

CAPITALIZATION OF
MSF MARAJÓ PROJECT

STRENGTHENING THE SEXUAL VIOLENCE RESPONSE IN
MARAJÓ

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All consultants contracted by the SEU must adhere to the SEU Ethical Guidelines for Evaluations.

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ACRONYMS

ANC	- Antenatal Care
ARO	- Annual Review of Operations
CAPS	- Centro de Atenção Psicossocial (Psychosocial Care Center)
CHW	- Community Health Workers
CRAS	- Centro de Referência de Assistência Social (Social Assistance Reference Center)
CREAS	- Centro de Referência Especializado de Assistência Social (Specialized Social Assistance Reference Center)
FP	- Family Planning
HAO	- Humanitarian Affairs Officer
HPAM	- Health Promotion Activity Manager
HR	- Human Resources
IML	- Instituto Médico Legal (Medical Legal Institute)
KAP	- Knowledge, Attitudes and Practices
MAM	- Medical Activity Manager
MHAM	- Mental Health Activity Manager
MHPSS	- Mental Health and Psychosocial Support
MoH	- Ministry of Health
MPF	- Ministério Público Federal (Federal Public Ministry)
MPDFT	- Ministério Público do Distrito Federal e Territórios
MPSP	- Ministério Público de São Paulo
PEP	- Post-Exposure Prophylaxis
PHC	- Primary Health Care
PJP	- Promotoria de Justiça de Portel (Public Prosecutor's Office of Portel)
PMR	- Project Medical Responsible (a.k.a. Project Medical Coordinator)
PNC	- Postnatal Care
POR	- Project Operations Responsible
PS	- Posto de Saúde (Health Post)
RAV SV	- Revision of Attitudes and Values regarding Sexual Violence
RMS	- Registro do Ministério da Saúde (Ministry of Health Registration)
RQA	- Rapid Qualitative Assessment
RST	- Regional Support Team
SEMUSA	- Secretaria Municipal de Saúde (Municipal Health Secretariat)
SESPA	- Secretaria de Estado de Saúde Pública do Pará (Pará State Public Health Secretariat)
SICLOM	- Sistema de Controle Logístico de Medicamentos (Medication Logistic Control System)
SINAN	- Sistema de Informação de Agravos de Notificação (Notifiable Diseases Information System)
SRH	- Sexual and Reproductive Health
SUS	- Sistema Único de Saúde (Unified Health System)
SV	- Sexual Violence
UBS	- Unidade Básica de Saúde (Basic Health Unit)

INTRODUCTION

This capitalization report analyses the experience of the MSF Portel project (March 2023 - June 2025), with special emphasis on the strategic innovation that constitutes its main differential value: the development of a comprehensive care model for sexual violence survivors within formal health system contexts.

Although the project began as a Primary Health Care and Sexual and Reproductive Health intervention, its strategic reorientation toward sexual violence (August 2024) generated replicable institutional methodologies that represent its greatest contribution to MSF's organizational knowledge. The paradigmatic transformation achieved in sexual violence response—from a system centred on judicialization toward a humanized approach focused on the survivor—constitutes the core of this report's analysis.

The document responds to the Terms of Reference for the capitalization mission, providing lessons learned, operational recommendations, and assessment of the replicability potential of the developed model.

METHODOLOGY

DATA COLLECTION

Using a qualitative methodology, the capitalization procedure encompassed a comprehensive review of written material related to the project, including the exploratory mission report (2022), project design documents, narrative medical reports (ARO 2025), Mental Health report (2025), Sexual Violence Technical Manager end-of-mission report (January-April 2025), and available project documentation spanning the implementation period. Individual interviews were conducted with stakeholder, who were integral to the implementation of the project. Open-ended interviews with current MSF staff, former team members who participated in different phases of the project, local authorities, intersectoral partners, and community representatives facilitated the retrieval of relevant events, understanding of their perspectives and soliciting feedback. A two-week field visit was conducted (May 19-31, 2025), including visits to the Municipal Hospital in Portel, two rural communities, health authorities, and specialized infrastructure.

DATA ANALYSIS

Data were subjected to in-depth analysis to assess the strategic evolution, operational effectiveness, institutional innovation, and transferability potential of the intervention. Triangulation of information from multiple sources ensured a robust interpretation of the data and validation of findings.

ETHICS

The capitalization was conducted in accordance with SEU ethical guidelines and verbal informed consent was obtained from all interviewees. A detailed description of the purpose of the capitalization, assurances of confidentiality of information and protection of anonymity were provided. Respondents were informed of the voluntary nature of their participation, retaining the freedom to discontinue or withdraw from the interview at any time. All data collected was handled in compliance with data protection standards and stored securely to ensure participant privacy throughout the analysis and reporting phases. Interviews were conducted in Portuguese and English, always maintaining a professional and ethical approach.

LIMITATIONS

Several methodological constraints affected data collection:

- **Project closure timing:** Capitalization exercise conducted during project closing phase when many activities had already been discontinued, limiting opportunities for direct observation of operational programming and requiring reliance on retrospective accounts.
- **Limited community access:** Only 2 rural communities could be visited during the mission, as MSF activities in other communities had already concluded.
- **Staff turnover:** High personnel rotation throughout project implementation limited access to institutional memory from early phases, compounded by difficulties in contacting former MSF staff who not always respond to interview requests.
- **Documentation gaps:** Incomplete records for certain periods, particularly during initial implementation months.

VALIDATION PROCESS

Findings were validated through triangulation of multiple data sources and stakeholder perspectives, review of draft findings with project team and key stakeholders, and cross-reference of stakeholder accounts with available documentary evidence.

EXECUTIVE SUMMARY

PROJECT OVERVIEW

The MSF Marajó project operated from March 2023 to June 2025 in Portel, a remote Amazonian municipality characterized by extreme territorial duality between urban areas with significant capabilities and isolated rural communities facing structural vulnerability. While initially designed as a Primary Health Care and Sexual and Reproductive Health intervention within Brazil's Unified Health System (SUS), the project underwent a fundamental strategic reorientation toward specialized sexual violence response after identifying systematic barriers that forced survivors to obtain police authorization before accessing medical care.

The intervention's central achievement was transforming Portel's sexual violence response from a system requiring police authorization before medical care to a person-centred approach prioritizing health, survivor autonomy, and comprehensive intersectoral coordination. Through strategic advocacy, institutional capacity building, and operational changes, MSF influenced local policy frameworks and established mechanisms that attempt to institutionalized humanized care principles beyond the organization's direct presence.

This capitalization report analyses the project's strategic evolution, operational methodologies, and transferability potential, with particular emphasis on lessons learned for humanitarian interventions within formal health system contexts where legal frameworks can be reinterpreted rather than replaced.

STRATEGIC EVOLUTION AND CORE INNOVATION

The project's impact emerged from transforming judicialization-centred to person-centred sexual violence response. MSF encountered a system where survivors were required to file formal police complaints before accessing health services, with hospital doctors mandated to obtain official police authorization before performing clinical examinations. This bureaucratic maze created systematic revictimization and frequently resulted in lost opportunities for critical interventions like Post-Exposure Prophylaxis within the crucial 72-hour window.

The breakthrough came through MSF's strategic reinterpretation of existing legal frameworks rather than attempting to replace them. The organization worked systematically with judicial authorities to demonstrate that identical regulations could be applied from a perspective that placed health as an absolute priority. This approach culminated in the reorientation of Portaria 06/2024, eliminating police authorization requirements for medical examinations and establishing comprehensive medical evaluation as both therapeutic and documentary without requiring prior police involvement.

The transformation extended beyond individual protocols. The Public Ministry incorporated MSF methodologies into official recommendations, issuing two formal documents that established person-centred approaches for both children and adults. A municipal sexual

violence law was developed and approved, embedding MSF's principles into permanent local legislation.

INSTITUTIONAL INNOVATION AND SUSTAINABLE MECHANISMS

MSF's institutional innovations addressed the fragmentation that characterized Portel's sexual violence response system through specific institutional changes. The creation of the Sexual Violence Response Committee became the first formal coordination mechanism between hospital and primary care levels, achieving official municipal recognition through ordinance. This committee evolved from an initial unwieldy structure to a streamlined group of managers with decision-making authority.

The physical manifestation of the paradigmatic shift materialized through the establishment of two specialized "Salas Lila" reception rooms, meeting national standards for dignified survivor care. These spaces, fully financed by MSF but maintained by municipal commitment, embodied the person-centred approach through non-institutional therapeutic environments that guaranteed privacy and comprehensive functionality for medical evaluation, psychological support, and guidance within single safe spaces.

The infrastructure investments were complemented by systematic capacity building that transformed professional practices across the municipal network. MSF trained 108 health professionals in comprehensive medical care protocols that eliminated revictimization, replaced forensic procedure terminology with therapeutic language, and established integrated care flows respecting survivor autonomy. This professional transformation extended beyond health services to encompass 174 community health workers and intersectoral partners across education, protection, and justice sectors.

STRATEGIC ADVOCACY ACHIEVEMENTS

The project's advocacy component generated concrete results that secured permanent public investment in specialized services. MSF's systematic engagement with state health authorities resulted in Portel's inclusion in the restored "Mais Medicos" program, securing federal investment in medical personnel for the municipality despite initial exclusion from the relaunched initiative. This achievement reflected MSF's strategic leveraging of established credibility from sexual violence work to demonstrate humanitarian need through documented evidence.

