

Contributing Factors and Strategies for Prevention of Intimate Partner and Sexual Violence in Papua New Guinea

Marieke Broekhoff
The Netherlands

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Contributing Factors and Strategies for Prevention of Intimate Partner and Sexual Violence in Papua New Guinea.

At thesis submitted in partial fulfillment of the requirement of the degree of Master of Public Health

By

Marieke Broekhoff

The Netherlands

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Signature:

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International Course for Health and Development

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Table of Content

List of Tables and Figures	vi
Figures:	vi
Tables:	vi
Abbreviations.....	vii
Glossary.....	viii
Acknowledgements.....	x
Abstract.....	xi
Introduction.....	xii
Chapter 1: Background information on PNG.....	1
1.1. Geography.....	1
1.2. Demography.....	1
1.3. Government.....	2
1.4. Socio-Cultural.....	2
1.5. Economy.....	3
1.6. Health system.....	3
1.7. Health.....	4
1.7.1. Reproductive indicators.....	4
Chapter 2: Study overview.....	6
2.1. Problem statement.....	6
2.2. Justification.....	7
2.3. Methods.....	8
2.3.1. Objectives:.....	8
2.3.2. Methodology.....	8
2.3.3. Search strategy.....	8
2.3.4. Data from Tari FSC.....	9
2.3.5. Conceptual framework: The Ecological framework.....	9
Chapter 3: Contributing factors to IPV and SV in Papua New Guinea.....	11
3.1. Individual.....	11
3.1.1. History of violent behavior, previous abuse.....	11
3.1.2. Alcohol.....	11

3.1.3. Age of woman	11
3.1.4. Level of Education of both perpetrator and victim.....	13
3.1.5. HIV infection	14
3.2. Relationship level.....	14
3.2.1. Marital discordance	14
3.2.2. Polygyny	14
3.2.3. Arranged marriages and Bride price	15
3.3. Community level.....	15
3.3.1. Poverty.....	15
3.3.2. Social isolation.....	16
3.3.3. Illicit drug use and trade.....	16
3.3.4. peer pressure.....	16
3.4. Society level.....	17
3.4.1 parenting practices.....	17
3.4.2. Traditional gender norms and roles.....	17
3.4.3. Social acceptability of violence.....	18
3.4.4. Legislation	18
3.4.5. Religion.....	19
Chapter 4: Review of activities addressing IPV and SV in PNG and evidence of best practice	21
4.1. Response to IPV and SV in PNG.....	21
4.2. Individual Level	23
4.2.1 Violence during childhood	23
4.2.2. Addressing alcohol use.....	23
4.2.3. Survivor care.....	23
4.3. Relationship level.....	25
4.3.1. Couple counseling and anger management.....	25
4.4. Community level.....	25
4.4.1. School-based programs.....	25
4.5. Society level.....	25
4.5.1. engaging men	25
4.5.2. Female empowerment.....	26
4.5.3. Legislation and court	26
4.5.4. Media / change social norms.....	26

4.5.5. Service organization.....	27
Chapter 5: Discussion.....	29
5.1. Responding to IPV and SV in PNG.....	29
5.1.1. Individual level.....	29
5.1.2. Relationship level	30
5.1.3. Community level.....	30
5.1.4. Societal level.....	31
5.1.5 Policy level.....	32
5.2. Limitations of the study	32
Chapter 6: Conclusion and Recommendations.....	34
6.1. Conclusion.....	34
6.2. Recommendations.....	35
Bibliography	36

LIST OF TABLES AND FIGURES

FIGURES:

Figure 1: Typology of violence

Figure 2: Map of PNG (World Maps 2005-2012)

Figure 3: Ecological model (Heise 1998)

Figure 4: Women presenting at Tari FSC after IPV

Figure 5: Women presenting at Tari FSC after SV

TABLES:

Table 1: Key indicators from Demographic and Health survey 2006 (National statistical office[Papua New Guinea] and ORC Macro 2009)

Table 2: Is it acceptable for a wife to beat her husband? (Toft 1986)

Table 3: Is it acceptable for a man to beat his wife? (Toft 1986)

ABBREVIATIONS.

AUSAID	Australian Aid
CEDAW	Committee on the Elimination of Discrimination Against Women
FSC	Family Support Center
FSVAC	Family and Sexual Violence Action Committee
GDP	Gross Domestic Product
GNI	Gross National Income
HIC	High Income Countries
HMIS	Health Management Information System
IMAGE	Intervention with Micro finance for AIDS and Gender Equity
IPO	Interim Protection Order
IPV	Intimate Partner Violence
JICA	Japan International Cooperation Agency
LMIC	Low Middle Income Countries
LNG	Liquid Natural Gas
LSHTM	London School of Hygiene and Tropical Medicine
MSF	Médécins Sans Frontières
NDoH	National Department of Health
NGO	Non Governmental Organization
OSS	One Stop Shop
OXFAM	Oxford Committee for Famine Relief
PCC	Pacific Conference of Churches
PNG	Papua New Guinea
PPO	Permanent Protection Order
SHP	Southern Highlands Province
SV	Sexual Violence
SVRI	Sexual Violence Research Initiative
SWAp	Sector Wide Approach
TFR	Total Fertility Rate
UN	United Nations
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
WHO	World Health Organization

GLOSSARY.

Clan - Basic cultural unit that comprises extended family networks which form the primary unit of political and social loyalty (Hogbin 1973).

Family Support Center – Set of services provided to survivors of Family and Sexual Violence; these include medical, psychosocial, legal, and financial services (MSF 2010).

Intimate Partner Violence – “any behavior within an intimate relationship that causes physical, psychological or sexual harm to those in the relationship” (Krug *et al.* 2002, p89).

LMIC – Low Middle Income Countries is how the Worldbank classifies economies by gross national income (GNI) per capita. Low Income Countries (LIC) and LMIC are also sometimes referred to as developing countries. (Worldbank 2012a)

LNG Project – The Papua New Guinea (PNG) Liquid Natural Gas (LNG) project is a multi-million tonne per annum gas project of which the contributing gas fields are located in the Southern Highlands and Western Province. The gas will be transported through pipelines to the coast.

Melanesian culture – Anthropological term to distinguish culture from Micronesia and Polynesia.

Polygyny – The practice of having more than one wife at the time either through statutory, customary, religious or various forms of informal unions.

Patriarchal society – a system of society or government in which the father or eldest male is head of the family and descent is reckoned through the male line.

Raskol – young men, usually in groups, who engage property crime, violence and rape. (Harris 1988)

Sexual violence – “Any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic, or otherwise directed, against a person’s sexuality using coercion, by any person regardless of their relationship to the victim, in any setting, but not limited to home and work” (Krug *et al.* 2002, p149).

Tribe- aligned or related clan groupings (Reilly 2008).

Violence – “the intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community, that either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment or deprivation” (Krug *et al.* 2002, p11)

Violence Against Women – “any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life” (UN 1993, p3)

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ABSTRACT

Problem: Intimate Partner Violence (IPV) and Sexual Violence (SV) are a public health concern and a violation of human rights. It is estimated that worldwide 13-71% of women will suffer from SV or IPV at least once during their life time. In Papua New Guinea (PNG) roughly 2 million women are affected. Consequences of violence include physical injuries, emotional trauma and indirect consequences such as loss of productivity.

Objective and methods: This thesis identifies the main contributing factors to IPV and SV in PNG with special attention to the Highlands region through a literature review. The ecological model was used as analytical framework to organize contributing factors and best practices to prevent IPV and SV. Data from one Family Support Center (integrated model approach) illustrate some of the findings.

Findings: For the PNG context child abuse, alcohol, marital discordance, payment of bride price, peer pressure, break down of communities parenting practices, gender norms and the acceptability of violence all contribute to violence.

Valuable interventions are parenting classes to decrease harsh punishment of children and empowering strategies for women to address power inequalities within relationships. A community participatory approach that engages men is most effective for interventions at community and societal level. Survivor care is important and not widely available.

Conclusion and recommendations: The causes of IPV and SV are complex. Participatory approaches have better results and gender transformative programs are more effective than gender informative projects at the same time care for victims should not be forgotten. Survivor care should not take place in isolation but link to community participatory approaches. Interventions should be evaluated to increase knowledge of what works in PNG. The Department of community development has an important role for developing an overall strategy to address IPV and SV. Finally, more information is needed on the prevalence of IPV and SV to better understand the burden of disease they represent.

Keywords: Papua New Guinea, Violence against women, Ecological model, contributing factors, Best practice

Word Count: 12,707

INTRODUCTION.

The 1993 UN Declaration on the Elimination of Violence Against Women defined the concept of violence against women as: “any act of violence that results in, or is likely to result in physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life” (UN 1993, p3).

The typology of violence divides violence in 3 categories: Self-directed, interpersonal and collective. Each category is divided in physical, sexual, psychological and deprivation/neglect. This thesis will focus on interpersonal violence; more specifically intimate partner violence (IPV) and sexual violence (SV) perpetrated by men against women in Papua New Guinea (PNG). IPV is a subgroup of family violence and defined as: “any behavior within an intimate relationship that causes physical, psychological or sexual harm to those in the relationship” (Krug *et al.* 2002, p89).

Sexual violence (SV) is “any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic, or otherwise directed, against a person’s sexuality using coercion, by any person regardless of their relationship to the victim, in any setting, but not limited to home and work” (Krug *et al.* 2002, p149).

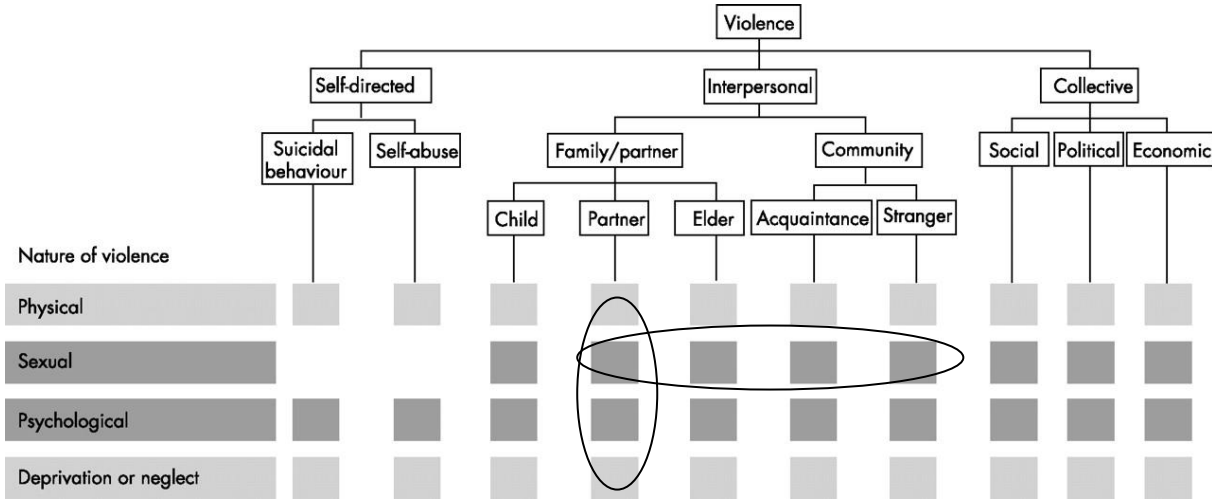


FIGURE 1 TYPOLOGY OF VIOLENCE, KRUG ET AL. 2002

Most of the research on violence against women focuses on IPV, the most common form of violence. IPV and SV share contributing factors with other forms of violence against women. Addressing these factors will therefore also refer to other forms of violence.

