

EVALUATION

PNG: Family and Sexual Violence in Lae, Tari and the RTT project: Assessing the effectiveness and sustainability of projects (2016)

Note: this evaluation was conducted by Tania Bernath, directly contracted by MSF OCA (Berlin). Stockholm Evaluation Unit provided limited methodological guidance during the process, but was not responsible for the evaluation itself.

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ACRONYMS

CHW	Community Health Worker
CMC	Case Management Committee
FSC	Family Support Center
FSV	Family and Sexual Violence
FSVAC	Family and Sexual Violence Action Committee
IEC	Information Education Communication
IPV	Intimate Partner Violence
MSF	Médecins Sans Frontières
MSF-H	Medecins Sans Frontieres-Holland
MSF-OCA	Medecins Sans Frontières-Operational Centre Amsterdam
NCD	National Capital District
NDOH	National Department of Health
NS	National Staff
PDOH	Provincial Department of Health
PMGH	Port Moresby General Hospital
PNG	Papua New Guinea
PMGH	Port Moresby General Hospital
PFA	Psychosocial First Aid
RTT	Regional Treatment and Training
SV	Sexual Violence
WCSC	Women's and Children's Support Centre

EXECUTIVE SUMMARY

Background

Family and Sexual Violence (FSV) in PNG is pervasive and widespread, centered within the family and the extended family (*wantok*), and manifests itself as physical or emotional abuse, sexual abuse, and social isolation. Children are a particularly vulnerable group because of their inability to seek care independently of a parent, especially in cases where family members are the perpetrators, which is a common occurrence in PNG. There is also a stigma attached to young survivors making it difficult to report. The endemic nature and high rates of violence within the family impact women and children the most in PNG.

Within PNG, there is a lack of understanding of the health consequences of sexual violence and abuse, including but not limited to: serious injuries, unwanted and early pregnancy, unsafe abortion, sexually transmitted infection including HIV, sexual dysfunction, infertility, increased vulnerability to disease, mental trauma, and/or death. Although the scale of the violence is well documented, prior to MSF's entry into PNG in 2007 the medical and psychosocial needs of survivors in PNG were completely neglected with little emphasis on healthcare provision.

An exploratory mission in 2006 to PNG found high levels of violence against women and children especially. The mission found a lack of services, and a lack of understanding of the problem especially of children including child abuse and the psychological effects of violence on children. A weak health care system and a general lack of care for survivors of Family and Sexual Violence notably derived from a lack of expertise, knowledge, and political will.

MSF's decision to intervene came with ambivalence within the organization as PNG is a development context and not a classic emergency or natural disaster where MSF would normally intervene without reservation. However, the widespread nature of the violence, the lack of the acknowledgement of the problem by the government and the lack of appropriate and available medical and psychological services to address the violence were factors that ultimately compelled MSF to intervene.

Time-frame

Since 2007 when MSF first arrived there have been four major interventions addressing FSV in PNG and the Solomon Islands. These include: Lae 2007-2013, Tari 2008-2016, the Regional Treatment and Training (RTT) project 2013-2015 (represented by Port Moresby General Hospital and Alotau in this report) and the Solomon Islands for three months in 2014.

In October 2015 an external consultant was hired by MSF to look at the effectiveness and sustainability of the different modes of care the organization had been using in PNG to address FSV. The evaluator visited the FSCs in Tari, Port Moresby and Alotau, interviewed a range of key stakeholders including MSF national and international staff and national and international actors in PNG as part of the project evaluation.

The survivor-friendly approach

MSF promotes a survivor-friendly approach to accessing FSV services. The minimum package of services that MSF provides are five medical services that MSF feels are essential but also advocates for other support including mental health support and referral services such as police, legal, safe house and child protection services. The minimum package includes medical first aid (including wound care and a medical exam), psychological first aid, post-exposure prophylaxis and vaccines including for the prevention of Hepatitis B and Tetanus as well as medicines to protect against sexually transmitted diseases and other infections; and emergency contraception to prevent unwanted pregnancies. The survivor accesses these services in one location, free of charge, in a secure and confidential environment.

