patients had injuries that required treatment. Two in three had been attacked with weapons, including sticks, knives, machetes and blunt instruments.

Children are also exposed to serious violence from a very young age, MSF's data shows, most often at the hands of family members or others they know in their community. More than half of all MSF consultations for survivors of sexual violence were with children, around one in six of which were with children younger than five years. Children also made up one in three of all family violence consultations in Port Moresby, and one in eight in Tari.

Forty-nine percent of patients who sought care following sexual violence said the abuse – in most cases, rape – occurred at home. The younger the survivor, the more likely it was that they were abused at home. For most patients, the perpetrator of sexual violence was someone they knew. Again, the younger the child, the more likely this was, with a known perpetrator involved in the sexual violence against almost nine in ten children younger than five years.

Many of the patients who returned home after their consultation were in danger of experiencing further abuse. One in ten adult women reported that the latest incident of sexual violence was part of a repeated or ongoing pattern. For children, this risk was heightened, with almost two in five children experiencing repeated or ongoing sexual violence.

Family and sexual violence are clearly widespread and destructive in Papua New Guinea. This makes it all the more vital that survivors have access to free, quality, confidential treatment, in addition to services beyond medical care to keep them safe. But, at present, this is too-often not the case. Patients face multiple obstacles for obtaining essential medical and psychological care, and they face severely limited options for accessing the legal, social and protection assistance they require. They are thus made 'double victims' – suffering first from brutal attacks, and then from failures in service provision and in the protection system.

Inadequate or inappropriate responses from the country's hybrid system of formal and traditional justice, and the dysfunction of the protection system, are putting survivors' lives and health at risk. Patients' experiences expose a culture of impunity, and a continuing reliance on traditional forms of justice to solve serious family and sexual violence cases. The widespread tradition of 'compensation', whereby either money or pigs are paid to victims' families for crimes committed, means that perpetrators often remain within their communities, exposing survivors to the threat of repeated violence.

Without access to social assistance, women's financial dependence creates obstacles to seeking safety and obtaining justice. With no way to feed themselves or their children, many simply cannot afford to leave an abusive partner. Cultural practices, such as the payment and repayment of 'bride price', also hinder women's ability to obtain protection, often trapping them with a violent partner.

Those who wish to flee violence need access to safe alternative accommodation, such as refuges or safe houses. Yet delays in the creation and implementation of critical laws and policies have stalled the development of much-needed safe houses. With only six in the country, five of which are in the capital, most survivors have no hope of escape. This is alarming, considering that partner and family violence tends to be repetitive and often escalates over time.

For child survivors, gaining access to protection and justice is even more difficult. None of the existing safe houses will accept boys older than seven years. In addition, safe houses currently operate in a legal limbo with regard to children who flee violence without a guardian's consent. Most safe houses will refuse to take these children in. Without official fostering in place, unaccompanied minors are effectively abandoned by the formal system. If their family or community is unable or unwilling to protect them, they are forced to remain with their abusers, with often devastating consequences.

As MSF prepares to hand over its final Family Support Centre in Papua New Guinea to the Provincial Health Authorities, it acknowledges the significant strategic and policy steps already taken by the country to address family and sexual violence. However, an adequate response to survivors' needs is still far from reality in many areas of the country.

There is simply not enough comprehensive medical and psychosocial care for survivors of family and sexual violence. As a result, many survivors are left on their own to suffer

in silence. Only seven of 16 Family Support Centres across the country are deemed to be fully functional by national authorities, with services in the remaining nine centres varying greatly. Too often, the minimum package of medical care that should be available to all survivors of violence exists only on paper. There is also no effective referral pathway to connect them to assistance beyond immediate medical care, particularly in rural areas without hospitals, safe houses or an effective police presence.

MSF hopes that this report will accelerate an improved response from all sectors of society, but especially from the national government and provincial authorities in Papua New Guinea. MSF encourages these authorities to build on recent improvements and to address serious shortcomings in services and safety provision. This will require the investment of resources and a sustained political will. It will also be essential to implement existing legislation and policies quickly and effectively. In addition, MSF trusts that this report will help propel increased support and efforts from international donors working with Papua New Guinea.

The scale-up of essential medical and psychosocial services is urgently required. What needs to be addressed, in particular, is the lack of functioning protection mechanisms, combined with the continuing culture of impunity and weak justice systems. Special attention must be paid to increasing appropriate care and protection for child survivors.

Without an escalated response, women will remain trapped in violent relationships, unable to remove themselves or their children from harm; vulnerable minors who are raped or beaten in their homes will continue to be returned to their abusers; and medical assistance, while vital, will be relegated to patching survivors up between abuse sessions, with medical staff treating the same patients for repeated and escalating injuries.

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Two out of every three survivors of partner violence MSF treated had been wounded with weapons, including sticks, knives, machetes or blunt instruments.

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A bush knife covered in juice from a fruit, in Tari, in the Highlands region of Papua New Guinea.

INTRODUCTION



Joanne,¹ a severely malnourished mother, came to an MSF-run Family Support Centre in the National Capital District with her 10-month-old baby girl.

Joanne left her baby with the child's father one day when she had to go out to beg for food. When she returned, the baby was distressed. The next morning, her daughter developed a fever and Joanne noticed that the baby's genitals were swollen and bruised. Joanne immediately suspected the child's father. Some time ago, he had sexually abused Joanne's eldest daughter, so Joanne had sent her away to live with relatives in another province.

During her consultation with MSF, Joanne expressed her deep sense of hopelessness, believing there was nowhere she could go to escape the abuse. MSF staff tried to get both Joanne and her baby into short-term safe housing. However, every safe house was full. Joanne had no choice but to return home later that day. When she came back for the baby's follow-up medical consultation, a temporary room in a safe house had become available, and Joanne moved there with her daughter.

The safe house did not provide financial assistance, and safe-house rules require that children are never left unattended. Unable to leave the safe house without her baby to find work or to beg, Joanne had no resources to get by. Eventually she returned with her child to her abusive partner.

¹ Names of patients have been changed to protect their identity.

In Papua New Guinea, disturbing levels of family and sexual violence are directed towards women and children. Such violence is a global problem, with one in three women worldwide experiencing some form of sexual or intimate partner violence,² and one in ten girls under the age of 20 experiencing forced intercourse or other forced sexual acts.³ Nevertheless, rates of abuse in Papua New Guinea are estimated to be some of the highest in the world outside a conflict zone.

Nationwide studies from the 1980s found that two-thirds of husbands interviewed beat their wives, while two out of three women interviewed had been beaten.⁴ A more recent 2013 study of 10,000 men across ten Asia-Pacific countries found that the highest rates of family and sexual violence occurred in Papua New Guinea, where, in one location, one in five women's first experience of sex was rape and one-third of men had experienced sexual abuse as children.⁵

Despite the general picture, statistics on the prevalence of family and sexual violence in Papua New Guinea are variable and outdated. Yet MSF's experience in the country of providing medical care to survivors of such violence since 2007 is consistent with existing reports of high levels of violence.

The MSF-run Family Support Centre in Tari, Hela Province, in the Highlands region of Papua New Guinea.



© Jodi Bieber



More than half of all MSF consultations for survivors of sexual violence in Tari and Port Moresby in 2014 and 2015 were with children.



adapted services and the protection system. While an improved response, with additional resources, needs to be prioritised for all victims of violence, those in most urgent need of immediate action are the child survivors of family and sexual abuse.

More than half of all MSF consultations for survivors of sexual violence in Tari and Port Moresby in 2014 and 2015 were with children. However, across the country there is a serious shortage of adapted services for abused minors. A lack of temporary shelters or alternative care, and the difficulty for children of effectively accessing the justice system, mean that they are frequently forced to return to their abusers.

The lack of safety and protection for survivors has another pernicious effect: the medical and psychosocial services that are available, while vital, are too often relegated to a role of patching up women and children between increasingly serious abuse sessions. MSF teams have seen the same women and children returning a second and third time for treatment as a result of repeated, escalating violence.

This report reveals the dangers that survivors of family and sexual violence are forced to endure. It documents severe violence against them in the places where they should be most safe, and describes how children, especially, are falling through cracks in systems that should provide essential medical care, protection and justice.

Recent clinical data from 2014 and 2015 from two MSF-run Family Support Centres – in the capital, Port Moresby,⁶ and in Tari, in the rural Hela province in the Highlands region - detailed in this report, attest to the suffering that women and children, in particular, continue to endure in Papua New Guinea.

A serious but neglected issue for too long, when MSF first began running projects to support survivors of family and sexual violence, there was limited national capacity and expertise to provide assistance in-country. What services

did exist were fragmented and piecemeal, and psychosocial support was almost entirely absent. Today, there is growing recognition that this violence is a national problem and there have been notable improvements to address the issue in recent years, with authorities identifying gender-based violence as a public health and social emergency and a major threat to the country's development.^{7,8}

However, wider acknowledgement of the problem has not always translated into the practical action required to safeguard the lives, health and dignity of survivors of violence. The pace of putting key national laws and policies

into practice has been particularly glacial. This has resulted in serious delays in improving and increasing the provision of essential medical and psychological services. In addition, policy revisions and hold-ups have hindered the development of a stronger justice system that is accountable to survivors and their needs, and obstructed the implementation of meaningful protection mechanisms to keep them safe.

Limited options beyond healthcare services mean that once patients leave the MSF clinic, their physical and psychological health often remains at risk. They are thus made double victims – suffering first from brutal attacks and then from failures of

⁶ In July 2015, MSF handed responsibility for running this centre over to the authorities and staff of Port Moresby General Hospital.



This report is based primarily on statistical data from two MSF projects responding to family and sexual violence in Papua New Guinea – one in an urban and one in a rural setting. The first is MSF’s ‘Treatment and Training Programme’ which was run from the capital, Port Moresby, until mid-2015; the second is the Family Support Centre that MSF continues to run in Tari, Hela province.

The data captures the realities facing 3,056 survivors of family and sexual violence who sought assistance for the first time from MSF in 2014 and during part of 2015:

- Data from the Port Moresby-run project reflects all of 2014 and the first six months of 2015, after which MSF successfully handed over clinical management of the Family Support Centre in Port Moresby General Hospital to the Provincial Health Authorities, specifically the hospital administration.
- Data from Tari Family Support Centre, which will continue as an MSF-run project until end-March 2016, when it will be handed over to the Provincial Health Authorities, covers all of 2014 and the first eleven months of 2015 (the latest statistics available before this report went to print).
- Data is disaggregated by age and sex, to provide insights into risk and protective factors.

This report is a follow-up to two previous MSF reports: the first issued in 2011,⁹ which called for family and sexual violence to be responded to as a public health emergency, recommending concrete actions to meet the needs of survivors; and the second released at the end of 2013,¹⁰ which urged better data collection to accurately quantify prevalence and identify gaps in the response. In 2013 MSF also pushed for an increase not only in medical and psychosocial services, but also in services beyond medical care, including protection and justice.

LIMITATIONS

- In certain places in this report, we analyse subsets of the data, which can sometimes result in small numbers, leading to an increased probability that chance influences those findings.
- It is important to note that our data only accounts for patients who were able to overcome obstacles and reach care at MSF’s Family Support Centres, and is therefore likely to be an underestimate of the extent of the problem in these areas.

Based on the data from two locations, MSF makes no statistical claims regarding prevalence of family and sexual violence against women and children in Papua New Guinea. While the results cannot be extrapolated as countrywide results, the view from these two locations nevertheless provides an alarming snapshot of the severity and range of violence that survivors experience, the risks of repeat abuse and the toll this takes on survivors’ psychological and physical health.

In addition to the data from the 3,056 first visits by survivors of violence to these two Family Support Centres in 2014 and 2015, MSF also draws on more than eight years of experience in Papua New Guinea providing emergency medical and psychosocial care. Moreover, MSF’s analysis of the situation facing survivors of family and sexual violence in Papua New Guinea builds on

Two dolls used by staff in the Family Support Centre in Tari, Hela Province when talking with child survivors of family and sexual violence.

