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Medical and Psychosocial Care for Survivors of Sexual and Gender-Based Violence

National Clinical Practice Guidelines

Papua New Guinea

National Department of Health

2021

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1 | Introduction to sexual and gender-based violence in the PNG context

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Sexual and gender-based violence (SGBV) can occur in every culture and setting, including the home, the workplace, schools, prisons and communities, and cases exist at all levels of society and in every country. The root causes of SGBV include power, control and inequality, and studies from various countries, including PNG, have revealed that SV can affect adults, children and adolescents.

In PNG, SGBV is a common issue that affects many communities. DV (also referred to as IPV) occurs more frequently than other forms of SGBV; however, survivors of such violence often do not seek justice or healthcare, despite the serious risks the victims face. Health consequences of IPV, including physical injuries and psychological trauma, can be severe, and SV perpetrated by an intimate partner, another known perpetrator or a stranger is the most severe form of SGBV, with many cases reporting serious health consequences.

SV can result in unwanted pregnancy, the unsafe termination of a pregnancy, gynaecological and fertility problems and an increased risk of sexually transmitted infections (STIs), such as the human immunodeficiency virus (HIV) and acquired immune deficiency syndrome (AIDS). SV can also lead to an increased risk of dangerous and unhealthy sexual behaviours, such as early and increased sexual involvement and exposure to older or multiple partners. Moreover, violence during pregnancy can affect both the mother and the baby, creating additional risks for the victim.

SGBV also affects mental health, and the consequences can be serious and long-lasting. Survivors are more likely than their non-abused counterparts to experience post-traumatic stress disorder (PTSD), depression, anxiety, sleeping and eating disorders, low self-esteem, a decreased ability to function due to fear, substance abuse and an increased risk of suicide later in life.

In addition to high rates of general SV, PNG has extremely high levels of rape and gang rape. A 2013 United Nations study of community members from the Autonomous Region of Bougainville revealed that 62.4 per cent of male respondents reported having perpetrated some form of rape against a woman or girl, and 14 per cent reported having committed gang rape.[1] Moreover, 33 per cent of women experienced sexual abuse as a child, with 12 per cent having been forced into sex as a child. Additionally, one in five women reported their first experience with sex to be rape.

[1] E. Fulu, et al., 'Why do some men use violence against women and how can we prevent it? Summary report of quantitative findings from the United Nations multi-country study on men and violence in Asia and the Pacific', *UNDP, United Nations Population Fund (UNFPA), UN Women and UNV*, September 2013, p. 7, <http://www.partners4prevention.org/sites/default/files/resources/p4p-report-summary.pdf>, accessed 26 Oct. 2020.

Several other PNG studies highlight the scope of SGBV in the country:

- The Sade study at the Australian New Guinea Administrative Unit (ANGAU) Hospital conducted in 2002 surveyed 239 SV survivors (98 per cent female and 2 per cent male).[2] The results revealed that 29 per cent of the survivors were raped by more than one man, 57 per cent were under 20 years old, 12 per cent were under 10 years old and 50 per cent were assaulted in the daylight hours. Additionally, 89 per cent had no signs of sexual assault, 55 per cent had genital injuries and 55 per cent had no semen detected. Moreover, 52 per cent of the victims knew their perpetrators.

- According to Dr Seginami's study from 2004–2007 of 445 rape survivors at the Port Moresby General Hospital, 53 per cent were raped at home, 29 per cent were raped by more than one man, 62 per cent had no visible injuries and 69 per cent had no evidence of semen.[3] Moreover, 53 per cent were under 16 years old, 23 per cent were under 10 years old and the youngest was 1 year old.

- The 2007 Lewis et al. study of 400 women at health clinics revealed that the main trigger for violence against women was refusing to have sex or asking their partner to use a condom (80 per cent of DV cases).[4] Half of the women interviewed also expressed they cannot refuse to have sex with their partners without being punished.

- FHI 360 conducted a study on populations vulnerable to HIV and discovered high rates of STIs and HIV within the target populations.[5] According to the data, 58 per cent of men who have sex with men experienced anal sexual assault in the previous year, while 78 per cent of female sex workers reported sexual assault in the previous year. Additionally, 73 per cent of men who have sex with men and 66 per cent of female sex workers reported a non-sexual physical assault in the previous year.