This approach was largely developed by MSF based on its experience in Lae and Tari that took into account the scarcity of human resources in PNG (especially doctors and mental health counselors) as nurses and counselors are trained and equipped to provide urgent life-saving care to survivors of FSV. The many advantages to the provision of care have been the reduced waiting time for the survivor. Another key aspect is that the survivor only needs to tell his or her story one time in order to receive life-saving treatment. A medical report is also provided as evidence of the health impact of the violence to provide to the police, for compensation in the village court, or for an interim protection order.

Main Findings, Conclusions and Recommendations

The evaluation assessed the effectiveness of each of the projects based on project objectives, the availability and accessibility of patient's access to care, the effectiveness of the advocacy in reaching project goals and improving patient's access, the level of sustainability of the projects, and the effectiveness of the internal management and support.

Effectiveness of the intervention

Overall the projects in Lae, Tari, and the RTT effectively met the overall objectives of each of the projects. However, in the Solomon Islands the strategy designed for the intervention was not an appropriate approach to meet the goal and therefore not effective. This fact not only made it difficult to reach the goal but to have a lasting impact.

Overall between 2007 -2015 approximately 20,000 survivors of FSV, IPV, and SV were provided medical and psychosocial support. These interventions were carried out in hospital based FSCs, and in healthcare centres.

- In Lae between 2007-2013 approximately 11,000 FSV survivors accessed services.
- In Tari between 2008 and 2015 approximately 8,000 FSV survivors accessed services
- In the RTT and Solomon Islands between 2013-2015 approximately 1500-2000 FSV survivors accessed services¹

There was also evidence of increased use of services over time. By 2015 the FSC caseload in Tari averaged over 100 FSV survivors per month with numbers steadily increasing over time². In the PMGH, staff highlight that following MSF's support, there was a massive increase, from 10 FSV survivors accessing services per month to 100-120 per month with these numbers being maintained today.

Key to the Lae and Tari interventions were the show by doing aspects and the collection of data needed in order to do the advocacy. Additionally, in Tari where there was no existing structure MSF trained staff and did the implementation themselves. Also, in Tari and Lae, MSF had more control over the quality of care provided than in the other projects. For instance, it could guarantee 24-hour access to services while in PMGH and Alotau this was not available. It is also important to state that the RTT project was only possible following the policy change that took place in PNG as a result of the advocacy carried out by MSF based on what they learned from the Lae and Tari project. There is an important sequencing that was needed in PNG which MSF followed. Sustainability of the approach in Lae and Tari were a concern. However, in Lae this was ultimately addressed following the hospital hiring MSF staff that had been trained. In Tari the long-term viability is still in question.

Effectiveness in terms of accessibility and availability of care for FSV survivors

All survivors in all locations have access to free services, in a confidential and secure location provided by qualified and well-trained medical staff. In Tari, access to services are maintained at 24 hours a day and in the other locations between 8-4 PM during the weekdays and on weekends, survivors are referred to emergency room at the hospital. Toll-free hotlines are also available. Transportation was a concern in all locations limiting access due either to cost, security or both. FSC services remained at the level of the hospital as health clinics struggled to provide FSC services due to insufficient numbers of available health staff and a lack of dedicated FSC staff. It was only in places where dedicated FSC were available that it was possible.

MSF promotes a survivor-friendly approach to accessing FSV services. This approach was largely developed by MSF based on its experience in Lae and Tari that took into account the scarcity of human resources in PNG (especially doctors and mental health counselors) as nurses and counselors are trained and equipped to provide urgent life-saving care to survivors of FSV. The many advantages to the provision of care have been the reduced waiting time for the survivor, that the survivor only needs to tell his or her story one time in order to receive life-saving care. A medical report is also provided as evidence of the health impact of the violence to provide to the police, for compensation in the village court, or for an interim protection order.

While minimum package of 5 ES was available throughout all the projects, the range of other critical services varied by location. An overview of these are listed in the table below:

¹ This is a number estimated by the evaluator

² In Tari survivors of both general violence and FSV also had access to surgical care.