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Children, especially, are falling through cracks in systems that should provide medical care, protection and justice.

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the organisation's experience in other humanitarian contexts across the world, where MSF teams have been providing care to survivors of sexual violence in emergencies since the 1990s.

INTERVIEWS

Semi-structured individual interviews were conducted with 25 survivors of family and sexual violence, in both the National Capital District and the Highlands region, the majority between September and December 2015.

- Interviews were carried out either in English or local languages through a female interpreter.
- All patients interviewed gave informed verbal and written consent. They were advised of the purpose of the research; of the voluntary nature of the interview, and that they could refuse to be interviewed, decline to answer any question, or terminate the interview at any point.
- The names of the survivors of violence have all been changed to pseudonyms to protect their privacy and security. At all times we have withheld the exact location where the abuse occurred, and other identifying information.
- These interviews were conducted in order to place the experience and voices of survivors in the centre of any discussion about their needs.

Additional information was collected from:

- Several interviews with key interlocutors, from provincial authorities, civil society, government ministries and international donors, in both locations and at country level, exploring national policy and contextual factors.
- Brief literature review on health services in Papua New Guinea, including grey literature.

Note: The exchange rate at the time of research was US\$1=3.03 Papua New Guinea kina (PGK). This rate has been used for conversions in the text, which have been rounded to the nearest dollar.



FAMILY AND SEXUAL VIOLENCE IN PAPUA NEW GUINEA

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3.1 PAPUA NEW GUINEA

Home to more than seven million people, Papua New Guinea is the South Pacific's largest island, consisting of a mainland and 600 smaller islands. A country of rich ethnic and cultural diversity, where more than 800 languages are spoken, this Commonwealth country gained its independence from Australia in 1975.

With an extractives-led economy, Papua New Guinea has enjoyed 14 years of successive double-digit growth¹¹ and a total GDP which tripled between 2005 and 2013.¹² In 2015, a global commodity slump triggered a reported 12 percent contraction in government revenues,¹³ while rapid increases in public debt¹⁴ and other economic factors are likely to lead to harsh budget cuts in 2016.¹⁵

More than 80 percent of the population subsists on agriculture, while 85 percent of the population lives in rural areas.¹⁶ With limited infrastructure, a mere 3.5 percent of Papua New Guinea's roads are paved.¹⁷ Ranked 157 out of 187 countries on the UN's Human Development Index,¹⁸ Papua New Guinea has not achieved any of the UN Millennium Development Goals¹⁹ and it is estimated that more than two-thirds of the population live under the poverty line on less than US\$1.25 a day.²⁰ Issues with corruption also affect the country, with Transparency International putting Papua New Guinea at 145 out of 174 countries in its 2014 Corruption Perceptions Index.²¹

The country has the worst health indicators in the Pacific region, and treatable diseases such as malaria and pneumonia remain common. With maternal mortality doubling over

the past 10 years,²² the lifetime risk of a mother dying during pregnancy stands at one in 20.²³ The overall adult prevalence of HIV, at nearly 1 percent of the population, is the highest in the Pacific region.²⁴ TB prevalence is 534 per 100,000 people – 72 times higher than neighbouring Australia – with 150,000 new cases recorded annually²⁵ and increasing cases of drug-resistant TB.

The prevalence of gender-based violence in Papua New Guinea is another area of concern in terms of its impact on the health and wellbeing of the population. A 2006 report described gang rape as a common practice, with approximately 60 percent of interviewed men indicating they had participated in gang rape.²⁶ The country's 2015 *Lukautim Pikinini* (Child Welfare) Policy cites statistics claiming that around 75 percent of children experience physical abuse during their lifetime,²⁷ while PNG's Office of the Public Prosecutor estimates that 55 percent of all sexual violence cases that have reached the courts since 2012 have dealt with the abuse of children under 16.²⁸

"I came home from work at 4 pm. When Grace went to do a pee she was in pain. She kept crying and putting water and soap where it hurt. When I asked her what was wrong, she cried again, but after some time told me that the boy next door took her to his house, put her on his bed and took off her clothes. She told me that 'he took his thing and put it in my pee'.

I am angry and her brothers are too. We found out that he has done this to her at other times before. We came to the hospital and the doctors were so sorry when they examined her. She was so sore and black inside. She is on medicine in the morning and the afternoon to try to stop the sickness in her body."

Mother of a four-year-old girl who was raped by an 18-year-old neighbour, Port Moresby

A woman receives treatment at the Provincial Hospital in Tari, after her husband had attacked her with a bush knife.

MEDICAL AND PSYCHOLOGICAL CONSEQUENCES OF VIOLENCE

“Abuse and violence in the home is often not a one-time traumatic event, but can go on for years, chipping away at the basic core of a developing child’s ability to trust, to learn, to regulate emotions and to solve problems. In many cases, parents may be reluctant to come forward because this may create conflict in the family or community.”

Cindy Scott, MSF psychologist

The health consequences of family and sexual violence are significant, including but not limited to: serious injuries; unwanted pregnancy; unsafe abortion; sexually transmitted infections, including HIV; urinary tract infections; chronic pelvic pain; miscarriage; sexual dysfunction; infertility; increased vulnerability to disease; mental trauma; and even death.^{29,30}

Children are more physically susceptible to injury than adults, as their bodies are still in development, and physical injuries can include broken bones, lacerations, sprains and burns that cause pain long after the initial incident of abuse.³¹ Unwanted pregnancies for young girls can exacerbate psychological trauma and cause heavy strain on developing bodies, whilst sexually transmitted diseases wreak havoc on their health and future reproductive ability.³²

Family and sexual violence can also result in immediate and longer-term mental health and psychosocial problems, with symptoms such as anxiety and mood-related complaints, including concentration problems, sleeplessness, hypervigilance, feelings of shame, depression and suicidal thoughts, and behaviour-related issues, including aggression, anger, loss of control over emotions and other antisocial behaviour.³³ A complex and stigmatising form of abuse, sexual violence can generate long-lasting consequences for both adults and children. Trauma can have long-lasting effects on people’s ability to function and carry on with their lives³⁴ and can impede children’s natural development.

3.2 MSF RESPONSE TO FAMILY AND SEXUAL VIOLENCE IN PAPUA NEW GUINEA

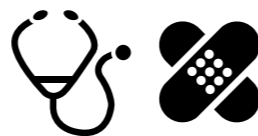
Adequate and timely medical and psychological care is crucial to help minimise the consequences of family and sexual violence, in order to treat often-serious injuries and to treat or prevent diseases and any other medical and psychosocial conditions.

In response to the significant and unmet needs in Papua New Guinea for access to immediate, quality healthcare for survivors of family and sexual violence, in 2007 MSF set up a Family Support Centre in Angau Memorial Hospital, in Lae, Morobe province, expanding existing services being provided by the Women and Children's Support Centre. The following year, it created a second Family Support Centre in Tari Hospital in Hela province. In 2013, MSF started a regional treatment and training project based in the National Capital District, which developed medical services in Maprik District Hospital, Port Moresby General Hospital and Alotau General Hospital by providing hands-on treatment, training and clinical support.

MSF-run Family Support Centres have developed a model of care that offers five essential medical services to all family and sexual violence survivors in a single session. This package of care ensures that integrated medical and psychosocial assistance is provided as soon as possible, establishing a 'one-stop shop' so that victims of violence are not forced to move back and forth between different service providers. Traipsing between multiple sites searching for care creates insurmountable barriers for many survivors, forcing them to repeatedly explain and relive the violence they have experienced, which can then lead to disengagement and re-traumatisation. MSF has consistently advocated for this one-stop approach to be adopted in Papua New Guinea as a minimum level of care.

THE FIVE ESSENTIAL MEDICAL SERVICES INCLUDE:

Medical first aid to treat injuries



Psychological first aid



Medicine and post-exposure prophylaxis (PEP) to prevent HIV infection and treat other sexually transmitted infections (STIs)



Vaccinations to prevent hepatitis B and tetanus



Emergency contraception to prevent unwanted pregnancies as a result of rape



In addition to the five essential services, MSF provides additional psychological care to patients who proactively request more in-depth counselling or who, during a consultation, have been identified as experiencing high levels of anxiety, fear, panic attacks or thoughts of suicide. They then receive further MSF support or are referred elsewhere for more specialised assistance, such as psychotherapy or psychiatric care.

MSF offers a medical-legal certificate to all survivors of physical and sexual violence. This certificate is a requirement if they decide to press criminal charges against the perpetrator of the violence. MSF has also pushed for the establishment and improvement of 'referral pathways' between the multiple service providers required by a survivor of violence. As part of this, MSF staff in Family Support Centres do their best to help patients access further specialised medical care, and to access protective, social welfare or legal services, when and where they are available. In addition, MSF provides training and clinical supervision for counsellors who consistently listen to graphic accounts of violence, to minimise the risk of staff 'burn-out' or vicarious trauma.

MSF's work in Family Support Centres and hospitals has shown that a quality, comprehensive response delivers essential and concrete benefits for survivors. Providing the minimum 'five essential medical services', coupled with effective community awareness, has helped facilitate access to essential curative and preventive care for survivors of violence. It has also increased peoples' understanding that this violence has serious medical consequences, and motivated survivors to seek treatment, including within the crucial 72 hours after an assault.³⁵

At the end of March 2016, MSF will hand over its final Family Support Centre in the country and Papua New Guinea's authorities will lead the further roll out of the medical response to family and sexual violence. A number of significant challenges lie ahead to ensure the required scale-up of quality, integrated medical care across the country. In particular, there is an urgent need to improve the availability of services beyond medical care. To effectively address these challenges, it is crucial to understand the realities and obstacles that survivors of violence continue to face.

"Last year, my brothers, aunt, cousins and I were travelling home after a relative's funeral in the evening when a group of 10 boys with guns and bush knives stopped our vehicle. They ordered the four women to come outside to search us for money. They stripped us and took turns putting their hands all over us, from face to breast to vagina. It was painful and shameful. They did this in front of our brothers and cousins, who were helpless because of the boys' bush knives and guns.

I knew about the Family Support Centre, so afterwards I told my cousins we should go there, but they were too ashamed. I went and received counselling and it helped.

I became very scared whenever I saw a man if I was alone, but I am learning to face my fears. But one of my cousins who lives far away, I don't know how she is coping. Another can't even talk, and can't bring herself to come for help.

For months after, my brothers and I could not look at each other freely. We were passing each other with heads down. But I told them it wasn't their fault and it wasn't our fault. Now we can talk freely."

Female, age unknown, Tari

³⁵Timely medical assistance, including psychosocial care, is vital after rape. Vaccinations against tetanus and hepatitis B are relevant for months after the assault. However, the potential of some preventive measures is limited to the first few days afterwards. PEP for the prevention of HIV infection has to begin within 72 hours of the assault, and although emergency contraception can be offered up to 120 hours after the event, it is most effective in the first 70 hours. After this, the success rate halves.

"I was beaten up by my husband with an empty bottle. He has often beaten me. I am always with black eyes. I hardly ever get money for food from him. Sometimes we have been without food for two days at a time. He uses the money for drink and gambling. He comes home drunk and belts me even if I am holding our child. Once he threw our baby in a bush. One day I got the space to run away."

25 year old woman and her 8-month old daughter, safe house, Port Moresby.

A 25-year old woman and her eight month old daughter at a safe house in the capital, Port Moresby. After her husband beat her with an empty bottle she fled to the safe house seeking safety and protection.

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In both MSF-run centres, the majority of consultations were for survivors of violence perpetrated by partners.

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WHEN HOME IS WHERE THE HURT IS

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4.1 FAMILY AND SEXUAL VIOLENCE IN TARI AND PORT MORESBY

MSF consultations with 3,056 men, women and children who sought care for the first time in MSF-run Family Support Centres in Port Moresby General Hospital and in Tari in 2014 and 2015 provide important insights into the types and levels of violence perpetrated against people by their partners, families, community members and others.³⁶

"If a woman is beaten by her husband, even if she goes back to her relatives, they'll still send her back to him. They are scared of such guys who are beating up women and are very aggressive in the community. So, she has to go back and get beaten, over and over again.

