A. The Purpose of the Assessment

According to one of Papua New Guinea’s leading child welfare authorities, “Current HIV/AIDS trends in the country, combined with the social, economic and political realities threaten a unique epidemic. The impact on women and children could be terrible.” In this context, the concern and resources of the government, civil society and its development partners must be immediately harnessed to plan for, and address, the worst of the social and economic effects of the epidemic that are already becoming visible in many parts of the country. This study provides an overview of the situation of children and families affected by HIV/AIDS and of other vulnerable children and represents a first step in mobilizing this broader response.

As an initial step towards a more detailed process of policy development, this assessment was designed to help the Government to develop policies and programs for on-going support and for the monitoring of community-based assistance to families and children affected by HIV/AIDS.

This assessment will need to be expanded and refined over the next few years as more data becomes available about the HIV/AIDS epidemic in the country, but in the meantime the government, civil society and development partners should implement the policy and programme recommendations that have emerged from the assessment – within the broader context of the national strategy for HIV/AIDS and child welfare policies. A draft of this assessment was presented to partners involved in policy development and service delivery in January 2005 to initiate a broader dialogue on issues and challenges facing affected families and children.

In line with international policy guidelines, this assessment is designed to assist the government and its partners in identifying opportunities for supporting family and community-based care, and to support the channelling of resources into its development. As is typical in a country in the first phases of a HIV/AIDS epidemic, efforts have been focussed largely on prevention and medical care. However, international experience suggests that while medical resources play a important role in epidemic management, communities can be mobilized for prevention and home care for persons with AIDS and for their surviving children as well as for children made vulnerable by AIDS.

B. International Programming Framework

Following a two-year joint consultative process, UNAIDS and UNICEF promulgated in 2003 global “Programming Principles for

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**Figure 1**

Problems among children and families affected by HIV and AIDS

- HIV infection
- Increasingly serious illness
- Children may become caregivers
- Psychosocial distress
- Deaths of parents and young children
- Problems with inheritance
- Children without adequate adult care
- Discrimination
- Exploitative child labour
- Sexual exploitation
- Life on the street


Orphans and Other AIDS-Affected Children. The continued evolution of international programming and policy documents has been stimulated by the impact of the AIDS epidemic on children, families and communities in Sub-Saharan Africa and the growing threat of large-scale epidemics in Asia. While the statistics of orphans and children affected by HIV/AIDS continue to change, basic notions of programme design have remained relatively constant since the earliest programmes originated in Africa in the late 1980s. Programmes have been born out of a growing experience, but a preference for family and community-based care and the full integration of HIV/AIDS-affected children into social life have always been at the heart of responses. Necessarily, responses have also been multi-sectoral in order to respond to the wide array of problems faced by HIV/AIDS-affected children and their families.

As Figure 1 illustrates, children in HIV/AIDS-affected families face economic hardship as the fortunes of their family decline; a common occurrence in AIDS-affected households around the world. Children suffer from a lack of attention and love; social displacement when they lose family members, friends and guardians; possible family homelessness and loss of inheritance; lost schooling opportunities, food and regular health care; increased possibility of abuse and trafficking; and psychosocial distress from parental death, homelessness, abuse, stigma, discrimination, isolation and the loss of hope. These problems are discussed at length in all editions of Children on the Brink and in the latest update of the Framework for the Protection, Care and Support of Orphans and Vulnerable Children Living in a World with HIV and AIDS that was endorsed in 2004 by 23 organizations prominent in global development work, including UNAIDS and UNICEF.

The Framework for the Protection, Care and Support of Orphans and Vulnerable Children Living in a World with HIV and AIDS articulates five key strategies to address the needs of HIV/AIDS-affected children and families, and other vulnerable children. These strategies, as addressed in this assessment, underpin the overall objective of strengthening the capacity of families to protect and care for orphans and vulnerable children by prolonging the lives of parents and providing economic, psychosocial and other support. The five key strategies are:

1. Mobilize and support community-based responses. Families and communities are the first line of response – it is in family and community settings that most HIV/AIDS-affected families and children are found and from these sources that most receive care. Some 98 percent of vulnerable children are now living with their families and by better understanding the processes of care and current support mechanisms in these settings, external actors (both government and non-government) can develop systems which support the natural care giving responses of families and communities;

2. Ensure access for orphans and vulnerable children to essential services, including education, health care and birth registration. Families and communities affected by HIV/AIDS, usually the poorest and most vulnerable to begin with, lack equitable access to essential social services in many countries around the world;

3. Ensure that governments protect the most vulnerable children through improved policy and legislation, and through the channelling of resources to families and communities;

4. Raise awareness at all levels through advocacy and social mobilization to create a supportive environment for children and families affected by HIV/AIDS.

International guidelines and experience suggest that:

1. Programming should include all vulnerable groups, not just AIDS-affected families and children. Programming for HIV/AIDS-affected children and families should be integrated with programming for other vulnerable children. HIV/AIDS-affected children and families cannot be identified easily because of the lack of widespread voluntary counselling and testing. HIV/AIDS-affected children and families should not be singled out in any response as this increases stigmatization. Integration will in the long run lead to higher quality programming that is more sustainable, affordable and accessible;

2. Programming should lead to the strengthening of protection and care within families and communities, including financial assistance to cope with economic hardship, natural coping responses of families and communities;

3. Programming should link prevention and care. Assistance should be provided so that multi-generational epidemics do not become self-reinforcing and in order to reduce transmission and the long term burden of care;

4. Institutional care should be temporary and a last resort. The role of institutional care in the overall system of family and community care should be deliberately and consciously developed so that children in need of institutionalization are not denied access.

C. HIV/AIDS-Affected Children and Other Vulnerable Children

In line with international guidelines, children affected by HIV/AIDS include children under the age of 18 years who are:

1. Infected by HIV/AIDS at birth or later in their lives;

2. Orphaned by HIV/AIDS (children whose mother, father or both parents have died from AIDS);

3. Abandoned because of their HIV/AIDS status or that of their caregivers;

4. Living in families with HIV positive members; and

5. At high risk of HIV infection.

Interventions for both groups should be linked to avoid stigmatizing children affected by HIV/AIDS. Although it is acceptable for planning purposes to talk about AIDS-affected children and vulnerable children, it is now recommended that acronyms not be
used. These terms have “trickled down” in programming and have been used to label children in the community which has, in certain instances, led to stigmatization. The term “AIDS orphan” has also led to inappropriate categorizations and stigmatizations. Therefore, “orphans due to AIDS” or “children orphaned by AIDS” — or simply “orphans” — are now the recommended terms. In all cases, it is suggested that interventions for all vulnerable children are linked and that programmes take care to avoid stigmatizing AIDS-affected children.

It is also important to link programmes as children frequently move among vulnerable groups according to the changing vulnerability patterns of their lives – children may be vulnerable in several different ways at the same time, or endure multiple vulnerabilities. For example, many of the growing number of street children in African countries and child labourers in Asian countries are children orphaned by AIDS or children who come from AIDS-affected families. In line with the International Guidelines, cited above, this study takes the broader view of HIV/AIDS-affected children recommended by international experience and includes children who are vulnerable, but may or may not be infected with HIV. This approach is particularly useful because of the wider vulnerabilities of families and children. Most policy makers and programmers have focused largely on HIV positive children and while these children are a small and very visible segment they are more vulnerable than HIV/AIDS, over the long term, they may not be the most at risk.

Children orphaned for any reason are categorized into three types: maternal orphans, paternal orphans and double orphans. Experience has shown that the vulnerability of orphans varies by type; for example, children under age 5 who have lost their mother are more vulnerable than children under five who have lost their father. Even before the HIV/AIDS epidemic, double orphans were widely recognized as among the most vulnerable children in almost every society. Over time, as HIV/AIDS epidemics worsen in a country, the proportion of double orphan’s increases.

### Typical Age of Orphans

<table>
<thead>
<tr>
<th>Age</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-5 years</td>
<td>12%</td>
</tr>
<tr>
<td>6-11 years</td>
<td>33%</td>
</tr>
<tr>
<td>12-17 years</td>
<td>55%</td>
</tr>
</tbody>
</table>

The cut off age of 18 is used when assessing the characteristics and needs of vulnerable children, because it is internationally defined as the beginning of adulthood and also because most countries have legally adopted it as the age of majority, or adulthood. In developing countries the number of children orphaned also increases with the age of the child, from 12 percent of children aged 0 to 5 years to 55 percent of children aged 12 to 17. This increase occurs because parents are more likely to die as the child becomes older. There are substantial differences in the age group of children and the needs of children in each age group and these are typically reflected in orphan programmes. Children on the Brink and ‘The Framework’ provide information and guidance on questions of need.

The “orphan epidemic” lags behind changes in HIV prevalence and cumulative deaths from AIDS. Without antiretroviral (ART) treatment orphan rates in any country do not stabilize until at least 20 years after HIV prevalence stabilizes because of the lag between infection and subsequent death in adults. In Papua New Guinea, where AIDS deaths will not peak before 2015 or 2010 at the earliest, this point will not be reached until at least 2030. As ART becomes more widely used in the next several years, orphan care options and needs will increase as the number of AIDS orphans starts to rise.

## Chart 1 - Epidemic Curves, HIV/AIDS and Orphans

- **Epidemic Curves, HIV, AIDS & Orphans**

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**Objective Section**

<table>
<thead>
<tr>
<th>Objective</th>
<th>Section</th>
</tr>
</thead>
<tbody>
<tr>
<td>Working with partners, upon a definition of children affected by HIV/AIDS and other vulnerable children appropriate to Papua New Guinea context</td>
<td>I, II, III</td>
</tr>
<tr>
<td>Estimate the current and future number of AIDS affected and other vulnerable children in Papua New Guinea, identify their demographic location and relate to vulnerability and the needs of these children</td>
<td>II, IV</td>
</tr>
<tr>
<td>Investigate children and young people’s perceptions, coping methods and alternative mechanisms of support</td>
<td>II, III, IV</td>
</tr>
<tr>
<td>Investigate the nature of social care arrangements and children’s perception of them</td>
<td>II, III, IV</td>
</tr>
<tr>
<td>Investigate family care arrangements (adoption, fostering, guardianship, community, including differing assistance) and care arrangements for children in urban and rural settings</td>
<td>II, IV</td>
</tr>
<tr>
<td>Investigate family and community responses to support for AIDS-affected families and children at family, community and district level</td>
<td>IV</td>
</tr>
<tr>
<td>Investigate community-level impact, perceptions, coping methods and alternative mechanisms of support for community-based programming for children and families affected by HIV/AIDS and other vulnerable children</td>
<td>IV</td>
</tr>
<tr>
<td>Investigate the nature of social care arrangements and children’s perception of them</td>
<td>IV</td>
</tr>
<tr>
<td>Investigate the need and adequacy of risk of security for the protection of vulnerable children in Papua New Guinea given the expected severity of the impact of the HIV/AIDS epidemic</td>
<td>IV</td>
</tr>
<tr>
<td>Investigate the need and adequacy of risk of security for the protection of vulnerable children in Papua New Guinea given the expected severity of the impact of the HIV/AIDS epidemic. This review should include assessments of public well-being, access to health, education and food security</td>
<td>IV</td>
</tr>
<tr>
<td>Investigate the legal framework for protecting the rights of vulnerable children, especially those made vulnerable by HIV/AIDS</td>
<td>IV</td>
</tr>
<tr>
<td>Describe the overall system of care for orphans and other vulnerable children, including family and community-based options, institutional services and in regard to the delivery of basic services (education, health, psychological care)</td>
<td>V</td>
</tr>
<tr>
<td>Assess needs of care and identify successes, gaps, practices and areas for further development</td>
<td>II, IV, V</td>
</tr>
<tr>
<td>Assess data collection and planning needs to improve the response</td>
<td>II, III, IV, V</td>
</tr>
<tr>
<td>Recommend to the Government, the national steering committee on orphans and vulnerable children, NGOs and other cooperating partners appropriate strategies for addressing the needs of orphans and other vulnerable children</td>
<td>II, V</td>
</tr>
<tr>
<td>To promote further development of explicit policy and strategies of support for community-based programming for families and children affected by HIV/AIDS. The participatory data collection approach for this study has established dialogue at local, national and international levels. The strategy should be continued over the coming year to develop policy and strategies for community-based care. Support appropriate changes to the Lubukwupi Act if needed</td>
<td>V</td>
</tr>
</tbody>
</table>

## E. Assessment Approach

Data for the assessment were gathered in five provinces from children, families and communities, and from government and non-
This assessment adds to a growing body of information about the situation of families and children affected by HIV/AIDS. The following studies Table four add to the overall picture of other vulnerable children and families (for full citations, see the bibliography in Appendix 2).

F. Limitations of the Assessment

Many important trends in relation to epidemic response that were uncovered by this assessment could not be studied in detail. It was also, given the limited nature of data on the epidemic by province, impossible to develop detailed pictures of responses for each province. However, when programmes to support family and community responses are initiated, the methodology developed for investigating family and community-based responses can be used to investigate these matters in more detail.

By focussing on care at the family and community level this report will encourage on-going dialogue, policy development, and on-going support to families and communities, as well as with policy makers and organizational leaders. Special thanks are due to all the children, families and community leaders who participated in interviews and discussion groups convened for this study. Hopefully, this study will assist in bringing about changes that will benefit people who participated in these interviews and discussions.

Interviews who worked with the study consultants to collect data from vulnerable children, families and communities had a very demanding task. Anyone who has

Table 2 - Summary of Data Collection Activities

<table>
<thead>
<tr>
<th>Activity</th>
<th>East Sepik</th>
<th>Eastern Highlands</th>
<th>Western Highlands</th>
<th>Morobe</th>
<th>National Capital District</th>
</tr>
</thead>
<tbody>
<tr>
<td>Case histories of vulnerable children</td>
<td>22</td>
<td>None</td>
<td>22</td>
<td>22</td>
<td>20</td>
</tr>
<tr>
<td>Discussion groups with children</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>6</td>
</tr>
<tr>
<td>Family case histories</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>25</td>
</tr>
<tr>
<td>Interviews with care givers</td>
<td>2</td>
<td>None</td>
<td>1</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Discussions with government and community organizations</td>
<td>1</td>
<td>3</td>
<td>2</td>
<td>15</td>
<td></td>
</tr>
<tr>
<td>Village discussion groups</td>
<td>2 urban</td>
<td>2 rural</td>
<td>2 rural</td>
<td>1 urban</td>
<td>none</td>
</tr>
<tr>
<td></td>
<td>1 rural</td>
<td></td>
<td>2 rural</td>
<td>2 urban</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2 periurban</td>
<td></td>
<td>2 periurban</td>
<td>2 periurban</td>
<td></td>
</tr>
<tr>
<td>Discussion groups with provincial and district level districts</td>
<td>1 district</td>
<td>2 districts</td>
<td>2 districts</td>
<td>1 district</td>
<td>None</td>
</tr>
<tr>
<td>Data collection from NGOs and CBOs assisting children</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>Stakeholders survey</td>
</tr>
</tbody>
</table>

Table 4 - Surveys and Studies of Vulnerable Children and Families

<table>
<thead>
<tr>
<th>Children and Families</th>
<th>Assessment Approach</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIV-positive children</td>
<td>Estimates of number, brief descriptions of current status and care, care, information from provincial and village discussion groups</td>
</tr>
<tr>
<td>Children abandoned by HIV-infected mothers</td>
<td>Data collected from hospitals and provincial discussion groups</td>
</tr>
<tr>
<td>Children in families with infected members</td>
<td>Data on numbers, location, needs, coping strategies, problems, support to families and communities from provincial and village discussion groups, stakeholder survey</td>
</tr>
<tr>
<td>Orphans (AIDS and non-AIDS)</td>
<td>Numbers, locations, needs, coping strategies, problems, support to families and communities from census and in provincial discussion groups and from NGOs, stakeholder survey</td>
</tr>
<tr>
<td>Children and adolescents at risk of HIV infection</td>
<td>Literature review, data collected in provincial discussion groups, interviews, stakeholder survey</td>
</tr>
<tr>
<td>National program for prevention among young people</td>
<td></td>
</tr>
</tbody>
</table>

Table 3 - Summary of Assessment Approach

<table>
<thead>
<tr>
<th>Focus</th>
<th>Related Programs or Studies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Street children</td>
<td>Street Kids Invariable, 1992, Copenhagen and Connolly, Humanity Foundation, 2003</td>
</tr>
<tr>
<td>Child laborers</td>
<td>No studies, census data 2000</td>
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<tr>
<td>Disabled children</td>
<td>No studies</td>
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<tr>
<td>Children at risk of HIV/AIDS infection</td>
<td>NACNASP Social Mapping Project studies of risk behaviour and community responses in all provinces of Papua New Guinea. Survey work completed in 2004</td>
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<tr>
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<tr>
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<td>No studies</td>
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<tr>
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G. Assessment Partners

This assessment was developed by the Department for Community Development and the National AIDS Council Secretariat with support and advise from civil society and UNICEF. Particular thanks are due to the Minister for Community Development, Dame Carol Kidu and the Secretary, Joseph Klapat, who supported the stakeholder meetings and advised the assessment team on its development. The Department for Community Development prioritised the assessment in order to better understand ways in which the government and partners could support family networks and community groups in caring for vulnerable children. The study will contribute to the development of a national response and could serve as a basis for creation of a national five-year plan. Dr. Ninkama Moiya, Director of the National AIDS Council Secretariat, encouraged the assessment as a way to expand the information base for implementation of the National HIV/AIDS Strategic Plan for 2004 to 2008. Dr. Nii-K Plange, UNAIDS Country Director, made many helpful comments on the overall approach and reviewed Sections II and III that are related specifically to estimates and projections. UNICEF supported the study by providing the ‘engine room’ for logistic support and technical assistance. UNICEF also assisted to the table international examples of good practice and lessons learnt.

On 19 September 2004, 35 stakeholders representing Government and non-governmental Organizations, and seized by providing support to vulnerable children and communities, as well as with policy makers and organizational leaders. Special thanks are due to all the children, families and community leaders who participated in interviews and discussion groups convened for this study. Hopefully, this study will assist in bringing about changes that will benefit people who participated in these interviews and discussions.

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Interviewers who worked with the study consultant to collect data from vulnerable children, families and communities had a very demanding task. Anyone who has
done this type of work can attest to how difficult and emotionally taxing it is to gather information on the intimate details of people's experience of HIV/AIDS and its impact on their lives. In the National Capital District interviewers were young people affiliated with the Special Youth Project that helped them to combatting the HIV/AIDS epidemic. These young people had been trained in interviewing techniques and were able to conduct interviews in a variety of settings. The study of families affected by HIV/AIDS and other vulnerable children since 1998 also involved the collaboration of researchers who worked with community leaders in the provinces on a volunteer basis. All of these collaborators demonstrated that community spirit and dedication to social improvement exist everywhere. Within UNICEF, Papua New Guinea, working through local offices, is responsible for the design and execution of the study rested with HIV/AIDS Focal Point Mila Hanninen, and Child Protection Officer Bruce Grant. Programme Assistant for HIV/AIDS, Regina Kagl, worked with logistical arrangements, made plans for research work and assisted with stakeholder meetings. Joe Anang who worked with community leaders in the Trobriand Islands and Karkar Island as a UNICEF consultant on community care, provided advice. He is now coordinating the development of community-based responses for UNAIDS and the UN Country Team in Papua New Guinea.

The lead consultant for this assessment was Susan Hunter, Ph.D., who along with collaborating researchers, worked for six weeks in Papua New Guinea on the design of the study, data analysis, final report writing and presentation of the findings. The research team included collaboration with researchers who worked on a volunteer basis. Without their help most of the interviews with children and AIDS-affected families would not have been possible. Their knowledge of communities and the trust they developed have been essential to the success of this study. Provincial AIDS Action Committees and village councils in the study areas patiently and enthusiastically gave their inputs. Thanks also must go to the provincial interview teams trained through National AIDS Council's Social Mapping Project, who did most of the data collection in the provinces on a volunteer basis. All of these collaborators demonstrated that community spirit and dedication to social improvement exist everywhere. Within UNICEF, Papua New Guinea, working through local offices, is responsible for the design and execution of the study rested with HIV/AIDS Focal Point Mila Hanninen, and Child Protection Officer Bruce Grant. Programme Assistant for HIV/AIDS, Regina Kagl, worked with logistical arrangements, made plans for research work and assisted with stakeholder meetings. Joe Anang who worked with community leaders in the Trobriand Islands and Karkar Island as a UNICEF consultant on community care, provided advice. He is now coordinating the development of community-based responses for UNAIDS and the UN Country Team in Papua New Guinea.

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Less than 10 percent of 80,000 or more carriers are aware of their HIV status. With limited access to voluntary counselling and testing, those who are unaware of their status could unwittingly spread the infection to 5 or 6 sexual partners each year for the 6-10 years they remain asymptomatic and undiagnosed. Since 70 percent of current diagnoses are identified at Port Moresby General Hospital, knowledge of the geographic distribution and other characteristics of infected persons is seriously distorted and biased toward urban areas.

In his introduction to the National HIV/AIDS strategy for 2004 to 2008, the Prime Minister Sir Michael Somare, stated that the “socio-economic and cultural determinants that drive the spread of HIV must be addressed with vigour. Within a period of fifteen years, the spread of this epidemic could have been contained but our efforts have not measured up to expectations.” The National AIDS Secretariat admits that “in general, responses to the epidemic by various organizations have been slow.” The epidemic was allowed to grow unfettered for almost a decade before serious planning got underway and its impact is unfortunately still not taken seriously by many decision makers in the country.

Many factors suggest that the epidemic has already spread far enough into the general population to suggest that it will be extremely difficult to contain. Because of major social and economic vulnerabilities, there is very little before serious planning got underway and its impact is unfortunately still not taken seriously by many decision makers in the country.

1. Low employment, illiteracy, urban migration, squatter communities, violent crime and growing poverty;
2. Rapid, pseudo-modernization (for example, a rapid increase in violent pornography and circular migration to urban areas) is increasing victimization and violence against women and children, including rape and sexual abuse. Traditional patterns of violent male sexual behaviour (rape, gang rape, assault) and family violence against women and children are not adequately contained through law enforcement, and at the same time traditional community protection systems for women and children are being eroded;
3. Poor health services availability at primary, secondary and tertiary levels, including lack of voluntary HIV counselling and testing; ART treatment; and treatment for opportunistic infections related to HIV/AIDS;
4. “Exceptionally high” STI rates. According to the 2004 Consensus Workshop on HIV and STIs, more than one million new cases of STIs occur every year, two-thirds of them Chlamydia infections. Two factors play a major role: the relative late advent of STIs in the country and the absence of widespread male circumcision, which is correlated with high STI infections, including HIV, and
5. Low levels of access to, and use of, condoms, which the MDG report says are “scantily distributed, especially in the rural village sector” – the rural sector comprises 83 percent of the population.

The MDG report notes other contributing factors:
1. Low awareness of HIV/AIDS, especially in rural areas;
2. Low levels of education and literacy, which make prevention education very difficult;
3. High levels of gender inequality and women’s lack of empowerment; and
4. “Complacency with regards to the HIV/AIDS threat at the decision making level. HIV/AIDS is not seen by many as a priority area.”

According to the national HIV/AIDS plan, “socio-economic conditions in Papua New Guinea place its people in a vulnerable state.” The national MDG report notes that in regard to social and economic progress, Papua New Guinea has stagnated since 1980 when its mortality transition stopped. Since then, the situation of children and women has improved little and is possibly worse. A 2004 World Bank, AusAID and Asian Development Bank assessment noted the same factors and stated that a large proportion of the population is “of reproductive age and sexually active.”

None of the problems that could fuel a rapid spread of the HIV/AIDS epidemic can be resolved quickly, and in the meantime, the epidemic may increase by as much as 33 percent per year. Without social and economic progress, prevention education is difficult, especially because sexual behaviour change requires the empowerment of women. Unless extraordinary measures are taken immediately to step up HIV prevention and impact mitigation (on an emergency basis) and to vastly accelerate responses, it is highly possible that infection levels could increase to 30 to 40 per cent of the adult population (levels now being experienced by the worst affected African countries).
their own children;  

9. The socio-economic impact of HIV/AIDS will effectively negate the per capita growth, absorbing resources that might have been invested in family and community-based care for PLWHAs, families and children; and

10. Infected women’s advocacy campaigns to reduce stigma and encourage development of community-based responses to address women’s severe impact on children and families. Discussions on each of these issues will help to clarify how exactly the HIV/AIDS epidemic is being exacerbated by the violation of women’s and children’s rights (for more information, see Appendix 3). The stagnation of development has also occurred as a consequence of these violations - policy makers and programmers who understand how severe the epidemic will be should, in this context, be motivated to make changes. In this way, the control of the HIV/AIDS epidemic will require political commitment and a massive investment of resources.

D. Feminization of the Epidemic

Unlike Cambodia, Thailand and Myanmar – the other three Asian countries where HIV is spreading in the general population – an equal number of men and women are infected in Papua New Guinea. This pattern is unusual in Asia, although it is typical of most African epidemics and is now the global norm. In Papua New Guinea, more than one in every 100 pregnant women is testing positive and while the gender of 96 percent of Papua New Guinea’s known cases has been recorded, it is entirely possible that more women than men are infected as women generally have less access to health care and testing than men. The detection of infection in women is largely through antenatal care, or discovered by young women or their husbands who in particular are at risk of infection in high-risk groups. The socially embedded poverty and economic distress, “Sexism facilitates the spread of STDs, obscures the social relations by which transmission occurs and worse, drags down the public health by enabling the misidentification of what are often for women the real risks of infection: monogamy, heterosexuality, trust and love.”

When a woman becomes infected with HIV, gender myths lead to stigmatization by the community. Women are perceived as the ‘bearers’ of HIV. HIV-positive women whose status is known are more likely to be abandoned, or even murdered. Even if they were infected with HIV by their husbands it is assumed that they are “bad” women who sought sex outside of marriage or exchanged sex for money. Men use alcohol and drugs, which increase the likelihood of risky behaviour. Double standards are solidly in place.

