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Rapid Assessment of Institutional Readiness to Deliver Gender-Based Violence and HIV Services in Five Provinces of Papua New Guinea



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◀ Clement Api, HIV Technical Advisor (on right), and colleagues are seen here outside the Simbu Provincial AIDS Committee office.

FOREWORDS

HIV and gender-based violence (GBV) remain major challenges to the development of Papua New Guinea (PNG). With the national HIV prevalence rate still hovering at about 1 per cent, and reported cases of GBV on the increase, stepping up services delivery is critical in response to these two major issues.

Given the close linkage between HIV infection and gender-based violence, the National AIDS Council Secretariat, as the mandated coordinating body for the HIV response in PNG and with support from United Nations Development Programme (UNDP), instituted this study to assess the readiness of service providers to deliver HIV and GBV services. This assessment is also a follow-up to a 2010 snapshot assessment on progress made in PNG towards the achievement of Millennium Development Goals 3 (*promote gender equality and empower women*) and 6 (*combat HIV/AIDS, malaria, and other diseases*), with specific focus on the readiness of services across the HIV/health, justice, and social sectors from five selected provinces.

A number of recommendations are highlighted, including establishing an overarching body to develop an overall national multisectoral policy as well as service standards, strategies, and accountability measures for the provision of gender-based violence and HIV services, in consultation with service providers, service users, and community representatives.

The report further recommends the need to develop a centralised national data collection system for recording categories of reported crimes to ensure that accurate information about the various categories occurring in each district and province informs planning and service delivery. It also looks at areas such as initiating a national public education programme about gender-based violence and its relationship to HIV, and addressing the resourcing needs of GBV and HIV services across all sectors to increase access for GBV survivors and HIV most-at-risk populations.

Looking ahead, the National AIDS Council Secretariat (NACS) – in collaboration with other national departments, including the Department for Community Development, together with our partners – are keen to advance the implementation of the recommendations of this study. Further, these findings are particularly timely given that the NACS will shortly be embarking on a mid-plan review of the National HIV Strategy, which will also take into consideration recommendations of this report as a stepping stone to further scale-up service delivery, particularly in underserved rural areas.

In recent months the NACS and the Department of Health have embarked on a robust programme for scaling-up health service delivery in the rural areas. This rural drive is grounded firmly on interventions that also address GBV and HIV in the health sectors, such as: 1) primary prevention, e.g., promote community awareness and prevent GBV; 2) secondary prevention, e.g., early identification, confidentiality, monitoring, and respectful treatment of survivors in addressing physical, mental, and reproductive health care needs; 3) tertiary prevention, e.g. more long-term counselling, mental health care, and rehabilitation; and 4) referral to social, economic, and legal support.

I would like to take this opportunity to acknowledge the invaluable support and technical assistance provided by UNDP in performing this comprehensive assessment, as well as the additional support from the Provincial AIDS Committees, staff of NAC Secretariat, Department for Community Development, and all other partners who provided support, information, review, and feedback at various levels.

I am confident that you will find this report highly useful, particularly in informing policies and programme decisions in scaling-up service delivery to address the twin scourge of gender-based violence and HIV. To that end, we hope to have the privilege of your continued support and collaboration.



Dr. Moale Kariko
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There is very little cause for optimism that Papua New Guinea will be able to meet the targets of Millennium Development Goals 3 (*promote gender equality and empower women*) and 6 (*combat HIV/AIDS malaria and other diseases*) by the 2015 deadline.

With respect to MDG 3, gender parity indices of both primary and secondary school, gender enrollment ratios, and cohort retention ratios continue to remain low, dropping below the 1990 base year values in several instances. At the same time, gender-based violence (GBV) seems to be on the increase. The National MDG Report produced in 2009–2010 noted that gender-based violence poses a severe threat to the stability and future development of the country. Poor performance on the MDG 3 front is mirrored by poor performance regarding the HIV component of MDG 6. Even though the annual rate of increase in HIV infections has stabilised, the annual number of newly infected people living with HIV who need treatment, care, and support show a steady rise.

The report that we present here provides a detailed assessment of the country's organizational readiness in delivering services related to gender-based violence and HIV across the health, justice, and social sectors. It is heartening to find such strong evidence of the commitment and dedication of service providers in their efforts to serve the people of Papua New Guinea. The assessment particularly highlights the role of family support centres in providing vital services for women and children, and the role played by the specialised police gender-based violence units in responding to the needs of GBV victims and survivors and in providing redress to their human rights violations.

However, current efforts fall far short in providing necessary services to all victims and survivors of gender-based violence. Notably, there are serious gaps in services – or no services at all – for marginalized population groups, such as men who have sex with men, transgender people, sex workers, and orphans and other vulnerable children.

This study therefore recommends as a matter of urgency steps to address gaps in services, including ensuring that service centres are fully equipped, that the capacities of service providers are strengthened, and that barriers to reporting and accessing HIV and GBV services are removed. The study also recommends the formulation of an overarching implementing body that will coordinate national multisectorial policies and programmes on gender-based violence and HIV services, including access to justice.

This assessment is one of the first of its kind where an attempt has been made to assess readiness to deliver GBV, HIV, and legal services, understanding at the onset the need for integrated services to address the dual challenges of HIV and GBV. It has been developed by leading experts on HIV and GBV with years of experience working in the Pacific. It has benefited from the advice of UNDP colleagues working on gender and HIV at the country level in PNG, at the regional centres in Bangkok and Fiji, and in UN Headquarters in New York.

We are confident, therefore, that this assessment will provide the evidence to direct and guide the national response in addressing the challenges faced by the dual epidemics of gender-based violence and HIV in Papua New Guinea, and trust that it will assist in formulating informed and effective policy and programmatic national responses. We also hope that the assessment will serve as an example for other countries looking into assessments of intergartion of services on HIV and GBV.



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ABBREVIATIONS AND ACRONYMS

A&E	Accident & emergency (departments)
AIDS	Acquired Immunodeficiency Syndrome
APCOM	Asia Pacific Coalition on Male Sexual Health
ARB	Autonomous Region of Bougainville
ART	Antiretroviral treatment
CID	Criminal Investigation Division
CBO	Community-based organization
CWA	Country Women's Association
DV	Domestic violence
ESP	East Sepik province
FHI	Family Health International
FSC	Family support centres
FSVAC	Family and Sexual Violence Action Committee
GBV	Gender-based violence
HAMP	HIV and AIDS Management and Prevention
HCT	HIV Counselling and Testing
HIV	Human Immunodeficiency Virus
IA	Internal Affairs (police)
IPO	Interim protection order
K	Kina (currency, approx. \$ 0.46)
MDG(s)	Millennium Development Goal(s)
MSF	Medecins Sans Frontières
MSM	Men who have sex with men
n =	(Denotes the number of interviewees)
NAC	National AIDS Council
NACS	National AIDS Council Secretariat
NDoH	National Department of Health
NGO	Non-governmental organization
NHATU	National HIV/AIDS Training Unit
NZ	New Zealand
PAC	Provincial AIDS Committee
PALJP	Papua New Guinea – Australia Law and Justice Partnership
PEP	Post-exposure prophylaxis
PNG	Papua New Guinea
PPTCT	Prevention of parent-to-child transmission (of HIV)
SP	Simbu province
STI	Sexually transmitted infection
UN Women	United Nations Entity for Gender Equality and the Empowerment of Women
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
VAW	Violence against women
VCCT	Voluntary confidential counselling and testing
VSO	Voluntary Service Overseas
WHO	World Health Organization
WHP	Western Highlands province

EXECUTIVE SUMMARY

Violence against women by intimate partners and others and the sexual abuse of children are common in Papua New Guinea (PNG), and these acts increase the risk of HIV transmission [World Health Organization (WHO) and UNAIDS, 2010; Lewis, Maruia, and Walker, 2007]. Sexual violence against men who have sex with men, boys, and transgender people is also at high levels [Family Health International and US Agency for International Development, 2011]. The understanding of gender-based violence that underpins this assessment is:

Any harmful act that is perpetrated against a person's will and that is based on *socially associated* differences between males and females. As such, violence is based on *socially ascribed* differences. Gender-based violence includes, but it is not limited to, sexual violence. While women and girls of all ages make up the majority of the victims¹, men and boys are also both direct and indirect victims. It is clear that the effects of such violence are both physical and psychological, and have long-term detrimental consequences for both the survivors and their communities [United Nations Economic and Social Council Humanitarian Segment, 2006].

The relationship between Human Immunodeficiency Virus (HIV) and gender-based violence (GBV) is both strong and complex. There are five major areas in which gender-based violence and HIV overlap: (1) forced sex increases the risk of HIV through physical trauma; (2) violence against women in intimate relationships reduces their capacity to negotiate safe sex; (3) child sexual abuse leaves victims vulnerable to sexual relationships at earlier ages and increased sexual risk-taking, including involvement in sex work; (4) women who test positive for HIV and disclose their test results face increased risk of violence from partners and other family members [(Lewis, Maruia, and Walker, 2008; WHO, 2004); (5) men who have sex with men; transgender people; and male, female, and transgender sex workers are at greater risk of gender-based violence due to the high levels of stigma and discrimination as well as to legislation that criminalise homosexuality and sex work.

In this assessment, the forms of gender-based violence studied include physical, sexual, and emotional abuse of women by their husbands and partners; sexual assault by non-partners; and the physical, sexual, and emotional abuse of children. The needs of men who have sex with men; transgender people; and male, female, and transgender sex workers were also included because these groups are often targets of gender-based violence, including harassment, blackmail, and police violence [United Nations Development Programme (UNDP) and Asia Pacific Coalition on Male Sexual Health (APCOM), as cited in Godwin, 2010]. GBV victims and survivors may have also experienced accusations of sorcery, and discrimination in relation to their HIV status.

¹ The terms "victim" and "survivor" are used in this report to refer to people who have experienced gender based violence. "Victim" is a legal term which means the law will be applied to protect the victim and that they are entitled to restitution. "Survivor" is a term that is strengths-based and implies resilience. When "survivor" is always used to describe people who have experienced gender based violence, definitional errors may occur. The term "victim" will be used when referring to interventions by police and courts, and "survivor" for discussion of gender based violence services. "Victims and survivors" will be used to refer to all service users.

The national prevalence of HIV in Papua New Guinea was 0.9 percent in 2009. The total number of people living with HIV was estimated to be 34,100 – approximately 10 percent of whom were children and adolescents. In 2009, some 1,300 people died from HIV, and 3,200 people contracted and tested positive for HIV. New infections reached a peak in 2003, but have since declined due to the scaling-up of HIV interventions [National AIDS Council (NAC) PNG, 2010]. Young women show the highest rates for new HIV infections [National AIDS Council Secretariat (NACS), 2008], although this result may be due to the greater surveillance of young women’s HIV status through antenatal testing. The Highlands and Southern regions have higher rates of adult prevalence than the national average at over 1 percent [AusAID, 2011], with 60 percent of all HIV cases occurring in the Highlands region.

Due to the high rates of GBV and the widespread HIV epidemic in Papua New Guinea, it is important that vulnerable groups have access to services that meet their needs and that GBV and HIV services are effectively linked and available throughout the country.

Method

The objective of this study was to conduct an institutional readiness assessment of GBV and HIV services across the health, justice, and social sectors in five provinces of Papua New Guinea: Western Highlands (including Jiwaka), Simbu, East Sepik, Madang, and the Autonomous Region of Bougainville.

The assessment was conducted in order to identify the effectiveness of gender-based violence and HIV services, including their areas of strength; gaps in policy, capacity, and physical resources; and the challenges these services face. The study assessed how services respond to GBV victims and survivors and the facilitating factors and constraints in the environments in which these services operate. The study included focus groups and public meetings with community representatives and leaders, service users, and people living with HIV. Key informants in each sector at the national level were also interviewed to provide an overview of policy and standards and to comment on the data being collected (see Table 1, Appendix two).

The services assessed included:

- Family support centres (three in urban hospitals and one in a rural hospital);
- HIV counselling and testing centres (seven based in health facilities and three free-standing centres);
- Specialised GBV police units and criminal investigation divisions in police stations;
- Community policing units;
- District court and village court magistrates;
- Non-governmental organizations that provide GBV and/or HIV services.

The participating services were evaluated using detailed service inventory tools (refer to Table 3 of Appendix three). The inventory tools were developed through an extensive review of service operating procedures and literature relating to service responses to GBV and HIV, policy directives, legislations, manuals, and practice standards.

Key findings

The major finding of the study is that, overall, there is uneven performance by services due to the lack of effective measures of accountability. The assessment found that:

- Both gender-based violence and HIV services are unevenly distributed across provinces and are not always accessible to the people who need them;
- There is serious under resourcing of key GBV and HIV services in the health, justice, and social sectors, which reduces their capacity to provide effective services;
- There are gaps in services or no services at all in the provinces surveyed for men who have sex with men, transgender people, sex workers, and orphans and vulnerable children, even though they are at greater risk of gender-based violence and HIV than the general community;
- Effective responses to GBV and HIV were found in some provinces due to active advocacy and referral networks operating between local agencies.

The major audit and interview findings for family support centres, HIV counselling and testing centres, specialised police GBV units, district courts, village courts, and social sector organizations appear below.

Family support centres

Family support centres (FSCs) were found to provide a vital service for woman and children experiencing gender-based violence; however they are not readily accessible for women living in rural areas unless they are based in rural hospitals. The FSCs in Mt. Hagen (Western Highlands province), Kundiawa (Simbu province), Maprik (East Sepik province), and Buka (Autonomous Region of Bougainville) are performing relatively well against the National Department of Health draft standards, although more resources, training, and standardised procedures (particularly for HIV post-exposure prophylaxis for rape victims, known as PEP) are needed. The referral and support networks for gender-based violence in Kundiawa, which operate through the provincial Family and Sexual Violence Action Committee, are strong and effective.

Family support centres provide couple counselling and mediation in situations of domestic violence, although they have not been trained to do so. Counselling in domestic violence requires specialised skills to avoid increasing the risk of retaliation against women when they return home. Policies, models, and training in couple counselling, trauma counselling, and mediation are urgently needed for FSC workers.

There is a lack of specialised health services for men who have sex with men, transgender people, and sex workers who experience gender-based violence in the provinces studied. Services for these groups are needed to prevent HIV transmission and to address their psychosocial and health issues. Orphans and vulnerable children are another underserved group identified by this study in Western Highlands and Simbu provinces.

HIV counselling and testing centres

HIV counselling and testing centres are located both in health facilities and free-standing locations, and are auspiced by the National Department of Health and a range of non-governmental organizations (NGOs), such as the Catholic and Anglican churches. However, the centres vary greatly in meeting the National Department of Health and National AIDS Council standards. In particular, referral of gender-based violence to support services and/or police, condom distribution, and the provision of regular supervision and debriefing of core staff are areas in which many centres did not meet standards. Additionally, the centres located in health facilities usually do not provide outreach services to remote areas. In contrast, stand-alone centres provide a wider range of services, including skills training for people living with HIV, home-based care, awareness and remote testing, respite care, and day care. Some centres in Western Highlands and East Sepik need more staff trained in the prescribing of antiretroviral treatment (ART) to ensure clients are able to access treatment without long waiting times.

Specialised police gender-based violence units

Various forms of specialised police GBV units exist in the capital towns of all the provinces studied. Those located in the Mt. Hagen (Western Highlands), Kundiawa (Simbu), and Buka (Bougainville) police stations are responsive to the needs of victims and survivors of gender-based violence. Station commanders and other police provide support to the specialised GBV units. Police have GBV referral networks in place with health and social sector organizations. However, resources and facilities, including additional staffing, transport, interviewing rooms, and office equipment, are needed to enable police to perform more effectively.

Police officers in these units require regular training on gender-based violence and human rights and on the use of interim protection orders and responding to breaches of such orders. Buka (Autonomous Region of Bougainville) is a model for the availability of interim protection orders around the clock. The district court magistrate and police prosecutors in Buka make a strong contribution to the availability of the orders through the training of police officers and liaising with other services. Buka also leads the way in using radio as a means of issuing summonses.

District courts

District courts are perceived to be fairer than village courts by service providers and community members, although they are based in urban centres and therefore more difficult to access despite the fact that hearings are held every few weeks in some rural districts. The district court in Buka (Bougainville) is effectively implementing protection orders through excellent working relationships with service providers in the health, justice, and social sectors.

Village courts

Village courts are the most accessible form of legal intervention in rural areas. However, women interviewed in villages and communities do not perceive village courts as fair, but instead believe their decisions are weighted against women. The different jurisdictions of village and district courts were not well understood by village court magistrates or the community.

The access of village court magistrates to ongoing training is limited in the provinces included in this study. Some magistrates had not received recent training, particularly in relation to handling gender-based violence cases, village court preventive orders, and limits in the legal jurisdiction of village courts.

Social sector organizations

The social sector organizations providing services for GBV and/or HIV differ across provinces and districts, so effective service models cannot readily be expanded into other provinces. Faith-based organizations and NGOs provide much needed services for GBV survivors, including safe houses for women and children, longer-term counselling, and care centres and living skills groups for people living with HIV. However, there is a lack of overarching service standards and policy frameworks for services provided by social sector organizations.

Summary

Some effective referral systems are in place among health, police, district and village courts, and social sector organizations for some categories of gender-based violence survivors in each province studied. However, the assessment found that the lack of national standards and accountability mechanisms prevents effective programmes from being rolled-out nationally.

Referral of gender-based violence survivors for HIV testing and post-exposure prophylaxis following sexual assault is not assured in all provinces, even in urban centres. HIV counsellors do not systematically include the risk of gender-based violence in their pre- and post-test counselling sessions, and as a result fail to refer their clients to GBV services.

This study found many barriers to reporting gender-based violence, including the risk of further violence to victims, the cost of transportation to appropriate services, lack of knowledge about legal processes, and the risk that a woman will lose custody of some or all of her children to her husband in the process of leaving a violent relationship. Men who have sex with men, transgender people, and sex workers are prevented from reporting violence to police by legislation that criminalises homosexuality and sex work, as well as by shame, stigma, and discrimination.

These findings can be used to guide policy and the development of service standards, and for decision-making about funding to improve these services.

LIST OF RECOMMENDATIONS

1. Establish an overarching body to develop an overall national multisectoral policy, service standards, strategies, and accountability measures for the provision of gender-based violence and HIV services, in consultation with service providers, service users, and community representatives, and including the following issues:
 - 1.1 Identifying crosscutting issues relevant to GBV and HIV policy and service provision.
 - 1.2 Establishing the linkages, referral pathways and partnership agreements needed between GBV and HIV services and other types of services accessed by vulnerable groups at risk of GBV and/or HIV.
 - 1.3 Establishing quantitative and qualitative indicators and data collection systems for quarterly and annual reporting and monitoring of each agency, as well as the effectiveness of their interlinkages.
 - 1.4 Developing client-centred systems that provide services free of charge to victims/survivors of GBV, and which minimize the associated travel costs, wait times, and security risks for clients, and that respect client choice for a female or male service provider.
 - 1.5 Providing regular supervision and debriefing to GBV and HIV service staff.
 - 1.6 Responding to the specialised needs of vulnerable groups, including gay and other men who have sex with men, transgender people, and sex workers.
 - 1.7 Using models that prioritize victim safety, gender equality, and women's rights to custody of their children for mediation in conflicts involving GBV.
 - 1.8 Providing temporary safe houses for victims/survivors of GBV.
 - 1.9 Re-naming family support centres so as to clearly identify the specific services that they provide to victims and survivors of GBV.
 - 1.10 Scaling-up couple counselling in HIV counselling and testing services.
 - 1.11 Improving the distribution of female and male condoms to all sexually active people, regardless of marital status or sexual orientation.
 - 1.12 Improving the quality of HIV counselling and testing outreach, and attention to GBV risks, in remote areas.
 - 1.13 Ensuring ongoing access to HIV medication for incarcerated people living with HIV, whether in police holding cells or corrective institutions.

- 1.14 Ensuring that all police interfacing with victims of GBV have special training on GBV, HIV, and human rights, and that police services (e.g., service of summonses for protection orders and the investigation of alleged GBV crimes) are free of charge to the victim.
2. Develop a centralised national data collection system for recording categories of reported crimes, which allows accurate information on each type of GBV to be identified at the provincial and district level and to be used for planning related services. To this end:
 - 2.1 Police need to be trained in electronic data entry and the monitoring of data for accuracy.
 - 2.2 Each police station needs to be equipped with adequate information and communication technology resources.
 - 2.3 Data analysts should be located at constabulary headquarters to analyse and report on the data accurately and meaningfully.
3. Develop national multisectoral training on GBV and HIV consistent with national policy and service standards:
 - 3.1 Establish competency-based training programmes for counselling for each type of GBV, integrating a code of ethics based on human rights principles and overseen by a professional certification body.
 - 3.2 Ensure that family support centre staff members have ongoing access to advocacy training in justice sector services, in advanced counselling and trauma counselling (grounded in an understanding of power imbalances in marriage in Papua New Guinea), and in the interventions needed to address power imbalances and ensure women's safety.
 - 3.3 Provide staff in HIV counselling and testing services with training in GBV risk assessment skills for vulnerable groups, and in strategies for engaging men in pre- and post-test couple counselling.
 - 3.4 Provide training for staff in GBV and HIV counselling and testing services in assessment of clients' capacity to negotiate safe sex. Training should include strategies for improving the sexual negotiation skills of vulnerable groups.
 - 3.5 Involve user groups and their advocates in delivering training on barriers to seeking help and reporting violence experienced by men who have sex with men, transgender people, and sex workers.
4. Implement a national public education programme about GBV and its relationship to HIV with the aim of changing attitudes that condone male use of violence to control women. The programme should provide information about services available for victims and survivors, including post-exposure prophylaxis (PEP) for survivors of sexual assault.
5. Scale-up the 24-hour availability of PEP following sexual assault, and establish formal protocols between accident & emergency departments and HIV services to ensure the provision of PEP to all survivors of sexual assault.

6. Address resourcing needs of GBV and HIV services across all sectors to increase access for victims and survivors:
 - 6.1 Open family support centres and police family and sexual violence units in all provinces as a matter of urgency, with female staff of both to work with female GBV victims.
 - 6.2 Ensure that fees are not charged for medical treatment of GBV-related injuries. Provincial family and sexual violence action committees, councils of women, and non-governmental organizations should be trained to monitor fees charged by hospitals and to advocate for their removal.
 - 6.3 Provide GBV centres with adequate funding to help pay the transportation costs for women and families travelling from villages to access services.
7. Review legislations in order to decriminalise homosexuality and sex work and to ensure service provision to all GBV victims without discrimination.
8. Further research should be undertaken on:
 - 8.1 Strategies for ensuring that effective responses to and prevention of GBV and HIV are integrated into primary health care services and specialised clinics (such as maternal/child health, family planning, and sexual health) accessed by GBV victims/survivors and people living with HIV, with particular focus on rural areas, for inclusion in the new national policy and standards.
 - 8.2 The risk of intimate partner violence against pregnant women diagnosed with HIV through routine provider-initiated counselling and testing in antenatal clinics, and the impact on their willingness to access antenatal care and other services, or programmes for the prevention of parent-to-child transmission of HIV.
 - 8.3 The lived experience of service providers in relation to GBV and HIV, and how those experiences affect their readiness to provide GBV and HIV services.
 - 8.4 The nature, extent, and impact of family and sexual/gender-based violence in all the 22 provinces of PNG. Evidence and findings from this research will further guide GBV prevention strategies, policy, planning services, and programme implementation.

CHAPTER ONE

Introduction

This study assesses the readiness of services across the health, justice, and social sectors of Papua New Guinea (PNG) to deliver gender-based violence (GBV) and Human Immunodeficiency Virus (HIV) programmes. Services included in this study have been established to respond to the physical, sexual, and emotional abuse of women by their husbands and partners; sexual assault by non-partners; and the physical, sexual, and emotional abuse of children.

The prevention of all forms of gender-based violence is important for the social and economic future of PNG. Such violence is an impediment to economic development, a considerable public health cost, a violation of human rights, and a risk factor for HIV. There are five main areas in which gender-based violence and HIV overlap:

1. Forced sex, which directly increases the risk of HIV through physical trauma;
2. Physical violence and threat of violence, especially by a husband or partner, which may limit the ability of women to negotiate safe sexual behaviours, particularly condom use and the ability to say no to sex;
3. Sexual abuse as a child, which may lead to adult sexual relationships at earlier ages and increased sexual risk taking, including involvement in sex work and higher numbers of sexual partners in adolescence and adulthood;
4. Women who test positive for HIV and share test results with partners and families may be at increased risk of violence from their partner or other family members [Lewis, Maruia, Mills, and Walker, 2007; World Health Organization (WHO), 2004];
5. Men who have sex with men²; transgender people; and male, female, and transgender sex workers are at greater risk of gender-based violence due to high levels of stigma and discrimination, as well as legislation that criminalises homosexuality and sex work.

The understanding of gender-based violence that underpins the assessment is:

Any harmful act that is perpetrated against a person's will and that is based on *socially associated* differences between males and females. As such, violence is based on *socially ascribed* differences. Gender based violence includes, but it is not limited to, sexual violence. While women and girls of all ages make up the majority of the victims, men and boys are also both direct and indirect victims. It is clear that the effects of such violence are both physical and psychological, and have long term detrimental consequences for both the survivors and their communities [United Nations Economic and Social Council Humanitarian Segment, 2006].

2 The term "men who have sex with men" (MSM) is used in the Pacific region as an inclusive term for men whose sexual identity is homosexual or bisexual, and men who have both male and female sexual partners. The National AIDS Council (2010, p. 65) defines transgender as "individuals whose gender identity and/or expression of gender differs from the social norms related to their sex of birth ... a wide range of identities, roles and experiences which can vary considerably." In PNG, homosexuality is an offence against the Criminal Code, and engaging in sex work is an offence under the Summary Offences Act.

The relationship between GBV and HIV is complex and multilayered [WHO, 2010], with cultural, social, and religious factors contributing to an individual's vulnerability to violence and HIV infection [National AIDS Council (NAC) PNG, 2010]. The national prevalence of HIV was 0.9 percent in 2009; and the total number of people living with HIV was estimated at 34,100, of whom some 3,100 were children and adolescents. Approximately 1,300 people died from HIV in 2009, and there were estimated to be 3,200 people with new HIV infections that year. New infections peaked in 2003 and have since declined due to the scaling-up of HIV interventions [Ibid.]. The Highlands and Southern regions have higher rates of adult prevalence than the national average, at over 1 percent [AusAID, 2011], and the Highlands region alone represents 60 percent of total HIV cases in the country. Young women show the highest rates for new HIV infections [NACS, 2008], although this result may be due to the greater surveillance of young women's HIV status through antenatal testing.

Disempowerment is a common driver of gender-based violence and HIV [Ferdinand, 2009], linked to low levels of education, living in rural areas, youth, unemployment, and sexual orientation. Difficulty in accessing services also increases the risk of HIV [NAC PNG, 2010].

This chapter will briefly examine four areas relevant to institutional readiness to implement GBV and HIV services in Papua New Guinea: 1) the social inequality of women, 2) child sexual abuse, 3) the vulnerability of certain groups, including men who have sex with men and transgender people, and 4) male perspectives on gender-based violence.

The social inequality of women

It is well established that discrimination against women in Papua New Guinea occurs in public and private spheres of life, in law enforcement, in schools and organizations, as well as in everyday interactions in villages, gardens, homes, and families [Brouwer, Harris, and Tanaka, 1998; UN Women, 2011a]. Women experience powerlessness and exclusion in public spheres, including, for example, attaining lower levels of education than male peers and acquiring fewer skills for employment. Educational enrolment rates for girls relative to boys are among the lowest among the Pacific Island countries [AusAID, 2008a, as cited in UN Women, 2011a]; representation of women in all levels of government is only 4.3 percent [UNDP, 2010]; and violence against women continues to be tacitly accepted in the community [Borrey, 2000; AusAID, 2008b]. These social inequalities undermine the exercise of human rights for women and prevent the achievement of the Millennium Development Goals (MDGs) in Papua New Guinea.

The PNG health system is under-resourced, especially in rural and remote areas, and as a result women face higher risks of maternal mortality (733 per 100,000 maternal births in 2006) than women from all other Pacific Islands [Awofeso and Rammohan, 2010]. However, an upward trend in life expectancy indicates improvement in physical health. The average life expectancy in Papua New Guinea is 60 years for men and 65 years for women [World Bank, 2012].

Social interventions made in PNG to advance the status of women include improving girls' access to secondary and tertiary education; improving the promotion and protection of women's human rights; increasing women's opportunities for paid employment; and expanding women's leadership in their communities and at the legislative, policy, and service level. However, access to education and participation in the workforce are not sufficient to protect women from violence in their intimate partnerships – their families and their communities – as a considerable gap remains between men's and women's access to economic and social resources [Lewis, Maruia, and Walker, 2008]. Changes in women's roles as a result of social and economic development, and education that challenges traditional gender norms, can also increase their vulnerability to relationship violence.



◀ Women prepare food in a village in Kerowagi district, Simbu province.

There is no strong evidence base for estimating current levels of violence against women in Papua New Guinea, nor a uniform data collection system to collect statistics on the incidence of gender-based violence nationally [Amnesty International, 2006a]. Most researches, policies, and discourse make reference to a study on family and sexual violence prevalence conducted in 1982 by the Law Reform Commission. As such, the pervasiveness and nature of violence against women has not been captured at the national level for three decades. Amnesty International estimates that relationship violence against women affects somewhere between half and all of the women, depending on the geographical area. The WHO's [2005b] multi-country study on women's health (which did not include Papua New Guinea) focused on physical and sexual violence, and found that 15 to 71 percent of women were affected, depending on the country. This is an under-researched area in which data continues to be limited.

Lewis et al. [2008] found very high rates of partner abuse reported by women in four provinces of PNG: 58 percent of 415 women surveyed reported physical and/or emotional abuse, and 44 percent reported sexual abuse. An additional aspect of sexual abuse in marriage is where men 'rent' their wives for sexual favours [Amnesty International, 2006a]. The most common triggers for domestic violence are women saying no to sex with husbands or partners, asking husbands or partners to use condoms, and men drinking alcohol [Lewis et al., 2007]. Notably, the first two of these triggers have strong implications for vulnerability to contracting HIV.

Other forms of gender-based violence include gang rape and "pay back rape" of women in areas of tribal fighting as a form of retaliation against another tribe, and the torture and murder of women suspected of "sanguma" (witchcraft or sorcery) or having HIV [UN Women, 2011a]. Elderly men and women, widows, and those resented by others are most at risk of accusations of sorcery. Victims have been beaten, stoned, electrocuted, forced to drink petrol, and buried alive [Wilson, 2012]. Women who sell goods in local markets and travel on public motor vehicles are additionally exposed to frequent physical and sexual violence [Amnesty International, 2006b].

Such customary practices as brideprice and polygamy are evolving with cash economies to further disadvantage women [UN Women, 2011a]. Women feel unable to leave abusive marriages unless their families support the separation as they do not have the economic resources to pay back the brideprice to their male relatives [UN Women, 2011a]. Payment of compensation for gender-based violence to women's male relatives in order to restore harmony and relationships between groups overlooks the experience

of the victims and denies women access to justice in district and national courts. In a study of men's use and experience of violence [Lewis, 2010], a male participant spoke on the lack of justice in compensation payments: "*the victim will not get anything out of that violence.*" The sociocultural contexts contributing to inequality of women also contribute to HIV vulnerability.

Child sexual abuse

Experiences of child sexual abuse are strongly linked to the risk of HIV and gender-based violence in adult life [Lewis, 2012]. Family poverty, dysfunction, and separation; the neglect of children; substance abuse; and tribal fighting in which children are sexually targeted all contribute to the incidence of child sexual abuse [UN Women, 2011a], as does the widespread practice of informal adoption of children [Help Resources and UNICEF, 2006]. Children with disabilities are particularly at risk [UN Women, 2011a].

Organized child sexual abuse in Papua New Guinea has developed as a result of a mobile male workforce, both national and expatriate, with disposable incomes; unregulated urban brothels employing children; child prostitution networks; the trafficking of children as sexual partners, wives, and workers; and the widespread availability of child pornography [Pacific Regional Rights Resource Team, 2008, as cited in UN Women, 2011a; Pacific Regional Rights Resource Team, 2006; Help Resources and UNICEF, 2006]. Paying cash for sex involving children has become more common in developing countries as a result of poverty, customary practices such as brideprice, and the breakdown of traditional norms around sexual behaviour with modernisation [Lalor, 2008].

There is no reliable reporting or data collection system in Papua New Guinea to monitor the prevalence of child sexual abuse, apart from presentations to hospitals for treatment of sexual assault. Consequently, reports of child sexual abuse to hospitals and police are not accurate indicators of prevalence. The majority of patients presenting for treatment following sexual assault for the period 1994 to 1996 were children and young people. Seventeen percent were aged 2–10 years, 20 percent were 11–15 years, and 21 percent were 16–20 years [Pacific Regional Rights Resource Team, 2006]. Stepfathers and mothers' de facto partners were reported to be most frequently responsible for child sexual abuse [Help Resources and UNICEF, 2006]. While the majority of offenders are male, a small number of female sexual offenders targeting young boys have been reported [ibid.].

Studies in Papua New Guinea have found child sexual abuse survivors have a higher number of sexual partners and are more likely to be involved in sex work and exchange sex [Hammar, 2006; Lewis, 2012]. Survivors are also more vulnerable to HIV infection as a result of higher rates of sex partners, unprotected sex, and gender-based violence in adult relationships [Lewis, 2012; WHO, 2004].

Gender-based violence against men who have sex with men and transgender people

Studies show that men who have sex with men (MSM) and transgender people are at greater risk of gender-based violence due to high levels of stigma and legislation that criminalises homosexuality – factors that also reduce access to services [Godwin, 2010]. Although there have been no research studies conducted in Papua New Guinea on the issue, the National Dialogue on HIV and Law conducted in 2010 heard accounts of physical and emotional violence faced by men who have sex with men and transgender people.

The National AIDS Council also notes that stigma and discrimination further exacerbate the social inequality experienced by gays, lesbians, men who have sex with men, and transgender people [NAC PNG, 2010].



◀ Clients of the Dugal Care Centre for people living with HIV, in Simbu province, gather with community representatives and Clement Api of the Simbu Provincial AIDS Committee (front row, right).

A systematic literature review on the prevalence of sexually transmitted infections (STIs) found no published or unpublished research on HIV prevalence among MSM in Papua New Guinea [Vallely, Page, Dias, Siba, Lupiwa, Law, Millan, Wilson, Murray, Toole, and Kalder, 2010]. Nonetheless, it is known that MSM have a higher risk of HIV, particular young men, as they are more likely to be receptive partners [Asia Pacific Coalition on Male Sexual Health, 2010]. UNAIDS and the Asia Pacific Coalition on Male Sexual Health (APCOM) [2005] estimate that the HIV risk for MSM is 5–15 times higher than the overall HIV prevalence in the Asia Pacific Region. Surveys in Papua New Guinea have shown that 12 percent of young men have sex with men, for example in boys' dormitories [APCOM, 2010]. More research is needed to inform programme planning and for effective interventions to reduce the incidence of unsafe sex for men who have sex with men.

Male perspectives on the use of violence

It is important to study male perspectives on gender-based violence to better inform effective community education and violence prevention campaigns. The perspectives of men have not been consistently included in GBV research, an oversight that distorts both findings and recommendations [Ferdinand, 2009]. Sai [2007] undertook her doctoral research on masculinities in Papua New Guinea and discovered hybridized forms of masculinity that combine customary and modern expressions of manhood, which have developed as a result of colonisation and modernisation. Hybridized forms are where traditional customs are still practiced, but the roles of men and women and the use of power are changing and adapting to the modernising of everyday life. Therefore, traditional culture cannot be used as the sole explanation for gender-based violence.

A study by Lewis [2010] asked a sample of men (sample size $n = 125$) in Western Highlands, Madang, and Western provinces about the impact of the use of violence in relationships. Male participants described victims as suffering such emotional effects as feeling "*used, hopeless, and exposed*." Male offenders paid compensation to relatives of their wives or partners, paid for medical treatment, and felt "*guilty*," "*remorseful*," "*not good*," and "*uneasy*." Men described how their intimate partner relationships were affected. They are not respected and "*lost proper communication*" with wives and partners. Their children suffered a range of emotional impacts. Children may stay away from school, be sent to live with relatives, imitate their fathers' violence towards their mother, or hate their father.

Men's social status is affected by their use of violence against wives. They may be stigmatised in their families and communities as "*drunkards*" and "*wife-beaters*" and lose the respect of others. This creates a "*lack of harmony*" and "*disunity*" in families. Families have to help pay compensation, lose the contribution of the wife to gardening and tending pigs, and other family members have to care for the children [Ibid].

Summary

This chapter has briefly reviewed research and reports on gendered social inequality, gender-based violence, and HIV in Papua New Guinea. The high rates of gender-based violence against women, children, men who have sex with men, transgender people, and sex workers is cause for deep concern. Links between gender-based violence and HIV transmission pose a considerable health risk, and thus the scaling-up of services to reduce gender-based violence and lower rates of HIV are urgently needed [NAC PNG, 2010].

The next chapter describes the methodology used in this study to audit GBV and HIV services currently in place in the health, justice, and social sectors.

CHAPTER TWO

Methodology

Objective

The objective of this study was to conduct an institutional readiness assessment of gender-based violence and HIV services delivered by health, justice, and social service sectors in five provinces of Papua New Guinea, including the Autonomous Region of Bougainville, in order to identify strengths, gaps, and challenges in capacity and physical resources for addressing these services. The findings presented here can and should be used to guide future policy and funding decisions aimed at improving these services.

The local contexts of service provision were studied using focus groups and public meetings with community representatives and leaders to identify the facilitating factors and constraints in the environments in which services operate. Constraints in developing effective programmes may arise from the social and cultural contexts in which the human interactions between service providers and service users take place [Holt et al., 2007]. The organizational support for providing GBV and HIV services were assessed by asking about supports within organizations for the implementation of services [Ibid.].