The Government of PNG considers Family Violence and Sexual Violence as a problem since surveys in the eighties revealed high levels of IPV and SV (Toft & Bonnell 1985).

From 2010 to 2011 I worked as Medical Coordinator for the Médecins Sans Frontières (MSF) mission in PNG. The focus of the mission was provision of medical and psychosocial care to survivors of violence using the “One Stop Shop” model. The PNG response to intimate partner and sexual violence was chaotic with different actors offering a variety of services.

This thesis attempts to organize contributing factors and possible interventions through application of the ecological framework. The ecological framework organizes factors at individual, relationship, community and societal level. The term “risk factor” is an expression of the public health discourse and “contributing factor” of a social discourse. In this thesis these terms shall be used interchangeably.

Chapter One will provide background information on PNG in relation to partner and sexual violence. The scope and magnitude of violence and study description are explained in Chapter Two. Chapter Three identifies contributing factors to IPV and SV in the Highlands of PNG with the help of the ecological model. In Chapter Four best practice prevention and treatment strategies are lined out as well as potential opportunities for PNG. Gaps identified will lead to the formulation of recommendations in order to improve the strategy on IPV and SV in PNG. Data of the Tari Family Support Center are used to identify groups most affected.

The vast tribal, linguistic and cultural variety in PNG cannot be captured in one thesis. This thesis will focus on patriarchal societies, more specifically the Highlands of PNG with a focus on Southern Highlands Province (SHP) where MSF supports a Family Support Center. Patriarchal societies in PNG report higher levels of violence against women. While both men and women use violence within relationships the consequences of violence against women tend to more severe (Toft & Bonnell 1985; Kopi *et al.* 2011). Most of this thesis will focus on IPV. Contributing factors for IPV and SV are however interlinked.

There is a vast body of research on IPV and SV. This thesis, however, adds to this body of research by critically reviewing contributing factors, best practice and promising interventions applied to the Highlands of PNG. I hope this thesis will be useful to those who involved in either prevention of or care for IPV and SV in PNG.

CHAPTER 1: BACKGROUND INFORMATION ON PNG

1.1. GEOGRAPHY

PNG is located in the Pacific north of Australia, east of West Papoea; west of Solomon's Islands, and has an area of 463,000 square kilometers. The landscape varies greatly with wetlands in the Sepik and Fly region, the Islands and coastal areas and the rugged Highlands inland. PNG is a country with few roads; the capital Port Moresby cannot be reached by road from the Southern region nor from the second largest city Lae or the Highlands. The terrain in the Highlands is so rough that for long the colonizers believed it to be uninhabited.



Figure 2. Map of PNG (World Maps 2005-2012)

1.2. DEMOGRAPHY

The population of PNG is estimated to be 7 million people based on the 2000 census with a 2.7% annual growth. Urbanization is ongoing, though an estimated 85% of the population still lives in rural areas (National statistical office Papua New Guinea 2002). International companies are developing natural resource projects in different areas of the country which contribute to internal labor migration. Larger cities such as Port Moresby and Lae have become melting pots with people from many different areas and tribes living together and intermarrying. PNG has a young population with 40% below the age of 15 years (National statistical office Papua New Guinea 2002). Different Christian religions (e.g., Catholic, Protestant, and Seventh Day Adventist) were introduced in rapid succession and the majority of citizens identify as Christian (Eves 2012).

1.3. GOVERNMENT

PNG was one of the last countries to be colonized and the colonizers had mostly a trade relationship with PNG. The Highlands only came in contact with the colonizers in the 1930ies. The country gained independence from Australia in 1975 and ever since has had an elected democratic government. Representatives of provinces are chosen directly into parliament. PNG has decentralized power and has given great autonomy to provinces. Implementation of policies is shaped through local practices in cultural and social manners.

In PNG women are underrepresented in parliament, where men occupy all but 2 of the parliamentary seats. There are few women in legal positions and women are three times less likely than men to have formal employment (Department of Community Development 2011). PNG ranked 140th out of 146 on the gender inequality index in 2011 (UNDP 2011). Within the parliament, violence against women is addressed as a community and development issue. PNG was one of the first developing countries to pledge to make domestic violence a punishable offence after the 1985 UN Women conference; however no law on domestic violence has been passed (Jivan & Forster 2007). Reinforcement of existing laws, including those of (sexual) assault is lacking (Coursen-Neff 2006)

1.4. SOCIO-CULTURAL.

The large cultural variety of PNG is illustrated by the over 800 different languages that are spoken and the more than 1,000 tribes that have been identified. Tribes differ greatly in customs and practices though four cultural regions are recognized: Islands, Southern, Momase and Highlands (Whittaker *et al.* 2009). Some tribes have a matriarchal organizational structure while the vast majority has a patriarchal structure characterized by inheritance via the male line, payment of a bride price resulting in an uneven access to and control of resources, and in an unequal power distribution within the community and marriage (Korare 2002). Men in certain parts of the Highlands have a hegemonic concept of masculinity and notions of sexual entitlement.

PNG has recorded high levels of family, sexual, community and tribal violence in absence of conflict (Dinnen 1996). The prevalence of violence varies between the regions. In some areas in Momase, family violence is practically absent (Mitchell 1999).

While traditionally violence was a way to restore order in some parts of the Highlands, urbanization has led to a breakdown of communities and a rise of community and criminal violence (Görlich 1999). Patterns in violence in PNG (tribal, domestic, sexual and self-harm) have changed over time. In the early to mid-nineties urban and tribal violence was so extreme in Port Moresby that a curfew was imposed (Josephides 1994). High levels of community violence are associated with higher prevalence of IPV (Görlich 1999; Raghavan *et al.* 2009). Theories about what causes

the high levels of violence in PNG tend to focus either on social issues to do with reemerging tribalism or to troubles adjusting to modern times and external influences (Josephides 1994).

The transition from a traditional society to a “modern westernized” society took place within decades. Until recent the Highlands had a culture of opposite gender avoidance where men and older boys lived in men’s houses. Nowadays men and women live together and, more importantly, men’s roles and duties have changed as territorial defense has become less important. Meanwhile women’s roles remain largely unchanged (Wardlow 2006). Polygyny is common; men aged 20-24 years, divorced or with higher education or men living in the Highlands are more likely to have multiple partners compared to other men (National statistical office [Papua New Guinea] and ORC Macro 2009).

Literacy is low with 40% of the population having no formal education (men 34,9% and women 44.5% - (National statistical office [Papua New Guinea] and ORC Macro 2009). In 2010, 12.9% of women and 24.4% of men had completed secondary education (UNDP 2011). The majority of teachers are male. On average 39% of teachers are female, this percentage is 50% in Port Moresby and 30% in SHP (National Department of Education 2009).

1.5. ECONOMY

Historically PNG did not have a cash economy. Goods and services were exchanged and shells and pigs were commodities for exchange. A cash economy gives to those who own cash more power than to those who do not. The Gross National Income (GNI) in 2011 was \$1,480 classifying PNG as a Lower Middle Income Country (LMIC) (Worldbank 2012b). Approximately 37% of the population live below the poverty line (World Bank 2012a). PNG experienced annual economic growth varying from 4% to 8% since 2002 and it is expected that this trend continues for the coming years (Martin 2011). Eighty five percent of the population lives from subsistence farming. The department of community affairs issued a policy to improve financial inclusion specifically recognizing that women are overrepresented in the informal economy (Department of Community Development, 2011).

1.6. HEALTH SYSTEM

Total expenditure on health was \$82 per capita in 2010 and this amounted to 3.6% of the Gross Domestic Product (GDP) or 8.1% of total government expenditure. Just over 70% of health expenditure is government expenditure (WHO 2011). PNG adopted the Sector Wide Approach (SWAP). In theory this means that the government decides where to put the donated funds and donors have little influence on priorities and policies. In practice however, the Australian Aid agency (AUSAID) has an influential presence.

The health system is decentralized and the provincial level is responsible for budgeting, planning and implementing activities. There is a shortage of medical personnel that is more pressing for doctors than nurses and that strains implementation of policies and activities (WHO 2006a). Health facilities are concentrated in urban areas and a third of the rural health posts are rundown or closed. The system works with user fees although identified IPV and SV survivors are exempted.

Health priorities are outlined in the National Health Plan (NHP). The latest NHP had the provision of survivor care as one of its priorities¹ (Government of PNG 2010). Within the National Department of Health (NDoH) IPV and SV are under the responsibility of reproductive health. The Health system links with other sectors through the (independent) Family and Sexual Violence Action Committee (FSVAC) that is tasked with the implementation of Family Support Centers (FSC), awareness raising, and with being the link between different disciplines (AUSAID 2007). FSVAC is, however, not responsible for the overall development and implementation of a multi-sectorial and multi-level approach to IPV and SV.

1.7. HEALTH

PNG is facing a double burden of disease and non-communicable diseases account for 45% of the overall disease burden. Top morbidities are malaria, tuberculosis and diarrheal diseases. Accidents and injuries were the third leading cause for hospital admission in 2008. (Government of PNG 2010) The maternal mortality ratio of 733/100.000/live births is a concern (National statistical office[Papua New Guinea] and ORC Macro 2009; WHO 2010). Health indicators vary between regions and between urban and rural areas.

1.7.1. REPRODUCTIVE INDICATORS

On average a women in PNG will have 4.4 children (The desired number of children is 3.6 for women, 4.0 for men). Over the last 20 years there is a trend of women becoming mothers at younger age in the Highlands. The average sexual début for women in PNG is 18.7 years median and 19.5 years for men. In the Highlands women have their début at the age of 18.4 and men 19.6. Lower education level is associated with lower age of sexual début. Men have become sexually active 2 years earlier than 25 years ago; for women this is only 3 months. The median age for women to start child bearing is 20.5 years overall and 20.1 years in the Highlands; this is late compared to other Low Middle Income Countries (LMICs).

However, about one fifth of women marry between the ages of 15-19 years. Nearly 14% of Highland women have begun childbearing before

¹ Objective 7.1: Increase health sector response to prevention of injuries, trauma, and violence with an impact on families and the community." (Government of PNG, 2010. PNG national health plan 2011-2020(p 28)).

the age of 20. Teenagers with no education more often have children at an earlier age (20.8% vs. 11.2% have their first child when aged 15-19 years). There is a low uptake of family planning services, a large unmet need for family planning of 41.3% and a discrepancy between the desired and actual fertility rates (National statistical office[Papua New Guinea] and ORC Macro 2009). Access to family planning services is restricted due to stock ruptures, attitudes of health workers and husbands (Hayes 2010).