If women are beaten badly and even forced to have sex, they don't call it rape. Many think it's normal because they faced this before, with their own parents or in the community. That is why violence keeps going here. Maybe through the work we are doing [in the hospital], we might see some changes, but it's more difficult to change the attitudes."

Nurse from Papua New Guinea, Tari Hospital

WOMEN AND GIRLS AT GREATEST RISK

MSF uses three categories – intimate partner violence, sexual violence and family violence – to register the experience of patients who seek care in its Family Support Centres. For all three categories combined, almost 19 out of 20 – 94% (2,870/3,056) – of all patients MSF treated in both projects were female, confirming that Papua New Guinea remains an extremely dangerous place to be a woman. At least three-quarters of all consultations with female survivors – 78% (2,242/2,870) – were for adult women over 18 years old.

Men and boys represent approximately 6% (176/3,056) of patients treated. However, the lower numbers of males compared to females may reflect the additional barriers they face in coming forward to seek assistance.³⁷

INTIMATE PARTNER VIOLENCE³⁸

In both centres, the majority of consultations were for survivors of violence perpetrated by partners. In Tari, close to half – 46% – of all consultations were as a result of intimate partner violence, and in the Port Moresby clinic, intimate partner violence resulted in more than half – 52% – of all consultations. Survivors of intimate partner violence were predominantly female – 98% (1,432/1,465) – and older than 18 years – 97% (1,420/1,465). In both locations, the violence they had been subjected to was pervasive and severe, with serious consequences for their physical and psychosocial health.

³⁶ Almost two-thirds - 65% (1,998) - of the total 3,056 consultations were carried out in the MSF-run Family Support Centre in Tari, while 1,058 were carried out in the MSF-run Family Support Centre in Port Moresby General Hospital.

³⁸ Intimate partner violence is defined in the glossary at the end of the report.

MAJOR INJURIES AND DEATH THREATS

“Many women told me about the traumatic violence they had experienced – disturbing threats of harm, the use of dangerous weapons, prolonged torture and multiple injuries. These were common occurrences for women, who lived with levels of fear that impacted every aspect of their lives.”

Colleen Dockerty, MSF nurse

In both locations, nearly all – 97% – of the 1,465 survivors of intimate partner violence had injuries requiring treatment. One in five – 21% (301/1,465) – had injuries classified by medical staff as major, including permanent injuries, open wounds, infections, chest or abdominal trauma, trauma requiring surgery under general anaesthesia or fractures. The remaining injured patients had injuries such as bruising, sprains, tears, burns, cuts and bites.

A variety of weapons, including sticks, knives, machetes, whips and blunt objects – were used to inflict these injuries on more than two out of three – 69% (1,003/1,465) of the survivors. This is significant because violence or threats with a weapon is a risk factor for death in intimate partner violence and is included in routine risk assessments for this type of violence.³⁹

In addition to the violence they experienced, one in four – 26% (386/1,465) – of the patients had been threatened with death by their intimate partner, which research indicates increases a survivor’s risk of being killed.⁴⁰ In the Port Moresby centre, more than half – 57% (311/546) – and in Tari, one in 12 – (75/917) – of those who had experienced intimate partner violence informed MSF that their partner had also threatened to kill them.

FAMILY VIOLENCE⁴¹

At least four out of five of those who experienced family violence were female – 87% (465/536) – and most were adults. In Tari, four out of five – 81% (371/461) – were adult women, while in Port Moresby, just over half were adult women – 56% (42/75).

Children in Papua New Guinea are exposed to violence from an early age, including within the family. Children under the age of 18 made up one in three of all family violence consultations – 36% (27/75) – in Port Moresby, and one in eight – (36/461) – in Tari.

⁴¹ Family violence is defined in the glossary at the end of the report.

⁴² Sexual violence is defined in the glossary at the end of the report.

SEXUAL VIOLENCE⁴²

“I was in the field to collect the piglets. It was 6 pm and no one was around. Then a guy came up behind me. He tore off all my clothes. He raped me. Then he ran away. I was weak, but I rounded up the pigs and then I went to the house to inform my relatives what had happened. They brought me to MSF. The guy left town and we didn’t go to the police. My relatives prefer to do compensation.”

Female, age unknown, Tari Family Support Centre

Nine out of ten sexual violence survivors MSF treated were female – 93% (977/1,046) – and more than half were children – 56% (587/1,046). Close to nine out of ten of these sexual violence survivors – 88% (916/1,046) – had been raped, while the other 130 – (12%) – had experienced attempted rape or sexual assault.

However, these are only the patients that made it to one of MSF’s centres, and are likely an underestimation of the

numbers of people experiencing this form of violence. Sexual violence and rape stay largely unreported due to stigma, especially when committed within marriage or against men.⁴³ Although women and girls are the primary targets of sexual violence, MSF teams also provided emergency medical and psychosocial care to 68 males – 38 adult men and 30 boys.

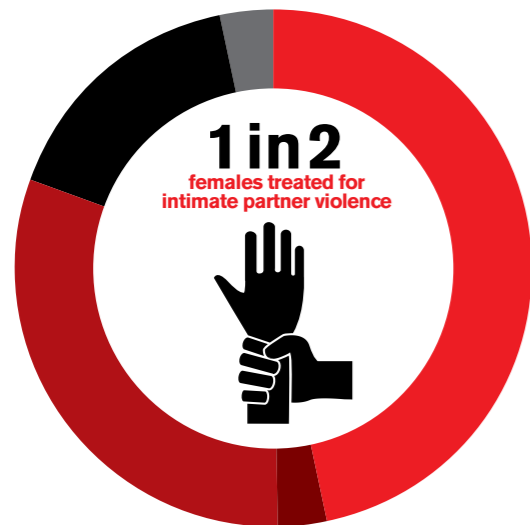
SEXUAL VIOLENCE AGAINST CHILDREN

Child survivors of violence are particularly vulnerable because of their inability to seek medical or psychological care independent of a parent or guardian. In the case of sexual violence, there is additional stigma for young survivors.

The country’s latest 2015 Child Welfare Policy⁴⁴ acknowledges that information on sexual violence against children is limited, reporting that only “one small-scale study indicates that 55% of children experience some form of sexual abuse” but that “evidences from different Family Support Centres indicate that between 49 and 74 percent of cases of violence presenting at Family Support Centres are children less than 18 years.”

TYPES OF VIOLENCE: FEMALES

Of all survivors, 94% were female

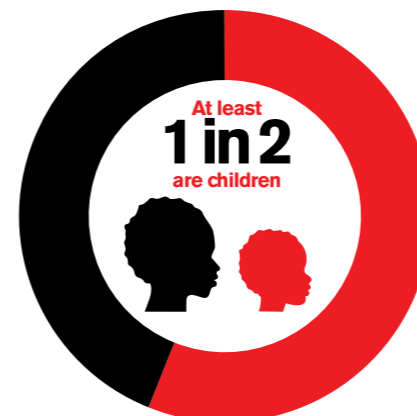


- Intimate Partner Violence
- Mixed Violence (partner and sexual)
- Sexual Violence
- Family Violence
- Other

SEXUAL VIOLENCE

ALL SURVIVORS

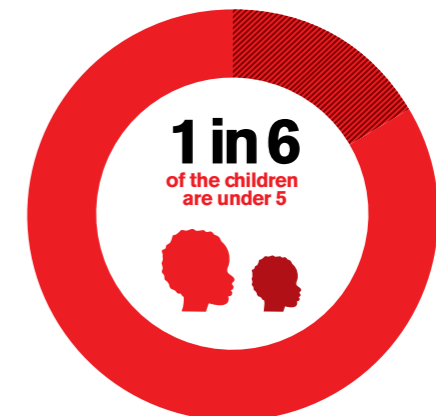
Adults and children



- All adults 44%
- All children 56%

CHILD SURVIVORS

All children, with 1 in 6 younger than five years



- under 18
- under 5

Benaria village is about an hour and a half from Tari Provincial Hospital. It is one of the most remote villages that the MSF outreach team travels to in order to raise awareness about family and sexual violence.

© Jodi Bieber



MSF data from its Family Support Centres in Tari and Port Moresby confirms the risk of sexual violence faced by children of all ages, from 18 years down to infancy. More than half of all MSF consultations for survivors of sexual violence were with children – 56% (587/1,046). Four out of five of these children – 86% (506/587) – had been raped, including 361 children under the age of 15 (71% of all children), and 46 children (9%) under the age of five.

In the Port Moresby centre, more than two out of three – 69% (307/442) – consultations for sexual violence were for children. The vast majority – 81% (248/307) – were under 15 years, and one in five – 22% (69/307) – was under five. In Tari, at least two out of five survivors of sexual violence were children – 46% (280/604); 65% (181/280) were under 15 years, while almost one in eight – 12% (33/280) – were under five.

PATTERNS OF REPEAT SEXUAL VIOLENCE

“He pushed me into the house and took off my pants, but then my father came in and caught him. He had done this to me two times before. The first time I was walking by my house and he pulled me into the bush. Afterwards he said, ‘if you tell them, I will beat you or cut your neck off’. The second time I was coming back from school. He says he didn’t do anything and so the village leaders want to know what the doctor says.

I spoke up and now I am afraid to go home. We use the same road to the market, to the bus stop, to school. He might attack me. Because I have spoken up I feel ashamed. All my friends are laughing at me.”

13-year-old girl in Tari Family Support Centre following an attempted rape and two previous rapes

For many patients, the latest incident of sexual violence was part of a repeated or ongoing pattern and, if they returned home after their consultation, they were at clear risk of experiencing further violence. One in ten – (42/419) – adult

women who sought care for sexual violence reported that the latest incident was part of a repeated or ongoing pattern. This was even more likely for children, with almost two out of five child survivors – 38% (116/307) – experiencing repeated or ongoing sexual violence.

WHEN HOME IS WHERE THE HURT IS: LOCATION OF SEXUAL VIOLENCE

MSF data reveals that a significant percentage of sexual violence takes place in the home. This was the reality for 49% of all patients – (510/1,046) – most of whom (426) had been raped. For almost a quarter of all survivors of sexual violence – 24% (250/1,046) – the abuse occurred during a daily activity, while for one in five – 22% (231/1,046) – it happened when they were travelling.

The younger the survivor, the higher the likelihood of the home being the site of sexual violence. In Port Moresby Family Support Centre, close to three in five – 59% (106/181) – survivors of sexual violence younger than 15 had been abused in their home, and this was true for as many as seven in ten of the same age group in Tari – 69% (170/248). In both locations, the home was where four out of five children younger than five years had experienced sexual violence – 82% (83/101) – the majority of whom had been raped.



The younger the survivor, the higher the likelihood of the home being the site of sexual violence.



Perpetrators known* to survivors of sexual violence

Known perpetrator	Total	Men	Women	Children <18	Children <15	Children <5	Missing or blank data
Tari and Port Moresby 2014 and 2015	791 of 1,046 (76%)	12 of 38 (32%)	289 of 419 (69%)	489 of 587 (83%)	371 of 429 (86%)	90 of 102 (88%)	2
Total records	1,046	38	419	587	429	102	2

* Note: A 'known perpetrator' includes someone from the survivor's family, someone known from outside the family or an intimate partner cohabitant.

PERPETRATORS OF SEXUAL VIOLENCE

"When my Mum was away, she left me with a woman and a man from my village to take care of me. One day he told me to come into the house and take off my pants. He touched me down there and told me to suck him. I started to cry and he used his hand to cover my mouth. Then he put it inside me. I was trying to shout but he was covering me. He told me, 'I am the one who has started to have sex with you. We will have sex again. The second time you can tell people, but not this time.'