Dame Kidu argues convincingly that the abuse of traditional customs exacerbates the spread of HIV and that traditional customs had already worsened conditions for women, even before AIDS arrived in Papua New Guinea. The modern adaptations of bride price customs have continued to result in a commodification of women and children, while polygamy has become promiscuity and is used to gain access to additional women by men who cannot successfully support one wife. “In the traditional environment, there were many customs that protected women and these customs have broken down.” Kidu says. Sister Rose Bernard of the Sisters of Notre Dame Pastoral Care Programme in Banz believes that 90 percent of the women who are currently infected with HIV got it from their husbands because “women have no control over their sex life.” Many husbands have more than one partner, but if a wife challenges that privilege, she faces the risk of being beaten.

Canberra based anthropologist Nicole Haley says that women are being victimized in even more ways. In the Southern Highlands, after a young man in a remote tribe died from AIDS-related tuberculosis, the tribe went on a witch hunt. According to Haley, “six women from the Hiranle parish were held captive and repeatedly tortured over the space of a fortnight...beaten, stabbed, cut with bush knives and burnt with reinforcing iron. Two of the women were sexually assaulted and one had her uterus ripped out with a hot iron hook. She died as a result.” According to Haley’s 2004 report, as a result of HIV/AIDS, “women in Southern Highlands and elsewhere in Papua New Guinea are now being killed and/or subjected to torturous trials with increasing regularity.”

Sexual violence against women is common in and often takes the form of pack rapes, which are staged to demonstrate male dominance or as acts of retaliation between clans and family groups. Almost half of all rapes in the country are perpetrated by a group of men, as few as two or as many as 50. First sexual intercourse for about one-third of all women in the world is forced and sexual coercion continues to threaten women throughout their lifetimes. The ritual of group rape, where one woman and many men call line-up may be contributing to transmission of HIV, both to the women involved and among the men who participate. In this ritual of male bonding, “an urge to assert male superiority over women, the intent to punish, and an ethos of sexual opportunism and violence, are all stressed.”

As health expert Chris Breyer pointed out in 2001, in Asia, “the single most important risk factor for HIV infection among women is marriage.” This is true in Papua New Guinea as well. Women who seek voluntary counselling and testing for HIV, or ask their partners to use condoms often face violence, so much so that a major international effort is being focused on developing “couples counselling” programmes that will counsel the husband and wife together. A 2002 UNAIDS survey in three dozen countries found that even where HIV infection rates are high, the large majority of women say they were either forced, used low risk for AIDS, where 20 to 30 percent of the population is HIV positive, this belief is at best naïve opportunism. Half the female respondents to the 2000 and 2002 surveys in 28 countries say they are unconcerned about getting sexually transmitted infections, while 60 percent think that they are not taking measures to protect themselves. Even if women are aware of the risks, their right to refuse sex is usually limited. In Asia as in Africa, men who have sex outside of marriage experience no stigma, but if their wives demand condom use, they often risk partner violence.

Women the world over are disadvantaged in fundamental ways that facilitate transmission. Ultimately women have little say in their own sex lives. Every year 80 million unwanted pregnancies and 20 million unsafe abortions occur worldwide. More than half a million women die in pregnancy or child birth each year. Not only are women four times more physically vulnerable to HIV/AIDS than men, but almost one-third of all women in the world are victims of domestic violence and 130 million report to health posts, and hospitals because their babies are sick.

Several things contribute to high infection rates among Papua New Guinea women. The age of first sex (15) is the same for men and women. However, in most of the world, where the age at first sex is higher for women than men, there are high rates of multiple partner behaviour, including among women as well as men, much of it informal commercial activity and work done to make ends meet and support husbands and children in an economy with high unemployment and gender disparities. In many cases, a woman enters the sex trade when her husband offers her sex in exchange for another form of arrangement, which proceeds to a more formal brokering of sexual services. Many men are living off the sexual services of their wives, through which they gain access to cash and other resources that are otherwise unavailable to them. When women and men providing and brokering sexual services migrate between urban centres, rural settlements, work camps and mines to earn a living, it is often “a last-gasp survival strategy” that is becoming increasingly common because of the “economic distress, cultural stigma and political marginalization” of Papua New Guinea’s desperately poor. Men ostensibly own the women they sell by virtue of marriage and the lives of these women and their children are filled with danger, insecurity, and often take the form of pack rapes, which are stage to demonstrate male dominance or as acts of retaliation between clans and family groups. Almost half of all rapes in the country are perpetrated by a group of men, as few as two or as many as 50.
they are born or shortly afterward, aborted or victims of infanticide.

According to Human Rights Watch, widespread rape and brutal attacks on women by their husbands are contributing to a resurgence of HIV/AIDS in Uganda, a country that succeeded in stopping the spread of HIV in the mid-1990s. Almost half of all women in Ethiopia, Uganda and Kenya, and one in five in Canada and a fifth in the United States have been beaten by their husbands – the most common form of violence against women in every country. The health-related and developmental costs of rape, physical assault and of homicide perpetrated by intimate partners are extraordinary. In Papua New Guinea, as in many parts of Asia, men and many women believe they deserve a beating if dinner is not ready on time or if they go out without their husband’s permission. Women with HIV are much more likely to have a physically violent partner and almost half said they could not deny their husbands sex after a beating, or if they feared HIV infection. Human Rights Watch has stated that the “Women especially at risk are those in unstable or broken marriages or long term unions in a society where men commonly engage in sex outside the union and women confront abuse if they demand condom use.”

In 1997 women accounted for 41 percent of all world’s HIV/AIDS cases – currently they account for 48 percent. In sub-Saharan African Countries which have the oldest epidemics, women comprise 57 percent of all HIV/AIDS cases, and while the proportion is lower in Asia, it is rising fast. Globally, women comprise 62 percent of new HIV infections, and their overall share will continue to increase. Among infected South and South East Asians, 25 percent are female and 22 percent of the new infections are among women. In Eastern Europe and Central Asia, 33 percent are women and the proportion is rising fast. Experts predict that as the epidemic spreads more widely in the general population, the proportion of women infected in Asia will exceed men, just as it has in Africa.

In developing countries, where household and agricultural chores are labour intensive, women provide no-cost labour for farms and homes and men can work for very low wages. Women who are marginalized in this way can easily be exploited for sex work, which is big business in many developing countries. Women provide unpaid labour to care for sick family members, and generally girls and not boys are taken out of school to replace household labour lost due to AIDS, or to care for sick family members. In many Asian countries besides Papua New guinea, women cannot own or inherit property, which helps to concentrate the distribution of wealth in male spouses of influence. While gender inequities provide many benefits for the economic elite, the economic context which society as a whole are substantial. A World Bank study in sub-Saharan Africa showed that gender discrimination is reduced per capita economic growth in the region by at least 0.8 percent each year since 1960 which is roughly the same annual loss that experts attribute to AIDS.

There are no social safety nets, unemployment insurance, or social security systems in Papua New Guinea as in most Asian countries because governments work with employers to hold costs down and maximize profits. Families are the only social safety nets for women, but while they may “provide protection they can also be a prison in which they are trapped and have no voice to take place…” Women who are married are prey when families fail,” says Asian expert, Brown. Until a society modernizes, there is no other protector of women, no economic or social status for females and no other social support systems. “When they do not belong to one man,” Brown says, “they belong, by default, to all. Women in these situations constitute a large proportion of all sex-workers in Asia.”

Without education, women’s ability to acquire information of any kind—but especially about sex and STIs—is vastly reduced. Gender norms also limit what “good” women are supposed to know about sex and sexuality so their ability to accurately determine their level of risk of HIV and STIs, and to learn how to protect themselves from infection is reduced. They must rely on their husbands to know about these things but many husbands are just as ignorant as their wives, or more so. They also rely on their husbands to be honest about sexual relations outside the union, but instead gender myths about sexuality en an antilal fide, both of which sustain the sex industry.

Papua New Guinea’s traditional social systems control women’s ability to speak out, either within their family or in public settings, and make it difficult for women, without the assistance of men, to own property and/or build up economic security. Kinship systems determine where females live when they are children, and for women, how much say they have in their own lives. Children and women are considered to be possessions in the traditional P apua New Guinea family and marriage for most women in Papua New Guinea is the principal means to acquiring a livelihood and social status. Women caught in the economic elite, the economic context which promotes and propagates sexual coercion often tolerate sexual assault without ever raising a voice. This of course increases women’s vulnerability to HIV/AIDS.

E. Growth of HIV/AIDS among Papua New Guinea’s Young People

In PNG women are infected at a younger age than men – twice as many women as men are infected in the 15 to 29 year age group. This situation reflects patterns in sexual behaviour all over the world, principally because older men commonly pursue sexual relations with younger women. As such young girls are in frequently infected with HIV ten years earlier than men. The United States Census Bureau predicts a sustained imbalance in population of men and women that will lead men to continue to seek even younger women leading to further increasing infection rates in female adolescents and young women. Some men around the world believe that younger girls are less likely to be infected with HIV, while others hold the mistaken belief that having sex with a virgin can cure AIDS. To the contrary, HIV-positive young people are highly infectious because in many situations they were recently infected with HIV – it is most easily transmitted immediately following infection when viral loads in the blood are high, a condition that lasts only a few months.

In South Africa, for example, young women are infected for every one young man, which is causing great concern about the future demographic composition of the country. Like women, substantially more young men are infected because they typically have lower levels of access to testing and diagnosis than older people. In Papua New Guinea it is difficult to know the true demographic distribution of current cases, because gender is not recorded for 40 percent of the cases in NAC’s data base.

Young people in Papua New Guinea are disadvantaged in many ways. Their basic rights to education, health care, and survival are in many cases not met. In PNG, society provides “little or no voice for youth,” and many are sexually victimized and exploited by adults. Young people who are bored and unoccupied are often drawn from rural villages to “hot spots,” or nodes of high risk areas which increases their vulnerability to infection. The youthful age structure of Papua New Guinea’s population, where 43 percent of rural and 53 percent of urban populations are aged between 15 and 39, may well be a contributing factor to violence, other social problems and the spread of HIV.

In 2000 UNAIDS estimated that worldwide, six people under the age of 24 were being infected with HIV every minute and half of all people who are now infected got the disease before they were 25 years old. Epidemiologists have shown that in countries with infection levels over 15 percent (among adults) one third of fifteen-year-olds will also become infected at some time in their lives. A 2004 UNICEF report notes that, similar to Asia where two thirds of Asia’s young people are uninformed about the risks of HIV/AIDS, youth in Papua New Guinea are “alarmingly ignorant about HIV/AIDS’ and more than half say they know nothing about the relationship between HIV and drug abuse. “Even where
HIV prevalence is known to be high, unsafe sex and drug use are often still common. Many young people who know how to avoid infection are unwilling to use condoms or to avail themselves of voluntary counselling and testing services. Girls are particularly at risk as they are often unable to negotiate their sexual relations, including condom usage.

The largest ever adolescent population the world has seen faces an increasing risk of disease, unwanted pregnancy and poverty. Besides making up more than half of all new HIV infections, adolescents each year acquire more than one third of the world’s 333 million new cases of curable sexually transmitted diseases (STDs). Young girls face teen pregnancy, early marriage and violence, and because only 17 percent of women in developing countries between the ages of 15 and 49 years have access to contraception, they account for one quarter of the 20 million unsafe abortions performed each year. One contributor to very high rates of maternal mortality in Papua New Guinea for younger and older women alike are self-induced or unsafe abortion practices.

F. Growth and Formalization of the Sex Sector

Poverty is pushing many young people in Papua New Guinea into informal sex work, especially young women. Amongst 15 to 24 year old women interviewed in 1996 for a study of rural and urban youth, those who never took cash for sex had a median number of 1 partner in the last year (although 32 percent had more than one). For those who received non-cash gifts for sex, the median number of partners in the last year was 5.5 (with 23 percent having 15 or more).

According to one long time student of Papua New Guinea culture, “Plurality of sexual partners, both as serial partners, in and out of marriage, and female partners in groups, is a very common and highly valued aspect of sexuality in Papua New Guinea. Although the number of their lovers gradually drops with age, over the lifespan, many people have a large number of partners.” Commercialized and transactional sex in Papua New Guinea is a survival strategy in rural as well as urban areas, and “increasingly villagers are observing married men seeking extramarital partners from among the pool of single, divorced and separated women in their own or nearby villages, paying for these liaisons with cash, beer, or both.” Sex is available at clubs, discos, markets and government stations. Large numbers of women may be brought in by managers or migrate of their own will to provide sexual services for men on road building crews; at canning factories; petroleum and gas installations; logging camps; and mining operations.

The spread of the HIV epidemic in Papua New Guinea has been maintained by an indigenous sex industry that has arisen principally as a response to poverty but is now being consciously and deliberately expanded, especially among communities that have never had a sex industry before. According to one long time student of Papua New Guinea culture, “Plurality of sexual partners, both as serial partners, in and out of marriage, and female partners in groups, is a very common and highly valued aspect of sexuality in Papua New Guinea. Although the number of their lovers gradually drops with age, over the lifespan, many people have a large number of partners.” Commercialized and transactional sex in Papua New Guinea is a survival strategy in rural as well as urban areas, and “increasingly villagers are observing married men seeking extramarital partners from among the pool of single, divorced and separated women in their own or nearby villages, paying for these liaisons with cash, beer, or both.” Sex is available at clubs, discos, markets and government stations. Large numbers of women may be brought in by managers or migrate of their own will to provide sexual services for men on road building crews; at canning factories; petroleum and gas installations; logging camps; and mining operations.

Families and Children Affected by HIV/AIDS and Other Vulnerable Children in Papua New Guinea

A factory like atmosphere, anonymity and alienation. According to a 1998 International Labour Office (ILO) study in four countries (Indonesia, Malaysia, the Philippines and Thailand) prostitution in South East Asia has grown so rapidly in recent decades that the sex industry has assumed the characteristics of a thriving economic sector, whose commercial dispositions, contributes substantially to employment and national income.

The coordinator of the ILO study, economist Lin Lim, has stated that “the harsh reality is that the sex sector is big, black, best well entrenched in national and international economies.” Ms. Lim states that “prostitution is deeply rooted in a double standard of morality for men and women, as well as in a sense of guilt or obligation that children feel towards their parents.” By resulting in widespread unemployment, Asia’s economic crisis may have fuelled growth in the sex industries. As Ms. Lim notes: “if the evidence from the recession of the mid-1980s is any indication, then it is very likely that women who lose their jobs in manufacturing and other service sectors, and whose families rely on their remittances, may be driven to enter the sex sector.” In addition the ILO report observed that demand for commercial sex never slowed as men lost their jobs and “poverty has never prevented men from frequenting prostitutes, whose fees are geared to the purchasing power of their customers”.

The four countries included in the ILO study earn between two and 14 percent of their gross domestic product (GDP) directly from the sex sector. The ILO estimates between 0.25 and .5 percent of all females in the world are sex workers. Indonesia has at least 230,000 sex workers, Malaysia about 140,000, Thailand about 300,000 and the Philippines about half a million. Authorities collect licensing fees and taxes on the many legitimate businesses, hotels, bars, restaurants, game rooms, tourist agencies, escort services, spas and special clubs that flourish around the sex sector. In countries where prostitution is illegal, tribes are collected from businesses the sex industry uses as fronts, including night clubs, cocktail lounges, karaoke bars, night clubs, saunas and massage parlours. The income that the sex industry generates is crucial to the livelihoods of millions of workers in peripheral businesses, supporting tens of thousands of cleaners, waitresses, cooks,
parking lot attendants and security guards. In Malaysia, physicians are employed for regular checkups, food vendors near sex establishments gain more customers and property owners earn rent.

In Thailand, close to $300 million is transferred annually by urban-based sex workers to rural families, more money than all rural development programs combined. And another $300 million is sent home every year by Jakarta’s sex workers and sex workers make similar transfers in Asian countries where accounts have not been quantified. Rural remittances, as they are called, constitute a “poverty relief” program that allows the poor in subsistence agriculture to survive in the absence of government interventions. The report states that in the absence of social welfare programmes sex work is “often the only viable alternative for women in communities coping with poverty, unemployment, failed marriages and family obligations”. 70 percent of Philippine sex workers state they are supporting poor parents, their own children, or their spouses and boyfriends which are the same issues frequently mentioned by Thai sex workers. Half of all sex workers have previously worked on family farms, in rural cottage industries or in domestic labour.

The sex industry is fully entrenched in the four countries studied by the ILO report and in all Asian economies. Ms. Lim states that the increases in disposable incomes among growing middle classes has resulted in “an enhanced capacity and motivation of men to buy sexual services in a much wider and more sophisticated range of settings.” The internet has made the sex business and more sophisticated range of settings.”

G. HIV/AIDS in Papua New Guinea is a Rural Phenomenon

Despite the fact that national data collection systems are biased toward urban settings, HIV/AIDS in PNG is overwhelmingly a rural problem. The 2002 World Bank assessment notes this rural bias:

“The virus is firmly established in the general population with prevalence rates in the 5 to 49 year old population of between 3 and 4 percent in Port Moresby, well over 2 percent in other urban areas and over 1 percent in rural areas. But these differential prevalence rates must be seen in the context of a population that is still 83 percent rural. As a result, 70 percent of all infections are among the rural population (despite lower prevalence rates), 15 percent of all infections in the urban population.”

The ILO warns that the growing scale of prostitution in Asia and its increasing international significance have serious implications for public morality, social welfare, criminality, human rights violations, the sexual exploitation of children and the transmission of HIV/AIDS. Since the sex industry is not recognized as an official sector and often operates contrary to local and national laws, governments will find it difficult to track the sex industry. As little as $90 million is sent home every year by Jakarta’s sex workers and sex workers make similar transfers in Asian countries where accounts have not been quantified. Rural remittances, as they are called, constitute a “poverty relief” program that allows the poor in subsistence agriculture to survive in the absence of government interventions. The report states that in the absence of social welfare programmes sex work is “often the only viable alternative for women in communities coping with poverty, unemployment, failed marriages and family obligations”. 70 percent of Philippine sex workers state they are supporting poor parents, their own children, or their spouses and boyfriends which are the same issues frequently mentioned by Thai sex workers. Half of all sex workers have previously worked on family farms, in rural cottage industries or in domestic labour.

The sex industry is fully entrenched in the four countries studied by the ILO report and in all Asian economies. Ms. Lim states that the increases in disposable incomes among growing middle classes has resulted in “an enhanced capacity and motivation of men to buy sexual services in a much wider and more sophisticated range of settings.” The internet has made the sex business and more sophisticated range of settings.”
will, in turn, lead to further depression of the economy and further deepening of poverty." The 2004 Consensus Workshop's updated estimates of HIV infections in Papua New Guinea suggests that declines could be even more severe than those forecast by the CIE study and occur sooner than 2020. The CIE study estimates an overall decline in gross domestic project of 7.5 percent, although losses in the mining sector would only be around .06 percent because of the substitution of machinery for labour. The poor the sick and the elderly could decline by 7.9 percent by 2020. Important losses may also occur in specific sectors that are vital to women's and children's well being, including, education and health care. In other countries HIV/AIDS has profoundly affected professionals in these sectors. Countries in Sub-Saharan Africa that have lost physicians, nurses and teachers cannot replace lost human resource requirements for essential services. As a consequence the CIE study because "teachers tend to be disproportionately affected by HIV/AIDS epidemics." Although enrolments may decline as children, particularly girl children are removed from school to care for the ill and work in the household or on the farm. Declines in household income will also mean that parents cannot afford to pay school fees, further reducing enrolments, although specific impact studies for the health and education sectors can help planners anticipate changes and predict increases in demand.

Increasing wages for skilled workers may create more demand for vocational education. In many parts of Africa and because of high HIV prevalence, firms face increased costs for training skilled staff because they must train two to three people for every one position. CIE predicts that "infrastructure firms face generally higher rates of infection due to the nature of their work, and the managers of major infrastructure projects will need to be aware of the higher production costs that can be caused by increases in HIV infection." To prevent unnecessary personnel losses and even higher increases in their costs, African firms have increased spending on HIV prevention programs for staff and their families and provide antiretroviral treatment to keep infected staff members healthy and productive.

Loss of skilled personnel in the civil service has affected the ability of many countries to carry out basic AIDS awareness and prevention campaigns and their programmes. Two of the largest problems: 1. The task of mobilizing families and communities for care and prevention. The loss of skilled personnel also severely hinders government efforts to provide or expand services. In many Sub-Saharan African countries with severe epidemics, government decentralization has been slowed by the loss of local level government personnel and subsequently, the capacity to implement prevention and mitigation efforts is also severely impaired. 1. Food Security and Labour Availability

Unless prevention, care and support are scaled up the social and economic impacts of HIV/AIDS will be severe. The diagram at right, from the 2002 AusAID-sponsored study, shows how the microeconomic or household impacts of HIV/AIDS – illnesses, deaths, sick time, loss of productivity in formal and informal labour, and spending for medical care and, for care giving—multiply. These losses in turn form the basis of losses in both the public and private sector, which in turn will compound the macroeconomic losses projected for Papua New Guinea as a whole. The impact on women and children at the household level is projected to reduce subsistence agriculture production by 24.2 percent. The CIE study says that key impacts at this level will include:

1. The death and illness of the household’s wage earners, which will cause loss in incomes; 2. The burden of caring for the sick and for orphans, including additional costs for food, school fees and medical care. 3. A shift in family spending, including high expenditures for medical care, typical of families with HIV-infected members and the cost of funerals; 4. Removal of children from school as a consequence of lost income and in order to provide the labour needed to care for the sick and for domestic and farm work.

In this country, as in many developing countries, women and children represent the bulk of subsistence farm labourers and in some rural areas, where men migrate for work, they maintain all household food production. Experience in Africa and other parts of Asia shows that HIV infected women become ill and die, or as their labour is diverted to caring for infected children or other children that have been adopted from dead relatives, they have much less time to spend on food production. As such, the impact on food security for rural economies and households may reach crisis proportions over the next decade. In Southern Africa more than seven million farmers had died by 2000, according to a World Food Programme estimate, many of them women, many of them elderly. Females have occurred with greater regularity and farm land that has fallen out of use is difficult to bring back into production. Many African households were forced to sell off their animals, which in turn will compound the livestock for HIV/AIDS. Many farmers are driven into destitution by HIV/AIDS.

In this country, these issues have serious implications for children and women. Malnutrition already affects 30 percent of children under five in and is probably equally high in older children and women. As HIV/ AIDS prevalence increases, the number of children who are malnourished will also increase. For example, studies in Africa have shown that children in AIDS-affected families are less well-nourished than children in families not affected by HIV/ AIDS. Malnutrition's permanent effects on children and on their cognitive ability will, when coupled with the withdrawal of children from school, compromise children's rights to development and Papua New Guinea's ability to deal with both the HIV/AIDS epidemic, and other development challenges.

J. Women as Care Givers

HIV/AIDS epidemics increase the pressure on women to care for sick family members and other orphans. When relatives die, the challenge of taking care of additional orphans and other vulnerable
HIV/AIDS can also exacerbate women’s political vulnerability. In South Africa, Zambia and Zimbabwe, more women than men are infected and 75 percent of infections among young people are in women. Political observers are speculating that this will cause a major loss of franchise for women who will be outnumbered politically and become even more under - represented in Government than they currently are. South Africa’s 2004 Governance and AIDS Programme Report stated that “women in particular risk disenfranchisement, as they were most often acutely affected by the epidemic.” Malawi is also reporting that because women taking care of the sick are too busy to vote and women who are themselves sick with AIDS are not strong enough to vote.

K. Impact on the Elderly

In Papua New Guinea, the breakdown of the ‘wantok’ kinship system of support has left many of the elderly, who lack family support, in extreme poverty. In AIDS’s 2002 participatory poverty assessment, villagers all over the country identified elderly people and widows whose children cannot support them as the highest priority, with over 50 percent of the elderly in Papua New Guinea society. As HIV/AIDS deaths increase and people in the middle age groups die with increasing frequency, the elderly will not only be left with more grandchildren to care for, but will also have less resources for themselves and their families as remittances from their children cease.

Experience shows that elderly people experience psychological distress and economic difficulties, both of which are exacerbated by the added burden they cannot care for. Younger families that adopt, and foster families, also experience stresses when they end up with more mouths than they can feed. In Africa, this has contributed to increased child abuse and to increased levels of child trafficking for sex work. The breakdown of families results not only the loss of informal social safety nets, but also in the loss of psychosocial support and protection for children and young people, women and the elderly alike.

L. Absorption of Resources

As the HIV epidemic worsens in Papua New Guinea the relationships between the economy will slow per capita growth and absorb resources that might have been invested in family and community-based prevention and care. Business losses will reduce profits and the amount companies have available for employee benefits. The death of people in their most productive years as a consequence of AIDS has led to population structures that have never been seen before. Currently, demographers and economists are still grappling with the social and economic implications of the demographic changes that are occurring in some parts of the world as a consequence of HIV/AIDS. Chart 2 taken from the AusAID sponsored socioeconomic impact study of HIV/AIDS, shows the overall loss of population in a number of African countries.

Unless prevention and care interventions are scaled up similar losses could well occur in Papua New Guinea. The AusAID sponsored CIE study projects that declines in social welfare could reach 30 percent. One authority on Papua New Guinea states that “the current state of national finances spells future disaster.” But with HIV/AIDS affecting the economy, the financial situation will be worse than anticipated. At the individual level, HIV/AIDS epidemic increases as a consequence of the disease such as medical and funeral costs, which could result in lower expenditure on the needs of children, women and the elderly.

The AusAID-sponsored study predicts a rising gross domestic product per capita and higher wages for skilled workers, but a severe decline in economic conditions for most unskilled workers. The worst declines predicted by the study will be in subsistence agriculture (between 8.5 and 24.2 percent). The report forecasts massive increases in demand in the health sector, teacher shortages, rising costs, increased poverty and slowed growth on gender equality.

M. Communities are Unprepared

This assessment and other reports suggest that most Papua New Guinea communities are unprepared for HIV/AIDS prevention or to care for the sick, the dying and children left behind by the loss of their parents. Information campaigns to reduce stigma have not reached many communities and across the country, the development of community-based responses to avert the epidemic’s impact on women and children has been very slow.