- In the Family Support Centre (FSC) in Lae, data collected by Médecins Sans Frontières (MSF, Doctors Without Borders) from August 2010 to April 2013 illustrated that 5,652 individuals of 6,856 presentations for healthcare services received care. Of the surveyed individuals, 96 per cent were female, indicating that an estimated 4.9 per cent (with a confidence interval of 4.8–5.0 per cent) of females residing in the catchment area participated in the MSF program at least once during the analysis period. Additionally, 10 per cent of the presentations were children under 16 years of age. Of all presentations, 62 per cent reported specific events of IPV (sexual or physical), with 14 per cent reporting specific events of SV outside an intimate partner relationship, 3 per cent reporting other forms of violence and 21 per cent seeking counselling for experiences of past violence. Of the presentations cases for SV outside an intimate partner relationship, 79 per cent reported knowing the perpetrator, and 49 per cent were children under 16 years of age. Overall, 74 per cent of the presentations received medical treatment for physical injuries, while 71 per cent received at least one counselling session.

[2] K. Sade, Study at ANGAU Hospital, 2002.

[3] A. Seginami. 'Rape victims at Port Moresby General Hospital Gynaecology Clinic', 2004–2007.

[4] B. Lewis et al., 'Final Report on Links Between Violence Against Women and the Transmission of HIV in PNG', National Aids Council Secretariat, November 2007.

[5] FHI 360, 'Behaviors, Knowledge, and Exposure to Interventions: Report from a Behavioral Surveillance Survey, Port Moresby, PNG', *the United States Agency for International Development/FHI 360*, May 2011, p. 1, <https://www.fhi360.org/sites/default/files/media/documents/BSSPNGReportFinal2011.pdf>, accessed 26 Oct. 2020.

As these statistics demonstrate, the majority of SGBV survivors in PNG are women, though men and children of both sexes can also be victims. SGBV is a human rights issue as well as a public health issue and causes significant negative effects on the health and the rights of the people affected.

Several international laws and conventions protect the rights of individuals against SV, including the United Nations Universal Declaration on Human Rights, the Convention on the Elimination of All Forms of Discrimination Against Women and the Convention on the Rights of the Child.

The following PNG laws also protect the rights of individuals again SGBV: the PNG Constitution, the *Criminal Code and Evidence Act (Sexual Offences and Crimes Against Children) 2002*, the *Lukautim Pikinini Act 2009* (LPA) and the *Family Protection Act 2013* (criminalising DV). The repealed *Sorcery Act 2013* and the enacted *Trafficking and Smuggling in Humans Act 2013* are also relevant laws concerning SGBV.

The National Department of Health (NDOH) has increased its focus on SGBV within the Public Health's Strategic Directions 3 and 4 (Safe Motherhood and Control of HIV/AIDS and STIs), considering it a major factor affecting the health of women, children and men in PNG. In 2009, the NDOH Secretary instructed health facilities to include SGBV activities in all annual activity plans, including the operation costs of FSCs.[6]

When interacting with survivors of sexual and physical violence, health workers must provide non-discriminatory healthcare and remain inclusive of people with special needs. These National Clinical Practice Guidelines (CPG) were developed to support PNG health workers in achieving the NDOH's objective to provide adequate treatment and care to all survivors of SGBV.

These Guidelines aim to support key target populations, including survivors of all forms of family and partner violence, as well as all forms of SV, as illustrated in the table below. Sorcery accusation violence, as well as trafficking, are two forms of violence that frequently occur in PNG and are included under interpersonal violence.

[6] Circular information. November 17, 2009.

2 | Aim and objectives of the Guidelines

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AIM

These Guidelines aim to assist health professionals in improving health services and providing medical and psychosocial care to SGBV survivors, including women, men and children.