Study rationale

Evidence exists from numerous studies [WHO and UNAIDS, 2010], including in Papua New Guinea [Lewis et al., 2007], that violence against women by intimate partners and others, and the sexual abuse of children, increase the risk of HIV transmission. Forms of violence against women and children, including physical, sexual, and emotional abuse, are known to be common in Papua New Guinea. Recent research has established that sexual violence against men and boys, especially men who have sex with men and transgender people, is also at high levels [Family Health International (FHI) and US Agency for International Development (USAID), 2011]. People living with HIV are also at risk of increased violence, stigma, and discrimination.

Various efforts have been made over the last decade by government agencies and civil society organizations in the health, justice, and social sectors to prevent gender-based violence, hold perpetrators accountable, and provide GBV and HIV services to victims and survivors (see chapter three). However, in most parts of the country, such services are non-existent or difficult to access, and the needs of gay men, men who have sex with men, and transgender people are barely recognised. There is a need to provide accessible medical and psychosocial care for these people, particularly in relation to physical and sexual assault, and to link them with services to reduce the spread of HIV.

The **National Health Plan 2011–2020** calls for “Family support centres to reduce the impact of violence in the home and community” to be rolled out throughout the country [Strategy 7.1.2]. However, to be effective, these centres require strong links with HIV services; with justice sector services providing legal protection and redress, such as district and village courts, public solicitors, and legal aid; and social sector organizations providing practical support, safe accommodation, counselling, advocacy, emergency basic needs, alternative livelihoods, community support, and repatriation.

It is timely for a study of gender-based violence and HIV services and the inter-linkages between them to assess whether the needs of GBV victims and survivors are being met in ways that reduce the consequences of GBV on Papua New Guinea's HIV epidemic.

Method

This study identified the indicators of effective approaches to gender-based violence and HIV prevention and interventions in the health, justice, and social sectors, and assessed the extent to which these indicators already exist in the study locations through an audit process.

The study used rapid assessment qualitative methods to assess institutional readiness and service capacity [Holt et al., 2007], and to make recommendations for improved services and linkages based on lessons learned. The team consulted policy makers, key personnel, and policy documents of the National Department of Health, Family and Sexual Violence Action Committee, Police Headquarters, and the National AIDS Council Secretariat (see Table 1, Appendix two). The involvement of stakeholders was important to ensure that the final report and recommendations are relevant to policy makers and key service managers.

Tools and indicators

Detailed inventories listing key elements for each sector and service were developed through an extensive review of service operating procedures and literature relating to service responses to GBV and HIV, including policy directives, legislation, manuals, and practice standards (see Table 3, Appendix three). The inventory tools were refined through initial discussions with the National Department of Health, the National AIDS Council, the Papua New Guinea–Australia Law and Justice Partnership (PALJP), the PNG UNDP team, the National HIV/AIDS Training Unit at the International Education Agency of PNG, and the Provincial AIDS Committees based in the study locations. The inventory tools were further developed during consultations, and then refined to create more concise instruments with specific indicators for application nationally.

Sampling

Study locations were chosen where family support centres or crisis centres were known to be providing services to victims and survivors of gender-based violence. It was expected that lessons learned from their experience, their strengths, and their challenges would be of value in making recommendations for other centres where services are still rudimentary or non-existent. The study did not include the National Capital District (NCD), but was able to draw on the recent extensive assessment of health, justice, and social services for gender-based violence in the NCD carried out by Oxfam [2011].

Data collection was conducted in the following five provinces, towns, and districts:

Western Highlands province

- Mount Hagen
 - Minj, Kudjip, Banz, and Jiwaka districts

Simbu province

- Kundiawa
 - Kerowagi, Kond, Gagul, and Mingende districts

East Sepik province

- Wewak
 - Maprik

Madang province

- Madang town
 - Yaguam rural district

Autonomous Region of Bougainville

- Buka

The five provinces also represent significantly different 'culture areas' within Papua New Guinea, which influence relationships between men and women in different ways [Jenkins, 2006, p. 7; National Sex and Reproduction Research Team and Jenkins, 1994]. The Highlands provinces, the coastal areas of Wewak and Madang, and the island of Buka are distinct geographical regions that differ in beliefs, customary practices (such as brideprice), and social structures [Jenkins, 2006].

The Provincial AIDS Committee (PAC) in each of the five provinces was contacted by UNDP Team Leader Peterson Magoola and/or the National AIDS Council, and asked to set up meetings for the researcher with a range of services, including police specialised GBV units, family support centres, HIV counselling and testing centres, non-governmental organizations, and district and village courts. The coordinator in each PAC also set up focus groups, public meetings, and interviews with community representatives and leaders as well as with people living with HIV. It was not intended or possible to cover all services in each province.

While the PACs were important facilitators for data collection because of their extensive networks, they were not always linked strongly with the justice sector. Accordingly, interviews with justice services were often set up in the field. Data collected across the provinces varied as a result of which social sector organizations were based in each province, whether plans to set up family support centres and police family and sexual violence units had been implemented, the presence of key personnel in organizations during the data collection period, and the organizational and community networks of the Provincial AIDS Committee. These variations in data collection are discussed in the final section of this chapter on limitations of the study.

Data collection

Qualitative data was collected from family support centres and HIV counselling and testing services, health services, non-governmental GBV services, police, community police, and village and district courts. Inventory tools and interview questions were used to determine if key elements for effective GBV and HIV programmes were being delivered, and the degree of local support available to GBV victims and survivors.

There were three phases of data collection for the study:

Phase 1: Analysis of key service elements

This stage entailed using the inventory tools to establish what gender-based violence and HIV services were being provided by health, justice, and social sector services and to identify the gaps in services. Meetings with service providers in these sectors were held in all five provinces to audit services and to conduct semi-structured interviews with service providers. Data collected included

the strengths and weaknesses of current interventions, the local networks and contexts of service provision, and how these influenced service responses.

Phase 2: Focus groups, public meetings, and individual interviews with GBV and/or HIV services users and advocates

Focus groups, public meetings, and individual interviews were held to collect data on service users' experience of accessing services, the appropriateness of service responses, and referrals to other services. People living with HIV were accessed through life-skills groups and respite care centres. Service users were asked to make recommendations as to how services could better meet their needs (refer to Appendix six for service user questions).

Phase 3: Focus groups and public meetings with representatives of local communities and village leaders

Focus groups and public meetings were held with community representatives, village leaders, and a Council of Elders in Buka to collect data on the needs of communities in relation to GBV and HIV. Information was collected on the effectiveness of services provided by the health, justice, and NGO sectors. Data was collected on cultural and social contexts influencing gender-based violence and access to services, and what participants saw as the gaps in current service provision (refer to Appendix six for focus group questions for community representatives and leaders).

Interviewing in village settings called for flexibility. The team first interviewed male villagers and community leaders as a group and then women. In two villages, men stayed to hear what the women were saying. This may have compromised women articulating their views independently. Male and female village leaders spoke out against gender-based violence and advocated for women's needs to be met more effectively. Focus groups and public meetings were between 60 and 90 minutes to ensure that everyone could have their say.

Data collection was completed with the following services and groups:

Family support centres

Four centres were audited in Mt. Hagen, Kundiawa, Maprik, and Buka.

HIV counselling and testing centres

Ten centres were audited in total: seven based in health facilities in Mt. Hagen, Minj, Kundiawa, Mingende, Wewak, Madang, and Yaguam; three stand-alone centres auspiced by the Catholic Church in Banz, Wewak, and Buka.

Aid post

One aid post was visited in Kond. A health volunteer worked at the aid post, which was located in an unfinished building next to Kond village. The family support centre used the aid post for outreach programmes to villages.

Police units

Specialised GBV units of different kinds were audited in the provincial police stations of all five provinces. One criminal investigation division was audited in Madang.

Community police were interviewed in Wewak and Madang about responses to GBV victims and offenders.

Village courts

Three village court magistrates and a clerk of the court were interviewed in Kudjip, Kerowagi (n = 2), and Wewak.

District court

One district court magistrate was interviewed in Buka.

Non-government organizations and faith-based organizations

Thirteen social sector organizations were interviewed across the provinces about the services they provide to GBV victims and survivors, to people living with HIV, and to vulnerable children and orphans.

Community representatives and village leaders

One hundred and eleven community representatives and village leaders were consulted in three provinces of Western Highlands, Simbu, and Buka about their views on gender-based violence and HIV, and the effectiveness of services provided by health, justice, and social sector organizations.

Service users

Common and unique aspects of the needs of service users around gender-based violence and HIV, and how these services are delivered, were captured through the data collection. Five service users who had experienced gender-based violence were interviewed in Mt. Hagen, Wewak, and Buka. They also commented on how police had responded to their reports of gender-based violence.

Four community care centres for people living with HIV were visited in Jiwaka (n = 7), Banz (n = 3), Minj (n = 3), and Kerowagi (n = 7), as well as a support service for people living with HIV in Madang (n = 3). Focus group interviews were held in these five locations about the experiences of stigma and discrimination and the effectiveness of services. One person living with HIV was also interviewed individually in Wewak (total n = 14).

Two services for vulnerable children and orphans whose parents were ill or had died of AIDS were visited in the village of Jiwaka (n = 47) and Gagul (n = 21).

Refer to Tables 1 and 2 in Appendix two for further details of services and participants.

Data analysis

The data were systematically coded into themes and organized into five tables comparing services by province for family support centres, HIV counselling and testing services, police specialised GBV units, village courts, and district courts. Meaningful comparisons were facilitated by the display of data on services by province in tables, and unique and shared challenges of service provision for GBV victims and survivors and HIV service users were identified. The views of service providers, service users, and advocates and community representatives about the effectiveness and availability of these services have been included in the tables of findings in Appendix seven.

Ethical issues

A meeting with the Research Management team at the National AIDS Council was held to discuss the ethical issues involved in the study. The focus group and interview questions aimed to gather data on experiences of service users rather than personal information. The advice to the study team was to inform the Research Advisory Committee *in writing* about the study with the focus group questions. Informed consent forms were developed for service users and community representatives to ensure that their participation was voluntary. Where there were literacy issues, for example with interviews in villages, the consent form was read out to the participant and a tick box recorded “yes” or “no.” Each focus group participant gave consent. The interview notes and photographs were taken back to the villages and care centres for people living with HIV by the Provincial AIDS Committee. Interview notes were sent back to services by email or fax.

Focus group interviews may pose a risk to the confidentiality of service users, especially people living with HIV. The facilitators contracted with participants for confidentiality of information shared in focus groups. The team reminded participants not to share more information than they felt comfortable discussing in a public forum.

The study originally aimed to interview male and female participants and their advocates in separate groups, or individually if participants were concerned about their confidentiality. However, men and women living with HIV preferred to be interviewed as a mixed group.

The study team was also mindful that the data gathered from services has the potential to cause embarrassment to service providers and possible consequences with funding bodies. To address these concerns, the study has purposely highlighted strengths as well as gaps in service provision.

Limitations of the study

The travel itinerary placed great pressure on the research team and on the Provincial AIDS Committees, which provided logistical support. In some provinces, very short periods of time were allocated to interview those who were providing health, justice, and social sector services; service users; and people living with HIV. In Wewak, for example, 11 interviews were conducted in one day. With such a short time-frame, some services could not be included in the study if a key staff member was away. This prevented collection of data on all services across all five provinces. Furthermore, in relation to outreach and awareness programmes, the study was only able to determine whether these were being provided, not evaluate their quantity or effectiveness.

Audit tools were developed for antenatal clinics, HIV treatment units, paediatric AIDS units, tuberculosis (TB) clinics, treatment services for STIs and HIV, family planning clinics, and health services in rural areas (see relevant sections in Table 3, Appendix three). These are the main health services in Papua New Guinea, accessed by millions of clients each year, many of whom have experienced or are at risk of gender-based violence and/or HIV, including the large numbers of young women now being routinely tested for HIV in antenatal care (see chapter three). However, for logistical reasons it was not possible to assess these services in the study areas. As a result, no recommendations could be made for improving the ways in which these key services identify and respond to gender-based violence. This represents a major limitation of the study.

The study nevertheless provides a solid body of valuable information to guide policy makers and service providers in taking action to reduce the serious burden of gender-based violence and HIV in Papua New Guinea and the Autonomous Region of Bougainville.

The following chapter provides an overview of services currently provided for victims and survivors of gender-based violence and people living with HIV as a framework for the study.

CHAPTER THREE

Gender-based violence and HIV policies and services in Papua New Guinea

This chapter reviews the information available on gender-based violence and HIV policies and services in Papua New Guinea, and outlines the services and policies currently in place. As chapter one has shown, victims of physical and sexual forms of gender-based violence are at greater risk of HIV infection. Conversely, disclosure of HIV status can result in further victimisation of people living with HIV. In the context of Papua New Guinea's HIV epidemic, it is therefore essential that GBV and HIV services are integrated or interlinked to minimize the risks and impact of both.

An integrated approach is not only greatly beneficial to individuals but also to public health and welfare. Numerous reports in recent years have demonstrated that very few GBV survivors in Papua New Guinea are able to access the health, justice, and social services they require [Amnesty International, 2006a; Lewis et al., 2007; AusAID, 2008b; Siebert and Garap, 2009; Oxfam, 2011; *Medicin Sans Frontières* (MSF), 2011; UN Special Rapporteur on Violence Against Women, 2012]. Lack of access to appropriate services results from chronic under-resourcing of health, justice, and social services; the risks and costs of travel to urban-based services; and the practical difficulties faced by service providers operating in difficult, remote, and sometimes dangerous areas, such as conflict zones, areas of high crime, mountainous areas, swamps, and scattered islands.

Failure to perceive gender-based violence as a public health, civil security, and human rights concern also contributes to inadequate service provision. The persistence of traditional attitudes and customs that contribute to and justify the use of violence against women are barriers to survivors' access to services, and to implementing appropriate policies and funding allocations. It is unlikely that service provision will ever meet the level of need without substantial public efforts to bring about attitudinal and behaviour change.

Policy context

Papua New Guinea is a signatory to the United Nations Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), but has not yet followed through with the development of a comprehensive multisectorial policy and strategy to address gender-based violence. For example, Papua New Guinea lacks a comprehensive legal framework addressing all forms of violence against women [CEDAW, 2010, as cited in UN Women, 2011b]. Multisectorial actions recommended to Parliament as long ago as 1992 have still not been introduced into law or policy [Law Reform Commission, 1992]. A national multisectorial strategy aiming to combine gender-based violence services provided by government agencies, civil society, and the private sector was developed by a quasi-governmental advisory organization, the Family and Sexual Violence Action Committee [Bradley and Kesno, 2001; Siebert and Garap, 2009]. However, the strategy was not endorsed by the government, and a strong government agency with the mandate to lead implementation, such as a national commission on gender-based violence, is also lacking.

There has been some progress within individual sectors. The National Health Plan 2011–2015 calls for the roll-out of family support centres, and the Sexual and Reproductive Health Policy [National Department of Health (NDOH), 2009b] and Family Planning Policy [NDOH, 2009c] recognise the importance of addressing

gender-based violence, particularly in the context of Papua New Guinea's extremely high maternal mortality rate. However, there is no overall strategy to ensure effective health services to GBV victims and survivors in all areas of the country and at all levels of health service delivery.

The National Gender Policy and Plan on HIV and AIDS 2006–2010 [NAC PNG 2006], the National HIV Strategy 2011–2015 [NAC PNG, 2011], and the Operational Plan on Prevention of Parent to Child Transmission of HIV and Paediatric AIDS [NDOH, 2010d] have also identified gender-based violence as a priority issue for reducing the spread and impact of HIV. These call for better integration and linkages of gender-based violence and HIV services, particularly in HIV counselling and testing. Implementation has been slow and heavily focused on the province-level family support centres. The National AIDS Council Secretariat and the Provincial AIDS Committees do not provide direct services and have limited capacity to support and coordinate multisectorial implementation.

The justice sector does not have a sectorial policy or strategy on gender-based violence, but there have been initiatives in each agency to improve protection for victims. New legislation on sexual offences for adults and children has been introduced. Papua New Guinea is a signatory to the UN Convention on the Rights of the Child, and has enacted the comprehensive child protection Lukautim Pikinini Act in 2009.

In the social sector, the Department for Community Development has sponsored the National Policy for Women and Gender Equality 2011–2015, which lists gender-based violence as a priority issue but fails to set out an action plan. Services for victims and survivors (such as safe havens, counselling, and alternative livelihoods) and efforts to reduce gender-based violence through awareness-raising and attitude change are provided by social or private-sector organizations and are not covered by government policy or strategy.

Health sector services for gender-based violence and HIV

The health sector is the primary provider of gender-based violence and HIV services. The National Department of Health oversees policy and funding, although some responsibilities have been decentralised to provincial and district health authorities, and service delivery is often managed by social sector organizations. Approximately half of all health services are provided by faith-based and non-governmental organizations, the main one being the National Catholic Church Health Service [AusAID, 2011].

Clinics run by the NGO Susu Mamas provide antenatal and postnatal drop-in and outreach services to reduce the infant mortality rate in Port Moresby, Mt. Hagen, and Lae. The clinics provide HIV testing and advice on infant feeding for HIV-positive mothers, as well as a toll-free telephone counselling and referral service. The NGO Marie Stopes International provides clinics for integrated sexual and reproductive health services through a memorandum of understating with the National Department of Health. The clinics also address HIV and gender-based violence. Marie Stopes provides 60 percent of its family planning services through mobile outreach clinics to reduce the cost of travel for service users [Marie Stopes International, 2010].

In some provinces, community-based village health volunteers have been trained to carry out awareness activities and make referrals in cases of domestic violence, sexual violence, child sexual abuse, and HIV. The Health Promotion branch of the National Department of Health has run community awareness programmes on gender-based violence in the past, but these are no longer active.

Primary health care facilities such as aid posts and health centres are likely to be accessed by victims of gender-based violence for treatment of injuries caused by the violence. GBV survivors who live close to a provincial capital town may access treatment at family support centres, which are located in some provincial hospitals. Other victims and survivors come into contact with health services when seeking other forms

of care, such as antenatal and postnatal services, mother and child health, family planning, and STI and TB services. Gender-based violence cannot be identified unless health workers across all facilities are trained to assess and respond appropriately.

Family support centres

Family support centres are designed to operate on a 'one stop shop' model, at which all of the client's needs are met in one place by staff trained to provide holistic medical and psychosocial care [UN Women, 2011b]. Women and children who have been physically and/or sexually assaulted need immediate treatment for physical injuries, prevention of HIV and other sexually transmitted infections, and unwanted pregnancy. They are also in need of crisis counselling to deal with emotional trauma, protection from further violence, assistance with practical needs, information about legal rights, and justice for the crimes committed against them.

Holistic care that addresses the psychological impact of gender-based violence helps prevent the development of depression, anxiety disorders, and post-traumatic stress – mental health disorders that can affect survivors' lives, and their families, for many years [MSF, 2011]. Specialised GBV services also increase the likelihood that offenders will be held responsible, and the risk of future violence is therefore reduced. International authorities have recommended this type of service as good practice for the care of GBV victims and survivors, including in developing countries [UN Secretary-General, 2008; UN Women 2011b]. Despite problems of access, there is immense value in creating high-quality specialised services that can help improve other services in the surrounding districts through outreach and training.

The first two family support centres were opened in 2003 as independent collaborations between NGOs and local provincial hospitals. Through the initiative of the Family and Sexual Violence Action Committee, several more centres have since opened or are in development. Since 2008 the National Department of Health has adopted the roll-out of these centres as its main platform for improving health sector responses to gender-based violence. Implementation is incomplete, however, and even where facilities have been provided, there has been little or no training of staff [MSF, 2011].

The role of the National Department of Health is to set standards for health service delivery. In 2008, *Operational Guidelines for Hospital-Based One-Stop Centres for Family and Sexual Violence* was drafted by the National Department of Health; however, this document still had not been finalised at the time of this study.

The core services identified in the draft *Operational Guidelines* are:

- initial assessment and stabilization of shock;
- treatment of injuries;
- treatment of STIs (if any), and referral for HIV testing;
- collection of forensic evidence in case the client wishes to prosecute;
- trauma counselling and development of a plan for further crisis counselling;
- assistance with the basic needs of survivors and their children (e.g., food, clean clothing, money for public transport);
- information on legal rights, including obtaining custody of children, maintenance orders, and separation or divorce;
- assistance with laying charges through the police, and obtaining protection orders through district or village courts;
- relocation to a place of safety.

Additional recommended services for sexual assault survivors are:

- prevention of HIV infection by providing post-exposure prophylaxis (PEP), either by trained staff at the centre or by immediate accompaniment to the nearest PEP provider;
- prevention of sexually transmitted infections;
- prevention of unwanted pregnancy;
- prevention of tetanus and hepatitis B;
- specialised counselling.

These preventative measures are only effective if provided within a short time period following sexual assault. In particular, PEP for HIV prevention must be given within 72 hours. Therefore, it is vital to ensure that the availability of preventative treatment is well publicised so that survivors, their families, and local referral agencies (particularly police) understand the importance of seeking help immediately. When family support centres are closed and in the case of serious injuries, gender-based violence survivors are directed to the accident & emergency departments of hospitals, where staff often lack training in the needs of GBV survivors.

Best practices of the family support centres are run by the international organization *Medecins Sans Frontières*; and MSF centres in Lae and Tari have treated more than 6,700 gender-based violence survivors over the last two years. Despite their strong awareness and outreach programmes, only a little over half of their post-rape clients are accessing services in time to receive post-exposure prophylaxis against HIV [MSF, 2011].

Other health care services for gender-based violence

Most gender-based violence survivors only have the option of seeking help at their local aid post or health centre. Unless staff have prior training, clients are offered treatment for their medical injuries, but no assistance with trauma or guidance in accessing other sources of support is offered. If clients disclose that their injuries were caused by domestic violence, in many health facilities they are charged a higher fee, known as the “fight fee” (often from K20 to K200). “Fight fees” were originally introduced under legislation to discourage tribal fighting by penalizing those who engage in it voluntarily, but the concept has been extended by hospital boards in some parts of the country supposedly to discourage domestic violence. The charging of a “fight fee” by health services for treatment of domestic violence injuries has been frequently reported [Eves, 2006; Watters and Lourie, 1996]. Where high fees are charged as a deterrent, in many cases victims invent other explanations about the cause of injury and are thus unable to ask for appropriate support and referrals. Another consequence is that domestic violence clients remain invisible in the National Department of Health’s case record system, making it difficult to recognize and plan for the real level of services needed. In 2009 the Secretary for Health issued an official circular banning the charging of any fees for gender-based violence treatments and medical reports, but the practice still continues in many hospitals and health services.

During 2003 and 2004 the National Department of Health began to improve primary health care responses to domestic violence survivors. A new Six-step Domestic Violence Protocol was introduced, which required health care providers to identify patients at possible risk of gender-based violence, provide sympathetic care without charge, and develop a local support network for referrals.³ Tools such as a desktop checklist, public information leaflets, and posters were created and new pre-service and in-service training curricula were developed. However, the implementation of the protocol and related training appears to have lapsed several years ago.

³ The protocol does not include a step on referring victims for an HIV test because little testing or treatment for HIV was available at the time. Thus, updating is needed.

HIV counselling and testing services

Increasing the number of people who know their HIV status is an important strategy for reducing the spread of HIV. People who know they are HIV-positive can access antiretroviral treatment (ART), improve their physical health, and practice safe sex to reduce the transmission of HIV. The number of people living with HIV on ART increased from 320 in 2005 to an estimated 9,060 by the end of 2010 [Aggleton, Bharat, Coutinho, Dobunaba, Drew & Saidel, 2011], although AusAID more conservatively estimates 7,555 people accessed ART in 2010 [2011]. Gender-based violence is a risk factor for many people tested for HIV, because the disclosure of a positive test result to sexual partners and families may expose them to violence and stigma.

There are 266 HIV counselling and testing centres nationally [AusAID, 2011]. The National Catholic Health Service and other social sector organizations operate 111 HIV centres. The majority of HIV testing is conducted in health facilities, either in the counselling and testing centres at the request of clients, or performed by health care workers as part of provider-initiated counselling and testing when clients access certain health care services, such as for pregnancy, childbirth, sexually transmitted infections, or tuberculosis. In 2010 some 134,000 people were tested for HIV, an increase of almost 12,000 people from 2009 [AusAID, 2011].

The Independent Review Group on HIV/AIDS [Aggleton et al., 2011] found serious delays in confirmation of HIV reactive results in provincial labs, and more than half of initially reactive HIV tests are not confirmed. The Independent Review Group recommended an improvement in quality assurance practices in HIV testing sites [ibid.].

A gap identified in HIV counselling and testing is programming for young people aged 15 to 24 years, who are particularly vulnerable to HIV, and access to ART for children and young people. Only a few programmes target young people, including the Youth Outreach Project of Save the Children, the Clinton Foundation's Access Initiative, and the COMPASS project in Lae. UNICEF and the NACS have produced information material for youth on sexuality and sexual and reproductive health, but the reach and effectiveness of the materials have not been evaluated [ibid.].

Routine provider-initiated testing for HIV during antenatal care

Differences between voluntary and provider-initiated modes of testing have particular significance for women living in abusive relationships and who fear the consequences of positive test results. A woman may be accused of infidelity, beaten and/or forced to leave the family home, and deprived of her children, even though she may have contracted HIV from her husband or regular sexual partner. Pregnant women who test positive for HIV in antenatal care face particular challenges, as their partners are also likely to be positive. However, because women are more likely to engage with the health system, they are also more likely to be tested and, as a result, more likely to be blamed.⁴ In 2010 more than 49,000 pregnant women were tested for HIV in antenatal clinics, and nearly 5,000 more were tested in other health services. Nearly a half-million pregnant women will be tested for HIV between 2011 and 2015 according to the Prevention of Parent to Child Transmission Operational Plan 2011–2015 [NDOH, 2010e].

With this large volume of pregnant women being tested for HIV, it is crucial that any risk of negative consequences linked to HIV testing or status disclosure is identified in pre- and post-test counselling and that steps are taken to ensure their safety. Otherwise, women may choose to hide their diagnosis and not

⁴ The term "prevention-of-mother-to-child transmission" (PMTCT), long in use, was changed to "prevention of parent-to-child transmission" (PPTCT) to recognize the role played by fathers in HIV transmission to babies, to reduce the blaming of mothers, and to help increase enrollment in PPTCT programmes.

follow methods for the prevention of parent-to-child transmission (PPTCT) or access HIV treatment and care for themselves. Women are also tested for HIV during labour, and if given a positive diagnosis without careful counselling, sometimes leave the hospital and do not return for further medical or HIV care for themselves or their babies.

Under the HIV and AIDS Management and Prevention Act, 2003, all HIV testing must be accompanied by pre- and post-counselling, carried out by trained and accredited counsellors, conducted with voluntary consent and the results kept confidential. The *National Guidelines for HIV Counselling and Testing in Papua New Guinea* [NDOH, 2010a] emphasise the importance of assessing gender-based violence as a possible cause of HIV and a consequence of HIV disclosure. The guidelines suggest strategies for reducing the dangers of disclosure; and counsellors are expected to provide counselling and to make referrals to service providers for GBV victims and survivors for safe accommodation or to help in accessing a protection order, if needed [WHO, 2006]. Couple counselling and testing is recommended whenever possible and is currently being scaled-up in HIV counselling and testing centres [AusAID, 2011].

However, health workers providing provider-initiated counselling and testing receive less training than HIV counsellors, and receive little training in counselling skills or how to provide support for safe disclosure. Health care workers are very busy and often have only minimal time for counselling. Lack of attention to gender-based violence and women's safety in HIV testing may therefore lead to an increase in gender-based violence if women disclose their condition to abusive partners without precautions, and to an increase in HIV transmission to babies if women are too afraid to disclose their HIV status and therefore do not use services to address potential parent-to-child transmission.

HIV and STI treatment services

The *Minimum Services for STI Services Delivery in Papua New Guinea* [NDOH, 2008], the *Minimum Standards for HIV and AIDS Services and Activities* [NDOH, 2007], and the manual *Integrating Gender into HIV and AIDS Activities: A Guide for Implementers* [NAC PNG, 2006b] all call for staff to be trained to recognize and address gender-based violence as a factor affecting service provision for STIs and HIV, but the level of implementation of this service standard has not been researched. The Independent Review Group on HIV/AIDS found increasing patient loads with no scale-up of staffing levels, insufficient treatment facilities, and 'stock-outs' for treatment drugs and HIV test kits [Aggleton et al., 2011]. There is a need for follow-up of patients on ART, as drug adherence is difficult to ensure and many people living with HIV become ill and die without such follow-up [Ibid.].

Many people living with HIV face violence at home or in their daily lives, and their physical and emotional health suffers as a result. For example, one woman faced such severe abuse from her husband when she took her ART medication and felt well that she preferred to stop treatment because he left her alone when she was ill [Bradley, 2010]. Others, such as men who have sex with men, transgender people, and sex workers, face physical or sexual violence from sexual partners, from the police, or from the public [FHI and USAID, 2011; Kelly, Kupul, Man, et al., 2011].

Travel costs are also a barrier to accessing treatment and care for people living with HIV. Thirty percent of people starting ART treatment in Tininga, for example, do not continue taking medication. Services are needed to help people living with HIV understand and manage the side effects of medication. Existing resources, such as community support groups, aid posts, and outreach clinics, should be used to bring services closer to the people who need them [Aggleton et al., 2011].

Staff who provide HIV and STI services need to be knowledgeable about gender-based violence prevention and response and about appropriate services for referrals in order to identify clients who are at risk. Services for victims and survivors need to be accessible in local communities, supportive of human rights, and non-

discriminatory towards all clients, particularly vulnerable groups such as MSM, transgender people, and male and female sex workers.

Justice sector services for gender-based violence prevention and response, and stigma and discrimination against people living with HIV

Justice sector agencies with a role in responding to and preventing gender-based violence are the police, the national and district courts, and the village courts. All but the village courts apply the system of codified national laws, many of which were inherited from the British system during the time of colonisation by Australia. Papua New Guinea's Criminal Code and the Summary Offences Act recognise several forms of physical and sexual assault against the person, and cover female as well as male complainants. A 1992 *Report on Domestic Violence* by the Papua New Guinea Law Reform Commission recommended changes to the law that would better deal with assaults against wives, such as changes to police powers of entry, bail conditions, and the creation of enforceable protection orders that would remove offenders from the home and ban harassment. A form of interim protection orders is now being implemented; other recommended changes, however, have not yet been enacted.

In 2003 the Sexual Offences Amendment Act came into force, with greatly improved methods for responding to sexual assault. This ground-breaking legislation, which defined rape as the entry of the penis or other body part into any orifice of another person, made it an offence for a man to force his wife to have sex (marital rape), and removed the obligation for an alleged victim to provide medical evidence or other external corroboration. Sexual offences against children were clarified, making the issue of consent irrelevant for victims under the age of 16. Protection against abuse by a person in a position of trust was extended up to the age of 18, more categories of child sexual abuse were defined, and special arrangements were introduced for child witnesses giving evidence.

Training for the police and courts, as well as education of the general public, has been rolled-out as funding permits. A new Medico-Legal Pro Forma for Sexual Assaults was developed by the National Department of Health and the Office of the Public Prosecutor. Its use standardises the collection of medical and forensic evidence following sexual assault as recommended by the WHO (2003). The HIV and AIDS Management and Prevention Act (HAMP Act, 2003) is a positive example in the Pacific region of comprehensive, HIV-specific legislation that establishes a rights-based framework for HIV policies and services, for example, confidentiality in HIV testing, and a legal framework to intervene when people place others at risk of HIV [NAC PNG, 2010]. Cases have been taken to the District Court under the HAMP Act. However, access to justice for people living with HIV who experience human rights violations is very limited [Godwin, 2010].

Legislation that criminalises sex work and homosexuality continues to act as a barrier to justice services for sex workers, men who have sex with men, and transgender people due to fear of arrest and/or harassment by police if they report instances of violence [Ibid.].

The Royal Papua New Guinea Constabulary

For many years police treated domestic assaults differently from other forms of assault, because violence in the family was viewed as a private matter. Complainants were not responded to unless victims had been seriously injured. Between 1987 and 2007 several police commissioners issued instructions that domestic assaults must be prosecuted in the same way as other assaults, and training in gender-based violence and human rights has been introduced into the police training programme. However, problems persist in charges being laid for violence against women in marriage. The police's Interim Procedures for Attending to Family and Sexual Violence Cases explain the steps involved in accepting and investigating cases of domestic violence, and have been included in standard operating procedures, updated in 2011 [Taylor and Bernath, 2011].

There are continuing reports of extreme police brutality, including sexual abuse of sex workers, females remanded in custody, and even female crime victims who come to police stations to make complaints [Amnesty International, 2006a; AusAID, 2008b; CEDAW, 2010 as cited in UN Women, 2011b; Human Rights Watch, 2006; Human Rights Watch, 2005; Taylor and Bernath, 2011; UN Women 2011a; UN Special Rapporteur on VAW, 2012]. Notwithstanding such negative practices, there have been positive initiatives to improve the police response by introducing specialised police GBV units.

Sexual Offences Squads

Most provincial police forces have a Sexual Offences Squad as part of their Criminal Investigations Division. In some areas, the squads also include minor gender-based violence offences in their brief [Taylor and Bernath, 2011]. The squads began operating in the 1980s and originally were staffed by trained female plain-clothes officers; however, the squads are now staffed by both male and female police officers, some quite dedicated. Most staff members have had little relevant training in responding to gender-based violence. However, the overall under-resourcing of police and the lack of facilities prevent many complaints from being investigated [AusAID 2008b; Taylor and Bernath, 2011].

Women and Children's Desks

Most provincial police stations have established a Women and Children's Desk in recent years to provide a better service to these clients, mostly for cases of physical abuse. Women and Children's Desks were intended to provide similar services to the new Family and Sexual Violence Units now being gradually rolled out, but are integrated within services in police stations. They may be staffed by male or female officers; the officers may have little or no training; and, again, their resources and facilities are very limited [Ibid.].

Family and Sexual Violence Units

Since 2008 a new approach has been piloted under the Frontline Policing Improvement Project, funded by AusAID, which combines the Sexual Offences Squads and Women and Children's Desks in each province into more focused and better trained and resourced units [Taylor and Bernath, 2011]. Three units piloted in the National Capital District in Boroko, Waigani, and Badili apply a human rights approach, and treat domestic assault as a law enforcement issue rather than a matter for mediation. The system is in the process of expanding nationally. Units opened in Mt. Hagen and in Kopoko (East New Britain province) in 2010, and another is to open in Buka [AusAID, 2011; Taylor and Bernath, 2011]. Police in these units build referral networks with other GBV and HIV prevention and response services, and are responsible for transporting victims of physical and sexual assaults for medical treatment. Serious cases of physical and sexual assault are referred for investigation by the Criminal Investigation Divisions and Sexual Offences Squads.

Community Policing Units

Community police are not members of the Royal Papua New Guinea Constabulary, but are local citizens endorsed by them and given a few days training. They operate unpaid in their local area. When a crime is committed or the "peace disturbed," their role is to apprehend alleged offenders and take them to the relevant authority: the village court or the police, depending on the gravity of the crime. They also provide mediation, which is the primary role of the Community Policing Unit in Madang, for example. Community police have the potential to offer a valuable service for GBV victims – if properly trained and included in the networks for GBV and HIV referral – by ensuring that victims and survivors in their local area access timely medical treatment, as well as by bringing offenders to justice.

District courts

District courts apply the national laws on assault and sexual assault, and refer serious cases up to the National Court. New instructions from Magisterial Services in 2010 empowered district court magistrates to issue interim protection orders immediately in cases where the complainant is in fear of violence, protecting the complainant until the matter can be heard in court. Very little legal aid is provided to complainants by the Office of the Public Solicitor, who is therefore reliant on advice from counsellors at family support centres or civil society organizations. Currently, there are Office of the Public Solicitor branches in Port Moresby, Lae, Madang, Goroka, Mt. Hagen, Wabag, Kokopo, Kimbe, and Buka. Legal aid desks have been established in Bulolo, Kainantu, Manus, Wewak, Kavieng, Vanimu, Kerema, Alotau, and Popondetta. In 2012 there were plans to establish legal aid desks in Kiunga, Daru, Kundiawa, Mendi, Minj, Tari, Jiwaka, and Hela.

The Office of the Public Solicitor supports work in the area of HIV and gender-based violence, and in 2012 it received funding from the AusAID Development Budget for a project aimed to:

- a) establish a legal unit to deal with crosscutting issues, especially HIV/AIDS, gender-based violence, and fraud and corruption;
- b) increase representation of HIV/AIDS victims and related cases;
- c) increase representation of juveniles, women, and children in the lower courts;
- d) increase public awareness of legal rights and responsibilities and the functions and services provided by the Public Solicitors' office [personal communication, J. Robertson, PALJP].

A weakness of the current system is that women are afraid to serve summonses on their husbands or partners personally, and the police charge a fee for doing so. Police cannot act on breaches of protection orders unless the complainant goes back to court. District courts are urban based, but they go out to surrounding districts to hold hearings every few weeks. Therefore, district courts are more difficult to access for people living in rural areas.

Village courts

Village courts were established by regulation in 1974 and now operate under the Village Courts Act of 1989 and the Village Courts Policy of 2001. Magistrates and court staff receive only token pay and minimal resources. Communities are expected to provide their own facilities for village court hearings. The great advantage of the village courts is that they are community-based, use the local language, and apply modified customary law within certain limits. A disadvantage is that the customs that they apply are often unfavourable to women, and reinforce male privilege. Women complain that they find it difficult to get a fair hearing in cases of domestic abuse when most or all the magistrates hearing the case are male and local custom supports a man's right to discipline his wife.

Efforts are being made to provide better protection for wives against domestic abuse. The Village Courts Policy 2001 states: "Village courts will support and reflect changing attitudes to domestic violence. Instances of domestic violence will be treated as assault." Magistrates may also issue a Village Court Preventive Order on behalf of a wife being abused by her husband, and breach of the order may result in imprisonment if confirmed by the district court. Over the last decade more women have been recruited and trained as magistrates, and there are now around 700 women out of nearly 10,000 magistrates.