The advocacy success extended to infrastructure investment through the approval of Pará state's "Usinas da Paz" program for Portel. These multifunctional complexes integrate health, education, protection, and training services, representing significant permanent public investment that will operationalize MSF's developed principles beyond the organization's direct presence. The strategic advocacy process involved six systematic meetings in Brasília with federal authorities, demonstrating the effectiveness of comprehensive approaches backed by technical evidence.

Critical medication access barriers were systematically addressed through advocacy work that established continuous PEP availability at Portel Municipal Hospital, eliminating the critical need for survivors to travel 300 kilometres to Belém for essential treatment. This achievement was expanded through successful paediatric PEP availability advocacy and initiated decentralization to primary care level, further expanding access for vulnerable populations.

IMPLEMENTATION CHALLENGES AND LESSONS LEARNED

The project's implementation revealed critical insights for humanitarian programming in formal health system contexts. The most significant conditioning factor proved to be human resources challenges that transcended typical staffing problems, creating a critical turnover rate of 143% in 2023 that fundamentally affected operational capacity and strategic decision-making. The convergence of teams lacking MSF experience, sexual violence expertise, and management experience created systemic problems that consumed managerial resources and limited strategic focus capacity.

The strategic transition from general PHC/SRH to specialized sexual violence focus encountered significant resistance from project teams who had established comfortable operational routines and struggled to embrace specialization. This resistance stemmed from inadequate understanding of strategic rationale, exclusion from decision-making processes, and insufficient familiarity with MSF operational approaches, compounded by frequent staff turnover that left teams disconnected from evolving strategies.

The project's community engagement was fundamentally constrained by methodological limitations, particularly the absence of systematic Rapid Qualitative Assessment despite mobile clinics providing regular community access throughout the intervention period. The national health promotion team operated under assumptions that regional origin provided sufficient cultural understanding, eliminating perceived need for systematic assessment tools and resulting in overly cautious programming based on unvalidated assumptions about community dynamics.

TRANSFERABILITY AND REPLICATION POTENTIAL

The model demonstrates high transferability potential in contexts with formal health systems featuring existing institutional frameworks, local authority openness to sexual violence response improvements, functional intersectoral communication channels, and professional capacity for sustained implementation. The approach's greatest strength lies in its demonstrated capacity to work within existing regulatory structures rather than creating parallel systems, maximizing sustainability while minimizing institutional resistance.

Transfer modalities encompass both direct methodology implementation for contexts with characteristics like Portel and training of trainers approaches that multiply reach without prolonged MSF presence. The most immediate applications target similar Amazonian municipalities in Brazil with comparable regulatory frameworks, while broader potential exists

across Brazilian contexts with unified legal structures and decentralized health systems allowing humanitarian interpretation of sexual violence response protocols.

International applications require contexts with flexible legal frameworks permitting reinterpretation of existing regulations toward humanitarian approaches, decentralized health systems where municipal authorities possess significant decision-making autonomy, and institutional environments supporting relationship-building essential for successful advocacy work.

BOTTOM LINE IMPACT

The MSF Portel project demonstrated that sexual violence response transformation is achievable within existing public health systems through advocacy, capacity building, and intersectoral coordination. The intervention proved that judicialization-centred systems can become survivor-centred approaches through strategic engagement with existing regulatory frameworks. This represents a replicable model for humanitarian organizations working within formal health systems.

CONTEXT

MSF BACKGROUND IN PORTEL

MSF first arrived in Portel in 2021 during a 3-month emergency intervention as part of the COVID-19 response in Brazil. This initial intervention established contact with local authorities and revealed chronic problems beyond the pandemic, including sexual violence, low primary health care coverage, and limitations in the referral system.

In 2022, MSF conducted an exploratory mission that identified critical gaps requiring a more sustained intervention. Based on these findings, MSF initiated the Marajó project in April 2023, initially focused on Primary Health Care (PHC) and Sexual and Reproductive Health (SRH), working in integration with Brazil's Unified Health System (SUS).

The project would subsequently undergo a fundamental strategic reorientation toward sexual violence in 2024, a transformation that constitutes the core of this capitalization analysis.

PORTEL'S TERRITORIAL DUALITY: TWO REALITIES WITHIN ONE MUNICIPALITY

Portel represents an illustrative case of Amazonian complexities where aggregated municipal indicators homogenize profoundly divergent internal realities. With 62,445 inhabitants equally distributed between urban (50%) and rural (50%) areas and ranking as Brazil's 13th worst municipality by Human Development Index (0.483), aggregate indicators fail to capture the territorial duality that fundamentally shaped MSF's strategic approach.

URBAN PORTEL: CAPACITIES UNDERESTIMATED BY INDICATORS

Despite poor aggregated municipal indicators, Portel's urban centre possesses significant capabilities. As Pará state's second-largest açaí producer, it maintains a robust urban economy and complete municipal administrative structure. The urban health system includes a 50-bed secondary hospital with surgical and maternity units, and during the project period experienced significant improvements: complete emergency service rehabilitation, expansion from 4 to 23 medical professionals (reaching 3.71 physicians per 10,000 people, still below Brazil's national average of 21.5 per 10,000 but exceeding WHO's minimum standard of 10 per 10,000), improvements in health infrastructure and increased number of PHC facilities with better medical equipment, and increased "ambulanchas" (river ambulances) from 1 to 9 units. and expansion of hospital bed capacity from 20 to 50 beds in early 2024.

The dramatic increase in medical personnel reflected the restoration of Brazil's "Mais Medicos" program in 2023-2024, prioritizing socially vulnerable municipalities following its disruption during the Bolsonaro administration (2019-2022).

RURAL COMMUNITIES: ISOLATION AND STRUCTURAL VULNERABILITY

Rural populations comprise two main traditional groups: Ribeirinhos (descendants of 19th-century rubber workers) and Quilombolas (descendants of escaped enslaved Africans). Approximately 170 communities are distributed along four main river corridors, located 1-4 hours by speedboat from urban Portel, with some communities up to 7-8 hours away, accessible only by river transport.

Rural health infrastructure consists of converted Health Posts (PS) upgraded to Basic Health Units (UBS) during the project period. Initially, when the project started in 2023, there were no doctors in the rural area, so all facilities operated as Health Posts. With the arrival of the "Mais Medicos" program from late 2023 onwards, a gradual transition from Health Posts to Basic Health Units (UBS) began.

By 2024, four facilities had been upgraded to UBS status: Lisboa UBS, ABC UBS, Cocal UBS, and Boa Vista/Acutipereira UBS. In the first half of 2025, Acangatá was also transformed to UBS status and received a permanent medical team. Currently, five rural UBS are operational, with Ajará Health Post still planned for conversion to UBS status.

However, these facilities operate with critical temporal limitations: specialized professionals provide care only during specific periods (typically 2 weeks monthly), creating significant gaps in continuous care availability compared to permanent urban services. This territorial duality generated differentiated access patterns to health services.

SEXUAL VIOLENCE IN THE CONTEXT OF TERRITORIAL DUALITY

Sexual violence in Portel reflects and amplifies the municipality's urban-rural divide, evidencing how territorial differences determine both violence manifestation and institutional response. This local reality is embedded within Brazil's alarming national context: 83,988 registered cases

in 2023 (6.5% increase vs. 2022), with 88.2% affecting girls, 61.6% under 13 years old, and 84.7% perpetrated by family members or acquaintances. However, this data requires cautious interpretation given that mandatory notification for minors generates greater registration in this age group, while violence against adults remains significantly underreported.

The territorial divide manifests in fundamentally different cultural approaches to sexual violence. In rural contexts, sexual violence has become normalized through practices such as early marriages perceived as legitimate family economic strategies and intergenerational relationships accepted as customary. These dynamics are reinforced by economic dependencies where families rely on perpetrators for survival, creating cycles where survivors often do not recognize violence or feel unable to seek help due to family and economic pressures. Sexual and reproductive health topics are considered sensitive subjects requiring careful approach, with this sensitivity extending to health and protection professionals, creating challenges in early identification and adequate response protocols. Conversely, urban areas present greater access to information and services that can potentially challenge these practices, though significant cultural barriers persist.

This territorial disparity generates differentiated underreporting patterns: extreme in rural areas due to geographic isolation, economic dependence on aggressors, and absence of specialized services; lower but persistent in urban areas, where significant gaps exist between reported cases, cases entering the judicial system, and cases seeking health care.

EVOLVING CONTEXT DURING PROJECT IMPLEMENTATION

The project period encompassed dramatic transformation in Brazil's health system context. The Bolsonaro administration (2019-2022) severely degraded the health system through the "Mais Medicos" program disruption and resource reductions that particularly affected remote municipalities like Portel. The Lula administration's return in 2023 marked a reversal with substantial reinvestment in health infrastructure and program restoration.

This evolving context meant that MSF's operational environment changed significantly throughout the intervention. The restoration of federal health programs altered the institutional landscape in which MSF operated, while the transition from system degradation to reconstruction created both opportunities and challenges for humanitarian intervention within a recovering public system.

This contextual evolution fundamentally influenced MSF's strategic decisions and operational approach, themes that will be analysed in detail in subsequent chapters of this report.