OBJECTIVES

The key objectives of these Guidelines are to provide healthcare workers with:

- Necessary skills, knowledge and information to provide treatment, care and support for survivors of SGBV
- Improved understanding of the importance of providing timely access to medical and psychosocial care
- Skills, knowledge and information required for medico-legal interaction to facilitate the documentation and management of SV cases for medical and legal purposes
- Standards for the provision of both integrated medical and psychosocial services for survivors of SV
- Guidance on safe, confidential and consented referral pathways between multi-sectoral services for survivors of SGBV

3 | Ensuring survivors' access to health services

3 | Ensuring survivors' access to health services[7]

From the first moment of contact and throughout the entire interaction with survivors of SGBV, healthcare providers must apply a survivor-centred approach to every encounter. Such an approach involves prioritising the rights, wishes and needs of the survivors (see Chapters 3.3 and 4) and providing psychological first aid (PFA) from the first moment of contact (see Chapter 7.2).

3.1 |RAISING AWARENESS

Many people are unaware of the potential health consequences of SGBV and thus minimise the necessity of obtaining timely and essential healthcare, as well as psychosocial support, to prevent possible health consequences. This lack of awareness and the potential stigma and social consequences that survivors of SGBV may face often form barriers that prevent survivors from accessing timely healthcare services.

Survivors of SGBV must understand the importance of presenting for medical care as soon as possible, preferably within 72 hours of the incident. Raising awareness, building trust and strengthening linkages within the community and with all relevant sectors will reduce the access barriers that many survivors face.

Intervention strategies:

FSC staff (nurses, community health workers or dedicated health promotion teams) must provide:

- Awareness-raising messages in the waiting areas of hospitals and health centres (HCs). Installing television screens in waiting areas is a common method of addressing SGBV and presenting services offered at FSCs.
- Written information on SGBV in healthcare settings in the form of posters, pamphlets or leaflets. Staff should provide such information in private areas, such as women's washrooms, and include appropriate warnings on taking them home where an abusive partner may see them.
- A dedicated health promotion team, as well as a plan to raise awareness in community areas such as marketplaces, schools, churches or public events

[7] For more information, see Chapter 5 (Enabling environment for service provision) of the NDOH of PNG, 'Guidelines for PHA/Hospital Management establishing hospital-based family support centers', *Doc Player*, 2013, p. 23, <https://docplayer.net/9914862-Guidelines-for-pha-hospital-management-establishing-hospital-based-family-support-centres.html>, accessed 26 Oct. 2020.

Key advocacy messages:

Key advocacy messages should reference the five essential services offered to SGBV survivors:

1. Treatment of injuries
2. PFA
3. Prevention of HIV and STIs, pregnancy, the hepatitis B virus (HEP B) and tetanus
4. Safe referrals, including internal referrals to other specialist medical care providers and external referrals to other service providers (welfare, legal, safe house, police, child protection, counselling and repatriation)
5. Supportive follow-up
   - » SGBV, including rape, is a medical emergency and must be managed as such.
   - » Staff should ensure that the victim understands that SGBV is never the survivor's fault and can happen to anyone, including women, men and children.
   - » Staff should provide the location and phone number of free and confidential health services, as well as the phone number of the National Free Hotline (71508000).
   - » Staff should provide a free medical report upon the victim's request to report to the police.
   - » As per the directive from the Police Commissioner in the circular No. 04/2009, staff must attend to the issue of rape and sexual assault as a criminal offence.
   - » To provide the complete continuum of care, staff should encourage survivors to visit an FSC or health facility as soon as possible following an SGBV incident, preferably within 72 hours (three days); however, survivors may seek care at any time.

3.2 | IDENTIFICATION OF SURVIVORS

Providing access to an FSC facilitates the identification of SGBV survivors; however, most survivors do not have access to an FSC and must present to other departments. These departments are often unable to identify survivors and thus do not provide the target patients with the care they require.