	PNG	Rural	Urban	Highlands
Maternal Mortality ratio	733/100,000 live births/year	N/A	N/A	N/A
<5 Mortality Ratio (1000/year)	74.7	79.0	42.0	90.0
Average number of children	4.4	4.5	3.6	3.9
Age delivery first child (years)	20.5	20.3	21.0	20.1
Desired number of children women	3.6	3.7	3.2	3.8
Desired number of children men	4.0	4.1	3.5	4.3
Uptake of Family Planning	32.4%	30.5%	44.1%	22.9%
Desired vs. Actual Total Fertility Rate (TFR) in preceding five years.	3.0/4.4	3.1 / 4.5	2.6 / 3.6	2.6 / 3.9
Unmet need for Family Planning ²	44.1%	44.3%	42.1%	41.3%
Polygamous marriages	18.3%	18.2%	18.7%	28.6%
Age of First marriage (years)	19.5	19.7	20.5	18.9
Sexual début women (years)	18.7 overall	18.6	19.5	18.4
High education level	19.7			
Low education level	18.4			
Sexual début men (years)	19.5 overall	19.4	19.6	19.6
High education level	19.2			
Low education level	20.2			

Table 1: Key indicators from Demographic and Health survey 2006 (National statistical office[Papua New Guinea] and ORC Macro 2009)

² Unmet need for family planning refers to women in union who do not use contraception and do not want another child (yet), are undecided or don't know.

CHAPTER 2: STUDY OVERVIEW

2.1. PROBLEM STATEMENT

IPV is considered a manifestation of gender inequality and additionally sustains existing power imbalances. The reasons behind IPV and SV are complex and encompass factors at individual, relationship, community and societal levels. It has been discussed that in patriarchal societies men use violence to affirm their role as head of the household and punish insubordination; this is however influenced by social definitions of masculinity and community approval of IPV (Watts & Zimmerman 2002).

IPV is often a combination of physical, sexual and emotional abuse. Most of the available data on prevalence come from cross-sectional studies from developed countries (Alhabib *et al.* 2009).

The 2005 World Health Organization (WHO) report on domestic violence included survey data collected between 2000-2003 from 12 LMICs and reported life time prevalence of physical IPV from 13% in Japan to 61% in Peru. Either SV or physical IPV ranged from 15%-71% with the highest rates in rural areas of Bangladesh, Ethiopia, Peru and Tanzania. Samoa, the only Melanesian country in the sample was also the only country to report high life time prevalence of non-partner physical and /or sexual violence in addition to IPV (García-Moreno *et al.* 2005). Kopi *et al.* also described high levels of non-intimate partner violence in addition to IPV in PNG (Kopi *et al.* 2011). These findings illustrate that violence in the pacific region is, in many aspects, pervasive in a woman's life.

Contrary to IPV, information on SV perpetrated by strangers is scarce and originates mostly from police and justice reports and passive surveillance data from health care institutions. Yet, most violence against women is not perpetrated by strangers. Even in wartime SV by strangers is much less common than IPV (Stark & Ager 2011). The majority of survivors of violence do not seek justice. Worldwide it has been described that the justice system is not assisting survivors of violence and that women often fear law enforcers, face being dishonored by communities, and court cases take too long (Amnesty international 2005). In PNG this is not different and most survivors do not seek justice (Coursen-Neff 2006).

A study conducted by the PNG law reform commission 25 years ago reported that 67% of women stated they were being beaten by their partner and 66% of men admitted beating their spouse (the study focused on physical IPV) (Toft & Bonnell 1985). A more recent study amongst women accessing antenatal care and voluntary counseling and testing services found a 58% prevalence of physical and/or sexual IPV (Lewis *et al.* 2008). The author was unable to find evidence of a recent population based survey on the topic. Accidents and injuries are a leading cause for hospital admission but the information does not discriminate between

intentional and non-intentional injuries nor does it report on sex of the patients (Government of PNG 2010).

The consequences of IPV and SV include physical injuries, unwanted pregnancies, and emotional trauma including depression, post-traumatic stress disorder, and suicide. Prevalence of HIV is higher amongst victims of IPV than in the general population (Jewkes *et al.* 2011). Physical injuries require medical care for 40-70% of women suffering from violence. Results of violence include self-reported ill health, pain, memory loss, emotional distress, suicidal thoughts and attempts (Ellsberg *et al.* 2008; Devries *et al.* 2011). As well as negatively impacting health, violence breaches human rights and brings along costs due to increased service utilization and absence from work. (Ulrich *et al.* 2003; Koss *et al.* 1990). Violence against women is increasingly seen as a risk factor for various conditions amongst victims such as smoking and alcohol abuse (Campbell 2002). Toft found that 29% of women and 13% of men have visited a health service after a domestic dispute (Toft & Bonnell 1985).

2.2. JUSTIFICATION

Violence comes with a cost to society. In addition to direct costs related to violence (hospital bills and legal services) there are considerable indirect costs such as lost productivity and lost investment in human capital (Rutherford *et al.* 2007). Levels of violence in PNG have reached such levels that violence hampers development of the nation and interferes with the achievement of the Millennium Development Goals (AUSAID 2007).

While many activities are undertaken to prevent and condemn IPV and SV, overall coordination is weak (Ellsberg *et al.* 2012). The response to family and sexual violence in PNG is multi-pronged and includes prevention through participative community sensitization, the installment of the Family and Sexual Violence Action Committee (FSVAC), training of (female) police officers, and the setup of Family Support Centers (FSC). Not much is known about the effectiveness of the different campaigns and scaling up of activities is lagging behind as well. Ten years after the introduction of the FSC initiative services are still unavailable in most parts of the country including the capital. Less than 10 FSCs have been set up and services provided vary greatly (MSF 2010).

Violence and its response do not take place in isolation. Root causes of Family and Sexual Violence (FSV) are often ignored in research (Counts, Brown, Campbell 1999). This thesis will therefore analyze contributing factors of IPV and SV in the context of PNG, provide a review of best practices worldwide and their counterparts in PNG, and provide recommendations that build on the strategy addressing IPV and SV in the PNG context.

2.3. METHODS

2.3.1. OBJECTIVES:

Overall objective:

Analyze current strategy applied to prevent IPV and SV in the PNG context using a literature review and analysis of primary data from a Family Support Center (FSC) with the aim to formulate recommendations to further develop prevention and treatment strategies.

Specific objectives:

1. Describe the scope and magnitude of IPV and SV in the Melanesian context with special attention to the patriarchal societies in PNG.
2. Report on the characteristics of the survivors presenting to the FSC in Tari and compare to what is known on the types and contributing factors of IPV and SV in PNG.
3. Analyze the evidence on what influences the contributing factors and their consequences and apply findings to the Papua New Guinean context.
4. Formulate recommendations in order to improve strategy addressing IPV and SV in PNG.

2.3.2. METHODOLOGY

This thesis consists of a literature review that includes both published and grey literature. Primary data from a Family Support Center are compared with the outcomes of the literature review. A phased search strategy was carried out. Findings are organized under subheadings that correspond to the analytical framework.

2.3.3. SEARCH STRATEGY

Science Direct, Scopus and Google Scholar were searched for articles related to prevalence, reasons for, and lessons learned of programs designed to prevent or treat consequences of IPV and SV worldwide, in the Melanesian context and in Papua New Guinea. The search was repeated with different search terms after reviewing the found literature. Websites of the government of Papua New Guinea, UNWomen, Guttmacher institute, Sexual Violence Research Initiative (SVRI), United Nations Population Fund (UNFPA), AUSAID, Amnesty International, Human Rights Watch, Committee on the Elimination of Discrimination Against Women (CEDAW), and the WHO were also searched for relevant documents. Preferential searching for literary reviews and systematic reviews was done.

Key words: intimate partner violence, gender-based violence, violence against women, spousal violence, domestic violence, wife beating, wife abuse, spousal abuse, sexual violence, rape, Africa, Asia, Melanesia, Melanesian, Papua New Guinea, developing countries, strategies, patriarchal, Highlands, bride price, alcohol, drugs, cannabis, marijuana, prevalence, prevention, effectiveness, one stop shop, survivor care,

lessons learned, lessons learnt, family support centers, education, community, risk factors and contributing factors.

2.3.4. DATA FROM TARI FSC

The Tari FSC was set up in the Tari district hospital by MSF in September 2009. Information on the number of consultations, nature of the abuse and medical care are routinely collected for program monitoring and evaluation purposes. Data from the FSC were used to illustrate personal risk factors.

In the first 2,5 years the center treated 2,177 survivors of family, intimate partner and sexual violence (about 80/month). Out of the 2,177 survivors 107 were men (5%). Female victims of IPV account for 48% and survivors of SV for 20% of patients seen; Family Violence accounts for 32% of patients seen.

2.3.5. CONCEPTUAL FRAMEWORK: THE ECOLOGICAL FRAMEWORK

The integrated ecological framework from Heise (Heise 1998) explains violence against women taking into account personal, intra relational, community and societal level factors. The model consists of four nested ovals of which the outer and largest circle stands for societal level, followed by the community level, relationship level and individual level circles (Fig. 3). Risk factors for violence against women can be organized by level.

For purposes of this thesis, relevant risk factors have been identified for each of the levels. At the Individual level personal history and behavioral factors that increase the likelihood to become a victim or perpetrators have been defined. At relationship level risk factors include close relations whereas the community level describes the context in which relationships are embedded such as neighborhoods. The Societal level comprises larger societal factors that enable violence and include norms and beliefs. Organizing contributing factors using the ecological framework will facilitate understanding of a complex problem in a systematic way and will structure preventative measures accordingly.

An important application of the ecological framework is "Preventing intimate partner violence and sexual violence against women: taking action and generating evidence" published by the London School of Hygiene and Tropical Medicine (LSHTM) and the WHO published in 2010. The ecological framework was used to organize over 50 contributing factors and possible interventions that could reduce violence against women (LSHTM/WHO 2010). This document has been a valuable resource for this thesis.