STRATEGIC CONDITIONING FACTORS OF THE PROJECT: HUMAN RESOURCES CHALLENGES

The Marajó project faced a human resources crisis that transcended typical staffing problems, fundamentally conditioning its operational capacity and strategic decision-making. The difficulties generated a critical turnover rate of 143% in 2023, reduced to 48% in 2024, creating significant operational instability.

RECRUITMENT DIFFICULTIES AND CRITICAL GAPS

Difficulties in finding experienced international staff who spoke Portuguese and were willing to work in an integrated modality with the Ministry of Health rather than in more classical humanitarian contexts significantly restricted recruitment options, resulting in repeated gaps in key positions. Portel's remote location with high cost of living and isolation combined with the complexity of the Brazilian labour system, extended incorporation times and a significantly limited pool of available local candidates. This required MSF to develop enhanced compensation packages to make the location more attractive, which subsequently generated additional challenges in personnel management. The shortage of qualified candidates resulted in assigning management positions to staff without previous experience in management or MSF methodologies, limiting the project's effective leadership capacity in specific areas.

COORDINATION INSTABILITY AND CONTINUITY FRAGMENTATION

Instability in key positions reached critical levels with 7 HR Managers in a single year (February 2023-January 2024), three unplanned departures of POR and PMR positions, and temporary replacements, which fragmented operational continuity in addition to generating profound team destabilization.

ABSENCE OF MSF EXPERIENCE AND INDUCTION DEFICIT

The critical circumstance arose in teams where no local staff had previous MSF experience, eliminating the possibility of internal mentoring and organic appropriation of organizational methodologies. The combination of this total absence of experience with limited effectiveness of induction processes generated systematic management problems, complaints due to lack of knowledge of HR policies, incomprehension of working conditions, and resistance to strategic reorientations. This situation was compounded by managers who themselves lacked both institutional knowledge and supervisory experience. Additionally, the secure context made Portel a suitable location for first-mission International staff, which further contributed to the overall inexperience problem within the team.

IMPACT ON OPERATIONAL EFFECTIVENESS

This systemic HR crisis generated a cycle where managerial resources were continuously diverted toward resolving internal problems, limiting strategic focus capacity. The consumption of energy in internal conflict management affected the project's operational capacity and strategic decision-making. High turnover hindered the development of lasting relationships with local authorities, affecting advocacy work. The human resources crisis was further evidenced by operational data showing an average of 50 absent days per person per year during QMM2, which compounded the already limited operational capacity. This high absenteeism rate reflected the broader pattern of poor institutional appropriation and lack of understanding of MSF operational standards documented throughout the project period.

ORGANIZATIONAL CONTEXT AND MANAGEMENT SUPPORT LIMITATIONS

The project's management challenges were further compounded by broader organizational transitions occurring within MSF during the implementation period. The establishment of cell\RST 5 and the absence of a coordination structure in Brazil (the CST was established in 2024) created institutional instability that affected project oversight and strategic guidance.

STRATEGIC EVOLUTION OF THE PROJECT: FROM GENERAL TO SPECIALIZED APPROACH

PHASE 1: GENERAL PHC/SRH (MARCH 2023 - JULY 2024)

INITIAL STRATEGY AND IMPLEMENTATION

The Marajó project was initially implemented as a Unified Health System (SUS) strengthening intervention focused on Primary Health Care (PHC) and Sexual and Reproductive Health (SRH). The implemented design responded to gaps identified during the 2022 exploratory mission, which documented low PHC service coverage (only 50% of the population had access to basic health services), insufficient essential medicines (limited availability covering only 30% of demand), and critical human resources deficit, especially among doctors, with long waiting lists of months.

Intervention Design

The implemented operational strategy was designed to address four main intervention lines: human resources reinforcement through 1 MSF doctor and 1 nurse working integrated with local teams; provision of essential medicines and medical equipment; capacity strengthening through technical training of local staff in PHC and SRH; and infrastructure improvement with rehabilitation of priority health units.

Mental Health and Psychosocial Support Component

The initial project design included mental health and psychosocial support (MHPSS) as a transversal component across all activities, with plans for 3-4 clinical psychologists to provide individual consultations, support groups, and community-based interventions. This component was designed to provide comprehensive MHPSS services, with its inclusion justified by the high levels of trauma and stress documented during the previous COVID-19 response. However, implementation of this component faced significant delays during Phase 1 due to recruitment difficulties and operational constraints. During this period, substantial work was conducted on sexual violence programming, including comprehensive actor mapping, intersectoral cooperation meetings with municipal departments of education, health and social assistance, and development of foundational frameworks that would later inform the care flowchart for sexual violence survivors

Geographic Coverage and Location Selection

During Phase 1 implementation, MSF adopted a gradual approach shaped by initial operational constraints and the imperative to build solid foundations before reaching the territory's most vulnerable areas. While the 2022 explo had systematically mapped 170 rural communities scattered across four main river corridors and confirmed these areas harboured the greatest humanitarian needs, MSF's limited operational capacity—particularly lacking dedicated watercraft during initial months—necessitated phased implementation prioritizing locations where immediate impact was achievable while building logistical capabilities to effectively reach remote zones.

Implementation commenced in strategic urban locations, acknowledging that despite the urban area's relatively lower vulnerability compared to rural communities, specific high-vulnerability pockets demanded priority attention. MSF established operations at the municipal hospital and across 9 urban UBS throughout Portel, with particular focus on Portelinha and Castanheira UBS—the primary urban vulnerability hotspots. These facilities serve "occupied lands" populated by Ribeirinho communities facing heightened vulnerability, where PHC coverage remained critically deficient despite geographic proximity to health services.

Rural expansion, once MSF had its own boats, followed strategic accessibility criteria: the selection of 5 priority rural UBS (Acangatá, Santo Amaro, Cocal, Boa Vista, Sobradinho) was based on identifying locations that served as convergence points for multiple communities along each river axis, maximizing geographic reach.

Location selection reflected a pragmatic balance between identified humanitarian needs, available operational capacities, and institutional collaboration opportunities—prioritizing locations that were both SUS priorities and had municipal personnel available for collaboration.

Working within the SUS Framework

The implemented operational strategy was based on integration with existing SUS structures. MSF professionals worked within existing UBS and health centres, following public system

protocols, functioning as reinforcement for local teams in the case of UBS and adding specialist profiles in the case of health posts. The support of specialists (gynaecologist and paediatrician) was especially valued, as these profiles were not available locally. This modality avoided creating parallel structures and facilitated acceptance by municipal authorities. Close collaboration with the Health Municipal Secretary allowed MSF to understand SUS system functioning and local institutional dynamics.

PHASE 1 RESULTS

The project faced systematic limitations in accessing complete information from the municipal health system, significantly conditioning quantitative results analysis. Despite initial negotiations with the Ministry of Health to receive complete monthly data, MSF did not have access to complete municipal SUS data, operating as an external actor that complemented services without full integration into local information systems.

The data presented reflects only **consultations conducted by MSF personnel** during consultation days at each UBS or health centre, not the totality of consultations performed at each health unit.

In terms of healthcare activity, MSF recorded 1,046 total medical consultations during 2023, including 276 consultations for children under 5 years (26% of total), 87 family planning consultations, and 225 prenatal care consultations. For 2024, figures increased to 1,624 total medical consultations, with 524 consultations for children under 5 years (32% of total), 247 family planning consultations (representing a 184% increase versus 2023), and 324 prenatal care consultations (44% increase versus 2023). However, 2024 data is not directly comparable to 2023 due to differences in operational periods. These figures represent relatively low consultation volumes, averaging approximately 7 consultations per working day across the entire project, which is significantly below consultation rates (normally 30-50 consultations per doctor per day), reflecting both the project's limited operational scale and the challenges in reaching target populations.

The recorded increases, especially in family planning and prenatal care consultations, suggest unmet demand that MSF partially managed to cover. Nevertheless, without municipal contextual data allowing comparison with total local health system activity, it is impossible to evaluate whether these figures represent significant improvements in population coverage or simply substitution of existing services.

Project documentation does not record specific data on participant numbers and PHC/SRH training results during Phase 1, constituting an additional limitation for evaluating the effectiveness of this initial phase.

Gaps in Mental Health and Psychosocial Support: The planned MHPSS component was not systematically implemented during Phase 1, despite being identified as a transversal element in the original design. While some sexual violence cases were sporadically identified through limited mental health contacts, the absence of structured psychological support services created a critical gap when survivors required trauma-informed care. This limitation reflected both the

chronic barriers to accessing psychosocial support services that characterize Brazil's health system and the specific HR difficulties faced by the project. This limitation became particularly evident as the project's understanding of sexual violence prevalence deepened, highlighting the need for specialized psychological capacity to complement medical interventions.

ANTHROPOLOGICAL ASSESSMENT AND METHODOLOGICAL LIMITATIONS

In January 2023, as part of the project design phase, MSF conducted an anthropological study focused on sexual abuse and exploitation of children and adolescents in Portel. This study provided essential analysis for understanding social, economic and cultural aspects that contribute to sexual violence, including profiles of aggressors and victims, local determinants that aggravate cases, and challenges in care and protection processes.

However, the study operated under specific methodological limitations that would later condition understanding of community dynamics. The assessment was conducted with restricted geographic coverage due to logistical constraints - dependence on municipal transport limited access to remote communities and reduced time spent in rural locations.