The National Plan notes that “care for people with HIV is almost non-existent, except where church health services are building programs of community-based care.” Papua New Guinea’s new AIDS plan says that “the extent of fear in the community about HIV/AIDS...contributes to a serious neglect and abuse of PLWHA.” Reports of PLWHA left undernourished, without food, water, or assistance for cleaning themselves are numerous. Papua New Guinea’s National Home Based Care Network drafted a training programme for health workers and families in 2004 and plans to soon train health workers and families in selected areas. Home based nursing kits and Living with Dignity Kits are being tested and evaluated for use around the country. However, the roll out of these interventions may be too limited in geographic coverage or too slow to keep up with the increasing numbers of AIDS related deaths.

While some NGOs and faith-based organizations are setting up community care facilities for people living with HIV/AIDS and their children, “the prevailing discrimination and stigmatization [results in] PLWHA sometimes being abandoned by their families or rejected from their homes.” Although the national strategy is to reduce bed occupancy among AIDS-related patients by 50 percent by 2008, this will be difficult to accomplish, because communities are unprepared, and referral and support services are undeveloped.
This under-resourced communities with the burden of care which will further push down productivity and limit the time available for the care and supervision of children.

Noting that “care for people with HIV is almost non-existent, except where church health services are building programs of community-based care,” the national plan suggests that systems of care must not only address the needs of adults and families living with AIDS, but provide medical and psychological support to the whole community. Families and community leaders need assistance in “providing care and support to children orphaned by AIDS,” and in reducing stigma and discrimination.

Family and community care and support systems must be strengthened quickly. These systems need to address not only the needs of adults living with AIDS, but the needs of an increasing number of children made vulnerable by the epidemic. While communities were traditionally a vital source of protection for all people in Papua New Guinea, their gradual breakdown leaves many people vulnerable, especially women, children and young people. As experience in Africa has demonstrated, increasing vulnerabilities extend the epidemic in Papua New Guinea down through a second and third generation unless concerted action occurs. They must be taken into account in building sustainable responses at the local level.

II. Vulnerable Children in Papua New Guinea

A. Introduction

In addition to poverty and unemployment and a lack of access to land and resources, HIV/AIDS is in Papua New Guinea another source of vulnerability for children and their overwhelmingly female caregivers. Because suffering from HIV/AIDS may be delayed for many years, the disease is much less of an immediate concern than an empty stomach or limited access to school, even though infected children, and children in AIDS-affected families, already report discrimination and exclusion in many parts of the country. Most of this study’s respondents agreed that all children in Papua New Guinea are vulnerable and the vulnerabilities stem much from two decades of stagnated development, as they do from the HIV/AIDS.

Because the vulnerabilities of children and their families that are caused by HIV/AIDS must be contextualized in relation to other vulnerabilities, this section discusses the multiple ways that children are made vulnerable. Estimates of the number of children affected by HIV/AIDS are provided along with a discussion of the problems they face. The number of other vulnerable children in Papua New Guinea is also estimated, and the section closes by examining underlying vulnerabilities that affect all children.

B. Children Affected by HIV/AIDS

1. Current Number

In the late 1990s, the Committee on the Rights of the Child identified three categories of children made vulnerable by HIV/AIDS: infected children; affected children (orphans and children living in families with HIV-positive members); and children likely to be infected or affected (for more information, see Section I and Appendix 3 of this report). The table summarizes estimates for each, their sources of vulnerability and principal interventions:

<table>
<thead>
<tr>
<th>Source of Vulnerability</th>
<th>Principal Interventions</th>
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<tbody>
<tr>
<td>Exposure to HIV</td>
<td>Antiretroviral therapy</td>
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<tr>
<td>Loss of schooling</td>
<td>Education</td>
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<tr>
<td>Loss of income</td>
<td>Livelihood</td>
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<tr>
<td>Loss of employment</td>
<td>Livelihood</td>
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<tr>
<td>Loss of protection</td>
<td>Social services</td>
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<tr>
<td>Loss of shelter</td>
<td>Social services</td>
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<tr>
<td>Loss of access to health care</td>
<td>Social services</td>
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<tr>
<td>Loss of care and support for dying family members</td>
<td>Social services</td>
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<tr>
<td>Loss of family capacity for care</td>
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<tr>
<td>Low family capacity for care</td>
<td>Social services</td>
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<tr>
<td>Loss of school</td>
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<td>Loss of access to health care</td>
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<tr>
<td>Loss of access to school</td>
<td>Social services</td>
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<tr>
<td>Loss of access to family</td>
<td>Social services</td>
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<td>Loss of access to work</td>
<td>Social services</td>
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<tr>
<td>Loss of access to food</td>
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<td>Loss of access to shelter</td>
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<td>Loss of access to education</td>
<td>Social services</td>
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<tr>
<td>Loss of access to health care</td>
<td>Social services</td>
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</table>
The introduction of low cost antiretroviral therapy (ART) in Papua New Guinea will make treatment for parents significantly more feasible.

<table>
<thead>
<tr>
<th>Problem</th>
<th>Number of Cases</th>
<th>Sources of Vulnerability</th>
<th>Principal Interventions</th>
<th>Vulnerability</th>
<th>Interventions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>a.</strong></td>
<td></td>
<td></td>
<td>Social welfare supervisors, monitors, trains, counsels Health and social welfare professionals provide home visiting</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>b.</strong></td>
<td></td>
<td></td>
<td>Trauma Exposure to HIV infection by abuse in family or by providing care to infected family members Removal from school to provide care and household labour Loss of access to health care Poverty forces children into sex work including child sex work Child subjected to exploitation</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>c.</strong></td>
<td></td>
<td></td>
<td>Poverty pulls children into high risk situations Children need to work to support family Children drawn into high risk behaviours</td>
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<td><strong>d.</strong></td>
<td></td>
<td></td>
<td>Poverty reduction programs Increase health and education services and social welfare benefits for all children Support family income so children are not removed from school Institute counselling programs and school feeding programs to keep children in school Provide frank HIV/AIDS prevention education and counselling</td>
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<td><strong>e.</strong></td>
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</table>

74 The four problems:  

- **i.**  Reduced family circumstances  
- **ii.**  Children living in AIDS-affected families  
- **iii.**  Children living in vulnerable situations  
- **iv.**  Children living in vulnerable situations

75 Of all children under 18; 5.9% if children at risk of infection are not included

Numbers (with the exception of children living in poverty) can be doubled to get a low estimate of children affected by HIV/AIDS for 2010. When the 2004 consensus group completes their work, the following estimates can be modified according to their final projections:

**Estimated HIV/AIDS affected children in 2010**

<table>
<thead>
<tr>
<th></th>
<th>2010</th>
<th></th>
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</thead>
<tbody>
<tr>
<td>Infected children</td>
<td>9,400</td>
<td></td>
</tr>
<tr>
<td>Orphans</td>
<td>27,000</td>
<td></td>
</tr>
<tr>
<td>Children living in AIDS-affected families</td>
<td>77,000</td>
<td></td>
</tr>
<tr>
<td>Children at risk of infection</td>
<td>138,108</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>272,508</td>
<td></td>
</tr>
</tbody>
</table>

It should be kept in mind that all of these estimates are tentative and can be improved once the report of the November 2004 Consensus Workshop is completed and more up-to-date estimates of current cases and future cases become available. Several predictions, however, can be made with confidence. First of all there will be a rapid increase in double orphans – high HIV infection rates among younger adults in Papua New Guinea mean that many children will lose one or both of their parents at a very early age. Equal rates of infection among males and females mean that more children will become double orphans sooner than in African countries. This is a concern, because double orphans have already been identified as one of the Papua New Guinea’s most vulnerable groups by the ADB poverty study. Secondly, the number of AIDS orphans has just begun to take off and will not level well after seroprevalence levels and AIDS deaths stabilize and begin to decline. The high number of orphans means that a problem in Papua New Guinea until well past 2020.

**3. Problems of HIV/AIDS-Affected Children**

The following problems, reported by HIV/AIDS-affected children in PNG, are shared by HIV/AIDS-affected families and children worldwide:

- **a.**  Reduced family circumstances  
- **b.**  Discrimination and stigma  
- **c.**  Trauma and psychological problems

Children can suffer severe trauma when they care for ill parents or family members because the progression of AIDS related illnesses is long and often very difficult. They are also traumatized when they are orphaned, particularly if they are separated from their siblings or other family members and may go through a period when they are frequently displaced and shifted from
Families and Children Affected by HIV/AIDS and Other Vulnerable Children in Papua New Guinea

one foster care arrangement to another. Some end up facing the risk of infection themselves through abuse – children in foster homes report physical and mental abuse, very heavy workloads and a deep sense of rejection and blame.

d. Isolation: Families may move to new locations if they can afford it so their status is not known. Children are isolated because their friends are not allowed to associate with them and because fostering families often make them work hard and do not allow them to go to school or give them any time for play or recreation. Many children have become homeless, living on their own with their siblings or in family-like groups. Children are experiencing depression, grief and anger, but are forced to accept their situations and survive as best they can.

4. Special Needs for Care

While care for children affected by HIV/AIDS needs to be integrated as fully as possible within programmes of care for all vulnerable children, it is important that programmes for children in general, HIV/AIDS affected children also have a number of special needs:

a. HIV-infected children need diagnosis, treatment and care. HIV-infected children who have dangerous infections, are in pain, treatment for opportunistic infections as they arise

b. Children living with HIV-affected parents or siblings: usually end up providing child care and welfare to other children, and do not become infected in the process. They also need psychosocial support and are more prone to depression, grief, anger and illness. They tend to leave school unless they are provided assistance with school fees and their family with additional support for care giving. All of these problems can be addressed by appropriately trained home and community care support groups and the methods for doing so add to the existing psychosocial needs in an extensive literature from African and Asian countries.

c. Children orphaned by AIDS are often more traumatized than other orphans because they have gone through the long and difficult period of dealing with the illnesses of one or both parents. They will then begin what may become a process of being passed from one guardian or care giver to another. Their physical and mental status needs special monitoring and care, which can be done by community volunteers under the guidance of professional social welfare workers or trained community counsellors. Older caregivers may need income support and counselling to continue to provide care to their grandchildren. When care is provided by community groups, it must be monitored and supported by professionals, who can protect the children from the threat of physical and sexual abuse. As it has been mentioned previously, is typically higher for children affected by HIV/AIDS.

d. Children and young people at risk of infection need appropriate information and the means to protect themselves from infection (condoms), as well as the support from their communities to avoid drug addiction and other risky behaviours. If drug addiction they need rehabilitation and reintegration into their communities. Programs to prevent child sexual abuse are critical in Papua New Guinea because many children will be infected in this way.

5. Pre-Emptive Planning

In a special report on antiretroviral treatment, Save the Children UK says that “The early identification of HIV/AIDS-affected families, possibly before the onset of symptoms, allows service providers of all types, social and preventative in their approach. This is a radical change in programme planning. This can have emphasized impact mitigation.” The report continues by noting that “Pre-emptive planning can avert many of the problems that characterize heavily affected communities at the present time.” Community health workers, home care givers and social workers should be trained to track and monitor the often hidden but severe psychological consequences that children in AIDS-affected households frequently experience. “Psychosocial needs are frequently overlooked because many parents and service providers lack basic skills in recognizing children’s psychological or behavioural reactions. Patterns of psychological morbidity in children include showing signs of being unhappy, lonely and worried,” says the Save report. Widespread provision of ART will reduce the number of severely ill adults, preventing much of the trauma and difficulties faced by affected children and families.

C. Other Vulnerable Children in Papua New Guinea

International guidelines, based on the experience of other countries with severe HIV/AIDS epidemics, recommend that programmes should not single out children affected or infected by HIV/AIDS from other vulnerable children because they need support. As it has been mentioned, promotes their separation and isolation from other children and increases discrimination against them and their families. From a practical point of view, many children who are affected or infected in Papua New Guinea, so it would be difficult for assistance programs to single those out made vulnerable by one disease.

In the 2002 ADB poverty study, participants from 18 villages in five Papua New Guinea provinces said that orphans and abandoned children were among the most disadvantaged members of their communities. Participants in the ADB study agreed, but also said that many other children in their communities are equally vulnerable, with providers of care and support having emphasized impact mitigation.

In Table 8 below, estimates of Papua New Guinea’s other vulnerable children are provided in column 2, along with the sources of vulnerability and the principal interventions that have been found successful in other countries.

<table>
<thead>
<tr>
<th>Problem</th>
<th>Number of Children</th>
<th>Principal Interventions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Orphans</td>
<td>220,000 total</td>
<td>Support from parents and adoptive and foster caregivers</td>
</tr>
<tr>
<td>and other</td>
<td>210,600 due to besides AIDS</td>
<td></td>
</tr>
<tr>
<td>causes</td>
<td></td>
<td>Loss of loved ones</td>
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<tr>
<td></td>
<td></td>
<td>Trauma in caring for dying family</td>
</tr>
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<td>Foster parents may accept children to use their own ends</td>
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<tr>
<td>Adopted</td>
<td>110,000 (14%) and 570,900 (21.4%) of children under 18</td>
<td>Extended family</td>
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<td>Fostered</td>
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<td>Assistance from government</td>
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<td>Street</td>
<td>5,000 in NCD and</td>
<td>Social welfare supervisors, monitors, training of carers</td>
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Discussion groups said “all children in Papua New Guinea are vulnerable,” and that they were saddened by this fact because they felt unable to protect them or improve their prospects for the future.

ADB study participants also said that elderly households, follows with no one to support them and single mothers were extremely vulnerable, all of whom are the most common care givers of orphans and children affected by HIV/AIDS. These turangau lain, “people in a bad situation” were “considered to be at the bottom of the economic ladder” by all the ADB participants. Participants in this study identified the same groups of adults as vulnerable in their villages and communities.

In Table 8 below, estimates of Papua New Guinea’s other vulnerable children are provided in column 2, along with the sources of vulnerability and the principal interventions that have been found successful in other countries.

<table>
<thead>
<tr>
<th>Problem</th>
<th>Number of Children</th>
<th>Principal Interventions</th>
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<tbody>
<tr>
<td>Orphans</td>
<td>220,000 total</td>
<td>Support from parents and adoptive and foster caregivers</td>
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<tr>
<td>and other</td>
<td>210,600 due to besides AIDS</td>
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<td>causes</td>
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<td>Loss of loved ones</td>
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<td>Trauma in caring for dying family</td>
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<td>Low family capacity for care</td>
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<td>(21.4%)</td>
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Families and Children Affected by HIV/AIDS and Other Vulnerable Children in Papua New Guinea

2. Orphans of Other Causes of Death.

According to the 2000 census 104,452 children were reported to be maternal orphans (children whose mothers have died). This is 4.2 percent of children under 18 and 3.5 percent of children under 15. Data on children’s fathers were not gathered, so it is impossible to know how many children are paternal orphans or double orphans (children who have lost both parents) from the census. However, the 2004 international study, Children on the Brink, uses the Papua New Guinea census data to estimate that 9 percent of Papua New Guinea’s children under 18, or 220,000 children, are missing one or both of their parents, a level comparable with many Southeast and South Asian countries. Of the total, 35 percent are maternal orphans, 57 percent are paternal orphans and 8 percent are double orphans. Papua New Guinea was included for the first time in 2004, as in many developing countries, services for helping vulnerable children are not available in this country.

3. Adopted and Fostered Children

High rates of adoption and fostering, formal and informal, are common in many developing countries and serve as a coping strategy for families unable to regulate their fertility. In this way, families can access services for their children. For example children who live too far from school can be fostered to relatives who live closer by, or through fostering, families can reduce their size or change their sex balance. Fostered children also often provide assistance to elderly relatives. The proportion of children not residing with their biological parents at the time of the census was 22.4 percent in 2000; in countries of Western Africa and parts of the Caribbean rates can be as high as 36 percent. Unfortunately, increasing urbanization and deteriorating social and economic conditions over the last two decades have led to what was once an effective coping strategy to become, instead, detrimental to many adopted or fostered children whose guardians are unable to provide care for them.

A joint Government and UN report in 1999 noted that “children are affected by the erosion of the political, economic and social life that has been experienced in the last quarter of a century. The most obvious and immediate effect of the erosion is the deepening poverty being experienced by families, forcing many to jettison the extended family and communal systems that have traditionally served as safety nets for children. It is now commonplace to observe ‘families’ where the caregivers are themselves young children or are not the natural parents of the children in that family. These unstable child-caring arrangements result from children being casually ‘adopted’ by a family, or by children themselves sometimes ‘adopting’ new parents or families when their own families fail to provide care for them. This situation often seriously threatens the best interests of both the caring and cared-for, with the net result being that often nobody is really responsible for taking care of the child.’ In November 2004, Dame Carol Kidu, Minister of Community Development, spoke of an urgent need to investigate the outcomes of modern practices of adoption and fostering.

Data from the 2000 census suggests that the practice is quite common. Close to 10 percent of households include ‘step or adopted children’ and in two provinces (Milne Bay and Northern), 16 percent or more of households include children of this description. The proportion of households with step and adopted children is also high, relative to the national average, in Chimbu, Eastern Highlands, Madang and Manus.
Biological parent were identified only as "other relatives" or "not related." Children in these two groups might be staying in the household on a more permanent basis, but they are not recognized formally by the household head as step or adopted children. If children in the "other relatives" and "not cases" categories are included, the number of children not staying with their biological parents increases to 84.9. This raises the proportion of children who might be fostered considerably, from an average of 5.2 percent countrywide for children formally identified 2000–22.4 percent of total children resident in other households than those of their biological parents. Children were fairly evenly distributed in five age groups (0 to 4, 5 to 9 and 10 to 14) in all of the categories, although children in the "other relative" and "not related" categories seemed to be slightly older than children in the "step and adopted" category.

Papua New Guinea has customary adoption and statutory or legal adoption. Most adoption and fostering is done under traditional networks; and statutory or legal adoption. Most adoption seemed to be slightly older than children in groups (0 to 4, 5 to 9 and 0 to 4) in all communities. The implication of fostering and adoption varies considerably, from an average of 5.2 percent of total children resident in other households than those of their biological parents. Children were fairly evenly distributed in five age groups (0 to 4, 5 to 9 and 10 to 14) in all of the categories, although children in the "other relative" and "not related" categories seemed to be slightly older than children in the "step and adopted" category.

Social Welfare Officers do explain to parents the implications of fostering and adoption when cases of formal adoption are brought to them, but many children appear to be passing back and forth between families without consideration for the best interests of the child.

Children are fostered for many reasons:
- To reinforce family ties and exchange networks;
- To provide care for children whose mother died in childbirth – according to 22.4 percent of total children resident in other households than those of their biological parents. Children were fairly evenly distributed in five age groups (0 to 4, 5 to 9 and 10 to 14) in all of the categories, although children in the "other relative" and "not related" categories seemed to be slightly older than children in the "step and adopted" category.

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One authority on family patterns says that fostering and adoption arrangements are often made very casually, with little thought for the child's preference or needs. Orphans who are fostered out "are disadvantaged twice over" because they lose their parents and contact with siblings, and are often not treated like other children in the adopting household. Breastfeeding infants are even taken away from their biological mothers, and parents sometimes feel obligated to give their children to higher status adults who express an interest in them. However, the adoptive parents may quickly lose interest in the child and begin to resent his or her presence, or prospective parents offer to take care of a child only to later find that their resources are insufficient to provide adequate care. Children have no say in these decisions and receive no psychosocial assistance when changing families or school districts. These situations may well lead to resentment and frustration experienced by children in passing back and forth between families.

Children were identified for interviewing because they were vulnerable, it is impossible to generalize from this research about children overall and more research is definitely needed on these critical issues.

4. Abandoned and Homelessness Children and Child-headed Households

Most children accept their situation without complaint and only run away to the street to escape extreme cruelty or sexual abuse from adoptive and foster parents or family members. This pattern of acceptance is typical. Only half of a representative sample of Papua New Guinean children interviewed in an international study expected their parents or guardians to listen to them and over two-thirds reported being scolded, beaten and insulted when they did something wrong. Children who are not a family's fault, about half said their parents and guardians would not listen, so they kept quiet. When older, vulnerable children move frequently in attempt to better their circumstances, they may end up living entirely outside of family relationships. According to the 2000 census, 33,495 children under 18 were not living in the district of their birth. Many children migrate with their families when younger, but the proportion of migrants begins to increase at age 15 and peaks at 29. Slightly more males of all ages than women migrate and the main destinations for all migrants are the National Capital District, Morobe and the Western Highlands.

Abandonment of children is extremely rare, but participants in this study said it is increasing in urban areas, especially as a consequence of the threat of AIDS. In almost all reported cases, newborn infants are abandoned by single mothers who see that they cannot support the child, or that infanticide is a rational act. Children head households, which will become a more frequent phenomenon as the HIV/AIDS epidemic worsens, were relatively rare in 2000. Less than half of one percent of households were headed by children between 10 and 19 years of age. Less than 1 percent of children under 15 were reported as married in most provinces, but levels ranged around 1.5 percent in Chimbu, Eastern Highlands, Western and Gulf provinces.

Respondents to the stakeholder survey and participants in village, district and provincial discussion groups believed that street children are increasing in number, not only in Port Moresby, but in the smaller cities of the country. Homeless street children are a new phenomenon in urban centres, in settlements around urban centres and in urban-like villages in rural areas. A recent street children survey in Port Moresby estimated that there were between 1,000 and 5,000 street children in National Capital District. Of these interviewed, 89 percent were males and 11 percent females. The majority was between 10 and 15 years of age and 20 percent reported surviving on one to two kina per day.

In Port Moresby, 10 percent of the children said they went to live on the streets because of parent abuse or neglect, 18 percent because of poverty and 13 percent because of parental death. The survey found that one percent of the 92 street children interviewed were forced to live on the streets after their parents died of HIV/AIDS and another 12 percent because of parental deaths of unreported cause. 27 percent had friends or relatives living with AIDS and 39 percent had lost a friend or relative to AIDS. Many of the children were at risk of infection themselves – 33 percent reported sexual harassment or work, and a similar proportion reported being used and/or forced to work. Very few children told anyone about this, while 13 percent slept in an NGO or church shelter and 26 percent slept on the streets.

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in their foster lineage. Therefore children in these circumstances are often expected to support both sets of parents when they reach old age. If the child is reclaimed, the natural parents are expected to make an exchange payment. When these situations may well lead to resentment and frustration experienced by children in these situations will lead to resentment and misbehaviour, which can in turn make life difficult for the adopting or fostering parents. The children must act as though they are grateful, although they usually have very low status in their new family and are sometimes mistreated by their new guardians and "siblings". Fostered children who were interviewed for this study said they were:

- Beaten for very minor infractions;
- Exploited as domestic household labour; Not sent to school;
- Sexually abused and harassed by step fathers and new "brothers";
- Not fed much, fed last, or not fed at all; Not allowed to eat with their new families; and
- Isolated, kept within the house, or not allowed to have friends or social contacts.

The minority of children interviewed for this study did report that their care givers were kind to them. Since children were identified for interviewing because they were vulnerable, it is impossible to generalize from this research about children overall and more research is definitely needed on these critical issues.

Chart 6: Non-biologically Related Children by Category
Half reported no assistance from NGOs, but one-quarter received money and food from street vendors and 7 percent received some assistance from sex workers.

Only 39 percent of the street children said they steal to survive, but according to an earlier 1995 Juvenile Street children study, up to 60 percent of all crimes are committed by children under 16 years old (25 percent of thieves were committed by children between 10 and 14). Juveniles kept in prisons with adults report that they are repeatedly raped. Juvenile crime is not confined to urban areas; the street children study cited earlier reported raids on a rural plantation and NAC’s recent Social Mapping Study reported many areas where young men are banding together to live, supporting themselves with armed robbery and engaging in drug use and other behaviour that is threatening to surrounding communities. The failure to provide adequate opportunities and services and the growing gap between “haves” and the “have nots” has alienated many young people. Half of the children interviewed in the 2003 street children study aspired to a normal job and a normal family life, but many also believed it would not be possible for them to achieve.

Many of the children interviewed for this study spoke of these problems and their desires for a normal life and their stories are included in Appendix 4 of this assessment. Two of these stories that illustrate the factors at play in their lives and the frustration and shame they feel about the coping strategies they are forced to adopt are reproduced below.

The boy’s story (age 14)

I am mixed, father from Gulf and mother from Central. My mother died when I was a baby. I live with my step-brother, who is from my father’s first marriage. But the treatment I receive from my brother is not good and sometimes I don’t eat because she doesn’t feed me.

Because of this, I left for the streets. Out in the streets, people feel sorry for me and they give me kina, 20 toea, 10 toea and 10 toea. I do small jobs like baby sitting and helping people in their household chores. In return, they give me clothes and food. I know that by doing this, I am helping myself.

While out on the streets, I meet with boys. We team up to steal. We go to people’s houses and steal from them and re-sell what we have stolen. I stay with them and got in the habit of drinking and smoking marijuana. I ended up in the hospital twice, after being beaten. In the hospital, I thought of this life I was going through.

I thought the next time I might be bailed again and might die. So from there I ended up at 4 Mile, begging people for food and money like 10 toea, 20 toea and also collecting cups and tins and selling them for three Kina or four Kina a day to support myself and my siblings during the day, close to the house or school in front of shops and road sides or card boards.

During the times I go to 4 Mile, I see my own size children wearing good clothes and going to school. I get worried over this. I wish I was like them, go to school and have good clothes, but it’s very difficult for me at this moment. I am very ashamed to talk about my story. I am also very ashamed to talk with the brother interviewing me. But this brother is telling me that there are people who will help me and the problems I face and it’s not only me. I know that it’s not only me. There are others out there like me. If you are the guys helping, please see us and help us.

The girl’s story (age 16)

My name is Wendy John [a pseudonym she chose]. I come from Central mix East New Britain Province. I am 16 years old and attending secondary school and in Grade 10 this year. I have no father and mother. Both my parents died of HIV/AIDS three years ago.

So I was looked after by my uncle. Then my uncle abused me. He forced me to have sex with him. From that time on, I felt like I was nobody’s child. So I started to go around with my peers to look for money. From that time on, I felt like I was nobody’s child. So I started to go around with my peers to look for money. I get worried over this. I wish I was like them, go to school and have good clothes, but it’s very difficult for me at this moment. I am very ashamed to talk about my story. I am also very ashamed to talk with the brother interviewing me. But this brother is telling me that there are people who will help me and the problems I face and it’s not only me. I know that it’s not only me. There are others out there like me. If you are the guys helping, please see us and help us.