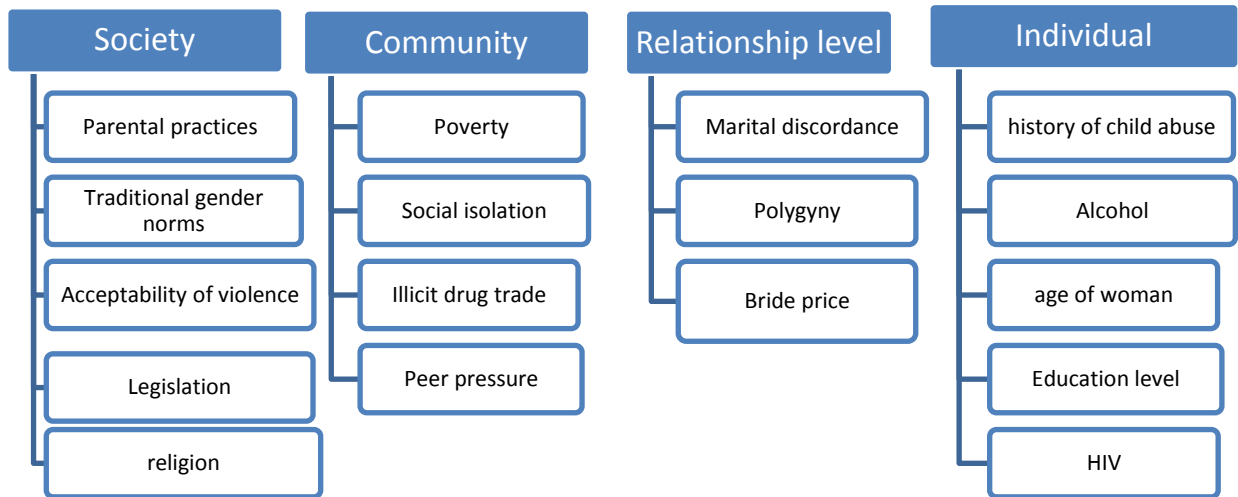
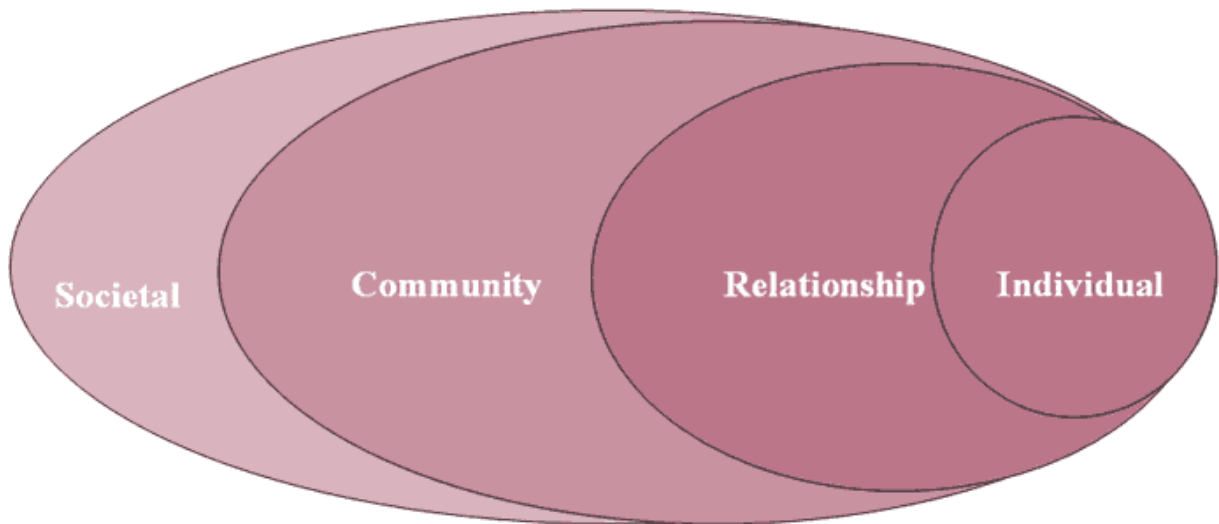


FIGURE 3 ADAPTED FROM HEISE 1998

CHAPTER 3: CONTRIBUTING FACTORS TO IPV AND SV IN PAPUA NEW GUINEA.

This Chapter describes contributing factors to IPV and SV using the ecological model.

3.1. INDIVIDUAL

3.1.1. HISTORY OF VIOLENT BEHAVIOR, PREVIOUS ABUSE

Men abused as children or who witnessed violence have a greater risk of becoming perpetrators. Similarly women who witnessed violence as children have greater risk of becoming victims (Gil-González *et al.* 2008; Rutherford *et al.* 2007). Harsh punishments and poor parenting influence social learning and gender socialization. Children from these families learn that violence is a way to resolve conflict and have an increased likelihood of being traumatized (Heise 2011). PNG is one of the few countries in which child corporal punishment at home or at school is legal (Human Rights Council 2011). Corporal punishment of children is common.

3.1.2. ALCOHOL

Alcohol abuse by men is a risk factor for perpetrating violence against women (WHO/LSHTM 2010). While alcohol does not cause violence against women the consequences of the violence tend to be more severe. Women abusing alcohol face a greater risk of being victims (Gil-González *et al.* 2006). Papua new Guineans do not have traditional alcoholic beverages. During colonization the native population could not legally access alcohol and homebrew started (Marshall 1999). Only after independence in 1975 alcohol was legally obtainable.

Toft and Bonnell found that alcohol was a common reason for marital dispute although it was not related to violence. This might however have to do with the limited availability of alcohol in PNG at the time of the research (Toft & Bonnell 1985). Nowadays alcohol abuse is common, often reason for marital dispute (Government of PNG 2011). Alcohol is often combined with the use of stimulants as betel nut and associated with violent behavior (observation author).

3.1.3. AGE OF WOMAN

Young women are more at risk than older women for both IPV and SV (Jewkes *et al.* 2002; WHO/LSHTM 2010). There is a link between violence experienced in teen years and victimization by intimate partners in later life (O'Donnell *et al.* 2009). The fact that older women in general experience less IPV is possibly due to their changed position within the household as mother, mother in law or grandmother. PNG does not follow

this pattern. Amongst women accessing antenatal care facilities those who suffered from IPV were slightly older than those who did not (Lewis *et al.* 2008). Bearing children is a way of obtaining agency for women in the Highlands. Therefore women want to have more say when they have born children because they “paid for their bride price”. This change in dynamic causes an increase of marital disputes leading to IPV. (Wardlow 2007).

Since the opening of the FSC in Tari 2,177 victims of violence were seen. Of these, 48%, thus 1,049 women were treated after IPV. In Tari IPV is less prevalent or less often reason to seek care in younger than in older women. The age brackets from 25-29, 30-34 and 35-39 are over-represented indicating that IPV increases after the early years of marriage to decrease when women approach menopause (Figure 4). During pregnancy women are less likely to suffer from IPV. Based on analysis of DHS data, IPV prevalence during pregnancy is highest in the age bracket 20-24 years. This is more often the first pregnancy (Devries et al. 2010).

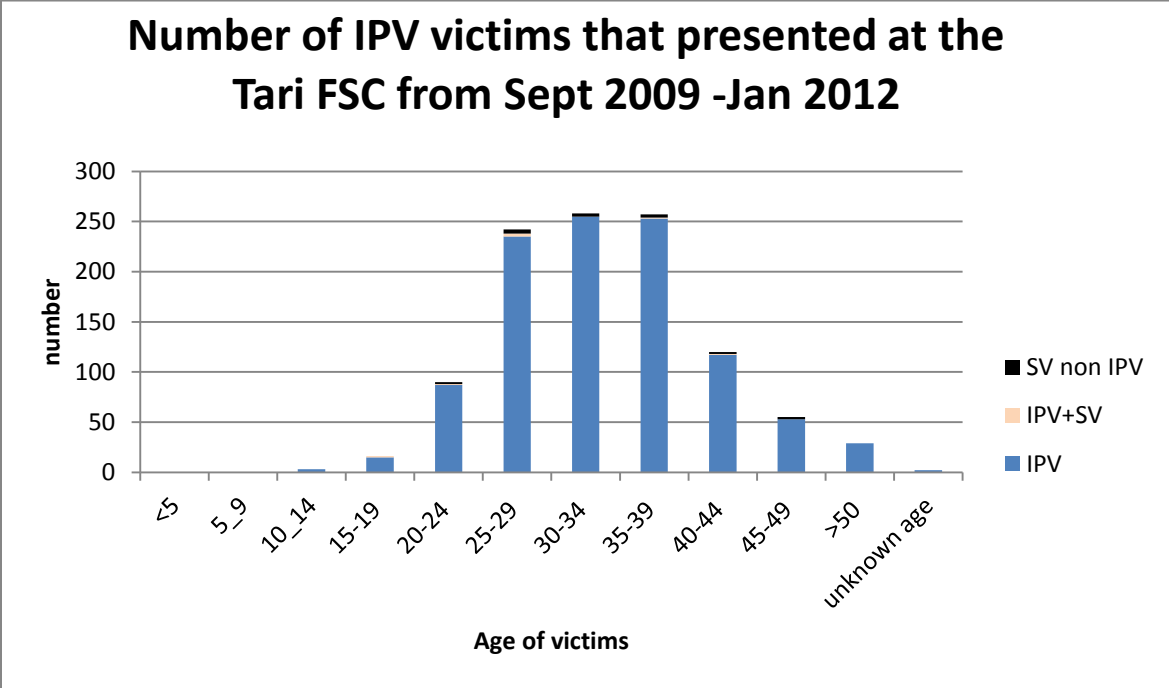


Figure 4: Number of women that presented to Tari FSC after IPV.

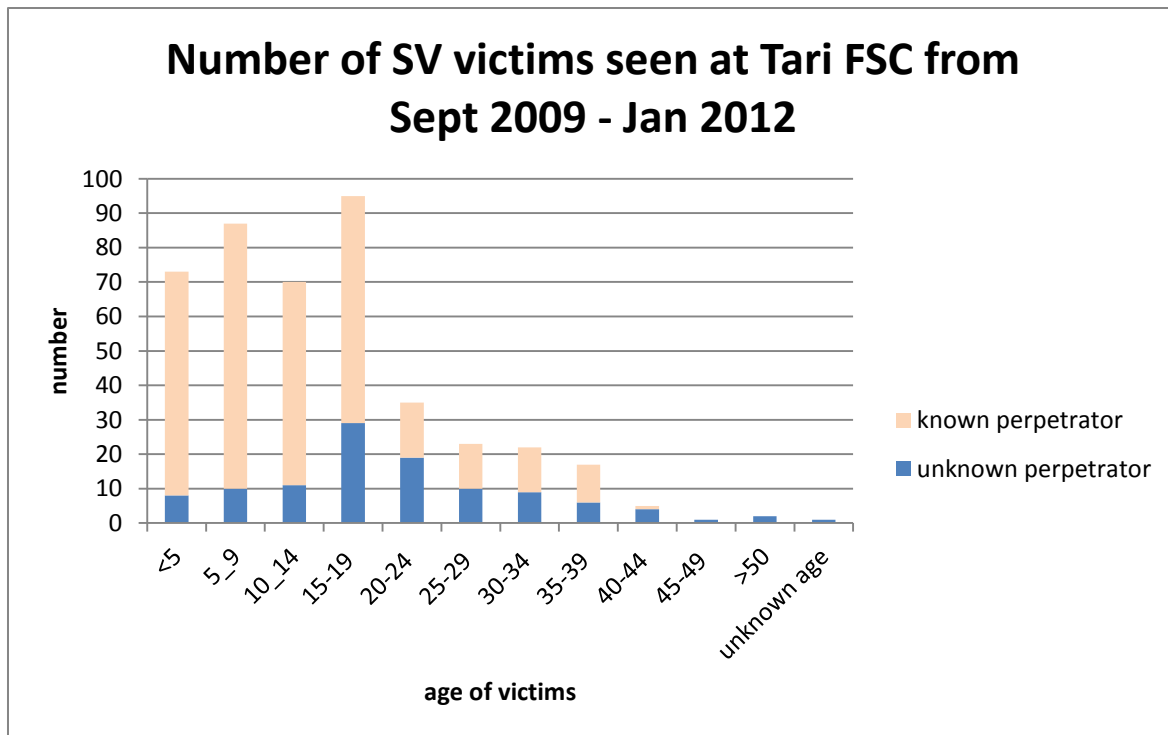


Figure 5: Women presenting to Tari FSC after SV (non IPV).