Village courts are not empowered to hear cases of serious physical assault, sexual assault, or any crimes against children. These must be referred to the police. However, police are not on the spot and generally have a poor reputation, so village courts often do deal with these cases. This can be unsatisfactory for sexual assault victims, since traditionally rape is treated as an offence against male relatives (father, uncles, brothers), and compensation is paid to them to restore harmony in the community. The serious mental health effects of rape, and the risk of HIV infection, are not acknowledged or followed-up by village courts.

Cases relating to HIV are not within village courts' jurisdiction, though they may deal with the stigmatization of people for their HIV status or breach of confidentiality as an issue of defamation [J. Robertson, PALJP, personal communication, November 1, 2011]. Village courts are empowered to hear cases about the practice of sorcery, but they have not recognized that the killings of females alleged to have committed sorcery, which have become more frequent and brutal in recent years, are a form of violence against women who need their protection.

Social sector services for gender-based violence and HIV

There are many organizations providing services for gender-based violence and HIV in Papua New Guinea.

Department for Community Development

The only government agency with a role in gender-based violence is the national Department for Community Development, which houses the Office for the Development of Women and the Office for Child Protection. It does not provide services, but sets standards for the provincial and district community development and welfare services. The department has implemented positive initiatives, such as a national dialogue on HIV, human rights, and the law in partnership with community organizations.

All cases of child abuse are required by law to be reported to the Director for Child Welfare, and a strategy on orphans and children vulnerable to abuse due to the HIV epidemic is being developed. Progress has been slow. There is no strategy on gender-based violence; and although welfare officers in the provinces are often approached by GBV survivors, these officers are not trained or resourced to respond effectively. One ground-breaking provincial initiative is the development of a child protection manual by the Eastern Highlands Provincial Division of Community Development.

National Family and Sexual Violence Action Committee

The national Family and Sexual Violence Committee has an important coordinating and advocacy role through its multi-agency committees on various topics and through provincial committees. The committee does not provide services. Rather, it operates under the umbrella of a quasi-governmental organization, the Co-ordination and Implementation Monitoring Council, but is funded almost entirely by development partners. Since 2001 it has been guided by a long-term multisectorial strategy [Bradley and Kesno, 2001; Siebert and Garap, 2009], though this has not been endorsed by the national government.

The Family and Sexual Violence Action Committee has promoted action on gender-based violence around the country, for example, collaboration with hospitals for the development of family support centres, supporting development of safe houses for survivors, workplace action against sexual harassment, awareness raising within communities on family and sexual violence, the creation of community-based referral systems, data collection, mobilising male champions against violence against women and children, and initiating joint training for HIV and GBV workers [Siebert and Garap, 2009].

Councils of Women

The National Council of Women and their provincial networks were effective in gaining the inclusion of marital rape in the Criminal Code of Papua New Guinea in 2003. However, the council needs to strengthen its engagement with community service organizations and reach out to communities.

Safe havens

Many women and children who have experienced gender-based violence need temporary safe accommodation while their situation is resolved. A small number of safe havens providing short-term shelter have been set up by churches and NGOs, such as City Mission, the Salvation Army, and Oxfam. Some Provincial Councils of Women provide support for gender-based violence survivors, such as in East Sepik, described in this study. A new approach seen in an urban settlement near Port Moresby is a self-help refuge set up and run by a group of local women to meet their own needs. Where safe havens exist, demand for accommodation is greater than what can be provided [AusAID, 2008b; Oxfam, 2011].

Counselling for gender-based violence victims and survivors

Many church pastoral services offer counselling for people who have experienced or are experiencing family or sexual violence. Their approaches can exacerbate the risks to women and children by prioritising the unity of the family over the safety of the women, or by imparting moralistic attitudes towards gender-based violence survivors [AusAID, 2008b; Bradley, 2009]. Counselling in cases of domestic or sexual assault and child abuse requires a deep knowledge of the underlying causes of violence and forms of violence, and the use of trauma counselling techniques to establish safety and control trauma symptoms. A detailed training manual for counselling domestic violence, rape, and child abuse has been developed [Milne Bay Counselling, 2010]. This is a useful start; however, there is an urgent need for the development of standardised training programmes and an accreditation system for gender-based violence counsellors in Papua New Guinea.

Services for men who have sex with men and for transgender people

The Poro Sapot project in three provinces and four locations, including Port Moresby and Lae, is funded by Save the Children, and has been operating since 2003. Poro Sapot provides HIV prevention, counselling, and testing services for men who have sex with men, sex workers, and people living with HIV. The organization also provides advocacy, training, and sensitisation for the police regarding the rights of transgender persons, MSM, and sex workers. In addition, Tingim Laip is a project of the National AIDS Council Secretariat and AusAID that provides community-based HIV prevention and care. It focuses on high-risk environments rather than on individuals. However, services such as Poro Sapot and Tingim Laip are limited in reach, and the scale-up of HIV prevention for the key populations in need has been slow [Aggleton et al., 2011].

Support for people living with HIV

Numerous civil society organizations are active in providing various kinds of support and care for people living with HIV. Family Health International and Tingim Laip run home-based care programmes for people living with HIV when they become sick, and both of these services train workers to recognise gender-based violence and raise community awareness. The Catholic Church, Anglicare, and other churches and community organizations run care centres, such as the Dagul Community Care centre in the Kerowagi district of Simbu province, which offers respite care and living-skills for people living with HIV. Care centres are usually linked to HIV counselling and testing centres and supported by the Provincial AIDS Committees. In Madang, the Real Involvement of People Living with HIV/AIDS project provides advocacy, home-based care, support, and treatment. The project trains volunteers who work in the Id Inad HIV Counselling and Testing Centre.

Services for children

The Nambe Faith-based Community Care Centre in Jiwaka, with partial funding from the Lutheran Church, and the St. Clement's Orphans and Vulnerable Children's Foundation, linked to the Catholic Church, provide orphanages and other services for vulnerable children. The orphanages support the education of

the children in their care. Some faith-based organizations, such as Mercy Works, based in Mt. Hagen and Goroka, provide drop-in services to homeless young boys known as “taxi boys.” Showers, food, clothing, and classes in finances and literacy are all provided to homeless young people.

Alternative livelihoods

Some efforts are being made to assist women living with HIV who are the heads of households, or who are victims of gender-based violence, to find alternative ways of supporting themselves so they are not faced with selling or exchanging sex, or returning to abusive partners. There are still very few of these initiatives; however, some efforts are being made by the Baptist Union of Papua New Guinea in Mount Hagen (Western Highlands province) and AusAID, and by the Seventh Day Adventist Church in conjunction with the Lae Chamber of Commerce and the Asian Development Bank [2010]. Many stand-alone HIV counselling and testing services provide life-skills programmes for people with HIV.

Microfinance programmes have been rolled out in Papua New Guinea by Nationwide Microbank and Papua New Guinea Microfinance, Ltd., with well over 5,000 active borrowers and total loans of \$19.8 million in 2011 [Microfinance Exchange Information, 2012]. However, unless microfinance programmes are combined with HIV education and gender awareness training, international evidence suggests they fail to reduce violence against women [Kim, Watts, Hargreaves, Ndhlovu, Phetla, Morison, Busza, et al., 2007].

Private sector

The private sector has an increasingly prominent role in responding to gender-based violence and HIV in the absence of adequate government capacity. For example, Oil Search International, Ltd., the largest oil company in the country, has now taken over as the principal recipient implementing HIV programmes funded by The Global Fund to fight AIDS, Tuberculosis and Malaria, including the gender-based violence components, in place of the National Department of Health. The Business Coalition Against HIV and AIDS (BAHA) is assisting Papua New Guinea businesses to set up workplace policies on HIV and AIDS. BAHA has managed the National Department of Health’s national condom distribution programme for the last two years. Chambers of Commerce are working with the BAHA to encourage the development of workplace sexual harassment policies and to integrate GBV prevention and response into HIV training for workers and their families [Lae Chamber of Commerce and the Asian Development Bank, 2010].

Women who travel to sell goods in local markets are exposed to frequent physical and sexual violence [Amnesty International, 2006b]. A model for new services to protect women travelling to market is being developed by the National Capital District Commission for implementation by town councils (with the Department of Community Development and UN Women). In Port Moresby, Lae, Rabaul, Madang, Mount Hagen, and Goroka a free gender-based violence hotline has been operated since 2008 by Digicel (a mobile phone company) in partnership with the Yumi Lukautim Mosbi Project and Protect Security (a private company providing security services). People at risk of violence can call the hotline and be transported away from the risk situation by Protect Security. However, there is no report available on the number of people using the hotline or on its effectiveness.

In the absence of strong and effective government services in all provinces of Papua New Guinea, partnerships with the private sector, with its capacity and responsiveness, have contributed to the availability of vital services for gender-based violence and HIV victims and survivors.

Gender-based violence data collection

Papua New Guinea has an inadequate data collection system for documenting the prevalence of all forms of gender-based violence [Bradley, 2006]. The Oxfam study of gender-based violence services in the National Capital District found consensus among stakeholders that national data collection is a priority,

as improved data collection will facilitate the development of effective programmes and interventions [2011]. The Family and Sexual Violence Action Committee is currently establishing a central database on the incidence of violence. However, past attempts to collect data systematically have failed. Barriers to data collection include the capacity to ethically research, analyse, manage, and share data; lack of expertise needed to maintain data bases; and the absence of mechanisms for liaison and reporting on data across services and provinces [Oxfam, 2011].

Community education and awareness programmes

Community education and awareness programmes operate in many provinces using community-based approaches to increase awareness of local contributing factors, driving forces, and behaviours that influence the risk of HIV and other sexually transmitted infections. Examples include community conversations in rural areas such as Banz and Jiwaka; the use of theatre groups, including interactive theatre through programmes such as the Tok Aut AIDS project; and the production of media and film using local media producers and crews. Each of these efforts highlights the increased value placed on local knowledge to identify the local drivers of the epidemic [Aggleton et al., 2011]. The effectiveness of programmes is greater when empowerment and human rights approaches are used and where there is local support and time to develop skills [UN Women, 2011b]. Some less well-planned and resourced strategies, such as speaking in local markets, may be ineffective and need evaluation. Overall, greater reach and consistency of programmes is needed.

Services for men who use violence in their relationships

The involvement of men in changing gender-based norms that contribute to gender-based violence has been called for by many organizations and researchers [e.g., Eves, 2010; UN Women, 2011a]. The Family and Sexual Violence Committee and World Vision have run successful training for men to work as advocates in communities. The National AIDS Council has supported male HIV counselling and testing trainers and PACs to participate in male advocacy training with the Fiji Women's Crisis Centre, with funding from AusAID, to build capacity in addressing violence against women [Godwin, 2010]. A male advocacy manual was developed in collaboration with the trained male advocates and launched by the Family and Sexual Violence Action Committee in 2011. Prison Fellowship offers male prisoners and ex-prisoners transformation through religion [Oxfam, 2011].

Another successful outreach project is COMPASS (Community Outreach, Men's Program, Advocacy and Sexual Health Services), operated in Lae, Morobe, Kopoko (NB), and Wewak (ESP) by a consortium of organizations funded by AusAID. The COMPASS Men and Boy's project focuses on the responsibility of men to prevent sexually transmitted infections, and uses community and workplace education to discuss issues related to sexual health, domestic violence, and conflict resolution [Family Planning International, 2012]. The National Catholic AIDS Office set up a men's health clinic in Mindenge in 2010, which provided services to 455 men in the first eight months of its existence [AusAID, 2011].

However, there remains a lack of counselling programmes for offenders to target behavioural change and a scarcity of professional development for counsellors working with men [Oxfam, 2011]. Oxfam recommends that the Duluth model – a strengths-based approach using narrative therapy principles – be used for counselling offenders, and calls for a human rights-based code of ethics for counsellors working with gender-based violence [2011]. The National AIDS Council also recommends strengthening communication in family and couple relationships through open discussion of gender, sex, sexuality, and relationships [2010].

Summary

Many different services are working in the areas of gender-based violence and HIV to meet community needs. However, services and programmes are fragmented and based only in a few locations. Further, the lessons of successful programmes are not implemented in other provinces. Previous reviews have indicated a need for multisectorial, integrated responses at the national, organizational, community, and individual level to prevent gender-based violence and HIV [Bott et al., 2005; Oxfam, 2011; WHO and UNAIDS, 2010]. Currently there is no single coordinating agency in Papua New Guinea responsible for both gender-based violence and HIV service provision, and many services are located in urban centres and so do not reach people in villages and remote areas [UN Women, 2011a].

The majority of those at risk of gender-based violence in Papua New Guinea are women and children, and thus services must focus primarily on the needs of these clients. However, it is also important to address the service needs of other groups who are particularly vulnerable to both gender-based violence and HIV, such as men who have sex with men, transgender people, and male and female sex workers and their regular sex partners. There is a lack of services for these vulnerable groups in most provinces.

Chapter four presents the findings of the audit of gender-based violence and HIV services across the health, justice, and social sectors, as well as their interlinkages, in five provinces of Papua New Guinea.



◀ A colourful sign announces the Kond Aid Post in Simbu province, as yet unfinished.

CHAPTER FOUR

Audit findings and discussion

This chapter discusses the organizational readiness to implement gender-based violence programmes with linkages to HIV services in the health, justice, and social sectors. The study specifically focused on the five provinces of Western Highlands, Simbu, East Sepik, Madang, and the Autonomous Region of Bougainville. Key informants based in Port Moresby were also interviewed. The data on which the discussion of findings is based are presented in Tables 5 to 9 for each of the services assessed (refer to Appendix seven). All tables display data for each province included in the study and are the subjective perceptions of participants, based on their lived experience.

Section one discusses the findings for health sector services. These include services provided by family support centres, which were audited against their Draft Operational Guidelines [NDOH, 2008a], and HIV counselling and testing centres, which were audited against their approved national guidelines [NDOH and NACS, 2009].

Table 5 (Appendix seven) displays data collected on FSCs, including the views on their effectiveness collected through interviews and focus groups with other service providers, service users, and community representatives. Table 6 (Appendix seven) displays data collected on the effectiveness of HIV counselling and testing centres, including the views of people living with HIV, organizations providing HIV services, and community representatives.

Findings for the justice sector are discussed in section two of this chapter. The audit of police services was based on police standard operating procedures relevant to gender-based violence and HIV. Table 7 (Appendix seven) displays the data collected in the audit of service standards for specialised police GBV units. The data includes the views of other services and community representatives on their effectiveness.

Table 8 (Appendix seven) displays data collected on district courts against standards relevant to GBV and HIV, derived from the Magistrates Manual [Hill and Poles, 2001], as well as the views of police and community representatives on their effectiveness.

Table 9 (Appendix seven) displays the results of the audit of village courts against standards relevant to GBV and HIV, derived from the Village Courts Act 1989, National Village Courts Policy 2001, and the *Village Courts Handbook 2001*. (Although later editions of the handbook have been issued, these were not able to be accessed during the study.) Police and community perceptions of the effectiveness of village courts are included in Table 9.

Section three discusses the findings of consultations with social sector organizations, services users, and community representatives and leaders. The sourcing of data on GBV and HIV services from multiple viewpoints, including service providers, service users, people living with HIV, and community representatives, provides a holistic perspective, which is a strength of this study. The discussion of findings draws on relevant literature, legislation, and handbooks to analyse the data (as described in chapter three).

Section one: Health sector findings

Family support centres

A major finding for family support centres, where they exist, is the importance of the services they provide for those victims and survivors of gender-based violence able to access them. Overall, the centres perform fairly well against standards. Service gaps include assured referral pathways for victims and survivors treated in accident & emergency departments after hours, and specialised services for men who have sex with men and transgender people. Funding is needed for administrative workers so that centre staff can concentrate on service provision, and to provide child-friendly spaces for children who experience physical and sexual abuse.

1. Access to family support centres for victims and survivors of gender-based violence

Family support centres are spread unevenly and are not readily accessible to all victims and survivors in the provinces studied in this project. However, where they are available they are well-utilised. Wewak in East Sepik and Madang do not have FCSs. Rather, Modilon General Hospital in Madang and Wewak General Hospital provide medical services to victims and survivors of violence; however, they also charge fees for these services. According to the Provincial Council of Women in Wewak, Wewak General Hospital has put land aside for a family support centre, and a new building is to be erected in 2012. In Buka in the Autonomous Region of Bougainville, the FSC was not yet fully operational at the time of this study.

Madang in particular lacks an operational network of gender-based violence services. The agencies that respond to such violence in Madang – for example, the Country Women's Association and the district Community Development Office – need assistance from the national Family and Sexual Violence Action Committee to network with and energise the Provincial Council of Women.

Western Highlands, Simbu, and East Sepik each have an FSC. The Well Women's Clinic in Mt. Hagen opened in 2010 and serviced some 500 GBV victims and survivors in the first 11 months of operation. On average, the centre provides services to 5–10 clients per day and approximately 50 clients per month, and the rate of referrals to the centre is increasing. In Kundiawa in Simbu province, the centre, based in the Late Joseph Nobri Hospital, opened in 2008 and services more than 30 GBV cases each month, including 8–10 cases involving children. East Sepik province has a district FSC in Maprik, which provides services to 10–11 GBV survivors each month. Overall, it is clear that family support centres are well utilised.

2. Staffing

Four family support centres participated in the audit in Mt. Hagen, Western Highlands province; Kundiawa in Western province; Maprik in East Sepik; and Buka in the Autonomous Region of Bougainville.

The FSCs in Mt. Hagen and Kundiawa were adequately staffed except in the area of administrative support. Nurses in the Maprik centre, based in a rural hospital, also work across other hospital departments. Administrative positions are lacking in the centres at Mt. Hagen, Late Joseph Nobri Hospital (Kundiawa), Buka General Hospital, and Maprik Rural Hospital. As a result, centre workers undertake such routine administrative tasks as filing. Rather, these hospitals should fund administrative positions for their family support centres.

3. Centres affirm that gender-based violence is not acceptable

FSC staff affirms that gender-based violence is not acceptable. The stance of staff against GBV is demonstrated in their provision of advocacy services for GBV victims and survivors to ensure that their rights are protected.

4. Direct access for victims and survivors of gender-based violence

Accident & emergency (A&E) departments provide a 24-hour response for victims of gender-based violence and operate as intake and referral for the family support centres. In towns and provinces where there are no centres, hospitals provide the primary health response to gender-based violence. Therefore, all A&E, outpatient, and reception staff need training to identify and to respond appropriately to gender-based violence, for example by making referrals to the centre or other appropriate service, and by providing post-exposure prophylaxis for HIV and other preventative treatments as needed. At present, only FSC staff members provide this training to A&E staff.

Family support centres in Maprik (ESP) and Kundiawa (SP) provide after-hours services. In Maprik, the nurse lives on the hospital grounds and is awakened if there is an emergency. FSC staff at Late Joseph Nobri Hospital work in the respite care ward after hours, and they cook and care for women injured by gender-based violence.

To facilitate treatment of gender-based violence without delay, FSCs should establish formal referral protocols with their A&E and outpatient departments as well as with reception clerks. Trained volunteers could also be used to expand the accessibility of services. However, the use of volunteers would not be resource neutral, as training and regular support and supervision would be required.

5. Centres should be easy to find with clear signage and located near hospitals

In the provinces studied, family support centres that are located within hospital grounds can be easily located. However, access is difficult for women and children living in villages, as they travel to centres on public motor vehicles. Travel is costly and may place survivors of gender-based violence at further risk. Access to services and intervention is therefore currently restricted to women and children living in rural areas. Consequently, centres need to be funded to provide financial support to women and families travelling from villages, and they need to do more outreach to villages. The naming of centres needs to be reviewed to provide greater clarity for service users about the purpose and nature of the services that the centres provide. The Mt. Hagen service, for example, is called the Well Women's Clinic. "Family support centre" may be misleading, and cause clients with family problems unrelated to gender-based violence to seek help at such centres.

6. Security services

The family support centres that participated in the study do not require security guards because hospitals already have adequate security services in place. The audit standards for staffing a FSC specify a female security officer for each centre. However, security guards at hospitals are male rather than female.

7. Funding

The Well Women's Clinic in Mt. Hagen and the FSC in Buka do not have funding difficulties. However, hospital administrators expect the centres to provide additional reproductive and sexual health services. The coordinator and nursing officer of Maprik District Family Support Centre work across several services in the rural hospital. Many centres work closely with HIV services to provide integrated services that identify and intervene in gender-based violence and to ensure referral pathways between services.

Centres should be fully funded and hospital administrators should not expect centres to provide additional services.

8. Services to be provided by staff of the same gender as the client

All the centres employ female staff only, except for the Maprik Rural Hospital, which has two staff members, one male and one female. The male nurse coordinator covers family health and maternal and child health services as a result of a staffing shortage in the hospital. The provision of services to female victims and survivors of gender-based violence does not meet best practice standards.

Centres need to evaluate their services with clients, and gather feedback from male clients, including boys, on their preference for seeing male or female workers to better inform decisions about the gender of staff.

9. Staff training

Most staff interviewed had attended some counselling and/or gender-based violence training, or were about to attend training. The counselling model used by centres appears to be directive and advice oriented, which does not uphold the clients' autonomy and their capacity to make their own decisions. Staff found training in trauma counselling difficult to access, and reported that the quality of trauma training is uneven.

Family support centres need ongoing access to advanced counselling and trauma counselling training to enable them to meet the range of psychosocial needs of GBV victims and survivors. Staff should also have access to specialist training to meet the needs of children who have experienced sexual or physical assault. The models used must be tailored specifically for the different forms of gender-based violence. For example, counselling for domestic violence needs to be grounded in an understanding of the power imbalances in marriage in Papua New Guinea, and of the techniques needed to address them and to ensure women's safety. Appropriate models need to be developed at the national level, and competency-based training programmes need to be established and overseen by a professional certification body [Milne Bay Counselling Services Association 2010; Bradley 2009].

10. Advertising of family support services in hospitals and to the community

Most of the participating centres provide training on gender-based violence for hospital staff and the community, and referrals of women and children to the centres are regularly made by staff in Mt. Hagen, Kundiawa, Maprik, and Buka hospitals. Therefore, training of hospital staff appears to be an effective strategy for advertising family support services.

Some centre staff reported that some male medical and nursing officers have had interim protection orders for domestic violence taken out against them, and that the attitudes of hospital staff are representative of the range of community attitudes about gender-based violence. Therefore, senior hospital administrators should ensure that all staff members attend gender-based violence training run by their family support centres. The FSC staff at Buka General Hospital cited the example of a recent training at the hospital with only one male participant in attendance for half the day.

The quality and effectiveness of awareness and outreach programmes could not be established through the audit. There is a need to develop standards for GBV training and awareness based on evidence of effectiveness in facilitating changes in the attitudes of participants, and increasing referrals of victims and survivors to the support centres.

Villagers and community leaders advocated for public awareness and training programmes that cover laws against violence in marriage and child abuse to be made available to people in rural areas and villages. Specifically, they thought that two useful strategies to reduce the incidence of gender-based violence would be to inform husbands that violence in marriage is a crime and to educate women about their rights in marriage.

11. Medical services should be provided free of charge for victims of gender-based violence

In Simbu, East Sepik, and Madang, provincial hospitals fees were charged for medical services and medical reports for victims and survivors of gender-based violence. In Maprik the Nana Kundi Crisis Centre was effective in lobbying the hospital to drop fees for GBV victims; and a National Department of Health Circular (2009) from the Office of the Secretary to hospital CEOs and provincial health advisors directed that no fees were to be charged for domestic violence, sexual violence, child abuse, or for women and children injured in tribal fighting. Given the importance of this directive, it would be useful for the National Department of Health to remind hospitals and health services of the 2009 circular.

AusAID [2008] has expressed concern over health services charging extra fees for treatment of domestic violence victims and survivors as a deterrent. Provincial Family and Sexual Violence Action Committees, Councils of Women, and NGOs should be trained to monitor fees charged by hospitals and should advocate for their removal.

In addition, it was noted that hospitals are underresourced and need to be adequately funded to provide services.

12. Be available at all times to victims of gender-based violence

Family support centres do not stay open 24/7 and therefore provide only limited accessibility to victims and survivors of gender-based violence. As a result, A&E departments in hospitals play an important role in providing after-hours services. Thus, GBV training for such hospital staff is necessary to ensure that the needs of victims are met, in particular the needs of rape victims for HIV post-exposure prophylaxis.

13. Be welcoming, non-judgmental, respectful, and sensitive to the feelings of clients

All centres participating in the audit met the standard for welcoming clients. Staff members demonstrated a high level of regard for clients and were non-judgemental, respectful, and sensitive to the needs of victims and survivors of gender-based violence.

14. Provide immediate reception and assessment, comfortable and private waiting rooms (not benches), and child-friendly space and toys

All of the centres strive to provide immediate reception and assessment. Staff absences for training or sick leave, staff meetings, and the number of clients all affect whether this standard can be met at any given time.

In terms of waiting rooms, the Well Women's Clinic in Mt. Hagen provides benches rather than comfortable chairs. However, clients seem to prefer to wait outside the building and were observed sitting on the grass. Covered seating outside the centres should be provided for clients and their support people.

The centres need funding to provide child-friendly spaces and quality toys, such as doll houses and art supplies, to engage child victims and survivors of physical and/or sexual abuse during interviews. It is difficult for children to talk about experiences of victimisation, and toys assist in telling the story.

15. Facilitate speedy medical treatment and the collection of forensic evidence, if possible

Medical treatment and collection of forensic evidence take place in all hospitals regardless of whether family support centres are established. At hospitals with FSCs, medical treatment of serious injuries is likely to take place in the A&E department. Medical assessment and collection of forensic evidence takes place in the centres. The Medico-Legal Pro Forma is used for standardised collection of forensic evidence.

The provision of post-exposure prophylaxis to sexual assault victims at Modilon Hospital was not assured. Hospitals urgently need to develop protocols for their A&E departments to supply sexual assault victims with PEP within 72 hours, and to ensure referral pathways to HIV counselling and testing are in place for such victims.

16. Ensure privacy and confidentiality of clients

Family support centres are operating ethically to protect the privacy and confidentiality of clients. The Voluntary Confidential Counselling and Testing consent form is used to ensure that informed consent is provided to patients prior to HIV testing. However, family support staff at Buka General Hospital commented on the lack of security for medical records left around the wards. Hospitals need to ensure that records of patients who have experienced gender-based violence and of people living with HIV are stored securely to protect their confidentiality and privacy.

17. Informed consent of clients

FSCs meet the standard for obtaining informed consent of clients. The Medico Legal Pro Forma is used for recording the informed consent of clients or guardians to the collection of forensic evidence, and the HIV Counselling and Testing consent form is used in HIV testing.

18. Offer information and support for decisions to be made by the client (uphold client autonomy)

The family support centres participating in this audit met the standards for supporting client autonomy in decision-making and providing information and support. However, the model of counselling used is directive, which may infringe on client autonomy – for example, where advice is given to clients. All FSC staff would benefit from further training on how to explore available options in counselling and regarding strategies for empowering victims of gender-based violence to make their own decisions.

19. Services provided to male clients (male clients to be referred to hospital social workers unless they have experienced sexual assault)

Centres provide a broad range of services, including for male children who are victims and survivors of physical and/or sexual abuse. During their first year of operation the Well Women's Clinic in Mt. Hagen provided services to a small number of men ($n = 3$) who were victims of violence in their relationships, and the FSC in Kundiawa also accepts male clients. The male partners of female clients are also provided with mediation and counselling services in cases of domestic violence.

Other male client groups at risk of gender-based violence include gay and other men who have sex with men as well as transgender people. These are clearly underserved groups, as there are no specialist services outside of the National Capital District.

Villagers in Western Highlands and Simbu provinces emphasised the sociocultural difficulties about men asking for help. Among the comments that were recorded:

- *Shame and fear stops men asking for help – they pretend they have a good family.*
- *The other families might say he is a violent man.*
- *We are men. We can't ask for help.*
- *If I raise my hand up and say 'I need help' I am not a man.*

There are clearly issues of shame, discrimination, and stigma that prevent men from seeking help at support services and police.

The National Department of Health is considering a national policy on male health. Accordingly, there should be consultation with male service users to determine their needs and preferences for services and their preference for seeing male or female workers. Services that support transgender people and gay and other men who have sex with men, such as Poro Sapot, should also be consulted to find out their views and recommendations. The health promotion services needed for men include self-esteem, drug and alcohol abuse, and sexual negotiation skills. Such programmes could be successfully delivered by peer educators. Attention also needs to be paid to unique contextual issues, such as young men's relationships with older men, possible involvement in transactional sex, and their sexual identity [APCOM, 2012].

20. No discrimination against sex workers

The Well Women's Clinic in Mt. Hagen provides services to sex workers; however, the other three FSCs do not accept self-identified sex workers as clients. Centre and hospital staff members need training to understand the vulnerability of sex workers to gender-based violence and their broader biological and psychosocial needs.

Community awareness that sex workers can seek help at family support centres without discrimination could be increased through a programme of targeted outreach. Liaison with HIV counselling and testing centres and PNG Friends Frangipani would help to build referrals for sex workers.

21. No discrimination against people living HIV

It was determined that the FSCs meet the standards for providing services to people living with HIV without discrimination. Referral pathways to HIV counselling and testing centres are in place, and clients are frequently referred for HIV and STI counselling and testing.

22. Require providers to follow a code of practice

Training for staff in counselling and gender-based violence should include training on ethics. FSC staff members belong to professions that have codes of ethics that their members are obliged to follow – most commonly nursing, psychology, social work, and medicine. –

23. Referrals to other services

Family support centres have active referral networks in place. Despite strong links with police and courts through the provincial Family and Sexual Violence Action Committees, centre staff noted that they need to accompany victims of gender-based violence to the police and court hearings to ensure the best outcomes for clients.

This assisted referral process indicates that advocacy is an important part of FSC services. Consequently, advocacy should be included in FSC policies, procedures, and training.

24. Referrals from other services

Centres routinely receive referrals from other hospital departments, including antenatal clinics, as well as from police and non-government organizations. For example, the Provincial Council of Women in Wewak is the lead agency in coordinating services for female victims of violence in the absence of a family support centre. Similarly, in Madang the police, the Country Women's Association, and the Department of Community Development make referrals to the hospital in the absence of a local FSC or an active Provincial Council of Women.

25. Partnerships: Formal agreements with partner organizations and agencies providing related services

The partnerships between family support centres and other services differ in each location according to the NGOs based in each province and the strength and effectiveness of the services. Provincial Family and Sexual Violence Action Committees and Provincial Councils of Women play vital roles in networking and coordinating responses to gender-based violence. However, partnerships are not documented as formal written agreements. The development of formal partnership agreements should be a priority for family support centres.

26. Gaps in services

FSCs should be opened in all provinces as a matter of urgency. The services most commonly provided are medical examinations following sexual and physical assaults, and individual and couple counselling sessions for domestic violence, though this is often done without adequate training. Centres should also consider running support groups for survivors of gender-based violence, as group work provides additional support for survivors and fosters mutual support between group participants.

The provision of safe houses is a service gap in some provinces, for example Western Highlands and Madang. The FSC in Kundiawa provides respite accommodation for up to a week. Services providing safe accommodations for women and children who have experienced gender-based violence are the Provincial Council of Women in Wewak, the Nana Kundi Crisis Centre in Maprik, and the Nazarene Rehabilitation service in Buka. Women in Western Highlands province have advocated for safe houses, noting:

If we could be there for a month and they can counsel our husbands and he has a proper mind, then we can go home.

Safe houses should be established in each district by Family and Sexual Violence Action Committees, provincial Councils of Women, and faith-based organizations, as FSCs are not resourced to provide safe accommodation for women and their children beyond forty-eight hours. Also needed is training for support staff and NGOs in trauma counselling and other forms of gender-based violence.

27. Community views of the effectiveness of family support centres (service interviews and focus group data)

Organizations providing services to victims and survivors of gender-based violence report that family support centres are effective in providing an important short-term service to GBV victims and survivors. Other service providers, such as Mercy Works in Mt. Hagen, the Provincial Council of Women in Wewak, the Nana Kundi Crisis Centre in Maprik, and Leitani Nehan in Buka, all provide longer-term counselling, support through criminal court processes, and follow-up.

In villages and rural districts in Western Highlands and Simbu, few women had ever accessed FSCs for help with gender-based violence. The cost of travel via public transportation makes access difficult for women living in villages. Instead, women have turned to community and church leaders in their local area for help. However, victims and survivors need access to a range of services locally, including the collection of forensic evidence, safe houses, counselling, and advocacy with police and courts.

The FSCs included in this study are developing referral networks and are becoming increasingly well known in their districts, and consequently client statistics are increasing. The next section of this chapter will present the findings of the audit of voluntary counselling and testing services for HIV.

HIV counselling and testing centres (refer to Table 6, Appendix seven)

HIV counselling and testing services are available throughout the five provinces included in this study. Free-standing centres are auspiced by the Catholic Church, with the primary responsibility for outreach and testing in villages and remote areas. Compared to family support centres, HIV counselling and testing centres are extremely variable in how well they meet audit standards.

1. Staffing: HIV counselling and testing counsellors are trained and certified

All HIV counselling and testing centres meet the audit standards for trained staff, other than the Mary Mother of Hope Voluntary Confidential Counselling and Testing Centre in Buka, which was staffed by a newly employed nursing officer.

The inventory found that ART prescriber training is difficult to access for centre staff working in Banz and Wewak districts. In Banz, clients with HIV face long waiting periods to see ART prescribers. As one centre coordinator noted: "Everyday people wanting ART is like the bank queue." In Wewak, doctors in the hospital have completed training for administering post-exposure prophylaxis for people exposed to HIV through sexual assault or workplace accidents, but they are too busy to come to the centre to prescribe ART for people living with HIV. Centres therefore need more staff trained in ART to meet the needs of people living with HIV. For example, the Shalom Care Centre requires three more trained ART prescribers to adequately meet client need. It is clear, then, that PEP training needs to be prioritised.

It was found that HIV counselling and testing centres located in health facilities are more likely to prescribe and supply ART and PEP than stand-alone centres, which are less resourced than those based in health facilities. However, stand-alone centres do conduct outreach programmes in villages and visit remote areas to conduct counselling and testing. The Voluntary Confidential Counselling and Testing Centre at the Late Joseph Nobri Hospital in Kundiawa provides includes HIV outreach as part of its rural outreach programme.

Stand-alone centres also provide a wider variety of psychosocial services and care for people living with HIV, including day care and respite care provided in the centre, support groups, living skills groups, and home visits when clients become too ill to attend the centre. In contrast, voluntary confidential counselling and testing centres in health facilities do not usually conduct outreach and remote testing.



◀ These colourful shirts are among the products made by people living with HIV as part of the "living skills" programme at the Shalom Care Centre in Banz.

2. Voluntary confidential counselling and testing facilities

Overall, the facilities available in voluntary confidential counselling and testing centres meet the audit standards. Some health-based centres have excellent facilities, such as the centre located in the grounds of the Late Joseph Nobri Hospital, Kundiawa. A significant issue raised by centres in rural districts is that ART supplies often run low due to delays in delivering medical supplies.

3. Counsellors assess risk of gender-based violence during pre-test counselling sessions and of safe disclosure of test results to a sexual partner or other person, and facilitate couple counselling wherever possible to avoid blame and negative consequences

Counsellors and nursing officers in the HIV counselling and testing centres demonstrated a concerning lack of awareness of gender-based violence, with many counsellors failing to include it in pre- and post-test counselling. This may be due to over focusing on sexual behaviour as the primary risk factor for HIV.

Couple counselling is often used to assess HIV and STI risk and to aid in the adjustment to discordant test results (where one partner has a positive test result for HIV and the other a negative test result). Experienced counsellors find that pre-test counselling with couples reduces the risk of blame, violence, and abandonment. However, in outreach and remote testing, couple counselling is difficult because of the volume of clients and lack of time. Although such counselling and testing is in the process of being implemented, open discussion of risk of gender-based violence with women, a focus on how to disclose positive test results to partners and families, and the offer of mediated disclosure where risk of violence is present [WHO, 2006] was not routinely implemented in centres included in this study.

Staff training needs to focus on building risk assessment skills for vulnerable groups and strategies for engaging men in pre- and post-test couple counselling. Improving the coordination between free-standing voluntary confidential counselling and testing (VCCT) centres and HIV counselling and testing services based in health facilities will enhance the quantity of outreach through resource and skill sharing.

Interventions to assess the capacity of women to negotiate safer sex and increase their sexual negotiation skills are overall lacking. Better integration of VCCT and GBV services is needed to overcome this gap. An example of the lack of integration is the failure to ensure that PEP is routinely provided to survivors of sexual assault at Modilon General Hospital, due to protocols not having been developed between the Id Inad VCCT Centre and the hospital's A&E department. In the words of the Id Inad nursing coordinator:

Sexual assault patients are not all sent from accident & emergency for PEP – I am thinking of talking to the medical officer in charge. I supplied them with ART drugs for PEP before and left it there with forms so they can report back to me ... the whole container of drugs went missing, so now I am reluctant to supply drugs. We need a PEP protocol to be in place so patients have easy access to it. There are many sexual assault patients....

WHO and UNAIDS [2010] emphasise the importance of PEP for rape survivors to prevent the spread of HIV and as a human rights issue. The lives of sexual assault victims are being compromised through the lack of coordination between VCCT centres and A&E departments.

4. Staff follow the HIV Counsellors' Code of Ethics, including informed consent for testing and confidentiality of test results

Confidentiality about HIV status, sexual identity, and involvement in sex work is clearly very important to clients, who often travel to HIV counselling and testing centres away from the village or town where they live. The majority of HIV counsellors follow the Code of Ethics, which is part of their training, including seeking informed consent for testing and maintaining confidentiality of test results. However, an HIV

counsellor in Simbu province discussed a case example where disclosure of test results to a family with the client's consent had tragic consequences, as the client was taken back to the village by her family and reportedly buried alive.

The focus on ethics, including confidentiality, informed consent, and the importance of protecting clients' safety, should be maintained in all training provided to counsellors, and orientation provided for new staff must include the Code of Ethics.