5. Violence, including Infanticide

Children experience relatively high levels of violence (assault, fighting and threats) compared to children in other Asian-Pacific countries. While most said they feel safe in their communities during the day, close to half said they felt rather, or very, unsafe at night. 75 percent of the children said that in their home people hit each other and 70 percent said that people scream at each other. These proportions were very high compared to other countries in the survey, as shown in the chart below.

There is a high degree of violence in many societies in the country. There are relatively high numbers of men to women in every age group, for example, there are almost 331,000 10 to 14 year old boys and only 290,000 10 to 14 year old girls which yields a sex ratio of 114 for that age group (114 males to 100 females). The two age groups that are normally dominated by males in most developing countries (20 to 24 and 25 to 29, the early child bearing years) have more females than males or an equal number.

While this reversal is unusual, in fact, demographic complexities run even deeper. Although there are more men than women, according to census data, more boy babies die than girl babies and more male children die than female. While in all populations, more boy babies die than girls, this tends to even out the sex ratios at later ages, but this is not the case in Papua New Guinea. Female life expectancy was lower than male life expectancy in the 1990 census, but females gained a slight advantage over men in the 2000 census.

While at birth many Melanesian societies have high male to female sex ratios – many more boy babies than girl babies – than other populations around the world, the explanation has been by deliberate infanticide or what some demographers call “infanticide by neglect.” However, since the vast majority of women give birth with only the assistance of family members, birthing practices are difficult to study. Within this country, “preferences regarding the sex of a child vary by culture and this variance, in some areas, plays a significant role in differential mortality rates between boys and girls. However, while the desire for sons is often expressed, the common pattern of preference is for an approximately equal number of sons and daughters.”

Martin Bakker, the Dutch demographer who worked on Papua New Guinea’s 2004 Millennium Development Goals report, several Papua New Guinea censuses, and a number of Demographic and Health Surveys, argues that the overall gender imbalance in this country is not due to migration of males out of the country, as it is in Melanesian populations. However, many imbalances in the provinces are probably due to the migration of certain age groups of males within the country. For example, the National Capital District has an extraordinary “bulge” of males in the 40 to 44 year old age group (see chart below).

Bakker also argues that gender imbalances may be due to female under-enumeration in censuses. Women are undercounted and in polygamous families, the “second, third, fourth, wives are sometimes not been reported by the head of the household.” He also found that quite a lot of children were reported as born to women older than 50 years of age. When he researched in the Highlands provinces, he found that this was due to adoption, i.e. that “children...
were sometimes allocated to the first wife “by younger wives.”

The high number of males that Asian countries have tried to achieve through amniocentesis and abortion has been achieved “naturally” in this country. Because gender imbalances lead to so many social complications, India in this country.  Because gender imbalances and abortion has been achieved “naturally” have tried to achieve through amniocentesis and abortion were sometimes allocated to the first wife” by the extended family network and multiple caregivers who could diffuse a parent’s violent reactions. Sexual abuse was prevented by customary rule and taboos. But the situation has been changing over the last two decades, especially for urban households, which are isolated from the extended family support system and frequently endure economic shortages.

Sexual abuse is believed to be much more common than reported cases. However, it is hard to know if the situation of children is actually changing because there is no comprehensive system for the collection of data on child sexual abuse and exploitation. The Family Sexual Violence Action Committees in the various provinces are now collecting data from hospitals, crisis and counselling centres that should in the future yield a more comprehensive picture of child sexual abuse.

In one small survey in the early 1990s, 80 percent of respondents said they had witnessed, been involved in, or experienced child abuse when they were children – 55 percent said they had been sexually abused. Most cases of child abuse are not reported unless they result in severe injuries or death. Papua New Guinea’s 1999 report to the Committee on the Rights of the Child noted that according to police records, half of all victims who reported sexual abuse were under 15 years of age. Hospital records showed that 17 percent of sexual assault patients were between 16 and 20 years of age. In 2000, one-third of the rape victims treated at Lae’s Angau Hospital were under 16 years of age, including five girls less than five years old. In the first six months of 2000, 53 percent of the rape victims seen at Goroka Hospital were under 16, including three, three-year old girls. Girls between 15 and 19 have the highest rate of HIV/AIDS in the country, four times that of boys the same age.

7. Child Sex Work

While adults may choose to engage in sex work, children usually become involved in sex work as a result of prior sexual exploitation by adults. They fall prey to force or coercion (poverty, hunger, lack of food) and are often 18 years old. The raising the age of consent and marriage can be considered as one way of responding to HIV/AIDS.

8. Poverty and a Lack of Services

Deepening poverty and the declining availability of services are frequently blamed for the deteriorating quality of life for children and their families. 30 percent of children live below the poverty line and poverty is perceived by the poor to have worsened over the past five years. Many “harbour a sense of grievance against the government,” says ADB’s 2002 report. Cox argues that through rural areas, where 83 percent of the population lives, “the quality of life has generally deteriorated over the past two decades due to shrinking health and education services access.

Because of development stagnation, most rural populations cannot access male communication infrastructures, information and welfare or justice services. For school aged children enrolment is still below 50
percent, female retention is low at primary level and gender disparities in enrolment ratios increase with age. In addition, schools prematurely push out 50,000 school leavers, many of whom take on the identity of society’s drop-outs or failures.

Papua New Guinea’s 2004 Millennium Development Goals Report argues that it is only the country unable to meet MDG targets, it may not be able to even meet its own targets which are already set below international MDG targets. The country’s mortality rates, which are understood by social planners to be a measure of a society’s overall well-being, are frozen at 1980 levels. The 2004 report also says of the mortality rates that “In some cases, there have not been any improvements at all, and that after 1980, mortality transition slowed down very significantly and may now have come to a complete standstill. The level of infant and child mortality, as well as adult mortality, remains high.”

10. Geographic Differentials in Development

While the research for this report was unable to gather sufficient information to develop a vulnerability index for each province as was initially planned (see Appendix 1), it is safe to say that children are more vulnerable in areas with poor development where the economic and social deterioration has been more retarded. One indicator of this is the difference in mortality levels at the provincial level and between urban and rural areas, which the MDG report says “are enormous by any standard.” The MDG report also constructs indices of overall development by county and observes that the government and its development partners have not made sufficient efforts to funnel development resources into the provinces that are the furthest behind (the Gulf, Northern, Western and West Sepik, followed closely by all of the Highland provinces). In all of these “low achieving” provinces, poor results are partly the result of a violation of women’s and children’s rights. However, underlying problems are aggravated by the inability of provincial leaders to access development resources, and if more resources were channeled to low achieving provinces greater progress towards development targets could be made in a shorter timeframe.

11. Children’s Happiness and Well-being

In a recent UNICEF regional survey, only 28 percent of children reported feeling happy most of the time, 37 percent said they do not have much to be proud of and 22 percent said they never express what they think. Only 10 percent said that the person they admired most was their mother and 13 percent mentioned their father. While only 48 percent thought children had rights, 84 percent believed all children should be able to get an education. Only 49 percent thought children had a right to health care and only 31 percent believe they have the right to be loved.

Cox argues that “throughout Papua New Guinea, both rural and urban youth have a simple explanation of how the perceived bleak social and economic prospects result in the adoption of ad hoc gendered strategies to alleviate poverty, support themselves and their families and lead what looks like the good life. [They say] ‘We have to survive. The boys turn to petty crime and the girls have to sell themselves. Everybody knows that. That’s why no one says anything and accepts the cash, food and other things we can bring home.’” Some children’s bleak prospects can lead directly to survival sex, while the prospects lower the self-esteem of even children who are not on the poverty line, which in turn leads to high-risk experimentation with alcohol, drugs and sex.

12. Lack of Voice and Participation

Some children have no voice in the family, community or in the political arena. Vulnerable children interviewed and included in discussion groups conducted for this study said they want an end to isolation, and the violence and abuse that dominate their lives. They want to be treated like normal people and not stigmatized or discriminated against. They want education, but believe that it is an entitlement of the rich. They want jobs and relief from the sex trade. They want protection from violence in their homes, from their step fathers, uncles and brothers, from police and other authorities. They are wishful about working, learning and “leading a normal life”, which they wish for, but never actually believe they will have. Finally, they want relief from the researchers who frequently come to study and count them but never actually seem to help.

Given the economic and social deterioration in the country it is not surprising that the number of vulnerable children in the country is so high. The unchecked growth of the HIV/AIDS epidemic will make at least several hundred thousand more children vulnerable to the problems already experienced by many children. HIV/AIDS-affected children will also suffer from a lack of diagnosis, treatment and care, stigma and discrimination, rejection, loss of their parents, trauma in caring for very ill adults, broken homes and -- like all vulnerable children—broken dreams.

The children who were kind enough to talk about their families and their feelings told very sad tales of how children survive when their dreams are shattered (Appendix 4). These children live harsh lives and survive by scavenging, from handouts at church feeding areas, anorexia, from begging and selling sex. Their lives are characterized by unpaid domestic work, beatings, isolation and sexual abuse and harassment so severe that several left their households to escape inhumane conditions, preferring to take their chances on the street.

Knowing little else, children often assume that they must do what they have to in order to survive. Many adults they meet treat them harshly but sex workers and some other marginalized adults occasionally feed them and provide care. In many cases, adoptive families do not protect children, and these children from this lifestyle and they are isolated from communities except at centres or programs, where they meet kind adults and talk with children of their own age. Almost all of the children interviewed informed that the interior was the last time they had ever told their stories to anyone. Because of the culture of silence that surrounds many families it is rare to see community members step in to protect them. Here is the story of one woman who did step in:

Janet and her husband have eleven children of their own. They come from a small island near Wewak. They are also guardian of four other children. Two are her brother’s children who are with them attending school. The other two are Gina and Liana who have been taken away from their adopted parents due to continuous violence and abuse.

Janet is the aunty of the two girls and has been involved in a lot of activist work in issues concerning women and girls. She was very concerned when she heard about her niece’s situation in November 2004. Everyone in the village could not do anything or say anything because the adopted parents would take them to court if they did. This is usual in many villages throughout the country where children are mistreated in adoption cases and in this case, the villagers had no say about what went on between the adopted child/children and parents. This is what Janet had to say:

“When I came back to the village, I started doing some work in seeking advice on how I could assist the two girls. After collecting substantial information, I immediately reported the case to the police. After a week of the police being informed (on the 17th of November 2004), they went to the island, picked up the girls and brought them to Wewak. The adoptive parents could do nothing. Police then took all the reports about the abuse and mistreatment of these two girls. They went to the court, and the adoption family’s care whilst awaiting a date for court hearing.

“These two girls experienced the worst kind of abuses since they were born. They grew up in an environment where they did not experience a normal life that any ordinary child would have gone through. Just to mention a few of these devastating experiences, Gina was raped by the son of the adoptive parents (2004) and Liana was HIV/AIDS positive. Liana was told by her foster father that she will never marry her for raising them up. It is suspected that Liana was also raped by her adoptive father’s work place driver. Liana was placed in grade eight. This is still under investigation.

“My family are all supportive. The girls are being loved and cared for. They have changed in their appearance in the little time they have been with us. I have had to take them for medical check. The result is that Gina is HIV/AIDS positive. Liana is negative. Gina does not know this. She already has suffered enough pain therefore as much as possible.
we do not want to tell her. She is being told that she’s got TB. They are being treated with herbal medicine to clean out their system. It is working and is making them eat a lot, unlike the first time they came. They could not eat much. This is a healthy sign.”

III. Caregiver, Community and Government Response

A. The Context of Childhood in Papua New Guinea

Of Papua New Guinea’s 2.6 million children less than one percent live in institutions or the street (fewer than 20,000 children). Most children are living in a family setting, either with their biological parents or with a guardian. Although this is in accordance with international guidelines, this research suggests that it is no guarantee that children are living safe, comfortable or fulfilling lives (see Section III). A large proportion of children live in families and households that are themselves vulnerable for many reasons – families are not always safe havens or protective environments. The Government at the local, provincial and national levels does not have sufficient resources to help and the maintenance of law and order in many places is extremely challenging.

B. Women’s Status and Family and Clan Relationships

The same forces condemning many children – and the neglect of responsibilities. As the previous section of this report argues, the majority of family environments are not of high quality, and in most families, men’s primary role as a caregiver, their mother, is as vulnerable to domestic violence as they are. Papua New Guinea has one of the highest reported rates of violence against women in Asia; the same poverty undermining the vulnerability of children in Papua New Guinea and HIV/AIDS epidemic is among the factors also driving what Cox refers to as “an epidemic of rape and assault against women.”

Although Papua New Guinea’s rates of domestic violence are exceptionally high, violence against women and children is common in many countries. Amnesty International states that violence against women is the most pervasive yet least recognized human rights abuse in the world. Although gender violence cannot be explained by a single factor, international comparative studies show that worldwide, women in poverty are more likely to experience violence than women of higher socio-economic status. Violence against women and poverty reinforce each other – gender-based discrimination and violence contribute to poverty and poverty increases violence and damages the country’s social development. Violence against women has social and economic costs as well as personal, physical and mental costs. It has relatively high direct health care costs, causes productivity losses in domestic, farm and wage labour, and “hinders women’s participation in public life and undermines the economic well being of societies.” Some husbands have stopped their wives from attending meetings “by locking them in the house, by pulling them off the vehicles taking them to the meetings, or by pursuing and dragging them home.” A Department of Education study found that female teachers have refused promotions because they were afraid it would provoke their husbands to behave more violently.

The World Bank’s 1998 study, Gender Analysis in Papua New Guinea, states that 70 percent of women in 10 P Lapita Gardens in Port Moresby reported experiencing domestic violence. The Papua New Guinea Law Reform Commission’s 1992 report said that 100 percent of women in some areas were beaten and that one out of six urban women sought medical treatment for injuries sustained from their partners. A recent survey of 57 percent of women said they had been beaten by their husbands and 66 percent of men admitted that they beat their wives. There are great variations in levels of violence by province and by ethnic group, from 49 percent in coastal and non-highland areas to 100 percent in some highland areas. In urban areas, 62 percent of husbands said they beat their wives and 50 percent of women reported beating their husbands. The rate of rape was 80 cases per 100,000 in 1990 but it is believed that most rape cases go unreported. Rape is one of the most frequently committed offences against a person in the country and is usually committed by a relative or friend. Physical abuse in families is typically accompanied by verbal, psychological and sexual abuse and often goes unreported unless it nearly kills the woman. The national Family Sexual Violence Action Committee is working with hospitals, women’s shelters and crisis centres in various provinces to collect up-to-date information on violence, rape and abuse, and when completed will provide a better picture of the situation.

Violence breeds violence. Children that experience violence in their families are more likely to perpetrate violence themselves and to engage in risky sexual behaviour that leads to sexually transmitted diseases and HIV infection. In this study, many vulnerable girls reported that they were sexually and physically abused not only by adult males (most commonly step fathers, foster fathers and uncles), but also by step and foster brothers and young male cousins. Many of the girls reported that this violence led them to leave the home. Some of the girls who were interviewed said that they were forced into sex work by male relatives, or that when they abandoned abusive families, they took up sex work to survive. Many boys also reported physical and psychological abuse. Cox noted that rape “has become a major threat to social stability, economic development and impedes the full and active participation of women and girls.”

Customary marriage rights are often invoked as an excuse for men’s violence, aggression and forced marriage in non-Christian clans. Experience domestic violence. The Papua New Guinea Law Reform Commission’s give men relatively free reign over what goes on in the home, violence is more common. Other societies have demonstrated that interpersonal violence can be controlled through policies and laws that mandate unacceptable and costly to the perpetrators by enforcing prosecution, fines and jail time.

In this country, family matters are considered “private” and where family matters lie outside of public scrutiny, rates of wife abuse are higher. International comparative studies have shown that prompt intervention by family or community members reduces the likelihood of domestic violence. Communities tend to take the stance that “family business is family business” and do not intervene to help abused women and children. Wife beatings are also regarded as a private matter. The same acts of violence that would be subject to arrest and prosecution if they were directed at a neighbour, work mate, or acquaintance, “go unchallenged when men direct them at women.”

In countries where women have authority and power outside the home, levels of abuse are lower. But the 2004 MDG report notes that only a very small percentage (5.3 percent) of all employed women had a wage earning job (compared to 15.2 percent for men). During the 1990s, there was a slight decrease in the proportion of both women and men who were employed in agriculture, which the Highlands Region has a high labour force participation rate, but this is because women are employed in non-agriculture, raising household food in family farms and gardens.

In many provinces, women are disadvantaged in terms of access to services. The gender gap in education and literacy is significant, although recent evidence suggests that the situation is improving. Young females (aged 15 to 24) are catching up with their male counterparts. Gender differences in adult literacy are even larger than those for those aged 15 to 24, with a strong bias in favour of males. According to the 2004 MDG report, “these gender differences are more profound in the Highlands Region. This also applies to many other key indices, such as health, morbidity, [and] mortality.” The MDG report shows that provinces with the highest gender equality are also the ones that are developing the fastest (National Capital District and the Coastal Region (with the exception of Gulf Province) and the Islands Region provinces).
The exception is the Momose Region, where relatively high gender equity is dragged down by low performance on poverty, hunger and mortality indices. The Highlands provinces score relatively low on gender equity and on overall development – AIDS data also suggests that Highland provinces are some of the worst affected provinces.

One woman has observed that “men’s violence against women is based on a loss of control and power. This loss may be due to the disorientation of men in a changing world or a fear that these changes will remove women from their control and afford them independent ways of understanding their universe and acting within.” Zimmer-Tamakoshi says that men’s identities depend on subordinating women and a man’s standing among other men depends on superiority over women. Many husbands and wives have less attachment to one another than they do to their natal families.

According to Cox, “Social change, economic and political development in Papua New Guinea is gendered. One very clear example is the ease with which gender discriminatory and oppressive aspects of traditional culture (bride price, polygamy and women as compensation) are transmitted, adopted and reinforced normative and in societies where they never existed previously.” Gender discrimination has spread and “the resulting gender imbalances in status and diminished rights of women, throughout most of the country has terrible consequences for the quality of male/female relationships and family life and is a central contributing factor to the two of the most critical social problems facing the country: rising levels of gender and sexual violence and a rapidly rising HIV/AIDS epidemic. These two problems define the context and experience of family life for the country’s children today.”

C. Household Characteristics

Despite high levels of marital violence, roughly two-thirds of the population over age 15 is married according to the 2000 census, although the proportion has declined slightly since the 1980 census. The age of marriage has increased by a year and a half to two years in urban areas and slightly less than one in rural areas, where couples are younger at first marriage than in urban areas. Variations by province and region in age at marriage are small. Across the country, the husband is typically three to four years older than the wife. Women are treated as junior minors and as property of the clan, they can be punished and raped for offences committed by male clan members and pledged or given in payment to rival clans. Domestic and family violence is not viewed as an offence against the woman, but against her clan.

More women are married than men (66 percent compared to 58 percent) and more women were separated, divorced or widowed (10 percent compared to 5 percent), reflecting in part their younger age at marriage. A much higher proportion of men over 15 are unmarried (38 percent compared to 24 percent for women) and the highest proportion is in the Southern Highlands, reflecting inequalities in gender ratios and polygamous behaviour. The province with the highest proportion of women who have never married is the Autonomous Region of Bougainville. Urban residents of both genders were more likely to be single and more women in rural areas than urban were separated, divorced, or widowed (11 percent compared to 7 percent). Female headed households increased from 12.7 percent of total households in 1980 to 15 percent in 1990, but dropped again to 13 percent in 2000. There are more female-headed households in urban areas and the proportion of female-headed households varies significantly by province, probably reflecting, more than any other factor, rates of male migration for work.

Many rural households are headed by women, which one authority argues is “a legacy of the recruitment of men to working plantations from 1890 to 1975, especially in Sepik and the Highlands.” Historical patterns have persisted, so that “continuous circular male migration from these areas, regardless of the needs and wishes of wives and children, is now a family norm. Long absences of men ages 15 to 50 from their families are accepted because subsistence agriculture provides no cash income. Men travel in search of work, markets and a reprieve from routine and the rigorous manual labour of village life.”

These migration patterns are today sustained by employers who do not provide housing for their employees and for many migrants who are formally employed, the minimum wage is too low to support a family. Provincial sex ratios from census data suggest that male out migration in middle age is particularly high in East and West Sepik and all of the Highlands provinces, leaving women in charge of their households while men seek work elsewhere. Finally, the exploitation of natural resources and pollution caused by mining operations has displaced and marginalized families in some provinces, among them families who traditionally lived from fishing and farming along the Fly River. This has impoverished them economically and led many to risky survival strategies that could exacerbate the rapid spread of HIV/AIDS.

Average household size also varies little among provinces. The largest households are located in the provinces with the highest proportion of poor villages and settlements (largely in the Southern Region) – it is likely that household size declines as income increases.

International comparative studies show that violence toward women and children is more common in families with many children because larger numbers of children increase the stress levels in families, especially those in poverty. The country still has a very high fertility rate and among the poor, families are large in some provinces. In larger families where all adults are working long hours in the formal or informal sector, children have less supervision and guidance from adults, leaving these children vulnerable to abuse. A significant number of women do not have access to contraceptives and large numbers have attempted abortion at some point in their lives, according to a national survey in 1994. This is not surprising in a culture that is as sexually active as Papua New Guinea, and contributes to the very high rates of maternal mortality.

In most families, all members of the family contribute in some way to family subsistence and support. Men’s contributions range from hunting and farming to wage-earning labour, while most women are still engaged in cultivating food for the family or small cash crops. Most people surveyed in both rural and urban areas by the ADB poverty study said that the lives of women have worsened over the last 5 years because women are “responsible for planting and selling the produce and producing food for the provision of family food when men do not have jobs. In situations where men are employed, women have taken over roles such as fishing and cutting sago palms– work that used to be done by men.”

Children also begin to contribute to household, agricultural, or business tasks at an early age. In the last census, one-third of children under 18 reported working during the week before the census. Most worked in family gardens raising subsistence or cash crops (26.8 percent) and 7 percent worked in some type of business, the bulk providing unpaid help to commercial activities conducted by the family. Close to 40 percent of children in Southern Highlands and Enga Provinces were employed, the bulk in agricultural activities.
D. Family Residence Patterns

Settlement patterns vary among ethnic groups, especially in rural areas. In the Highlands, many extended families live in compounds, share household tasks and eat together. In other areas, related nuclear families live in separate houses close to one another. In most areas of the country, traditional men’s houses are a thing of the past and men live and sleep in family houses with their wives and children. In urban areas, nuclear families are more common, resulting in increased dependency for married women, and reduced family cohesion and levels of interaction among units of the same extended family.

Along the coast and on the islands, settlement patterns are typically more stable than in the Highlands because there is an established pattern for inheritance of chiefship and the rules of succession are clear. Villages are permanent and relatively orderly. Political relationships in Highland provinces are more chaotic, governed by “big men” who continuously contest control of key resources and leadership. The residences of many highland groups are marked by frequent changes in location and their loyalty patterns are governed by tribal violence, patterns of shifting cultivation and the changing use of natural resources.

Violence at the community level not only damaged developmental prospects, but many of the issues of children and families insecrete and dangerous. Tribal warfare is a major disruptive force in contemporary highland life, with disputes between clans over land rights, leadership prerogatives and criminal activities. Although tribal violence is severe, it is relatively common and has escalated from ritualized battle to full scale armed conflicts that causes property damage, disruption to social services, rape and pillage, and other types of retaliations against children, who when orphaned or abandoned are left in the care of their grandparents or other close relatives.

Strategies for family- and community-based child protection and with coping with HIV/AIDS will vary according to patterns of residence and levels of violence in communities. Other factors that will affect cohesion in communities include how long families have been living in the same area and what kinds of organizations and services exist in the community. UNDP’s 1998 Papua New Guinea Human Development Report used participatory rapid appraisals to explore differences in community structure and opportunities in Papua New Guinea, where it is a sample of provinces representing different cultural groups. Common denominators to family and community stability were plentiful year-round subsistence agriculture and strong community organizations, usually church based.

E. The Wantok System

As in most developing countries, extended family, kin and clan groups, or wantoks (“one-talks,” who speak the same language), provide the main informal social safety nets for women, children, the elderly and the poor. “Kinship systems and reciprocal exchange networks traditionally have been the core mobilization forces in communities [and] have provided the social safety net for sustaining economic development,” said one researcher two decades ago. The wantok system also was the most effective means of transfer of resources from urban families to rural kin. However, most groups in this city are poor and do not have the means and traditions to provide help to family members. However, the traditional and cultural way of life is not completely lost. Wantok systems and wantok organizations are the main informal social safety nets for women, children, the elderly and the poor. Kinship systems and reciprocal exchange networks traditionally have been the core mobilization forces in communities and have provided the main informal social safety nets for women, children, the elderly and the poor.

F. Community Organization

Community structure and size varies from tiny traditional villages to large urban areas. More than 80 percent of the people live in rural areas, where 83 percent of the country’s population lives, is organized into traditional villages. However, in the Highlands, many isolated rural dwellers have migrated to larger rural settlements along the side of the Highlands Highway to gain proximity to transportation and access to services unavailable in the villages. Cites in the country include many smaller communities and traditional villages engulfed by urban growth. Richer urban residents live in established communities or neighbourhoods, while the poor live in squatter settlements without services.

Homes of the poor in urban settlement communities are built of waste materials. According to the ADB study, their inhabitants “lack decent clothing, fear for their personal security due to crime and basically ‘have no money, no food and are hardly surviving.’” It is increasingly common for families living in settlements to have only one meal a day. They are the emerging landless class — because they do not own land and tenures to have little or no land to cultivate food and are constantly faced with the threat of eviction from landowners. The presence of the settlers also prevents landowners from using their own land. Although urban settlers said that their lives were difficult, they also said that the situation is much worse in the rural areas where they must walk long distances to sell their produce and to get to school and aid posts. They do not have traditional and cultural backgrounds and are expected to make it on their own. They lack the resources to support them. Settlements that have been established for a longer period of time gradually improve their self-governance and slowly acquire services such as schools, health clinics, water and sanitation. Settlements that have been established for a longer period of time have learned to improve their self-governance and slowly acquire services such as schools, health clinics, water and sanitation. Settlements that have been established for a longer period of time may have also learned to improve their self-governance and slowly acquire services such as schools, health clinics, water and sanitation.