On the other hand, women who are not married and not protected by a husband are seen as available and more prone to be victims of SV (Wardlow 2006). Therefore, young women are more prone to SV than older women and this is confirmed by data from the Tari FSC. Four hundred thirty one women presented at the clinic after SV of which the vast majority was below the age of twenty (see Figure 5). These findings are consistent with findings by Haley and Muggah who reported that in Tari over 75% of SV victims were younger than 20 years. (Haley & Muggah 2006)

3.1.4. LEVEL OF EDUCATION OF BOTH PERPETRATOR AND VICTIM

Low education level is linked to both IPV and SV (WHO/LSTHM, 2010). Education often improves the socio-economic position of women and adds to female empowerment. However, higher levels of education of men do not protect against the occurrence of IPV (Morrison *et al.* 2007). Having said that, in education discordant couples in which women are the more educated half, high education levels of women can trigger IPV (Eves 2007; Spark 2011; Boyle *et al.* 2009). Women in PNG have a domestic and reproductive role in addition to duties to work the land. Modesty is valued while being educated is not. Therefore being an educated woman can be seen as being 'bighead', and challenges gender roles (Wardlow 2006; Spark 2011). Educated women are not only more vulnerable to IPV if they choose to engage in relationships but also when single they have a high(er) risk of being targeted for violence and SV (Spark 2011).

3.1.5. HIV INFECTION

The nature of the relation between HIV and IPV is not well understood. Several studies do show that men who are HIV positive more often perpetrate IPV and therefore victims of IPV are more often HIV positive than the general population (Jewkes *et al.* 2008; Shamu *et al.* 2011). SV is common in PNG and it is argued that rape contributes to the spread of HIV in PNG (Eves 2011; Reid 2009). Jewkes *et al.* studied the relation between gender based violence and HIV in South Africa, a country where both SV and HIV are highly prevalent. A relation between HIV infection in men and perpetration of rape could not be established in that context. Possibly because both HIV infection and rape were highly prevalent (Jewkes *et al.* 2011). The data on HIV prevalence in PNG are not so reliable and are estimated at around 2% of the population (Vallely *et al.* 2010). It is likely that true HIV prevalence is higher than this.

3.2. RELATIONSHIP LEVEL

3.2.1. MARITAL DISCORDANCE

If the power imbalance in a relationship is more distinct men act more violently. Physical violence is often accompanied by sexual violence (Garcia-Moreno *et al.* 2006). Data of the Tari FSC do not show this tendency although Kopi *et al.* found that many women in Tari get beaten by their husbands for refusal of sex. (Kopi *et al.* 2011)

When men migrate to urban areas they fear losing control over their wives and this "jealousy" leads to the use of violence with the aim to regain control (Wardlow 2006). Nowadays women oppose their husbands more, attributing to conflict that could explain the increase in IPV (Toft 1986). PNG men embrace tradition more than women (Josephides 1994) and the viewpoints of men and women differ on the amount of control a husband should have over his spouse (Bradley & Kesno 2000).

Sexual jealousy is an expression of male ownership over their wives' sexuality. While gender separation was traditionally the norm, nowadays there is more interaction between men and women. Jealousy rose in Highland societies since the traditional culture of gender avoidance was breached. Sexual jealousy can be caused by something as simple as women receiving betel nut from a man who is not a relative. Women can retaliate by not performing their duties, a form of negative agency; that then leads to more violence (Wardlow 2006).

Many disputes involve money and men feel that women do not need money when they do not yet have children (Wardlow 2006; Koczberski 2007). Kopi *et al.* found that money was an important cause for marital dispute as was jealousy over money or sexual jealousy (Kopi *et al.* 2011).

3.2.2. POLYGYNY

Bride price and polygyny are both common in PNG and they underline the concept of the woman as property stressing gender inequalities (Dinnen

1996). Marriage can be according to custom or to general law. Bigyny or polygyny is not allowed when married under statutory law. Overall the proportion of men having more than one wife is decreasing. Older women more often have one or more co-wives compared to the younger age brackets. In the Highlands polygamous marriages are more common than in the rest of PNG. Thirty percent of marriage or unions are polygamous in the Highlands compared to 12% in the Southern region (National statistical office [Papua New Guinea] and ORC Marcro 2009).

3.2.3. ARRANGED MARRIAGES AND BRIDE PRICE

Paying bride price is common practice and bride price inflation has put a strain on a man's ability to marry. A future husband in the highlands has to pay up to three times as many pigs as 20 years ago (Wardlow 2006). The clan is often involved by arranging the marriage because of bride price practice (Feil 1987). Most marriages in the Highlands are arranged and about a third (35.1% men, 33.9% women) of the rural population do not like their spouse (Toft 1986). This probably enhances marital discordance. Payment of bride price enhances the notion of sexual entitlement of husbands over their wives. Women have little room for negotiation about sexual intercourse and refusing sex is an important cause for IPV (Bradley & Kesno 2000; Eves 2011; Wardlow 2007; Eves 2007). While bride price is not a new phenomenon in PNG traditionally the family of the bride would be involved in marital conflict resolution. Nowadays however women can be married out for cash or pigs putting them in a marriage in which they have little to say without a family willing to defend their interest (Schoeffel 2009).

3.3. COMMUNITY LEVEL

The large variability in cultures makes it difficult to generalize factors at community level. Community level in this context can be seen as village or area of town level.

3.3.1. POVERTY

Poverty is recognized as a contributing factor to IPV though nature of the link between poverty and IPV is not well understood (WHO/LSHTM 2010). In PNG however levels of violence did not differ between low and high income groups. Interestingly money is just as much a cause for marital problems in rich as in poor families. Money is supposed to be shared with relatives, so more money means more demands (Toft & Bonnell 1985).

Low income and unemployment are linked to higher rates of IPV. Low self-esteem caused by unemployment and failure as breadwinner of the family is linked to higher rates of IPV (Taft *et al.* 2009). Urban poverty, social disorganization and codes of the streets enhance IPV. Migrated men who did not succeed in the city and who return to the rural area are regarded as drop-outs and failures (Toft 1986).

The multi-million LNG project that encompasses the extraction and transport of liquid natural gas from the Highlands to the coast will become an important employer. While some land will be lost for gardening and “sacrificed” to the gas project, the project will create paid unskilled labor opportunities. Cash will become more important at the same time that there will be less land to work on for women impeding their duty to grow staple crops. Simultaneously duties of men will change when they seek paid labor and no longer grow cash crops. Transition of gender roles and the associated shift in power balance often adds to marital discordance (WHO/LSHTM 2010).

3.3.2. SOCIAL ISOLATION.

The Wantok system (Pidgin for “One Talk”) is an intercommunity social system that connects people who share the same language. Wantoks have a role in conflict resolution and intervene when a husband becomes very violent with his spouse. With the migration of people this social safety net weakened, making women more vulnerable (JICA, 2010).

Keeping up appearances is a form of social isolation that favors the occurrence of IPV. Rich urban couples keep marital problems private if at all possible. Where poorer couples seek help from relatives, church or neighbors the rich try to resolve problems themselves. In rural areas it is common for neighbors, often wife’s relatives, to intervene. Toft and Bonnell found that three quarters of interviewees would intervene in marital disputes (Toft, S. & Bonnell 1985). Living with extended family is a protective factor for IPV (WHO/LSHTM 2010). Due to the erosion of social cohesion neighbors are less likely to intervene if a fight gets out of hand. In urban areas Wantok support is weak, enabling the occurrence of IPV. Urbanization is ongoing in the Highlands through the rise of resource industry.

3.3.3. ILLICIT DRUG USE AND TRADE.

Drug use increases the risk of violence for both perpetrator and victim. Consistent marijuana use has been linked to a 1.2 - 2.4 times higher risk of being perpetrator or victim of IPV in the United States (Reingle et al. 2012). It is not known how marijuana affects IPV in PNG. Marijuana, however, is illegal and used by “raskols” to become ‘wild’. Marijuana is widely used in PNG and the drug trade, more specifically the marijuana trade, is linked to crime and leads to community violence (Thomas 2006; Caldwell & Isaac-Toua 2002).

3.3.4. PEER PRESSURE

Men who have multiple concurrent sexual partners are more likely to perpetrate IPV and/or SV (Johnson & Das 2009; Jewkes *et al.* 2006). Research also shows that men who have peers that perpetrate violence are often also more violent within their relationships (Raghavan *et al.* 2009; WHO/LSHTM 2010).

In Tari extramarital sex was until 40 years ago not accepted for either men or women. Sex was for reproductive purposes and self control was

valued. Nowadays extramarital sex, where men have sex with “available women”, is accepted as part of male bonding (combined with consumption of alcohol and gambling) Extramarital sex is valued amongst men in the Highland cultures while this is not the case for women (Wardlow 2007; Jenkins 2006; Wardlow 2002).

When cohesion and efficacy of communities decreased groups of violent men, or “Raskols” could come into existence (Dinnen 1996). Raskols have rites of passage including the “line up”, where multiple young men rape a girl (Jenkins and NSRRT 1994; Wardlow 2007). Gang rape as part of rites of passage or as form of punishment have been described outside conflict zones in South Africa, Papua New Guinea and the United States. Gang rape can be seen as an extreme form of male sexual entitlement and illustrates male/female power relationships (Jenkins 2006; Kopi *et al.* 2011).

3.4. SOCIETY LEVEL

3.4.1 PARENTING PRACTICES

Traditionally boys were raised to be warriors and had an important role in defending the territory. In order to fulfill this role physical aggression was part of the socialization of boys who lived in male houses separately from women. Women raised boys till they were able to live with men (Toft 1985). Children below the age of seven were not expected to follow any rules and were not disciplined (Langness 1981 quoted in Counts 1990).

Parenting practices altered in the Highlands when living arrangements changed. Boys are no longer raised by men to become warriors. However, lack of discipline in young children still exists and is now no longer corrected at a later stage through living in men’s houses contributing to maladaptive coping strategies for conflict at a later age. The transition to adulthood is up till now initiated through rites of passage and this underlines the importance of masculinity (Eves 2011).