Table 1: Range of services available by location

Availability of FSV services	Lae	Tari	RTT-PMGH/Alotau	SI
Minimum package: 5 ES including Psychological First Aid	Yes	Yes	Yes	Not all in the same place
Other Mental health	Yes, within hospital	No	Yes, within hospital	Some access
Surgical	Yes, within hospital but not MSF run	Yes, within hospital and MSF run	Yes, within hospital but not MSF run	Some in hospital
Referral Services Police/Legal/Child/Safe House	Yes, to some degree	Only police and limited	Yes, police, legal, child welfare, but limited access to safe houses	Some within

IEC services were utilized in all locations and were considered especially effective in the RTT projects with a dedicated IEC officer attached to the project. In both PMGH and Alotau following awareness training workshops carried out with referral partners, referrals doubled in both locations and remained steady for several months after that. In both Tari and Lae, they could have benefitted from consistent and strategic approaches to IEC as their effectiveness fluctuated with the interest levels of the various teams in the project. However, across the board, following awareness raising activities numbers of survivors accessing services within 72 hours to obtain needed lifesaving treatment, especially children, increased in all the projects. Targeted awareness raising activities were considered more effective with increased numbers of referrals coming from police and within hospitals following the trainings.

Emphasis for the need to focus on responding to treat children for abuse and sexual violence began from the early stages of the intervention. It was included as a focus in the Country Policy (2007) and continually highlighted throughout the various projects. And while MSF did provide some child friendly services to children including provision of staff with specialized knowledge in counseling children, the mission’s response to the needs of child survivors did not meet the urgency of the original call and there was little to no advocacy focused on the situation of children. For instance, a 2013 assessment of needs in the Solomon Islands identified a need to focus on children and adolescents as central to the intervention. In 2014 upon a reassessment of the situation, an MSF intervention was deemed unwarranted except for some technical assistance. In the end it was a missed opportunity for MSF as barriers for children had in accessing care was highlighted as a key challenge.

Additionally, what still persists today are the few options available to survivors especially children for protection from potential recurring violence. As the pattern of domestic violence and child abuse repeats and escalates over time the need to have safe locations and options for survivors is pressing as they are at risk of repeated violence, injury, and even death. According to MSF data collected between January and June 2015 more than one in every twenty survivors attending the MSF FSCs were repeat patients and 24 (out of over 1300) had come in following three or more incidents. MSF plays a protection role through ensuring that medical reports are available free of charge for survivors to use in court, in a police case, in the village court for compensation, or for obtaining an IPO. However, more is needed for both their protection and for their protection in the longer term.

Effectiveness of advocacy to reach project goals

MSF’s national level advocacy has been extremely effective. Their national level advocacy has made the health response to FSV central to the government’s national agenda. It has been instrumental in pushing forth and influencing the content of two major policies that have transformed the response to Family and Sexual Violence in PNG.

The first are the *Guidelines for PHA/Hospital Management establishing hospital based Family Support Centres* that provide instructions on the levels of care and priority services in Family Support Centres. The second major achievement has been the instrumental role that MSF has played in the development of the *Clinical Guidelines for the Medical Care and Support of Survivors of Sexual and Gender-Based Violence in PNG*. These use the 5 ES piloted by MSF in Lae and Tari as the basis for these guidelines.

The work done in Lae and Tari, the release of the advocacy report, *Hidden and Neglected* in November 2011 and the significant relationship building done in 2012 and 2013 by the CMT really centered MSF as a major player in PNG on FSV. The lead up and during the conference in November 2013 went even further as civil society more broadly began to see MSF as a major player and MSF gained significant respect from key community and government actors such as the FSVAC and the NDoH in PNG.

MSF along with community and government actors brought for the first time ever, representatives from around the country including medical, legal, psycho-social, and safe house partners to the national level to discuss increasing

protective services for survivors at the provincial level to a national conference in November 2013. The goal was to have concrete action plans by each province for increased referral services by 2014 and 2015.