These methodological constraints would subsequently influence the project's capacity to design community engagement strategies, particularly when the project later required detailed understanding of community cultural dynamics for sexual violence interventions.

STRATEGIC TRANSITION (MAY-AUGUST 2024)

DIVERGENT NARRATIVES ABOUT STRATEGIC ORIGINS

These anthropological insights regarding sexual violence dynamics suggest that foundational knowledge existed early in the project that could have supported a sexual violence strategy from the beginning, though this was not reflected in operational implementation during Phase 1.

Between May and August 2024, the Marajó project underwent a strategic reorientation process that completely redefined its objectives and methodologies. During capitalization interviews conducted for this report, divergent perspectives emerged regarding the project's strategic evolution. Some team members, particularly those in coordination positions, expressed that sexual violence had been considered as the primary strategy from the project's inception, deliberately maintaining a "low profile" during the first 18 months to first consolidate relationships with local health authorities before addressing such a sensitive topic. However, people in project coordination positions indicated they had not perceived SV as a clear strategic priority during the initial phases. This disparity suggests that while initial coordination positions may have understood this strategic vision, high staff turnover and communication gaps resulted in this understanding being lost in subsequent project coordination positions.

This disparity reveals an important communication gap between strategic vision at management level and operational understanding in the project. Documentary analysis and available operational evidence support the project positions' perspective. Project documentation does not reflect sexual violence as a primary strategy or explicit strategic element beyond its mention

as a "transversal component." Concrete operational indicators confirm that SV emerged as a response to the crisis identified in May 2024: complete absence of specialized national staff training in SV until June 2024, documented team resistance to strategic change, lack of systematic SV data collection during Phase 1, absence of specific SV protocols, and exclusive concentration of indicators on general PHC/SRH activities and deployment of specialized sexual violence technical management support only in January-April 2025, after the strategic reorientation was already complete. This timing provides further evidence that comprehensive sexual violence response was not operationally prioritized during Phase 1, despite confirmed strategic intentions for sexual violence programming at management level.

For capitalization purposes, this report acknowledges these divergent narratives while recognizing that communication gaps likely contributed to the loss of strategic clarity over time. However, for the purposes of this analysis and based on verifiable operational evidence, it is more valuable to examine the reorientation toward sexual violence because of lessons learned during Phase 1 implementation, as this approach yields more actionable insights for future project design and replication.

CATALYSTS FOR STRATEGIC CHANGE

Project operational crisis

At the beginning of 2024, the project faced concrete operational challenges that made evident the need for strategic reorientation. During Phase 1, the project encountered significant limitations in training implementation, evidencing difficult adherence from local professionals and difficulties in attracting participants to training activities. These barriers were attributed to weakened relationships with local partners, especially the municipal hospital, the absence of a person dedicated exclusively to intersectoral articulations, the perceived lack of relevance of the general PHC approach by local professionals, and an institutional credibility crisis stemming from high MSF staff turnover, creating a narrative of constant change that undermined confidence in the project's sustainability.

Recognition of lack of pertinence of the existing approach

The 18-month experience revealed that the project lacked sufficient pertinence by focusing solely on general PHC and SRH. The activities functioned as complementary support, potentially becoming redundant as they did not substantially differ from what the public system normally provided, even with greater frequency than MSF, which only conducted consultations twice per week.

Additionally, the implementation revealed a fundamental tension between MSF's humanitarian relevance criteria and local Ministry of Health decisions. Activities tended to concentrate where there was both facilitated logistical access and existing MoH infrastructure, rather than necessarily targeting areas with greater vulnerability. This evidence-based recognition of limited relevance provided the operational foundation for strategic reorientation, regardless of whether SV had been an original strategic intention.

Identification of Opportunities for Specific Added Value

Sexual violence, present since the initial design as a transversal element, emerged as a concrete strategic opportunity where MSF could contribute specific knowledge and methodologies that the local system required but lacked. Although epidemiological data on SV had been available since the exploratory mission, it was through 18 months of direct work within the PHC system that confirmed the absence of adequate approaches to address this issue. Unlike the general PHC approach, where MSF functioned as a complement to existing services, sexual violence represented an area where the organization could apply its expertise in humanized care for survivors.

FACTORS THAT FACILITATED THE TRANSITION

Timing opportunity: The reorientation coincided with the implementation of new municipal regulations on sexual violence (Portaria 06/2024), creating a window of opportunity to influence the practical application of the law from a humanized perspective.

Receptivity of local authorities: Municipal authorities, especially the Health Secretariat, showed high receptivity to the specialized approach to sexual violence, recognizing their institutional limitations in addressing this issue without external technical support.

Established community links: MSF's 18 months of prior presence had generated trust and connections with community leaders, facilitating the introduction of sensitive topics like sexual violence that required high levels of trust to be addressed effectively.

Contextual support factors: The transition was further supported by increased media attention on sexual violence cases in the region and MSF's strategic hiring of dedicated personnel (HAO) to establish connections with the judiciary and Public Ministry, which enhanced the organization's capacity to engage with key institutional actors.

ACTIVITY REORGANIZATION: FROM PRIMARY FOCUS TO STRATEGIC COMPONENT

The transition toward sexual violence programming represented a strategic reconfiguration rather than service abandonment, repositioning PHC/SRH activities within a new operational framework. This reorganization balanced pragmatic considerations with methodological opportunities that emerged during implementation.

MSF retained Primary Health Care and Sexual and Reproductive Health services as a complementary strategic component for several compelling reasons. Maintaining these services preserved crucial institutional relationships cultivated over 18 months of local collaboration, ensuring acceptance of the specialized approach while safeguarding MSF's credibility when introducing sensitive programming. More importantly, these services would serve as critical entry points for identifying sexual violence cases within communities where such violence had become normalized. Community engagement through these activities was also intended to enable health promotion teams to conduct the pending Rapid Qualitative Assessment, though this was ultimately never implemented.

The reorientation necessitated building partnerships beyond the health sector, engaging education, protection, and justice stakeholders. This intersectoral expansion contrasted sharply with the previous PHC phase, which operated primarily within health system boundaries.

Project Team Resistance to Strategic Change

The strategic shift encountered significant project team resistance. Local staff had established comfortable operational routines around general PHC programming and struggled to embrace sexual violence specialization. This resistance stemmed from multiple factors: inadequate understanding of the strategic rationale, exclusion from decision-making processes, insufficient familiarity with MSF operational approaches, and frequent staff turnover that left teams disconnected from evolving strategies. This resistance was particularly pronounced among project staff who had not been part of early strategic discussions, supporting the narrative that SV focus was not clearly communicated as a priority during Phase 1. Critically, the team lacked specialized expertise in sexual violence response, creating professional anxiety about managing unfamiliar territory. The challenge was compounded by MSF staff's own discomfort with sexual violence topics, necessitating comprehensive capacity building that addressed not only technical protocols but also cultural sensitization and overcoming internal resistance to engaging with such sensitive subject matter.

PHASE 2: SPECIALIZED SEXUAL VIOLENCE FOCUS (AUGUST 2024-JUNE 2025)

SITUATION FOUND: SYSTEM CENTRED ON JUDICIALIZATION

In Portel, MSF found a care system for sexual violence survivors that operated under premises that generated systematic revictimization and severely limited access to healthcare.

Judicialization as Mandatory Entry Point

The system operated under the premise that sexual violence response was fundamentally a legal and police matter rather than a health issue, requiring survivors to first file a formal police complaint before accessing health services. Hospital doctors required official police authorization (through the "documento de nomeação de perito não oficial") before performing clinical examinations on sexual violence survivors, creating absolute dependence on police procedures for basic medical care. Health professionals reduced medical attention to forensic procedures, fulfilling legal obligations without considering comprehensive clinical and psychological needs. This mandatory judicialization created critical barriers, particularly as the PEP window of opportunity (72 hours) was frequently lost due to bureaucratic procedures.

The magnitude of the problem became evident in concrete data: between June and July 2024, while police registered 41 cases of domestic violence, the Municipal Hospital recorded no spontaneous demand care for adult women. This disconnect demonstrated that official data did not reflect the reality of sexual violence in the municipality, as mandatory judicialization directly deterred survivors from seeking health services.

Extreme Institutional Fragmentation

Health, police, justice, and protection sectors applied independent protocols without effective communication, forcing survivors to navigate multiple institutions and repeat their testimony at each step of the process. This intersectoral fragmentation was further compounded by internal fragmentation within the health sector itself: without specialized structures to coordinate sexual violence response, cases were handled in an uncoordinated manner between UBS, hospital, and CAPS, each operating with their own protocols and lacking systematized referral mechanisms. This dual fragmentation multiplied opportunities for revictimization, as survivors had to repeatedly explain their situation both across different sectors and at different levels of the health system, without any continuity in the care process

Specific Barriers that Sustained the Judicialization-Centred System Critical Obstacles for Emergency Services Access

The absence of critical emergency medications (PEP) locally forced survivors to navigate complex bureaucratic processes or travel significant distances, reinforcing the system's emphasis on legal procedures over immediate medical needs.

Barriers to accessing legal abortion in Belém—including unofficial recommendations to present police reports and prior examinations—institutionalized judicialization as a de facto prerequisite for health services, contradicting national legal frameworks that establish the right to medical care independent of judicial processes.