5. Appropriate referrals to gender-based violence services, safe houses, or NGOs offering legal aid in getting interim protection orders, or to village courts for village court protection orders. Information is made available to clients about GBV and post-rape services, and referrals to appropriate services are made

This standard was not well met by the HIV counselling and testing centres included in this study. The risk of gender-based violence is not routinely assessed and identified in pre- and post-test counselling, and therefore appropriate referrals cannot be made. There is a greater likelihood that centre staff will refer GBV clients to the local family support centre when they are co-located – for example, the HIV counselling and testing centre in Kundiawa.

Centres refer serious cases of stigma and discrimination against people living with HIV or intentional transmission of HIV to police, but not other forms of gender-based violence. Four counsellors interviewed said they do not refer to police. The reasons for not referring to police vary, such as not having referral networks in place, not knowing who to talk to at police stations, and concern about personal safety. One health extension officer described seeing a couple for testing where the man had deliberately given HIV to more than 20 people and the wife said she didn't want to charge him: "I was happy not to be involved," said the officer. "He might have been angry at me and paid me back, and they are still together."

These findings demonstrate that VCCT counsellors and nursing officers need further training in how to make appropriate referrals for clients at risk of gender-based violence.

6. Female and male condoms are demonstrated, their use is promoted, and they are distributed to clients

This standard was not met. Staff in stand-alone HIV counselling and testing centres auspiced by the Catholic Church expressed negative attitudes towards promoting condom use. According to staff, promoting condom use increases relationship conflicts and reduces trust between spouses. They also had the view that the availability of condoms from other sources reduced the need to distribute condoms. Condoms are distributed during couple counselling rather than being demonstrated and promoted with all clients. Female condoms are even less available in centres than male condoms. However, HIV counselling and testing counsellors across the centres report low demand from clients for female condoms. The Business Association Against HIV and AIDS has been contracted by the National Department of Health to manage the national distribution of condoms, and reports that a low number of female condoms is distributed (2.86 million male compared to 186,000 female). Aggleton et al. [2011] propose that the low demand may be due to indifference in promoting female condoms.

Counsellors' negative attitudes towards condom distribution are of concern, as promoting abstinence and faithfulness for protection places women at risk of HIV and sexually transmitted infections. Women cannot control their partners' sexual behaviour.

Provincial AIDS Committees need to ensure that VCCT centres maintain adequate supplies of male and female condoms.



◀ Counselling and testing centre resources are stored at the Late Joseph Nobri Hospital, Kundiawa.

7. Staff members in voluntary confidential counselling and testing centres receive regular training, supervision, and debriefing to maintain their effectiveness and to prevent burnout

Understandably, HIV counsellors and nursing officers experience significant distress from the physical deterioration and death of their clients:

The death of a patient from AIDS is like losing part of yourself. We look after them like babies and they become healthy and happy on ART. Sometimes we don't understand why they die; it is very difficult [Id Inad VCCT Centre, Madang].

AIDS deaths have quite an impact on staff. We have had three deaths this year. We go to their homes and they feel comfortable with us, sometimes we give them what they can't receive from their immediate family. There is sorrow when one dies, but we can't do much [Sepik Centre of Hope, East Sepik].

Counsellors and nursing officers are additionally exposed to the grief of patients' families. They provide families with comfort and small gifts of money for funerals:

We go to the funeral and haus krai [a gathering to mourn and remember] and stay with the family and comfort them. We provide at least something to show we care and that we regret the death. (Sepik Centre of Hope, East Sepik).

While the audit found that staff meetings and debriefings take place regularly, resources for regular supervision are lacking. The experience of vicarious traumatisation by counsellors who listen to and empathically respond to trauma experienced by their clients was first identified by McCann and Pearlman [1990]. Counsellors are more at risk if they do not receive regular supervision, training, and support. Therefore, it is imperative that counsellors working in VCCT centres receive regular supervision, debriefing, and access to continuing education to maintain their resilience.

HIV counsellors providing outreach programmes report stress as a result of the high volume of clients and the time and risk involved in travelling to remote areas. There are guidelines for remote testing, which should be implemented by all centres conducting remote testing.

The services provided by VCCT centres would be considerably strengthened by closer working relationships with FSC staff. Some practice deficits identified in this study, such as failure to include assessment of risk of gender-based violence in pre- and post-counselling sessions, would be remedied by working more closely with family support counsellors. Where services are co-located, as is the case of the Mt. Hagen and Late Joseph Nobri General hospitals, this service improvement could be readily achieved and would be cost effective.

Next, section two of this chapter presents the findings for justice sector services.

Section two: Justice sector findings

Police specialised gender-based violence units (refer to Table 7, Appendix seven)

The audit of police responses to gender-based violence found a serious level of under resourcing, which reduces police capacity to respond adequately. Police need regular access to training to enhance their knowledge of gender-based violence, human rights, non-discriminatory responses to victims, and issuing interim protection orders, as well as further development of their overall policing skills. On a structural level, a review is needed of legislation that criminalises homosexuality and sex work to ensure that all victims of gender-based violence are able to access police protection without fear of being charged or abused.

All locations included in this study have specialised police GBV units of some kind, and all had a Sexual Offences Squad based in their Criminal Investigations Divisions. Mt. Hagen, Kundiawa, and Buka have Women's Desks or Women and Children's Desks to deal with complaints of assaults against women and children. Overall, where there are specialised units, they provide a stronger response and are more likely to take action on behalf of victims. The Mt. Hagen, Kundiawa, and Buka police services work hard to provide effective services to victims, and they perform relatively well against the audit standards, despite serious under resourcing.

However, there is no specialised police GBV unit in Wewak, which means that victims must make reports at the front counter of the police station without privacy. Due to the lack of resources, community policing provides the first response to reports of crime in Wewak, including such serious crimes as sexual assault. In Madang, community policing and the police station are co-located.

Domestic assaults are treated as unlawful assault, which is a non-serious crime, unless the victim suffers serious injuries. Cases of sexual assault and assault occasioning injuries are treated as serious crimes and referred to the Criminal Investigation Division. However, this study found that the 2007 circular from the Commissioner to treat all assaults as serious crimes is not being implemented in Madang. Five years on, a reminder from the current Commissioner of Police is needed so that charges will be laid against alleged offenders. There needs to be monitoring of compliance and follow-up where police officers do not comply.

There is a marked contrast between the villagers' views of police and how the police view themselves in terms of how the community relates to them. Villagers do not see police as accessible and express strong anger about fees charged by police (such as for delivering summonses or for petrol) and their lack of responsiveness to conflicts. However, police view themselves as being respected by the community.

1. Family and Sexual Violence Units

Family and Sexual Violence Units represent the most up-to-date specialised police service introduced by the Royal PNG Constabulary for crimes of gender-based violence. There is currently a national roll-out of these units to replace the older, less formal Women's and Children's Desks. These should be established in all provinces as soon as possible. Staff should include female police officers to work with female victims of gender-based violence. However, clarification of roles and standardized descriptions of positions and recruitment criteria are needed to avoid duplication and competition with Women's Desks and Sexual Offences Squads.

2. Staff are trained in gender-based violence, human rights, the medical and psychosocial needs of survivors, and the purpose of post-rape medical services

The audit found that the training of police GBV units has been haphazard and difficult to access. Pre-service training includes a rights-based approach to gender-based violence and lays out the police role of pursuing complaints and providing protection. However, some police officers wait years to attend similar

in-service training, for example, police working on the Women's Desk/Family Sexual Violence Unit at Mt. Hagen Police Station. Other police officers regularly participate in training on human rights through their involvement in Family and Sexual Violence Action Committees, such as police officers at the Kundiawa Police Station and the Provincial Council of Women in Wewak, which have provided consistent training for police on gender-based violence. Skills-based training in interim protection orders was provided by the female police prosecutor to female police officers at the Buka Police Station. One of the officers on the Women and Children's Desk in Kundiawa was trained in policing in the Solomon Islands as part of the international peace-building initiative there.

The Constabulary Headquarters have yet to integrate gender-based violence, human rights, and HIV into any of their core curricula in the recruit course, the various command and control courses, or the officer cadet course [private communication, Joanne Robertson, PALJP]. Poro Sapot is often invited to provide a "session on HIV" to police recruits. Sometimes they are allocated a whole day, but usually it is less and only a portion of the recruits attend, rather than all of them. Apart from the request for a "session on HIV," the RPNGC does not provide any other guidance to Poro Sapot about what it is they expect the recruits to know and be able to do in relation to HIV at the end of the training, nor do any of the Bomana staff attend to monitor the training (see Table 10, Appendix seven, for training on HIV required by the various levels of police staff).

These efforts, while less than satisfactory, are improving referrals and coordination between services; and in Buka they are leading to improved use of interim protection orders, although there are many problems identified in the data collected from community representatives and health and social sector services. Mercy Works in Mt. Hagen commented on improvements in police responses to reports of gender-based violence through a partnership approach:

In the past, police did not have knowledge of gender-based violence and treated all cases in one centre, and women were not screened for their needs.... Police have made a good partnership by offering joint service in the police station with a Mercy Works worker, and we can see the effectiveness of this programme.

Police who participated in the study were aware of the need to refer victims of sexual assault to A&E departments or family support centres for PEP within 72 hours to prevent HIV and sexually transmitted infections, and for the collection of forensic evidence, medical treatment, and counselling.

3. Protocols and standard operating procedures require police to take rape survivors immediately for medical treatment

The police interviewed for the study demonstrated adherence to this standard. However, the importance of PEP within 72 hours following sexual assault and the psychosocial needs of rape survivors should be included in police training.

4. Family and Sexual Violence Units provide private and secure reception and waiting areas

Police stations visited for the audit do not have adequate waiting rooms and areas for victims of gender-based violence. Victims and their support people wait outside on the grass or stand in the reception area. Overall, police stations are in urgent need of maintenance and repair, except for station in Buka.

5. Family and Sexual Violence Units provide private and secure interviewing areas with auditory and visual privacy

The Mt. Hagen Police Station has a private interviewing room for victims of gender-based violence, in addition to an office for the Family and Sexual Violence Unit. However, most police stations visited for

the audit do not have separate interviewing rooms. Instead, GBV victims are interviewed in regular police offices, and officers who share these offices go out of the room while the interviews are in progress to ensure the victims' confidentiality and privacy. While this is good practice, it also diminishes police productivity.

6. Female police officers are available at all times

The specialised police GBV units included in the audit operate only during business hours. At the Madang Police Station, however, female officers are on after-hours and weekend rosters. Additional female police are needed in Family and Sexual Violence Units to cover after-hours and weekend shifts so that female police officers are available to GBV victims at all times. Adequate staffing and resources and a minimum standard of hours need to be established for all Family and Sexual Violence Units.

7. Service hours cover periods when most calls are received (i.e., weekends and evenings)

Police stations that participated in the audit have front desks that provide after-hours and weekend cover. However, the lack of privacy and confidentiality affects victims of gender-based violence as they must make their report in front of other people queuing for assistance. All reception and front desk staff should also participate in training on appropriate responses to GBV victims given their involvement after hours.

8. Service provision without discrimination for male clients who have sex with men, transgender people, sex workers, and people living with HIV

This study found that men who have sex with men and transgender clients do not seek assistance from police stations. Legislation criminalising homosexuality, shame, fear of police violence, and harassment are all barriers to reporting gender-based violence for these groups.

MSM and transgender people who attempt to report gender-based violence to police may be charged, taken to court, and jailed. Further, once in jail they are vulnerable to rape and abuse from other prisoners and correctional officers. A review of legislation is required so that gay men, other MSM, and transgender people are able to report violence without being charged themselves.

Sex workers are discriminated against by some specialised GBV units, for example, in Mt. Hagen where the front desk, staffed by less specialised police, respond to reports of gender-based violence by sex workers, rather than the Women's Desk, which limits its services to married women.

Clearly, specialised units should accept complaints from all victims of gender-based violence; and the responsibility of Family and Sexual Violence Units to respond to all GBV victims without discrimination should be included in standard operating procedures and in police training. Speakers or resources from specialist services, such as Poro Sapot and PNG Friends Frangipani, should also be integrated into such training.

Standard operating procedures should also address the needs of incarceration offenders who are living with HIV to ensure they have ongoing access to HIV medication.

9. Services to male clients

Boys who are victims of child sexual abuse are commonly referred to the police, and are in turn referred to family support centres. Adult men are less likely to seek help from the police, as being identified as a GBV victim is very shameful, both culturally and socially. A small proportion of men who experience violence in their marriages, including physical and financial abuse, seek help from FSCs. The Criminal Investigation Division in Madang responds to men whose wives have abused them. Police training should include knowledge about the barriers that prevent or restrict male GBV victims from seeking help.

10. Resourcing for specialised police gender-based violence units

In general, all of the police stations visited in the provinces of Western Highlands, Kundiawa, and Madang are in urgent need of resources, particularly in regards to building maintenance, facilities enhancement, and access to transport. Without adequate resources, specialised GBV units and Criminal Investigation Divisions are unable to provide transport for victims to protect them from further violence, investigate offences, or lay charges. Increased budgets for the enhancement of police stations and adequate office facilities – such as filing cabinets, digital cameras, and up-to-date computers, printers, and fax machines – are urgently required.

In contrast to this state of affairs, the police station in Buka is adequately resourced as a result of New Zealand Aid, and a new building for the Family and Sexual Violence Unit was about to be opened. This finding is consistent with a UNDP study conducted by Taylor and Bernath [2011, p. 32], which found that “the lack of resources undermines the morale and motivation of police officers to work. Petrol for police vehicles is rationed at 30 litres per week. Communications is very difficult: most cars have no radios and the landlines do not work, as the bills are not paid. Sometimes there is no stationary or pens.”

However, although Kundiawa Police Station faces a serious lack of resources and the Women and Children’s Desk does not have modern equipment, the station’s strong partnerships with the local family support centre and the provincial Family and Sexual Violence Action Committee enable police to be effective. For example, police participate in coordinated case management meetings with education, health, justice, and social sector services for serious criminal cases. These deficiencies need to be addressed within the context of overall resourcing for the Royal Papua New Guinea Constabulary.

Community police are also in need of better resourcing, as they are often the first-line response to gender-based violence in provinces such as East Sepik.

11. Support from senior staff

Where specialised gender-based violence units are already established, police officers in those units report they have the support of senior staff as well as other police colleagues, police prosecutors, and the courts.

12. Data collection on reports of gender-based violence

This study found that police do not collect data in ways that can be used to track incidence of gender-based violence and to support the progress and outcomes of cases. There is no centralised data collection system [PALJP, 2012]. Rather, data collection occurs through the process of taking statements and recording them in a hard copybook that is kept by each station, with charges and dates.

WHO and UNAIDS [2010] advocate for the use of gender-based violence statistics as outcome indicators on national progress in combating violence and reducing HIV risk, particularly for vulnerable groups such as sex workers. The data can also be used by local groups to promote GBV awareness and prevention.

PNG is in need of a national electronic data base for recording reported incidents, training for police on entering information electronically, monitoring of data entry for accuracy, and adequate information and communication technology resources in each police station. Data analysts at Constabulary Headquarters are also needed to analyse and report on the data accurately and meaningfully.

In Madang, the Criminal Investigation Division and Sexual Offences Squad provides statistics on categories of assault, numbers for each category, numbers of arrests, and cases pending to the Country Women’s Association. The Country Women’s Association collates and uses police statistics in campaigns against violence against women and children, which demonstrates a useful partnership.

13. Transport is readily available for taking rape survivors and other gender-based violence victims needing urgent medical attention to a health facility, for taking survivors to a place of safety and collecting their belongings, and for locating alleged offenders and investigating cases. Complainants are not asked to bring the alleged offender in; police will collect offenders themselves.

This standard is not met in the provinces studied. Currently, police lack the necessary equipment to transport victims of gender-based violence. Notably, all units audited have petrol rationing for police vehicles in place.

The Well Women's Clinic in Mt. Hagen reported a serious sexual assault case to the police and found the police could not act because they lacked transport:

Three young girls were kidnapped from a public motor vehicle and kept in a remote area for a week by an enemy tribe. One girl ran away and was brought to the hospital. I escorted her to police and reported concerns about the safety of the other two girls. The police gave a lot of excuses and said there is no fuel. I told the relative to go and talk to the leaders and make peace with the enemy tribe – the girls were released. They were continuously sexually assaulted for a week.

14. Standard operating procedures for gender-based violence include providing protection for the client and preventing further violence, NOT attempting to mediate or give counselling; domestic assault, as noted in the 2007 Commissioner circular, is to be treated like other assaults, not as “a private/family matter”

Counselling victims and perpetrators of violence is not an appropriate role for law enforcement officers, as it confuses their role with that of counsellors or mediators. However, police interviewed in this study describe counselling victims of gender-based violence about their rights and informing offenders that they have broken the law. 'Advising' would be a more accurate description of this intervention.

Therefore, standard operating procedures for police should outline the distinction between police advising victims and offenders that violence against women and children is against the law and about human rights, on the one hand, and the provision of counselling by family support centres and NGOs, on the other.

15. Summonses for cases of gender-based violence are served by police free of charge

The audit found that police and courts charge fees for delivering summonses and make requests for money to buy petrol. People living in villages view such fees as a corrupt practice, and they are clearly a barrier to reporting crime for people who cannot afford to pay. Villagers in the Western Highlands and Simbu, for example, report that police charge fees as high as 100 to 200K (Kina, approximately \$0.46). The further from town, the higher the fees police charge for fuel.

The Director of Human Resources at police headquarters in Port Moresby commented on the issue of police charging fees:

If police are asking for their own personal benefit, that's not right, but if it's because they are not supplied with petrol and people are asked to assist, that's something else. Still, police are not supposed to be doing that.

A system with good governance is needed to regulate fees charged by police for delivering summonses. The schedule of fees should be posted in police stations and payments should be receipted and audited regularly. The police schedule of fees should be the same for urban and rural areas, as people living in villages are less able to afford such fees. Police should not charge fees for investigating reports of gender-based violence.

In Buka, delivering summonses over the radio is a way of overcoming difficulties in delivering summonses to villages and remote areas. This strategy could be considered in other provinces, as there is no cost to using radio, and radio is widely listened to throughout Papua New Guinea. Summonses delivered as text messages via mobile phones could also be considered.

NGOs that are providing assistance to GBV victims and survivors in East Sepik and Madang sometimes pay police fees on behalf of their clients using donor funding, as does the Provincial Council of Women in Wewak, funded by AusAID.

16. Effectiveness of interim protection orders: Breaches are acted on immediately

Interim protection orders (IPOs) are relatively new in the provinces studied here. IPOs are legal orders that can be taken out to protect gender-based violence victims. If breached, the offender can be charged by police; and if found guilty of a breach, the offender will be further charged. Not all police stations issued IPOs at the time of the audit, including those in Madang, Simbu, and East Sepik. Consequently, there is a need for training police and community agencies in the use and effectiveness of IPOs, as well as for greater awareness and training among communities.

Buka is a model for the effectiveness of IPOs as a result of improved collaboration among police, courts, and social sector organizations. As the coordinator of the Nazarene Rehabilitation Centre commented: "We were very empowered by all the services working together on interim protection orders."

Breaches of interim protection orders

Villages in Western Highlands and NGOs in Madang report frequent breaches of IPOs. It is important that police act on breaches to protect victims of gender-based violence and to increase community confidence that protection orders are effective.

17. Barriers to reporting and prosecuting gender-based violence

This study found the major barriers to reporting and prosecuting gender-based violence are:

- Cultural and traditional attitudes towards women;
- Police are abusive to GBV victims;
- Women experience pressure from husbands and families to drop charges;
- Women need advocates to assist with having charges laid against their husbands and with navigating the court process;
- Women return to their husbands, even though violence continues, so they have access to their children.

The study found some communities viewed police as abusive. Serious complaints about police are dealt with by the Ombudsman Commission of PNG and Internal Affairs. The director of Human Resources reports that some police have been arrested and prosecuted as a result of Internal Affairs' investigations.

18. Police referrals to other services

There are effective referral systems in place among police, courts, health services, and community organizations in each province. The National Department of Health requested that this study develop referral guidelines that identify a lead agency for GBV service provision. However, the study findings show that the lead agency differs from province to province. In Western Highlands, for example, Mercy Works leads the networking among various agencies. In Simbu, the provincial Family and Sexual Violence Action committee is very active in coordinating inter-sectorial cooperation. In Wewak, the provincial Council of

Women is the lead agency. In Madang, the Country Women's Association plays an emerging role, although police refer many cases to the overloaded district Welfare Officer. In Buka, the district court plays a major role in obtaining funding for GBV services and for providing paralegal training on IPOs for police officers, communities, and health agencies.

19. Services' referrals to police

Services actively refer victims and survivors of gender-based violence to police, although in some provinces the services express concern that police do not take action. HIV counselling and testing centres make referrals for people living with HIV who experience stigma and discrimination to the police.

20. Strengths of police services

There is a marked contrast between villagers' views of services provided by police and how the police believe the community views them. Police units are viewed more positively where there provide strong and effective links with community organizations. In Kundiawa, the provincial Family and Sexual Violence Action Committee has facilitated effective responses to victims and survivors of gender-based violence in partnership with the police. Buka is an example of the successful implementation of IPOs through inter-agency cooperation among the health, justice, and social sectors.

21. Gaps in services provided by police

Police commented on the gaps in services that they provide to gender-based violence victims, and the study noted that greater resourcing and staffing are needed in every province to effectively respond to GBV violence. Without proper facilities, access to transport, and adequate staffing, police are unable to fully implement the draft standards and meet standard operating procedures in the area of gender-based violence. However, some poorly resourced police stations, such as in Kundiawa, are able to effectively respond to gender-based violence through strong provincial Family and Sexual Violence Action Committee partnerships.

22. Community view of police effectiveness

Focus groups held in villages and interviews with health and social sector organizations provided data on views of police effectiveness. In many provinces, communities can see that police do not have the resources to adequately investigate crimes of gender-based violence.

In some provinces, police are not well regarded by the community, although community agencies have established close working relationships with police. The most common complaints from villagers and community representatives are that police do not respond to community needs and charge fees and/or require bribes.

The view was also expressed that police can be violent in their own relationships. Police station commanders have a major role in investigating complaints against police, and therefore they should also participate in training on gender-based violence and human rights.

Summary

In summary, the audit of police responses to gender-based violence and HIV has demonstrated that under resourcing is a seriously impediment. Additionally, training needs have been identified in relation to knowledge of gender-based violence, human rights, and non-discriminatory responses, as well as policing skills and interim protection orders. A review is needed of legislation that criminalises homosexuality and sex work to ensure all GBV victims are able to access police protection without fear of being charged or abused.

District courts (refer to Table 8, Appendix seven)

District courts are widely regarded as implementing the law and therefore delivering fairer outcomes for victims of gender-based violence than do village courts. However, service providers and service users commented on the time taken to complete cases at the district court level, and the need for victims to be informed about court processes. In addition, district courts are difficult to access for people living in rural areas.

1. Interim protection orders

As IPOs have only recently been introduced, legal training regarding their use is needed for police and workers in the health and social sector services. Community awareness as to how to take out an IPO is also needed. Buka is a model for how to roll-out IPOs through collaboration among the justice, health, and social sectors.

2. The police view of district court effectiveness and outcomes

Police view district courts as operating fairly and according to the law. However, police commented on the length of time to complete cases in the district court.

3. Gender-based violence services and community representatives' view of district court effectiveness

Decision-making and sentencing in district courts are seen as fair by participants in the study. In urban areas the district courts are presided over by educated magistrates. In Madang, however, community agencies reported that district courts still see violence against wives as a family matter rather than a criminal offence.

Victims of gender-based violence do not have enough information about how the courts operate or even which hearings they need to attend. Various organizations provide support to GBV victims to guide them through the court process, but the provision of standardised court preparations and support materials to victims would be a valuable resource. These service organizations also commented that delays in district court hearings can lead victims to withdraw complaints.

Police act as gatekeepers for cases reaching the district court. In East Sepik, for example, a service user who had been assaulted three times by her husband with a bush knife said that the police would not act. They did not lay charges so the case did not go to district court. In Buka a service user alleged that the police had covered-up for an offender who sexually assaulted her daughter, and as a result of the poor investigation and extensive delays in bringing the case to court, the offender was found not guilty.

4. Access to district courts

District courts are urban-based and therefore are difficult to access for women and other survivors who live in rural areas. Advocacy and court support services are needed to assist GBV victims through the legal processes, which are unfamiliar and intimidating, and this in turn will increase the number of cases that go to district court. For example, a service user at the Well Women's Clinic in Western Highlands who had been assaulted by her husband's second wife had not known that she was required to attend the district court hearing.

Family support centres and social sector organizations could support women in villages to attend district court hearings by providing financial assistance for their travel costs to town centres. However, the families of survivors may not support the use of formal court processes to address gender-based violence. Where charges are laid against men, women are often pressured by their families to withdraw charges so compensation can be sought through village courts [UN Women, 2011a].

Summary

Overall, district courts are perceived by users of GBV and HIV services to be delivering fair outcomes for victims. However, some victims and their families find the police investigation of cases to be poor, which affects court outcomes. People in rural areas in particular find it difficult to access the district courts, and court preparation and information is needed so that victims can better understand the court processes. The next section examines how well village courts are dealing with gender-based violence and HIV-related cases.

Village courts (refer to Table 9, Appendix seven)

Village courts are the most accessible way of resolving disputes and violence in most areas of Papua New Guinea. In many areas there is no other alternative because the district courts are only located in towns. Village courts apply customary law, and their way of operating is well known to the people around them, whereas district courts' formal procedures and application of national legislation are less well understood. Village courts operate in rural villages and urban settlement environments, where all parties and village court officials live. This makes the task of being impartial to both sides difficult and challenging. Village court magistrates in Western Highlands and Simbu reported being subject to bribes, threats, and assaults.

1. Female magistrates appointed to village courts

In 2004 there were only 10 female village court magistrates appointed in the country. The audit shows that while progress has been made in appointing female village court officials, rural areas are still less likely to have female magistrates, and female magistrates are in the minority on full village court teams. Kudjip and Minj districts raised the issue of the slow appointment of women as village court magistrates, despite recommendations from the local level. Many respondents, including male village court officials, suggested that the appointment of more female magistrates would help ensure women get a fairer hearing and reduce gender bias.

It has been the policy of the Village Courts and Land Mediation Secretariat to appoint and train female magistrates for some time, but the appointments have not been evenly distributed across provinces. In Eastern Highlands, 90 female magistrates were trained from 2008 to 2010 [Morgan, 2010]. The Secretariat has proposed shorter periods of tenure for village court magistrates, for example, three or five years, which would facilitate gender balance in village courts by opening up new opportunities to appoint women as village court officials [Ibid.].

2. Training of court officers in gender-based violence

GBV training for village court magistrates should be expanded to include issues related to HIV and to positive changes in the behaviour of men and boys, and should be provided regularly to improve access to training for village court officials. GBV training provided by Family and Sexual Violence Action Committees and Provincial Councils of Women should include village court magistrates on a regular basis.

3. Frequency of hearings

Village court hearings take place regularly in all districts and provinces included in this study. Village court magistrates are also on call for the informal resolution of grievances and disputes and for conducting mediation. In Bougainville, the Councils of Elders also play a role in maintaining peace and settling disputes.

4. Issuing Protective Orders and summonses

Protective orders are issued by village courts in Western Highlands, Simbu, and Madang. Service providers

who are assisting GBV victims and survivors should inform their service users about protective orders and should assist women in obtaining them. The Nana Kundi Crisis Centre refers to the provision of information about women's rights and legal remedies for violence as "awareness counselling."

5. Mediation in domestic violence cases

Village courts use mediation and reconciliation to attempt to resolve cases of domestic violence, guided by a model of mediation that is referred to in the Village Court National Policy as the restorative justice model, which aims to restore the balance of relationships. However, relationships between men and women are frequently based on unequal power relationships and men's customary rights to control women. For example, brideprice was frequently given as the reason why village courts do not protect women from violence by female villagers: "when magistrates know a brideprice has been paid, they say women are wrong, because that is the custom with heads of families" [Western Highlands province].

Women do not usually benefit from the restorative justice practice of mediation. Women interviewed for this study commented that women do not receive a fair hearing in village courts, as magistrates "go to the side of the men" [Jiwaka village]. Mediation in cases of gender-based violence can place victims of domestic violence and sexual assault at further risk, as harmony is valued over the rights and safety of women [AusAID, 2008a]. However, the Village Court Handbook and Village Court Policy are clear that customs that expose women to violence and abuse must not be promoted, and that village courts must ensure protection for women.

Transformative justice is more suitable for cases of violence against women as it seeks to address underlying inequalities that have allowed the violence to take place, and takes into account the social and cultural contexts of violence. Mediation in the transformative justice model seeks to address the social relationships that enabled violence against women and seeks to balance gendered power relations [UN Women, 2012]. Mediation should be combined with penalties for offenders and the provision of systematic training on how to respond to gender-based violence for all village court officials.

6. Resources for village courts

Village court officials noted that conducting hearings out in the open is a risk to safety, especially in Western Highlands. Venues for village court hearings, such as school buildings when not in use, could be arranged for each district by the provincial and district offices. The Nana Kundi Crisis Centre model of imbedding a village court magistrate within their services should be considered by other GBV service providers.

In Maprik, school buildings are used for village court hearings. Magistrates participating in the study called for appropriate payment for hours worked, as they are on call for informal dispute resolution and have responsibility for maintaining peace and harmony in villages. Notably, the allowances for village court officials have not been raised for 30 years [Department of Justice and Attorney General, 2011].

7. Village courts' jurisdiction

This study found that village courts frequently hear cases that do not come within their jurisdiction. Serious cases of injury and sexual assault are required by the Village Courts Act to be referred to police for prosecution through district and national courts. In Western Highlands and Simbu provinces, village court magistrates delineated between village and district court jurisdiction by the amount of compensation to be paid. Above a certain level (2,000–5,000K), village court magistrates stated that cases should go to the district court. Jurisdiction is complex, however. The Papua New Guinea–Australian Law and Justice Partnership (PALJP) HIV Advisor commented: "Village courts deal with the consequences of gender-based violence – how to maintain the community in a peaceful way – though they do not have jurisdiction to prosecute gender-based violence crimes." However, in many remote areas of PNG village courts are not easily able to make referrals to district courts or police.

8. Sexual assault is referred to police, not dealt with by compensation

Sexual assaults are frequently dealt with in village courts. If police were more mobile and able to investigate reports of sexual assault, victims and families would not turn to village courts for resolution. This could be because police are not functioning well, as in Wewak, or because they cannot easily access more remote provinces, such as Western Highlands and Simbu. The HIV Law and Justice Adviser noted that some aspects of the impact of sexual assaults are addressed by village courts to restore peace and harmony even when cases go to district courts.

Adequate resourcing, training, and staffing of police will increase their capacity to investigate complaints and take substantiated complaints to district court. This will also reduce the number of sexual assaults cases dealt with by village courts.

9. Meaningful penalties for domestic assault, or breaches of protective orders for domestic violence, are enforced

Village courts in the five provinces included in this study apply similar penalties for violence in marriage, for example 500–1,000K for a broken arm. In Madang compensation is set at higher levels for wealthy men. In some courts compensation is paid to the court as a fine, and in others it is paid as compensation to the victim and the victim's family. However, in many cases village courts hear compensation cases before they have been heard in district court, and women interviewed for this study noted that they do not believe that such plaintiffs receive a fair hearing.

10. Payment of a brideprice is not accepted as a defence

Village courts deal with violence in marriages where a brideprice has been paid differently from marriages where no brideprice has been paid. As a village court magistrate in Simbu noted: "Violence in marriage is linked up with brideprice payment. If violence occurred and the woman wants to divorce and the man says no, then there'll be three sittings to help them agree. When women with children get divorced and go, they have nothing." The outcome will usually be that men keep the children if the wife leaves, especially in Western Highlands and Simbu provinces.

11. Cases of alleged sorcery in connection with HIV infection, and alleged deliberate infection with HIV, are referred to the police

Alleged sorcery

Papua New Guinea legislation includes a Sorcery Act (1991), which aims to regulate the harmful use of sorcery. Accusations of sorcery and brutal murders are frequently reported in the media, and as a result the Constitutional Law Reform Commission and the Office of the Public Prosecutor have called for a review of the Act [Per, 2009]. When a person dies of unknown causes, which may include undiagnosed HIV, accusations of sorcery against a family or individual frequently occur.

Village courts' jurisdiction includes crimes of sorcery and threatening to use sorcery [Hill and Powles, 2001]. Magistrates interviewed for this study have experience dealing with cases that involve the torture of people accused of practising sorcery, as well as the loss of property to accusers and sexual assault in retaliation.

PALJP is monitoring how sorcery is linked to stigma and discrimination against people living with HIV [Godwin, 2010]. A further review of cases of sorcery heard by village courts is needed in order to make recommendations about the legal issues involved.

Intentional transmission of HIV

Village courts deal with some cases of deliberate HIV transmission, where a person living with HIV knowingly has unprotected sex. There is anecdotal evidence that village courts are dealing with intentional transmission of HIV in Western Highlands, and PALJP is currently conducting an audit.

12. Police views of village courts' effectiveness in dealing with gender-based violence

Police view the effectiveness of village courts differently across the provinces included in this study. Western Highlands police see the role of village courts as providing compensation to victims and their families. In Simbu, village courts are seen as biased towards men and corrupted by bribery and favouritism to relatives. In Madang, community police conduct mediation for cases that are before the village courts. In Buka, the district court plays a strong role in gender-based violence and works in partnership with GBV service providers. There is a close working relationship between village courts and community police.

13. Community views of effectiveness of village courts in dealing with gender-based violence

Men and women interviewed for the study believed that the decisions made by village courts about marriage, divorce, and violence against women are biased towards men. Equalising the proportion of male and female village court magistrates will help change community perceptions of gender bias in village court decision-making.

In Western Highlands, villagers were concerned about the risk to women's safety when court hearings are held in the community where the accused lives. A woman may be threatened by the husband's or partner's family or friends. A change of venue for court hearings may need to be considered when a victim's life is at risk.

14. Village court reporting

There are significant delays in reports being sent by village courts (which are sometimes in remote locations) to the Village Court and Land Mediation Secretariat. There are 1,500 village courts in Papua New Guinea, but only 300 of these report in a timely fashion on the number of cases related to family conflict and HIV (among other criteria), the number of complainants disaggregated by gender, and the number of defendants disaggregated by gender. There have been concerted efforts made by village courts to improve data collection [HIV advisor, PALJP], and timely reporting by village courts should be encouraged by the Secretariat and provincial and district offices. Accurate records are needed for more exact assessment of how village courts respond to family conflict and HIV-related cases.

A National Village Courts Information Management System has been funded by PALJP. However, the Internet is not available in many areas of Papua New Guinea, and therefore electronic reporting is not currently available.

15. Security

Village court magistrates in Western Highlands reported threats of violence and attacks when court decisions are made against one side in a dispute. Peace officers who are officers of the village courts should respond to any and all such threats.

In summary, the audit showed that village courts deal with aspects of serious crime to restore peace and harmony to communities. Mediation and reconciliation can work against the interests of women, as they return to unequal relationships in which they are likely to be re-victimised. Women do not perceive village courts to be fair because male magistrates predominate.

Section three: Social sector findings

This section presents the findings of interviews with social sector organizations that provide gender-based violence and/or HIV services in the five provinces included in the study.

In Mt. Hagen in Western Highlands, referral and support networks for gender-based violence are beginning to develop. Few NGOs providing GBV services operate in Western Highlands. Mercy Works, Anglicare, Susu Mamas, and Maria Stopes International provide services, but there are no safe houses available. Mercy Works plays a lead role in the provincial Family and Sexual Violence Action Committee, which is building networks between services.

Social sector organizations working in the area of gender-based violence were not visible in Simbu; however, a safe house provided by the family support centre on hospital grounds is available for up to seven days.

East Sepik has one safe house in Wewak, operated by the Provincial Council of Women, and one in Maprik, provided by the Nana Kundi Crisis Centre [Oxfam Australia, 2010]. The Nana Kundi Crisis Centre is based in a rural district in East Sepik, and is a well-resourced agency that networks very effectively with the police and the local family support centre. Its services include a village court magistrate working full-time and a paralegal officer.

Madang does not have a safe house despite the fact that funding has been offered by a foundation because land to build on is scarce in the province.

Buka, Arawa, and other districts in the Autonomous Region of Bougainville have safe houses operated by the Nazarene Rehabilitation Centre.

Orphans and vulnerable children

These children are very vulnerable to neglect, physical and sexual abuse, poor health, dropping out of school, and various forms of exploitation because they live in out-of-home care and/or have parents with AIDS-related illnesses. The researchers visited orphanages and foundations for children orphaned by HIV and children whose parents are living with HIV in Western Highlands and Simbu. Mercy Works in Mt. Hagen provides meals, showers, and educational programmes, including assistance with banking, to “taxi boys,” who are homeless.

Orphanages and foundations for vulnerable children are based in villages. The services did not appear to receive adequate funding to cover basic needs and school fees for the children in their care. For example, at the orphanage run by the Nambe Faith-based Community Care centre in Jiwaka, the girls’ hut accommodates over forty children but has only two beds with torn mosquito netting. The boys’ hut provides bedding on the floor. The children are looked after by two pastors who are a husband and wife team, and by women living with HIV in the village.

A national coordinating mechanism for services to orphans and vulnerable children has been established by the Department of Community Development and the National AIDS Council [Hunter, 2006]. However, there seems to be neither monitoring nor adequate funding of these services.

Community solutions for gender-based violence

Villagers recommend implementing microfinance, education, and training to reduce gender-based violence. Villagers see microfinance schemes as a way to stop violence because men and women focus on a common goal, have pride, and work together:

If there is a funding or finance system for seedlings or poultry or building that will keep us busy so we are not thinking about violence, our mind is always full of business. We won't have space for violence. Microfinance and business means we need to cooperate together – man and wife – for the future and plan for a good house and maybe a car [villager in Western Highlands].