Coinciding with this, next steps in MSF’s advocacy work were to move the national advocacy to the local level as a follow-up to the November 2013 conference’s provincial rollout strategies. It was planned that tailored advocacy plans would be developed at the provincial level such as lifting fees for survivors or addressing transportation challenges. Although this seemed a national progression for the advocacy and made a lot of sense and a good plan, the shift in focus did not materialize and the work of the HAO ended up staying at the national level. The failure to shift the focus was a missed opportunity as both a learning opportunity for MSF to understand clearly what barriers exist for survivors at the project level and provide them tools for addressing them and as a way to help increase access to the services more substantially at the project level.

The level of sustainability of each of the projects

There is clear evidence of sustainability in the Lae and RTT interventions. In the RTT the sustainability of the project was prioritized given the lessons that had been drawn from the Lae project. Built into the agreement was the NDoH’s commitment to provide dedicated human resources in the clinics to work alongside MSF in care provision for FSV survivors. NDoH was also required to hire the staff once the MSF project closed. This approach used proved successful as the staff that had been hired by MSF to work with the PMGH was retained. Additionally, utilizing an on the job training approach provided staff with practical skills with the opportunity to ask any questions or deal with any problems as they arose.

However, in Tari while the FSC staff were sufficiently trained and qualified to operate on their own without continued support from MSF by the end of the project, the long-term sustainability of the hospital in which the FSC was based was in question. It was unclear, if without the continued support of MSF, whether the hospital would remain secure and services would remain free of charge, including FSC services putting sustainability in question. In the Solomon Islands the intervention although introduced the concept of integrated care of medical and psychosocial care to nurses and medical staff, this did not lead to policy changes that were needed and as a result there was not a lasting impact. The Solomon Island intervention would have benefitted from an intervention that demonstrated to high level health officials the value of the 5 ES through setting up a Lae like intervention to demonstrate it.

The level of effectiveness of the internal management of the project

At the project level the setup of the projects has varied quite significantly with more MSF-like conventional set ups in Lae and Tari while RTT and the Solomon Islands have used less of a conventional MSF approach. For instance, in the Solomon Islands three staff were deployed including a psychologist, a midwife and a nurse. Also in the RTT project staffing varied but with a PC for overall coordination and otherwise with a range of health and mental health staff deployed based on perceived needs.

Following a strong and productive period between 2011-2013 where there were significant gains made on the project including MSF being recognized and respected as a key actor on FSV in the PNG, the project took a very different and unproductive direction when the Country Management Team changed in 2014. A crisis involving the entire coordination team in Port Moresby and the RTT project developed following the decision made to close the RTT project and the mission more broadly in September 2014.

MISSED OPPORTUNITIES, LESSONS LEARNED, and RECOMMENDATIONS

The successes have been highlighted and along with them there have been a number of lessons that should be acknowledged and learned from, good practice that should continue or be repeated elsewhere, and missed opportunities that should be highlighted

Table 2 Missed opportunities by location

Missed opportunities	Lae	Tari	PMGH	Alotau	Solomon Islands
Key issues	Maintaining closer links to Lae after 2013 in order to have a better understanding of the CMC in order to incorporate a CMC	Working with the community earlier on in the intervention as an opportunity to learn about the culture and how to support	Mapping of available services for children earlier on in the project. And then carrying out more advocacy around the lack of	Providing training to Health Centers that would provide access to services for the majority of the population of Milne Bay	Focus on children as a learning opportunity, introducing an integrated model of care, and making strong links with the NDOH in PNG

	<p>approach to protection of the health services outside of the health services.</p>	<p>locally developed protection strategies especially through links with women and youth groups</p>	<p>services for children outside the FSC</p>		
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Short and light intervention is preferable once policy change has taken place

One of the lessons learned from the RTT was that, if MSF was to support a short and light intervention of treatment and training, strict minimal criteria for intervention should to be in place. This included dedicated NDoH staff assigned to the FSC, available and motivated staff to continue after MSF’s departure and the hospital commitment to organize and prioritize the service and to refer patients from other wards. Additionally, having access to a referral network or at least some services available outside the hospital structure is a priority.