Specialized Training Deficit

Professionals lacked specific training in humanized care for sexual violence survivors, resulting in practices that inadvertently perpetuated trauma and discouraged help-seeking behaviour.

Absence of Appropriate Infrastructure

Health services lacked spaces that guaranteed privacy and confidentiality, compromising survivor dignity and discouraging service-seeking behaviour.

PARADIGM SHIFT: TOWARD PERSON-CENTRED APPROACH

Faced with the problematic situation identified, MSF worked to introduce a fundamental paradigmatic transformation: shifting from a system centred on institutional procedures toward one centred on the needs, decisions, and dignity of the survivor.

Foundations of the New Paradigm

Health as absolute priority: MSF introduced the principle that the survivor's physical and mental health must be the immediate priority, with judicialization being a subsequent option that the person decides according to their specific circumstances. This meant eliminating police reporting as a prerequisite to access health services.

Survivor autonomy: The new approach established that the survivor controls decisions about their own care process, including what information is shared, with whom, when, and what services they wish to receive. This contrasts radically with the traditional system where institutions controlled the process and automatically exchanged information.

Comprehensive care without fragmentation: Instead of forcing survivors to navigate multiple institutions repeating their testimony, the new paradigm established coordination between services to provide comprehensive medical and psychological care, along with guidance about their options in safe spaces that guarantee privacy.

Elimination of revictimization: All protocols were explicitly designed to avoid additional trauma, prioritizing respectful care techniques and training professionals to coordinate information sharing between sectors, thereby avoiding the need for survivors to repeat their testimony multiple times.

This paradigmatic shift—from forensic procedure to comprehensive medical care, from institutional obligation to respecting the survivor's timing, from institutional control to person-controlled confidentiality, and from reactive response to prevention and early detection—constitutes the central innovation of the Portel model, underlying all institutional and operational transformations that were subsequently developed.

OPERATIONAL COMPONENTS

Implementing the person-centred approach required developing specific operational tools that translated humanized principles into concrete practice. The following components operated in an integrated manner to transform the care system for sexual violence survivors.

STRATEGIC ADVOCACY ACHIEVEMENTS

ARTICULATION WITH LEGAL FRAMEWORK

Implementation of the person-centred approach faced a fundamental challenge: barriers to accessing health services did not stem from the absence of legal frameworks, but from institutional interpretations that prioritized bureaucratic procedures over survivors' wellbeing. MSF's work focused on demonstrating that it was possible to apply the same regulations from a perspective that placed health as an absolute priority, transforming existing frameworks into effective protection tools.

Reorientation of Portaria 06/2024

Portaria 06/2024 PJP (Administrative Procedure Implementation Order of the Public Prosecutor's Office of Portel/PA) (Portaria de Instauração de Procedimento Administrativo da Promotoria de Justiça de Portel/PA) developed by the Public Ministry of Portel in collaboration with the municipal hospital director, Civil Police, and Conselho tutelar, was a regulation that

responded to the need to standardize medical examination protocols in sexual violence cases within a context where no local Medical Legal Institute (IML) existed.

The Portaria established the mandatory performance of medical examinations by municipal hospital doctors, under penalty of the crime of disobedience (art. 330, Penal Code) and determined that before performing any clinical examination, doctors had to obtain an "unofficial expert appointment document" issued by police authority.

While it represented progress in formalizing institutional response, its initial application prioritized medico-legal aspects over the comprehensive needs of survivors, positioning police reporting as a prerequisite for accessing health services.

MSF developed a systematic dialogue process with judicial authorities, initially facing deep resistance. The strategy consisted of presenting technical notes from other states (MPDFT, MPSP, MPF-RJ) demonstrating humanized interpretations of identical legal frameworks, supported by external legal consultancy based on Law 10.778/2003. A turning point occurred in August 2024 when both authorities expressed support for MSF's approach.

MSF worked directly with health professionals to eliminate the previously required "documento de nomeação de perito não oficial" and established that doctors with RMS had complete legal competence, resolving professional insecurities that generated additional barriers. Training enabled professionals to understand that comprehensive medical evaluation simultaneously fulfilled therapeutic and forensic functions, eliminating the false dichotomy between "health care" and "legal procedure." This represented a professional mindset shift from forensic procedure to comprehensive care.

The reorientation generated measurable changes: critical time reduction from hours for police documentation to less than 30 minutes to initiate care; adoption of the Ministry of Health's multiprofessional form as the sole instrument; elimination of "sexological examination" terminology for "comprehensive medical evaluation"; establishment of medical urgency protocols where health care takes precedence over administrative requirements; and implementation of controlled confidentiality mechanisms where survivors control information sharing. However, measurement of operational improvements such as time reduction was limited by insufficient case volume during the implementation period.

Integration of Approach in Regulatory Frameworks

As a direct result of MSF's advocacy efforts, Public Ministry authorities incorporated MSF methodologies and principles into their own regulatory instruments, issuing two official recommendations that formalized the person-centred approach:

- Recommendation Nº 002-2024: Establishes protocols for children and youth, prioritizing healthcare independent of criminal proceedings.
- Recommendation Nº 003-2024: Defines protocols for crimes against sexual dignity in adults, establishing that health must take precedence regardless of how cases enter the protection system.

Development of Municipal Sexual Violence Law

Leveraging the consensus achieved with judicial authorities, MSF supported the development of a municipal law project that incorporated person-centred approach principles, working directly with the Health Secretariat to pre-approve instruments such as the Ministry of Health's multiprofessional form. The legislative proposal integrated key elements of the MSF model: prioritizing health over judicialization, survivor autonomy in reporting decisions (while maintaining mandatory reporting for children and adolescents as required by Brazilian law), and mandatory specialized spaces (Salas Lilás) in health services. The project was approved by the Municipal Chamber during the writing of this report, representing local appropriation of MSF methodologies, with authorities considering extending the model to other municipalities in the region.

HEALTH SYSTEM STRENGTHENING

Immediate Access to Medication: PEP without Barriers

MSF conducted advocacy work to address **HIV antiretroviral medication** access difficulties within the PEP package identified in the diagnosis. Through this process, continuous availability was established at Portel Municipal Hospital from April 2024, eliminating the critical need to travel to Belém (300 km distance, 20-hour journey) and preventing loss of critical treatment effectiveness windows.

A critical gap remained in **paediatric HIV antiretroviral medications** within the PEP package, particularly concerning given the high incidence of sexual violence against minors documented in the municipality. Through systematic advocacy and articulation with SESPA (State Health Secretariat), MSF successfully secured paediatric HIV PEP availability at Portel Municipal Hospital by May 2025, representing another significant achievement in ensuring comprehensive emergency response for all age groups of sexual violence survivors. Additionally, following the completion of this report, PEP for adults was successfully decentralized to UBS Portelinha, further expanding access at the primary care level.

"Mais Medicos" Program Inclusion

Despite meeting clear eligibility criteria for Brazil's restored "Mais Medicos" program, Portel was initially excluded when the program was relaunched in 2023. MSF developed systematic advocacy leveraging its established credibility from the sexual violence work and documented evidence of humanitarian need gathered during 18 months of direct collaboration with local health services.

The advocacy strategy involved direct engagement with state health authorities (SESPA), presentation of technical evidence based on project findings, and coordination with municipal authorities to strengthen the application process.

In 2024, Portel was approved for inclusion in the program, securing permanent federal investment in medical personnel for the municipality.

INFRASTRUCTURE INVESTMENT: "USINAS DA PAZ" PROGRAM

Alongside local legal transformation efforts, MSF developed strategic advocacy to secure permanent public investment that would institutionalize the achieved progress. Pará state's "Usinas da Paz" represented the most significant opportunity: multifunctional complexes integrating health, education, protection, and training services. In May 2023, the Federal Ministry of Human Rights and Citizenship announced 40 new units in Brazil, but in Marajó only one in Breves. Portel was excluded despite meeting eligibility criteria.

MSF implemented systematic advocacy between 2023-2024 through six strategic meetings in Brasilia, at Ministry of Human Rights and Citizenship and presentation of technical evidence based on project findings. The strategy leveraged MSF's established credibility in sexual violence work to demonstrate the effectiveness of humanized comprehensive approaches.

In August 2024, construction orders were signed for Portel's Usina da Paz, currently under construction. The infrastructure includes a specialized health unit, shelter centre for violence victims, school with comprehensive education, and psychological care services that will permanently operationalize MSF's developed principles.

OPERATIONAL TOOLS OF THE MODEL

SEXUAL VIOLENCE RESPONSE COMMITTEE: INSTITUTIONALIZATION OF THE NEW PARADIGM

The creation of the Sexual Violence Response Committee made progress toward addressing local fragmentation, yet the structure's reliance on MSF assistance until project closure represents a significant institutional innovation of the Marajó project. Previously, UBS, hospital, and CAPS handled sexual violence cases in isolation, without effective communication or unified protocols, generating multiple revictimizations and poor survivor follow-up.

The committee evolved through four distinct stages. During mass training sessions (June-July 2024), the initial proposal emerged to create separate committees for hospital and primary care but recognizing that poor inter-level communication was part of the problem, efforts were unified. The first iteration (August-October 2024) involved an unwieldy group of 15-20 people that proved ineffective due to inconsistent engagement and lack of official status. Strategic redesign (November 2024-January 2025) created a smaller committee comprising managers with actual decision-making authority, culminating in official formalization (February 2025) through municipal ordinance establishing composition¹, functions, and permanent institutional legitimacy.