However, international experience has demonstrated that unless microfinance schemes specifically incorporate training in HIV and gender awareness, they have variable success in reducing levels of domestic violence and other forms of gender-based violence [WHO and UNAIDS, 2010]. For example, when women aided through microcredit programmes in Bangladesh challenged gender norms, husbands and partners reacted with violence [Schuler, Hashemi, and Badal, 1998]. However, a South African study of microfinance combined with HIV education and gender awareness training (“microfinance plus”) found that interpersonal violence was halved over a 12-month period [Kim et al., 2007].

Education, training, and counselling are also seen as important mechanisms for reducing violence by building knowledge about laws and human rights in the community:

- *Education is another contributing factor because people aren't educated and they believe in things passed on from the ancestors. They don't think of human rights.*
- *We need training to change one community at a time – men, women, and children.*

Providing training to villagers without adequate long-term follow-up and support, however, is not helpful. Jiwaka village in Western Highlands was trained in Community Conversations, which is a community mobilisation programme funded by UNDP. The programme aims to empower communities to agree on solutions to the problems affecting their lives, and to put these into action. Structured group meetings are facilitated by trained leaders, and women and young people are encouraged to speak [McCarthy, 2010]. However, women in the village reported that the implementation was not successful as there was inadequate support:

Community conversations taught us community work with UNDP. We tried to start it out in the village, but there was no support so people were reluctant to come. The Provincial Community Development Office tried to get things started, but here was no follow-up.

Women in Western Highlands recommended that community leaders should be trained in gender-based violence and human rights because of their influential role in the community:

Community leaders don't do anything; they say it's family business.

Counselling is understood to help with reducing violence:

The pastor is the only one here with counselling training. We would like to do counselling training. Maybe through counselling we can find out what having a good family is all about and how to be a good husband and the cost to another person [of violence]. We will look after family.

Trained counsellors help us realise our problems. The causes of gender-based violence have been hidden for some time and now men realise their weakness.

The audit has showed that, overall, social sector organizations provide valuable services for gender-based violence and HIV.

Summary

Despite shortfalls in funding and resources, the study found active referral systems in place among family support centres, HIV counselling and testing centres, police and district courts, and social sector organizations in most provinces included in this study. Where there are strong partnerships and multisector initiatives, services are most responsive and effective in addressing gender-based violence and HIV.

CHAPTER FIVE

Conclusion and recommendations

The strengths and weaknesses of gender-based violence and HIV responses in five provinces of Papua New Guinea have been identified systematically throughout this study, employing an ecological approach to capture the “opinions, values, attitudes and knowledge base [of participants] as expressed in their natural habitat’ [Bryman, 2008, p. 33]. This approach included the local and cultural contexts that influence and shape gender-based violence and HIV services in each location. As a “rapid assessment,” the study has great value in identifying particular problems and gaps, but was not intended to come to grips with all the complexities of setting up systems that work and connect effectively across all sectors in Papua New Guinea. The overall picture gained was of the uneven spread of gender-based violence and HIV services in the five provinces studied; the under-resourcing of key services in the health, justice, and social sectors; gaps in services; and uneven performance on standards because effective measures of accountability are not in place.

Key issues for the health sector are:

- lack of resources and funding for health services;
- difficulties faced by rural victims and survivors of gender-based violence in accessing family support centres located in town centres;
- lack of reliable access to PEP against HIV for rape survivors, especially for victims in rural areas;
- inadequate training and resources for A&E departments providing services to GBV victims when family support centres are closed or absent;
- need for access to specialised training in culturally appropriate models of counselling, supervision, debriefing, and ART prescribing;
- variability in HIV counselling and testing services’ adherence to standards, particularly in addressing clients’ GBV risks;
- need for specialist services for vulnerable groups, including men who have sex with men, transgender people, and sex workers.

Family support centres

- The audit of family support centres demonstrated an encouraging level of integrated care for female survivors of gender-based violence in relation to medical treatment, basic counselling, HIV testing, provision of medical reports for court, and, in some provinces, short-term accommodation. Timely access to PEP against HIV for rape survivors is still problematic. Counselling training, data collection, and routine reporting are sparse. Operational guidelines for the centres have not yet been formally endorsed. However, it was clear from this study that the model is a successful one which, with the input of further resources and support, can greatly reduce the suffering of GBV victims/survivors, prevent further occurrences, and reduce the spread of HIV.

Other primary health care services

- The development of a strategy to provide effective care for gender-based violence survivors who cannot access FSCs is urgently needed. This should include the elimination of fees for medical services and court reports, the establishment of training for all health care providers, the provision of standard protocols and supplies, active public education programmes, and linkages with HIV services.

HIV counselling and testing services

- There are many centres for HIV counselling and testing available in rural districts as well as urban towns, and these centres provide an important and effective service for HIV testing and treatment. However, currently they are not consistently addressing the HIV risks of their female clients associated with spousal violence, or the risk to women who test positive for HIV of retaliatory violence from their untested partner. The counselling skills already developed by HIV counselling and testing providers are a good foundation for the further integration of assessment of, and intervention in, gender-based violence in pre- and post-test counselling.
- Further scaling-up of the integration of gender-based violence assessment and referral in HIV counselling services will require the support and cooperation of the Catholic and Anglican churches (which have a large number of stand-alone and integrated HIV services); other social sector organizations; the National Department of Health; provincial health divisions; the National AIDS Council; and Provincial AIDs Committees to develop overarching strategies, policies, and performance indicators for jointly delivered services.
- Community outreach, which is successfully carried out by the stand-alone VCCT centres and such theatre programmes as Tokaut AIDS, could include awareness of gender-based violence without a significant increase in resources. As the number of HIV-positive cases detected through testing is quite low in some areas, such as in rural areas around Wewak, the integration of GBV assessment and awareness with existing HIV services would be cost effective. Integration would provide an efficient use of resources and trained staff, an improvement in the quality of services, and a strategy for increasing referrals to gender-based violence services that would better meet clients' needs [Ferdinand, 2009]. However, it is crucial to include regular quality assessment of these verbal methods to avoid distortion by local prejudices and cultural expectations of male control over women.

Key issues for the justice sector are:

- police stations are under resourced and unable to investigate reports of gender-based violence;
- need for police Family and Sexual Violence Units to be opened in all provinces;
- lack of access for staff to gender-based violence training;
- gender-based violence victims' lack of access to district courts;
- widespread perception that the decision-making of village courts is unfavourable to women.

Police

- Facilities at all police stations surveyed are inadequate, except for Buka (ARB), which has benefited from New Zealand Aid and the co-location of New Zealand police in the Buka Police Station. The provision of suitable work and interviewing spaces, maintenance of facilities, and transport are inadequate. There are no suitable waiting areas for victims and their families, and only the Mt. Hagen Women's Desk had a separate room with auditory and visual privacy for interviewing clients. In most stations, other staff must leave the office, which reduces overall productivity. Necessary

basic equipment is lacking, such as functioning phones, computers and printers, photocopiers, and public education materials on gender-based violence. Despite these difficulties, the Kundiawa police have strong partnerships with the local family support centre and the provincial Family and Sexual Violence Action Committee, and participate in coordinated responses with other services in the health and social sectors. Deficiencies in resourcing need to be addressed in terms of the overall needs of the Royal Papua New Guinea Constabulary.

- The audit of police responses to gender-based violence confirmed findings of previous studies that police often fail to respond to cases of domestic assault unless there are serious injuries, and even at that stage inaction may continue. Violence against wives continues to be seen by some police as a private family matter. Mediation is provided to resolve conflict between individuals, families, and communities affected by gender-based violence, rather than enforcing the law [Amnesty International, 2006a; AusAID, 2008b].
- This study found that groups vulnerable to gender-based violence and HIV, including gay men, men who have sex with men, transgender people, and sex workers, do not report crimes to the police because they fear being arrested or abused. Decriminalisation of laws against homosexuality and sex work is needed to facilitate vulnerable groups at risk of GBV and HIV seeking police protection. Standard operating procedures for police and prisons should include continuing access to HIV treatment for people living with HIV who are incarcerated.
- Training in gender-based violence and human rights, and in-service training to develop policing skills, needs to be regularly provided by the Royal Papua New Guinea Constabulary for specialised GBV units in all provinces. Country-wide programmes were just beginning to be developed at the time of data collection. Police pre- and in-service training to facilitate attitudinal change and remove discriminatory practices will also improve access to police protection for these groups. NGOs and advocacy groups should participate in the development and delivery of training packages for police. The lessons learned from effective police networking with health and social sector organizations need to be included in gender-based violence training for police officers.

Key issues for the social sector are:

- ensuring effective referral pathways and collaboration across services;
- training in advocacy with the justice sector for victims of gender-based violence;
- providing adequate resources to provide services, including safe houses for women;
- meeting the need for specialist services for vulnerable groups, including orphans and vulnerable children, men who have sex with men, transgender people, and sex workers;
- promoting effective outreach and awareness strategies.

Effective collaboration is needed across all relevant sectors at the national level so that gender-based violence and HIV services can be better linked and coordinated, with shared resources for greater efficiency and cost effectiveness. Successful programmes can then be rolled-out across provinces to replace the current localisation and fragmentation of services at the district and province level.

List of recommendations

1. Establish an overarching body to develop an overall national multisectoral policy, service standards, strategies, and accountability measures for the provision of gender-based violence and HIV services, in consultation with service providers, service users, and community representatives, and including the following issues:
 - 1.1 Identifying crosscutting issues relevant to GBV and HIV policy and service provision.
 - 1.2 Establishing the linkages, referral pathways and partnership agreements needed between GBV and HIV services and other types of services accessed by vulnerable groups at risk of GBV and/or HIV.
 - 1.3 Establishing quantitative and qualitative indicators and data collection systems for quarterly and annual reporting and monitoring of each agency, as well as the effectiveness of their interlinkages.
 - 1.4 Developing client-centred systems that provide services free of charge to victims/survivors of GBV, and which minimize the associated travel costs, wait times, and security risks for clients, and also respect client choice for a female or male service provider.
 - 1.5 Providing regular supervision and debriefing to GBV and HIV service staff.
 - 1.6 Responding to the specialised needs of vulnerable groups, including gay and other men who have sex with men, transgender people, and sex workers.
 - 1.7 Using models that prioritize victim safety, gender equality, and women's rights to custody of their children for mediation in conflicts involving GBV.
 - 1.8 Providing temporary safe houses for victims/survivors of GBV.
 - 1.9 Re-naming family support centres so as to clearly identify the specific services that they provide to victims and survivors of GBV.
 - 1.10 Scaling-up couple counselling in HIV counselling and testing services.
 - 1.11 Improving the distribution of female and male condoms to all sexually active people, regardless of marital status or sexual orientation.
 - 1.12 Improving the quality of HIV counselling and testing outreach, and attention to GBV risks, in remote areas.
 - 1.13 Ensuring ongoing access to HIV medication for incarcerated people living with HIV, whether in police holding cells or corrective institutions.
 - 1.14 Ensuring that all police interfacing with victims of GBV have special training on GBV, HIV, and human rights, and that police services (e.g., service of summonses for protection orders and the investigation of alleged GBV crimes) are free of charge to the victim.
2. Develop a centralised national data collection system for recording categories of reported crimes, which allows accurate information on each type of GBV to be identified at provincial and district level and used for planning related services. To this end:
 - 2.1 Police need to be trained in electronic data entry and the monitoring of data for accuracy.

- 2.2 Each police station needs to be equipped with adequate information and communication technology resources.
- 2.3 Data analysts should be located at Constabulary Headquarters to analyse and report on the data accurately and meaningfully.
3. Develop national multisectoral training on GBV and HIV consistent with the national policy and service standards:
 - 3.1 Establish competency-based training programmes for counselling for each type of GBV, integrating a code of ethics based on human rights principles and overseen by a professional certification body.
 - 3.2 Ensure that family support centre staff members have ongoing access to advocacy training in justice sector services, in advanced counselling and trauma counselling (grounded in an understanding of power imbalances in marriage in Papua New Guinea), and in the interventions needed to address power imbalances and ensure women's safety.
 - 3.3 Provide staff in HIV counselling and testing services with training in GBV risk assessment skills for vulnerable groups and strategies for engaging men in pre- and post-test couple counselling.
 - 3.4 Provide training for staff in GBV and HIV counselling and testing services in assessment of clients' capacity to negotiate safe sex. Training should include strategies for improving the sexual negotiation skills of vulnerable groups.
 - 3.5 Involve user groups and their advocates in delivering training on barriers to seeking help and reporting violence experienced by men who have sex with men, transgender people, and sex workers.
4. Implement a national public education programme about GBV and its relationship to HIV with the aim of changing attitudes that condone male use of violence to control women. The programme should provide information about services available to victims and survivors, including post-exposure prophylaxis (PEP) for survivors of sexual assault.
5. Scale-up the 24-hour availability of PEP following sexual assault, and establish formal protocols between A&E departments in hospitals and HIV services to ensure the provision of PEP to all survivors of sexual assault.
6. Address the resourcing needs of GBV and HIV services across all sectors to increase access for victims and survivors:
 - 6.1 Open family support centres and police Family and Sexual Violence Units in all provinces as a matter of urgency, with the female staff of both to work with female GBV victims.
 - 6.2 Ensure fees are not charged for medical treatment of GBV-related injuries. Provincial Family and Sexual Violence Action Committees, Councils of Women, and non-governmental organizations should be trained to monitor fees charged by hospitals and to advocate for their removal.
 - 6.3 Provide GBV centres with adequate funding to help pay the transportation costs for women and families travelling from villages to access services
7. Review legislations in order to decriminalise homosexuality and sex work and to ensure service provision to all GBV victims without discrimination.

8. Further research should be undertaken on:

- 8.1 Strategies for ensuring that effective responses to, and prevention of, GBV and HIV are integrated into primary health care services and specialised clinics (such as maternal/child health, family planning, and sexual health) accessed by GBV victims/survivors and people living with HIV, with particular focus on rural areas, for inclusion in the new national policy and standards.
- 8.2 The risk of intimate partner violence against pregnant women diagnosed with HIV through routine provider-initiated counselling and testing in antenatal clinics, and the impact on their willingness to access antenatal care and other services, or programmes for the prevention of parent-to-child transmission of HIV.
- 8.3 The lived experience of service providers in relation to GBV and HIV, and how those experiences affect their readiness to provide GBV and HIV services.
- 8.4 The nature, extent, and impact of family and sexual/gender-based violence in all 22 provinces of PNG. Evidence and findings from this research will further guide GBV prevention strategies, policies, planning services, and programme implementation

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LIST OF APPENDICES

Appendix one

Profile of report authors

Professor Ione Lewis has conducted and published research in PNG on violence against women and links with HIV transmission, funded by the National AIDS Council of PNG with the support of the Australian Government, and on men's experience and use of violence, funded by the University of Canberra. She has published research on violence against women in PNG in the *Journal of Family Studies*, *Catalyst*, and *Journal of Child Sexual Abuse*. She provided training for HIV counsellors and trainers from 2004 to 2010, facilitated the development of the HIV Counsellors' Code of Ethics, and developed the *Gender Relations Training Manual* in partnership with the National HIV and AIDS Training Unit (NHATU) in 2010.

Professor Lewis' role in this study was the collection and analysis of data, liaison with Provincial AIDS Committees, and the writing of this final report.

Dr. Christine Bradley is an independent consultant who has worked on gender and development in the Asia-Pacific region for more than three decades, particularly in Papua New Guinea. Her work there has been acknowledged with a Prime Minister's Award for outstanding services to women and youth. She authored PNG's Parliamentary *Report on Domestic Violence* (1992); the national *Integrated Long-Term Strategy on Family and Sexual Violence* [Bradley, C. and Kesno, J., 2001]; and the *National Gender Policy and Plan on HIV and AIDS 2006–2010*. Over the last 25 years she has assisted in the development of institutional responses to violence against women and to HIV and AIDS in the health, justice, social, and education sectors in PNG. In addition, she is co-author of AusAID's major evaluation report on violence against women in Melanesia and East Timor (2008), and has served as a member of two United Nations Expert Panels on violence against women.

Dr. Bradley developed the audit tools for this study to assess institutional readiness to provide gender-based violence services, based on a review of the policies and procedures for family support centres, HIV counselling and testing services, police, and magistrates. She also provided valuable resources for, and feedback on, drafts of this report.

Appendix two

Interviews with organizations, community representatives, and service users

Table 1 displays the organizations in each sector interviewed for the study. Table 2 shows the villages and service users interviewed for the study. 'N' denotes the number of interviewees.

Table 1: Interviews with organizations by sector

1. Justice	2. Health	3. Social
National units	Government departments	National organizations
1. Papua New Guinea Constabulary Headquarters -Director of Human Resources; Family & Sexual Violence Unit Development Coordinator 2. Papua New Guinea-Australia Law and Justice Partnership HIV Advisor to Justice Sector N = 3	1. National Department of Health - Secretary and Policy Advisors; Consultant 2. National AIDS Council Secretariat Research Unit 3. National Program Coordinator at the national Family & Sexual Violence Action Committee 4. Coordinator of Family Support Centres at the national Family & Sexual Violence Action Committee N = 12	1. National HIV/AIDS Training Unit, International Education Agency of PNG 2. International Development Law Organization N = 2
Police specialised gender-based violence Units	Family support centres	Provincial women's organizations
1. Mt. Hagen police station, Western Highlands: Geoffrey Kuva, Station Commander Belinda Sibert, Women's Desk Unit 2. Kundiawa Police Station, Simbu 3. Police Prosecutor, Buka Police Station N = 3	Western Highlands 1. Well Women's Centre, Mt. Hagen General Hospital Simbu 2. Family support centre, Late Joseph Nobri General Hospital, Kundiawa East Sepik 3. Family support centre, Maprik Rural Hospital Autonomous Region of Bougainville 4. Family support centre staff, Buka General Hospital, Buka (centre not yet opened) N = 4	1. Simbu Family and Sexual Violence Action Committee 2. East Sepik Provincial Council of Women 3. Madang Provincial Council of Women 4. Buka Family and Sexual Violence Action Committee N = 4
Criminal Investigation Division (CID)	Aid posts	Civil society organizations
Madang 1. Madang Police Station N = 1	Simbu 1. Kond Aid Post N = 1	Western Highlands 1. Mercy Works Mt. Hagen 2. Shalom Care Centre for people living with HIV, Sisters of Notre Dame, Banz 3. Nambe Faith-based Community Care Centre, Jiwaka Simbu 4. St Clement's Orphans and Vulnerable Children's Foundation 5. Dagul Community Care Centre East Sepik 6. Wewak Provincial AIDS Committee 7. Nana Kundi Crisis Centre, Maprik District Madang 8. Country Women's Association (CWA) Violence Against Women Project 9. Tokaut AIDS 10. World Vision 11. Real Involvement of People Living with HIV/ AIDS Autonomous Region of Bougainville 12. Leitana Nehan Women's Development Agency 13. Nazarene Rehabilitation Centre, Bougainville N = 13
Community police		
East Sepik 1. Wewak community police Madang 2. Madang community police N = 2		
Magisterial Service Village court magistrate/clerk of court Western Highlands 1. Kudjip Simbu 2. Kerowagi x 2 East Sepik 3. Wewak N = 4 District court Senior magistrate, Autonomous Region of Bougainville 1. Buka N = 1		

1. Justice	2. Health	3. Social
	Voluntary confidential counselling and testing (VCCT) centres (based in health services)	
	Health facility	Stand alone
	Western Highlands 1. Rabiambul Voluntary Confidential Counselling and Testing Centre, Catholic Archdiocese, Mt. Hagen 2. Minj Community Care and VCCT Centre, Evangelical Brotherhood Church Health Service Simbu 3. Late Joseph Nobri Hospital Voluntary Confidential Counselling and Testing Centre, Kundiawa 4. St. Joseph's Hospital Voluntary Confidential Counselling and Testing Centre, Mingende East Sepik 5. Wasaie Voluntary Confidential Counselling and Testing Centre, Wewak General Hospital Madang 6. Id Inad Voluntary Confidential Counselling and Testing Centre 7. Yaguam Rural Hospital Voluntary Confidential Counselling and Testing Centre N = 7	Western Highlands 1. Shalom Voluntary Confidential Counselling and Testing Centre, Sisters of Notre Dame, Banz East Sepik 2. Sepik Centre of Hope Voluntary Confidential Counselling and Testing Centre, Wewak Autonomous Region of Bougainville 3. Mary Mother of Hope Voluntary Confidential Counselling and Testing Centre, Buka N = 3

Table 2: Interviews with community representatives and service users

Community representatives	Service user
Western Highlands	
1. Morawul village – 2 female community & 2 male community leaders/representatives 2. Jiwaka village – 7 female & 7 male community leaders/representatives N = 18	1. Well Women's Clinic service user N = 1
Simbu	
3. Gagul village – 13 female community & 11 male community leaders/representatives 4. Kond village – 30 female & 35 community leaders/representatives N = 89	
East Sepik	
No interviews conducted due to lack of time	2. East Sepik Council of Women service users N = 3
Autonomous Region of Bougainville	
5. Tsilalado Council of Elders – Chief and Elder (male) N = 2	3. Service user: police and district court, Buka (mother of rape victim) N = 1

Appendix three

Table 3: Inventory of gender-based violence and HIV policies, services, and standards

Note: The * symbol signifies the particular services and standards that were audited in this study.

* Health sector services responding to gender-based violence	
Provincial specialist gender-based violence services: Hospital-based family support centres	
<p>The purpose of the centres is to provide client-centred care for the medical and psychosocial needs of victims/survivors of family or sexual violence with respect and empathy in one safe location, and to assist in preventing future violence through improved access to justice for survivors, advocacy, and community education. These centres are included in the <i>National Health Plan 2011–2015</i> as the primary vehicle for improving the health sector response to “family and sexual violence” throughout the country.</p> <p>Eventually, a form of these services will be made available at district hospitals and the new community health centres envisaged in the <i>National Health Plan</i> adapted to local circumstances and level of demand.</p>	
Domain	Issues/activities/standards
* Adherence to the core principles of client-centred care	<ul style="list-style-type: none"> • Affirm that violence against women and children is neither acceptable nor inevitable • Centres are easy to find and safe to access • Services provided by staff of the same sex as the client whenever possible (international best practice) (UN Women, 2011b) • Allow direct entry, avoiding the delays of “normal channels” • Be provided free to the client • Be available at all times (through A & E department, if the centre is not open 24/7) • Be welcoming, non-judgmental, respectful, and sensitive to the feelings of the client • Provide immediate reception and assessment • Facilitate speedy medical treatment, as well as the collection of forensic evidence, if possible • Ensure privacy and confidentiality • Ensure informed consent • Offer information and support for decisions to be made by the client • Require a code of ethics for providers • No discrimination against sex workers or people living with HIV
* Scope of services for physical abuse from an intimate partner (“domestic violence”) or family member	<ul style="list-style-type: none"> • Initial assessment for category of violence, level of injury, and immediate physical safety • Physical examination and recording of history • Medical treatment in the centre (where injuries are minor), or referral to specialist care within the hospital if injuries are more serious • Accompaniment to referred services inside or outside the hospital • Documentation of injuries and provision of medical report to client • Sexually transmitted infection diagnosis and treatment • Voluntary confidential counselling and testing in the family support centre, or referral to the nearest VCCT centre if FSC staff is not qualified • Crisis counselling and safety planning • Information on legal options and assistance with obtaining an emergency interim protection order, maintenance order, and/or custody order from the district court where required by the client • Liaison with village court authorities for mediation, or for a preventive order, where required by the client. • If the client wishes, referral to the police for bringing criminal charges against the perpetrator, and for bail conditions to protect the client • Provision of a medical report to the police if required, using a format approved by the National Department of Health (NDoH) • Provision of emergency clothing, food, and assistance with transportation to a safe place for self and dependent children, if needed • Emergency accommodation at the centre (maximum 48 hrs), where needed • Referral to other safe accommodation, where needed

	<ul style="list-style-type: none"> • Referral with client's consent to other known sources of active help or appropriate emotional support in the client's community, such as a women's group, village health volunteer, or district/ward health committee chairperson • Development of a plan for case management • Follow-up medical care for the physical assault and the effects of treatment • Follow-up counselling, including information on family planning • Referral/provision of counselling for children who have witnessed the abuse of their mother • Referral to a medical social worker (preferably female) for mediation with the husband (to be conducted away from the centre), if requested by the client • Regular GBV support group for those clients who request it • Provision of written information about the laws relating to gender-based violence, rights, and services • Collection of service statistics and reporting
<p>* Scope of services Sexual assault</p>	<ul style="list-style-type: none"> • Initial assessment for categories of violence and types/levels of injury • Physical examination and recording of history • Medical treatment in the centre (where injuries are minor), or referral to specialist care within the hospital if injuries are more serious • Accompaniment to referred services inside or outside the hospital, whenever possible • If within 72 hrs of the rape, provision of VCCT and PEP for HIV where the client is not already HIV+, in line with NDoH approved protocols • If the survivor arrives within 72 hours of the rape during hours when the family support centre is not open, referral for immediate VCCT and PEP by the nearest provider (usually the A&E department of the hospital or the HIV treatment centre) • If within 120 hours of the rape, offer of prevention of rape-related pregnancy • Prevention of STIs, tetanus, and hepatitis B • Documentation of findings, collection and storage of evidence for possible criminal proceedings, and provision of medical report to the client (the examination and documentation should use the Medico-Legal Sexual Assault Pro Forma approved by the NDoH in 2011) • Crisis management and trauma counselling – what models are used? • Provision of information about procedures for criminal prosecution • Liaison with the police for laying criminal charges against the perpetrator, where required by the client, and for bail conditions to protect the client • Emergency accommodation at the centre (maximum 48 hrs), where needed. Extension should be made upon the nurse coordinator's approval when necessary • Provision of emergency clothing, food, and assistance with transportation to a safe place, if needed • Referral to other safe accommodation, where needed • Development of a plan for case management • Follow-up medical care for the sexual assault and the effects of treatment • Follow-up counselling with the client, and with family members if requested by the client using established NGO and community networks • Regular sexual assault support group for those clients who request it
<p>* Scope of services for suspected child abuse</p>	<ul style="list-style-type: none"> • Examination and treatment carried out by a paediatrician (preferably in the safe environment of the centre) wherever s/he is easily reachable without a delay, which would be detrimental to the child • When no paediatrician is available, services should be provided without delay as described above for cases of physical or sexual assault in adults (including prevention of HIV, STIs, pregnancy, etc.), taking special care not to further traumatise the child • Provision of emergency accommodation and referral to short-term safe accommodation for the child and a guardian (who should not be the suspected abuser) • Provision of emergency clothing, food, and assistance with transportation to a safe place, if needed, for child and guardian • Liaison with available government or non-government child protection services for the development of a case management plan and long-term support • Notification to the Director for Child Welfare • Further referral for child welfare should be made by the Director for Child Welfare

* Services NOT to be provided in family support centres

In some places, miscellaneous services that have no other existing homes, such as programmes for people with disabilities or with substance abuse disorders, or with terminal illness of mental illness, have been located in the FSCs. This is NOT recommended, as it interferes with the ability of the centres to carry out their core duties to gender-based victims and survivors in environments that are safe, private, and confidential, and where quality services are provided by well-trained staff and volunteers, of the same sex as the survivor wherever possible.

The term “family support centre” is misleading, and many people with family problems unrelated to violence often overload FSC staff with their enquiries. FSC staff cannot be all things to all people. There is an enormous gap in services for men and women experiencing family problems or personal difficulties, frequently linked with poverty. Hospital administrators and clients often pressure the family support centres to attempt to fill this gap, and FSC staff can end up taking the place of welfare offices or social work departments.

* Staffing	<ul style="list-style-type: none"> • Nurse coordinator as officer in charge • Categories of staff required are: nursing officer, community health worker, counsellor (professional or lay), and female security officer. MSF recommends that one nurse or counsellor should provide no more than 6 to 7 consultations a day (2011) • Full- or part-time services from an administrative officer, driver, and cleaner are needed, depending on client load. Access to a social worker for more complicated cases is advisable
Volunteers/lay counsellors	<ul style="list-style-type: none"> • Provide immediate and longer-term counselling • Accompany clients to other services, inside or outside the hospital • Companion clients through any court processes • Reception and data entry • After-hours duty at the centre, or be on call • Community outreach and advocacy • Organize public events • Run support groups at the centre or in the community • A memorandum of understanding should address how volunteers’ costs are covered and, if possible, the payment of a small stipend
* Training	<ul style="list-style-type: none"> • MSF recommends that the nurse coordinator and other medical staff must be trained in: • Introduction to sexual and gender-based violence, including the cycle of violence, gender bias, myths, and impacts on women, children, the family, and community • Guiding principles in caring for survivors • How to identify GBV survivors • Taking a clinical history • Physical assessment of injuries • Medical treatment for GBV survivors • Legal considerations relating to specific physical and sexual offences against adults and children and use of the Medico-Legal Pro Forma • The medical report • If possible, the nurse coordinator should also have training in VCCT and PEP prescribing • Basic communication skills • Skills in providing emotional support to GBV survivors • The principles of crisis management • Assessment of safety of children living with gender-based violence • Child sexual abuse • Safety considerations • Case management • Peer support (of other staff and counsellors) • Legal procedures for obtaining an IPO, child custody order, maintenance order, and divorce, if needed
* Publicising the services a) Among other services in the hospital	<ul style="list-style-type: none"> • Particularly to outpatients, A&E, inpatient wards, STI clinics, HIV units, FPCs, antenatal clinics, PPTCT service, maternal and child health clinic, gynaecology, and cleaning staff • Training of security guards, orderlies, cleaners, and revenue clerks (particularly important, as they will otherwise require GBV clients to pay on entering the front door, or simply send them away) • Flowcharts showing referral pathways • Clear signage at multiple points in and outside the hospital

b) Among potential users in the community	<ul style="list-style-type: none"> • With local leaders, businesses, community groups, churches, schools, sports groups, women's organizations, organizations of people living with HIV, etc. • With local agencies, e.g., the police, district courts, village courts, welfare, and NGOs
* Security	<ul style="list-style-type: none"> • Security of the centre, both during and after working hours, should be covered by the security service of the hospital. One or more guards should be designated with special responsibility for the centre, and they should be immediately reachable by radio-phone if they also have duties in other areas of the hospital • Focus both on security of staff and service users
* Funding	<p>Costs to be covered from the hospital's recurrent budget are:</p> <ul style="list-style-type: none"> • Salaries of core staff • Utilities and routine cleaning and maintenance of the centre • Security for the centre • Insurance for staff, volunteers, and clients while on hospital premises • Cost of a phone extension from the hospital's switchboard and a direct line for the centre, and coverage of phone bills • Service, repair, and virus protection for the centre's computer • Stationery, data collection forms, photocopying of leaflets related to the centre's work • Medical consumables related to the provision of care to clients • Costs for volunteer lay counsellors and other volunteer services providers (though the private sector or social sector organizations may also assist here)
* Fees	<ul style="list-style-type: none"> • No fees should be charged either for the treatment of GBV-related injuries or for the medical reports issued to assist in a current or future prosecution (as laid out in the NDoH Circular of 2009) • Regular refreshers on this with security guards, orderlies, cleaners, and revenue clerks
* Partnerships	<ul style="list-style-type: none"> • Formal agreements should exist with partner organizations, such as NGOs, Chambers of Commerce, private companies, and sponsors that may be needed to help with funding, supplies, or other assistance • Formal agreements should also exist with agencies providing related services, such as various branches of the police, the district court, the Public Solicitor, the provincial child protection officer, local NGOs or faith-based organizations providing safe havens, village courts, Peace and Good Order Committees, etc.
* Data collection	<p>Each centre must maintain confidential records on each client, and collate monthly data for monitoring and evaluating the services provided. Data collection should use a format approved by the National Department of Health, and should be linked in to the department's own data collection system. Such data should include:</p> <ul style="list-style-type: none"> • Number of first consultations, by category of violence (i.e., rape, physical violence, child sexual abuse, child neglect/deprivation) and by age group (under 5 years, 5 to 15 years, 16 and over), and by gender • Number of total consultations, as above. • Number and percentage of clients appropriately referred to the centre (i.e., attending for reasons directly linked to the experience of violence, rather than linked to poverty, abandonment, or other family or personal problems) • Source of referral/information about the centre (e.g., police, friend, community leader, media campaign, outreach talk, etc.) • Number and percentage of clients opting to prosecute, by type of offence (if possible, obtain monthly data from the police on referrals received from the centre, and actions taken) • Number and percentage of clients who receive initial assessment within one hour of entering the hospital grounds (during normal hours) • Range of time lapse for clients to receive care after first seeking it, outside normal hours • Number and percentage of rape cases presenting within 72 hours • Number and percentage of clients using emergency accommodation at the centre • Number and percentage of clients who receive more than one counselling session • Types of assistance with legal proceedings provided to the client, e.g., for obtaining emergency protection orders, accompaniment for court proceedings, maintenance and custody orders, village court preventive orders • Types of referrals made, e.g., to other medical services in the hospital, family mediation by medical social worker, safe accommodation, local support organizations, or individuals, etc.