The poorest urban residents live in newer settlements without proper services or civic organizations. Settlements that have been established for a longer period of time gradually improve their self-governance and slowly acquire services such as schools, health clinics, water and sanitation. The poorest urban residents live in newer settlements without proper services or civic organizations. Settlements that have been established for a longer period of time may also have learned to improve their self-governance and slowly acquire services such as schools, health clinics, water and sanitation.

As in most developing countries, the wide variety of settlement patterns and cultural patterns vary according to the relative access of communities to services and children’s vulnerability will widely according to the type of area in which they live. This study was not able to look closely at factors in household and community cohesion, but they should be studied in any planning that takes place for future mobilization.

G. Community Stress

Village, community, district and provincial leadership agreed that improving life for their wives, children and communities has been difficult because they must contend with the
results of Papua New Guinea’s 20-year-long development stagnation. Declines in mortality resulting from improvements in health and nutrition have slowed to a virtual standstill since 1980. Poverty has worsened over the last 5 years according to participants in the ADB 2002 study, gender balance in literacy is being achieved only because boys are losing ground, child malnutrition is at 30 percent and even Papua New Guinea’s adjusted (lowered) MDG targets are not likely to be met.

In many parts of the country, a picture is emerging of communities marginalized by a lack of access to services and employment, and fractured by violence and competition for resources. This research found that village, district and provincial leaders in most areas were distressed by the level of social breakdown in their areas. Researchers working on the NAC Social Mapping Project also reported high levels of dysfunction and risky behaviours that contribute to the transmission of HIV. They reported that young people, especially males, are separating themselves from their villages and forming their own settlements, then launching attacks on the more established villages.

Village, provincial and district participants in all four provinces agreed that “all children are vulnerable in Papua New Guinea.” They thought that social dysfunction was increasing and that authority figures (parents and political and traditional leaders) were losing control. Leaders at all levels regretted deteriorating conditions, which were said to want and take responsibility to do something. They want to learn ways that communities can respond and support people, children and young people, and asked for help from professionally trained health, education and social welfare officers, and for poverty alleviation programs and basic services (health, school, water and sanitation).

A wider availability of these services would help families affected by HIV/AIDS and other vulnerable families. Services like education and health would increase the ability to contain transmission through prevention education and testing.

In rural areas, women and children have to walk long distances to get water and some boil it to make it safe, which makes caring for people living with HIV/AIDS very difficult. When sick, many have no access to aid posts and more than half of respondents in the 2002 ADB study said they walked to town or to the traditional healer for orphans. Levi argues that “close relatives and care givers providing care and support to children who have lost both parents have additional burdens, including over-crowding as well as food shortages and diminished household financial capacity.” He also notes that “orphans are often deceived by their family members or care givers who sometimes take possession of their inheritance,” and that “adolescents who have lost both parents to HIV/AIDS feel hopelessness and desperation that leads them to risky behaviors and engage in unlawful activities in the community.”

1. Rural Responses

In rural areas, responses for vulnerable families and children are limited and came largely from church initiatives and women’s groups. Generally, they took the form of mutual assistance and labour-sharing projects, where the community started gardens to feed vulnerable families or sold produce to meet other needs. Child care was shared and in several areas are community “centres” for orphans that are more organized and usually church based.

Churches are also organizing prevention education in the form of guiding children to sports. A counselling and home-based care for ill adults and children. With the help of the Catholic Church in Mt. Hagen, communities are building centres where children can come for three or four days per week for education and care. At the beginning of January 2005, 550 children in 15 centres used for the first time by orphans and vulnerable children. orphans and vulnerable children.

One community project, still under development, is the Tengenga Orphans Care Centre in the Western Highlands Province. Joshua Levi, a volunteer associated with the centre says that his village has 25 HIV/AIDS cases and 58 affected children who are not infected. Of these, 39 are double orphans and the rest depend on other family members. Care givers of children with no parents, who number between 700 and 800.

Without community cohesion and mobilization, HIV/AIDS affected families have little to fall back on. In all rural areas, respondents agreed that government services are too limited to be of much help in protecting vulnerable children, families and communities. Churches which provide more than half the health care and community development work – and women’s groups, according to one observer, form a “vast network” of commitment that are linked through provincial women’s councils to the National Council for Women. Women’s groups are “a major human resource capacity that have potential for social and community development in Papua New Guinea,” according to one expert, McDowell, but their strength varies from area to area. Provincial women’s groups are variously perceived and have different levels of organization and membership. The National Council for Women, the Council for Women was an organized consortium of more than 500 rural village women’s groups with 30,000 members.

2. Provincial and District Leaders

HIV/AIDS is already becoming a dilemma in the provinces that were studied. It was found that the responses listed below were common to all provinces where discussions were held with village, district and provincial leaders:

- Children aged under 18 are vulnerable, especially where fathers have migrated to seek employment;
- Broken marital relationships leave children and women vulnerable;
- Grandparents, who are the main caregivers of children with no parents, cannot be relied upon forever;
- Adopted children are worse off today than before;
- Domestic violence is a routine occurrence, especially among poorer families in the settlements;
- Vulnerable children are getting involved in substance abuse and can be relied upon forever;
- Participants were aware of many vulnerable children and think a data base will be useful to highlight their numbers and situation;
- Childhood vulnerability is related to migration, unemployment, increasing poverty, civil unrest and HIV/AIDS;
- Vulnerable children are getting involved in substance abuse;
- Partnership among ward councillors, community leaders, women’s organizations, youth organizations, churches and other community based organizations within the provinces could be mobilized to address the needs of vulnerable families and children.

In Western Highlands Province, leaders said that:

- A cap is needed on bride-price to reduce family conflicts over women as property;
Community care centres are needed in all wards to help in the care of orphans and vulnerable children.

The Morobe Province participants said that:
- Urban migration is a big issue because of road links to Madang and the Highlands and the sea ports linking the New Guinea Islands;
- Many sex workers can be married couples, with the husband brokering for the wife and older daughters;
- The Catholic agency has been helping vulnerable families relocate to their homes since 2004;
- Some church agencies provide short term assistance including provision of clothes and food.

In East Sepik Province, respondents said that:
- Cases of sexual abuse are sometimes being treated with herbal medicine;
- Short term assistance for vulnerable children is provided; church or NGO-driven and designed to merely provide the need for a day or two.

3. Urban Responses
In urban areas, responses to vulnerable children and families, including those affected by HIV/AIDS are also limited. They are church or NGO-driven and designed projects for special-risk groups like street children and sex workers and some help families affected by HIV/AIDS. For this study, a survey of twenty organizations providing services in the National Capital District was conducted. Their views were sought about vulnerable families and children. They were also queried about the type of services they provided to the children.

a. Community Programmes
Twenty different types of services were provided for boys and girls from 0 to 18 years of age (Table 9). Most are providing feeding programs either weekly or as ongoing support. Two work directly with children affected and infected by HIV/AIDS, including double orphans.

Most of the service providers are faith-based organisations (FBOs), but there are almost community-based organisations (CBOs) that were started by concerned individuals. Two of the CBO-operated sites are administered in settlements, while one works with identified cases from the Port Moresby General Hospital. All are nationally operated organizations and are recognized by the National AIDS Council.

Most of the children seeking help are predominantly from the settlements and came from broken, poor, unemployed, large and HIV/AIDS affected families or those with elderly care givers. Some live on the streets and come to the service providers for clothing, food and shelter as well as for fun and a chance to talk with their peers. Services that are provided for these children range from weekly feeding programs to counselling and financial and moral support. Some of the children at the feeding program reported that the food they received was the only full meal they ate all week. The number of children visiting individual sites ranges from six to more than 1,000, although larger sites cater mostly to boys because girls tend to go to sites which are more comfortable and private.

Children who visit these sites range in age from 0 to 18 years of age. Depending on the services that are provided, the length of care provided ranges from one day to three months or more. In some cases, one day refers to feeding programs and counselling, while the longer periods involve children who have no homes at all but sometimes are in fear of their lives and need a place to stay and shelter from family violence and abuse.

b. Service Providers’ Views
The service providers stated that deteriorating social and economic conditions make families and children vulnerable. Problems include: widespread unemployment and lack of opportunities; the lack of education, housing; food, and water; poverty and illiteracy; violent behaviour at home; the failure of the sanitation system; pressure in the city; law and order problems; and gender inequities (“men control, manipulate and abuse women and children”). Families struggling to live in Port Moresby find it impossible to support children that they have fostered, families cannot afford school fees and children are forced in to work to help their families survive.

Providers said that parents are not giving enough care and attention to children, resulting in children experiencing low self-esteem. Children are subject to outside peer pressure, overcrowding at home, law and order problems and financial problems. Intoxicated fathers often fail to buy food for their mothers and children and many fathers are involved in gambling and commercial sex.

The providers also reported that parents argue constantly and abuse their children.

There are no strong ties among kin because of the environment in which many families live (mixed settlements) and mobile families can only make a commitment to the community in which they live. Many parents are not
married, or are divorced and separated, or are in relationships that are unstable because of social pressures. Children grow up lacking discipline and accountability.

HIV/AIDS is adding to the pressure faced by families and contributing to family break-ups. Children have an especially hard time when a caregiver is infected. Providers also reported that girls and women are particularly affected. Awareness in the community of HIV/AIDS and the impact of NACC-organised programs has been minimal. There is a lack of communication between fathers and mother and lack of advice to children. Also, most children whose parents die of AIDS got no advice from their parents before their death and subsequently find themselves in a great deal of trouble. Where young girls are having sex with men to pay school fees, guardians look the other way. Young boys say they are forced into crime to survive.

Service providers organise services when the need arises and respond to the current situations faced by those who drop in at the sites. Problems include the day-to-day reality of vulnerable families and children, mainly from settlements. Social and economic conditions are conducive to the selling of sex for cash, leading to the spread of HIV/AIDS - poverty distorts acceptable patterns of child, family and community mechanisms, one provider remarked.

With increased understanding of the epidemic's potential growth and the existence of previously unrecognized risk groups, further because many HIV-infected people have higher levels of illness than non-infected individuals and families must provide most of their care. Many more children and adults are infected than currently reported, but are not identified in the official statistics because of lack of diagnostic services. Children are affected in families affected by HIV/AIDS and are suffering the loss of rights and trauma. Providers also reported that girl children are frequently withdrawn from school to care for sick and dying parents and for relatives.

I. Institutions
 Currently, child care institutions are almost non-existent. Cheshire Home in Port Morebiy provides assistance to disabled children and in some areas quasi-residential community care centres are being developed by communities with high numbers of orphans. The Lukautim Pikinin Act clearly states that family and community-based care is preferred and institutionalization is to be the last resort for children as institutionalization is costly and because of its negative impact on children, the least preferred form of care. Community care centres are being developed with orphans of AIDS or with families where children are caring for ill parents, adding to the large numbers of families and children who are already vulnerable. Women face much work burdens, discrimination, lack of access to resources and continuous violence in their families and communities. Drugs are becoming more prevalent; a recent study says that "in parts of the Highlands marijuana use has superseded coffee in value," and brings cash into formerly remote villages, along with violence and sex work. Social dislocation is common due to poverty and migration in search for work.

The challenges of building a family and community-based response to HIV/AIDS-affected and other vulnerable children are large, but many communities around the country have demonstrated that they can be surmounted in order to care for the weak and vulnerable. Based on the findings of this report, the next section concludes with recommendations that will hopefully make it easier for them to do their work.

IV. Recommendations

A. Social and Legal Background

Consultations held by a Human Rights Project scoping team across the country in 2003 learned that the following human rights issues were "at the forefront of people's minds":

i. The need for better governance, the enfranchisement of voters and reduced corruption, increasing commercial sexual exploitation of children, and

On the policy level, the Lukautim Pikinin Act draft represents a solid and informed basis for dealing with child welfare issues, but its provisions are little known outside of National Capital District. The development in the maintenance of these social welfare officers at the provincial level and in some districts, but their capacity is limited as they have few resources to use in helping communities change their outlooks or approaches to family and community problems.

Hospital beds are filling with AIDS cases, along with the rising tide of tuberculosis cases associated with HIV. Some Highland communities are already becoming swamped with orphans of AIDS or with families where children are caring for ill parents, adding to the large numbers of families and children who are already vulnerable. Women face much work burdens, discrimination, lack of access to resources and continuous violence in their families and communities. Drugs are becoming more prevalent; a recent study says that "in parts of the Highlands marijuana use has superseded coffee in value," and brings cash into formerly remote villages, along with violence and sex work. Social dislocation is common due to poverty and migration in search for work.

The challenges of building a family and community-based response to HIV/AIDS-affected and other vulnerable children are large, but many communities around the country have demonstrated that they can be surmounted in order to care for the weak and vulnerable. Based on the findings of this report, the next section concludes with recommendations that will hopefully make it easier for them to do their work.

iv. The need to address the crisis of HIV/AIDS epidemic.

These conditions not only make it very difficult to prevent the rapid spread of HIV/AIDS to even in the most remote parts of the country, but also absorb the resources and human capacity and ingenuity and every other vice of the world and feel we do not have any ability to do anything? Will we continue to blame them for causing the increasing social welfare crises, especially in regard to response to the growing crisis in families, sexual violence and the lack of protection for children. The disproportionate share of proactive and preventive social work falls to the local and international NGOs."

Village courts, responsible for protecting women and children at the local level, are often manipulated. Many of these courts are comprised of older men who are conservative and uninformed on women's and children's rights. "In many parts of Papua New Guinea," says Cox, "dual systems of customary and state law and administration and a dual economy are maintained." Many men, especially in the culturally mostly male-dominated parts of the country, aim to manipulate both the traditional and modern political, economic and social systems to their own advantage. They thrive to indulge and enjoy the spoils of both worlds. Women and children are often left behind or caught in between. The Village Court is an active and approved institution (in many parts of the region, particularly) that has little or no impact on high levels of gender violence, child abuse and

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the most highly marginalized youth will respond when challenged by people they trust and believe in. Orphanages and juvenile detention centres are relics of a 19th century methodology that has no chance of succeeding. Instead there must be an emphasis on innovative community-based programming equipping young people with the basic skills that they need to become responsible members of society.

<table>
<thead>
<tr>
<th>Table 11 - The Rights of HIV/AIDS-Affected and Other Vulnerable Children</th>
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<tbody>
<tr>
<td><strong>Children's Rights</strong></td>
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<tr>
<td>Non-discrimination</td>
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<tr>
<td>Mothers are informed, have access to PMTCT and receive support to stay with and care for all of their children</td>
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<tr>
<td>Children affected by AIDS are assisted in their communities</td>
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<tr>
<td>Children are losing their access to health care, voluntary counselling and testing for HIV</td>
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<tr>
<td>Children have to hide their HIV status</td>
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<td>Stigma and discrimination has increased children's fear</td>
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<tr>
<th>Health and Development</th>
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<tbody>
<tr>
<td>All children have adequate and appropriate nutrition</td>
<td>All HIV-affected children do not receive regular meals without food, resulting in malnutrition and stunted growth</td>
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<tr>
<td>Children have access to health care in their communities</td>
<td>Children experience more illnesses but do not receive regular health care or immunizations, resulting in higher morbidity and mortality</td>
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<tr>
<td>Children are losing their rights to provide family income</td>
<td>Common disabilities are not prevented because treatment for HIV and other illnesses is so limited</td>
<td></td>
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<tr>
<td>√ Economically poor children have more access to health care</td>
<td>If positive, children do not receive care. They need information on how to protect their health</td>
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<tr>
<td>Children lack the ability to seek care</td>
<td>Children's health is affected by discrimination and need for HIV care</td>
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<tr>
<td>Children lack the ability to avoid discrimination</td>
<td>Many HIV/AIDS-affected children may need palliative care management and spiritual care</td>
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<tr>
<td>Children affected by AIDS are living in unsafe or hostile environments</td>
<td>Many HIV/AIDS-affected children are living in unstable or dangerous environments</td>
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<tr>
<td>Children lack effective access to education</td>
<td>Children are lacking access to education and are forced to work</td>
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<tr>
<td>Children lack opportunities to access to effective life support from relatives</td>
<td>Children are lacking access to education and are forced to work</td>
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<tr>
<td>Families in non-urban areas receive little support from relatives</td>
<td>Children and families are lacking access to education and are forced to work</td>
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<tr>
<td>Families are losing their livelihoods</td>
<td>Children lack access to education and are forced to work</td>
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<tr>
<td>√ Families lack adequate and appropriate nutrition</td>
<td>HIV/AIDS has disturbed the availability of food</td>
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<tr>
<td>√ Families lack adequate and appropriate clothing</td>
<td>Children lack access to education and are forced to work</td>
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<td>√ Families lack adequate and appropriate shelter</td>
<td>Children lack access to education and are forced to work</td>
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<tr>
<th>Education</th>
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<tr>
<td>All children have equal access to education and are effective learners</td>
<td>There is a high drop-out rate in the education system</td>
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<tr>
<td>Children have effective access to a conducive environment</td>
<td>Children lack access to education and are forced to work</td>
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<td>Children have access to effective education prevention</td>
<td>Children lack access to education and are forced to work</td>
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<td>Children lack access to education and are forced to work</td>
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<th>Shelter: clothing</th>
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<td>Children have safe and secure dwellings</td>
<td>Children lack access to education and are forced to work</td>
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<tr>
<td>Children have appropriate clothing</td>
<td>Children lack access to education and are forced to work</td>
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<th>Socialization</th>
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<tr>
<td>Children have a sense of identity, personhood, sense of community</td>
<td>Children are becoming socialized and are learning about their self-identity</td>
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<tr>
<td>Name and kinship</td>
<td>Children are becoming socialized and are learning about their self-identity</td>
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<tr>
<td>Customs and traditions</td>
<td>Children are becoming socialized and are learning about their self-identity</td>
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<tr>
<td>Knowledge and family orientation</td>
<td>Children are becoming socialized and are learning about their self-identity</td>
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<tr>
<td>Sense of future and direction</td>
<td>Children are becoming socialized and are learning about their self-identity</td>
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<tr>
<th>Understanding of health and development</th>
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<td>Children need information about</td>
<td>Children have an adequate standard of living</td>
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<tr>
<td>Physical</td>
<td>Children have an adequate standard of living</td>
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<tr>
<td>Mental</td>
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<td>Intellectual</td>
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<th>Protection from exploitation, abuse and neglect</th>
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<tr>
<td>Children have a regular caregiver</td>
<td>Children are becoming socialized and are learning about their self-identity</td>
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<tr>
<td>Ongoing access to and support for</td>
<td>Children are becoming socialized and are learning about their self-identity</td>
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<td>Regular routines</td>
<td>Children are becoming socialized and are learning about their self-identity</td>
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<tr>
<td>Child protection</td>
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<td>Children's risk-taking experiences</td>
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<td>Children have a safe and secure home</td>
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<td>Children have a sense of belonging</td>
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<td>Children have access to health care</td>
<td>Children have an adequate standard of living</td>
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<td>Children have counseling and mental health support</td>
<td>Children have an adequate standard of living</td>
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<td>Children have access to effective education</td>
<td>Children have an adequate standard of living</td>
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Children need care, they need services and they also need the protection of their society from the growing threat of HIV/AIDS. Instead, women and children are exposed to HIV infection because their basic human rights are not met. Table 11 contrasts the current situation of children’s rights, relative to the HIV/AIDS epidemic, with what it would look like if their rights were fulfilled.

The many violations of children’s and women’s rights are deepening the grip of the HIV/AIDS epidemic on the country, making it worse not only for children and women but for the society as a whole. As a signatory to the Convention on the Rights of the Child, Papua New Guinea has taken action to address, correct and reduce these violations, but the HIV/AIDS epidemic makes this progress slower. Females of child rights can only be realized by society as a whole. UNICEF’s “Protective Environment for Children” helps visualize responsibilities that must be met in eight spheres of action.
Under the Convention on the Rights of the Child, all levels of Papua New Guinea’s government have a responsibility to help families protect and fulfill children’s rights, an obligation that becomes even more essential with the rapid growth of HIV/AIDS in the country. AIDS is already threatening the fabric of family and community life in many ways. Neglect and rejection of PLWHAs, including children, by families and communities is widespread in the country’s most hard-hit districts. Severe abuses of children’s and women’s human rights are resulting. Current targets are too slow to keep pace with accelerating AIDS deaths. Stakeholders say that the national HIV/AIDS strategy is NCD-focused and must be taken to the grass-roots level if it is going to be effective. It is for this reason that they called for immediate action at the provincial level.

To respond to this imperative, UNICEF Papua New Guinea is now seeking funds to mobilize and capacitate existing responses in six provinces. Models for family and community-based responses will be drawn from communities and examples will also be sought from countries that have more experience with mobilizing family- and community-based responses to HIV/AIDS. The goal will be to expand province-wide responses in a total of eight hard-hit provinces over the next two years. Implementation must be rooted in action research, using the village discussion group approach of this research for participative assessment and strategy building.

In each province, the Department for Community Development must assist communities to:

- Set up a steering committee. This steering committee should be focused on achieving the items listed here.
- Collect and set up a centralized data base on vulnerable children from village assessments and local stakeholders.
- Create an MOU with the provincial government and the steering committee
- Provide training to all communities in

The National Structure below shows the National Advisory body should be charged with:

**Community Development**

- **2-3 professionals**
  - Responsibilities: Criteria for children
  - Community mobilization
  - Training of social welfare professionals, families and communities
  - Centralized collection of data
  - Monitoring of community and institutional care
  - Oversight of provincial staff

**Education**

- **1-2 professionals**
  - Responsibilities: Collection of data from community courts
  - Development of policy and regulation

**Health / NAC**

- **2-3 professionals**
  - Responsibilities: Role of health care professionals
  - Coordination of work of advisory committee
  - Development of health care side of community care
  - Coordination work of provincial AIDS Committees
  - Oversight of professional staff

- **2-3 professionals**
  - Responsibilities: Coordination of work of advisory committee
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  - Coordination of work of provincial AIDS Committees
  - Oversight of professional staff

**New Advisory Committee**

- **Family and Community Care**

**Representation**

- **2 professionals**
  - Responsibilities: Coordination of work of advisory committee
  - Development of health care side of community care
  - Coordination of work of provincial AIDS Committees
  - Oversight of professional staff

Capacity for dealing with AIDS affected families and children must be fast-tracked and coordinated among relevant ministries. Under the Family and Community Focus Area of Papua New Guinea’s new National Strategic HIV/AIDS Plan, five strategies are noted for building community capacity for care for orphans and vulnerable children through to 2008:

1. Construct criteria for identifying orphans and other vulnerable children;
2. Enable CBOs to compile information on orphans and other vulnerable children and to monitor their status on a regular basis;

**Recmmendation 1**

**Accelerate family- and community-based mobilization and response in five provinces**

- PNG’s “epidemic of violence” against women and children must be stopped through a broad societal commitment to change;
- Traditional customs such as bride-price and polygamy must be reported;
- Adoption and fostering must be re-examined in modern terms and reinvested in practice;
- Judicial and policing mechanisms need capacity-building in children and women’s rights and monitoring and review.

**B. Recommendations from the Assessment**

Many of the conditions that lead to persistent and extreme violation of children’s and women’s rights—and to the worsening of the HIV/AIDS epidemic in the country—are pervasive and must be addressed at every level of society. It is critical that broad-scale social action be mobilized now. As a country, Papua New Guinea has a very small window of opportunity to change the conditions that promise an expansion of the HIV/AIDS epidemic in the country. AIDS is already threatening the fabric of family and community life in many ways. Neglect and rejection of PLWHAs, including children, by families and communities is widespread in the country’s most hard-hit districts. Severe abuses of children’s and women’s human rights are resulting. Current targets are too slow to keep pace with accelerating AIDS deaths. Stakeholders say that the national HIV/AIDS strategy is NCD-focused and must be taken to the grass-roots level if it is going to be effective. It is for this reason that they called for immediate action at the provincial level.

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- Provide training to all communities in

The diagram below shows the National Advisory body should be charged with:

**Recommendation 2**

Fast track development of a National Strategy for AIDS-Affected and Other Vulnerable Families and Children under the national HIV/AIDS strategic plan

- **2 professionals**
  - Responsibilities: Coordination of work of advisory committee
  - Development of health care side of community care
  - Coordination of work of provincial AIDS Committees
  - Oversight of professional staff

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1. Construct criteria for identifying orphans and other vulnerable children;
2. Enable CBOs to compile information on orphans and other vulnerable children and to monitor their status on a regular basis;
3. Build capacity of school teachers to identify and register orphans and vulnerable children in their communities;

4. Build on traditional safety nets for the care and support of orphans and other vulnerable children;

5. Ensure that all orphans and vulnerable children have access to schooling and health care services through the establishment of a community-based trust fund for orphans and vulnerable children.

These strategies are complemented by strategies in other parts of the plan to increase family and community capacity for home care. While these strategies are sound, their implementation schedule does not reflect the urgency of the situation. New evidence suggests that the HIV/AIDS epidemic is rapidly becoming more severe and that communities and families are already having difficulty in coping. Unless the response is accelerated, the orphan and vulnerable children problem could quickly become a crisis. The response needs to be both quick and shared among a number of policies.

Recommendation 3
Strengthen the national network of provincial programs for families and children affected by HIV/AIDS, including collaborators in the Family and Sexual Violence Action Network and the NAC’s Home-Based Care Network.

A national network of provincial services and stakeholders will reinforce provincial level activities and help build capacity. It can also serve as a funding source for grass-roots or provincial projects and help keep local volunteers in contact with the national effort.

Recommendation 5
Reduce violence against women and children and improve the justice system so it addresses their needs.

One of the chief contributors to the rapid spread of HIV/AIDS is violence against women and children, including sexual violence and exploitation. The following steps are recommended to strengthen existing initiatives:

Recommendation 4
Fast track the development a national data base and monitoring system for vulnerable children.

Community leaders and organizations all said they need more data and information on affected and vulnerable families and children for use in planning, budgeting and providing services.