¹ The composition included strategic representation from all care levels: Primary Care with representatives from urban and rural UBS and health posts, Hospital Care with doctors, nurses, and social workers from the Municipal Hospital, Secondary Care with the CAPS coordinator serving as committee secretary, Epidemiological Surveillance with the monitoring nurse, and general coordination led by the Primary Care supervising nurse.

MSF facilitated gradual responsibility transfer through three phases. The intensive support phase (August 2024-February 2025) involved facilitating bimonthly meetings, transferring intersectoral coordination methodologies, and training in complex case management under person-centred principles. The transition phase (March-May 2025) gradually reduced direct support, enabling the committee to develop independent agendas and autonomous decision-making. The committee established the first formal coordination mechanism between hospital and primary care, overcoming historic system fragmentation. While anchored in the health sector, it maintains effective operational connections with education, protection, and justice sectors, promoting person-centred approaches across all sectors and working to eliminate revictimizing practices throughout the care network. The structure has operational foundations: trained personnel in permanent positions, Public Ministry legal support, and specialized physical infrastructure. However, long-term sustainability challenges remain, including dependence on sensitized individual leadership and the need for periodic training reinforcement. The ten-month consolidation period proved sufficient to establish solid foundations but limited for guaranteeing complete autonomous sustainability without external support. Public Ministry legal support, and specialized physical infrastructure. However, long-term sustainability challenges remain, including dependence on sensitized individual leadership and the need for periodic training reinforcement. The ten-month consolidation period proved sufficient to establish solid foundations but limited for guaranteeing complete autonomous sustainability without external support.

This institutionalization represents a fundamental ongoing transformation in Portel's health system culture, creating a permanent structure to ensure continuity of humanized approaches beyond MSF's presence.

SPECIALIZED INFRASTRUCTURE: CREATION OF RECEPTION ROOMS (SALAS LILA)

To address the identified problem of care provided in public or inadequate spaces that failed to guarantee privacy, MSF supported the creation of two specialized spaces that physically embody person-centred approach principles.

Previous conditions showed survivors were received without privacy in regular consultation rooms, lacked protocols guaranteeing confidentiality, and faced an institutional environment that contributed to revictimization.

MSF developed a collaborative model where the organization fully financed structural modifications, specialized medical equipment, furniture, and necessary materials following Salas Lila guidelines². The municipality assumed commitments for facility maintenance, provision of

² Salas Lila, established by Law nº 14.847/2024, constitute specialized spaces in SUS health services designed for humanized reception of sexual violence survivors, providing: a non-institutional therapeutic environment that reduces anxiety and trauma; guaranteed privacy through reserved spaces with separate access from general flow; and comprehensive functionality enabling medical evaluation, psychological support, and guidance in a single safe space.

trained personnel, regular medical supplies, and official integration into the municipal network with budget allocation for continuous operation.

Municipal Hospital: Secondary-Level Welcome Room

Expansion of the Social Service room agreed upon in September 2024 and inaugurated in December of the same year, creating a specialized space meeting Sala Lila standard.

UBS Portelinha: Primary-Level Welcome Room

UBS Portelinha was selected as the pilot unit to decentralize specialized care to the primary level, leveraging its location in a vulnerable area with higher case incidence and proximity to CRAS Portelinha for intersectoral coordination. Inaugurated in May 2025, it serves as a replicable model for other municipal UBS.

This intervention generated impact beyond physical structure: increased awareness among professionals about differentiated care, institutional recognition of sexual violence as a priority issue, and materialization of a tangible model of the person-centred approach.

TRANSFORMATIVE TRAINING: SYSTEMATIC MINDSET CHANGE

Methodological Innovation: Multi-sectoral Training Approach

To address the intersectoral fragmentation identified as a critical barrier, MSF developed a coordinated training methodology that simultaneously engaged health, education, social protection, security, and justice professionals under unified person-centred principles. This approach ensured that all network actors understood not only their specific roles but also how their actions integrated within the comprehensive care continuum. Critically, this training sought to transform professional mindsets toward a humanized, survivor-centred approach, rather than simply transferring technical knowledge.

Sector-Specific Capacity Building

The training maintains core transversal elements—person-centred approach, trauma-informed care and psychological first aid, and intersectoral coordination—while adapting content to each sector's specific competencies and institutional context.

Health Professionals: MSF trained 108 health professionals across the municipal system, addressing the critical confusion between comprehensive medical care and forensic procedures. The training established that medical evaluation serves simultaneous therapeutic and documentary functions without requiring prior police authorization. Implementation of the Ministry of Health's multiprofessional form as the sole instrument eliminated the previous practice of obtaining police authorization before examining survivors.

Training content encompassed non-revictimizing interview techniques, respectful physical evaluation protocols, immediate PEP management and other preventive treatments, plus

effective coordination with psychological and social services. This comprehensive approach fundamentally shifted clinical practice from procedure-focused to survivor-centred care.

Education Sector: Education professionals learned to recognize signs of trauma and sexual violence in students, apply psychological first aid techniques adapted to school contexts, and communicate appropriately across different age groups. Critically, they mastered referral protocols that prioritize health over judicialization while effectively coordinating with parents, health services, and protection agencies.

Social Protection Services: CRAS/CREAS workers developed understanding of survivors' health needs, intersectoral coordination protocols that respect decision-making autonomy, psychological first aid techniques, and person-centred approaches that contrast sharply with traditional institutional frameworks. This training proved particularly transformative in shifting from bureaucratic to humanized service delivery.

Security and Justice Professionals: Police and Guardian Council members received specialized content on health needs as priority, referral protocols eliminating bureaucratic requirements for medical service access, non-revictimizing communication techniques, and effective coordination with health sector while respecting survivor-controlled confidentiality.

Community Health Workers: The training of all 174 municipal CHWs recognized their role as the critical link between dispersed communities and formal health systems, particularly in contexts where sexual violence normalization requires profound cultural transformation. Content included recognizing sexual violence signs in normalized contexts, respectful initial support techniques contrasting with traditional revictimizing practices, discrete referral protocols respecting confidentiality and autonomy, and cultural adaptation of messaging—replacing potentially conflictive frameworks like "sexual rights" with culturally acceptable approaches centred on "child protection" and "family wellbeing."

Specialized Technical Support Integration

A critical turning point in the project's implementation capacity occurred with the deployment of specialized Sexual Violence Technical Manager support (January-April 2025). Through systematic team assessment using Knowledge, Attitudes and Practices (KAP) surveys, implementation of the Revision of Attitudes and Values (RAV SV) workshop, and development of tailored technical tools, this specialized support addressed fundamental gaps in team confidence and technical capacity that had persisted throughout the strategic transition period. The systematic approach to team development proved transformative in consolidating effective person-centred sexual violence care delivery during the project's final phase.

Transformational Outcomes

Health Practice Changes: Professionals adopted integrated protocols eliminating revictimization, replaced "sexological examination" terminology with "comprehensive medical evaluation," and established specialized care spaces. The 85% comprehension rate demonstrated successful knowledge transfer.

Intersectoral Coordination: Non-health professionals gained confidence in case management within their roles, achieving 82% satisfaction rates and documented coordination improvements that shifted practice from fragmented to collaborative approaches.

Community Strengthening: CHWs developed enhanced case identification and referral capabilities, establishing community-based detection foundations. However, sustainable consolidation requires implementation periods beyond current project timelines.

BARRIER-FREE PEP ACCESS PROTOCOLS

Implementation of immediate PEP access required comprehensive local staff training and elimination of bureaucratic barriers. Between June and July 2024, 108 health system professionals received 8-hour specialized training on sexual violence care including specific PEP protocols, indications and contraindications, follow-up procedures, and dispensation protocols. The Municipal Hospital pharmacist received specific training to manage medication control through the Medication Logistic Control System (Siclom), establishing automatic replenishment protocols.

Survivors can now access PEP without prior police documentation, prioritizing medical urgency over administrative requirements. In a single consultation, survivors receive complete medical evaluation, information about PEP and other preventive treatments, and immediate medication access. MSF also initiated PEP decentralization toward primary care using UBS Portelinha as a pilot to facilitate access for vulnerable populations facing difficulties reaching the hospital.

Decentralization Process Initiated

MSF initiated PEP decentralization toward primary care using UBS Portelinha as a pilot. Decentralization seeks to facilitate access for vulnerable populations facing difficulties reaching the hospital, particularly given that time is always critical for treatment effectiveness. The pilot process involved infrastructure adaptation for appropriate storage and coordination with the hospital pharmacist for stock replenishment.

This decentralization process achieved concrete results: PEP was officially decentralized to the Centro de Testagem with 3 kits available by June 2025. Additionally, specialized training was provided by an HIV specialist (MSF referent) to further strengthen local capacity for PEP management, demonstrating the successful implementation of the decentralization strategy initiated during the project period.

DEVELOPMENT OF INTERSECTORAL FLOW

MSF collaborated in designing a care flow that operationalizes official recommendations, presented to the entire network in November 2024. This flow establishes priority referral to health services from any institution, with subsequent intersectoral communication that respects survivor autonomy.