Afterwards I went to tell the man's wife, but she ignored me. My tummy was very painful and it was difficult to walk. A few days later I was bleeding and I fell down on the road. Some ladies found me. They took me inside the house and asked the man's wife for money to bring me to the hospital. She told them to go find her husband. The ladies were afraid of him. I went back to the house to sleep. Then another 'aunty' brought me here."

Six-year-old girl, brought to an MSF-run Family Support Centre one week after suffering vaginal and rectal penetration

Considering that the majority of sexual violence and rapes occurred in the home or while people were going about their daily activities in the community, it is not surprising that three in four survivors of sexual violence knew their perpetrator.

The younger a child survivor of sexual violence, the more likely it was that the perpetrator was someone they knew. This was the reality for four in five children younger than 18 years – 83% (489/587) – and almost nine in ten children younger than five years – 88% (90/102).

TYPES OF KNOWN PERPETRATORS

Half – 50% (146/291) – of the adult women in Tari Family Support Centre who had experienced sexual violence reported that the perpetrator was someone they knew from outside their family, while for one in seven – 14% (42/291) – it was their intimate partner, and for six women – 2% (6/291) – it was a family member. In Port Moresby, however, almost one-third – 31% (40/129) – identified their intimate partners as the perpetrator of sexual violence against them, while one in eight women – 12% (15/129) – reported that the perpetrator was a family member – both significantly higher figures than in Tari.



A woman holds her six year old son after he received medical treatment at Tari Hospital in Papua New Guinea.

“ Three in four survivors of sexual violence knew their perpetrator. ”

© Jodi Bleber

For children in both locations, the perpetrator was most likely to be someone they knew from outside their family. This was the case for seven in ten children in Tari – 71% (199/280) – and for close to half – 49% (151/307) – in Port Moresby. A family member was the perpetrator of sexual violence for one in ten children (28/280) in Tari and one in three children in Port Moresby – 33% (100/308).

MULTIPLE PERPETRATORS

In both locations, multiple perpetrators were involved in one in eight of the incidents of sexual violence – 12% (121/1,046). Multiple perpetrators were involved in the sexual violence against one in six women – 16% (65/419) and a least one in 12 children – 8% (44/587).

MENTAL HEALTH CONSEQUENCES

The deepest wounds for many survivors of violence and abuse are often the least visible. MSF carried out 4,064 psychological consultations in 2014 and 2015 as part of the minimum package of care. In Tari, at least three in five – 63% (436/690) – of the 690 women and children who attended psychosocial counselling sessions between March 2014⁴⁵ and December 2015 had anxiety-related complaints as a result of the violence, and one in six – 18% (127/690) – needed support for symptoms related to psychological trauma.

⁴⁵ In March 2014 the Tari Family Support Centre introduced a monitoring system to record consultations for those who required more in-depth counselling after they had received the five essential services.

RETURN TO ABUSER: FAILURES IN SERVICES ENDANGER HEALTH AND LIVES

5

5.1 DEVELOPMENTS IN THE RESPONSE TO FAMILY AND SEXUAL VIOLENCE

The severity of the physical and psychological injuries inflicted by family and sexual violence reinforces why Papua New Guinea must guarantee access to free, quality and confidential treatment to all survivors, and to ensure the provision of services beyond the medical realm.

MSF has witnessed the development of a number of important initiatives in Papua New Guinea in recent years. However, many of these have yet to be put into practice.

Lara, a 13-year-old girl, arrived at MSF's Family Support Centre alone. She had been repeatedly raped by her uncle. When her parents found out about the rapes, they blamed and then beat her.

During her consultation, Lara described a long history of neglect and physical abuse at the hands of her parents. She was anxious that she would be beaten again that day, as her visit to the clinic meant she would not be home on time to cook the family's meal.

She revealed a history of suicidal thoughts, and MSF counsellors considered her to be a current suicide risk. Staff in the Family Support Centre immediately contacted Child Welfare Services to request a Protection Order and seek official permission for Lara to be protected without the consent of her abusive parents. A senior manager replied that someone would take care of the case and come to meet Lara at the Family Support Centre.

Lara waited with MSF staff for the rest of the day, but no one turned up – not a Protection Officer from Child Welfare Services nor a police officer. Fearing further punishment from her family if she stayed away any longer, Lara refused further help and returned home.



“ Many survivors of violence have to travel for up to eight hours to reach a health facility that provides the essential services they need. ”

TIMELINE: POLICY DEVELOPMENTS



MEDICAL AND PSYCHOSOCIAL

2009 FREE CARE

National Department of Health circular on free care

The Secretary of Health sent a circular to all provincial hospitals directing them to provide free medical care to all survivors of family and sexual violence.

>> *Despite the circular, some health centres and hospitals still insist on payment for these services.*⁴⁶

2013 FAMILY SUPPORT CENTRE GUIDELINES

'Guidelines for PHA/Hospital Management establishing hospital-based Family Support Centres'.⁴⁷

The National Department of Health published an essential tool to guide hospitals throughout the country on how to establish Family Support Centres. These centres have been established in a number of the country's provincial hospitals, with a commitment to adopt and provide the minimum 'five essential services' as their model of care.

>> *Many provinces in the country still do not have a Family Support Centre providing the minimum package of five essential medical services. The National Department of Health considers that 16 Family Support Centres exist in the country,⁴⁸ but acknowledges that of these, only seven are fully functional, while the others are reported to function partially or not at all.*⁴⁹

2015 FREEPHONE HOTLINE

Papua New Guinea's first freephone hotline was set up in August to provide "counselling, information, guidance and referrals for care at local services" to survivors of family and sexual violence.

2015 REFERRAL PATHWAYS

'Guidelines for Family and Sexual Violence Providers in Papua New Guinea'

Coordinated by the National Family and Sexual Violence Action Committee (FSVAC), with partners including MSF, these guidelines, published in November, were designed to assist provinces to develop their own referral pathways – i.e. linkages between key services, agencies and groups needed to work together to assist survivors of violence to access the full range of services required.

>> *In urban areas, application of the referral pathway remains inconsistent. In rural areas, a meaningful pathway does not exist in most provinces.*⁵⁰

2016 CLINICAL GUIDELINES FOR MEDICAL AND PSYCHOSOCIAL CARE FOR SURVIVORS OF SEXUAL AND GENDER BASED VIOLENCE

Commenced in 2012, with the support of MSF and in collaboration with the National Department of Health, these clinical guidelines were finalised by the Sexual and Gender Based Violence (SGBV) Technical Working Group in January.

>> *The Minister of Health still needs to officially sign off the guidelines before they can be distributed and implemented. Once signed, it is critical that they are rolled out across the country, with proper training given to relevant staff.*

⁴⁶ MSF assessments of Family Support Centres in 2015 in Bougainville and East and West New Britain provinces found that most health centres and hospitals charged patients for referrals to medical and psychological services. In addition, some health providers claimed that applying fees would serve to 'discourage' violence. In West New Britain, patients at Biiala health centre were charged 200 Kina per ambulance journey. In East New Britain, most health centres and rural hospitals, including Kerevat Rural Hospital and Warangoi Rural Hospital, were charging patients at least half of the transportation costs if they needed to be referred. In Bougainville, patients paid 120 Kina to be referred from Arawa to Buka and 400 Kina to be referred from Buin to Arawa.

⁴⁹ The National Department of Health assessment of Family Support Centres in 2015 determined that out of 16 Family Support Centres in the country, seven are fully functional, three are partially functional, five are not functional, and one lacks personnel and is therefore not functional.

LEGAL AND JUDICIAL SERVICES

2009 TO PRESENT FAMILY AND SEXUAL VIOLENCE UNITS AND SEXUAL OFFENCES SQUAD

By the end of 2015, specialised Family and Sexual Violence Units had been established in 17 police stations.⁵¹ The Family and Sexual Violence Unit is intended to be a police station entry point where specially-trained officers can respond to cases of family and sexual violence in an appropriate and sensitive manner, as well to refer victims towards essential services and police departments for further investigation.⁵²

Sexual Offences Squads are in charge of investigating sexual offences and incidents of major physical violence.

>> *There are not enough Family and Sexual Violence Units or Sexual Offences Squads in the country, there are not enough adequately trained police personnel, and there are too few police stations in rural areas.*

2013 FAMILY PROTECTION ACT

The 2013 Family Protection Act, a law initially drafted in the early 1990s, criminalises domestic violence and set new penalties for family violence, making it a punishable crime for the first time in Papua New Guinea.

>> *Two years later the government is still drafting regulations. Though this law does not strictly require regulations before the Act can be implemented, many officials are unwilling to commit to full implementation without regulations in hand.*⁵³

2015 LUKAUTIM PIKININI (CHILD WELFARE) ACT

The original *Lukautim Pikinini* (Child Welfare) Act was passed in 2009. However, conflicts with pre-existing legislation meant it was not possible to implement this 2009 Act. Following a lengthy process of review in June 2015, the Act was finally passed as a Bill by Parliament.

The 2015 *Lukautim Pikinini* (Child Welfare) Act mandates Child Protection Officers to prevent and respond to violence, abuse, neglect, exploitation and discrimination against all children. It includes the power to remove a child from a situation where his or her health or safety is at immediate risk, without a court order, and to transfer the child to a licensed safe house as a last resort.

The new Act will also enforce a legal marrying age of 18 in a country where, without prior legislation, child marriage has been practiced legally and child-brides are not uncommon.⁵⁴

>> *Following the seven-year review, the revised mid-2015 Act still needs to be certified⁵⁵ (as of publication of this report in March 2016). Without certification, the regulations required to implement the Act have also not been finalised or approved.*

Without approved regulations, no Child Protection Officers can be 'gazetted' (officially vetted) to work with children, and no safe-house licenses (required by the 2015 Lukautim Pikinini (Child Welfare) Act) can be issued.

In addition to regulations, the Shelter Policy and Safe House Guidelines must also be finalised, detailing the minimum essential services that safe houses should provide and their responsibilities.

Furthermore, only four of the country's 22 provinces have allocated budgets for implementing this Act in 2016.

⁵⁵ Certification entails official endorsement through the signature of the Parliament's Speaker

A woman who received treatment after her husband attacked her with a bush knife, lacerating her hand, waits in the Family Support Centre in Tari, Hela Province.



“

There are not enough fully functional health facilities or Family Support Centres offering the minimum package of care to survivors of family and sexual violence in Papua New Guinea.

”

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5.2 GAPS IN MEDICAL AND PSYCHOLOGICAL SERVICES

LACK OF HEALTH SERVICES AND STAFF

Gaps in specialised services required to address the medical and psychosocial needs of survivors of violence worsen their suffering and place them at risk of longer-term damage. However, there are simply not enough fully functional health facilities or Family Support Centres in Papua New Guinea offering the minimum, comprehensive package of care. With only seven Family Support Centres officially deemed fully functional, services offered in the remaining nine centres vary greatly.⁵⁶ The minimum package of care exists only on paper in many, with centres falling into disrepair, or operating with inadequate budgets and insufficient staff numbers. In addition, an effective referral pathway system to connect survivors to assistance beyond immediate medical care is also lacking, particularly in rural areas without hospitals, safe houses or effective police presence.

The critical shortage of medical staff across the entire healthcare sector is a significant contributing factor to insufficient services provision. The World Health Organization (WHO) recommends 2.5 health workers per 1,000 people simply to maintain primary care, while Papua New Guinea has just 0.58 health workers per 1,000 people.⁵⁷ Existing staff often lack necessary training or qualifications to provide appropriate care for patients who have experienced family or sexual violence. Moreover, medical staff are often demotivated due to difficult working conditions, including irregular salary payments and poor physical infrastructure.⁵⁸ Consequently, acquiring, training and retaining healthcare staff in the treatment and management of family and sexual violence is an ongoing challenge.

INSUFFICIENT PSYCHOSOCIAL SERVICES

A survivor-centred approach that involves compassionate listening, a respectful attitude, privacy and the assurance of confidentiality are critical to build up patients' trust and increase their willingness to share. Safety planning is also a crucial component for survivors of family and sexual violence.