Recommendation 6
Build on partner surveys

Some partners in NCD have already provided information for this assessment. Forms developed for this purpose should be used in other provinces by social welfare officers, in collaboration with the PACs, to collect comprehensive data on care of vulnerable families and children. This could be done in collaboration with the FSVAC network, which is already collecting information on violence and abuse.

Recommendation 7
Involve children.

It is critical that children and young people are involved in data collection.
or up to date in women’s and children’s human rights and yet are responsible for administration of most local level justice, including family disputes. They must be trained to improve their ability to defend and protect women’s and children’s rights. Village Court Magistrates must also be trained on human rights and enforce jurisdictional division between Village Courts and formal justice system.

b. **Review adequacy of law**

Ensure that the structure and implementation of the law prohibits and punishes family violence.

c. **Prosecute child sex abusers**

Prosecute perpetrators of sexual abuse and the sexual exploitation of children swiftly, including members of their own families who facilitate their work in the sex business.

Reduce violence against women and children;

d. **Make violence unacceptable**

With the help of media and schools to reduce the acceptability of violence against women and children.

e. **Train parents and guardians in counselling**

A program aimed at the district level to train parents and guardians in counselling should be instituted. This must also include a formal reporting mechanism which will feed into part (f). From experience in other countries and from domestic reports, we know that the psychosocial issues of vulnerable children and families are severe. Children are isolated and generally have behavioural problems and grief issues.

f. **Strengthen provincial, district and local monitoring of family abuse**

No central data base exists to document cases of violence and abuse against women and children. Existing sources for this data include hospitals and courts. Each provincial committee implementing a family and community mobilization program can link partners to develop a coherent and consistent data collection approach. Primary responsibility for the monitoring system should rest with Department for Community Development who can also play a coordination role that ensures parallel data collection systems feed into this recommendation.

### Recommendation 6

**Conduct sectoral studies in health, education and agriculture by the end of 2006 so the impact of HIV/AIDS on families and children is better understood and can be anticipated in national planning.**

Enabling families and communities to respond to the HIV/AIDS epidemic will require that basic services in health, education and agriculture be made available to all vulnerable children and families. The impact of the epidemic on families and children will require a multisectoral response. As a first step, many countries conduct specific studies of epidemic impact by sector to increase the competence of national social planning in the face of the epidemic. These sectoral studies will allow more careful consideration of Papua New Guinea’s MDG target for HIV/AIDS. While the country has pledged itself to halt and begin to reverse the spread of HIV/AIDS by 2015, its 2004 MDG progress report noted that much work needs to be done in planning, program implementation and monitoring to realize the targets for HIV/AIDS set for the country. These sectoral studies can help to flesh out that plan and enable reasonable target setting. It is recommended that priority be given to sectoral studies in education, health, agriculture and social welfare/community development.

### Recommendation 7

**Increase direct support to vulnerable families and children, including provision of basic services.**

Orphans and other vulnerable children’s access to education and health care is limited. Children desire education and many are committing crimes or selling sex to gain access to it. While availability of education for orphans can be addressed case by case, country experience shows that it is more efficient and less stigmatizing to address these needs at the system level. Access to schooling through a special trust fund is a reasonable emergency solution, but experiences of other countries show that in the long run it is labour intensive and will probably not reach many children.

**Action in the following sectors needs to be given immediate and high priority by national and provincial governments:**

a. **Implement free, universal primary education as soon as possible**

It is recommended that the country implement national free universal primary education on an accelerated timetable (within the next two to five years) to prevent the spread of HIV/AIDS in school age children and help AIDS-affected and other vulnerable families deal with the problems of care for their children. In Malawi, free UPE was implemented in just two years as a response to HIV/AIDS; in Uganda it was implemented over the course of five years. In these cases and others, country policy makers saw that it was essential to controlling the epidemic among young people and mitigating its impact on families.

b. **Other basic services**

Communities also need more basic services, including water and sanitation services and health services.

c. **Agricultural development**

Agricultural development is needed to improve the prospects of the rural poor and their ability to cope with the impact of HIV/AIDS.

In order to avoid institutionalizing children, available alternatives for orphans and children need closer examination and support. The positives of the ‘wantok system’ need to be examined. In addition, this study and similar studies in other countries suggest that children in certain circumstances are more liable to be abused by their care givers, guardians, teachers, police and other professionals. The expertise of social workers and professionals familiar with family care practices and problems in Papua New Guinea should be called upon to develop a checklist or other simple evaluation tool to aid those responsible for detecting child abuse and mistreatment.

a. **Research fostering and adoption**

Thorough research into adoption and fostering is needed and existing networks can help to conduct such research.

b. **Review and monitor adoptions**

Welfare officers should conduct proper monitoring and follow up on reported adoption and fostering cases at all levels.

c. **Create a review mechanism**

Communities need criteria to review adoptions and foster systems to monitor them. Communities must recognize that every child who is adopted or fostered has a right to periodic review of their placement. This could be done through a voluntary visiting scheme whereby community volunteers can visit families who have adopted children or through village courts.

d. **Children need a voice**

Children themselves need a voice in the existing networks and in local legal systems. This will also require educating parents and guardians of a child’s right to express their opinion.

e. **Create a tool to detect and evaluate child care and abuse**

A tool for use by professionals and volunteers is needed to identify and prevent child abuse. Experts can be convened to draft, test and develop criteria and link it to data collection and monitoring systems. Health professionals and school teachers can be trained in its use. This tool must be part of a mandatory reporting system.

f. **Review laws**

Review, amend and publicize any changes to the Adoption of Children Act to suit the current situation.
Recommendation 9
Seek immediate passage of the Lukautim Pikinini Act to limit the growth of institutional care and develop a national policy that specifically contains and regulates institutional growth and makes it subordinate to a carefully developed national system supporting family and community care.

Increasing AIDS-related deaths usually result in the mushrooming of orphanages and other types of formal and informal institutions, care centres, shelters and drop-in centres. Unless they are regulated, these institutions can be seriously detrimental to the well being and rights of children and families. Their growth is costly and draws resources away from support for family and community care. It is critical that steps be taken early to define the role of various types of institutions and create a mechanism to supervise their establishment, registration, certification and operation because unregulated institutions can serve as the basis for widespread abuse of child rights and as centres for child trafficking.

a. Pass the Lukautim Pikinini Act. This Act contains provisions to limit and regulate institutional care and should be passed immediately.

b. Regulate growth
Develop the policy guidelines needed to contain the growth of new child care institutions, including orphanages, community care centres and temporary shelters.

c. Monitoring existing centres
Monitor residential institutions that are in place and monitor street children drop-in centres.

d. Register centres
Develop a registry and certification process for private institutions and community care centres that may be providing residential care to children.

e. Develop national policy
Based on the relevant provisions of the Lukautim Pikinini Act, develop a national policy for social welfare institutions and services that clearly defines the roles and circumstances of institutional care.

Recommendation 10
Involve children and young people in formulating national youth policy, data collection and implementing family- and community-based care

Young people in NCD and the study provinces included in this research were instrumental in getting interviews with vulnerable and HIV/AIDS-affected children and their families. Without them, many of the stories in this report would never have been told. At the national stakeholders’ meeting on 27 January 2005, a group of young people, most of whom worked as volunteers for this study, made the following recommendations for action:

a. Government must be more aware
Government agencies who work with children and children’s issues need to be more involved with communities rather than basing solely in their offices. Many senior staff who heard this research presented said they had been unaware of how pervasive violence against women and children was and how deeply it was affecting their society. Regular exposure to the realities of poverty and how deeply it was affecting their society will help sensitize policy makers and move them to action.

b. Visit the settlements
Government workers should be involved in sharing and caring by visiting settlements.

c. Avoid discrimination and violence against children
All adults have a responsibility to step in and teach parents how to respect the rights of their children. Violence can no longer be allowed to be a “family matter,” because too many women and children are suffering alone.

d. Build young people into regular data collection
Create a network between young people, Government, the private sector and NGOs so that first hand information can be delivered.

e. Volunteer and help
All community members should participate in programs regarding the problems affecting the orphans.

Recommendation 11
Expand PMTCT as quickly as possible and include counselling to prevent the potential cases of infant abandonment and the sale of babies.

In some African and Asian countries with serious HIV/AIDS epidemics, infant abandonment increases because mothers do not know their own HIV status and do not know the status of their newborns. Based on international experience, there is some evidence to suggest that implementing PMTCT with good counselling for mothers reduces the number of infants who are abandoned because their mothers think they are HIV-positive.

Whilst this experience has so far not manifested itself to a large extent in Papua New Guinea, it is crucial for the Government to begin preventative measures to ensure such a reality does not eventuate in Papua New Guinea.

Recommendation 12
Collect serodata on infection among children and young people by different age groups

Current levels of infection among young people seem high and may be related to widespread sexual abuse or sex work by children and young people. However, this could simply be because age data is collected for 0 to 2 and 2 to 9 year old age groups. It would be useful to collect specific data on all age groups of children up to the age of 18 years.

Recommendation 13
Examine related policy issues
Participants in this assessment raised a number of policy issues for urgent consideration by government. Each of these policy related issues provides a list of suggested organizations who should be responsible for advocating on the issue. The following are among the suggestions that were made:

- Standardise and raise the age of marriage to 18 years and ensure proper enforcement. This must also apply to customary marriages.
- Prohibit polygamy and enforce it.
- Prohibit or cap bride price payments.
- Review the Deserted Wives and Children Act (Child Rights Monitoring Committee).  
- Review PNG’s Poverty Reduction Strategy to ensure it addresses the impact of poverty on children and women, particularly in regards to orphans and vulnerable children.
- Fast track birth registration (Department for Community Development, Civil Registry).
- As part of the International Children’s Day celebrated annually in Papua New Guinea, include special attention on the situation of orphans and vulnerable children (Department for Community Development, Provinical FSVA/C).

Recommendation 14
Request ILO regional assistance for further studies of child trafficking/the sex sector and child labour

Poverty and customary informal adoption and fostering of children leave many children exposed to the worst kinds of abuses. The recent study into child sexual abuse and the commercial sexual exploitation of children, suggests that systematic child trafficking is developing with international participation and investment.

The International Labour Organisation’s Asia and Pacific Offices in Bangkok has studied the sex sector in four Asian countries and also champions the cause of controlling abusive child labour. It is important to have both issues studied more closely to prevent the further exploitation of children for international sex work or other kinds of exploitative labour. Using the model of the CSEC/CSA study, the Government (Department for Community Development) and/or relevant NGOs must identify what issues require further/more detailed attention and commission such studies.

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Recommendation 15
Investigate the causes of high male and female sex ratios in children and young people and the cause of variation in infant mortality rates

Investigation of unusual sex ratios should be given high priority. The skewed sex ratios are widely acknowledged and, coupled with polygamy, may be contributing to competition among men and widespread violence. The unusual ratios and high infant mortality rates among males suggest the most severe form of violations of children’s rights. There is some evidence that deliberate infanticide or infanticide through neglect may be occurring in Papua New Guinea.

Research expertise exists in Papua New Guinea to carry out this study, which could be linked to the study of adoption and fostering. It could also be carried out as part of the community mobilization activities to prevent HIV/AIDS.

Appendix 1: Methodology

A. Introduction

The methodology for the national assessment of children and families affected by HIV/AIDS and other factors was established by the assessment team through consultations with the assessment’s stakeholders and UNICEF staff, taking into consideration the constraints of the timetable, availability of data, budget and research partners.

B. Timetable

In addition to the timetable for assessment activities shown below, more detailed work plans were also completed by the study’s two national consultants to guide field data collection.

C. Target Groups

The assessment examined the vulnerabilities of key groups of children traditionally included in UNICEF programming such as children in especially difficult circumstances (CEDC) or children in need of special protection (CNSP). These include the categories listed in the first column of the table below. In prior assessments, children affected by HIV/AIDS were studied as an additional category of CEDC or CNSP. There are several difficulties with this approach:

1. These categories of children overlap because vulnerable children can fall into circumstances that place them in more than one category. For example, when children are orphaned by HIV/AIDS or other causes, they may become street children, or quit school and end up as child labourers, including child sex work. Many street children are also orphans, child labourers and children in conflict with the law.

2. Commonly, hard data on each of these categories of children are not available, especially child sex workers and street children.

UNIFEM has well-respected programs in reduction of gender violence and HIV/AIDS and their models from Asia and other parts of Africa would be useful in confronting the issue of male violence in Papua New Guinea. UNIFEM should be requested to expand their presence in Papua New Guinea as soon as possible.

Recommendation 16
Expand UNIFEM’s presence in PNG

The status of women and girls is deteriorating and threatened by stagnant socio-economic conditions, a growing sex industry and rapid spread of HIV/AIDS. More resources are needed to combat the growing violations of human rights; this has been declared a priority in Africa as well.

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3. Orphans, who are often viewed by their own societies as among their most vulnerable members, are not included in the traditional CEDC and CNSP categories.

4. When vulnerability is analyzed separately for each of the categories of children included in CEDC or CNSP, it leads to vertical, fragmented programming for children with overlapping vulnerabilities.

5. Children in most of these categories may or may not actually be vulnerable, depending on their family situations, income levels and other aspects of their living circumstances (like access to education and health care) so the analysis must be elaborated to identify other underlying vulnerabilities for each category of child.

6. This approach does not look at the types of family relationships or social-structural causes that lead to childhood vulnerability and so tends to target, label and stigmatize children and their families rather than lead to broad, structural and social solutions to the causes of their vulnerability. It tends to target the vulnerable with piecemeal, welfare-like programs rather than lead to enduring and sustainable policy changes that benefit children and families overall.

To avoid these difficulties, this assessment looked at childhood vulnerability from the perspective of its underlying causes. It examined the vulnerability of children living in different types of families with different types of care givers and the deeper, social, structural and economic sources or causes of vulnerability of children in the country. These were guided both by household situations known from research in Papua New Guinea and other countries to accentuate children’s vulnerability (listed in the second column of the table) and structural (social and economic) problems faced by all vulnerable children (third column of the table). The assessment asked village, district and provincial leaders and stakeholders to answer the following questions: What in a child’s underlying family and community situation makes him or her vulnerable? What types of family structures and situations lead to a failure to meet or fulfill children’s rights in Papua New Guinea? How is the HIV/AIDS epidemic increasing child and family vulnerability? One result of this also emphasized closer examination of the process by which children become vulnerable. Children and families in need of basic information about their vulnerability were interviewed with their information directly. Researchers who have studied Papua New Guinea’s families and communities for so many years and so expert observers—including the Minister for Community Development—believe that the changing social conditions of modernization and family migration have created holes in the traditional safety nets that are leaving many adopted and fostered children vulnerable to neglect, abuse and exploitation.

In addition, the study aimed to construct a vulnerability index for children for each
province that will enable comparison of the provinces' relative performance in sources, types and levels of data for the assessment.

Sources, Types and Levels of Data for the Assessment

<table>
<thead>
<tr>
<th>Source</th>
<th>Type of data</th>
<th>Level of data</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>National census</td>
<td>Characteristics of children and families, e.g.</td>
<td>National</td>
<td>Completed Jan. 2005</td>
</tr>
<tr>
<td>MDG report</td>
<td>Development indices by MDG sector</td>
<td>National</td>
<td>Completed Dec. 2004</td>
</tr>
<tr>
<td>FS/MC national</td>
<td>Violence against women</td>
<td>National</td>
<td>Not completed</td>
</tr>
<tr>
<td>FS/MC</td>
<td>Abandoned children</td>
<td>Provinces</td>
<td>Not completed</td>
</tr>
<tr>
<td>FS/MC</td>
<td>Violence and abuse against women and children</td>
<td>Provinces</td>
<td>Not completed</td>
</tr>
<tr>
<td>NAC Community Data by province</td>
<td>Saccasdomic, agriculture, health</td>
<td>Provincial &amp; below</td>
<td>Not used</td>
</tr>
</tbody>
</table>

Qualitative (interviews, case histories, life stories, discussion groups)

Selection of Study Areas

<table>
<thead>
<tr>
<th>Province</th>
<th>Urban/ Rural Results</th>
<th>Stakeholder NAC/OIC</th>
<th>HIV Prevalence</th>
</tr>
</thead>
<tbody>
<tr>
<td>East Sepik</td>
<td>West, east, urban and rural</td>
<td>NAC</td>
<td>NA</td>
</tr>
<tr>
<td>Morobe</td>
<td>East and western Highlands</td>
<td>NAC</td>
<td>ES PAC</td>
</tr>
<tr>
<td>Southern Region</td>
<td>Literacy status by age and gender</td>
<td>NA</td>
<td></td>
</tr>
<tr>
<td>Highlands Region</td>
<td>Population (&lt; 8 years) by age and gender</td>
<td>NA</td>
<td></td>
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</tbody>
</table>

E. Selection of Target Provinces

The five provinces targeted for intensive field work were selected with advice from the stakeholder group. They represent a range of HIV/AIDS incidence levels; each of the country's four regions; matrilineal and patrilineal systems of inheritance and social organization; and a variety of economic activity patterns. They are not necessarily the provinces with the highest HIV/AIDS levels (this is impossible to know from the NAC data set). However, they are provinces where stakeholders thought there were a significant number of vulnerable families, children and communities. The Eastern and Western Highlands are among the lower achieving provinces according to the 2004 MDG report, while East Sepik and Morobe are average performers and NCD is among the most developed provinces according to the MDG indices. In each of these provinces, a standard data collection approach was used, consisting of question guides for individual interviews and group discussions. The package was also sent to the PACs' social mapping interviewers in other provinces trained by the NAC, who were asked to administer the questionnaires themselves. None, however, responded. In all cases, researchers used a standard set of data collection guides and instruments so that data collection was parallel and comparable.

F. Tabulation of Census Data

To provide an overview of the study's population of interest, the 2000 census data will be tabulated and cross tabulated to gain basic information on children, families and communities and their characteristics as starting points for the study. The following is an illustrative list of tabulations that will be prepared by the local consultant:

Level of data presentation: National, Province, Districts and LGIs and urban/rural Target population: Population less than 18 years of age and their families

A. Household structure/composition

<table>
<thead>
<tr>
<th>Tab</th>
<th>1. Household size</th>
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<tbody>
<tr>
<td>Tab 2</td>
<td>2. Household heads by gender (% of total household heads)</td>
</tr>
<tr>
<td>Tab 3</td>
<td>3. Size of household by gender of household head</td>
</tr>
<tr>
<td>Tab 4</td>
<td>4. Size of household by age of head of household</td>
</tr>
<tr>
<td>Tab 5</td>
<td>5. Relationship of children to head of household</td>
</tr>
<tr>
<td>Tab 6</td>
<td>6. Population of households step/ adopted children</td>
</tr>
</tbody>
</table>

B. Children - Basic Characteristics

| Tab | 1. Children (<18 years) by age and gender |

Appendix 2: Selected References


Department of Justice and Attorney General, 2000, Initial Report to the UN Committee on Rights of the Child, Papua New Guinea.


National Sex and Reproduction Research Team (NSRRT) and Jenkins, C., 1994, National Study of Sexual and Reproductive Knowledge and Behaviour in Papua New Guinea, Monograph No. 10. Goroka: PNG Institute of Medical Research.


Buchanan, J. et al., 2003, Papua New Guinea Scoping Mission for Human Rights Project, UNDP.


Appendix 3: Children and Care Giver Stories

The data reported below includes interviews and discussion groups with children in NCD (A and B) and interviews with children and their care givers in East Sepik, Morobe and Western Highlands Provinces (C and D) and interviews with agency directors in Lae (E). Reports from three of the 25 case studies of people living with HIV/AIDS are also included (F). The remainder was not useful because of the interviews’ difficulties with the data collection instrument.
A. Interviews with Children in National Capital District

Interviews were conducted with 20 children in the National Capital District (NCD) with children in a range of living situations, with various numbers of guardians who are either unemployed, struggling to make ends meet in the city, or are affected by other related problems, such as large family backgrounds, or lack of basic food and clothing. The interviews were based on general issues that may have been easier for the children to comprehend and answer correctly, including their personal details; home and family situations; their education; community support; family type and support; and violence against the children.

The respondents were males and females aged 8 to 18, in different service provider locations in the NCD, including Anglicare Stop AIDS, Waigani; Hopeful Living Centre - I Gat Hope, Badili; City Mission, Badili; Kaugere Foursquare Mission: Heduru Centre, Horse Camp, Joyce Bay; and Street Children, SP Flats, Badili. Most interviews were with children who visit drop-in centres or day care centres, while some interviews were with street children who do not visit the centres. The interviews were members of the Special Youth Project (SYP) and Ms. Esther Lavu, a local consultant for the assessment. Individual case histories have been summarized and each is given vulnerability status. SYP interviewers had been trained as part of a study of child vulnerability status. SYP interviewers had been trained as part of a study of child vulnerability status. The interviewers were members of the Special Youth Project (SYP) and Ms. Esther Lavu, a local consultant for the assessment. Individual case histories have been summarized and each is given vulnerability status. SYP interviewers had been trained as part of a study of child vulnerability status. SYP interviewers had been trained as part of a study of child vulnerability status.
City Mission for over a year now. They have helped me to feel good about myself and they are very friendly. I do not miss home at all. My family is not very caring because my stepmother always treats me like nobody’s child. She does that because she is not my biological mother. I only wish my mother was alive. I am also mistreated at home by my stepmother and her family because of several occasions, by my stepmother and my cousin brothers. They hit me with a piece of timber and I was hospitalised for more than two weeks. My father is aware of the bad treatment I get, but he does not do anything about it, although he does care.

Case 6: Homeless child

Personal, Home and Family Situation. I am a fourteen-year-old boy and I live among members of my community. I am from Gulf and Central Provinces. I have no proper place to sleep and often sleep wherever I can find a suitable place. I live by collecting cans and bottles to sell and make my own money. I use this money to buy food and clothes.

Education and Community Support. I have never attended school. Most of my days I spend searching for cans and empty bottles to sell. This is my means of survival. Sometimes, I spend time gambling, so that I can make additional money to buy more food. I do not go to the places where they give out free food. I try to make ends meet myself.

Family Type and Support. My mother is dead and my father is very old. He lives with his son from his previous marriage. He cannot possibly care for me and therefore places me in a situation of caring for myself. I often get food from people when I do some work for them, otherwise, I am on my own. Life is good when I eat. When I am hungry, I feel sick and weak. Otherwise, I have no relatives checking on me to make sure I am okay. People in the community will not give any free food. They will give you food when you do some work for them.

Violence. Often, people in the community mistreat me or beat me when I do something wrong. I was once hospitalised because two boys beat me so badly when I stole some red berries from the tree in their yard. I only feel sick if I am hungry.

Case 7: 16 year old female orphan

Personal, Home and Family Situation. I am a sixteen-year-old girl and I come from West New Britain Province. Currently, I live with my foster parents in Gordons. There are five other people who also live with us. My foster father buys food for the family and all the adults are responsible for the food and the cooking.

Education. Currently, I attend a secondary school in Port Moresby and am in Grade 9.

Community Support. I started selling betel nut at the market to pay for my school fees. I have been doing this for more than two years now. I like the place where I sell my betel nut and cigarettes because that is where I make good money. I spend a lot of my time doing that, because it is better here and that is why I do not miss home at all.

Family Type and Support. Both of my parents are dead. I believe they died from HIV/AIDS. I live with my foster parents and I know they try to be good to me occasionally. However, I know they are not good to me at times because I am not their biological daughter. The family that I live with does not show these. They love me as their own daughter. Sometimes, my foster father mistreats me at home.

Violence. My foster father beats me up. He occasionally beats me up because I usually refuse to have sex with him. No-one really cares because, when I am selling betel nut, no-one comes to check on me.

I spend time at the market place at night with big mother, to sell betel nut and sell sex. I know that this is wrong, but I have to do that in order to survive. My foster parents often do not treat me fairly because of what I do, but I have to survive. They know that they cannot provide everything I need. On one occasion, my foster father hit and punched me because I refused to have sex with him. I usually sell sex at some houses where I make money. I share this with my boyfriend.

Case 8: Street boy

Personal, Home and Family Situation. I am a thirteen-year-old boy from Gollala District, in Central Province. I live along the main road and I try to take care of myself. I know I don’t have a home and I have to survive each day. As no-one is responsible for me, I have to look for my own food. I do not know if my parents are alive or dead. If they are dead, I have no idea of the sickness from which they may have died.

Education. As for school, I have no idea. I do not go to school and I don’t even know anything about school.

Community Support. I came to the town area in 2000. I am usually on the streets of Port Moresby town area begging for people to help me with food and money. I look after myself. In town, life is okay because lots of people give me money and food, although the security guards and other people chase me. I do not miss home, as I do not have a home.

Family Type and Support. I do not know if my parents are alive or dead. As for how my family should take care of each other, I have no idea, as I don’t have one. Because I do not have any experiences of family life, I do not know how a family should take care of each other.

Violence. On the streets, my worst enemies are security guards and other people. They chase me away when I ask the wrong person to assist me. When I follow people to ask them for money and food, the security guards abuse me physically and verbally. Generally, life is okay now and I like doing what I do. This is my way of life. I still wish that I had a good family to take care of me. I also wish they provided care and love that I have never experienced. And I also wish I was able to go to school.

Case 9: HIV positive young woman

Personal, Home and Family Situation. I am a seventeen-year-old young woman and I am married. I am HIV positive and was infected by my husband when I was still in school. I am from Gulf Province and I live with my husband in one of the old government properties in the town area. I left school after completing my Grade 10 education and married my husband at the end of that year. We live together at this old government property and it is either myself or my husband buying food for both of us. I am the one who does the cooking and I survive by selling betel nut and cigarettes at the bus stops. I started doing this after I left school two years ago. I like what I am doing because this is my means of life.

Education. I have been to school and have completed Grade 10. I no longer attend school or work in a formal wage job, because I ended up getting married. During the day, I sell betel nut and cigarettes at the bus stops. I left school in 2002 and got married at the end of the same year.

Community Support. I came to the old government property where my husband lives and started selling betel nut and cigarettes to make ends meet. I have been selling my betel nut and cigarettes since I left school. I like this place because it’s a central location for the general public to buy these things. I do miss my family home, but unfortunately, I can never visit them again because I am HIV positive. I have been told by my parents not to go back to the family home.