The presentation meeting featured active participation from multiple institutions - Primary Care, Municipal Education Secretariat, CREAS, Municipal Council for Children and Adolescents Rights, Civil and Military Police. Their constructive engagement in debating and clarifying questions about the new flow demonstrated that MSF's approach had successfully generated intersectoral consensus, transforming an initially external proposal into an initiative locally appropriated by the entire protection network.

MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT COMPONENT

Although MHPSS was included in the original project design as a transversal component with plans for 3-4 clinical psychologists, operational implementation faced significant delays. The first Mental Health Activity Manager was hired in mid-2023, with the first mental health assessment conducted in August 2023 and systematic activities beginning in September 2023—five months after project initiation despite being planned from the beginning.

Operational Framework and Implementation

The MHPSS component was originally designed with broader scope beyond sexual violence, reflecting the project's initial PHC approach. Sexual violence was one of several topics proposed for psychological support, alongside support groups for women, chronic disease patients, and adolescent mothers.

The component operated within the collaborative framework established with the Ministry of Health, focusing on integration with existing local services rather than parallel structure creation. Key operational elements included partnership development with the local CAPS (Psychosocial Care Centre) for specialized referrals and coordination with primary health care services for basic psychological support integration.

Integration with Sexual Violence Programming

Following the strategic reorientation toward sexual violence in August 2024, the MHPSS component adapted its approach to provide specialized support for sexual violence survivors. This included psychological first aid integration across all professional training programs and development of trauma-informed care protocols for health service delivery.

The component worked to establish referral pathways between primary health services and specialized mental health care, ensuring appropriate psychological support was available for sexual violence survivors while building local capacity for sustained service provision.

IMPLEMENTATION CHALLENGES

While the human resources challenges described in Chapter 2 constituted the overarching constraint that conditioned virtually every aspect of project implementation, the following analysis focuses on specific operational and strategic challenges that emerged during the sexual violence programming phase.

RESISTANCE TO PARADIGM CHANGE

The transition from a legally focused model to one prioritizing comprehensive care encountered significant institutional inertia. Professionals expressed uncertainty about new protocols, voicing concerns about potential legal repercussions for deviating from traditionally mandated automatic reporting procedures.

This resistance was particularly pronounced among doctors with less secure legal standing (RMS vs. fully registered practitioners), who felt especially vulnerable to procedural changes that might be interpreted as failing to meet legal obligations.

Institutional paternalistic attitudes also persisted, creating difficulty in accepting survivor autonomy as a guiding principle, with resistance to recognizing adults' right to control decisions about formal reporting.

ETHICAL AND LEGAL DILEMMAS

Healthcare professionals encountered complex conflicts between legal obligations and humanitarian and protection considerations. Beyond reporting dilemmas, professionals struggled with practical challenges of maintaining confidentiality while ensuring appropriate referrals within the care system. In situations involving chronic sexual violence where economic dependence existed between survivor and perpetrator, health workers expressed discomfort about reporting cases to SINAN when they perceived that mandatory notification could destabilize the survivor's economic and social situation.

A paradigmatic example involved adolescents aged 15-16 years experiencing second pregnancies with partners significantly older, where families were economically dependent on the perpetrator. Professionals feared that mandatory reporting would trigger retaliation, loss of family livelihood, or expulsion from the home, illustrating the fundamental tension between compliance with legal protocols versus immediate protection of the individual.

Additionally, the mandatory reporting requirement for minors under 14 years created tensions in applying person-centred approaches, as legal protection of the minor takes precedence over decision-making autonomy, creating a fundamental contradiction between legal principles of child protection and methodologies centred on survivor autonomy.

These dilemmas were compounded by the absence of a comprehensive legal framework document specific to the Brazilian context during most of the intervention period. A Legal Memo addressing these issues was developed only in the final months of the project (May 2025), created through collaboration between the former Humanitarian Affairs Officer and intersectional legal advisor.

COMMUNITY CULTURAL BARRIERS

The normalization of certain forms of sexual violence, particularly early marriage and intergenerational relationships constituted a significant barrier to intervention. Some communities perceived these practices as "part of local tradition," viewing external interventions as threats to established family structures. These deeply rooted practices were often justified as economic necessities or cultural customs, making dialogue about alternative approaches particularly challenging.

Survivors seeking formal services faced community stigmatization that actively discouraged help-seeking behaviour. This social ostracism created additional layers of vulnerability, as women and girls frequently chose silence over potential rejection from their support networks, perpetuating cycles of unreported violence.

ASSESSMENT LIMITATIONS AND THEIR CONSEQUENCES

The project's understanding of community dynamics was fundamentally constrained by methodological limitations that affected implementation approaches. The anthropological assessment, while valuable, was conducted before MSF acquired its own boats, requiring reliance on municipal transport that severely restricting access to remote communities providing insufficient depth on broader community cultural dynamics around sexual violence.

More critically, no Rapid Qualitative Assessment was ever conducted by health promotion teams, despite mobile clinics providing regular community access throughout the intervention period, representing a profound missed opportunity to capture essential cultural nuances.

The national health promotion team operated under the assumption that being from the region provided sufficient cultural understanding to design community engagement strategies. This assumption eliminated the perceived need for systematic community assessment tools like RQA, failing to recognize that each community has specific nuances depending on factors such as leadership types, women's groups dynamics, religious influences, and internal power structures that require detailed study to design effective interventions.

The health promotion manager lacked previous MSF experience and familiarity with standard assessment methodologies. Combined with constant changes in project management positions, there was insufficient follow-up to ensure implementation despite guidance from referents

Without systematic community assessment, the project operated on unvalidated assumptions, most notably characterizing sexual violence as an "absolute taboo" when community reality

revealed it was a sensitive but approachable subject. During implementation, many community leaders actively demanded information about sexual violence, directly contradicting initial assumptions about cultural barriers.

The cumulative effect was overly cautious programming that limited the potential for more direct and effective interventions, demonstrating the critical importance of systematic community-based qualitative assessments when addressing sensitive topics in humanitarian contexts.

INSUFFICIENT TIME FOR CULTURAL TRANSFORMATION

The August 2024-June 2025 period provided only 10 months to implement a completely new sexual violence strategy following the strategic reorientation. This timeframe proved fundamentally insufficient to generate the deep paradigmatic transformations required for effective sexual violence interventions.

With this limited timeframe, the project succeeded in establishing solid foundations but could not consolidate systematic and autonomous application of new protocols by local staff. Professional mindset changes and behavioural transformation require extended periods to become embedded in routine practice.

Although advances were documented in immediate MSF intervention implementation indicators (85% training comprehension, 100% of CHWs trained, formalized SV Committee creation, two specialized spaces inaugurated), the time was insufficient to measure sustainable transformations in survivors' help-seeking behaviours, lasting changes in community cultural dynamics, or autonomous application of humanized protocols without external supervision. Available indicators primarily reflected activity outputs rather than behavioural change outcomes or impact on survivors' quality of care

MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT LIMITATIONS

The project's MHPSS implementation revealed significant constraints in providing comprehensive sexual violence care. **The 18-month delay from project inception to operational MHPSS capacity** left critical gaps during Phase 1 when sexual violence cases lacked appropriate psychological support, demonstrating the importance of incorporating specialized mental health capacity from project design rather than as a later addition. The most critical limitation was the **absence of specialized sexual violence expertise** within the team, affecting both case identification and appropriate response protocols.

A deeper challenge emerged from **attitudinal barriers within the humanitarian team itself**. MSF staff demonstrated knowledge gaps and concerning attitudes toward sexual violence topics, revealing that personal and cultural barriers within teams can significantly impede program effectiveness when addressing sensitive subjects.

A critical ethical oversight identified in debriefings was that a significant proportion of staff and community health workers trained to detect sexual violence were survivors. The project failed to address their own trauma and support needs before expecting them to identify and respond to cases in others, potentially retraumatizing those meant to be helping and representing a fundamental breach of duty of care.

The **collaborative operational model** presented additional constraints, as MSF lacked established methodologies for integrating MHPSS within existing bureaucratic health system structures, requiring adaptation of traditional direct implementation approaches.

DATA MANAGEMENT AND MONITORING LIMITATION

The project invested significant resources in developing comprehensive data collection systems, preparing 32 datasets in DHIS-2 covering areas including sexual violence and vaccination indicators. However, these systems were ultimately underutilized during implementation, with datasets remaining largely unused for monitoring, evaluation, or programmatic decision-making. This represented both a missed opportunity for evidence-based programming adjustments and inefficient resource allocation during a project already constrained by human resources challenges.

PROJECT CLOSURE: BALANCING IMPLEMENTATION NEEDS AND ORGANIZATIONAL CONSTRAINTS

The decision to close the Marajó project in June 2025, despite recognizing insufficient time for complete consolidation of the sexual violence protocol, resulted from multiple competing factors that required careful evaluation by MSF's Cell and Country Coordination.

CONTEXT OF THE CLOSURE DECISION

Increasing global humanitarian crises created financial pressure on OCB to allocate resources to new emergencies, creating direct tension with Portel's need for extended implementation time to achieve cultural transformation around sexual violence response.

Simultaneously, the Brazilian government's restoration of health programs and infrastructure investment (as detailed in sections 4.1.2.2 and 4.1.3) addressed many gaps MSF was originally filling, reducing the humanitarian justification for continued presence.