Despite some progress in Papua New Guinea, poor recognition of and a poor response to the psychosocial needs of survivors of violence prevails. Existing psychological and social services are frequently ill-equipped to support those who need them.⁵⁹

Much of the counselling available, particularly for female victims of domestic violence, focuses on mediation, with a conflict resolution perspective.⁶⁰ This approach tends to view violence as an interpersonal problem, with a core objective of reconciling the survivor with the perpetrator, regardless of the violent nature of the relationship. This approach can make a survivor feel compelled to remain or return to sites of repeated or escalating violence.

Children are often unable to express or articulate their experiences and emotions following incidents of abuse, and need tailored child-friendly counselling in a safe space, with approaches that aim to establish and build trust. However, there are few trained counsellors in the country^{61,62} and even fewer with child-specific training. Most Family Support Centres lack child-friendly services and effective links to social welfare, child protection, the police, or a system geared towards preventing children from being returned to violent situations. In Port Moresby, a city of more than 250,000 people, the Family Support Centre in the General Hospital is the only site that provides child-suitable psychosocial care for young survivors of family and sexual violence.

⁶¹ Papua New Guinea's Family and Sexual Violence Action Committee (FSVAC) informed MSF in January 2016 that there are five counsellors in the country with counselling degrees, in addition to eight counsellors who received three months of semi-structured teaching in order to run the country's new helpline for survivors of violence. The remaining counsellors in the country are lay counsellors who receive basic short-term trainings.

"We still have a lot to do in this country in terms of child mental health and protection. After the counselling here, we want to refer children to the next services they need, but they are just not available. It's also difficult to see some of the children experiencing or witnessing violence, then beginning to develop aggressive or inappropriate behaviour towards other children."

Linda John, children's counsellor in Port Moresby General Hospital

FURTHER BARRIERS: DISTANCE, COSTS AND INSECURITY

With the few Family Support Centres that are fully functioning located at major referral hospitals, many survivors have to travel for up to eight hours to reach a health facility where they can access the minimum package of essential services. Difficulties in securing and paying for transport often hinder access. In parts of the country without roads, the only travel option is by boat over seasonally turbulent waters.

Charging for healthcare – despite the national circular directing that services for survivors of family and sexual violence should be free – also deter many survivors from seeking help. In addition, over half of the 22 health facilities MSF visited in the Western Highlands province, East and West New Britain provinces and in Bougainville either had no ambulance service, or admitted to sometimes charging patients to cover fuel costs, even though ambulance services should also be free.

Difficulties accessing healthcare are compounded by insecurity, either due to criminality or inter-tribal fighting, such as in the Highlands. These obstacles are enough to prevent survivors from seeking healthcare, or to result in their arriving at clinics past the recommended 72-hour period following an incident of sexual violence.

With children, all the above barriers are even more pronounced due to their lack of independence. Many young victims of violence who need medical attention are reliant on guardians who may be unaware of the abuse or who may have perpetrated it.

Fourteen-year-old Rebecca came into our clinic one day with an 'aunty' who had helped her reach MSF. Her face was bruised from a recent assault by members of a family who had taken her in as a baby, when her mother could no longer afford to care for her. Scars from previous beatings were visible across her arms and legs.

Rebecca described a history of abuse and violence, where she was treated as the family servant, severely beaten for small mistakes, and refused access to basic education. The latest incident had been extremely violent.

The day before Rebecca came to the clinic, an older 'sister' and the sister's husband had begun drinking heavily. Fearing violence, Rebecca tried to hide. When they found her, they stripped her naked as punishment and her brother-in-law raped her. Her 'sister' held her down and beat Rebecca around the head when she screamed. Afterwards, they threatened to kill her if she told anyone what had happened. She managed to flee, with the help of a neighbour who had heard her cries.

After telling us what had happened, Rebecca said, 'Please don't make me go back to that family'. I knew that we would do everything we could to find somewhere for her to stay. I also knew that we couldn't, in all honesty, promise her that she wouldn't have to return – even after the strength it had taken her to escape, to get medical help, and to begin to process her experiences."

Jenny Nicholson, MSF counsellor

5.3 GAPS IN JUSTICE AND PROTECTION ENDANGER HEALTH AND LIVES

"I found out something had gone wrong with my little girl and came here to get help for her. I feel very worried for her. This shouldn't happen. I feel angry. I don't know why this man did this. I know him, he lives in the same settlement, on the same road. I don't want to see his face when we get back home. His parents know what he did to my girl, to other little girls, and they don't discipline him. When I see this I feel more and more angry. I don't want compensation. I want him to be punished with justice, by the law."

Father of a three-year old girl who was raped on several occasions by an 18-year-old neighbour, Port Moresby

Those who manage to reach and obtain medical care face severely limited options to access the legal, social and protection assistance they require. Inadequate or inappropriate responses from the country's hybrid system of formal and traditional justice frequently fail to protect survivors of family and sexual violence.

Nevertheless, there have been advances in the legal and judicial response to the issue, particularly the establishment of Family and Sexual Violence Units; the increased provision of training for duty bearers and service providers across the law and justice sector; the development of the Family and Sexual Offences Unit in the Office of the Public Prosecutor; and a dramatic increase in the number of women village court magistrates recruited and trained across the country, which rose from 10 in 2004 to over 900 by 2014.⁶³

MSF staff in Port Moresby and Tari Family Support Centres have collaborated on multiple occasions with dedicated male and female police officers who have done their best to secure access to protection and safety for victims of violence. However, there have also been many instances where the existing legal and judicial system has blocked efforts to secure protection or commence criminal proceedings.

Patients regularly tell MSF of dealings with police officers who have actively discouraged them from obtaining Protection Orders or pursuing criminal charges, instead pushing women towards mediation, despite their obligations under the 2013 Family Protection Act. Survivors' stories from Tari and Port Moresby expose a justice system that continues to foster a culture of impunity, and to encourage traditional forms of compensation justice to solve family and sexual violence cases.

"My husband's violence started last year. He has given me many injuries – fractured wrist, cuts across my back and elbows, bruises all over my face. You can see all the scars on my body. Sometimes he threatens to kill me.

As he is a policeman, the police will not help me. This centre is the only place where I can come and get help. This is my fourth time here, and today I will get a fourth medical report. I have taken my three other medical reports to the officer in charge of my case at the Family and Sexual Violence Unit, but they don't do anything.

Each time I come here, I have to go back to my husband afterwards. I have nowhere else to go. My husband gives no money to support us. I have to do street selling so I can feed our kids.

“

I don't mind losing a limb, but I don't want to die.

”



A woman waits at the MSF-run Family Support Centre in Tari. Her husband attacked her with a knife in front of her seven year old son. While trying to fight him off, she suffered knife-wounds to her hand, her head and her eye.

I am feeling depressed by it all, seeing that nothing is being pursued, no matter how many times I go back and forth, seeing the police officers giving me all these excuses and not dealing with my case, and my husband just continuing to be violent. All I want is for someone to intervene and discipline him – a charge to be laid on him, a fine, a legal action or something to stop the violence.”

30-year-old mother of three and survivor of intimate partner violence, Port Moresby

FORMAL JUSTICE: OUT OF REACH

In Papua New Guinea, traditional village courts sit within the formal system and are legally not authorised to determine criminal matters such as rape or murder, which should always be referred to the district or national courts. However, district courts are located only in provincial capitals, and with more than 80% of the population living in rural areas, a journey to the police or court can mean several days of travel.

The costs, insecurity and time associated with travel create disincentives to use the formal system for some, and render it impossible for others. The police also face their own logistical and budgetary barriers to enforcing the law in remote areas – due to shortages of fuel or vehicles⁶⁴ or reluctance to travel to areas with little government presence where police are not welcome.

However, survivors' stories reveal that these logistical barriers are merely one factor in the complex, interconnected reasons for the continuing under-reporting of violence against women and children⁶⁵ and the strong reliance on the village court system, including for serious domestic and sexual crimes.

LACK OF POLICE SERVICES AND TRUST IN OFFICIAL SYSTEMS

A lack of legislative protection and support, combined with a general lack of confidence in the police and formal justice system, also contribute to the under-reporting of family and sexual violence.

Survivors need dedicated spaces within police stations for trained officers to respond to family and sexual violence cases in an appropriate, sensitive and effective manner. However, while Family and Sexual Violence Units were created for this purpose, some provinces still do not have any (14 provinces out of 22 have established Family and Sexual Violence Units) with a total of only 17 for the whole country.⁶⁶

In addition, Papua New Guinea's entire police force is understaffed. The UN recommends a ratio of 1 to 400 police officers to the population, but in PNG it is three times lower, at 1 to 1200.⁶⁷ Furthermore, stories from survivors reveal that police officers outside the Family and Sexual Violence Units and Sexual Offences Squad remain under-trained or under-committed to deal appropriately with this type of violence.

Incidents of police misconduct also fuel distrust in the formal justice system, leading to continued disengagement from reporting and pursuing criminal proceedings. In the last three months of 2015 alone, 41 officers in the capital, Port Moresby, were suspended on misconduct charges, while more than 1,600 complaints of police abuse were reported over a seven-year period.⁶⁸

"A neighbour came into my babies' room in the night and hurt them. A friend staying with me saw him, but she was afraid so she didn't say anything, just took her own daughter upstairs with her. At breakfast the girls saw the man and were frightened so they ran. Then my friend told me what happened. I checked them. I could see there was something wrong and we came to the hospital. I had to pay the police to go after the man, and after five days they caught him. If I didn't pay, they would do nothing. Since then [12 months previously] nothing has happened with the case."

Mother of two girls, aged six and two, who were raped by a neighbour. Safe house, Port Moresby

Many survivors of family and sexual violence have told MSF staff that their dealings with police were met with apathy or dismissive attitudes, at best, and with corruption, aggression and even violent abuse, at worst. It is telling that one in ten adult women – 10% (13/129) – who sought treatment in the Port Moresby centre following sexual violence in 2014 and the first six months of 2015 reported that the perpetrator was a member of the police or military.

Even when police do follow up a case and it makes it to court, the prosecution of perpetrators remains ad hoc, as shown by statistics from Lae, Morobe province, where the probability of a sexual violence case involving a female being successfully prosecuted was just 1 in 338, while one involving a child was 4 in 192.⁶⁹

TRADITIONAL JUSTICE AND COMPENSATION MECHANISMS

"My husband was fooling around and, when I confronted him, he bashed me. He cooked my hand on the fire. He threw me like a ball in the air. Then he came at me with a bushknife. He bashed my head and my jaw, which became loose. He told me that if I go to the police, I will never win."

I am waiting here for the medical report to give to the police. I will have to go back to him [the husband] until my father comes to help."

My father wants me to stay with my husband. He says he will come and help us work things out. It is up to my father to end this marriage, because he has to pay my husband back the bride price of 1,500 Kina. My husband has told me that even then there will be no escape – he will always be there."

Woman, 27 years old, in a safe house

The barriers to seeking protection through the official legal system contribute to a continuing reliance on village court culture.

Papua New Guinea's 'wantok system'⁷⁰ promotes a communal culture with a strong preference for dealing with issues within the clan or community internally, rather than through government-enforced national laws. So, although domestic violence was classified as a criminal offence under the 2013 Family Protection Act, it continues to be viewed by many as a private matter to be handled within the family, or by traditional community compensation mechanisms.⁷¹

⁷⁰ The wantok system (in Tok Pisin language), literally translated, means "one-talk". Wantoks (clan or kinsmen) are an indigenous population who speak the same tokples (talk place) or language

Village courts often rely on an approach that prioritises continuing wantok group unity over survivors' needs. The widespread culture of 'compensation', whereby money is paid to victims' families for crimes committed, means that perpetrators of family and sexual violence often evade imprisonment and any official recognition of their violence as a criminal act.