* Data collection	<ul style="list-style-type: none"> • Number of enquiries for information received by the centre (as opposed to case consultations), e.g., from students, interested community members, etc. • Attendance at support groups run by the centre • Number of outreach sessions held and numbers of males/females reached
* Location and access	<ul style="list-style-type: none"> • Close to the main services of the hospital, if possible, such as A&E • Direct access to the family support centre, without having to go through Outpatients, or A&E, or the revenue clerk • Regular refreshers for medical and all ancillary staff who interact with the public
* After-hours operation	<p>Options for providing services after hours are:</p> <ul style="list-style-type: none"> • Training A&E staff to provide client-centred care • Training hospital switchboard operators to give appropriate information • Rostering trained volunteers to be in the centre or on call (by cell-phone or radio-phone) for periods of peak demand (e.g., pay-Friday nights) • All centres, provinces, and locations could be linked with an existing 24-hour toll-free crisis line, with trained operators to respond appropriately • Transport should be provided for pick-up and drop-off for all FSC staff/volunteers working out of normal working hours
* Physical facilities and equipment	<p>For a provincial hospital, basic facilities should aim to include:</p> <ul style="list-style-type: none"> • Secure outer door that can be quickly barred from inside • A private and secure reception area for clients and their children to wait, with comfortable seating (not benches), and access to a toilet, hand-basin, shower, and baby-changing facilities • An intake office for the receptionist, with radio-phone for calling security; comfortable seating for the client and her children and/or companion; and a desk, computer, and lockable filing cabinets for the receptionist/data-entry clerk • A triage area • An office for the nurse coordinator, with phone, computer, and storage area for office consumables, spare clothes, and donated items for clients and children, etc. • An examining room, with necessary medical equipment (e.g., speculums) and locking cabinets for storage of medical supplies and medical evidence, and good lighting • Digital camera for documenting injuries • A counselling room with chair and coffee table • Room to accommodate a small number of survivors and their children, or abused children with their guardians, to stay temporarily for up to 48 hours • A staff-room (with safe storage for staff possessions) where simple meals can be cooked and which can also be used for meetings • A clean-up area with sluice/deep sink, autoclave, rubbish disposal, sharps disposal • Running water for cleaning • Drinkable water • A room (preferably with a separate entrance) where police can conduct interviews with clients • Bathroom with shower, separate toilet(s) • A storage area with a cupboard for towels, clothes, soap, detergent, toiletries, and other necessary items • A laundry facility • Décor should be cheerful and child-friendly, with toys and child-size seating available, if possible • A display stand of leaflets and other information materials for clients' use
* Commodities	<p>Items needed for treating basic medical needs should be kept securely in the FSC, e.g.:</p> <ul style="list-style-type: none"> • Materials for cleaning and dressing wounds • Injectable and oral painkillers, and anti-nausea drugs • Rapid HIV testing kits and ARTs for PEP (in line with NDoH specifications), if a trained prescriber is available • Post-rape emergency contraception • STI syndrome management drugs as designated by NDoH • Hepatitis B prevention • Tetanus toxoid • Female and male condoms • Note: For up-to-date list of all commodities needed, refer to NDoH and/or MSF

<p>* Management committee</p>	<p>The functioning of the centre and of its officer in charge will be supervised by a management committee, which will have the responsibility to:</p> <ul style="list-style-type: none"> • Ensure that the centre is adhering to its mandate and principles, and is providing its core services at a high standard of care • Receive and assess monthly reports provided by the centre's officer in charge • Establish and maintain clear internal referral pathways and good communication for each category of client, according to the level of injury • Ensure that trainings for hospital staff (including physicians, senior management, and all staff who interact with the public) are being conducted and that regular community outreach is taking place • Seek funding or other assistance that the centre may need to provide its services • Create and oversee a special account for weekly expenses incurred by the operations of the centre • Consider suggestions and complaints about the running of the service from hospital staff, volunteers, clients, or the public • Review and revise policies for the operation of the centre as needed • Liaise with the media to ensure that the centre maintains a high public profile • Report annually to stakeholders on the progress of the centre • Recruit lay counsellors if recommended by the management committee • Raise funds to cover the costs of the lay counselling programme
<p>Primary health care for gender-based violence at health centres and aid posts</p>	
<ul style="list-style-type: none"> • Nursing staff, community health workers, and health extension officers are trained on gender, gender-based violence, HIV, and human rights • The <i>Domestic Violence Desk Top Checklist</i> and associated public information leaflets and posters are in use • No fees are charged for treating survivors of domestic violence or sexual violence, or for providing medical reports • Staff provide sympathetic, non-judgmental care to gender-based violence clients, addressing emotional trauma and social needs as well as providing medical treatment, ensuring privacy and confidentiality • Rape survivors (female/male/child) are referred urgently for specialised post-rape care, including PEP, if possible; if not possible, treatment to prevent STIs, unwanted pregnancy, tetanus, and hepatitis B is given and injuries are documented • Domestic violence clients are assessed/treated for STIs and referred for HIV testing and family planning advice • Staff has active referral networks of local sources of assistance (formal and informal) for domestic violence, rape, and child sexual assault, including justice sector services where relevant, and village health volunteers • Records are kept of GBV cases (bearing in mind that if domestic violence fees are charged, few clients will admit their injuries were caused by domestic violence) • No discrimination against lesbians, gays, men who have sex with men, transgender and sex worker clients, or people living with HIV 	
<p>* Sexual and reproductive health services and gender-based violence</p>	
<p>* HIV counselling and testing services</p>	<ul style="list-style-type: none"> • HIV counselling and testing counsellors are trained and certified under National Department of Health's training programme, coordinated by the National HIV/AIDS Training Unit • Counsellors assess GBV risk during pre-test counselling session with all clients • Counsellors address safe disclosure of test results to a sexual partner or other person during pre- and post-test counselling sessions. • Couple counselling and testing is facilitated wherever possible, to avoid blame and negative consequences, especially if the couple has discordant test results. • Mediated disclosure (when the counsellor discloses on behalf of the client) is offered • Staff follows HIV Counsellors' Code of Ethics, including informed consent for testing, and confidentiality of test results • Staff is knowledgeable about local GBV services • Appropriate referrals are made to GBV services, including safe houses, NGOs offering legal aid in getting interim protection orders, or village courts for prevention orders. • Information is made available to clients about GBV and post-rape services, and referrals to appropriate services are made • Female and male condoms are demonstrated, their use is promoted, and they are distributed to clients • Staff receives regular training, supervision, and debriefing to maintain their effectiveness and prevent burnout

HIV testing in antenatal care (ANC)	<ul style="list-style-type: none"> • Clear distinction is made between the routine offer of the HIV test and routine testing in the wording of the pre-test counselling session, so that clients do not believe it is mandatory • Pre-test information session promotes voluntary testing and informed consent by explaining the cons as well as the pros • Counsellors assess GBV risk during pre-test counselling session • Counsellors address safe disclosure of test results to a sexual partner or other person during pre- and post-test counselling session • Records show that some women have refused the test • Staff is knowledgeable about local GBV services • Information is made available to clients about gender-based violence and post-rape services and referrals to appropriate services are made • Protocols/standard operating procedures address assessment of gender-based violence • Couple counselling and testing is facilitated wherever possible to avoid blame and negative consequences, especially if the couple has discordant test results. • Data collection records testing of male partners • Staff receives regular training, supervision, and debriefing to maintain their effectiveness and prevent burnout
HIV testing in labour	<ul style="list-style-type: none"> • Extreme care is taken to ensure consent is fully voluntary and that the client has been informed of the pros and cons of testing • Extreme care is taken to provide emotional support during and after delivery, with provision of a counsellor trained in VCCT or a trained Susu Mamas HIV programme worker to assist with decisions around status disclosure and PPTCT
HIV Treatment Unit	<ul style="list-style-type: none"> • Staff trained in gender-based violence and human rights • Knowledge of GBV violence services • Protocols/standard operating procedures, include addressing gender-based violence • Discussion of violence issues with clients and referral to GBV services where needed • No discrimination against gay, lesbian, MSM, transgender, and sex worker clients • Information leaflets about gender-based violence and available services provided in waiting area or verbally • Partner testing is facilitated • Availability of counsellors trained in disclosure of discordant test results • Demonstration and distribution of female and male condoms • Staff receive regular training, supervision, and debriefing to maintain their effectiveness and prevent burnout
Paediatric AIDS Unit	<ul style="list-style-type: none"> • Couple testing provided for parents • Specialised counselling provided to prevent blaming and violence, especially in cases of discordant test results • Staff receives regular training, supervision, and debriefing to maintain their effectiveness and prevent burnout
STI clinics (including those run by NGOs, such as Marie Stopes, World Vision, Hope Worldwide, etc., and by churches or private companies)	<ul style="list-style-type: none"> • Staff trained in GBV and human rights • Knowledge of local GBV services, and referrals made when needed • Same sex provider is routinely available. • No discrimination against MSM, transgender, and sex worker clients, people living with HIV, or youth • History taking includes all forms of gender-based violence, including intimate partner violence, sexual assault, and child sexual abuse • Referral to VCCT, if provider-initiated counselling and testing for HIV not already introduced • Support with partner notification, if required • Demonstration and distribution of female and male condoms • Information provided on GBV and post-rape services • Staff receives regular training, supervision, and debriefing to maintain their effectiveness and prevent burnout
TB clinics	<ul style="list-style-type: none"> • As for STI clinics

<p>Family planning clinics (including those run by NGOs, such as the PNG Family Planning Association, Marie Stopes, etc., and by churches or private companies)</p>	<ul style="list-style-type: none"> • Staff trained in GBV and human rights • Knowledge of local GBV and HIV services, and referral to GBV services where needed • History taking includes risk of gender-based violence, and high risk sexual practices such as anal sex • Female condom promoted as best option for clients with high risk of gender-based violence and HIV • Referral to VCCT centres • No discrimination against sex workers or people living with HIV
<p>* Justice sector</p>	
<p>* Police</p>	
<p>* Police specialised gender-based violence units</p>	<ul style="list-style-type: none"> • Staff trained in gender-based violence, human rights, the medical and psychosocial needs of survivors, and the purpose of post-rape medical services • Staff have knowledge of local GBV and HIV services and established referral pathways • Protocols/standard operating procedures require rape survivors to be taken immediately for medical treatment • Private and secure reception and waiting area • Private and secure interviewing area (auditory and visual privacy) • Female staff available at all times • Service hours cover periods when most calls are received (i.e., weekends and evenings) • No discrimination against clients who are gay, lesbian, MSM, transgender, sex worker, or people living with HIV • Ready access to a functioning phone, computer, photocopier, locking filing cabinets, and digital camera for recording injuries • Data collection system allows types of assault and assailant to be distinguished, as well as details of time, location, and circumstances of assaults, which can inform prevention strategies • Transport readily available for taking rape survivors and other GBV victims needing urgent medical attention to a health facility; for taking survivors to a place of safety, and for collecting their belongings; also for locating alleged offenders and investigating cases • Protection provided for relocating clients who need to collect their belongings • Interim protection order obtained on behalf of the client, if requested • Standard operating procedures for interpersonal violence designate the police role as providing protection for the client and preventing further violence, NOT attempting to mediate or give counselling; domestic assault is treated like other assaults, not as “a private/family matter” • Complainants are not asked to bring the alleged offender in – police collect offenders themselves • Summonses for GBV cases are served by the police free of charge • IPOs are registered with the local police and breaches are acted on immediately • Written information available to the public on GBV and post-rape services, and on the laws regarding sexual offences and wife-beating
<p>* Community police</p>	
<p>* Community police are often the first line of response to gender-based violence in provinces such as East Sepik. Community police are trained volunteers.</p>	
	<ul style="list-style-type: none"> • Staff trained in gender-based violence, human rights, the medical and psychosocial needs of survivors, and the importance of immediate post-rape medical services, including HIV prevention
<p>* District courts</p>	
<ul style="list-style-type: none"> • Clerks of Court (or assistants) are trained in gender-based violence and human rights. • Assistance in making an application for an IPO is provided to clients, free of charge • No discrimination against MSM, transgender, and sex worker clients • IPOs are fast-tracked • Written information available for the public on protection from gender-based violence • IPOs used to protect women against marital rape by husband known to have or be at risk of HIV 	

* Village courts

- Female magistrate(s) appointed
- Magistrates/court staff trained in gender-based violence and HIV
- Knowledge of gender-based violence and post-rape services
- Village court preventative orders used for protecting women from abusive husbands and partners
- Brideprice not accepted as a defence for gender-based violence
- Meaningful penalties for domestic assault, or breach of preventative order for domestic violence, are enforced
- Rape cases referred to the police (not dealt with by compensation to the family)
- Cases of alleged deliberate infection with HIV or of alleged sorcery in connection with HIV infection are referred to the police
- Assaults against suspected people living with HIV or their family or property are dealt with seriously

* Social sector

* Safe havens

- Staff trained in gender-based violence, human rights, and HIV
- Knowledge of gender-based violence and post-rape services.
- Available to female clients only with their dependent children of both sexes (separate arrangements need to be made for MSM and transgender people)
- No discrimination against sex workers or people living with HIV
- Admission only via agencies responding to gender-based violence (e.g., Family and Sexual Violence Action Committee, police, church pastoral concerns officer, etc.)
- Memorandum of Understanding with referring and collaborating agencies re responsibilities and expectations (e.g., regarding cost-sharing, repatriation, support services, etc.)
- Secure building and grounds
- Phone and emergency alarm system
- Individual counselling and legal aid
- Counselling for children
- Support groups (where resident numbers are high enough)
- Transport
- Computer and data collection system that allows the tracking of types of case, client (and children) outcomes, and patterns of usage by individuals

* Counselling services

General counselling services are offered by provincial and district welfare officers, churches, and other civil society and community-based organizations (CBOs)

Counsellors use a human rights counselling approach

- Training in gender-based violence, human rights, and the link between gender-based violence and HIV transmission provided to staff
- Protection from violence not sacrificed to maintenance of the family
- Knowledge of local GBV and post-rape services, including community networks
- Knowledge of legislation against gender-based violence, including child sexual assault
- Knowledge of the HAMP Act
- Operate within ethical guidelines, such as confidentiality, client autonomy, and respect (for example, the HIV Counsellors' Code of Ethics)
- Knowledge of counselling in grief and loss
- Staff receives regular training, supervision, and debriefing to maintain their effectiveness and prevent burnout

* Community education on gender-based violence and HIV (by NGOs, CBOs, and faith-based organizations)

- Community education on men's shared role in the transmission of HIV to babies, and also in successful prevention of transmission through PPTCT
- Community education on the consequence of forceful sex in increasing the transmission of HIV, and promotion of violence-free sex as safer sexual behaviour for men and women

* Gender-based violence networks

- Leaders, members, and village health volunteers trained in gender-based violence and HIV
- Knowledge about local GBV and post-rape services, VCCT for HIV, sexual health and STI clinics, HIV treatment availability, and the pros and cons of provider-Initiated counselling and testing in antenatal care
- Community-based networks for public education around GBV and post-rape services, stimulating local leadership (especially male champions), the development of safe emergency accommodation, speedy access to post-rape services, etc.
- No discrimination against gays and lesbians, MSM, transgender people, sex workers, and people living with HIV

Appendix four

Table 4: Interview schedule

Mt. Hagen, Western Highlands		
Provincial interview coordinator Rev. Apollos Yimbak, HIV Technical Officer, Western Highlands, Provincial AIDS Committee (PAC)		
Service and location	Interviewee's name and position	Date of interview
Mercy Works Mt. Hagen	Mariska Kua Coordinator and Sister of Mercy lay worker	3 November 2011
Mt. Hagen Police Station	Jeoffrey Kera Station Commander	3 November 2011
	Belinda Sibert Family and Sexual Violence Unit Police Officer	3 November 2011
Well Women's Clinic, Mt. Hagen General Hospital	Edith Numba Centre Coordinator and Nursing Officer; Patrina Lee Social Worker	3 November 2011
	Service user (female)	4 November 2011
Rabiamul Voluntary Confidential Counselling and Testing Centre, Catholic Archdiocese, Mt. Hagen	Marie Warea VCCT Counsellor and Community Health Worker; David Miwau Trainee, VCCT Counsellor	9 November 2011
N = 9		
Banz, Western Highlands		
Service and location	Interviewee's name and position	Date of interview
Shalom Care Centre Banz; VCCT Care Centre; Services for people living with HIV; Community conversations	Sister Regina Sisters of Notre Dame Order Catholic Church	3 November 2011
	Skills group for people living with HIV; three service users (two male, one female)	3 November 2011
Morawul village	Four community leaders and representatives (two male, two female)	3 November 2011
N = 8		
Minj and Jiwaka, Western Highlands		
Service and location	Interviewee's name and position	Date of interview
Minj Community Care VCCT Centre, Evangelical Brotherhood Church Health Service and Centre for People Living with HIV	Martin Tine Coordinator; Nurse (female and new to centre)	4 November 2011
	Three service users (two female, one male)	4 November 2011
Nambe Faith-Based Community Care Centre, Jiwaka Orphanage (47 children) Care centre (6 beds)	Seven male community leaders and representatives	4 November 2011
	Seven female community leaders and representatives	4 November 2011
N = 19		
Kudjip, Western Highlands		
Service and location	Interviewee's name and position	Date of interview
Kudjip village court	Male village court magistrate	8 November 2011
N = 1		
Kerowagi Rural District, Simbu		
Provincial interview coordinator Mr. Clement Api, HIV Technical Officer, Simbu PAC Assisted by Rev. Apollos Yimbak		
Service and location	Interviewee's position	Date of interview
St. Clement's Orphans and Vulnerable Children Foundation, Gagul village	11 male community leaders and representatives	5 November 2011
	13 female community leaders and representatives	5 November 2011

Kerowagi village court	Male chairman of village court	5 November 2011
Kond village	35 male community leaders and representatives	6 November 2011
	30 female community leaders and representatives	6 November 2011
Kond Aid Post	One male volunteer	6 November 2011
Dagul Community Care Centre	People living with HIV (four women and three men) and one advocate	6 November 2011
	Female Village court magistrate	6 November 2011
St. Joseph's Hospital Mengende VCCT Centre	Sister Dominika VCCT Health Extension Officer	7 November 2011
N = 101		
Kundiawa Town, Simbu		
Service and location	Interviewee's name and position	Date of interview
Family Support Centre, Late Joseph Nobri Hospital, Kundiawa	Nancy Bagme VCCT Counsellor; Marianne Okuk Psychiatric Nurse	7 November 2011
	Voluntary Confidential Counselling and Testing Centre, Late Joseph Nobri Hospital, Kundiawa	
Kundiawa Police Station, Women and Children's Desk	Mary Muile Senior Constable with Criminal Investigation Division Member of Family & Sexual Violence Action Committee; Alice Kai 1st Constable with Criminal Investigation Division Member of Family & Sexual Violence Action Committee	8 November 2011
N = 6		
Wewak, East Sepik		
Provincial interview coordinator Emill Trowathe, East Sepik PAC		
Service and location	Interviewee's name and position	Date of interview
Sepik Centre of Hope VCCT Centre (Catholic Office)	Joe Yalopa VCCT Counsellor	6 December 2011
East Sepik Provincial Council of Women	Sophie Mangai President Member of Provincial Government	6 December 2011
	Veronica Simogun Clerk of village court Volunteer, Welfare Section Community Development Auxiliary police volunteer Trainer in gender and human rights	6 December 2011
	Service users (three) from Numbo LLG	6 December 2011
Wasaie VCCT Centre, Wewak General Hospital	Nursing officer in charge Nursing Officer	6 December 2011
People living with HIV	Male government employee	6 December 2011
Wewak Provincial AIDS Committee	Paula Paime HIV Technical Officer Provincial AIDS Committee	6 December 2011
	Clement Paime HIV Secretary Catholic Office	
N = 11		

Maprik, East Sepik		
Service	Interviewee's name and position	Date of interview
Nana Kundi Crisis Centre	Centre coordinator Three counsellors Admin officer	13 December 2011
Family Support Centre, Maprik Rural Hospital	Raymond Pohonai Nursing Coordinator	13 December 2011
N = 6		
Madang		
Provincial interview coordinator Conrad Watunah, Madang PAC		
Service	Interviewee's Name and Position	Date of interview
Country Women's Association	Violence Against Women and Children project (two people interviewed)	7 December 2011
World Vision	Cathy Copland Research Officer for gender project	7 December 2011
Madang Community Development Office	Evelyn Mullel Community Development Officer for Madang district	7 December 2011
Madang Provincial Council of Women	Mary Kamang President Peer educator and trainer for HIV and AIDS Women's representative on NACS Board; Maggie Volunteer at Council of Women Treasurer on PAC Board	7 December 2011
Tokaut AIDS Madang	Andrew Apoi Theatre trainer; Lorraine Hale Theatre trainer	8 December 2011
Id Inad VCCT Centre	Nursing officer/coordinator	8 December 2011
Country Women's Association	Volunteer Service Overseas (VSO)/ coordinator	8 December 2011
N = 10		
Yaguam Rural District		
Service	Interviewee's name and position	Date of interview
VCCT Centre, Yaguam Rural Hospital, Lutheran Health Services	John VCCT Counsellor	8 December
N = 1		
Buka, Autonomous Region of Bougainville		
Service	Interviewee's name and position	Date of interview
Buka General Hospital	CEO, Buka General Hospital	21 February 2012
Family Support Centre, Buka General Hospital	Beryl Family Support Centre counsellor (New Zealand VSO and psychologist)	21 February 2012
Leitani Nehan (NGO)	Helen Lakana and worker	21 February 2012
Buka Family and Sexual Violence Action Committee (FSVAC), Nazarene Rehabilitation Centre, Bougainville	Sister Lorraine Garasu Chairperson, Buka FSVAC Coordinator, Nazarene Rehabilitation Centre	21 February 2012
Tsidalado Council of Elders	Chief and Elder	21 February 2012
Buka District Court House	Peter Toliken Senior Provincial Magistrate	22 February 2012
Service user, justice sector	Service user (mother of rape victim)	22 February 2012
Mary Mother of Hope VCCT Centre, Buka	Stella Morakana VCCT Counsellor	21 February 2012
North Bougainville Women's Federation	Hona Holan President; Marilyn Havini Advisor	22 February 2012
N = 12		

Moresby, National Capital District		
Service	Interviewee's name and position	Date of interview
Papua New Guinea-Australia Law and Justice Partnership	Joanne Robertson HIV Advisor to Justice Sector	1 November 2011
National AIDS Council Secretariat	Dr. Wilfred Kaleva Research Manager; Julie Airi Manager – Behavioural, Research, and Information; Dr. Cariko	31 October 2011
National HIV/AIDS Training Unit International Education Agency	Kerrie Kaveo National Coordinator, HIV and VCCT Training	31 October 2011
Papua New Guinea Constabulary Headquarters	Ivan Lakatani Director, Human Resources	30 November 2011
Papua New Guinea Constabulary Headquarters	Detective Inspector David Kila Development Coordinator, Family and Sexual Violence Unit	30 November 2011
National Department of Health	Dr. Dakulala Secretary, NDoH; Dr. Bieb; Policy advisors (four)	30 November 2011
	Shane Maarten, consultant	2 December 2011
International Development Law Organization	Naomi	30 November 2011
Family and Sexual Violence Action Committee	Ume Wainetti Isi Oro	15 December 2011
N = 15		
Total = 197		

Appendix five

Consent form for community leaders and representatives, service users, and people living with HIV

Project title

Assessment of Service Readiness to Implement Gender Based Violence and HIV Programs in Papua New Guinea

Consent statement

I have been informed about the purpose of the study. I am not aware of any condition that would prevent my participation, and I agree to participate in this study. I have had the opportunity to ask questions about my participation in the research. All questions I have asked have been answered to my satisfaction.

I agree to participate in the research

Yes []

No []

Participant code

Date

Province

This is a true record of the participant’s consent:

Interviewer’s name

Signature

If you have any concerns about the study please contact:

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Peterson Magoola at UNDP PNG:

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Appendix six

Focus group and interview questions

Questions for service providers

1. When was this service for gender-based violence first implemented here [at your service]?
2. What were the challenges of implementing gender-based violence services?
3. Who supports the service in your organisation? Probe - what position?
4. Who [and position] has resisted the implementation of gender-based violence services? Probe – what position?
5. How does the local community view the service?
6. How do you think service users view the service?
7. How does your service interact with police/village courts/district courts? How do service users experience police/village courts/district courts?
8. What other services do you make referrals to? How helpful are those other services to victims/survivors?
9. What is your service doing well?
10. What changes would you like to make in this service? What resources would be needed?

Questions for service users and their advocates

Male and female service users to be interviewed in separate groups, and might need to be offered individual interviews if there are concerns about confidentiality.

1. What do you see as the needs of people accessing the service? [Prompt physical, emotional, financial, etc.]
2. How does the [health/community] service here meet the needs of gender-based violence victims/survivors in your community? [Prompt: well, not so good ...]
3. What's the best thing about the [health/community] service? What are some things that changed in your life through coming to this service?
4. It would help the service do a better job if you could tell us some things they could improve on/do better to help people accessing the service here.
5. What might stop some people from asking for help here? [Prompt: women, men, young people]
6. How well do police meet the needs of gender-based violence victims in your community? [Prompt: well, not so good ...] Is there a female police officer here that victims can see?

7. What is your experience of village courts? Do village courts look after victims/survivors?
8. What is your experience of district courts? Do district courts look after victims/survivors?
9. What other services have you accessed? How well did they meet your needs?
10. What other services do victims/survivors of violence need in your area?

Questions for service users who are people living with HIV and their advocates

Male and female service users who are people living with HIV to be interviewed in separate groups, and might need to be offered individual interviews if there are concerns about confidentiality.

1. What do you see as the needs of people living with HIV accessing the service? [Prompt physical, emotional, financial, etc.]
2. How does the [health/community] service here meet the needs of people living with HIV who are victims/survivors of violence? [Prompt: well, not so good ...]
3. What's the best thing about the [health/community] service? What are some things that changed in your life through coming to this service?
4. It would help the service do a better job if you could tell us some things they could improve on/do better to help people living with HIV accessing the service here.
5. What might stop people living with HIV from asking for help here? [Prompt: women, men, young people]
6. How well do police meet the needs of people living with HIV who are victims of violence? [Prompt: well, not so good ...] Is there a female police officer here that victims can see?
7. What is your experience of village courts? Do village courts look after people living with HIV who are victims of violence?
8. What is your experience of district courts? Do district courts look after people living with HIV who are victims of violence?
9. What other services have you accessed? How well did they meet the needs of people living with HIV who are victims of violence?
10. What other services do people living with HIV who are victims of violence need in your area?

Appendix seven

Tables of audit findings

Table 5: Findings of audit of family support centres by province

Audit item	Western Highlands	Simbu
1. Staffing <ul style="list-style-type: none"> Nurse coordinator as officer in charge Nursing officer Community health worker Counsellor (professional or lay) Female security officer Administrative officer (part-time or full-time) Access to a social worker for more complicated cases is advisable Volunteer/lay counsellors 	Well Women's Clinic, Mt. Hagen <ul style="list-style-type: none"> Nurse coordinator (female) Two nursing officers (female) Social worker (female) Gynaecologists based in hospital do medical examinations for sexual assault victims/survivors An administrative officer is needed for filing and administrative support 	Family Support Centre, Late Joseph Nobri Hospital, Kundiawa <ul style="list-style-type: none"> Nurse coordinator (female) VCCT Counsellor (female) Psychiatric nurse and counsellor (female) for basic counselling Health extension officer for medical examinations (male) Doctors from the hospital assist where needed
East Sepik	Madang	Autonomous Region of Bougainville
Wewak There is no family support centre Maprik Family Support Centre, Maprik Rural Hospital <ul style="list-style-type: none"> Coordinator for family health and maternal and child health services (works across services) Male paediatric nurse with health administration degree Female nursing officer (sometimes rostered to other services because the hospital is short staffed) Doctors in the hospital work closely with the centre and write medical reports for victims of gender-based violence 	There is no family support centre	Family Support Centre, Buka General Hospital <ul style="list-style-type: none"> Acting nurse coordinator New Zealand VSO/psychologist filling the social work position Vacant positions were about to be advertised for the centre – it was yet decided whether these should be social workers or nursing officers
Audit item	Western Highlands	Simbu
2. Staff should affirm that gender-based violence is not acceptable or inevitable	Mt. Hagen Centre staff takes a strong stance against gender-based violence in working with clients, police, and other agencies.	Kundiawa Centre staff takes a strong stance against gender-based violence in their contact with clients, police, and other agencies.
East Sepik	Madang	Autonomous Region of Bougainville
Wewak <ul style="list-style-type: none"> There is no FSC East Sepik Provincial Council of Women is the lead agency for gender-based violence in Wewak and takes a strong stance against violence Maprik FSC takes a strong stand against violence.	<ul style="list-style-type: none"> There is no FSC Madang Provincial Council of Women is not functioning well Country Women's Association and the district Community Welfare Office provide services to GBV survivors 	Buka Centre takes a strong advocacy role against gender-based violence involving women and children.

Audit item	Western Highlands	Simbu
3. FSCs should provide direct access for GBV victims and survivors, without the need of going through A&E or the revenue clerk, thus avoiding the delays of “normal channels”	Mt. Hagen <ul style="list-style-type: none"> • Patients access the centre through the A&E department • Doctors do not always refer GBV victims to the centre, e.g., where there is violence between wives (this was a service user’s experience) • Hospital employees who experience gender-based violence self-refer to the centre 	Kundiawa <p>Patients access the centre through outpatient and A&E departments in the hospital.</p>
East Sepik	Madang	Autonomous Region of Bougainville
Wewak <p>The A&E department provides treatment for physical injuries.</p> Maprik <ul style="list-style-type: none"> • Women and children who are victims of gender-based violence can go directly to the centre, but they mostly go to A&E first • If they come to the centre first, the nursing officer checks them and then contacts the doctors in the hospital 	<p>The A&E department provides treatment for physical injuries.</p>	Buka <ul style="list-style-type: none"> • The FSC (although not yet open) is at the back of the hospital • A&E and reception are the first contact points for GBV victims
Audit item	Western Highlands	Simbu
4. FSCs should be easy to find and located near the hospital, with clear signage	Mt. Hagen <p>The Well Women’s Clinic is situated on the hospital grounds, and the name is above the front door; however, the clinic may not be recognised as an FSC by service users because of its generic name.</p>	Kundiawa <p>The FSC is clearly signposted and is situated on the hospital grounds.</p>
East Sepik	Madang	Autonomous Region of Bougainville
Wewak <ul style="list-style-type: none"> • There is no FSC • The Provincial Council of Women is situated some distance from the hospital and is not clearly signposted as a GBV service Maprik <p>The FSC is situated on the hospital grounds and is clearly signposted.</p>	<p>Organizations responding to gender-based violence, such as the Country Women’s Association, are not clearly identified to GBV service users.</p>	Buka <p>The centre, which is situated on the hospital grounds, is not yet open as the builders have not received final payment and have not handed over the key.</p>
Audit item	Western Highlands	Simbu
5. Security: <ul style="list-style-type: none"> • should be provided by a female security officer, and the cost covered by the hospital’s security service • one or more guards should be designated with special responsibility for the centre; and should be immediately reachable by radio-phone, if they also have duties in other areas of the hospital • focus should be both on security of staff and service users 	Mt. Hagen <p>Access to Mt. Hagen Hospital is strictly controlled at the front gate by a male security guard. This ensures safety, but could make access for clients difficult. Workers report there are no security/safety issues.</p>	Kundiawa <p>Workers report few security/safety issues. Once a worker was threatened by a husband with a bush knife and they contacted the security guard at the front gate.</p>

East Sepik	Madang	Autonomous Region of Bougainville
<p>Wewak The Provincial Council of Women provides services for women who are victims of gender-based violence, including a safe house. A security service is provided by volunteers.</p> <p>Maprik There is a security guard at the main hospital gate, which provides minimal security. The centre does not have its own security guard, but it is likely to happen in the future.</p>	<p>There is no FSC in Madang. When a safe house was provided at Alexishafen for women living with gender-based violence by the Sisters of St. Therese, there were security threats by husbands of service users. Men came to the safe house with sticks and stones and threatened one of the Sisters.</p> <p>The active network of agencies working on gender-based violence is planning to locate a safe house next to the police station.</p>	<p>Buka The hospital has one security guard at the front gate; there may be security issues for the centre once it opens, as it is located at the back of the hospital near a rear entry gate.</p>
Audit item	Western Highlands	Simbu
6. Funding	<p>Mt. Hagen The Well Women's Clinic is fully funded by the hospital, but staff is expected to take on extra duties such as reproductive and sexual health and antenatal services.</p>	<p>Kundiawa FSC staffing is fully funded by the hospital.</p>
East Sepik	Madang	Autonomous Region of Bougainville
<p>Wewak There is no FSC.</p> <p>Maprik Funding is provided to the hospital for family health and this is spread around the services, including the FSC. Adequate funding is a problem for the centre, which seeks additional funds from donor agencies. A foundation provided funding for the building of the centre; however, not all the promised funds were received. The male nursing coordinator works across other services.</p>	<p>There is no FSC.</p>	<p>Buka The centre coordinator is funded by the hospital. The staff member filling the social work position is a New Zealand volunteer. More positions are to be advertised.</p> <p>The hospital expects staff at the new centre to provide other reproductive and sexual health services until gender-based violence referrals increase.</p>
Audit item	Western Highlands	Simbu
7. Services to be provided by staff of the same sex as the client	<p>Mt. Hagen All centre staff are female. Male children are seen by female workers; however, most sexual assaults are committed by males so this is appropriate. Medical services may be provided by male doctors.</p>	<p>Kundiawa All centre staff are female. Male children are seen by female workers; however, most sexual assaults are committed by males so this is appropriate. Medical services may be provided by male doctors/health extension officers.</p>
East Sepik	Madang	Autonomous Region of Bougainville
<p>Wewak There is no FSC.</p> <p>Maprik The FSC coordinator is male, the nursing officer is female.</p>	<p>There is no FSC; other social sector organizations that respond to gender-based violence use female staff.</p>	<p>Buka All FSC staff are female; however, medical services are likely to be provided by males.</p>
Audit item	Western Highlands	Simbu
8. Training for staff	<p>Mt. Hagen The staff attended one week of trauma counselling training with Family Health International as well as training on the national Family Protection Bill. In addition, a social worker conducted an attachment (training placement) with the <i>Medecins Sans Frontières</i> (MSF) Family Support Centre at Lae, sponsored by the hospital.</p>	<p>Kundiawa The counsellor attended GBV peer education training run by the Young Men's Christian Association and introduction to HIV training run by the Provincial AIDS Committee; psychiatric nurse attended basic counselling training and psychiatric training at Moresby General Hospital.</p>

East Sepik	Madang	Autonomous Region of Bougainville
<p>Wewak There is no FSC.</p> <p>Maprik The nursing officer had not attended GBV training; however, MSF contacted the centre recently and offered training – the national Family and Sexual Violence Action Committee and the hospital were to fund travel and accommodation. The coordinator attended training in 2011 on FSC policy, coordinated by the national Family and Sexual Violence Action Committee, and on trauma counselling training.</p>	There is no FSC.	<p>Buka The acting coordinator was away on attachment to the MSF Centre in Lae; the psychologist had already attended training at the MSF centre.</p>
Audit item	Western Highlands	Simbu
9. Advertising of services in hospital and to the community	<p>Mt. Hagen The clinic distributes leaflets throughout the hospital advertising GBV services, and provides awareness training in the outpatient and A&E departments, and for district nurses and other hospital staff.</p>	<p>Kundiawa The FSC is networked with the provincial Family and Sexual Violence Action Committee, which does outreach and awareness training in the community.</p>
East Sepik	Madang	Autonomous Region of Bougainville
<p>Wewak There is no FSC.</p> <p>Maprik The coordinator uses radio for GBV community awareness, but the most effective advertising for the centre is when clients take information back to their communities. The number of clients is rising (10 cases + per month from four districts). When the centre does public fundraising, people attack them verbally. The centre and the Family and Sexual Violence Action Committee jointly conducted GBV training for all health staff in 2010.</p>	There is no FSC; the Country Women's Association does community education about gender-based violence.	<p>Buka The centre provides GBV training to Buka Hospital staff to increase identification and referral to the centre. It is concerning, however, that male staff do not attend training. Staff members often use radio to provide talks on gender-based violence, so people in the community hear about the service. Clients also come to the centre because of other women who have used the service. Some GBV awareness takes place in the marketplace using a loudspeaker – which may resemble preaching and could, therefore, be ineffective.</p>
Audit item	Western Highlands	Simbu
10. Free medical services for victims of gender-based violence	<p>Mt. Hagen FSC services are free of charge, including treatment in A&E and the medical report written by the examining doctor.</p>	<p>Kundiawa A&E charges victims of violence fees for medical services; the FSC staff sometimes give patients a note so they can have the fees refunded.</p>
East Sepik	Madang	Autonomous Region of Bougainville
<p>Wewak Provincial Council of Women clients who go to the hospital for treatment are no longer charged fees. Clients who attend the psychiatric unit because the court wants medical reports on their mental status are charged 50K.</p> <p>Maprik Patients are not charged fees for services provided by the Family Support Service – it is a free service, including medical reports. Nana Kundi Crisis Centre advocated for victims to receive free services, and the hospital dropped the fees.</p>	<p>The A&E at Modilon General Hospital charges GBV victims a fee of 6K and 50–100K for medical reports; the Country Women's Association pays the hospital fees for their clients because they know the hospital is short of resources and clients cannot afford the fees.</p>	<p>Buka The hospital charges GBV victims 20K for treatment of injuries, and medical reports cost 40–50K.</p>

Audit item	Western Highlands	Simbu
11. Family support services should be available at all times (through A&E, if the centre is not open 24/7)	Mt. Hagen The Well Women's Clinic is open Monday to Friday, 8am–4pm; the A&E is open to GBV victims 24/7, and clients return for services provided by the clinic on the next working day.	Kundiawa The centre is open to see clients Monday to Friday, 8am–4pm; the A&E is open to GBV victims 24/7, and clients return for services provided by the centre on the next working day. The centre has a safe house where women can stay two days to one week with their children The centre staff does night shifts to look after clients, including cooking meals
East Sepik	Madang	Autonomous Region of Bougainville
Wewak There is no FSC; the hospital A&E is open 24/7. Maprik The centre is open 9–4 pm. If women come to the centre late in the day, they are likely to be sent home until the next day, if this is safe for them. If GBV victims come after hours because of a crisis, the coordinator or nursing officer (who lives in residence) will be woken up to see them.	There is no FSC; the hospital A&E is open 24/7.	Buka The hours for the centre are business hours. After hours, GBV victims are treated at the hospital A&E. Victims return in the morning to see centre staff, if their injuries are not severe.
Audit item	Western Highlands	Simbu
12. Be welcoming, non-judgmental, respectful, and sensitive to the feelings of the client	Mt. Hagen The clinic aims to provide a user-friendly service. Staff members are welcoming and warm towards service users. Workers respond sensitively to the needs of their clients. A service user (also a nurse in the hospital) interviewed for this study reported good rapport with staff.	Kundiawa The centre staff are non-judgmental, respectful, and sensitive to clients' feelings. They welcome clients and are attuned to their needs.
East Sepik	Madang	Autonomous Region of Bougainville
Wewak There is no FSC. Maprik Centre staff members are friendly and welcoming of clients.	There is no FSC.	Buka Staff members are welcoming towards clients and demonstrate respect.
Audit item	Western Highlands	Simbu
13. Provide : <ul style="list-style-type: none"> • immediate reception and assessment; • comfortable and private waiting rooms (not benches); • child-friendly space and toys 	Mt. Hagen <ul style="list-style-type: none"> • Immediate reception depends on the number of clients, urgency (for example, victims of rape), and staff meetings. • There is a waiting room with benches. Clients were observed sitting outside the centre on the grass in family groups. • The clinic requires funding to provide a child-friendly space. 	Kundiawa <ul style="list-style-type: none"> • Immediate reception depends on the number of clients, urgency (for example, victims of rape), and staff meetings. • There is a waiting room with chairs. Clients were observed sitting outside the centre on the grass. • The centre provides child-friendly spaces.

East Sepik	Madang	Autonomous Region of Bougainville
<p>Wewak There is no FSC.</p> <p>Maprik</p> <ul style="list-style-type: none"> • The centre provides immediate reception and a comfortable waiting room • One of the nurses attends to clients straight away, as they don't have many patients, and performs the assessment • The centre provides limited child-friendly resources (e.g., balls and other toys) 	<p>There is no FSC.</p>	<p>Buka The FSC is not yet open. Staff members respond immediately to clients, however on the day the audit team visited the hospital, the coordinator was away at training in Lae and the other staff member was co-facilitating GBV training.</p>
Audit item	Western Highlands	Simbu
<p>14. Facilitate speedy medical treatment, and the collection of forensic evidence, if possible</p>	<p>Mt. Hagen</p> <ul style="list-style-type: none"> • Physical injuries are treated by A&E • Medical services are provided by gynaecologists in the clinic, including PEP, prevention of STIs and pregnancy, recording of injuries, and medical reports • VCCT is provided by centre staff • Counselling is usually provided after the medical examination. If the mother of the child or survivor is traumatised, counselling will take place before medical treatment. 	<p>Kundiawa</p> <ul style="list-style-type: none"> • Physical injuries are treated A&E • Medical examinations for sexual assault cases and collection of forensic evidence take place in the centre • PEP is provided by the VCCT centre after the medical examination and collection of evidence • The counsellor accompanies the client to the VCCT centre, which is located on the hospital grounds.
East Sepik	Madang	Autonomous Region of Bougainville
<p>Wewak Medical treatment and collection of forensic evidence occurs in the A&E of Wewak General Hospital</p> <p>Maprik Medical treatment is provided at the centre, including provision of PEP and the morning after pill for sexual assault victims Collection of forensic evidence is done by hospital doctors or the attending Sister. If the patients might be HIV+, they are referred to the hospital VCCT centre. The FSC only rarely sees people who disclose they are living with HIV.</p>	<p>Medical treatment and collection of forensic evidence occurs in the A&E of Modilon Hospital. PEP is not routinely provided for victims of sexual assault due to lack of protocols between the Id Inad VCCT Centre and the A&E.</p>	<p>Buka Medical treatment and collection of forensic evidence are currently provided in the A&E. Once the new building opens, collection of forensic evidence will be conducted in the FSC.</p>
Audit item	Western Highlands	Simbu
<p>15. Ensure privacy and confidentiality of clients</p>	<p>Mt. Hagen Interviewing rooms and medical examination rooms in the clinic are private. Staff members at the centre understand that confidentiality is very important for victims, and there is a confidentiality policy in place for all staff.</p>	<p>Kundiawa The centre has two private wards with a single bed in each. Interviewing rooms are private, and the centre upholds confidentiality.</p>

East Sepik	Madang	Autonomous Region of Bougainville
Wewak There is no FSC. Maprik The centre has a private examination room and a counselling room.	There is no FSC.	The new centre will provide privacy for clients and will have a policy on client confidentiality. Currently, however, medical files are not treated confidentially in the hospital. Anyone has access to medical records because they are left in wards, accessible to all staff.
Audit item	Western Highlands	Simbu
16. Informed consent	Consent forms and the Medico Legal Pro Forma are used to ensure informed consent by clients for collection of forensic evidence. The VCCT consent form is used when HIV testing takes place. Guardians must sign for children and young people below 18 years.	The Medico Legal Pro Forma is used before collection of medical evidence. Medical conditions such as HIV and TB are kept confidential.
East Sepik	Madang	Autonomous Region of Bougainville
Wewak There is no FSC. Maprik The Medico Legal Pro Forma is used to record informed consent.	There is no FSC.	Buka The Medico Legal Pro Forma is used, and women are asked what steps they would like to take next.
Audit item	Western Highlands	Simbu
17. Offer information and support for decisions to be made by the client (uphold client autonomy)	Mt. Hagen Client autonomy is upheld. Workers provide legal information, and clients can decide. Workers then make referrals dependant on client choices.	Kundiawa Client autonomy is upheld. Couple counselling and mediation are offered where there is domestic violence. However, the main focus is on the female clients.
East Sepik	Madang	Autonomous Region of Bougainville
Wewak There is no FSC. Maprik Information and counselling are provided to clients; however, the Sister has not been trained in gender-based violence or counselling. Instead, the FSC refers clients to the Nana Kundi Crisis Centre for counselling and court support.	There is no FSC.	Buka Women need information to help them make informed decisions. For example, one woman was badly injured but didn't want charges to be laid against her husband. The counsellor explained that the violence is likely to continue and get worse. The client didn't lay charges at that time.
Audit item	Western Highlands	Simbu
18. No discrimination against clients of the centre who are men who have sex with men (MSM)	Mt. Hagen MSM do not seek assistance at the centre.	Kundiawa MSM do not seek assistance at the centre.
East Sepik	Madang	Autonomous Region of Bougainville
Wewak There is no FSC. Maprik MSM do not seek assistance at the centre.	There is no FSC.	Buka There are some gay men in Buka, but MSM do not seek assistance at the centre.
Audit item	Western Highlands	Simbu
19. No discrimination against transgender people	Mt. Hagen Transgender people do not seek assistance at the centre.	Kundiawa Transgender people do not seek assistance at the centre.