Family Type and Support. Although both of my parents are alive, I will not be able to visit them. I was told to leave after completing Grade 10, because they knew I was HIV positive. From experience so far, family care for me is non-existent. When they knew that I was HIV positive, they told me to leave home. These days, when my family members see me, they pretend that they have never seen me before.

Violence. I am abused physically by my husband, when he is drunk. I do not really know why he does this. My immediate family has chased me away, so nowadays, when they see me, they ignore me as if they have never known me. I have not discussed any of these problems with anyone.

Case 10: 13 year old female orphan for three others

Personal, Home and Family Situation. My mother was dying, but she still had the motherly love for all of us. Although it was time, she never gave in to her relatives for comfort and care. She could not stretch far, as there was no-one within her reach. In the urban style of living, survival of the fittest has become a reality. I now know it is the true meaning in societies experiencing transitional change.

My dear loving mother painfully died from HIV/AIDS and as the eldest female child, I sensed the reality of life that was ahead of
us. She eventually died, leaving a huge debt that was owed by all of us. Life in its full package hit us at the heights of loss of parental love, real food, hunger and all necessities of normal healthy children. I was only ten years old when the four of us were in an open society as not ours and did not have the faintest idea of how we were going to survive.

For several months we wandered the streets of Port Moresby under the safety net arrangement of relatives. We gained additional attachment to our human bodies at the diseases of and worst of all, lack of food, turned us from normal to malnourished children. My lead role as the eldest female child could only take us so far. One day, a lovely woman of God came and rescued us from the misery of life and its compositions. Continuous treatment and decent food revived our small bodies and eventually gave us the strength to play like normal children.

As we became normal children, we continued to live with my uncle and his family. Although, we were assisted by the faith-based organisation, they stressed that we should continue to live with my uncle and family. At this home, my relatives often push me to sell stuff for them at the markets, to make money for the family. However, I know for sure that the money that I make is not for me and my siblings.

**Violence.** My cruel aunt often physically abuses me, as she is the sole breadwinner. My uncle cannot really do much, as he is not the breadwinner. If I do not sell stuff, two obvious things will happen as we will have no food for weeks and there will be nowhere for us to sleep. However, we continue to live under their supervision. I think we live and are under our uncle’s guidance because, some day, some financial assistance will be available because of our dead father.

Community Support. All is well for us now. We are being assisted by the faith-based organisation, but are obviously under our family care. I have the drive to continue my education, despite the fact that my school fees are not met. I have stayed away from school, but my friends tell me its okay to go back, so I have continued attending school. Unlike my other siblings, life is tough.

My older brother just cannot go on, so he has turned to interests and occupations that are fulfilling for him. My baby sister, who is eight, is unable to go to school because there is no-one to pay her school fees. Worst of all, my younger brother is very sick. Although I have said that we are under our relatives’ care, I am the one who has to be his guardian at the hospital.

My close adult relative was the caretaker until he became helpless in terms of using his senses to visit the toilet. The task became one of a twelve-year-old sister who must feel responsible and not just a close relative. Being the responsible one after mum’s death, I have been his guardian until God can make him well again. During the visits by the faith-based organisations, one of the members told me to always pray. There was a time when I prayed in the night because I saw my brother slowly losing strength. Next morning, he looked much better and I knew in my heart that God was there for me and will always be, even if life is not normal.

Education. Despite the miseries in life, one day I want to complete my schooling and get a job, so that I can look after my younger siblings. I think school is good and it will change my life and that of my brothers and sisters.

**Case 11: HIV positive 8 year old girl**

**Personal, Home and Family Situation.** I am eight years old and I come from Gulf Province. I am HIV positive and both my parents are also HIV positive. There are six of us living in the house. Both my parents take good care of me. I come to the city centre just to eat and chat with other children. The people at the centre are very nice and kind. All of us are still alive and I am the eldest. My parents are very loving and they take good care of me. The community respects us. Life is okay now, but I feel fear for my future, so I have planned not to marry.

**Case 12: 17 year old girl whose parents died of AIDS**

**Personal, Home and Family Situation.** I am a seventeen-year-old girl and I come from the Highlands. I live with my uncle and his family because my parents died in 2001. I know that my parents were HIV positive, but I am not aware of the cause of death. My uncle is also a diabetic and he gives us medicine when we go to see him. Since my parents’ death, I do not like the way people beat me and his family treat me. Although I get beaten up and abused verbally by my relatives and my aunty, I do not intend to move out because I have no other place to go. The only person concerned about my welfare is my uncle, as he is my mother’s brother. There is hardly any time for me to socialise with my friends. I am always busy doing the housework. Often, my two cousin brothers beat me up, for no good reason. My aunty usually abuses me by saying nasty things about me. I do not think that my relatives are a caring family.

**Violence.** I am one of those young people who experiences physical abuse everyday of my life. Mainly my two cousin brothers beat me up when they think I have done something wrong. I try my best to stay with my uncle, as I think he cares for me. Although, I feel pain, I continue to live with them because I have no other place to go. Sometimes, I go and stay with my friends until I feel fine and then I come back to the house. I have shared with my other uncle who has promised to send me back to the Highlands, when he has enough money to purchase my ticket.

**Case 13: Street boy**

**Personal, Home and Family Situation.** I am a nine-year-old boy and I come from Goroka District, in Central Province. I live with six other people in a shelter in the Baruni Dump surroundings. People who live with me do not work at wage jobs. We are all unemployed. Whatever we find for the night, the two females cook it and we all eat together.

**Education.** I do not go to school as it is impossible for a child like me. I have no parents who can support me, and send me to school. During the day, we all wait for the rubbish trucks to drop off rubbish. This is where we are able to collect something to eat. Some other days, I go to the shopping centre and beg people to give me money and food. This is a way of life for me.

**Community and Family Support.** My parents died and so did my two brothers. I do not know the causes of their deaths, but I have no immediate family left alive. I usually take care of myself, but people from the same ethnic group also look after me. We all live together in this tough world and we survive because we help each other. There are times when we really have to help each other, but most times its ‘survival of the fittest’.

**Violence.** I wish that I could live in a proper home, like other children. However, that’s impossible, as it will never be. I only experience being beaten up when I steal from other people. They beat me up, but I guess it’s a way of life for me in order to survive in Port Moresby. I get sick mainly from eating bad food which causes a lot of stomach upsets, but I know someone at Gerehu Clinic and he gives me medicine when we go to see him.

**Case 14: 15 year old boy abused at home**

**Personal, Home and Family Situation.** I am a fifteen-year-old boy and I come from Tari in Southern Highlands Province. I am now living at the City Mission. There are about 50 of us living at the City Mission. The centre provides food for everyone who lives there. The female members do the cooking at the centre and the boys clean around the area.

**Education.** I do not attend school now. During the day, I join the other members and we share the gospel of Jesus Christ in public places. There are other activities with which we get involved. I left home because my uncle chased me from his house. I have been at the centre for more than three years now. I like the services here because this centre provides activities that I fully enjoy. I have never experienced these things before. I do not miss home because my uncle and his family never gave me the care and treatment that I needed.

**Family Type and Support.** My parents died of HIV/AIDS and I ended up living with my uncle and his family. I left home because I
used to be abused very badly by my uncle and his family. I am now at the City Mission. I used to be given terrible treatment, until I came to the City Mission. The City Mission takes care of us and it is a good place in which to be. I have been living here for more than three years now and I call this place my home. I do not miss home as I do not regard my uncle’s home as a home for me. He has not even checked on me since I came to the City Mission. I now take part with the other young people in the ministry for outreach to the public.

Case 15: HIV positive 15 year old boy

Personal, Home and Family Situation. I am a fifteen-year-old boy and I come from Western Province. I live with my relatives. My parents are dead, but I do not know the causes of their deaths. I live with my uncle and family. There are six of us in the house and my uncle takes care of us by providing food.

Personal and Community Support. Currently, I am in school. My life is not always good, as I am the centre of discussions amongst my house members. I am talked about very often and it makes me feel very sad. I can only talk about my problems with other people in the community in which I live. On the other hand, my uncle is good to me and I know he does it for me. The household members these days treat me differently and I know that. I know I am living with HIV/AIDS.

Case 16: 16 year old girl whose parents died of HIV/AIDS

Personal, Home and Family Situation. I am a sixteen-year-old female and I come from mix parentage of East New Britain and Central Province. I live with my older sister and her husband and her daughter. There are six of us living in the house. Usually, the food for the house is bought by my sister and her husband and my sister and I do the cooking.

Education and Community Support. I do not attend school. During the day, I look after my sister’s children, while she goes to work. I do not go to school because my sister does not take me to. Instead, I look after her children. I come to the Four Square Mission because I learn things that my sister is unable to teach me. I have been attending life-skills training for two years now. I like the place because they provide skills that will assist me in the future. I do not really miss home; that is, my sister’s home, as I do not have a home of my own.

Family Type and Community Support. My mother died of womb infections and my father has remarried. I have ended up living with my sister. She sometimes gets mad at me when I do not do things correctly. The family can be caring when I make them happy.

Violence. One night, my brother-in-law hit me when he was drunk. He did that because he wanted to have sex with me and I refused him. I usually share with my boyfriend about what happens to me. Lately, I have been treated for STI infections, but I have now recovered.

Case 17: Street boy, Boroko

Personal, Home and Family Situation. I am a nine-year-old boy and I come from Simbu Province. My parents are back in the village in Simbu Province. I live with my friends on the streets of Port Moresby. There are six of us in the group and we hang out together. We sleep in shop fronts around the Boroko area. We make money by selling empty bottles and cans and then each of us buys food and we share it amongst ourselves.

Education. Like my other friends, we do not go to school. During the day, we hang out together collecting cans and bottles to sell. I stopped going to school because of school fee problems. School is for people with money and I do not fit into that category. I used to live in the village, until my aunt brought me to Port Moresby to go to school. Things did not work out as promised because of school fee problems. I left school when I was in Grade 1 and I don’t want to go back to school.

Community Support. I used to live with my aunt until three years ago. I used to go to school, but I did not like to join my other friends. Sometimes, in one day, we can make at least K18 to K30 to buy our clothes and food. Life is good. My aunt could not afford to give me that kind of money. After I saw that this was a good money-making business, I decided to live on my own. I left my aunt’s place in 2002 and decided to be based at Boroko. I like this place because I collect plenty of cans and containers to sell. This means I have some money to buy other necessities of life. I have been selling sex from the day I moved into the motel. I like this place because my customers are always available and the place suits me well. Also, it provides easy access to my family when they come into town. I do miss my family, but I have to do this for my son’s survival.

Family Type and Support. At the point of my brother’s home is not very good. I am often beaten up by my parents’ thoughts. Nobody cares about me and I think I am on my own. Following my parents’ death, I have stayed with my brother and his family. Many times my brother is on night shift and my brother’s wife abuses me verbally.

Violence. On many occasions, my brother and his wife and even their two children, beat me up. When I am still sleeping they pour water on me to wake me up. No-one checks on me on a daily basis because they do not care for me. Sometimes, the settlement people see me and talk with me. They tend to care for me more than my brother and his family.

Case 18: 17 year old girl selling sex

Personal, Home and Family Situation. I am a seventeen-year-old girl and I come from Central Province. I live in a motel room in Port Moresby. I share the room with another girl who is in the same industry. We rent this room because my parents are in the village. There are two people to a room. In this situation, we are not work, but we kind of earn money by selling sex to many customers. We do this to pay for the rent and buy other necessities of life. As we do not live with families, we eat out all the time.

Education. I came to Port Moresby after leaving school in 2003. The reason I left school was to sustain my family livelihood. When I started my Grade 10 education, I became pregnant and after giving birth to a little boy, the father of the child wanted nothing to do with us. In search for employment, I ended up doing what I have to make fast money through sex work. During the day or night, whenever there is a customer, I sell sex. This is my way of life now.

Community Support. I could not find a place in search of employment. This was to keep my son alive, because my parents are struggling to make ends meet back in the village. They are subsistence farmers and money is a problem for my family back home. I have been selling sex from the day I move into the motel. I like this place because my customers are always available and it suits me well. Also, it provides easy access to my family when they come into town. I do miss my family, but I have to do this for my son’s survival.

Family Type and Support. Although my parents are alive and they treat me well, deep inside my parents’ thoughts are the achievements of what I am doing. Again, the reason I do this is for survival and this may not change
for some time. My family will always treat me well. The only mistreatment I experience is when the girls fight over customers. There are always traces of jealousy when I handle more customers than the other girls.

Violence. In this business, it becomes risky because we are often beaten up when we do not perform as expected. Sometimes the fights are between the girls, when we fight for customers. Recently, I have talked to people from the Humanitarian Foundation about their treatment towards us. They are aware of this. I have not been sick yet and I think I am alright. Although I feel that what I am doing is not correct in society, I have to do this to support my son. The father of my son walked out on me when he found out that I was pregnant. This annoyed me and I had to do something to sustain my family, especially my son. So far, it has been okay and I am able to support my son. Some day, I want to get married and have a proper family.

Case 20: HIV positive 16 year old girl

Personal, Home and Family Situation. I am a sixteen-year-old female and come from Western Province. I live with people from different ethnic groups, who are not my relatives. There are fourteen of us living in the same house. Usually, my foster parents and other relatives buy food for the house, while the aunties and sisters cook the food.

Education and Community Support. I do not attend school. During the day, I go around the streets collecting empty cans and bottles to sell, so that I can help to buy food. This is my contribution to my living in the family home. I find the people good and they provide a good place in which to live. They are the ones who made me feel good, after feeling so bad about myself. I have been living here for almost eight months now. This place enables me to socialise with the family members and also the street people. Currently, I am well-looked after and I do not really miss home.

Family Type and Community Support. My parents died of HIV/AIDS, so I now live with my family from the Highlands. They have taken me in to live with them. My foster parents are good and they take care of me.

Violence. Because of the situation I have to live with, I am not treated badly. People look after me and do not abuse me physically. I am well-looked after. These days, when I get sick, I go to the hospital to help me get better.

B. National Capital District Discussion Groups

Six discussion groups were held with children in the NCD. Participants were males and females ages 8 to 18, in different service provider locations in the NCD: Anglicare Stop AIDS, Waigani; Hopeful Living Centre - I Gat Hope, Badili, City Mission, Badili; Heduru Centre, Horse Camp, Joyce Bay; and with street children, SP Flats, Badili. The discussion leaders in this study were members of the Special Youth Project Team and Ms. Esther Laviu, a local consultant for this assessment.

Children’s Discussion Group 1.

Site: Anglicare StopAIDS, Waigani.

Group Members: Two Girls and three boys, adolescents between 15 and 18 years of age who regularly drop in to the Centre for food, discussions and other activities.

Children’s Life Experiences. These young people come to the centre in search of love, care and protection. This is the place in which they would be comfortably knowing that this is a faith-based centre and that no-one can cause them any harm. Most of these young people had not heard from their parents that this was the place to rest and find love, as there were no other places where such services were offered. The group included young people from different ethnic groups within the city. Consequently, they all had different experiences concerning who they were and where they came from. They are often a difficult group to discuss their problems. One of the group members was an HIV-positive person and she did not have any difficulty discussing her problems. The others felt comfortable at the centre, discussing issues that directly affected their lives. Collectively, they all thought that this was a place where they could discuss their personal problems, with the help of the trained counsellors. Like many other young people, they felt that all their friends realized that it is difficult to be successful in life, it was only a dream that would never happen. Dreams of working abroad or becoming something important are part of an endless list of ‘hope’ in the minds of these young people.

Family Support. Family support is seldom experienced by these young people, as most of them live with relatives. The aunts and uncles have their own siblings to look after, so much of their attention is directed towards their own children. All of the participants stated that they were treated well, only when they did house chores. Otherwise, most of the time, they felt that they were additional burdens on their own relatives.

We are extra mouths in the home to be fed. We may ask our relatives for assistance, but they do not provide a good place in which to live. They do not have their own families to look after. Relatives are not the ideal people who we would like to ask for assistance. First of all, they don't like us very much and it is already too much to ask for, even if when there is a need.'

Maltreatment and physical abuse within communities are daily occurrences and often this is a way of life for some children. Some of participants had gone through such treatment at some stage of their lives.

Community Support. The young people come to the centre because they have no one else to turn to. One of the young people stated that his brother had died of HIV/AIDS. In such a situation, that affected person has experienced positive responses from the community. He has received assistance while the others in the group did not experience the same response from the community. Many stated that they had obtained scant assistance from any of their family members and other people within the community. In the communities from which they come, families are daily occurrences and often go back to a relative’s home. They expect love and care from the centre and the volunteers there also provide services that benefit them in the long term.

Children’s Feelings and Views about Themselves. These young people feel that they can talk to their relatives and community leaders, when they are comfortable to talk. When they know that others look at them and consider them to be problem young people, they do not talk to them. Instead, they come to the centre to talk and discuss with people who they believe are more likely to understand how they feel. Hopes for the future are discussed and this makes the young people feel that they are part of the community. There are activities that they take part in, such as belt-making and most importantly, the centre provides food. Like other children, their dreams of becoming successful were always discussed. Flying in aeroplanes and even going overseas are some of the dreams of these unfortunate children. It makes their hopes of the next day come to reality.
Family Support. Generally, their foster parents take care of them:

'We are treated reasonably well and they even assist us when there is need. This goes on until we do not help with the house chores. This is when life becomes unbearable because they treat us badly. It places us in a difficult situation to even ask for assistance, although we need help.' This is what we are put on us when we get treatment that we do not deserve. Then we know that we are not their biological children.'

Community Support. These young people come to the centre because they need assistance, or when one of them is seriously in need of assistance. Both of one boy's parents died of HIV/AIDS when he was very young. In such a case, the community and other family members assisted him. The rest of the young people come to the centre because it provides what they long for at home, with their foster parents. The young people know that the community members will only assist them if someone is in real need. This brings to mind that if we go on without that criterion, then people will definitely assist them. Usually, that is regarded as a family matter. All of the young people believe that they can do without the support of the centre, if only their relatives cared for them and provided the support they needed.

Violence against Children. Violence at home in their communities is a daily occurrence. There are several reasons why this happens. For many, it is because their given chores are not completed and they end up being beaten by their foster parents or caretakers. In one instance, a young girl was beaten up by her brother-in-law because she refused to have sexual intercourse with him. These are the main situations that lead to abuse.

Children's Discussion Group 3.

Site: City Mission, Badili.

Group Members: Six girls, 10 to 16 years old.

Introduction. These girls come from different family backgrounds. Two girls have lost both their parents to HIV/AIDS, two of them are from single parent families, while another two are from broken homes.

Community Support. The girls usually come to the City Mission to eat because this is the one decent meal they get to eat in a week. Although their parents would love to look after them and provide them with all the good things they need, they know that they cannot afford it any more. The city life has become too costly for families like these. When a family is confronted with a situation that they may not be able to resolve, the community gets involved. Often, the community gets involved to resolve the family conflict:

'We would not need to come here, if only our parents could afford to pay for our food. However, now what really matters is that we eat to survive in Port Moresby. If the City Mission stops this feeding program, we will begin to lose weight and become unhealthy.'

Violence against Children. Violence against children is a daily occurrence, particularly when children do not meet their obligations by doing house chores. According to these girls, children are mistreated because of other reasons, such as no food and life becomes difficult. The girls were open in discussing their problems:

'We feel comfortable discussing our problems with friends, family members and school teachers. We come to the City Mission mainly to eat. Like any other girls our age, we would like to go to school and complete our secondary education. We feel sad when we go on without that criterion, then people will definitely assist them. Usually, that is regarded as a family matter. All of the young people believe that they can do without the support of the centre, if only their relatives cared for them and provided the support they needed.

Family Support. Although the girls like the way their families treat them and take care of them, they still want to have things they may never obtain at all in their lifetimes. They know that their families are very caring, but life becomes miserable when there is not enough to share among family members in Port Moresby. Occasionally, some of the girls are beaten, mainly because they have not contributed through completing house chores or minding their younger brothers or sisters. From their experiences in the settlement, and their own ethnic group, they tend to notice that their relatives are no longer caring and sharing. They know this from comments that they hear when they are sent by their mothers to ask for assistance from other relatives.

'People become tired of giving food to us every now and then. They can only assist with so much and as a result, we go hungry and we come to the City Mission.'

Children’s Life Experiences. The girls come from a community where all extended families live together under one roof. They all come to the City Mission for an important reason — to eat a decent meal for five days a week. At home, they eat when there is enough, but otherwise they go to sleep without eating anything. At least two of the girls come to the City Mission to read and write, as they cannot afford to go to a community school. If their parents or guardians could afford the fees, they would love to go to a community school.

Children’s Feelings and Views about Themselves. The girls were open in discussing their problems:

'We feel comfortable discussing our problems with friends, family members and school teachers. We come to the City Mission mainly to eat. Like any other girls our age, we would like to go to school and complete our secondary education. We feel sad when we go on without that criterion, then people will definitely assist them. Usually, that is regarded as a family matter. All of the young people believe that they can do without the support of the centre, if only their relatives cared for them and provided the support they needed.'

Community Support. As most of the boys are orphans, they experience a lot of ill-treatment from their guardians and foster parents, most days. According to them, a very small mistake may result in terrible experiences for them. These young boys collectively experience times of hardships through not having anyone to talk to. On occasions, family members have been asked for assistance, but they have turned a blind eye to them. These children grow up in rough environments where there is no love and care to be shared with their foster parents. Education and health are not in the list of needs in their upbringing community. Therefore, they find themselves on the streets, wandering around aimlessly. When hungering around, they cannot afford all of the necessities of city life expectations.

Children’s Discussion Group 4.

Site: City Mission, Badili.

Group Members: Six boys, 8 to 13 years old.

Introduction. These boys are from different family backgrounds. Two boys are from the same ethnic group and have both parents alive. The others are from different ethnic backgrounds. Each of the other boys has either one parent dead or both of the parents dead. Only one of them was an adopted child. This is a mixed group of orphans and non-orphans and all of the boys live in settlement areas in Port Moresby.

Children’s Life Experiences. These boys drop in for a feed at the city mission, but it is not their permanent location. They all live at home, but come to the City Mission to eat a plate of food. The City Mission became known through their peer group friends, who often come to the City Mission. They only come here to eat food and be happy.

Children’s Feelings and Views about Themselves. These boys do not feel comfortable discussing their problems with anyone in the communities. They have often approached people, who did not listen. They feel that it is not worth trying to talk to an adult, because, from experience, they know that no-one will listen. They have no one to turn to eat. Two of the boys attend school at the City Mission where they are taught how to read and write. According to them, the City Mission provides these services free of charge.

Family Support. All of the orphans agreed that the lack of care and protection at home makes them come to the City Mission. If they were cared for at home, they would not come here. The City Mission gives them an opportunity to eat. In the communities from which they come, domestic conflicts are common, but they are treated as personal problems. There is no community involvement in resolving the conflicts. People usually live their own lives. Again, at the level where the children are ill-treated, no-one comes to their rescue. It is a norm that children must be taught hard lessons.

Violence against Children. These boys have all experienced violence, as they are not cared for by their biological parents. When they make any small mistakes, they are beaten. It is almost an everyday experience. Because they have no food in their stomachs, they steal from people, to eat and end up in a prison. They stated that there is no-one to help them. All of their relatives have their own problems. Usually, their relatives’ own children are given love and care, but these boys get mistreated. In the midst of the happenings, they stated that they miss their
own parents and wished that they were here to see them. Even in the situation where a father has remarried, problems are created where a boy gets mistreated at home. At the end of the discussions, one of the boys stated that there should be proper children’s care centres, for the unfortunate ones.

Children’s Discussion Group 5.

Site: Heduru Centre, Horse Camp, Joyce Bay.

Group Members: three girls and two boys ages 15 to 18.

Introduction. The three young girls are aged between 15 and 18 years of age and are from different parts of the country. A private citizen provides assistance to young people in difficult situations and operates the centre.

Children’s Life Experiences. These young people come to the Heduru Centre because they do not have anywhere else to go. According to them, their parents died of HIV/AIDS. This has created difficulties for them in terms of basic needs and wants, as well as love and care. They started coming to the centre because they were encouraged to do so by other people. They were told of the centre and care and support that they would find in this centre. This place is set up for people like them.

‘Here in this centre, we expect love, care, and protection. They look after us as if we are our own children. They try their best to help us in many ways. Unlike our own families, they try to understand and help us.’

Children’s Feelings and Views about Themselves. In their communities there are some people with whom they are able to discuss their problems. This centre plays an important role in doing just that. There are people available to listen and discuss their problems with them. Most of their problems are with their families and the community. On the other hand, their own families do not take time to listen to any of their problems.

‘They view us as nobodies and do not allow us to talk to them about our own problems. Although the situation may not seem good now, we have dreams for the future. We want to be good people when we grow up. We want to travel to other parts of Papua New Guinea and overseas.’

Family Support. Some of the group members felt that their foster parents do not always treat them well and that is why they came to the centre. Some foster parents did not look after them. They cheated them out of the house and told them to live on the street. On the other hand, some of them are well-looked after by their foster parents. They come to the centre to talk and meet with people of their own age group. In relation to asking for anything, it is interesting that, while they may find it easier to ask other people to help, they cannot ask that of their relatives. This happens because the foster parents and relatives are not their real parents.

Community Support. These young people come to this centre because they feel that their uncles and aunts have their own children to look after and that they are in the way. They have friends who give them food and sometimes take them to their houses for a night. Whenever there is a family conflict, the community does not get involved, as it is viewed as a family problem:

‘We come here because we need a better life and the people at the centre encourage us to be good citizens. We collectively know that, if we did not come to this centre, we would be doing criminal things. One of the streets of Port Moresby begging for food and looking for places to sleep.’

Violence against Children. These young people have been beaten up by their foster parents, mainly because they did not complete house chores and for other reasons. One of the girls stated that because she refused to have sexual intercourse with her own uncle, she was beaten up very badly. For those children who are poor, whose parents are dead, or whose parents have remarried, this situation is very bad. Usually, they are the ones that are beaten up.

Children’s Discussion Group 6.

Site: Street Children, SP Flats, Badili.

Group Members: Six boys, 8 to 14 years old.

Introduction. These young boys are all from one ethnic group. They are all good boys, own and have no adult supervision. They live in an abandoned building left by a private company. They live together in a group, for protection and perhaps to keep watch on each other.