Such rulings fail to protect the survivor, or others, from further violence and harm, as the perpetrator is free to return to the community where the victim lives. The compensation approach also reduces incentives to make complaints against perpetrators who come from the same family or clan as the victim – which is the reality for all survivors of intimate partner violence and almost half the survivors of sexual violence treated by MSF.

CHILDREN AND VILLAGE COURTS

As with domestic violence, cases of physical abuse of children are also often dealt with by village courts. Sexual violence cases should not be tried by a village court, but in practice this also still occurs.

Village courts need increased training to take survivor-focused realities more fully into account. Deeper awareness is required among parents and guardians of children who have been sexually abused about the importance of pushing for legal proceedings rather than simply accepting compensation, in order to protect the child from further distress and danger if the perpetrator remains in the community or household.

SOCIAL MECHANISMS AND BARRIERS TO FLEE VIOLENCE

"My father married me to the man. When he gets jealous, my face becomes swollen from his bashings. Someone helped me get away to here [a safe house] and the police locked him up. But then my family and his family had big violence in the village. To stop the [clan] fighting, my family went to the police to get him released, but the police say no."

If I go back while he is in jail, his family will attack me. The bride price needs to go back to his family and he needs to be released. Then I will be safe."

13-year-old girl, married, survivor of intimate partner violence, in a safe house in Port Moresby

Women's financial dependence creates a further obstacle to seeking and obtaining protection and justice. Many women, particularly those with dependent children, tell MSF they fear that an official complaint to the police could result in jail for their husband, the family's breadwinner, leaving them unable to feed themselves or their children. They face a similar dilemma if they wish to flee partner violence, as there is no social safety net to provide temporary support to help end their financial dependency on their partner.

"For three years I had sexual and physical violence from my husband. I never got a medical report as I never went to the hospital. If I ever left the house, he bashed me. I got here [a safe house] and have been here six months. I am waiting. The police and court haven't done enough. Twice my husband was to appear in court but didn't show up. Everything is taking so long. I need to find a job and leave here. My father is looking for money to bring me back to the village."

Woman, age unknown, safe house in Port Moresby.



Men cross a bridge on their way to a traditional 'peace compensation' ceremony in Tari, in the Highlands region. In Papua New Guinea up to 85 per cent of the population live in rural areas.

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The men are saying, 'Oh, I have paid this much money or pigs and so I can do whatever to her'. So we are telling them, 'No, bride price is something, her life is something else, and violence is another thing'.

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On other occasions women who successfully file for maintenance through the courts withdraw from the legal process following threats by their partners. Survivors have also told MSF staff that judicial sentences, jail terms or attempts to flee from the perpetrator can exacerbate the dangers they face. For instance, if the perpetrator is sentenced, his clan may retaliate with violence not only against the victim of the violence, but also against the victim's entire family. The result is that many women and their children are condemned to a lifetime of abuse.

The experiences of survivors of violence who came to MSF's Family Support Centres reveal that cultural practices such as the payment and repayments of 'bride price' have also hindered their ability to obtain the protection they required to safeguard their physical and psychosocial needs. While not all marriages in Papua New Guinea involve a bride price, it is common in certain areas, including Tari, where men pay the woman's family when marrying, often in money or pigs. This can mean that a new wife is viewed as just another possession.^{72, 73} The requirement to repay this bride price can also delay or prevent a woman from fleeing from a violent partner.

"A lot of times the man has paid the bride price for their wife, and the men are saying, 'Oh, I have paid this much money or pigs and so I can do whatever to her'. So we are telling them, 'No, bride price is something, her life is something else, and violence is another thing'"

Sergeant Alice Arigo, Tari Police Station

A young girl plays with a pig in Benaria Village, Tari, Papua New Guinea. People who commit violent crimes are often required to compensate the victims with pigs or money in judgements handed down by village courts.



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To get a divorce, or to leave her husband, a woman must often obtain the approval of the village court and an agreement from her family to repay the bride price. Even with the village court's permission to repay the bride price, many women or their families simply do not have enough money. Thus they remain trapped with an abusive partner and at risk of further exposure to psychological and physical harm. Women also told MSF that they must remain until they have sustained serious injuries, as only then will the village court grant permission for their family to repay the bride price.

"My husband often beats me. He has used bush knives and sticks, and he punches or slaps me. I have tried to get a divorce from him, but the village elders would not grant it because he had paid a bride price for me – eight pigs and 300 Kina. He had also threatened them, so they told me I had to go back to him.

Sometimes when it [the violence] was very bad, I would go to stay at my parents' house, but he would come and threaten all of us with a gun. My family wanted to report him to the police, but even the police are scared of him.

I was eight months pregnant the last time I left to hide with my parents. He waited for me by the road and attacked me. He chopped my arms and legs with a knife and punched me. Villagers heard my screams, found me and took me to the hospital. Three days later, the baby slid out [it was stillborn].

That was a month ago. My family has now returned the bride price, and this time the village court has granted me a divorce, but my children have to stay with my husband."

25-year-old mother of two, inpatient department, Tari hospital

NO BED FOR THE NIGHT: LACK OF SHORT-TERM SAFE HOUSES FOR SURVIVORS

Recognising that domestic and family violence tends to be repetitive and often escalates over time,^{74,75} staff in Family Support Centres are supposed to help survivors access safe alternative accommodation, such as refuges or safe houses.⁷⁶ However, in Papua New Guinea the creation of safe houses has been stalled, in large part because the policies required for their establishment and roll-out across the country remain in draft form – including regulations for the long-awaited *Lukautim Pikinini* (Child Welfare) Act, the Shelter Policy and the Safe House Guidelines and Code of Conduct.

"He threatened me at the last safe house, so I came to this one. I have been here for seven months and the shelter wants me to leave, to go back home, but I can't. The perpetrator is my neighbour. It is not safe. If I have to leave here, I have nowhere to go. So I will go to the police station with my children and ask for a cell to sleep in."

Mother of two girls, aged six and two, who were raped by a neighbour. Safe house, Port Moresby

In total, there are only six safe houses across the country, in addition to a number of mainly church-supported houses that serve as temporary refuges. Five of those six safe houses are in the National Capital District⁷⁷ and four of them have four beds or fewer. The result is that the majority of women and children who wish to leave abusive homes have nowhere to turn if kinship networks fail to protect them. In Tari, where there is no safe house, one in 15 survivors (41/604) MSF treated at the Family Support Centre between January and June 2015 were repeat patients who had been treated by MSF following a previous violent incident. These survivors had no choice but to return home to their abuser after each treatment.

⁷⁷ These five safe houses are Haus Ruth, Meri Safe Haus, Lifeline, Haus of Hope and Meri Seif Room.

"What I have found hardest is the lack of protection services available to children here once they have been brave enough to come forward and disclose their experience. There is no functioning welfare service that we can refer children to. There are no children's homes, no foster homes, no alternative care arrangements. Often there is simply no alternative but for children to return home to abusers."

Jenny Nicholson, MSF counsellor

The safe houses that currently exist are private, unregulated and unmonitored by national authorities. They operate without licensing regulations in place, or standard operating guidelines to ensure safe and consistent operations. Without regulations from the *Lukautim Pikinini* Act, a finalised Shelter Policy and the Safe House Guidelines and Code of Conduct, safe houses will remain without a defined mandate or clear definitions of the essential minimum services they must provide.

Furthermore, current safe houses are seriously under-resourced. Staff in existing safe houses do their best to provide some food or clothing for women and children seeking refuge, but this is not formalised. None have a childminding facility, meaning that mothers who have fled violence are unable to go to work, look for work or beg. This leaves many with no choice but to return to their partners to feed themselves and their children.

NO REFUGE: UNACCOMPANIED MINORS

The police brought Michael, a 12-year-old boy, to the Family Support Centre for treatment for severe injuries from a blunt instrument. MSF staff treated over 100 bruises and cuts over Michael's torso, arms and legs.

After treatment, Michael could not return home. Following the one-hour beating he had received at the hands of his brother, his family had threatened to break his legs if he returned. However, as an unaccompanied minor, no existing safe houses would take him in.

A police officer handling his case knew of a man living in Port Moresby who unofficially takes children at risk into his family household, and who agreed to temporarily take Michael in.

However, six weeks later, when Michael failed to return for his follow-up consultation, MSF staff visited the household. The man said that in the weeks after Michael had been dropped off there, neither the police nor welfare services had come to check on him, and that a month after arriving, Michael had gone to live with a group of street children.

The situation facing children who wish to flee violence is even more complicated. No existing safe house accepts boys over seven years of age. A woman seeking refuge with children, where one is a boy older than seven, can face an impossible choice: to leave the boy behind, or to keep the rest of the family in the violent situation.

A woman receives treatment at Tari Hospital, Hela Province.



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Safe houses currently operate in a legal limbo in relation to children who flee violence without parental consent and will not take them in. These children are left with nowhere to run.

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Currently, safe houses effectively operate in a legal limbo in relation to children fleeing violence without parental consent – ie ‘unaccompanied minors’. Without an official licence to work with at-risk children, service providers who remove them from their homes or take them in themselves, are at risk of a penalty of 2,000 Kina (\$659), imprisonment or both. No licences will be issued until regulations from the long-awaited *Lukautim Pikinini* Act are signed off and passed in 2016.

So far, only one safe house in the country has ever taken in isolated cases of unaccompanied minors considered to be at extreme risk. The safe house staff did this despite the legal insecurity they faced, after receiving explicit guidance from government officials on how to proceed in relation to these specific children. However, this is a rare exception, and most unaccompanied children fleeing abuse have nowhere to run.

If a child does turn up at the door of a safe house seeking assistance, there is little guidance for safe house managers. Some of these facilities have never received a visit from the relevant Welfare Officers in the Office of Child and Family Welfare Services (OCFWS), while the under-staffed and under-funded Welfare Office has no functioning phone system and is not easy to contact.

This compounds the challenges of protecting children at risk. Previously, there were a small number of Child Protection Officers covering the needs of the country, but since the 2009 Child Welfare Act was repealed, there are no Child Protection Officers officially ‘gazetted’ (vetted and empowered to legally do their duties) in the country.

In addition, official fostering procedures for at-risk children do not exist. The result is that unaccompanied children have no alternative care options beyond their community. If the community is unable or unwilling to protect them, they are effectively abandoned by the formal system, trapping them with their abusers.

CONCLUSION AND RECOMMENDATIONS

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This report details the unacceptable and unnecessary suffering that those who experience family and sexual violence are forced to endure as a result of serious gaps in the systems that should assist and keep them safe. MSF experience treating 27,993 survivors in Papua New Guinea since 2007 and clinical data from MSF-run Family Support Centres confirm the severe levels of violence that women and children, in particular, experience, most often in their homes and communities and at the hands of someone they know.

As MSF prepares to hand over its final Family Support Centre in Papua New Guinea, it acknowledges the important strategic and policy steps that the country has taken to address family and sexual violence. MSF also commends the vital work carried out on a daily basis by committed individuals, communities, service providers and national authorities. However, a sufficient response to meet survivors' needs is far from a reality in many areas of the country.

Though much improved, there is still an inadequate provision of medical and psychological assistance for those who experience violence. Scaling up these essential services across the country is urgently required. In particular, the lack of functioning protection mechanisms, combined

with a continuing culture of impunity and weak justice systems, must be addressed to safeguard the health and lives of survivors. Special attention must be paid to increasing appropriate care and protection for child survivors.

Long delays in translating crucial laws and policies into effective practice are creating confusion among service providers. This further reduces the protection available, in the short and long term, to those experiencing violence at the hands of their partners, parents, siblings, wider family or known social networks. Faster and more effective implementation and resourcing of existing legislation and policies is required.

Without an escalated response, women will remain trapped in violent relationships, unable to remove their children from harm; vulnerable minors who are raped or beaten in their homes will continue to be returned to their abusers; and medical staff will continue to treat the same patients for repeated and escalating injuries.