East Sepik	Madang	Autonomous Region of Bougainville
Wewak There is no FSC. Maprik Transgender people do not seek assistance at the centre.	There is no FSC.	Buka Transgender people do not seek assistance from the FSC staff based at the hospital.
Audit item	Western Highlands	Simbu
20. No discrimination against sex workers	Mt. Hagen The centre provides services to sex workers who are raped.	Kundiawa Sex workers do not seek assistance at the centre. Staff members hold the view that Kundiawa does not have sex workers because it is a small town.
East Sepik	Madang	Autonomous Region of Bougainville
Wewak There is no FSC. Maprik Sex workers do not seek assistance from the centre. The male coordinator felt that having a male coordinator might deter sex workers from seeking help at the centre.	There is no FSC.	Buka There are sex workers in Buka, but they are not seen at the centre.
Audit item	Western Highlands	Simbu
21. No discrimination against people living with HIV	Mt. Hagen People living with HIV are not discriminated against. The centre aims to be a user-friendly service where everyone is treated equally.	Kundiawa People living with HIV are not discriminated against by the centre.
East Sepik	Madang	Autonomous Region of Bougainville
Wewak There is no FSC. Maprik People living with HIV do seek help at the centre, and are referred to the VCCT centre at the hospital.	There is no FSC.	Buka Some HIV-positive clients are seen by centre staff. There is no discrimination.
Audit item	Western Highlands	Simbu
22. Services to male clients	Mt. Hagen The clinic works with husbands and fathers, e.g., provision of counselling; however, it does not register adult males as clients. Three men were seen as clients in 2011 because they were beaten by their wives. Men who are abused by wives are often too ashamed to seek help. The centre works with male children who have been physically or sexually abused.	Kundiawa The centre does accept men as clients.
East Sepik	Madang	Autonomous Region of Bougainville
Wewak There is no FSC. Maprik The centre has been open less than a year, and one male client has been seen. His wife deserted him and left him with the children. Nana Kundi referred the client for counselling and assisted him with court papers, and the court said the wife had to come back.	There is no FSC.	Buka The staff see men who are offenders and provide couple counselling. They refer to Leitani Nehan for longer-term counselling, as they work with couples and do mediation with family and community groups.

Audit item	Western Highlands	Simbu
23. Require providers to follow a code of ethics	Mt. Hagen The PNG code of practice is followed, and the social worker and nurses work within their own professional code of ethics.	Kundiawa Workers were not sure and referred the question to their coordinator.
East Sepik	Madang	Autonomous Region of Bougainville
Wewak There is no FSC. Maprik Staff abides by the Nursing Council of PNG philosophy of nursing and code of ethics.	There is no FSC.	Buka There is a code of ethics for FSCs, and the training provided by the Family and Sexual Violence Action Committee also covers ethics The NZ volunteer working for the centre must also work within the NZ psychologists' code of ethics. Nurses have their own code.
Audit item	Western Highlands	Simbu
24. Referrals to other services	Mt. Hagen <ul style="list-style-type: none"> • The Well Women's Clinic refers to: • Police • NGOs, particularly Mercy Works and Anglicare • Village and district courts • Welfare officers and district welfare officers in the areas that clients live 	Kundiawa The FSC refers to: <ul style="list-style-type: none"> • Village leaders and counsellors to ensure violence does not happen again • Department of Community Welfare • VCCT centre (on hospital grounds). • Accompany victims to police and court on the Public Motor Vehicle: "Things run more smoothly for women because we are there."
East Sepik	Madang	Autonomous Region of Bougainville
Wewak There is no FSC. Maprik The centre refers to: <ul style="list-style-type: none"> • Nana Kundi Crisis Centre • Police • VCCT centre • Village courts There are no other services in Maprik, as it is a rural district.	There is no FSC	Buka The centre staff refer to: <ul style="list-style-type: none"> • Police for interim protection orders: "We accompany women to police and court – they get treated much better if we are with them." • Nazarene Centre of Rehabilitation to stay in the safehouse when it isn't safe for women to go home • Department of Community Development for child maintenance issues • Leitani Nehan for follow-up counselling.
Audit item	Western Highlands	Simbu
25. Referrals from other services	Mt. Hagen Referrals to the clinic come from: <ul style="list-style-type: none"> • NGOs, such as Mercy Works and Anglicare • District nurses who have been trained by the centre to make referrals • Antenatal clinic refers victims of gender-based violence • Police refer victims of physical and sexual assaults. 	Kundiawa Referrals to the centre come from: <ul style="list-style-type: none"> • Police who bring victims of serious cases of gender-based violence to the centre.

East Sepik	Madang	Autonomous Region of Bougainville
<p>Wewak There is no FSC. The Provincial Council of Women refers women who are victims of violence to the hospital for medical services and for medical reports to be used in court.</p> <p>Maprik Nana Kundi Crisis Centre: the two coordinators are male and have known each other from school – they work well together.</p>	<p>There is no FSC. Country Women's Association and the Welfare Officer employed by the Community Development Office refer victims of assault to Modilon General Hospital for medical treatment and medical reports.</p>	<p>Buka The provincial Family and Sexual Violence Action Committee manages the local FSC and is very important for networking between agencies. Other services, such as police, refer women to the hospital when they are injured or have been victims of sexual assault for collection of forensic evidence, medical treatment, and testing.</p>
Audit item	Western Highlands	Simbu
26. Partnerships: Formal agreements with partner organizations and agencies providing related services	<p>Mt. Hagen The FSC has partnerships with the provincial Family and Sexual Violence Action Committee, NGOs, police, and village and district courts, although these are not necessarily formal agreements. A foundation has offered funding for a safe house in Mt. Hagen.</p>	<p>Kundiawa The centre has a strong partnership/membership with the provincial Family and Sexual Violence Action Committee.</p>
East Sepik	Madang	Autonomous Region of Bougainville
<p>Wewak There is no FSC.</p> <p>Maprik There is a strong partnership between the centre and Nana Kundi Crisis Centre.</p>	<p>There is no FSC. The Country Women's Association has good relationships with doctors at the hospital who write medical reports.</p>	<p>Buka The centre is a member of the Family and Sexual Violence Action Committee and this helps networking with other services.</p>
Audit item	Western Highlands	Simbu
27. Gaps in services	<p>Mt. Hagen MSM and transgender people who are GBV victims do not seek help at the clinic. The name of the Well Women's Clinic may deter male victims from seeking help. The clinic does not run GBV support groups.</p>	<p>Kundiawa Men who have sex with men, transgender people and sex workers who are victims of gender-based violence do not seek help at the centre. The centre does not run GBV support groups.</p>
East Sepik	Madang	Autonomous Region of Bougainville
<p>Wewak There is no FSC. The Provincial Council of Women provides services to fill the gap in Wewak, for example, a safe house for women and volunteer security service.</p> <p>Maprik More staff is needed for the centre, particularly a social worker, community health worker, two nursing officers, and a security guard. This would enable the centre to do community outreach.</p>	<p>There is no FSC. The District Community Development Office and NGOs such as the Country Women's Association provide GBV services to fill the gap in Madang. There is no safehouse, although services are meeting to discuss establishing one. The difficulty is finding land, as a foundation has already offered to fund the building. The back of the police station has been suggested as a possible location.</p>	<p>Buka The service is not yet open, so this is a gap. Many women need trauma counselling, and counsellors need more training in this area.</p>
Focus group results	Western Highlands	Simbu
28. Community view of effectiveness	<p>Villagers in Jiwaka and Minj noted that it is difficult to travel to the clinic to access service.</p>	<p>Police in Kundiawa say "Women really cry and say the safe house at the family support centre is a very helpful place to stay"; and villagers agree there is a need for a safe house in the district.</p>
East Sepik	Madang	Autonomous Region of Bougainville
<p>Wewak There is no FSC.</p> <p>Maprik Nana Kundi Crisis Centre views the FSC as mainly providing medical treatment, while they provide counselling.</p>	<p>There is no FSC.</p>	<p>Buka Other GBV services make referrals to FSC staff and involve them as co-facilitators in training on gender-based violence.</p>

Table 6: Audit of HIV counselling and testing (HCT) centres by province

Audit item	Western Highlands	Simbu
1. Staffing	<p>Rabiamul Voluntary Confidential Counselling and Testing Centre, Mt. Hagen</p> <ul style="list-style-type: none"> • VCCT counsellor /community health worker • Two VCCT counsellors • Trainees (on attachment) <p>Shalom Care Centre, Banz</p> <ul style="list-style-type: none"> • VCCT counsellors /Catholic Sisters • Three ART prescribers (“We need three more.”) 	<p>Late Joseph Nobri Hospital Voluntary Confidential Counselling and Testing Centre, Kundiawa</p> <ul style="list-style-type: none"> • Nursing officer/ART prescriber • VCCT counsellor <p>St. Joseph Hospital Voluntary Confidential Counselling and Testing Centre, Mindenge</p> <ul style="list-style-type: none"> • Health extension officer/Catholic Sister • VCCT counsellor • Doctor from the hospital does ART prescribing for centre clients
East Sepik	Madang	Autonomous Region of Bougainville
<p>Wasaie Voluntary Confidential Counselling and Testing Centre, Wewak General Hospital</p> <ul style="list-style-type: none"> • Health extension officer/VCCT counsellor/ART prescriber (on leave) • Two nursing officers (one yet to attend VCCT training) <p>Sepik Centre of Hope, Wewak</p> <ul style="list-style-type: none"> • Nurse coordinator/ART prescriber • Trained VCCT counsellor 	<p>Id Inad Voluntary Confidential Counselling and Testing Centre, Modilon Hospital</p> <ul style="list-style-type: none"> • Nursing officer in charge/ART prescriber • Male nursing officer • Community welfare workers • Two volunteers who are people living with HIV <p>Yaguam Voluntary Confidential Counselling and Testing Centre, Yaguam Rural Hospital</p> <ul style="list-style-type: none"> • Community health worker/VCCT counsellor • Two health workers 	<p>Mary Mother of Hope Voluntary Confidential Counselling and Testing Centre, Buka</p> <p>One nursing officer employed as the VCCT counsellor who attended intro to HIV and other trainings. The counsellor was only two weeks employed and had not received adequate orientation.</p>
Audit item	Western Highlands	Simbu
2. Facilities	<p>Rabiamul VCCT Centre, Mt. Hagen</p> <p>Eight rooms:</p> <ul style="list-style-type: none"> • Three counselling and testing rooms • Dining room • Office • Resting room for people living with HIV • ART clinic • Waiting room <p>Shalom Care Centre, Banz</p> <ul style="list-style-type: none"> • Seven rooms • Dining room • Group room for skills groups for people living with HIV • One counselling and testing room • Four rooms for respite care for people living with HIV (live in) • Home-based care for people living with HIV • Outreach to community groups, churches, and Simbu and Enga provinces with trained advocates 	<p>Late Joseph Nobri Hospital VCCT Centre, Kundiawa</p> <p>Six rooms:</p> <ul style="list-style-type: none"> • Waiting room equipped with wide-screen TV to show HIV awareness videos • Staff room • Two gender-specific STI examination rooms • Two counselling and testing rooms <p>Outreach programmes are difficult due to the lack of a vehicle and poor roads. The Kond Aid Post is used for VCCT and antenatal testing and counselling. Doctors accompany VCCT counsellors during rural outreach efforts, which visit various settings, e.g., the Dugal Care Centre for people living with HIV.</p> <p>St. Joseph Hospital VCCT Centre, Mindenge</p> <ul style="list-style-type: none"> • A large confidential counselling and testing room • No outreach programmes

East Sepik	Madang	Autonomous Region of Bougainville
<p>Wasai VCCT Centre, Wewak General Hospital Six rooms:</p> <ul style="list-style-type: none"> • Waiting room • Two gender-specific STI rooms • One ART room • One VCCT room • Staff room <p>The centre does not provide outreach or mobile testing.</p> <p>Sepik Centre of Hope, Wewak 10 rooms:</p> <ul style="list-style-type: none"> • Five care rooms to provide day care, including nutritious meals, to people living with HIV for up to three days at a time • Two counselling and testing rooms • One office • One testing room • Reading/waiting room <p>The centre has a training and hospitality unit (with 10 rooms and three beds for trainings), which raises funding for the centre to support 12–16 outreach programmes annually. Travelling to remote villages on the Sepik River is very expensive.</p>	<p>Id Inad VCCT Centre, Modilon Hospital Six rooms:</p> <ul style="list-style-type: none"> • Waiting area • Staff room • Two gender-specific STI examination rooms • One ART prescribing room • One counselling and testing room <p>The centre does not conduct outreach, awareness, or remote testing.</p> <p>Yaguam VCCT Centre, Yaguam Rural Hospital Four rooms:</p> <ul style="list-style-type: none"> • Two gender-specific STI examination rooms • One large group room • One VCCT room <p>Outreach is provided, for example, looking for patients who have not picked up ART medication, and support groups for people living with HIV.</p>	<p>Mary Mother of Hope Voluntary Confidential Counselling & Testing Centre, Buka Four rooms:</p> <ul style="list-style-type: none"> • Counselling room • Testing and treatment room • Office with chairs for clients • Large training room in the same building as the centre <p>The waiting area is outside the centre. Drugs are also stored outside the centre.</p>
Audit item	Western Highlands	Simbu
<p>3. Counsellors assess risk of gender-based violence during pre-test counselling session (vulnerable groups are transgender people, gay men, and men who have sex with men and women. Child sexual abuse survivors and sex workers are more vulnerable to both gender-based violence and HIV);</p> <p>Counsellors address safe disclosure of results to a sexual partner or other person during pre- and post-test counselling sessions;</p> <p>Couple counselling and testing is facilitated wherever possible to avoid blame and negative consequences, especially if the couple has discordant test results</p>	<p>Rabiamul VCCT Centre, Mt. Hagen When problems arise over discordant test results, the centre refers the clients to the police for resolution.</p> <p>Shalom Care Centre, Banz Couple counselling is used to enable counselling about discordant test results, which reduces the risk of violence. The centre provides testing and risk assessment for sex workers, taxi boys (homeless young people), school boys, and gay men.</p>	<p>Late Joseph Nobri Hospital VCCT Centre, Kundiawa Pre-test couple counselling is used to prepare couples. With discordant test results, usually they understand and accept.</p> <p>St. Joseph Hospital VCCT Centre, Mindenge Group pre-test counselling is used when there are many clients waiting for testing.</p>

East Sepik	Madang	Autonomous Region of Bougainville
<p>Wasaie VCCT Centre, Wewak General Hospital Couple testing is easier pre-test and more difficult post-test when status is known. Women reject their husbands when men's HIV+ status becomes known. There is a lot of counselling needed.</p> <p>Sepik Centre of Hope, Wewak Couple counselling and testing is done at the centre, including risk assessment of gender-based violence. Women are more likely to be at risk of violence if they disclose HIV+ status because of lack of knowledge about HIV.</p> <p>Couple testing takes time to make sure couples are ready for testing. One person might be ready and the other might not. Overall, women are more ready than men because of doubts about their husbands HIV status. In villages, counselling and testing is done individually rather than with couples, because it's easier. Sex workers, MSM, and gays and lesbians are seen infrequently. Such people are not tolerated by villagers, and are at risk of death.</p>	<p>Id Inad VCCT Centre, Modilon Hospital Couple counselling is provided; however, the centre does not see husbands who come in with women for testing. More females are tested than men. Men come in when they are too sick to go on ART</p> <p>Yaguam VCCT Centre, Yaguam Rural hospital The centre does couple counselling, but it is hard to get men to come. If women are tested on their own, husbands won't respect them, so the centre encourages husbands to come and prepare themselves for the results. The centre also sees women who have been raped, and the female counsellor normally works with these women.</p>	<p>Mary Mother of Hope VCCT Centre, Buka The newly employed HIV counsellor was not trained in couple counselling and did not feel comfortable testing couples together. She had no experience counselling people who had a positive test result. She did not understand confidentiality, for example, saying: "I ask the person in pre-test counselling who they would like me to tell their test results to – usually their sister or mother."</p>
<p>Audit item</p> <p>4. Staff follow the HIV Counsellors' Code of Ethics, including informed consent for testing and confidentiality of test results</p>	<p>Most centres audited follow the HIV Counsellors' Code of Ethics. Informed consent is obtained before testing, and test results are kept confidential. Sometimes clients come to a centre from another province or town to ensure confidentiality. One centre described a woman who was HIV+ who was reported to have been buried alive in the bush, following disclosure of the test results to her and her adult daughter at the centre. Disclosure to family members was not the current practice of the centre. The newly employed counsellor at the Mary Mother of Hope VCCT Centre, Buka, was unsure about confidentiality and was in need of orientation and training.</p>	
<p>Audit item</p> <p>5. Appropriate referrals are made to GBV services, a safe house, an NGO offering legal aid in getting an interim protection order, or a village court for a village court protection order;</p> <p>Information is made available to clients about GBV and post-rape services, and referrals to appropriate services are made</p>	<p>Western Highlands</p> <p>Rabiamul VCCT Centre, Mt. Hagen Referrals are made to police.</p> <p>Shalom Care Centre, Banz The centre does not involve police or village courts.</p>	<p>Simbu</p> <p>Late Joseph Nobri Hospital VCCT Centre, Kundiawa The centre does not involve the police, but refers victims of violence to the family support centre, the social worker, or the Provincial Aids Committee.</p> <p>St Joseph Hospital VCCT Centre, Mindenge The centre offers VCCT for rape cases, and in some cases clients are referred to the police or welfare by the matron. Eight 12-year-old girls were pack-raped in Kundiawa last month: "Sometimes people prefer to settle it between themselves – if it's incest or the family did the raping. You cannot force people, and thus the child suffers."</p>

East Sepik	Madang	Autonomous Region of Bougainville
<p>Wasia VCCT Centre, Wewak General Hospital The centre does not deal with the police because it does not have cases where people are spreading HIV.</p> <p>Sepik Centre of Hope If a particular person living with HIV complains about stigma and discrimination, or if there is a very serious case, counsellors call the police, as they can do more to interpret the HAMP Act. If the police conclude that the case is serious, they investigate and take it to district court.</p>	<p>Id Inad VCCT Centre, Modilon Hospital The centre does not refer to police because staff members do not know who to speak to: "We have nothing in place."</p> <p>Yaguam VCCT Centre, Yaguam Rural Hospital The centre refers women who have been sexually assaulted to the police in Mandang.</p>	<p>Mary Mother of Hope VCCT Centre, Buka The counsellor was not sure if the centre refers to police as she had only just started work there.</p>
Audit item	Western Highlands	Simbu
<p>6. Female and male condoms are demonstrated, their use is promoted, and they are distributed to clients</p>	<p>Rabiamul VCCT Centre, Mt. Hagen There were initial difficulties with the Catholic Church regarding condom distribution, which opposed it, but condoms are distributed in the context of couple counselling.</p> <p>Shalom Care Centre, Banz Condoms are given out in the context of couples counselling only.</p>	<p>Late Joseph Nobri hospital VCCT Centre, Kundiawa The centre distributes male and female condoms to clients.</p> <p>St. Joseph Hospital VSST Centre, Mindenge The centre distributes male and female condoms to clients.</p>
East Sepik	Madang	Autonomous Region of Bougainville
<p>Wasia VCCT Centre, Wewak General Hospital Male condoms are made available in the waiting room and at the front counter. "We supply condoms for STIs and HIV. People want male condoms so we distribute them. No-one wants female condoms. If married women find condoms in their husbands' pockets, it starts fighting."</p> <p>Sepik Centre of Hope The counsellor does not take condoms for testing in villages. Instead, centre staff encourages people to be faithful and delay first sexual encounters. The nurse coordinator takes a few condoms to help couples, e.g., if there are STIs and family planning needs. Information is provided about condom use. People are very reluctant to use condoms, but workers encourage people to use them. Young males can buy condoms from stores and markets.</p>	<p>Id Inad VCCT Centre, Modilon Hospital Volunteers are responsible for distributing condoms, which are supplied by Family Health International. However, they do not have female condoms, as they had a box that expired without being distributed.</p> <p>Yaguam VCCT Centre, Yaguam Rural Hospital The centre distributes male condoms, every morning they refill a bag on the wall so clients can help themselves. The centre does not distribute female condoms.</p>	<p>Mary Mother of Hope VCCT Centre, Buka The centre did not have condoms. The counsellor said the Provincial AIDS Committee should distribute condoms to the centre.</p>
Audit item	Western Highlands	Simbu
<p>7. Staff receives regular training, supervision, and debriefing to maintain their effectiveness and prevent burnout</p>	<p>Rabiamul VCCT Centre, Mt. Hagen The centre has regular staff meetings and provides debriefings. The centre has staff members from other centres on attachment, so it is important to have meetings to check in with them. However, there is no regular supervision.</p> <p>Shalom Care Centre, Banz The centre has regular staff meetings and debriefings to discuss stressful events. The centre staff also liaises with the Mt. Hagen centre.</p>	<p>St. Joseph Hospital VCCT Centre, Mindenge Staff experienced stress when three-quarters of the patients were HIV+, there was no ART, and many people died. Now there are only 10 or fewer cases who are HIV+, so stress and burnout is much less. Staff members attend regular meetings, but are not supervised. It is difficult to access training.</p>

East Sepik	Madang	Autonomous Region of Bougainville
<p>Sepik Centre of Hope Staff members have meetings with their manager and come together to share. Meetings help with unity and accountability. Workers see what they have done for the client and how they can continue to care for affected families. This helps with accountability: knowing what to do, understanding when there are more actions to take, or when they are acting in ways they are not supposed to. “As the centre provides a continuum of care, we try to love our clients and help them live longer.”</p>	<p>Id Inad VCCT Centre, Modilon Hospital Staff members are given on-the-job support and debriefing; there is no time for supervision.</p>	<p>Mary Mother of Hope VCCT Centre, Buka The newly employed counsellor will be attending regular monthly meetings with the Provincial AIDS Committee.</p>

Justice sector audit

Table 7: Findings of audit of police specialised gender-based violence units by province

Audit Item	Western Highlands	Simbu
1. Specialised police GBV unit staffing	<p>Mt. Hagen Three female police officers work in the Family and Sexual Violence Unit, dealing with GBV offences. Sexual assault cases are referred to the Criminal Investigation Division, which also has three female officers.</p>	<p>Kundiawa The Senior Constable and First Constable work on the Women and Children's Desk. A female police officer works on minor cases: three female police officers in total. Sexual assault cases are referred to Criminal Investigation Division, which has three female officers.</p>
East Sepik	Madang	Autonomous Region of Bougainville
<p>Wewak There is no Family and Sexual Violence unit. The Criminal Investigation Division and Sexual Offence Squad respond to complaints of gender-based violence.</p>	<p>There is no Family and Sexual Violence unit in Madang. Domestic violence is viewed as a minor crime where there are no serious physical injuries, and referred to community police for mediation. The Sexual Offences Squad responds to complaints of sexual assault. The Sexual Offences Squad has two female officers.</p>	<p>Buka The Family and Sexual Violence Unit in Buka is not yet open. Female police officers who work with gender-based violence in the Criminal Investigation Division, the Sexual Offences Squad, and the front desk will staff the new unit when it opens.</p>
Audit Item	Western Highlands	Simbu
<p>2. Staff trained in gender-based violence, human rights, the medical and psychosocial needs of survivors, and the purpose of post-rape medical services</p> <p>* See Table 10 on information required in police training on HIV</p>	<p>The police officer in the Family and Sexual Violence Unit at Mt. Hagen Police Station had not attended GBV training for four years; however, she was scheduled for training the following week.</p>	<p>Both constables are active members of the Simbu Family and Sexual Violence Action Committee, which runs awareness training in Simbu and Minj in Western Highlands province. The Senior Constable attended the Fiji Women's Crisis Centre training on ending violence against women for one month. Both constables attend Family and Sexual Violence Action Committee training on gender-based violence.</p>

East Sepik	Madang	Autonomous Region of Bougainville
Auxiliary/community police attend the GBV training run by the Family and Sexual Violence Action Committee. They are volunteers, so they do not need approval to attend training. The Provincial Council of Women emphasised the importance of community police accessing training on human rights. Police need approval from the Provincial Patrol Commander to attend training, which reduces police participation in training.	The district police trainer runs training in child welfare and human rights, but these trainings are out of date. The female officers in the Sexual Offences Squad liaise on awareness and prevention campaigns with agencies that work with GBV victims and survivors, such as Country Women's Association and World Vision. A sergeant in the community police attended GBV training run by Country Women's Association.	Buka Training in writing interim protection orders has been provided for all female police officers by the two female police prosecutors. Police officers attend training on gender-based violence and human rights run by the Family and Sexual Violence Action Committee and Leitani Nehan.
Audit item	Western Highlands	Simbu
3. Protocols /standard operating procedures require police to take rape survivors immediately for medical treatment	Mt. Hagen Rape victims are taken to Mt. Hagen hospital for medical treatment and post-exposure prophylaxis (PEP) when they present to the Family and Sexual Violence Unit at the police station.	Kundiawa Rape victims are taken to the A&E at the Late Joseph Nobri Hospital for medical treatment and PEP. The women and children's desk works closely with the family support centre at the hospital.
East Sepik	Madang	Autonomous Region of Bougainville
Wewak There is no Family and Sexual Violence Unit. The Sexual Offences Squad takes rape victims to the A&E department at Modilon Hospital.	Rape survivors tend to go immediately to the police and are taken to Modilon General Hospital for medical treatment and PEP. However, there is no protocol in place to ensure the provision of PEP to the A&E by the Id Inad VCCT Centre.	Buka Rape victims are taken to Buka General Hospital for medical treatment and PEP.
Audit item	Western Highlands	Simbu
4. Private and secure reception and waiting area	Mt. Hagen People sit and wait on the grass outside the Family and Sexual Violence office within the police compound.	Kundiawa The police station is very overcrowded and there is no private reception or waiting area.
East Sepik	Madang	Autonomous Region of Bougainville
Wewak There is no Family and Sexual Violence Unit in place.	People wait on the steps outside the back of the police station.	Buka There will be waiting areas in the new unit, but it has not yet been opened.
Audit item	Western Highlands	Simbu
5. Private and secure interviewing area (auditory and visual privacy)	Mt. Hagen The office and an adjoining room provide visual and auditory privacy during interviewing.	Kundiawa There is no separate interviewing room to see victims. Police officers ask their male counterpart to leave the office to interview victims. The office provides visual and auditory privacy during interviewing.
East Sepik	Madang	Autonomous Region of Bougainville
Wewak There is no Family and Sexual Violence Unit in place.	There is no separate interviewing room. The office provides visual and auditory privacy for interviews. Male counterparts leave the office to provide privacy for interviewing victims of gender-based violence.	Buka The new centre has interviewing rooms that are separate to offices, so there will be private interviewing rooms for GBV victims. At the time of audit, victims were interviewed in offices.
Audit item	Western Highlands	Simbu
6. Female staff available at all times	Mt. Hagen The hours of operation of the Family and Sexual Violence Unit are Monday to Friday, 8–4 pm. Female police in the unit do not usually work outside these hours. Police officers can do overtime with permission when needed.	Kundiawa Hours of operations of Women and Children's Desk are Monday to Friday, 8–5pm. Female police in the unit do not usually work outside these hours.

East Sepik	Madang	Autonomous Region of Bougainville
Wewak Some community (auxiliary) police are female. The Community Policing Unit is more accessible than regular police.	The Sexual Offences Squad has two female staff rostered on shift work, e.g., 3–11 pm and on weekends.	Buka A trained female police officer works on the front desk as well as the female officers in the Criminal Investigation Division and Sexual Offences Squad. Community policing also includes a female police officer. The new unit will operate 9–5 pm.
Audit item	Western Highlands	Simbu
7. Service hours cover periods when most calls are received (i.e., weekends and evenings)	Mt. Hagen After hours, GBV victims are responded to by the front desk and followed up by the Family and Sexual Violence Unit the next day.	Kundiawa GBV victims who seek help after hours are responded to by police and taken to the hospital. Victims are followed-up by the Women and Children's Desk or the Sexual Offences Squad the next day.
East Sepik	Madang	Autonomous Region of Bougainville
Wewak The Community Policing Unit is more accessible to the community than regular police.	Police officers in the Sexual Offences Squad and Criminal Investigation Division do shift work to increase their availability after hours.	Buka Interim protection orders are available 24 hours per day, seven days a week, from the front desk.
Audit item	Western Highlands	Simbu
8. Police do not discriminate against male clients who are gay, men who have sex with men, and transgender people	Mt. Hagen Male clients who have sex with men and transgender people are not seen at the police station – they are too shy to come to the police and may be discriminated against or prosecuted.	Kundiawa Male clients who have sex with men and transgender people are not seen at the police station.
East Sepik	Madang	Autonomous Region of Bougainville
Wewak There is no Family and Sexual Violence Unit in place.	Men who have sex with men are visible in Madang; however, they don't seek help from services in relation to gender-based violence. Transgender people do not access help from police.	Buka The police station does not see men who have sex with men or transgender people, as such people would be too ashamed to seek help.
Audit item	Western Highlands	Simbu
9. Police do not discriminate against sex workers	Mt. Hagen The Family and Sexual Violence Unit defines its role as responding to violence in marriage. Therefore, sex workers who are victims of violence are responded to by the front desk. Sex workers often experience gender-based violence, e.g., they are assaulted and raped on the streets and at clubs.	Kundiawa The Women and Children's Desk does not see sex workers: "We are a small town."
East Sepik	Madang	Autonomous Region of Bougainville
Wewak Whether police see sex workers is not known. The Catholic Diocesan office reported that 500 sex workers are registered with Friends Frangipani in East Sepik. It is known that sex workers are subject to attack and rape, but they do not report violence to police.	The Sexual Offences Squad will take reports from sex workers who report gender-based violence.	Buka Sex workers do not report gender-based violence to police. The Nazarene Rehabilitation Centre reports that people often seek help for their relatives who are sex workers rather than sex workers directly asking for help.

Audit item	Western Highlands	Simbu
10. No discrimination against people living with HIV	Mt. Hagen Some people living with HIV, such as men who beat their wives, are seen at the police station. Police only advise them that incarceration is not good for their health. Wives are even more likely to protect their husbands from being charged when husbands are HIV+.	Kundiawa Police are not aware of seeing people living with HIV because they do not disclose.
East Sepik	Madang	Autonomous Region of Bougainville
Wewak VCCT counsellors at Sepik Centre of Hope call the police with serious cases of discrimination against people living with HIV. The centre advocates for action under the HAMP Act. If the police see that the case is serious, they investigate and take to district court.	Police have received and investigated complaints from VCCT centres about harassment and physical assaults of people living with HIV. VCCT centres are the point of contact for victims and make referrals to police.	Buka There is a low rate of HIV in Buka and the police are not aware of seeing people living with HIV who are victims of gender-based violence.
Audit item	Western Highlands	Simbu
11. Services to male clients	Mt. Hagen Men are too ashamed to come to the police. "We are men. We can't ask for help."	Kundiawa Men and male children are also victims. Male workers at the hospital sometimes see the FSC counsellors at the hospital – when they are bashed and their money is taken.
East Sepik	Madang	Autonomous Region of Bougainville
Wewak There is no Family and Sexual Violence Unit in place.	Some women bash their husbands and the husbands complain to police about their wives, and about their wives' mistreatment of children. These cases usually relate to women involved in gambling. Frequency of male victims is about one per month.	Buka Male children who are victims of sexual assault are seen at the police station. Usually the offenders are older male children or men.
Audit item	Western Highlands	Simbu
12. Resources in Family and Sexual Violence Units	Mt. Hagen <ul style="list-style-type: none"> • Phones • Lockable filing cabinets • Computer • Printer • Fax • Photocopy machine • City pharmacy does digital photos of injuries • No leaflets on gender-based violence available; however, law and justice posters on violence against women are displayed. 	Kundiawa <ul style="list-style-type: none"> • Phone does not work. Officers are contacted on their own mobiles. • No filing cabinets • There is one outdated computer shared by the officers working on the Women and Children's Desk • Photocopier/printer needs updating as it prints poorly • Central fax • One camera for recording injuries; police officer's personal camera also used <p>Consultative Implementation and Monitoring Council leaflets are given to GBV victims.</p>

East Sepik	Madang	Autonomous Region of Bougainville
<p>Wewak Police lack resources (Provincial Council of Women).</p>	<p>Criminal Investigation Division resources:</p> <ul style="list-style-type: none"> • Phones • Lockable filing cabinets, but they are old • Criminal Investigation Division has two computers but needs more. • Wiring for the Internet has just been installed, but they are yet to install modems • Printer out of order • Central fax • Crime scene officers are equipped with digital cameras and take photos of victims, offenders, and crime scenes • Sexual Offences Squad gives leaflets to victims when they have them, but they do not have any at the moment <p>Community Policing Unit They have no vehicle or resources, they have to buy their own paper and the Sergeant uses his own laptop.</p>	<p>Buka</p> <ul style="list-style-type: none"> • The police station is in good condition. • New Zealand police officers are attached to Buka Police Station and have their own vehicle • Police have computers, printers, and filing cabinets • There are phones and fax machines • There will be a vehicle attached to the Family and Sexual Violence Unit, but as the police station accommodates the unit, the vehicle will be shared with other officers • There will be funding for digital cameras in the new centre • The opening of the centre is delayed because the final payment has not been paid to the builders. David Kila from Constabulary Headquarters, Port Moresby, said the final payment is coming soon.
Audit item	Western Highlands	Simbu
<p>13. Support for Family and Sexual Violence Units from other police</p>	<p>Mt. Hagen The unit is supported by the task force commander. Most police have the same attitudes about women. Policemen who use violence and bash their wives are brought in quite often. The first time they are warned, and if they do the same thing again they are arrested. There is no sexual harassment against female police.</p>	<p>Kundiawa The Women and Children's Desk is strongly supported by the police superintendent and other policemen. They borrow the superintendent's vehicles to do outreach. Policemen volunteer to drive the vehicle for the one week road show on violence and drugs. They feel part of it.</p>
East Sepik	Madang	Autonomous Region of Bougainville
<p>Wewak There is no Family and Sexual Violence Unit in place.</p>	<p>The Family and Sexual Violence Unit is not yet implemented.</p>	<p>Buka There is support for the Family and Sexual Violence Unit from managers. The district court and police prosecutors also support the unit, e.g., by providing interim protection order training and mentoring.</p>
Audit item	Western Highlands	Simbu
<p>14. Data collection system allows types of assault and assailant to be distinguished, as well as details of time, location, and circumstances of assaults, which can inform prevention strategies</p>	<p>Across all provinces, this information is only recorded in each police station in hard copy books with information on charges and dates, and through the process of taking statements. There is no centralized data system [PALJP, 2012]. Madang police provide statistics on categories of assault, number of complaints for each category, number of arrests, and number of cases pending to the Country Women's Association, who use the statistics for campaigns to end violence against women.</p>	
Audit item	Western Highlands	Simbu
<p>15. Transport readily available for taking rape survivors and other GBV victims needing urgent medical attention to a health facility; for taking survivors to a place of safety, and for collecting their belongings; and for locating alleged offenders and investigating cases. Complainants are not asked to bring the alleged offender in; police collect offenders themselves.</p>	<p>Mt. Hagen Police do not go out to remote areas, as it takes too long – they wait for people to come to town to make complaints.</p>	<p>Kundiawa Transport is affected by poor road condition and remoteness of villages. Criminal Investigation Division has only one old vehicle. Police cars have petrol rations, which limits travel. Police transport victims to the hospital for medical treatment where women cannot walk due to injuries and to stay in the safe house. They do not collect belongings for women. Police arrest known offenders once a statement has been taken from the victim.</p>

East Sepik	Madang	Autonomous Region of Bougainville
Wewak The capacity of police to provide transport is affected by petrol rations. Remote villages in East Sepik can only be reached by car, and by dinghy for villages along the Sepik River, which is very expensive.	The Madang police force has only one old vehicle. There are petrol rations, so it is difficult to provide transport to GBV victims or to pick up offenders.	Buka There are petrol rations. The Family and Sexual Violence Unit shares its vehicle with other police officers, which could reduce the capacity to provide transport for victims. In Buka, other forms of transport are frequently used. Boats are used for transport across the Buka Channel and along the island. Leitani Nehan reported women being stalked by their husbands' friends when they come for help in Buka. Police should provide transport to counselling services.
Audit item	Western Highlands	Simbu
16. Standard operating procedures for interpersonal violence include providing protection for the client and preventing further violence, NOT attempting to mediate or give counselling; domestic assault is treated like other assaults, not as "a private/family matter" (circular from Commissioner to police to treat all family violence as crime)	Mt. Hagen Police provide counselling/advice, especially with men. Counselling is difficult for police as it is hard to change men's attitudes toward women. Police speak strongly to men to make them aware of the law about women, including family violence and child abuse. Police inform women of their legal rights.	Kundiawa Women's Desk police officers have attended basic counselling training and provide counselling/advice to women about their rights and to men about the law. Domestic violence is very actively followed-up.
East Sepik	Madang	Autonomous Region of Bougainville
Wewak There is no Family and Sexual Violence Unit in place. Maprik There is a good working relationship among the FSC, the Nana Kundi Crisis Centre, and the police, who take violence seriously. Victims are taken to police by the Crisis Centre, and protection orders are obtained for three years.	Domestic violence without physical injuries, child abuse, adultery, and minor charges such as threatening and insulting are categorised as minor crimes and mediated by the Community Policing Unit. Serious cases are referred back by the Criminal Investigation Division to Community Police for mediation. The Community Policing Unit does 15 to 20 mediations per month, nearly every day from 8am to 3 or 4pm. Mediations take differing amounts of time, according to their complexity.	Buka Gender-based violence is taken seriously by the police and district courts in Buka and surrounding areas, and interim protection orders are used to keep victims safe. A volunteer lawyer from New Zealand working with the Family and Sexual Violence Action Committee in 2010 liaised with the police and courts and made a real difference to how the justice sector worked, together with health and non-government organizations. IPOs are now available 24-hours a day from the police station. In 2011, 27 IPOs were issued in Buka in 2011, six in Arawa, and none in Boin (there is no court in Boin).
Audit item	Western Highlands	Simbu
18. Summonses for cases of gender-based violence are served by the police free of charge	Mt. Hagen If possible, women serve the summons themselves. There is a 20K fee for police to serve a summons.	Kundiawa Police don't have money for petrol and small car parts as the local government is not functioning. If there is fuel, the police will act for free; but when there is no money, police ask for fees.
East Sepik	Madang	Autonomous Region of Bougainville
Wewak Petrol rations are not sufficient for police to cover the area as the Wewak population has increased. Police ask for fees to deliver summonses or for fuel. In town the fee is 20K, but for outstations it is 50–60K. Community auxiliary police are volunteers who lack incentives, so sometimes they do not deliver summonses. The Provincial Council of Women writes letters to the officer in charge of the auxiliary base and pays the fees for delivering summonses.	Police ask for fees of 10K to deliver summonses. Fees are the same amount if police have to travel out of town to deliver them.	Buka Summonses for IPOs are read out over the radio because it is difficult to deliver them in person. Otherwise, police charge 10K for delivering a summons.