Children’s Life Experiences. They come to the Kaugere Foursquare Centre because this is where they can eat a decent meal. They all live in an abandoned flat and survive by collecting cans and bottles to sell in order to pay for something to eat. They started coming to this centre when they heard that the centre was giving out free food to children. This centre is basically their second home.

Children’s Feelings and Views about Themselves. The boys were quite open about their lives.

“We don’t know anyone. We are children who live alone. This means that we have no one to talk to about our problems. This is the first time that we have told anyone that we live alone. People are not interested in us. We come to this place mainly to eat because we do not eat good food. We have dreams about becoming good people, but it will never be normal for me, like people who live in the city. We sometimes imagine that we could attend school, drive cars and work, but it’s all a dream.’

Family Support. All the young boys started off living with their relatives, but they did not like the way the relatives used to treat them, so they left their houses and now live on their own. They stated that they were always mistreated so badly that they all decided to leave where they used to live and start out on their own. They all come from different families, but have lived together for a long time. They stated that they all now feel that they are brothers. Although they fight among themselves, over food or drinks, they are still together:

‘No relatives feel responsible for us. We take care of ourselves by collecting cans and bottles, to buy food. Other things do really matter, but we still try to survive.’

Community Support. They boys started coming to the centre to get a decent meal. They stated that the centre looks after them and this is usually the only good food they get. They sometimes get clothes, money and food from the neighbours. Sometimes, if they are lucky, the public gives them food and money:

‘We often witness family fights, but that does not bother us, because we have no families ourselves. We have no idea if the community assists in resolving those conflicts. All we know is that we come to eat and these people tell us to be good citizens. We are capable of looking after ourselves.’

Violence against Children. The young boys stated that they experience violence almost everyday of their lives, particularly when they steal to survive. In one recent incident, one of the foster mothers hit one of the boys when he stole a scene from her stall. Some people show concern, but the majority of the people don’t care about them. Their worst enemies are the security guards and drunks. They believe that people need to treat children fairly. A good example of this dilemma is those children who live in difficult situations.

C. Interviews with Children in East Sepik, Morobe and the Western Highlands Provinces

A total of 86 interviews were conducted in three other study provinces (East Sepik, Morobe and Western Highlands). For the total, the 76 conducted by social mapping researchers trained by the NAC for a 2004 study were brief and reviewed principally for overall consistency with more detailed interview data. Summaries of ten more detailed case histories collected by the local consultant are provided below.

Case Study 1. Broken Marriage. 13 year old girl with mixed background (Madang and North Wagi, Western Highlands).

My mother comes from Madang and my father is from the Highlands. My father transferred to Mt Hagen, leaving my mother and me behind in Madang. My father got married to a new wife shortly after arriving in Mt Hagen. My mother also got married to another man from Madang. It was alright living with my mother and her new husband for a little while but after a few years, the man started beating me and my mother. He hated me because I was not his child. He paid no attention on his own child from my mother. As I grew big, I was always the victim of any matter/problems that arose in the house. He would pick on me for anything and everything.
I went to school but had many problems with my step father. I did not concentrate at school. He would beat my mother up in front of me before giving her money for my school fees or buy me clothes and other things. He would get on me to go to my real father because he would not want to spend more money on me. Every time he gives money, food or anything to my mother, he would follow up and made sure I am not treated and given the best above his child and himself.

As my step father’s child and I grew up, my concerns and rights became non-existent whilst the other child was given all the care, love and attention. In fear of the husband, my mother totally submitted to him and forgot that I existed. She did not show any affection for me. I was left hopeless and rejected. In 2002, I could not go to school because of no fees and decent clothes. I was treated like a slave for my own mother and her husband.

This led to a situation where I made up my mind to go and look for my real father. Towards Christmas in 2002, I told my mother of my intention to return to my real father when I was alone with her. She was sad to hear what I told her but had no option but to let me go. She advised me on how to get on the bus and come up to the Highlands where my father was. I finally found my father and settled with him and his new family. I am now living with my father and foster mother. After being a slave for my own mother and her husband, I was treated in Madang, he quickly enrolled me to be with my peers to play and enjoy peers that I do not deserve. I need to have a break from my father’s selfishness to remarry leaving me in this situation.

Case Study 2. Orphan. Both parents died in car accident. Male, 13 years old, Nebilyer District.

When I was very young, my father and mother were killed in a car accident a few years ago. I was adopted by my Father’s elder brother (uncle) and his wife who have seven children of their own. There are three boys and four girls. Out of the seven children, four are attending school with two in high school and the other two in a community school.

My uncle is a subsistence farmer in the village. He is not employed but earns little money by growing vegetables and sells them at the market. The little he earns, he tries to pay school fees for the four children and buy their clothes and their other needs at school. We don’t get new clothes every year. I have to look after my pair of shirt and short for a long time because there are too many of us and my uncle cannot afford to buy clothes for all of us every year. He only buys for the ones in school.

I have never been to school since my parents died. I wish my parents were still alive (with tears rolling) so that I could go to school like everybody else and enjoy friends and life at school. At times, I enjoy spending time with my grand parents (maternal) have been taking care of us since my parents died by providing us with our daily needs, especially food. Because there are three of us to feed, my grand parents do not have enough money for our schooling especially when my brother was to continue into high school. I do not have the interest to try again. I have a school fees for the two children and the other two in a community school.

I was in school until my mother died in 1998 and my father in 1999 due to HIV/AIDS. My brother left school in 1998 after grade six. My little brother has never been to school. My mothers sisters and my grand mother (maternal) have been taking care of us since our parents died. My step father is a subsistence farmer in the Highlands.

Case Study 4. Double Orphan. Female, 13 years old, both parents died of HIV/AIDS. Parents from Daaulo (EHP) and Morobe.

My name is Naomi and I am 13 years old. My father married three wives. My mother is the first of the three wives. There are three children from my mother, my bigger brother who is 15 years old and my other younger brother who is 10 years old. The second wife has one child and the third wife has two children. My father, mother and the second wife have all died from HIV/AIDS including one child from the third wife. The third wife and her other child are positive and living with the virus. My two brothers and I are negative.

Currently, my younger brother and myself are both attending school. My step father is such a good that I do not want him to work. My step father is such a good that I do not want him to work. I love and appreciate his father and step father for the step father has never been to school. I do not have the interest to go to school anymore because I am being told that I am just a girl anyway.

I have been helping my grand parents with all the house work. I feel more safe and comfortable with my mother’s relative as a girl but when it comes to work, I am just an adopted son as I do not have any part in the household. We all have to work with my brothers and myself can be fed (tears rolling down her cheeks). When I tried to rest further by saying that I was a ‘bush kanaka’ who has never been to school. That was the very last thing I wanted to hear so I bashed him up which made him loose a tooth. I was taken to village court for this and I was made to compensate him with K100 and one pig which my parents helped to pay. Today I still don’t know whether I am an adopted child or not.

Case Study 5. Adopted Girl Child. 8 years old, Morobe.

This 8 year old girl was sexually abused by a relative while being fostered. The biological uncle (maternal) was made aware of the incident. He exclaimed the little girl and has been taken to hospital for medical checks. She was diagnosed with Gonorrhoea and was treated at the STI clinic in Angar hospital. She is now in the custody of the maternal uncle(mother’s brother).


I am a grade eight learner. Currently I am living with my mother and step father. My step father is a very violent man. He does not want me to pursue further in my education. I have to stay home to do all the house work, mind my step brother and sister as well as cook three meals each day. My mother is a teacher but is not allowed to make any mention of my wellbeing in my step father’s presence. If she does, he violently beats both us.

When I was eight years old, I was raped by my step father’s nephew. This incident has never been told to anyone. My mother also was very quiet about it because she was scared of the way she was treated in her current marriage. Just recently, I secretly approached the catholic mission counsellor and informed them of my early life trauma. I am treated with herbal medicine as I have been having very heavy period flows since I had my menstruation when I turned 14 years old in 2003. The counsellor is taking me in for a thorough medical check if the flows do not improve after the medication.
Case Studies 7 and 8.

Two girls adopted by same Foster Parents. Females, 18 and 20 years old, East Sepik.

Their case is a very unique and a very serious criminal case. They were picked up by the Wewak police from their home island where they were residing with their adopted parents and family. They are now in police custody awaiting court hearing. They have been placed with a caregiver family who is related to their mother. They were adopted when they were newly born from their mothers who are sisters. The two biological mothers are related to their adopted mother who is their aunt. They were raised in Port Moresby since child hood where the adopted father had employment. The adopted parents have six children of their own. Priority was given to their own children in anything. In 2003, the adopted father retired from his job so everyone returned home to the island (name withheld).

The two girls were interviewed separately. The first girl said the following:

I knew I was adopted at the age of four years old. My sister and I were abused daily from both adopted parents at a very young age. Our clothes were torn off from our bodies, we were beaten up with thonged sticks, we were not allowed to eat with the rest of the family for days, we were locked up in the house without food, we were even asked to mix flour dough and eat raw which we did in fear of being belted up. At one stage, we were locked up in the house without food for the whole day. As children, we were very hungry and family. They worked very hard in the garden to help us with food, clothes and school fees. She is getting well and can not do much. I help her in the gardens at most times. My uncles are there with our maternal grand parents in one house. As a young girl, I caught a few times and belted up. My uncles are there to look after them. It is very difficult looking after six children who are still under age.

The second sister repeated what her sister stated above about all the abuses and the treatment the two girls went through in their family. She added the following. In addition, she said the following. I knew about being adopted at the age of six years old.

My biological mother was a young banker at the time I was born. She was living in the bankers flat and was not allowed to keep me at the flat so her sister (adopted mother) took me. The understanding was that my mother would take me back as soon as she finds accommodation. This did not happen till today.

I was raped by my second son when I was in year eight in Port Moresby. After raping me, he tried to throw me out through the window to blame me for jumping through the window if anything happened. The second time, I was released, they rushed me off to the hospital because I was unconscious. My biological mother came to see me, but the adopted parents said that I was just down with Malaria and kept it as a big secret. Since, the rape I have been getting sick very often.

The current caregiver has sought medical check for both of the girls. The medical report revealed that Gina is HIV/AIDS positive. They are now currently with a caring and lovely family who are pursuing this as a criminal case against the adopted parents.

Case Study 9.

Double Orphan. Male, 14 years old, Eastern Highlands.

There are two of us in the family. I am 14 and my sister is 10 years old. Currently, we are living with our paternal grand parents in one of the urban villages. My father died in 1998 from Malaria and my mother stayed on as a widow in my father’s village for 2 years after his death. She worked very hard in the garden to help us with food, clothes and school fees. She sold garden produce daily at the market so that we could have money for school fees, clothes etc.

She got very sick and died in 2001. I have not been to school after my mother’s death. No one is willing to pay for my school fees. I could not believe that my only hope for the future is gone(with tears in his eyes) Again, the villagers have told me that my mother has died from the same sickness as my father. I was told that sorcerers are after my family so I must be careful in my daily living.

My grand parents are good but cannot provide for us with all our needs. They only do so much, that is, lighter work. I have not been to school after my mother’s death. There are a lot of children who come from this type of background who are getting into all types of illegal activities. I don’t want to be like that.

Case Study 10.

Orphan (father died). Female, 15 years old, East Sepik.

I am fifteen years old and I come from Lufa in the Eastern Highlands Province. My father died when I was 13 years old. I have two other brothers who are younger than me. We live with our grand mother in our mother’s village. Our mother got married again after a few years. The three of us have never been to school.

My grand mother is only able to provide us with some food each day. She is getting old and can not do much. I help her in the gardens at most times. My uncles are there but they have their own families to take care of. My mother has forgotten all about our existence. We are not getting the care and love from her anymore. I am sad for my brothers because they both have turned to marijuana drugs. They have been living off stolen garden produce. They have been caught a few times and belted up.

At nights, I used to sleep at my grand mother’s house but with an increase in a lot of the town activities in the village, I stay at my uncle’s for the nights. As a young girl, I don’t feel safe anymore without a father and a mother. I wish my father was still alive.

D. Interviews with Care Givers

Interviews were conducted with three caregivers of orphans and vulnerable children and their responses are summarized below.


My sister got divorced by her husband and left her with three children. They are all girls. They were living in Lae at the time of the divorce. The father of the children is from Southern Highlands Province and is a school teacher. The mother is from Bukawa in the Morobe Province. Since he left them, he has never supported the children with any thing at all. The mother was a house wife and was not employed at the time of the divorce and even at the start of their marriage.

As she did not have any employment, it was difficult living in the city with her three children. The mother had to earn income somehow to look after her children. She took up commercial sex so that she could provide for her children. At one stage, 11 men in East Taraka raped her. She left the city with her children and left for the village after that horrible incident. After sometime, she went for medical check and was diagnosed HIV/AIDS positive and eventually died in her village. The children are currently living with their uncle (mother’s brother). He does not have employment. He has three children of his own. Their father does not assist me to look after them’. It is very difficult looking after six children who are still under age.

The two bigger children are in school with my three children. School fees are becoming difficult the higher they go in school. The younger one is not in school but could be HIV/AIDS positive because she was still breast feeding when the mother was very ill. She has not been checked as yet. To date, the children are not been told of the cause of their mother’s death.

The girls indicated that they really miss their father and mother but they have to accept the fact that their mother is gone for good and their father may never return to them. They expressed that they are happy living with their uncle. At times he is hard but we have to cope with it because we don’t have anywhere to go to.

Case 2.

Care givers of two abused adopted girls

Please note: This summary appears at the end of Section III.

Case 3.

Grandmother of Six Orphans (HIV/AIDS related).

The father of these six children died of HIV/AIDS in 1998. The wife is remarried but her health condition is deteriorating. She has deserted her six children who are been taken care of by her mother. The oldest daughter who is 21 years is living with her mother. Their father died when she was 17years old. She
does not have a job. To date, the children are not told of the cause of their father’s death.

Currently, the second boy, who is 17, left school in 1998 when his father died and has not been to school since. He is eager and desperate to go back to gain some sort of education but unfortunately he has no school fees. The third born girl who is 15 years old is in grade 7. She is not sure if she is going to school. There are all facing school fees problem. She does not know whether she will be able to complete her education. Their grand mother is not able to meet all their needs. She is only providing food for them to survive. The community is reluctant to assist because everyone has to work very hard to survive themselves.

The other 13 year old girl decided to go and live with her ailing mother. The fifth born who is 9 years old is living in Siassi Island with one of the uncles(mother’s brother) who brought her away to put her to school. The baby who is 5 years old is living in Wewak with one of the grand parents.

This is what the 17 year old boy had to say: “Life is really bad without a mother and a father. We are missing out on the care, love and the need for the needs of children that other children are enjoying from their parents. All my brothers and sisters are separated. I wish our mother and father were still around to gather us together and take care of us. We don’t have any clue about the death of our father. We also don’t know why our mother had to leave us and run away from the village”.

This is what the grand mother had to say: “The source of my income is selling garden produce and betel nut at the market. I also get some support from time to time from one of the children’s bubs. The other uncles and aunts do not help at all. Life is getting harder, especially for my extended family members. I am not able to meet all their expenses but as long as we have food to eat each day. I wish somebody could help me out and unload some of these burdens.”

E. Interviews with Stakeholders in Lae

Coordinator, Catholic Agency, Lae.

The coordinator of Catholic Agency Family Life (name withheld) and the person in charge of HIV/AIDS section of the agency (name withheld) were very supportive and said that this assessment is very vital at this point in time due to the HIV/AIDS epidemic in the country. They further pointed out that this group of children and families have not been well served. All the many social problems in the past and current should indicate to us that there are so many families and children in this category who are not being taken care of or living in situations where their socio-cultural and economical needs are not met. There is no guarantee that every one is living and enjoying the fullest of life. Our programs and activities have been targeting some of these vulnerable children and families. This is only from time to time as and when our funds are available or when the need arises. This is what they had to say:

There are so many vulnerable children and families in Morobe Province, to be precise in Lae City. Our agency can only support and help those who come to us for assistance in kind or most often for counselling. At the moment, the Catholic Family Life is assisting eight families in Papuan compound and many others who are scattered in other locations within the city of Lae. Each family consist of about five to seven children. Many of these families are widows, homeless women and children or homeless families. There are other children who come to us from families who are unemployed, deserted by parents and guardians, parents who have died through sicknesses or accidents and others as a result of urban migration in the hope of getting employment in the city. We do not have records of HIV/AIDS related cases, but we are optimistic that there are many who come through the centre. Our assumption is that because of the discrimination and stigma attached many are reluctant to come forward. One of the Catholic Priests has opened up his home and is taking care of street kids(mostly boys). He has a full house of children who have been living on the streets of Lae.

Urban migration is and has been an issue for Morobe Province because of the main road links to Madang, the Highlands Region and the sea ports linking the New Guinea Islands. The population seem to be increasing because families are migrating into Lae from all over the country. The more they prolong their stay in Lae, either in search of employment or other reasons, the more vulnerable they become.

From working many years in Lae, we find that, there is no longer a community or extended family concern. Care giving is the responsibility of the immediate families in most vulnerable cases but only for a short term. There is hardly any care giving for a long term. Due to no on going support from families and the communities many who come from the above group end up as sex workers to survive. Many sex workers are or can be married couples.

There is also an increase in the intake of drugs especially in the settlements which leads to other related issues such as violence against women and girls, rapes etc. Violence against women is a very big problem especially in the settlements. Children are neglected because many marriages are breaking up and a lot of children are the products of these marriages. There is an increase in violence against children too. Many children are bashed up by their mothers or fathers or other caretakers. There are also cases of abuses from the mother in retaliation to the husband, sexual abuse from known people to the family and the list goes on.

Our view of the Village Court system in settling family disputes is that most often the decision is in favour of the man more than the woman. There are more adultery cases as well as working mothers being deserted by husbands but the court system is ineffective in protecting women’s rights. Further, in protecting children’s rights, there is no proper follow up because in most cases the mothers are illiterate and do not know the legal systems. There need to be a lot of awareness education on the human rights laws especially protecting the rights of the women and the children in the communities.

The Village Court magistrates and the other officials also need proper training on the laws and regulations relating to settling family disputes, protecting women and children’s rights because these are regular issues that are common in the communities. One major achievement this year was that the Catholic agency assisted many vulnerable families in relocating them back to their home provinces. We are currently working on some more families to relocate back to their home provinces.

Captain, Salvation Army, Lae.

The Salvation Army has a centre in Lae and has been involved in providing material assistance and counseling to many vulnerable children and families. They distribute second hand clothing and foodstuff to the vulnerable families. They are currently visiting families affected with HIV/AIDS in the settlements, urban villages and rural villages on the highlands highway. I was not given any further information on this. This is what the captain had to say:

Many of the vulnerable children come from families who are unemployed, deserted families, death through sicknesses not
Families and Children Affected by HIV/AIDS and Other Vulnerable Children in Papua New Guinea

specified and migration into the city in the hope of getting employment. There are orphans from either one of the parents dead or both dead, there is no proper record in place. These children are also vulnerable because there is no long term care giving even by the immediate families. It is customary that the immediate families take on the child of the foster parent if both are dead, unfortunately this dying out.

Many of these children end up on the streets of Lae City. When these children were asked that the Salvation Army assisting them to return to their home villages, will they be willing to return? The response was: No one in the village knows us. We have been living in Lae for the rest of our lives. We do not know our parent’s relatives. If we return to the village who will take care of us? There is nothing in the village for me to return to. The family and community response is negative. There is no support at all from extended relatives. They may have shown sympathy when the cases were new and fresh but after sometime, there is no long term guarantee support.

Pastor, Puttim Christian Life Centre, Western Highlands Province.

This church was built in 1989 using bush possibilities of the founding Pastor had a vision which was more than just preaching the Word of God. His vision was to raise up disciples who come from similar background as himself(orphans, vulnerable children, youths who are rated as rascals) who would make God and live a decent life. His father died when he was a very small boy in Simbu. His mother was only able to provide food and shelter for him and his younger sister. He did not go to school like many other children because his mother was not able to meet the school fees.

When he was around 14 or 15 years old, he decided to visit his sister in Madang. He never returned home the same person. He got involved in rascal activities with other children who lived in settlements and came from such backgrounds. He went to many places other than Madang, surviving the many rascal activities he was involved in. One day in 1986, he returned to Simbu to visit his sister. He adopted a boy of 4 or 5 years old whom he knew from church. His next plan is to build a permanent building with dormitories for the boys and girls under our care. The extended families and the community have not supported them in any way since the death of their husbands.

As the years went by, the first lot of disciples became mature in their Christian walk and were helping out with all the church programs and activities followed by the second batch and so on. Because most of them did not have a father or parents to initiate the bride price for their sons. The old church building was replaced with permanent building materials in the year 1996. Most of our activities and meetings with the youth are held in the church building. To date, he has never received any assistance from any organization at all. He has depended totally on God and what little he could make from the garden produce. This centre is now 15 years old. All other community care centres started at almost the same time WHP started. Those who are at all very well for one who is employed but when the person is unemployed the concept of ‘survival of the fittest’ is practiced. The theme of ‘survival of the fittest’ will be the basis of life in the city.

We were knowledgeable about HIV/AIDS through the media of newspaper, television and radio even before we knew we were HIV positive. Almost ten years ago when we went for tests through pregnancy regular checks she was told that she was HIV positive and then I was tested positive. It is common for people to go for test through partners pregnancy tests through the sexual transmission infection clinics.

I know that I am not worried about the future of my children contracting HIV/AIDS because we know the prevention and how to protect them. I also got both HIV positive couple so we should not infect anyone else. Our children will live with the knowledge that we have HIV and any act will be an act of responsibility for them. In the similar way my wife and I have taken
it upon us to inform as many people as possible about the HIV AIDS dilemma. My view about the spread of the virus is that use of condom must be emphasised to people in the reproductive age. Because I fear that this disease will spread like fire if we don’t take charge of the disease.

As for the organisations that put in efforts to stop the virus from spreading are not doing enough. I know that there are services available for PLWHA and other than that I do not know. For the children’s services, I think money gets spent but not many children benefit from these funds that are spend. I think my relatives can look after my children when I die but while I am alive I will look after my own children. From what I see my relatives may not be able to look after orphans because if they have their own, they will tend to care for their own.

Case Study 2. Young couple with HIV AIDS

This is the story of family who have adult children living with them in a Port Moresby Settlement home. The parents accommodate their youngest son who is a widow and two other female relatives not married. Although they indicated that they have been to school at some stage, all have not complete primary education. This family is made up of 4 adult women and two adult male.

As in any squatter settlement setting, people go to their relatives with running water, when they have no water at home. In this family, no one works in salary job. According to them, relatives and friends are likely to help when need arises. However, they are subsistence farmers in Port Moresby and they earn their livelihood by selling their produce and betel nut and cigarettes at the local markets and within the settlement area in Port Moresby. According to the head of the household, there are two young girls who live with them to help out in the gardens and other house chores. These two girls apparently do not go to school because there is no money for school fees. For livelihood in Port Moresby these family continues to rely on their relatives for assistance when need arises.

These family collectively first learned about HIV AIDS about 10 years ago through mediums of newspapers and television and radio. It dawn on them that their family members were HIV positive through the death of the grand son. After the test, both the young couple tested positive. The family is worried about the young children in fear of HIV infections but they can not do much as they are illiterate and perhaps the government of the day must do more to spread of HIV AIDS.

Organisations that have taken on the responsibility of stopping HIV AIDS are doing their best but it’s the attitude of the people that may not assist in combating the spread of HIV AIDS. Although these is knowledge of entities that provide care and assistance to people affected by HIV AIDS in general, they don’t know of services they provide for specific groups such as orphans, abandon children, adult with HIV AIDS and children aged 18 years and below who are HIV positive.

This particular ethnic group feels that one should look after their immediate family members as relatives are in no position to take of other children other than their own. In the same sentiments, orphans are no exception to the situation mentioned earlier, other relatives will not take care of them.

To stop the spread of HIV AIDS, people must stick to one partner and use condom. According to the head of the household, people living with HIV AIDS should live in alone area so that it will not spread. Since he is still alive, he takes care of his infected children. When he dies, there will be no hope for the son and the wife. Similar thoughts were shared by the infected couple, life is useless now as they know they will die and no body will look after them.

Case Study 3. Loving parents encouragement help to live on

I am seventeen years of age and I am HIV positive. I am single and I live with older brother 22 years of age and my parents. My grand parents also live with us. Most of my family members have lived in Port Moresby for over 10 years with the exception my relative and I. I have lived in Port Moresby for about five years. I have only completed primary education along with my mother and grand mother while my male family members have completed secondary education.

We live in our family home. Both my parents work in wage jobs and that is why my grand parents live with us in Port Moresby. Since both of my parents work in wage jobs we do not face difficulty in terms of financial support. Generally people in the Port Moresby may not support each other because most people do not work in wage jobs. If I were to need assistance I would ask my relatives to help out.

I heard about HIV AIDS about 5 years ago. The main source of my information was through TV and radio. I only learnt that I was HIV positive from the blood test at the hospital. I do worry about the future of our children and they should be protected from this virus. The only way to do this is by increasing campaigns on HIV. In addition, the organisations that provide services also must conduct campaigns on HIV awareness to protect people.

When I first learnt that I was HIV positive I was devastated. Thoughts about ending my life were a priority among many things I resorted to doing. My parents however, were very dedicated parents. They committed themselves to looking after me until I was able to deal with the situation. They eventually encouraged me be part of the community awareness campaigns. These days my community has accepted my status as HIV positive and people now treat me as one of the community members.

I know that there are services around Port Moresby for orphans, children less than 18 years who are HIV positive and abandoned children but did not know that there were services for adults living with HIV AIDS. The services provided are good and should be encouraged so that more people can become of the HIV campaigns. The organisations are proving to be very successful in the campaigns. I think that people can take care of each others children when the need arises. I am worried about future generation. There must vigorous campaigns on HIV AIDS. Service providers must continue their campaigns on HIV awareness.

Although relatives can take care of children, these days it is getting difficult as most people are not in wage jobs. I personally think that the community must take lead steps to conduct awareness campaigns on HIV AIDS.

My experience of life in general is that, when you contract HIV AIDS you must let your community know that you are HIV AIDS. Then gradually people accept you as a HIV positive person and you will find that your community may treat you special. In addition to that, you will not infect anyone else.