3.4.2. TRADITIONAL GENDER NORMS AND ROLES

Unequal distribution of power within relationships and in society in favor of men, and acceptability of violence are strongly linked to IPV and SV (WHO/LSHTM 2010). In the Highlands of PNG men are seen as powerful and protector of land and women. At the same time they are vulnerable and can be harmed by contact with women (Wardlow 2006). Women in the Highlands of PNG provide the daily needs of the family as “gardening” of staple food, taking care of children, house and pigs (Toft & Bonnell 1985; Toft 1986). Although tasks of men can be difficult, men usually have more freedom to arrange their time. Men are responsible for digging the trenches or paths to the fields, growing cash crops and territorial defense.

While women work the land and are foremost responsible for staple crop cultivation they do not own the land they work on. In traditional patriarchal societies inheritance is through the male line (Government of PNG 2009; JICA 2010). Since men have migrated out of the Highlands in search of paid labor or abandoned gardening for other activities, women have become more responsible for all gardening. This redistribution of tasks has led to strained marriage relations (Wardlow 2006). The economic dependency caused by limited access to resources by women limits their negotiation space, stressing power imbalance and increasing the risk of IPV (Bradley & Kesno 2000).

3.4.3. SOCIAL ACCEPTABILITY OF VIOLENCE

The law reform commission research looked into acceptability of IPV in different areas of PNG and found that overall 66.5% of men and 56.6% of women found it acceptable that a man beats his wife (the most commonly given reason was that wife was not fulfilling her obligations). The reverse, a woman beating her husband was slightly less accepted by both (52.9% and 46.8%). Self-defense was given as the most accepted reason for women to beat one’s husband (Toft 1986). These findings illustrate the acceptability of violence as conflict resolution (see Table 2 and 3). The population based study was not repeated so the most recent information on this topic originates from 1985.

Table 2: Is it acceptable for a wife to beat her husband?

	Rural		Urban low income		Urban elite	
Response	male	female	male	female	male	female
Yes	53.3%	45.1%	44.1%	33.2%	38.8%	37.4%
No	46.7%	54.9%	55.9%	66.8%	61.2%	62.2%

Table 3: Is it acceptable for a man to beat his wife?

	Rural		Urban low income		Urban elite	
Response	male	female	male	female	male	female
Yes	67.5%	57.0%	42.3%	25.3%	41.2%	36.4%
No	32.5%	43.0%	57.7%	74.7%	58.8%	63.6%

Source (Toft 1986)

3.4.4. LEGISLATION

When domestic violence is not punishable it leads to impunity, aggravating the problem. The justice system in Papua New Guinea does not provide for survivors of violence reporting. Attitudes of police officers and few cases being taken to court result in few survivors reporting (Mcleod 2002; Coursen-Neff 2006).

A call for speeding up the process on legislation making IPV a punishable offence was made in 1986 (Toft 1986). In 2010 the CEDAW was disappointed to see that the “Family Protection Bill” was still pending (CEDAW 2010). Since 2009 it has been possible to get an “Interim or Permanent Protection Order” (IPO/PPO) (Ellsberg *et al.* 2012). In 2007

the Lukautim Pikini Act (child protection bill) was passed making child abuse and neglect, child illegal and punishable offences. The attitude of the police force towards IPV and SV is not keeping up with changes in legislation, which is hampering implementation and reinforcement of existing laws (Coursen-Neff 2006).

Only if the village elders cannot resolve the issue they refer the couple to the village court where it can then be solved according to customs of the specific Wantok (Toft 1986). Village courts are involved in conflict resolution, deciding on payment of compensation and will often reinforce the subordination/inferior position of women (Dinnen 1996). In the author's view a greater involvement of the community is a locally accepted way of dealing with partner violence. However the referral to village court is seen with skepticism. These courts most often favor men and hardly give the floor to women. Nevertheless gender equity has improved and many village courts now have a female magistrate (AUSAID 2007; Toft 1985; Ellsberg *et al.* 2012). Notwithstanding the weaknesses of the village courts, the largest proportion of marriage disputes filed to these courts is done so by women. (Toft 1985). This has to do with the accessibility of the village courts that are located in the communities as opposed to formal courts that are a bus ride away and often unaffordable. Divorce is possible for marriages under general law and can be filed by both men and women. Under customary marriage, when the bride price was paid is it difficult for women to file for divorce. The family of the bride would have to reimburse the husband. The husband most often keeps the children.

3.4.5. RELIGION

Belonging to an association, such as a church, is a protective factor for IPV (WHO/LSHTM 2010). In the last century new influences such as Christianity, western education, modern media, urbanization and labor migration impacted views on gender (Eves 2012). Over 95% of PNG identifies as Christian in addition to the influence of the traditional notions. Some forms of Christianity in PNG try to influence masculine behavior by promoting non-violent forms of masculinity. Public language and documents are full of references to Christian values. Christianity is mentioned in the national anthem and constitution. Because of its influential position the church has a role to play in addressing violence against women.

The Catholic Church has publicly stated since 1987 that a marriage should be a contract between two equals and there was no place for violence in marriage. Additionally the bishops stated that bride price payment did not allow men to beat their wives (Bradley 1990 quoted in Eves, 2012). Some churches expel members of the church or prohibit them from fulfilling public functions for a certain period if they engage in domestic violence.

However, not all Church initiatives were helpful in limiting violence against women. For example some of the Catholic Church initiatives such as Papa

Groups in some highlands locations were merely focused on reasserting male authority and not on decreasing family violence (Eves 2012; Ellsberg *et al.* 2012).

New forms of Christianity such as the "Born again Christians" are upcoming in PNG and can be considered fundamentalist because they believe in absolute accuracy of the Bible. However they respect considerable gender equality and moreover denounce alcoholic drinks and extramarital affairs, violence and actively practice generosity and compassion (Eves 2012).

CHAPTER 4: REVIEW OF ACTIVITIES ADDRESSING IPV AND SV IN PNG AND EVIDENCE OF BEST PRACTICE

In the following Chapter first the existing response to IPV and SV in PNG is summarized. In addition to the activities already taking place in PNG several best and promising practices exist that address different contributing factors of the ecological model that is used to outline the thesis. Results of program evaluation are included when available.

4.1. RESPONSE TO IPV AND SV IN PNG

Many initiatives addressing violence and its consequences take place in PNG. There is however no overall strategy that addresses IPV and SV and there is little coordination (Ellsberg *et al.* 2012). At the individual level the provision of survivor care initiated by the health sector aims to provide survivor care through the roll-out of FSC. These FSCs provide medical and psychosocial care and link where possible with other organizations including the police and legal system. The FSC in Tari is considered promising practice in the field of survivor care in PNG (Ellsberg *et al.* 2012).

Women who left their spouse and cannot return to their kin can, in some areas, benefit from safe houses. Examples are Haus Ruth in POM, Mary Seif Haus in POM and Lae, Salvation Army in Lae. Unfortunately there are no safe houses in most areas in PNG. The activities of safe houses are also not well defined and, therefore services provided vary. Something that is often overlooked is that these houses need to have a safe and secret location in order to avoid angry husbands, relatives of the husbands or even his Wantok coming to the safe house demanding the woman to return to her husband.

Very few interventions at relationship level take place. The Tari FSC started anger management trainings and couple counseling. Anger management tries to avoid angry outbursts that lead to violence by using a "color coding" for moods (green is calm while red is a violent anger outburst). The sessions were initially intended for staff members of the hospital and they felt that it should be more widely available. The trainings also try to teach alternatives for violence such as conflict resolution. Because the couple counseling in Tari takes place on request of the community it is possible that both men and women are willing to participate and they find alternative ways to resolve marital conflicts. The program, however, has not yet been evaluated.

A promising society level initiative on women's empowerment is "loose fruit mamas", in the Oro province, which was introduced to achieve more equitable payment of women at a palm oil plantation. Palm nuts were picked by men in bunches while women did not have any income

generating opportunities. Marital disputes about money were common. The scheme allowed women to pick up the loose fruits and generate income. Women earning their own money reduced the marital disputes over money considerably. Interestingly, the men were found to donate bunches of fruits to the women so they could generate more money. Men were however reluctant to part from their salary in favor of family obligations. Money needs to be spent also on requests from extended families, gambling and drinking with peers (Koczberski 2007). An advantage of the scheme is the reduction of marital conflict; yet it does not provide a solution to the uneven access to resources within relations. In the shorter term it seems a practical solution.

The UN habitat initiative "safer cities" is implemented in Port Moresby, though the activities are limited (making Gordons market safe) and not yet evaluated.

Different sectors put in their contribution to combat IPV and SV. The gender equity policy 2009-2014 aims to augment the number of female teachers and protect teachers and students from violence through a zero tolerance policy and gender sensitization (National Department of Education 2009). To address gender equality in representation at the macro level a reserved number of seats in parliament is a frequently applied measure worldwide. In PNG the bill to reserve 22 seats for women was rejected. There are however positions reserved for women working at the "office for development of women and community development".

Grass root movements such as "Papua Hahine" advocate for abolishing the payment of bride price (Ellsberg et al. 2012). In addition to the traditional initiatives of protest marches and posters, there are social media platforms such as "Papua New Guineans against Domestic Violence" on Facebook (Nayahamui-Rooney 2012).

Gender sensitization training is provided by various organizations such as "Partners for Prevention", FSVAC, "Lifeline" and "Help resources" amongst others. The impact of this training is highly influenced by the quality of trainers and the continuity of engagement. When not imbedded in, for example, church or micro credit programs they are risk becoming one-off workshops (Ellsberg *et al.* 2012) .

Another important actor is the Pacific Conference of Churches (PCC) that trains clergies on the correct use of the Ephesians 5:21-24³ to improve equity in relationships and denounce IPV (Ellsberg *et al.* 2012).

³ Ephesians 5:21-24: 'Be subject to one another out of reverence for Christ. Wives, be subject to your husbands as you are to the Lord. For the husband is the head of the wife just as Christ is the head of the church, the body of which he is the Saviour. Just as the church is subject to Christ, so also wives ought to be, in everything, to their husbands.'

4.2. INDIVIDUAL LEVEL

4.2.1 VIOLENCE DURING CHILDHOOD

As described in Chapter 3.1, harsh child punishment, child abuse and children witnessing violence can contribute to IPV and SV in later life. Therefore parenting classes that include information on child development and skills training that aspire to prevent child maltreatment can potentially lessen IPV and SV in later life. Unfortunately, IPV and SV are usually not outcomes of parenting programs, making it difficult to estimate the impact of such programs. In High Income Countries (HIC) parenting programs diminish abusive punishment and improve parent-child relations, improve mothers' mental health and can prevent child abuse (Mikton & Butchart 2009). There is limited evidence on how that translates to LMIC (Knerr, Cluver & Gardner 2011). The Canadian "learning through play" program was successfully adapted and implemented to the Pakistan context as was the UK "social baby" program to the South African context. These interventions use lay personnel, and service delivery is through home visits or integrated into routine maternal health services. The programs were evaluated and a positive impact on mother child relations was measured (Rahman *et al.* 2009; Cooper *et al.* 2009). To the knowledge of the author there are no such programs in PNG.