Audit item	Western Highlands	Simbu
<p>19. Effectiveness of interim protection orders: Breaches are acted on immediately</p>	<p>Mt. Hagen IPOs are written by police and taken to district court, which issues summonses to husbands. Police say these are effective in protecting women from violence because men face jail if they breach the orders. However, villages had different views from the police:</p> <p>1. Reporting to police increases women's risk Men beat women, but if women go to police and return to their homes, they will be killed by their husbands [Jiwaka village women].</p> <p>2. IPOs are ineffective They are not working, as men continue violence toward women no matter what the courts say. There is a need for training young couples about the law [Jiwaka male community leaders].</p>	<p>Kundiawa IPOs are relatively new to Simbu, beginning in 2012, but they are considered effective in stopping husbands' violence and empowering women.</p>
East Sepik	Madang	Autonomous Region of Bougainville
<p>Wewak IPOs are not working in East Sepik (Wewak Provincial Council of Women). A service user from a rural area said she went to the police but did not receive proper help, even on the third instance of violence, which was committed in retaliation for going to police. Police did not seek an IPO to protect her. They said they would go and see her husband but nothing really happened. They said they did not have a car [service user].</p>	<p>Criminal Investigation Department does not use IPOs. The Community Policing Unit writes IPOs and the courts issue the orders. Sometimes IPOs work, but some violent men never listen, and instead they go back home and beat their children and wives [head of Criminal Investigation Division].</p> <p>Breaches of IPOs When there are breaches, the victims come to community policing and they have discussions and solve their issues. There are cases where the offender goes to court together with the breach notice. The Community Policing Unit will write the breach notice. NGOs note that they do not know how to get IPOs for victims, and there is not enough awareness about the orders in Madang. World Vision asked community police about obtaining orders, but they did not know. Training is needed.</p>	<p>Buka The process for breaches of IPOs is that they are reported to police by the victim, family members, or an NGO; the police interview the victim and offender; there is a court hearing; and if the offender is found guilty, he is sentenced to three months in jail.</p> <p>Police act on breaches of IPOs "One of our clients with an IPO came back after being assaulted. The husband and children came to find the woman. We rang the police who said to keep the man there and came straight away with another victim in the car. She said he had to go to court and we all went to the court house ... the magistrate asked, do you want to wait while the police officer types up the warrant? We were all very tired and it was a public holiday but we waited The wife told her story and we all told our stories. The magistrate sentenced him to three months' jail" [Nazarene Rehabilitation Centre].</p> <p>We are very empowered All agencies interviewed in Buka said the IPO process is working well.</p>
Audit item	Western Highlands	Simbu
<p>20. Barriers to reporting and prosecuting gender-based violence</p>	<p>Police do not act The Well Women's Clinic contacted police when they heard three school girls were abducted in a tribal fight and were continuously sexually assaulted for a week. One girl escaped and was seen at the clinic, but two girls were still being held captive. Police would not act; they gave excuses and said there was no fuel.</p> <p>Dealt with at village court People deal with gender-based violence at the village court because police do not arrest offenders.</p>	<p>Access to police Poor roads and cost of travel make it difficult for women to get to police stations from the villages.</p> <p>Pressure from husband and family Where police charge the husband, the woman is pressured by the husband and family to drop the case and instead go to village court to get compensation.</p>

East Sepik	Madang	Autonomous Region of Bougainville
<p>Police are abusive Women complain about police assaulting and raping them and of police brutality. Police use abusive language.</p>	<p>Victims change their mind Women pressure police to lay charges and an hour later they change their minds. Police refer them to the Community Policing Unit for mediation or welfare services [head of Criminal Investigations Division].</p> <p>Access to children Husbands chase after the woman and hold onto the children when she tries to leave. Women come back and suffer violence because of the children. Children are valuable [Country Women's Association].</p> <p>Culture Culture is the biggest barrier because of attitudes toward women [Country Women's Association].</p>	<p>Women need advocates "We go with women to the police and courts. They are treated much better if we are with them" [Family Support Centre, Buka General Hospital].</p>
Audit item	Western Highlands	Simbu
<p>21. Police referrals to other services</p>	<p>Mt. Hagen Police make referrals to:</p> <ul style="list-style-type: none"> • Welfare officer for women neglected by their husbands • Mercy Works • Susu Mama (for breastfeeding mothers) • Well Women's Clinic • Village court, if women need to move out 	<p>Kundiawa Case management meetings are held at the police station for serious cases Police refer to:</p> <ul style="list-style-type: none"> • District court for IPOs • Family support centre at the hospital – police officers go there every Wednesday or when the Sister rings to obtain statements and to make arrests. • Police also refer victims for trauma counselling.
East Sepik	Madang	Autonomous Region of Bougainville
<p>Wewak</p> <ul style="list-style-type: none"> • Provincial Council of Women provides counselling for women as well as a safe house • Village courts • Community Policing Unit 	<p>Police make referrals to:</p> <ul style="list-style-type: none"> • The district welfare officer at the district Community Development Office • Community Policing Unit for mediation • Modilon General Hospital A&E for rape victims • Sexual Offences Squad works closely with Country Women's Association • Madang Provincial Council of Women is not operating [source: Community Policing Unit] so referrals are not made. • Village courts to witness agreements made in mediation conducted by the Community Policing Unit. 	<p>Police and police prosecutors belong to the provincial Family and Sexual Violence Action Committee, which fosters networking and referrals. Police make referrals to:</p> <ul style="list-style-type: none"> • FSC at Buka General Hospital • Leitani Nehan • The Nazarene Centre for Rehabilitation, which provides safe houses for women • Department of Community Development for maintenance issues.
Audit item	Western Highlands	Simbu
<p>22. Referrals to police from other services</p>	<ul style="list-style-type: none"> • Well Women's clinic • Mercy Works • Susu Mama <p>make referrals for victims of gender-based violence to police.</p>	<ul style="list-style-type: none"> • Family Support Centre at the Late Joseph Nobri hospital • Provincial Family and Sexual Violence Action Committee • refers victims of gender based-violence to the police.

East Sepik	Madang	Autonomous Region of Bougainville
<p>Wewak</p> <ul style="list-style-type: none"> Provincial Council of Women refers victims to police and community policing Sepik Centre of Hope VCCT Centre refers people living with HIV who are victims of stigma and discrimination to police. 	<ul style="list-style-type: none"> VCCT centres and advocacy services make referrals to police when people living with HIV are victims of violence. Country Women's Association workers take victims of gender-based violence to see police in the Sexual Offences Squad and Criminal Investigation Division. Police interview them, and put cases on the schedule to go out and arrest offenders Welfare officer (district Community Development Office) writes referral letters for police to assist women to get their children back when the father holds onto them. She also writes referral letters to Sexual Offences Squad for women or young females who are being sexually abused by their relatives. 	<ul style="list-style-type: none"> FSC at Buka General Hospital Leitani Nehan The Nazarene Rehabilitation Centre refers victims of gender-based violence to the police.
Audit item	Western Highlands	Simbu
23. Strength of services provided by police	<p>Mt. Hagen</p> <p>Police see that IPOs are working well.</p>	<p>Kundiawa</p> <p>Networking with other services, such as courts, education, welfare, and the FSC, through the provincial Family and Sexual Violence Action Committee, which has 30 members who meet monthly. The aim is to provide 'a one-stop shop' to victims and survivors of gender-based violence.</p>
East Sepik	Madang	Autonomous Region of Bougainville
<p>Wewak</p> <p>Community policing has a good relationship with the community.</p>	<p>The female Criminal Investigation Division police officer networks with women's services. There should be more GBV awareness and training to increase utilisation of services, especially with school-aged children and mothers [head of Criminal Investigation Division].</p>	<p>Buka</p> <p>The availability of IPOs at all hours and the follow-up of breaches is a strength of the justice response to gender-based violence.</p>
Audit item	Western Highlands	Simbu
24. Gaps in services provided by police	<p>Mt. Hagen</p> <p>If women do not want to proceed with charging their husbands, we send them home – we would like to do more investigation and arrests.</p>	<p>Kundiawa</p> <p>The police station is in need of repairs as the roof leaks and there is a problem with the toilets (there is a terrible smell throughout the building). Petrol rations restrict travel to villages. Vehicles can be re-fuelled Monday, Wednesday, and Fridays up to 20 litres. Up-to-date equipment and increased office space are needed.</p>
East Sepik	Madang	Autonomous Region of Bougainville
<p>Wewak</p> <p>There is no Family and Sexual Violence Unit in place.</p>	<p>Criminal Investigation Division needs six more staff to be able to investigate all complaints, six computers, and two more vehicles.</p> <p>The police station is very old and some offices complain of the heat. Old newspapers are stuck on windows for blinds.</p>	<p>Buka</p> <p>A mother of an adolescent girl was raped twice at school, became pregnant, and gave birth told of systemic failures in the justice sector. "The police failed to investigate, and in court the police prosecutor lied and made excuses for the lack of police investigation. The man was released from custody by the magistrate because there was no investigation. ... Police are slow to respond to victims, they just take note of the complaint. They don't have time to investigate and they don't have knowledge about the impact of the crime."</p>

Audit item	Western Highlands	Simbu
<p>25. Community view of police effectiveness</p>	<p>Communities normally help the police. Some do not like the police intervening in their family; they want to deal with it themselves.</p> <p>Police are respected and are more recognised through the Family and Sexual Violence Unit [Mt. Hagen police].</p> <p>Actively refer gender-based violence victims for treatment Police are very good; they register GBV victims and tell them to come to the hospital and get the medical report [FSC].</p> <p>Not responsive The police are not doing their job in Western Highlands; they know there is violence, but they don't want to go and stop it [village in Western Highlands]. Police are not chasing and arresting perpetrators; it is the survivor's family members who bring the offender to justice. Thus, people are settling matters in village court [FSC].</p> <p>Lack of adequate police staff There are not enough police to help, particularly in rural areas. Police never do their duty to stop violence in the community because they are outnumbered [Jiwaka village].</p> <p>Bribery Bribes are paid to police to stop investigating crimes [Jiwaka village].</p> <p>Police want payment Police say you have to pay a fee for them to go and arrest someone who has been violent, even though they are public servants and the government pays them [Jiwaka village]. Clients may need to pay police for admin work. This stops women from making charges and delays court – if she doesn't pay, it delays the process of the charges going to district court [Mercy Works].</p> <p>Transport is not provided for victims We ask police to provide transport for the victim and they say they don't have money to provide transport [Mercy Works].</p>	<p>Women know where to report violence, especially when we do awareness raising [Kundiawa police].</p> <p>Not responsive Police do not assist when there are fights, and their response is very poor 75% of the time. Tribal flights begin because of police corruption. Instead, village court officials and village leaders come and solve the problem. Payment was dropped for community policing so now we don't have police.</p> <p>Police want payment Police want payment, cigarettes, and fuel when they are already being paid by the government. Villagers feel very angry about this as people can't afford the cost – 100–200K [Kond and Kerowagi villages].</p> <p>Lack of adequate police staff Police are 1 against 10 – it is a manpower issue [Kond village].</p> <p>Women lack awareness and access to police People in the villages do not have access to police. Women are not aware of their rights, and men are not aware of the law.</p>

East Sepik	Madang	Autonomous Region of Bougainville
<p>Not functioning well At the moment, the police and Sexual Offences Squad are not functioning well. We refer to them, but they lack manpower and resources [Provincial Council of Women].</p> <p>Good working relationship Nana Kundi Crisis Centre refers victims of physical violence and sexual assault to the police. There is a good working relationship with police [Maprik].</p> <p>Women are married to police who are offenders Nana Kundi Crisis Centre sees women married to police. These cases are referred to the police station commander. If he says to file for court action, we do. Otherwise, the couple sorts it out with the Provincial Patrol Commander (PPC) [Maprik].</p>	<p>Some are pleased with what the police are doing, some are not, especially the 'anti-police'. Police must use force to make arrests – those that think they are smart and don't want to follow rules and laws. They hate police when they have been arrested [head of Criminal Investigation Division].</p>	<p>Police are seen as effective by NGOs and the FSC at Buka General Hospital in working together on IPOs to protect women from GBV violence. Other effectiveness issues include:</p> <p>Women need advocates to go to the police Victims of GBV violence who do not have an advocate are not treated as well [FSC, Buka General Hospital].</p> <p>Offenders are friends with police "Men who are violent have friends in the police. Once my daughter was assaulted by the husband of a client of the centre. He had a gun and was threatening us to say where his wife was. I rang my husband and he put up a road block for his car when he was going back to the village, and took him to the police with his gun, but in the end we found out he got his gun back" [Leitani Nehan].</p> <p>Women are married to police officers who are offenders "Police are offenders too. Women are married to police who beat and rape them and threaten them with guns" [Leitani Nehan].</p>

Table 8: Findings on district courts by province

Audit item	Western Highlands	Simbu
<p>1. Interim protection orders are legal orders that can be taken out to protect victims of gender-based violence. If breached, the offender can be charged by police. If found guilty of a breach, the offender will be charged.</p>	<p>Mt. Hagen Community workers now have authority to issue an IPO, but community workers doubt these will have any authority. The order just sits on a desk and the district court has to issue the interim protection order. Women are told: "You take it to your husband, and if he offends bring him to court" [Mercy Works].</p>	<p>Kerowagi District courts are writing IPOs, which is something new for police. And they do work. We had one case where the man was a little bit scared about the order and no longer came down to his wife's house. And when he rings, she says: "You can't ring" [Kundiawa police].</p>
East Sepik	Madang	Autonomous Region of Bougainville
<p>Wewak Not known.</p> <p>Maprik There is a district court in Maprik. Nana Kundi Crisis Centre provides a paralegal aid support service to GBV victims with affidavits, summonses, IPOs, and legal advice.</p>	<p>District courts are issuing IPOs. However, agencies such as Country Women's Association do not feel confident to write the orders.</p>	<p>Buka Here one can get an IPO 24-hours a day, 7-days a week. So IPOs are having an impact. It is difficult to serve summonses. We use the radio to read summonses – the court takes it as proof that the summons has been delivered. So if someone doesn't turn up at court, they have disobeyed a summons.</p>

Audit item	Western Highlands	Simbu
2. Police view of district court effectiveness and outcomes	<p>Mt. Hagen District courts do a good job. They ask the husband to compensate 1,000K, which will go straight to the woman – and give good behaviour bonds or four months in correctional service. Women normally share compensation with brothers and uncles who supported her to come to court [Mt. Hagen police].</p>	<p>Kundiawa District courts give a fair trial because the magistrate's decision is based on the law If the husband is found guilty the woman can ask for compensation and he will have to pay a fine – up to 100K depending on the seriousness of the crime. If the man does not have the money to pay for the fine and compensation, he gets imprisonment [Kundiawa police].</p>
East Sepik	Madang	Autonomous Region of Bougainville
<p>Wewak Not known. Maprik Not known.</p>	<p>District courts are fair, and magistrates and judges are well trained. However, it can take years for the courts to finalise a case.</p>	<p>Buka District courts work very well here, and there are close relationships between the prosecutors and the police. The prosecutors have trained the female police officers in writing IPOs.</p>
Audit item	Western Highlands	Simbu
3. Gender-based violence services and the view of community representatives of district court effectiveness	<p>Increased risk to women “If women go to court in their own family's village, it will be ok (safe), but if they go to court in their husband's place, the whole community will mobilise and kill the woman” [Jiwaka village]. They are frightened their husbands and families will kill them, or their children will be kidnapped, so they withdraw the charges.</p> <p>Delays The delay in papers reaching court can take months or years. Women withdraw complaints in frustration with delays and the violence continues.</p> <p>Need for information Magistrates do not clarify their role or give enough information, and clients and agencies get confused.</p> <p>Need for coordination between services There is a need for a bridge between services.</p> <p>Courts need to exercise the law The court has failed gender-based violence victims. It doesn't attend to their rights. Courts need to exercise the law.</p> <p>Domestic violence seen as a family matter Courts still think domestic violence is a family matter.</p>	<p>Sentencing is appropriate for the crime “With the district court, we are happy with the sentence. Like rape cases, they go to jail” [FSC, Kundiawa].</p>

East Sepik	Madang	Autonomous Region of Bougainville
<p>Go by the law They go by the law; they are more gender sensitive than the village courts. They are educated men and women who have been exposed to a lot of trainings.</p> <p>Not available in all districts District courts are not located in all the districts. Maprik has a district court, but Angoram and other places have circuits so the district court goes out there.</p> <p>Police are gatekeepers to the district court “The three assaults by my husband didn’t go to district court as police took no action” [service user, Provincial Council of Women]. If the police see the case is serious then they do investigate and take it to district court [Sepik Centre of Hope].</p>	<p>Qualified and fair District court is good because they are qualified magistrates and you cannot bribe them, they will throw you in court [Country Women’s Association].</p> <p>Delays Major causes for delays in hearings are in producing evidence and having to wait for all the evidence. Court cases can go on for three years. Country Women’s Association tries to help by getting the medical report so the magistrate can make a decision on available evidence.</p>	<p>The District Court at Buka decided to get involved in alleviating violence. People here in Bougainville think that autonomy means anarchy. We have taken an active role in promoting IPOs — we took on the challenge last year. The courts did not get use to the idea of championing against gender-based violence – courts like to look neutral – but things started moving with IPOs, forms, and other improvements.</p>

Table 9: Findings of audit of village courts by province

Audit item	Western Highlands	Simbu
1. Female magistrates appointed to village courts	<p>There is only one female village court official in the province.</p> <p>Kudjip and Minj Female community members have been recommended to the provincial office, but the office has not appointed them or arranged training. The lack of female magistrates is difficult for women; they do not feel represented or supported in GBV [Jiwaka village].</p>	<p>Nine female officials work as clerks of the court and village court magistrates in the province.</p> <p>Kerowagi One female magistrate has been appointed. At the full sitting of the village court there is only one female magistrate on the team. She focuses on how to settle the women’s side of the problem; the men focus on how to settle the men’s side.</p>
East Sepik	Madang	Autonomous Region of Bougainville
<p>Three to five female officials work as clerks of the court and village court magistrates in the province.</p> <p>Wewak and Maprik Wewak and Maprik have female village court magistrates but there are no female magistrates in village courts located in rural areas The Nana Kundi Crisis Centre has an imbedded fulltime male village court magistrate</p>	<p>There are 20 female village court officials who work as village magistrates and clerks of the court.</p>	<p>Buka There are 47 women in Bougainville working in the village courts, including magistrates and clerks. Some of these have been appointed as deputy chairpersons. A review of village courts was undertaken by the Bougainville administration in 2011, during which 91 of the 96 village courts were visited. The review called for more female village court magistrates to be appointed [district court magistrate].</p>
Audit item	Western Highlands	Simbu
2. Training of court officers in gender-based violence	<p>Kudjip The village court magistrate interviewed for the study has not attended gender-based violence training.</p>	<p>Kerowagi Magistrates initially receive two weeks of training, and there is a further two weeks of training per year on topics such as changes in the law. Training is run by UNICEF in Simbu and the village courts and by the Land Mediation Secretariat in Moresby.</p>

East Sepik	Madang	Autonomous Region of Bougainville
<p>Wewak UNICEF funds a training programme for female magistrates. Ten to 15 have been trained already and are now working in village courts. Village court magistrates need to be educated on cross-cutting issues, such as GBV, HIV/AIDS, and men and boys' behaviour change [clerk of village court]. Village court magistrates attend GBV and human rights training run by the Provincial Council of Women, and they disseminate the information to others.</p> <p>Maprik The magistrate located at Nana Kundi Crisis Centre has attended gender-based violence trainings run by the centre.</p>	<p>Village court magistrates need training. The Country Women's Association ran GBV awareness training, which was attended by a village court magistrate who learned a great deal from the training as he had previously thought violence against women was normal.</p>	<p>Village court magistrates need training. For example, they need to know to refer cases such as sexual assault to police [district court magistrate].</p>
Audit item	Western Highlands	Simbu
3. Frequency of hearings	<p>Kudjip The village court holds hearings when needed – usually several hearings a week – and deals with 5–10 GBV cases per month.</p>	<p>Kerowagi There are two regularly scheduled hearings per week, on Tuesdays and Thursdays, but there can be hearings every day when there are disputes to settle.</p>
East Sepik	Madang	Autonomous Region of Bougainville
<p>Wewak Village court hearings take place three times per week.</p> <p>Maprik There are only a few village courts operating in Maprik.</p>	<p>Village court hearings take place several times a week.</p>	<p>Buka Village court hearings take place regularly. Councils of elders also play a formal, though non-customary, role in dispute resolution [Tsidalado Council of Elders].</p>
Audit item	Western Highlands	Simbu
4. Writing protective orders and summonses	<p>Kudjip Magistrates write out protective orders and summonses at the village court [village court magistrate].</p>	<p>Kerowagi Village courts have the power to write out summonses for different sections of law [village court magistrate].</p>
East Sepik	Madang	Autonomous Region of Bougainville
<p>Wewak Protective orders are not being implemented in East Sepik [Provincial Council of Women].</p>	<p>Community policing advises village courts to write out summonses for issuing protective orders.</p>	<p>Buka Village courts can write protective orders, but police play a greater role [district court magistrate].</p>
Audit item	Western Highlands	Simbu
5. Magistrates' perception of function of village courts	<p>Minj and Kudjip The village court tries to solve the problems of couples or between two people. Magistrates are mediators and try to make peace.</p>	<p>Kerowagi Village courts try to find ways to solve conflicts. They enable the community to live normally. Village courts do their duty, process cases in line with the laws, and make decisions.</p>
East Sepik	Madang	Autonomous Region of Bougainville
<p>Wewak Village courts have hearings where there are disputes, and the magistrate listens to all sides. There is discrimination against women in village court.</p>	<p>Village court officers witness the agreements between parties in conflict following mediation.</p>	<p>Village courts operate in far-flung places and are too distant from district courts and police stations to be able to refer cases easily [district court magistrate].</p>

Audit items	Western Highlands	Simbu
<p>6. Resources for village courts</p>	<p>Kudjip Resources are needed to strengthen the court's capability and system, and to improve wages so magistrates can spend more time solving conflict in marriages. Magistrates are paid 60K every three months. This is not enough. We don't agree with the amount of money we receive. People at the district office get the money and they don't pass it on to magistrates. There is no village court house and court hearings are held outside at a public gathering [village court magistrate].</p>	<p>Kerowagi Magistrates are only paid 26K per month and the chair 30K per month. There is no proper court house. Lack of resources and support make it hard. The hearings are held outside with the sun and rain. There are people all around [chairman, village court].</p>
<p>East Sepik</p> <p>Wewak The chairman gets 26K a month. The court clerk works three days per week and does all the warrants, summonses, paperwork, recording, and reporting. It can be a year until village court officials are paid. Classrooms are used for hearings, as the village court has no building [village court clerk].</p> <p>Maprik There is a village court magistrate placed full-time at the Nana Kundi Crisis Centre. Village court hearings take place at the centre.</p>	<p>Madang Village court can take place anywhere, it is a public gathering. They do not have their own building [community policing].</p>	<p>Autonomous Region of Bougainville Village courts operate in remote places and do not have many resources.</p>
Audit item	Western Highlands	Simbu
<p>7. Delineation between village and district courts' jurisdiction</p>	<p>Kudjip District courts deal with compensation cases above 2,000K. If there is agreement with both parties, it is dealt with at the village court. Village courts deal with GBV cases, and sometimes they appeal to the district court and the district court will agree with the decision made by the village court [village court magistrate].</p>	<p>Kerowagi There are limits to decisions. Village courts cannot deal with compensation above 5,000K or 10,000K [chairman, village court]. Village courts deal with compensation below 300K [village court magistrate]. Issues of violence against women come before the village court, and if there is no agreement the case goes to the district court.</p>
<p>East Sepik</p> <p>Wewak District courts go by the law, they are more gender sensitive than the village courts – they are educated men and women who have been exposed to a lot of training. However, district courts are not in all districts. They go out to rural areas on circuit, and hearings are infrequent [village court clerk].</p> <p>Maprik If a case cannot be settled at the village court level, then it goes to the district court. Sexual assault victims should go straight to police.</p>	<p>Madang Cases might be heard in both village and district courts.</p>	<p>Autonomous Region of Bougainville</p> <p>Buka The law is meant to be crystal clear, but village courts delve into cases where they do not have jurisdiction. However, compensation does not stop a case from coming to district court. It should come to the district court first and then go to the village court for the compensation hearing. Criminal court proceedings come first [district court magistrate].</p>

Audit item	Western Highlands	Simbu
8. Sexual assault is referred to police, not dealt with by compensation	Kudjip Sexual assaults are dealt with at village courts [village court magistrate].	Kerowagi Sexual assault would go to the district court [chairman, village court]. Sexual assault is also heard by the village court. The magistrate gets the story and works with both sides. The man gives some money to compensate the husband, father, or brother (of the woman who was raped) and to the woman [female village court magistrate].
East Sepik	Madang	Autonomous Region of Bougainville
Wewak The Provincial Council of Women refers cases to the Sexual Offences Squad, but they lack staffing and resources for investigation. Thus, cases might go to village court rather than having no action on their complaints.	Village courts refer sexual assault to the Sexual Offences Squad in the Criminal Investigation Division.	Buka Sexual assault can go to village court [Tsidalado Council of Elders].
Maprik Sexual assault is referred straight to the police, as it is a criminal offence [Nana Kundi Crisis Centre].		
Audit item	Western Highlands	Simbu
9. Meaningful penalties for domestic assault or breach of protective order for domestic violence are enforced	Kudjip For violence in marriage resulting in a broken arm, the compensation is 1,000K. Village courts do some counselling. For example, if a man beats his wife, they bring them together and tell them how to live a better life. They look at the reasons for the man using violence and say: "Don't ever practice it again." If a man reoffends, 500K should be paid for the violence as a fine [village court magistrate].	Kerowagi For violence in marriage resulting in a broken arm, the compensation paid by the husband is 1,000K.
East Sepik	Madang	Autonomous Region of Bougainville
Wewak Male village court magistrates do not come to fair decisions, but when women participate in district court hearings it is a fairer decision. More women magistrates are needed, an equal number of men and women, so that the village court is gender balanced and women have a fair say [village court clerk].	The Criminal Investigation Division will investigate a serious assault (e.g., a broken arm). The division will refer back to the village court and Community Policing Unit for mediation for the husband to compensate – below 5,000K and/or a pig, depending on the wealth of the husband and family. The compensation goes to the woman and her family. Most times the village court finds for payment of compensation, and then both families cook and exchange food. At the village court all agree on something – a husband would give money and a rooster, which goes to whoever is looking after the victim [World Vision].	The compensation for a broken arm is 500K.

Audit item	Western Highlands	Simbu
10. Payment of brideprice is not accepted as a defence	Jiwaka When magistrates know a brideprice has been paid, they say women are wrong – because that is the custom with the heads of families [villagers and community representatives].	Kerowagi Violence in marriage is linked with brideprice payment. If violence occurred and the woman wants to divorce and the man says no, then there will be three sittings to help them agree. When women with children get divorced and go, they have nothing [village court magistrate]
East Sepik	Madang	Autonomous Region of Bougainville
Wewak When men pay a brideprice, men own the woman and violence occurs when women disagree on certain issues. Men say: "I paid this much for you" and then the immediate family retaliates and tribal conflicts break out here [Provincial Council of Women].	Brideprice does not really make a difference to village court decisions [Community Policing Unit].	Buka Brideprice is generally paid in Bougainville, but is not accepted as a defence for gender-based violence [police prosecutor].
Audit item	Western Highlands	Simbu
11. Cases of alleged deliberate infection with HIV or of alleged sorcery in connection with HIV infection are referred to the police	The village court does deal with these cases [Kudjip village court magistrate].	Cases of sorcery and HIV infection come to village courts. Sorcery cases are a major problem; people suspect both males and females and put them on fire or use hot iron on the body to make them reveal sorcery. If there is no agreement the cases will go to district court [Kerowagi village court magistrate].
East Sepik	Madang	Autonomous Region of Bougainville
There have been no cases of deliberate HIV infection in Wewak, although there are unconfirmed rumours of a man spreading HIV [Provincial AIDS Committee]. Accusations of sorcery are referred back to the community for mediation [Nana Kundi Crisis Centre].	Community Policing Unit deals with one to two cases of sorcery per month. They do a normal mediation to a win-win solution, and with the parties' agreement they settle it out themselves. They do not see cases of deliberate HIV infection.	Deliberate HIV transmission and sorcery were not identified as issues in Buka.
Audit item	Western Highlands	Simbu
12. Police view of village court's effectiveness in dealing with gender-based violence	Mt. Hagen Village courts give compensation to the women's relatives and they share it out, including with the victim.	Kundiawa Village court has mostly male magistrates: one female against the many, so it is unfair. The process is affected by bribery and <i>wantoks</i> (people you know, i.e., "connections") – that is the Melanesian way.
East Sepik	Madang	Autonomous Region of Bougainville
Wewak Not known. Maprik Not known.	The Community Policing Unit refers domestic violence to the village court for settlement and restitution. When there is no agreement, the case is referred back to the Community Policing Unit for mediation. After mediation they are sent back to the village court for restitution or compensation – payment of a chicken or pig. Both parties pay compensation – if the woman provoked the situation she will pay too. Like when the husband comes in drunk and says 'have I got food in the kitchen?' and if she shouts back and he punches then they would both pay compensation [Sergeant, Community Policing Unit].	Buka In areas where there is a district court then gender-based violence cases go there. In remote areas where there are only village courts, they deal with gender-based violence, even though they don't have jurisdiction [district court magistrate].

Audit item	Western Highlands	Simbu
13. Community view of effectiveness of village courts in dealing with gender-based violence	<p>Go to the men's side Magistrates go to the men's side [female villagers, Jiwaka] Magistrates come to our side and support us [male villagers, Jiwaka].</p> <p>Bribery There is bribery [Jiwaka village] Men give betel nut or small payments of 2K or 5K to bribe magistrates [Kudjip magistrate]</p> <p>Doing job properly Village courts are doing their job properly. They give a preventative order for a first offence – if it's a serious offence they must pay compensation [male villagers, Jiwaka].</p>	<p>Go to the men's side Sometimes village magistrates do understand the position of women, but village courts normally decide on the side of men. Female magistrates go to the side of the women – they understand the daily life of the women. But decision-making is still dominated by men [Kerowagi village]</p> <p>Threats against magistrates Magistrates are threatened by the men's extended family [Kerowagi village].</p>
East Sepik	Madang	Autonomous Region of Bougainville
<p>Do not make fair decisions Male magistrates do not come to fair decisions, but when women participate in court it is a fairer decision.</p> <p>More women magistrates are needed We need more women magistrates, an equal number of men and women so it is gender balanced and women have a fair say.</p> <p>Bribery Bribery is normal for PNG and there is a lot of bribery going on in rural areas [village court clerk].</p> <p>No threats against magistrates I have not come across threats to village court magistrates [clerk of village court, Wewak].</p>	<p>Wantok <i>Wantok</i> use their influence so village courts decide in favour of their relative's side [Country Women's Association].</p> <p>Bribery Bribery does exist in village courts [Country Women's Association].</p>	Not known.
Audit item	Western Highlands	Simbu
14. Village court reporting	The government does ask for statistics, but the court clerk does not provide statistics [Kudjip].	The court clerk reports statistics to the government in Moresby [chairman of village court, Kerowagi]. There are about 50 gender-based violence cases a month around Kerowagi.
East Sepik	Madang	Autonomous Region of Bougainville
The clerk of the court does reporting of statistics [village court clerk, Wewak]	Not known.	Not known.
Audit item	Western Highlands	Simbu
15. Security	Magistrates do get threatened and even beaten. Police do not intervene.	When there is tribal conflict people try to attack magistrates. Sometimes the general community tries to attack the court. If a decision is made against a certain man, his extended family will come with a stick to beat up the magistrate. It is not safe.
East Sepik	Madang	Autonomous Region of Bougainville
Wewak There are no threats to village court magistrates [village court clerk].	Community policing has a close relationship with village courts. There are no security issues.	Security issues for village courts are not known.

Table 10: Training for police in HIV

Recruit training: Basic knowledge all police officers should have	
<i>To know:</i>	<i>To do:</i>
<ul style="list-style-type: none"> i. How HIV is transmitted and how it is not transmitted ii. How HIV is prevented iii. How HIV is treated iv. Overview of the epidemiology of HIV in Papua New Guinea v. The RPNGC HIV/AIDS workplace policy vi. Role of RPNGC and individual police officers in the PNG national response to HIV/AIDS vii. Recognize the role of police in upholding and enforcing the human rights of all citizens in Papua New Guinea viii. Approaches to interacting with key affected populations ix. Approaches to interacting and working with HIV-positive colleagues x. The range and scope of legislation related to HIV/AIDS in PNG xi. The potential effects of HIV/AIDS on individuals, families, communities, organizations, and the country 	<ul style="list-style-type: none"> i. Accurately assess individual risk to HIV and take appropriate action to minimize risk ii. Be able to practice safe sex to prevent HIV infection iii. Effectively deal with potential occupational exposure iv. Identify and effectively deal with situations of stigma and discrimination in the workplace v. Apply the law in situations of: <ul style="list-style-type: none"> • Intentional transmission • Reckless transmission • Unlawful disclosure • Stigma • Discrimination vi. Effectively deal with complaints related to stigmatization and discrimination due to HIV/AIDS vi. Establish working relationships with key affected populations
Additional Information required by police officers working in Family and Sexual Violence Units	
<i>To know:</i>	<i>To do:</i>
<ul style="list-style-type: none"> i. The link between family and sexual violence, HIV/AIDS, law, and justice ii. Where and how to refer people for Voluntary Counselling and Testing and ART iii. What evidence would be required to pursue charges related to intentional transmission, reckless transmission; unlawful disclosure; stigma; and discrimination iv. The various HIV/AIDS stakeholders and service providers and what services they provide: e.g., Igat hope, IDLO/PNGDLA, Office of Public Solicitor, Friends Frangipani, RPNGC Internal Investigations, District Courts (IPO), National Courts (Human Rights Track), Provincial AIDS Councils, Business Against HIV & AIDS (BAHA), PNG Alliance of Civil Society Organizations against HIV and AIDS, etc. 	<ul style="list-style-type: none"> i. Make effective referrals to appropriate service providers ii. Make an accurate assessment of clients risk of HIV iii. Make appropriate referrals to HIV/AIDS service providers iv. Collect and document necessary evidence
Additional information for police participating in officer cadet training	
<i>To know:</i>	<i>To do:</i>
<ul style="list-style-type: none"> i. How to implement workplace HIV/AIDS policies ii. How to resolve issues of stigma and discrimination in the workplace iii. What care and support HIV-positive workers will need in the workplace iv. What to do when a colleague or subordinate reveals his or her HIV status to you v. How to manage staff who breach policies and laws related to HIV/AIDS vi. How to monitor and report organizational progress in addressing HIV 	<ul style="list-style-type: none"> i. Make an accurate assessment of organizational risk of HIV and take action to minimize risk ii. Ensure staff living with HIV are supported in the workplace iii. Report on progress in addressing HIV/AIDS iv. Ensure staff who breach approved HIV workplace policies are appropriately disciplined

Source: PALJP, 2012



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