Efforts to end the high levels of family and sexual violence in the country and to improve the assistance available to survivors must be led by Papua New Guinea. MSF hopes this report will accelerate an improved response from all sectors of society, but in particular from the national government and provincial authorities. MSF encourages these authorities to build on recent improvements and to address serious shortcomings in services and safety provision. This will require a multi-sectoral approach, investing resources and sustained political will. MSF also trusts that this report will help propel increased support and efforts from international donors working with Papua New Guinea.

MSF RECOMMENDS THAT NATIONAL POLICY MAKERS AND IMPLEMENTERS:

Increase availability of and access to essential medical and psychological services.

- Establish and strengthen Family Support Centres in every province, with adequate human and financial resources, to provide integrated medical and psychosocial support to survivors.
- Ensure that all patients receive, at a minimum, the five essential medical services, expanding and improving the availability of psychosocial services, and strengthening the capacities of the local workforce to deliver key services, including to children experiencing psychological trauma.
- Improve ambulance services and expand outreach community awareness activities to increase survivors' access to healthcare.
- Guarantee the implementation of the national policy on providing free-of-charge health services to survivors of family and sexual violence.
- Require healthcare personnel to promptly provide medical reports free of charge in cases of family and sexual violence.
- Develop a family and sexual violence data collection system to help better understand national prevalence and improve the response to survivors' needs.

Increase availability of and access to safe havens and meaningful protection, so survivors of violence are not forced to return to abusers, paying specific attention to the needs of children.

- Ensure safe alternatives for both adult and child survivors wishing to flee abusive environments. Set up sufficient numbers of short- and long-term shelters and safe houses in all provinces, with adequate human and financial resources. Ensure quality assurance by setting standards, establishing monitoring systems and conducting regular assessments.
- Enact the *Lukautim Pikinini* (Child Welfare) Act, ensuring all relevant stakeholders are fully equipped to implement it. This includes the 'gazetting' (vetting) and training of sufficient Child Protection Officers to guarantee children's safety and security.
- Improve access to protection and justice for survivors of family and sexual violence by: establishing adequately resourced Family and Sexual Violence Units in all provinces; increasing police training and capacity to collect evidence from children to be used in legal proceedings; guaranteeing that village courts refer all cases involving indictable criminal offences to official courts.

MSF RECOMMENDS THAT INTERNATIONAL DONORS, SUPPORTERS AND POLICY MAKERS:

- Urge and support the government of Papua New Guinea to undertake the reforms recommended above and increase services available and accountability to survivors of family and sexual violence.
- Ensure that all the work that donors fund to help the government improve service provision to survivors of violence includes a focus on the specific needs of children.



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A six year old girl at a safe house in Papua New Guinea. Her mother brought her there after she and her two year old sister were raped in their bedroom by a neighbour.

GLOSSARY

In Papua New Guinea, MSF provides medical and psychosocial care to survivors of intimate partner violence, sexual violence, child abuse and family violence.

Sexual violence: Any act, attempted or threatened, that is sexual in nature and is done with force – physical, mental/emotional, or social – and without the consent of the affected person/survivor. This includes any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic a person’s sexuality, using coercion, threats of harm or physical force, by any person regardless of relationship to the victim in any setting, including but not limited to home and work. Includes rape, attempted rape/sexual assault and sexual exploitation.

As a medical organisation, MSF provides care to survivors of sexual violence whose physical and mental health has been damaged or is at risk as a result of certain sexual acts including:

Rape: An act of non-consensual sexual intercourse using force or the threat of force or punishment. This includes the penetration, to any extent, by a person of his penis into the vagina, anus or mouth of another person without their consent and the introduction by a person of any object or a part of his or her body (other than the penis) into the vagina or anus of another person without their consent. Marital rape, incest and rape of a minor are all included under this definition.

Attempted rape/sexual assault: Efforts to rape someone that do not result in penetration are considered attempted rape or sexual assault.

Sexual abuse: The actual or threatened physical intrusion of a sexual nature, whether by force or under unequal or coercive conditions.

Sexual assault: When a person touches with any part of his or her body or with an object manipulated by him or her the sexual parts, including the genital area, groin, buttocks and breast, of another person without their consent.

Child abuse: The physical, sexual, psychological abuse or neglect of a child by a parent or caregiver. Under Papua New Guinea law, a child is defined as anyone under 18 years of age, with children aged under 16 not deemed as having the legal capacity to consent to sexual acts.

Domestic violence versus family and intimate partner violence: MSF also treats survivors of family violence and intimate partner violence. These types of violence fall under the more general term domestic violence, which is generally agreed to include any act of physical, sexual or emotional abuse perpetrated by a spouse, partner or family member. In Papua New Guinea, MSF uses the terms ‘family violence’ and ‘intimate partner violence’, as they are more widely understood and they more accurately reflect the violence inflicted on our patients and reflect their medical and psychosocial needs.

Family violence: People who have been physically, sexually or emotionally harmed by another member or members of the family, regardless of the age or sex of the victim or perpetrator. As family has a very broad definition in the context of Papua New Guinea, MSF defines family members as people who live within the same household or compound; this can include blood relatives, co-wives and members of extended family such as in-laws.

Intimate partner violence: Violence by a current or former sexually intimate partner (such as a husband, boyfriend or lover) including acts of physical, sexual, and emotional abuse. It can occur in the household or outside the household. It can include legally-recognized spouses; spouses from second or third marriages that may not be formally recognized by a court of law; In addition to relationships where a couple do not live together (teenagers, adults, “boyfriends”, etc.).

Clearly the different categories overlap: a survivor of sexual violence can also be a survivor of family violence. MSF uses these definitions in order to provide the best care possible and keep a record of that care. Survivors are treated according to their immediate health needs, which are determined according to the act or event.

Patient: Describes the medical status of a person who has been subject to an assault, related to their need for medical assistance and the commitment to confidentiality due to all patients. Further, “patient” recalls the medico-legal responsibility of medical practitioners when treating a victim of an assault, which is regulated under most national legislation.

Survivor/victim: Person who has experienced gender-based violence. The terms ‘victim’ and ‘survivor’ are often used interchangeably. ‘Victim’ is a term often used in legal documents and procedures, but the stigmatisation and perceived powerlessness associated with being a victim means the term is often exchanged for survivor. Literally, a survivor is a person who has overcome a deadly threat, be it violence, disease or accident; in relation to sexual violence, it is often used to describe a living victim, even of usually non-fatal harm, out of respect for their strength and resilience, and to help them heal and feel empowered.

Perpetrator: Person, group or institution that directly inflicts or otherwise supports violence or other abuse inflicted on another against her/his will.

Child or minor: Person under the age of 18, according to the United Nations Convention on the Rights of the Child.

ACRONYMS

MSF Médecins Sans Frontières/Doctors Without Borders

PEP Post-Exposure Prophylaxis

STIs Sexually transmitted infections

UNDP United Nations Development Programme

UNICEF United Nations Children’s Fund

WHO World Health Organization

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While an escalated response is needed to assist survivors of family and sexual violence in Papua New Guinea, MSF commends the vital work being carried out each day by committed individuals, communities, service providers and national authorities.