4.2.2. ADDRESSING ALCOHOL USE

In PNG alcohol is an important provocation for quarrels and while not causing violence, the consequences tend to be more severe when alcohol is involved. There is emerging evidence that restricting access to alcohol and harmful use of alcohol prevent IPV and SV (WHO/LSHTM 2010). Reducing the availability of alcohol can be achieved either through restricting opening hours of bottle shops or putting an alcohol ban (WHO 2009). The latter is a commonly used measure in the SHP. There is currently no evidence that banning advertisement of alcohol reduces IPV or SV. Short interventions (ranging from 5-10 minutes to several sessions) in primary health care settings do decrease harmful use of alcohol in both HIC and LMIC settings. More or longer sessions did not improve the outcomes (Kaner *et al.* 2007). A Cochrane review on the effects of interventions to reduce alcohol consumption on injuries did not find strong evidence that reduced alcohol intake has a positive impact on domestic violence (Dinh-Zarr *et al.* 2004).

4.2.3. SURVIVOR CARE

While fees are exempted for survivors of IPV and SV, availability of services is lagging behind and most district and regional hospitals do not have a Family Support Center in place. Lack of personnel has led to overworked health workers with little knowledge of care for survivors of violence. On top of that there is a shortage of appropriate drugs and material, and private consultation rooms (Ellsberg *et al.* 2012). Few hospitals in PNG have adequate resources for survivor care. These are either 5 star rated regional facilities or FSC supported by an international

organization. None of the FSC in PNG has fully implemented the multi-sectorial One Stop Shop (OSS) model (See also section 4.4.5.).

A minority of women presenting at a health facility disclose that they suffer from IPV or SV. Screening for violence against women in all health care practices increases the number of victims identified. During pregnancy, when women visit health care facilities there is a window of opportunity to discuss violence. Therefore, health care providers should be trained on how to talk about violence with (female) patients and inform them on the appropriate services and options (Ellsberg 2006). A recent randomized controlled trial in England studied the impact of a two times two hour training to general practitioners. The training resulted in a 22 times rise in referral, improved record keeping and six-fold rise of victims arriving at referral institutes (Feder *et al.* 2011). In Tari hospital all violence related admissions are screened to see if they could benefit from the FSC services. If the capacity of services is limited and women cannot be referred to appropriate services, active screening for IPV and SV should not take place. Some even say that screening without the provision of treatment is unethical (García-Moreno 2002).

Survivors of both IPV and SV require treatment for physical injuries, besides which SV survivors may require prophylactic treatment of sexually transmitted infections and, if indicated, emergency contraception or termination of pregnancy, vaccination against hepatitis B and tetanus and post exposure prophylaxis to prevent HIV infection. Emotional support to help the victim carry on with their lives, and possibly prevent psychological disorders as depression and post traumatic stress disorder on the longer term should also be provided (MSF 2010). Presently there is no medical protocol in PNG that conforms with WHO standards for survivor care.

PNG does not have the cadre counselor in its workforce, nor is provision of emotional support part of the curriculum of nurses. This leaves the task of provision of emotional support to untrained volunteers in many instances. Counseling sessions improve female safety behavior but there is little evidence that they reduce IPV (Ramsay *et al.* 2009).

In addition to routine record keeping, physical injuries should always be documented and forensic evidence collected only if it is likely that it will be used for prosecution (WHO 2004). Collection of forensic evidence in most instances in PNG is futile due to lack of capacity, material and proper storage. A medico-legal form is used in PNG and is a useful tool for documentation; however health workers need training on correct use of the long and complex forms. At a bare minimum survivors need to receive a medical certificate summarizing the findings of the medical examination (Freccero & Harris 2011; Ellsberg *et al.* 2012).

4.3. RELATIONSHIP LEVEL

4.3.1. COUPLE COUNSELING AND ANGER MANAGEMENT

No conclusive evidence of effectiveness of communication and relationship skills training exists in reducing IPV. (WHO/LSHTM 2010). In PNG churches play an important role in reconciliation of marital discordance. However, Christian values tend to focus much on forgiveness and sometimes female subordination benefitting men more than women (Ellsberg *et al.* 2012).

4.4. COMMUNITY LEVEL

The WHO initiated the Safe Communities Model to lessen injuries. The model promoted community based injury prevention activities. The projects evaluated from the evaluated countries varied greatly and the results were mixed and any reductions of "violence related injuries" could not be linked to the interventions (Spinks *et al.* 2009).

4.4.1. SCHOOL-BASED PROGRAMS

The school-based 'safe dates' training program that was based in the United States in the late nineties was effective in reducing both IPV and SV by 60% (Foshee *et al.* 1998). The effect of the training was measurable for several years. Refresher trainings did not increase the effect (Foshee *et al.* 2004). Promising are school based multi-component violence reduction programs that lessened violence at schools by 15% on average. Lower levels of violence were observed not only in schools but also in the communities to which the schools belonged. School attendance and performance improved as well. The focus of most programs was disruptive and antisocial behavior and included teacher training on management of unwanted behavior. Involvement of community and parents was part of the program (Hahn *et al.* 2007). Being a bully and being bullied increased the risk of violence later in life by 30-60%, highlighting the relevance of such programs (Ttofi *et al.* 2012). Unfortunately, none of these programs is currently available in the PNG context.

Teaching girls about self-defense without actually giving them real life experience is ineffective as are rape awareness programs for students. Confrontational rape prevention was found to be harmful (WHO/LSHTM 2010).

4.5. SOCIETY LEVEL

4.5.1. ENGAGING MEN

Often engagement of men in violence prevention programs does not happen from the start and the male perspective is often not well understood. An emphatic approach without excusing violence facilitates

meaningful male engagement. Men play an important role in IPV and SV and should therefore be engaged in the prevention of it. More equitable gender attitudes are associated with less violence against women (Barker *et al.* 2011). When only women promote gender issues men tend to oppose them. Engaging men as “male champions” will increase the acceptability of the message (Musuya 2011). Gender transformative programs (those that aim to change gender norms) are more effective at reducing violence against women than gender sensitization programs that merely provide information (Flood 2011).

Stepping stones, a program that consists of small same sex group participatory workshops to challenge beliefs on gender, sexuality and concepts of masculinity with the aim to reduce HIV transmission and IPV, engages men from the beginning of the program. This intervention has emerging proof of effectiveness in many different contexts (Jewkes *et al.* 2008; WHO/LSHTM 2010).

4.5.2. FEMALE EMPOWERMENT

Empowerment of women has shown to impact women’s quality of life and improves the health status of themselves and the members of their family. Empowering strategies also increase community efficacy leading to increased community action. A participatory approach is a crucial component of a successful empowerment program (WHO 2006b). Micro credit schemes without a women’s empowerment component can trigger IPV, highlighting the importance for a multi-pronged approach. The Intervention with Micro finance for AIDS and Gender Equity (IMAGE) combines microcredit and women’s empowerment and targets poor women with the aim of preventing HIV infection. Men are engaged in early stages of the program as transition roles in communities with rigid gender concepts can negatively impact the outcome of micro credit schemes. The program reduced IPV two years following the introduction of the scheme by 55% (Kim *et al.* 2009; Barker *et al.* 2011).

4.5.3. LEGISLATION AND COURT

A huge amount of effort has been put into making laws and access to the judiciary system more equitable, and the law and justice sector more responsive in order to raise the number of complaints filed and increase to judicial response. Whether changing laws prevents violence is yet to be evaluated. However, acceptance and impunity of violence increases the risk of occurrence of violence. Women-only police stations aim to increase access to the legal system for women. Women are more likely to file complaint when they visited a women-only police station (Heise *et al.* 1999).

4.5.4. MEDIA / CHANGE SOCIAL NORMS

Rigid gender and social norms contribute to the occurrence of IPV and SV and transforming these rules and expectations plays a role in the prevention of violence. Male attitudes are more predictive of violence occurring than female attitudes, stressing the importance of engaging

men (WHO/LSHTM 2010). Recognition of the problem combined with willingness to confront key people in society, ministry and perpetrators is essential (Heise *et al.* 1994). If a problem is not seen as urgent then not much will be done about it. In the next section the few evaluated and promising initiatives are outlined.

Media campaigns such as “UNiTE to End Violence” by UN Women raise awareness and create political will but do not change gender norms. They do however take IPV and SV out of the private sphere (Heise 2011).

The OXFAM “We Can” campaign consisted of men signing a pledge with changes they would incorporate into their life to reduce violence. These “change agents” then transmitted the message to others. Gender norms changed in 80% of participants. This is an example of a gender transformative campaign (Raljan & Chakraborty 2010).

In the Pacific the best example of a media campaign is “Wan Smol Bag” in Vanuatu that does edutainment through theatre, the TV “Love Patrol” soap opera and workshops with local leaders and radio drama. Many of its male advocates are policemen (Howell & Hall 2010).

4.5.5. SERVICE ORGANIZATION

The systems approach to service delivery that involves training to all levels of staff in the organization, procedures and protocol implementation, data collection, allocation of budget, equipment and working space improves attitude of providers, quality of care and patient confidentiality (Ellsberg 2006; Freccero & Harris 2011). A successful implementation of the systems approach is the nurse assault examiner program Refentse that was implemented and evaluated in South Africa. After initial training hospital nurses were able to provide services at low cost to survivors of SV. Key to success of these programs was a sector wide approach that included personnel, material and space within hospital settings (Kim *et al.* 2009).

HIV and gender based violence are partly interconnected epidemics, women who suffer from IPV are more often HIV infected than women who are not in violent relationships. For this reason integrating care for HIV and IPV/SV is suggested by UNAIDS (UNAIDS 2011). Others have advocated for integrating survivor care in sexual and reproductive health (SRH) services since women of reproductive age are most prone to violence (Shamu *et al.* 2011). Integrating care for survivors at primary level makes care more readily available for the rural population. Integrating survivor care in existing primary care will improve availability of care and is more cost effective than a vertical implementation of survivor care services. However many challenges exist as knowledge level of staff, need for supervision, the need for private consultation rooms, supplies and a functioning referral network (Church *et al.* 2010).

The alternative is the “integrated model approach” of which the OSS is widely seen as the best practice. In the OSS, institutions and organizations collaborate with health, education, social and justice sectors

and referrals to community networks. A criticism of this model is the strain it places on resources while serving a very specific population (Freccero & Harris 2011).

There is no overall policy to address violence against women in PNG

CHAPTER 5: DISCUSSION

5.1. RESPONDING TO IPV AND SV IN PNG

IPV and SV are a public health problem and a violation of human rights. Factors contributing to these forms of violence take place on individual, relationship, community and societal levels. To be successful different levels need to be addressed in a multi level approach assuring embedment in the different levels and sectors of society. While not all factors can be influenced, such as age for example, they can help target interventions thus enhancing the efficient use of resources.