The chronic HR challenges—high turnover, management instability, and limited MSF experience within teams—represented a significant factor that cannot be underestimated in the closure decision. These persistent gaps and operational limitations created scepticism about whether additional time would result in meaningful sustainable change, as the fundamental constraints hindering effective implementation remained unresolved.

STRATEGIC DECISION-MAKING RATIONALE

The joint decision between Cell and Country Coordination acknowledged that paradigmatic transformations around sexual violence response require timeframes that often exceed standard humanitarian project cycles, while recognizing that even with additional time, complete cultural transformation could not be guaranteed given the persistent structural constraints.

The analysis concluded that while additional months might produce incremental improvements, the combination of global humanitarian pressures, evolving local context, and unresolved HR challenges created diminishing returns that did not justify continued resource allocation compared to alternative humanitarian interventions where MSF could generate greater impact.

The strategy prioritized developing robust handover mechanisms that could function effectively without complete consolidation, recognizing that sustainability often requires local ownership and adaptation rather than extended external presence that might delay local appropriation of methodologies.

LESSONS LEARNED

STRATEGIC CHANGES: DOCUMENTATION, AND TEMPORAL FLEXIBILITY

The two-phase strategy requires two critical elements for success. First, explicit documentation: "implicit" or "low profile" strategic approaches generate operational confusion and staff resistance. The divergence between the team's retrospective narrative ("sexual violence was always the primary strategy") and available documentary evidence demonstrates that all strategic elements must be explicitly documented in formal project instruments, even those considered sensitive. Strategies that remain undocumented become vulnerable to loss and misinterpretation, particularly in high turnover contexts. Second, temporal flexibility: when the transition between phases is delayed beyond what was planned, extending the project timeline should be considered. The late reorientation toward sexual violence left insufficient time to implement the second phase, clearly inadequate for consolidating paradigmatic transformations that required changing professional mindsets and established cultural dynamics.

HUMAN RESOURCES: UNDERESTIMATED STRUCTURAL CHALLENGES

The project's main operational challenges were linked to human resources rather than technical or contextual limitations. The convergence of teams lacking MSF experience, sexual violence expertise, and management experience created problems that significantly affected implementation. High turnover rates and scarcity of staff with previous MSF experience significantly limited possibilities for institutional knowledge transfer and operational strategy continuity. Without proper appropriation of MSF working methods, the team did not

understand institutional policies and resisted strategic changes from perspectives outside the organization. The experience demonstrates that robust inductions on MSF working methodologies are critical for operational functioning, particularly when most of the team is new to the organization.

The specific recruitment challenges represent structural characteristics of the context that will persist in similar future projects. Remote contexts exponentially amplify these HR problems. It is essential to ensure availability of adequate human resources before considering opening projects with similar characteristics.

WINDOWS OF OPPORTUNITY IN REGULATORY CHANGES

Regulatory changes create temporal windows where humanitarian interventions can be significantly more effective. During these periods, institutions have not yet consolidated operational routines, allowing influence on interpretation and implementation toward humanized approaches. Teams can benefit from remaining alert to emerging regulatory changes in their context that may create strategic timing opportunities. The coincidence with Portaria 06/2024 was fortuitous but demonstrates the potential for leveraging these moments of institutional transition when they arise.

SYSTEMATIC COMMUNITY ASSESSMENT VERSUS CULTURAL ASSUMPTIONS

The decision not to conduct systematic Rapid Qualitative Assessment, justified by the team's "local knowledge," resulted in suboptimal strategies based on incorrect assumptions about community dynamics. Local knowledge can generate more limiting biases than external ignorance when teams take things about communities for granted without verification. Not prioritizing RQA reflected an underestimation of its importance for culturally sensitive topics. The gap between team assumptions and community reality represented a missed opportunity for effectiveness that would have allowed developing more direct approaches from the beginning.

WORKING WITH IMPLEMENTERS VERSUS POLITICAL LOBBYING

Changing the application of existing legal frameworks requires working simultaneously on both levels - directly training professionals who implement protocols daily and engaging high-level authorities. Front-line professionals can adopt humanized interpretations of existing regulations more quickly, generating immediate operational changes, but these transformations require institutional backing from higher levels to become sustainable. Neither approach alone is sufficient: working only with implementers creates changes that remain vulnerable to institutional reversal, while focusing solely on high-level lobbying generates policies that may not translate into improved practice without front-line buy-in.

CRITICAL VALUE OF SPECIALIZED TECHNICAL LEADERSHIP

The late deployment of specialized Sexual Violence Technical Manager support represented a turning point that demonstrated the critical importance of technical expertise for complex sexual violence programming. The systematic assessment and capacity-building approach—including KAP surveys revealing significant knowledge gaps, RAV SV workshops addressing attitudinal barriers, and tailored technical support—transformed the team's implementation capacity during the final months.

For future sexual violence interventions, deploying specialized technical capacity early in programming rather than as a late addition could maximize impact on team development and implementation effectiveness throughout the entire intervention period.

LEGAL FRAMEWORK DOCUMENTATION

The experience of operating without clear legal guidance for most of the intervention period demonstrates the importance of developing country-specific legal framework documentation before initiating sexual violence programming. Such documentation should address mandatory notification requirements, patient confidentiality protections, and healthcare provider obligations to support teams in navigating complex ethical and legal scenarios.

TRANSFERABILITY OF THE OPERATIONAL MODEL

The MSF Portel project generated organizational interest for its operational **innovation in sexual violence response** and capacity to **influence local public policies**, transforming traditionally punitive systems toward humanized approaches through advocacy, transformative training, and intersectoral coordination within functioning formal health system contexts.

The model's greatest success was the advocacy component, demonstrating that significant policy changes for sexual violence survivors are achievable at the local level, even in bureaucratic environments, representing a case of interest as MSF increasingly works in collaboration with ministries of health and public authorities.

CONDITIONS OF REPLICABILITY

TARGET CONTEXT CONDITIONS

The model can be transferred to contexts that meet several basic requirements. Formal health systems with existing institutions and protocols provide the foundation for the advocacy approach, as these can be modified rather than replaced entirely—which proved essential in Portel's success.

Local authorities must show openness to changing how sexual violence is handled. Without this receptivity, the advocacy strategies that drove Portel's transformation would face insurmountable resistance.

The approach also requires health, protection, and justice actors who communicate with each other, even if these relationships are currently fragmented or ineffective.

Finally, the context must have professionals who can learn and sustain new approaches after the initial transfer period ends. The model's long-term success depends on local capacity to continue applying person-centred principles without ongoing external support.

MSF IMPLEMENTATION CONDITIONS

Successful transfer requires specific implementation capacities from MSF. **Specialized expertise from inception** proves essential, as the Portel experience demonstrated that late deployment of specialized technical capacity in sexual violence and advocacy significantly limits model effectiveness.

Human resources stability emerged as a critical factor. The high turnover that characterized the Portel project significantly affected operational continuity and advocacy effectiveness, constituting a fundamental barrier to successful transfer.

Sufficient **implementation time** represents another essential condition. The Portel experience suggests paradigmatic transformations require periods significantly longer than the 10 months implemented, although the exact time needed for complete consolidation remains to be determined.

Finally, **systematic pre-evaluation** must precede any transfer effort. This includes comprehensive analysis of legal context and reinterpretation opportunities, assessment of political will among key authorities, and detailed evaluation of local absorption capacities before transfer initiation.

TRANSFER MODALITIES

Based on the Portel experience, two distinct approaches emerged for transferring the model to different contexts.

DIRECT METHODOLOGY TRANSFER

For contexts with characteristics like Portel, direct methodology transfer represents the most comprehensive approach. This modality would focus on MSF providing all the developed instruments—complete training protocols, proven advocacy tools, and the approach for establishing specialized care spaces—in a new operational context. This approach requires functioning health systems and sufficient time to achieve deep changes.

TRAINING OF TRAINERS

The Training of Trainers approach allows multiplying the model's reach without prolonged direct MSF presence. This involves transferring the complete training package to local teams who can replicate the methodologies, including the specific techniques for attitude and value

transformation. Success depends on careful selection and preparation of local trainers capable of maintaining the person-centred approach.

POTENTIAL CONTEXTS FOR TRANSFER

The most obvious contexts for model transfer are Amazonian municipalities in Brazil with characteristics like Portel—remote locations with formal health systems requiring strengthening and similar legal frameworks governing sexual violence response. The model's tools and advocacy strategies were developed specifically within the Brazilian regulatory context, making adaptation to similar municipalities more straightforward.

Beyond Amazonian contexts, the model shows potential for broader application throughout Brazil, given the country's unified legal framework for sexual violence response and similar institutional structures across municipalities. The demonstrated capacity to reinterpret existing regulations without violating legal requirements could prove applicable across different Brazilian states with similar regulatory structures.

Transfer to other countries presents greater complexity but remains possible in contexts where sexual violence response operates through comparable legal frameworks allowing for flexible interpretation. Countries with decentralized health systems where municipal authorities possess significant decision-making autonomy over service delivery protocols offer opportunities for local policy influence. Conversely, countries with rigid legal frameworks that mandate specific procedures without interpretation flexibility would limit the advocacy approach's effectiveness.

Settings where health systems lack basic institutional capacity or where intersectoral actors operate in complete isolation would require substantial preliminary capacity building before model implementation becomes viable. Similarly, contexts with high political instability or frequent changes in local authorities would undermine the relationship-building essential for successful advocacy work.