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ENDNOTES

- ² World Health Organization (WHO), (2016) 'Violence against women: Intimate partner and sexual violence against women' WHO Fact sheet No. 239 [online] Available from <<http://www.who.int/mediacentre/factsheets/fs239/en/>> [10 January 2016]
- ³ United Nations Children's Fund (UNICEF) (2014) 'Hidden in Plain Sight: A statistical analysis of violence against children' UNICEF Division of Data, Research. [online] Available from <http://www.unicef.org/publications/index_74865.html> [10 January 2016]
- ⁴ Toft, S. and Bonnel, S. (eds.) (1985) 'Marriage and Domestic Violence in Rural Papua New Guinea', Law Reform Commission of Papua New Guinea. Occasional Paper No. 18.
- ⁵ Jewkes, R., Fulu, E., and Sikweyiya, Y. (2013) 'Family, Health and Safety Study, Bougainville, Papua New Guinea', Medical Research Council. South Africa: Cape Town
- ⁷ Government of Papua New Guinea (2010) 'National Health Plan 2011–2020: Vol.1 Policies and Strategies' [online] Available from <http://www.health.gov.pg/publications/PNGNHP%20Vol1_2014.pdf> [10 January 2016]
- ⁸ Papua New Guinea (PNG) National Department of Health (NDoH) (2014) 'Health Gender Policy 2014' PNG Reproductive Health Training Unit. [online] Available from <http://www.rhtu.org.pg/wp-content/uploads/2013/02/PNG_Health_Sector_Gender_Policy_June_27.pdf> [10 January 2016]
- ⁹ Médecins Sans Frontières (2011) 'Hidden and Neglected: The medical and emotional needs of survivors of family and sexual violence in Papua New Guinea' MSF International. [online] Available from: <<http://www.doctorswithoutborders.org/news-stories/special-report/papua-new-guinea-hidden-and-neglected>> [10 January 2016]
- ¹⁰ Médecins Sans Frontières (2013) 'Services for Survivors: A survivor-centred medical response to family and sexual violence in Papua New Guinea – the experience of Médecins Sans Frontières', MSF Australia [online] Available from <https://www.msf.org.au/fileadmin/.../MSF_Brochure_FSV_LR_A4.pdf> [10 January 2016]
- ¹¹ United Nations Development Programme/UNDP (2015) 'Papua New Guinea reckons with unmet development goals' UNDP [online] 27 May 2015. Available from <http://www.pg.undp.org/content/papua_new_guinea/en/home/presscenter/pressreleases/2015/05/27/papua-new-guinea-reckons-with-unmet-development-goals.html> [10 January 2016]
- ¹² United Nations Data 'Papua New Guinea: UN Data' World Statistics Pocketbook, United Nations Statistics Division [online] Available from <<http://data.un.org/CountryProfile.aspx?crName=papua%20new%20guinea>> [10 January 2016]
- ¹³ Oxford Business Group, 'Papua New Guinea Year in Review 2015' [online] 11 January 2016, Available from <<http://www.oxfordbusinessgroup.com/news/papua-new-guinea-year-review-2015>> [10 January 2016]
- ¹⁴ The 2016 Budget has already pushed debt figures past the legislated debt limit of 35% of GDP – cited in: Pryke, J. (2016), 'Lingering questions for PNG's 2016 budget: APEC and public debt' The Interpreter. [online] (12 January 2016) Available from <<http://www.lowyinterpreter.org/post/2016/01/12/Lingering-questions-for-PNGs-2016-budget-APEC-and-public-debt.aspx>> [15 January 2016]
- ¹⁵ Flanagan, P. (2015) 'Expenditure in PNG's 2016 Budget – a detailed analysis' The Development Policy Centre, DevPolicy Blog [online] (2 December 2015) Available from <<http://devpolicy.org/expenditure-in-pngs-2016-budget-a-detailed-analysis-20151202/>> [10 January 2016]
- ¹⁶ United Nations Development Programme (UNDP), (2016) 'About Papua New Guinea' UNDP Facts [online] Available from <http://www.pg.undp.org/content/papua_new_guinea/en/home/countryinfo.html> [10 January 2016]
- ¹⁷ The Commonwealth (2016) 'The Commonwealth Member Countries: Papua New Guinea' [online] Available from <<http://thecommonwealth.org/our-member-countries/papua-new-guinea>> [10 January 2016]
- ¹⁸ United Nations Development Programme (UNDP), 'Human Development Reports: Papua New Guinea', UNDP [online] Available from: <<http://hdr.undp.org/en/countries/profiles/PNG>> [10 January 2016]
- ¹⁹ United Nations Development Programme/UNDP (2015) 'Papua New Guinea reckons with unmet development goals' UNDP [online] 27 May 2015. Available from <http://www.pg.undp.org/content/papua_new_guinea/en/home/presscenter/pressreleases/2015/05/27/papua-new-guinea-reckons-with-unmet-development-goals.html> [10 January 2016]
- ²⁰ United Nations Development Programme (UNDP), (2016) 'UNDP Facts: About Papua New Guinea' UNDP Facts [online] Available from <http://www.pg.undp.org/content/papua_new_guinea/en/home/countryinfo.html> [10 January 2016]
- ²¹ Transparency International (2014) 'Corruption by Country/Territory: Papua New Guinea' Transparency International [online] Available from <<https://www.transparency.org/country/#PNG>> [10 January 2016]
- ²² Adu Krow W, Funk M, Nad P, Nanawar L, Ogaranko C, Karahure P, and Skeen, S. (2013) 'WHO Profile on mental health in development: Papua New Guinea', World Health Organisation: Geneva. P3
- ²³ Eccles, G. (2015) 'Maternal Health in Papua New Guinea: Limited public healthcare and misinformation have given PNG the highest maternal rate in the Asia-Pacific' The Diplomat. [online] 24 November 2015. Available from <<http://thediplomat.com/2015/11/maternal-health-in-papua-new-guinea/>> [10 January 2016]
- ²⁴ USAID (2012) 'Technical support for HIV/AIDS prevention, care and treatment project: Summary of achievements and lessons learned from a five-year experience in a multi-country and regional project in the Asia Pacific; Papua New Guinea, end of project report', USAID website [online] Available from <http://pdf.usaid.gov/pdf_docs/pdacy302.pdf> [10 January 2016]
- ²⁵ Australian Doctors International, 'PNG Health Statistics' [online] Available from <<http://www.adi.org.au/health-in-png-2/png-health-statistic/>> [10 January 2016]
- ²⁶ Hammar, L. (2006) "'It's in Every Corner Now": A Nationwide Study of HIV, AIDS and STDs' Papua New Guinea Institute of Medical Research. Operational Research Unit. Goroko
- ²⁷ Papua New Guinea's Ministry for Youth, Religion and Community Development (2015), 'National Lukautim Pikinini (Child Protection) Policy' Papua New Guinea: Port Moresby (p.15 in document, p24 in .pdf format)
- ²⁸ Médecins Sans Frontières discussion in February 2016 with Mr. David Kivu, State Prosecutor and Prosecutor in Charge at the Office of the Public Prosecutor, Family and Sexual Offences Unit, Port Moresby. Note: The Family and Sexual Offences Unit was established within the Office of the Public Prosecutor in 2012.
- ²⁹ World Health Organization (2005) 'WHO multi-country study on women's health and domestic violence against women: summary report of initial results on prevalence, health outcomes and women's responses'. WHO, Switzerland: Geneva
- ³⁰ Garcia-Moreno C. et al., (2013) 'Global and regional estimates of violence against women: prevalence and health effects of intimate partner violence and non-partner sexual violence' Department of Reproductive Health and Research, World Health Organization, Switzerland: Geneva.
- ³¹ Krug E.G. et al., eds. (2002) 'World report on violence and health' World Health Organization: Geneva
- ³² United Nations Children Fund (UNICEF) and The Body Shop, (2006) 'Behind Closed Doors: The impact of domestic violence on children' UNICEF website [online] Available from www.unicef.org/media/files/BehindClosedDoors.pdf [10 January 2016]
- ³³ Campbell J. C. (2002) 'Health consequences of intimate partner violence' The Lancet. Volume 359, Issue 9314, pp:1331-6.
- ³⁴ Hustache, S., Moro, M. et al. (2009) "Evaluation of psychological support for victims of sexual violence in a conflict setting: results from Brazzaville, Congo", in International Journal of Mental Health Systems, Vol. 3, No. 7, April 2009, [online] Available at <<http://link.springer.com/article/10.1186%2F1752-4458-3-7#page-1>> [10 January 2016]
- ³⁷ Bullock C.M., and Beckson M., (2011) "Male victims of sexual assault: phenomenology, psychology, physiology", in Journal of the American Academy of Psychiatry and law, no. 39, issue 2. pp 197-205, April 2011, [online] Available at: <http://www.jaapl.org/content/39/2/197.long>> [10 January 2016]
- ³⁹ Campbell, J. C., et al. (2007) 'Intimate Partner Homicide: Review and Implications of Research and Policy' in Trauma, Violence, & Abuse Journal Vol. 8. No.3 pp: 246-269.
- ⁴⁰ Campbell, J. C., et al. (2007) 'Intimate Partner Homicide: Review and Implications of Research and Policy' in Trauma, Violence, & Abuse Journal Vol. 8. No.3 pp: 246-269.
- ⁴³ Russell, W., Hilton, A. and Peel, M., (2011) "Care and Support of Male Survivors of Conflict-Related Sexual Violence," Sexual Violence Research Initiative, Briefing Paper [online] Available at <<http://www.svri.org/CareSupportofMaleSurviv.pdf>> [10 January 2016]
- ⁴⁴ Papua New Guinea Ministry for Youth, Religion and Community Development (2015) 'National Lukautim Pikinini (Child Protection) Policy' Papua New Guinea: Port Moresby p15
- ⁴⁷ Papua New Guinea National Department of Health (2013) 'Guidelines for PHA/Hospital Management establishing hospital-based Family Support Centres', Papua New Guinea: Port Moresby
- ⁴⁸ Papua New Guinea's National Department of Health (NDoH), (2015) 'Mapping of Family Support Centres in Papua New Guinea' - document provided by the NDoH to MSF on 31 July 2015
- ⁵⁰ Human Rights Watch (2015) 'Bashed Up: Family Violence in Papua New Guinea', [online] 4 November 2015, Available from <<https://www.hrw.org/report/2015/11/04/bashed/family-violence-papua-new-guinea>> [10 January 2016]
- ⁵¹ Department for Community Development, (2014) 'Papua New Guinea National Review on the Implementation of the Beijing Declaration and the Platform for Action and the Outcomes of the 23rd Special Session of the General Assembly', p.23 cited in Human Rights Watch (2015) 'Bashed Up: Family Violence in Papua New Guinea', [online] 4 November 2015, Available from <<https://www.hrw.org/report/2015/11/04/bashed/family-violence-papua-new-guinea>> [10 January 2016]
- ⁵² Justice Services and Stability for Development Program (2015) "Investment Design for the Justice Services and Stability for Development" Australian Department of Foreign Affairs and Trade [online] Available at <<https://dfat.gov.au/about-us/grants-tenders-funding/tenders/business-notifications/Documents/investment-design-png-law-justice-support.pdf>> [10 January 2016]
- ⁵³ Human Rights Watch (2015) 'Bashed Up: Family Violence in Papua New Guinea', [online] 4 November 2015, Available from <<https://www.hrw.org/report/2015/11/04/bashed/family-violence-papua-new-guinea>> [10 January 2016]
- ⁵⁴ United Nations Children's Fund (UNICEF) 2015 statistics found that one in five women aged 20-24 years old had been married or in a union by 18 years, while 2 per cent of women were married by the age of 15. Cited (online) in Girls Not Brides website, Available from <<http://www.girlsnotbrides.org/child-marriage/papua-new-guinea/>> [10 January 2016]
- ⁵⁶ Papua New Guinea's National Department of Health (NDoH), (2015) 'Mapping of Family Support Centres in Papua New Guinea' Document provided by the NDoH to MSF on 31 July 2015.
- ⁵⁷ World Health Organization (WHO) 'Global Health Workforce Alliance: Papua New Guinea' [online] Available from <http://www.who.int/workforcealliance/countries/png/en/> [10 January 2016]
- ⁵⁸ World Health Organization (WHO) 'Global Health Workforce Alliance: Papua New Guinea' [online] Available from <http://www.who.int/workforcealliance/countries/png/en/> [10 January 2016]
- ⁵⁹ Adu Krow W, Funk M, Nad P, Nanawar L, Ogaranko C., Karahure P, and Skeen, S. (2013) 'WHO Profile on mental health in development: Papua New Guinea', World Health Organization. Switzerland: Geneva. p16
- ⁶⁰ Human Rights Watch (2015) 'Bashed Up: Family Violence in Papua New Guinea', [online] 4 November 2015, Available from <<https://www.hrw.org/report/2015/11/04/bashed/family-violence-papua-new-guinea>> [10 January 2016]
- ⁶² Medhora, S. (2015) 'Papua New Guinea helpline flourishes as country deals with endemic violence' The Guardian Newspaper [online] (26 September 2015) Available from <<http://www.theguardian.com/world/2015/sep/26/papua-new-guinea-helpline-flourishes-as-country-deals-with-endemic-violence>> [10 January 2016]
- ⁶³ Australian High Commission (2014) 'Address by Australia's High Commissioner to Papua New Guinea, HE Ms Deborah Stokes, to the Port Moresby Business and Professional Women's Club's International Women's Day Breakfast' [online] (10 March 2014) Available from <<http://png.embassy.gov.au/pmsb/221.html>> [10 January 2016]

- ⁶⁴ Human Rights Watch, (2015), 'Bashed Up: Family Violence in Papua New Guinea', Human Rights Watch Report Summary (online) (4th November 2015) Available from <https://www.hrw.org/report/2015/11/04/bashed/family-violence-papua-new-guinea> [10 January 2016]
- ⁶⁵ Australian Department of Foreign Affairs and Trade (DFAT), (2015) "Justice Services and Stability for Development: Investment Design", [online] Available at: <https://dfat.gov.au/about-us/grants-tenders-funding/tenders/business-notifications/Documents/investment-design-png-law-justice-support.pdf> [10 January 2016]
- ⁶⁶ Consultative Implementation & Monitoring Council (2015) 'Guidelines for Family and Sexual Violence Providers in Papua New Guinea, Annex H', Institute of National Affairs, Papua New Guinea: Port Moresby
- ⁶⁷ Chandler, J. (2014) 'Violence against women in PNG: How men are getting away with murder', Lowy Institute for International Policy, [online], 29 August 2014, Available at: <http://www.lowyinstitute.org/publications/violence-against-women-png-how-men-are-getting-away-murder> [07 January 2015]
- ⁶⁸ Radio New Zealand International (2016) '41 police officers suspended in PNG's capital in three months' [online] [5th January 2016] Available at: <http://www.radionz.co.nz/international/pacific-news/293542/41-police-officers-suspended-in-png-s-capital-in-three-months> [10 January 2016]
- ⁶⁹ Howes, S. and Lokuge, K. (2013) 'Sexual violence in Lae: impunity and resistance' Development Policy Centre [online] Available at: <http://devpolicy.org/sexual-abuse-in-lae-impunity-and-resistance-20130319/> [10 January 2016]
- ⁷¹ Justice Services and Stability for Development Program, (2015) "Investment Design for the Justice Services and Stability for Development" Australian Department of Foreign Affairs and Trade, [online] Available at: <https://dfat.gov.au/about-us/grants-tenders-funding/tenders/business-notifications/Documents/investment-design-png-law-justice-support.pdf> [10 January 2016]
- ⁷² Consultative Implementation & Monitoring Council (2015) 'Guidelines for Family and Sexual Violence Providers in Papua New Guinea, Annex H', Institute of National Affairs, Papua New Guinea: Port Moresby, p6
- ⁷³ Lewis I, Maruia B, Walker S. (2008) 'Violence against women in Papua New Guinea' Journal of Family Studies. 14(2-3): 183-197
- ⁷⁴ Krug E.G. et al., eds. (2002) 'World report on violence and health' World Health Organization: Geneva
- ⁷⁵ UK Department of Health (2005) 'Responding to Domestic Abuse: A Handbook for Health Professionals' Department of Health Publications: London p13
- ⁷⁶ Safe houses should have staff that specialise in supporting women and children during the difficult time when they have chosen to leave a violent situation, and who can also assist with legal matters and other support services. Ideally the location and details of the safe houses should be confidential in order to maintain security and the safety of those who have fled violence. Some women will use a safe house for a break from the violence, to allow themselves time and space to think away from the abuse. They may decide to return home – perhaps to try again, or, frequently, according to survivors in both areas, due to of a lack of preferred alternative options. Others should be able to use their stay in a safe house to plan for the next stage of their lives and to try to find alternative accommodation away from their abuser.