During the nineties PNG was one of the first countries to have a multi-sectorial and multi-level approach including pop songs, advocacy for legislation and government initiatives as well as the intention to provide survivor care. With the heightened insecurity in the mid-nineties however these activities collapsed. Nowadays there are a variety of activities aimed at prevention of IPV and SV but overall coordination is weak.

The following paragraphs sum up potential approaches to address the problem of IPV and SV in PNG.

5.1.1. INDIVIDUAL LEVEL

Alcohol abuse is an important contributing factor for IPV and marital discordance. Though interventions, such as 5-10 minute counseling sessions in primary care settings and alcohol bans aimed to reduce alcohol intake are effective in other settings, this approach is not feasible in PNG. First of all for men in the Highlands alcohol use is a social activity and used for male bonding. And secondly there is a severe shortage of qualified medical personnel as a consequence of which the additional task of alcohol (ab)use counseling sessions may not be feasible. Reducing alcohol intake is important but should be part of the broader discussion on alcohol.

The use of corporal punishment and the high prevalence of IPV in PNG make childhood interventions high priority. Parenting programs have shown to be promising practice and the "Learning Through Play" initiative could be adapted to the PNG context. This is a feasible intervention because it is a relatively cheap that does not rely on the literacy of parents. The activity can be integrated in the routine ante and post natal care visits or as a separate activity including home visits. For the Highland setting where people live scattered, have their properties fenced and (sexual) jealousy is cause for IPV, integration in existing SRH services is preferred.

Efforts restricted to the consequences of violence, focusing on the individual survivor and perpetrator will not end violence. It is vital not to delink IPV and SV consequences from causes otherwise the risk exists that

determinants of the problem will be ignored. While beating one's spouse is perpetrated by both men and women, women are more often the injured party requiring medical care. Provision of survivor care therefore increases gender equity of services.

The OSS approach to the provision of survivor care is best practice. It is however resource intensive, this is probably one of the reasons the roll out in PNG is very slow. In Tari elements of the OSS are implemented such as the medical and emotional care but links with the justice and educational sector and grass root movements are lacking. The current "hybrid approach" that is somewhere between integration and the OSS model seems the most promising practice at district level. To improve quality of care the operational and clinical guidelines for OSS should be finalized and made to conform to WHO standards.

To achieve a scale-up of activities an integrated approach at Health Center level is used in some settings. Taking into account that many rural health facilities are not functional, the shortage of trained staff and lack of materials this is not feasible in PNG.

Screening for IPV and SV increases the number of victims identified, however if there is no treatment available, as is the case in many areas in PNG, systematic screening should not be done. It is probably best to invest in improved referral systems through training of health staff, increased awareness in communities and measures as restitution of bus fares.

5.1.2. RELATIONSHIP LEVEL

Agency of women, or the lack of it is affected by bride price, attained level of education, access to resources and the rigidity of gender roles is a multi-level issue. The combination of an uneven distribution of power in a relationship, disputes about money and dislike for one's spouse fuels marital discordance. No effective programs at relationship level were identified. Internationally there is little evidence that couple counseling reduces IPV. In Tari it does however seem a promising intervention because of its focus on alternative ways of conflict resolution. More importantly, the population requested provision of this service.

However, given the strong cultural ties of the bride price and other gender norms, counseling at the individual level is unable to change the broader notions of identities. Instead, the impact will be limited to the counseled persons and its main effect will be to limit severity of IPV and SV rather than the practice as such.

5.1.3. COMMUNITY LEVEL

Taking participatory approaches to implement community interventions appear to be effective. Stepping stones that has been successfully

implemented in various settings can also be adapted to the PNG and more specifically, the Highland context. The program should not operate in isolation but be linked to the FSC to affirm multi-level approach.

The program can take place at health facilities, schools or one of the Churches. As very few community initiatives have been evaluated in PNG it is important to secure funds for monitoring and evaluation of Stepping Stones in PNG.

The selection of facilitators is challenging as the facilitators need to be able to grasp the program, be gender sensitive, speak the local language, able to listen, respected in the community and able to facilitate discussions (Agency for Cooperation and Research in Development 2007). Possibly the emotional support staff of the FSC can initially be part of the Stepping Stones facilitators pool. More likely a new cadre needs to be created in the long run.

In the short term programs with a practical gender approach as the “loose fruit mamas”, meaning that they do not aim to change broader gender inequities can improve access to resources and decrease IPV. These programs are feasible in the short term because it does not require change of societal norms. In the longer term however a more strategic gender approach that aims to change concepts of masculinity, gender roles and access to resources is desirable and more sustainable.

5.1.4. SOCIETAL LEVEL

Traditional and rigid gender norms, uneven access to resources, notions of sexual entitlement and combined with social acceptability of violence all contribute to IPV and SV. They are reflected in a weak legal sector that fails both to implement and enforce legislation addressing IPV and SV.

Fortunately notions and attitudes are socially defined and can therefore be changed and the same is possible for the legal system. Grass root movements have a role to play instigating the debate on violence against women, bride price amongst others. “Papua Hahine” that advocates to abolish bride price payment instigates the debate on the desirability of bride price payments. It is, however, a women’s movement and when changing gender norms engaging men is essential. Many of the grass root initiatives have as ultimate goal to redistribute power between genders and within relationships with the aim to reduce violence as an accepted way to discipline, punish, or, settle disputes.

Programs with a gender informative approach as mass media campaigns take IPV out the private sphere and challenge notions of masculinity and sexual entitlement. The FSVAC should embrace these organizations and support them where possible financially and with material and trainings.

5.1.5 POLICY LEVEL

Initiatives as women-only police stations as part of OSS or a network of providers increase the likelihood that women will file complaints and that they will receive medical care. The “women only approach” however does make violence against women a woman’s problem and creates a parallel track, excusing the regular law enforcers to act upon IPV and SV complaints. With the shortage of trained female police officers women only police stations are not feasible in PNG. A more suitable approach would be to train all cadres of law enforcement on legislation on SV and IPV/physical assault.

Measuring violence is a tool for advocacy. A missed opportunity is that presently the HMIS does not make the burden of disease caused by SV and IPV visible, since it does not register violence related injuries separately from accidents. Different sectors as the health, education and legal sector all dedicate resources to combat violence against women, however there is little overall coordination of policies, programs and activities that aim to reduce IPV and SV.

Lastly, a national strategy on violence against women that includes all separate activities, pays attention to links of the different levels of the ecological model, and the roles of various sectors can establish a multi-level and multi-sectorial response to violence.

5.2. LIMITATIONS OF THE STUDY

The focus of the study is on intimate partner violence in general. Contributing factors and interventions to SV are interlinked with IPV but are as such not highlighted. Most research focus on physical forms of IPV and SV with or without emotional abuse but not on emotional abuse in isolation. Therefore, emotional abuse without a component of physical or sexual abuse is not covered. The literature review on best practice also mostly concentrates on the physical consequences of violence.

This study limits itself to violence against women. Violence against men is not covered because it often has different dynamics as it tends to be linked to crime, gang activity, war and therefore the focus in gender based violence traditionally is on women (Watts & Zimmerman 2002, Peden *et al.* 2002). Gender based violence against men is highly stigmatized and those who suffer from it are vulnerable. By excluding men as victims, gender based violence is less likely addressed in a way that includes men not only as perpetrators but also as victims.

The primary data used from the FSC providing survivor care were not collected with the objective to study contributing factors to violence but to monitor the activities of the centers. Data from health facilities have various limitations. Firstly, victims presenting to health facilities are usually not representative of the general population because they decided

to seek care and were able to access the facility. Secondly, it is difficult to say if utilization of services is good because there is no population based survey describing the extent of violence. However anecdotal evidence suggests that the majority of women do not present themselves to the facilities. Finally, numbers from clinics tend to mask violence happening in the home while it inflates 'stranger violence' (Stark & Ager 2011). This means that victims of IPV are less likely to present to the FSC. Even though the majority of cases seen come after IPV they still are underrepresented in the data.

Secondary data was used to describe contributing factors and prevention strategies to IPV and SV in PNG. This makes the study prone to bias. If the search terms were too narrow relevant articles might have been excluded, and articles in other languages than English were not included. Another important form of bias derives from the fact that most information was acquired through internet and library searches. Local and possibly effective interventions addressing violence are therefore missed (publication bias).

CHAPTER 6: CONCLUSION AND RECOMMENDATIONS

6.1. CONCLUSION

Violence against women, and more specifically IPV and SV are rampant in PNG. These forms of violence not only negatively impact health, have indirect costs to society due to loss of productivity but also violate human rights.

The causes of IPV and SV are multiple and complex and take place at different levels of the ecological model. In the PNG context interventions aiming at prevention should use a multi-sectorial and multi-level approach. Programs need to be adapted to local context in PNG taking into account the cultural differences.

Interventions should aim both at the short term (immediate) and the long term; include different levels of the 'ecology' of society (individual, family, community and society) and focus on both men and women.

A multi-pronged approach to IPV and SV is needed. A vast body of research shows that participatory approaches have better results and gender transformative programs are more effective than gender informative projects. Combining community participatory approaches that are gender transformative such as Stepping Stones, the provision of survivor care and media campaigns address different levels of the ecological framework.

The health sector plays an important role taking care of victims. While systematic screening for IPV and SV is not advisable, investing in referral systems seems a viable option to increase uptake of services.

The many initiatives from various actors and sectors should be harnessed in an overall strategy to improve streamlining of activities and avoid duplication and gaps. A participatory approach in the formulation of the policy is crucial to maximize public consent. The department of community development should take the lead since many of the contributing factors take place on community and societal level. An important aspect of the strategy will be assuring a coordinated multi-level approach, guidelines on the evaluation process for implemented activities regarding prevention of violence and monitoring of levels of IPV and SV. Not only will monitoring and evaluation help to improve the approach in the middle and long term, it will also help to bring the effects of IPV and SV fully into the picture. Currently, the true burden of disease caused by IPV and SV in PNG is not known because these injuries are not separately registered in the HMIS.

6.2. RECOMMENDATIONS

The following recommendations aim to enhance a multi-level approach to IPV and SV.

- The department of Community Development should take the lead in the development of a streamlined policy that includes health, education, justice and economic affairs, preferably through the use of a participatory approach.
- The NDoH should make survivor care more widely available. Taking into account the scarcity of resources an integrated approach can be combined with the OSS model.
- Questions on sexual and family violence should be included in the demographic and health survey that is household based. The HMIS should include registration of injuries due to family and sexual violence.
- Parenting programs as “Learning Through Play” should be adapted to the PNG context and integrated in routing ante and post natal care.
- The NDoH should develop and implement referral protocol for survivors of IPV and SV and train health workers on application of the protocol.
- The Stepping Stones project should be adapted to the PNG context and implemented in by the provincial FSVAC in collaboration with the relevant Family Support Center.
- The FSVAC should link key stakeholders and grass root initiatives that advocate implementation of the CEDAW recommendations and gender informative projects
- To increase knowledge on what works in PNG, implemented activities need to be evaluated. The FSVAC, as coordinator and often funding organization should make sure this is adhered to.

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