Referral pathways for survivors of SGBV include:

- Self-referrals in which the survivor voluntarily presents directly to the clinic or FSC
- Referrals from within the hospital or HC, including accident and emergency (A&E), obstetrics and gynaecology (O&G), antenatal care (ANC) or the Paediatric Ward
- Referrals from outside the hospital, including other health facilities, nongovernmental organisations (NGOs), police, welfare, church organisations, schools or community leaders

Intervention strategies

Healthcare providers should implement the following strategies when interacting with potential SGBV survivors:

- Healthcare providers must screen survivors on their potential exposure to SGBV when assessing conditions that such violence may cause or complicate; however, providers should not implement universal screening or routine enquiry at this point, such as asking all women of possible exposure in every healthcare encounter.[8] Health workers must be trained to recognise possible 'silent signs and symptoms' of SGBV and be comfortable with asking questions when necessary. Additionally, providers must know how to respond correctly if a survivor discloses an SGBV incident.
- Early and confidential identification of survivors of SGBV at possible referral entry points is essential for ensuring direct referrals to FSCs for medical care and psychosocial support. All staff working at these departments or organisations must be trained and sensitised to provide confidential and appropriate referrals.
- Healthcare staff who are unable to provide appropriate services should refer all identified survivors to an FSC or other department where the survivor can receive the complete continuum of care.

[8] WHO, 'Responding to intimate partner violence and sexual violence against women: WHO clinical and policy guidelines', loc. cit., 2013.

Clinical conditions associated with IPV and SGBV

Symptoms of depression, anxiety, PTSD and sleep disorders include:[9]

- Suicidal or self-harming tendencies
- Alcohol or other substance use
- Unexplained chronic pain
- Unexplained chronic gastrointestinal symptoms
- Unexplained genitourinary symptoms, including frequent bladder or kidney infections
- Adverse reproductive outcomes, including multiple unintended pregnancies or terminations, delayed pregnancy care or adverse birth outcomes
- Unexplained reproductive symptoms, including pelvic pain or sexual dysfunction
- Repeated vaginal bleeding and STIs
- Traumatic injury, particularly if repeated and with vague or implausible explanations
- Problems with the central nervous system, including headaches, cognitive problems or hearing loss
- Repeated health consultations with no clear diagnosis
- Involvement of an intrusive partner or husband during consultations

[9] Ibid.

3.3 | RECEPTION OF THE SURVIVOR

Healthcare providers should offer immediate, confidential and survivor-centred support to women, men and children who disclose any form of violence by an intimate partner or other family member or a sexual assault by any perpetrator. First-line, survivor-centred support (at a minimum)[10] includes:

- Offering non-judgemental support and validating what the survivor says
- Providing practical, non-intrusive care and support that responds to the survivor's concerns
- Asking about the survivor's history of violence. The provider should listen carefully but refrain from pressuring the victim to talk. Staff should take care when discussing sensitive topics with survivors who require an interpreter
- Providing survivors with access to information on relevant resources, including legal and social
- Ensuring the safety of the survivor, as well as their children, when necessary
- Providing or referring for social support

Intervention strategies

Healthcare workers should implement the following strategies when interacting with potential SGBV survivors:

- Providers should apply a survivor-centred approach and refrain from moving survivors between departments unless necessary. Providers should instead consult relevant experts to visit the survivor in one location, preferably the FSC.
- Providers should maintain confidentiality while also informing the survivors or their guardians (in the case of a minor) of the limits of confidentiality, such as the mandatory reporting of CSA.
- When a child is involved, healthcare providers must consider the best interest of the child at all times.
- Providers should conduct all consultations in private.
- Healthcare providers should refer survivors for any special needs they may have that the health worker is unable to provide.

[10] Ibid.

First-line support[11]

Healthcare workers should offer immediate support to survivors who disclose any form of violence by an intimate partner or other family member or a sexual assault by any perpetrator.

Such support includes:

- Conducting the consultation in private
- Ensuring confidentiality while also informing the survivor of the limits of confidentiality, such as cases of mandatory reporting
- Remaining non-judgemental and supportive and validating what the survivor says
- Providing practical, non-intrusive care and support that responds to the survivor's concerns
- Asking the survivor about their history of violence, listening carefully and refraining from pressuring them to talk. Health workers should take care when using interpreters to discuss sensitive topics
- Providing the survivor with access to information on relevant resources, including legal and social support
- Ensuring the safety of the survivor and their children, when necessary
- Providing or referring social support

[11] WHO. 'Responding to intimate partner violence and sexual violence against women: WHO clinical and policy guidelines', 2013.

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