However, an important lesson to also take from the Solomon Islands’ intervention is that this approach is only possible after policy change has taken place at the national level with clear support from the government at the national level. In the Solomon Islands a short and light investment of training and capacity building was not effective because there had not yet been the needed change on the policy level first. Therefore, in any new location where MSF may consider introducing this minimum package of care, the organization needs to engage in policy level change as a first priority.

Availability, accessibility, quality, and timeliness ensures needed care

FSV services need to be provided in a secure environment and free of charge at the very least by a well-trained medical staff. Services should be available on a 24-hour basis and accessible. Services should be age and gender specific. The nature of the violence and the perpetrator should be understood and part of the analysis for a better response.

Awareness raising needs to central to the project and strategic

Awareness raising strategies should be central components to all FSV interventions and strategies to raise awareness need to be adapted to the situation. Dedicated staff and resources should also be attached. Awareness raising and IEC support were provided in all projects, their effectiveness fluctuated and were dependent on the interests of teams and/or leadership at any given time. The strategies used in the project were also largely focused in one direction, which was extremely effective when engaging with referral partners and hospital staff with the aim of increasing the number of referrals to the FSC. Some lessons from the IEC work include:

- A strategic approach that is targeted to specific groups had a greater impact than less directed non-strategic approaches such as carrying out general awareness raising in the market (IEC officer)
- Engaging police resulted in higher numbers of referrals of child survivors of sexual violence to the FSC (PMGH, Lae)
- Awareness raising to hospital staff on available FSC services resulted in higher numbers of referral of child survivors of sexual violence. (Alotau, Lae)

Two-way dialogue is also needed especially in places where there are no referral partners such as in Tari. Engagemnt with the community is critical. This can be done by ongoing focus group discussions in the community, small focused outreach activities, exit interviews with survivors and engaging with women, youth, or church groups to network and develop strategies.

Engagement with survivors should also go hand in hand to ensrue their concerns, ideas and needs are also part of the awareness raising strategy. This includes ensuring that survivors understand the importance of seeking lifesaving care, know how to access vital services, and go beyond that to include developing an understanding of what prevents or constrains potential survivors from seeking care. Strategies should be sex, gender, and age friendly and take into account understanding the various points of contact in the community, their role in the community and then taking steps to engage with them. Engagement at the field level could possibly assist with follow up and developing community based PEP adherence strategies.

Leadership should understand community approaches and SGBV projects

Evidence suggests that further intervention is needed to be guided by CMT leadership who embrace community approaches, have an understanding and interest in SGBV projects and feel excited and challenged by out of the box thinking. In fact, any staff working or supporting these types of projects should also have this understanding and interest.

Greater focus on provision of mental health services

In this project little was known about what happens to survivors once they leave the FSC except that there is a great likelihood that they will return to the same dangerous environment that they came from. This reality has been demonstrated by the high number of survivors returning for services in the FSC. MSF has also gathered compelling data on the mental health status of IPV survivors that should be further explored. The data suggests that those that seek out psychological services are benefitting from these services, however only a fraction of survivors are seeking these services out.

A Centre of Excellence should be set up in Tari, or a context like Tari, where there are a high number of IPV survivors and where there are few referral services available to meet their needs. This includes working with women's groups and other community structures to help try and address some of the protection and mental health services gaps especially for FSV survivors including children.

Testing a decentralization strategy: Milne Bay

In Alotau geographical challenges were the main issue preventing physical accessibility to the FSC, as over half the population of Milne Bay live in the 160 inhabited islands and access to the mainland is expensive and distant with few services outside of Alotau. Discussions with hospital management revealed that they were interested in exploring how MSF could support them to further decentralize FSC services. It was suggested that the Health Center staffed by a doctor that was accessible to many of the other islands by boat be capacitated to provide FSV services.

Understanding children's barriers to accessing care: Solomon Islands

The 2013 assessment proposal for the Solomon Islands focused on children. During the three-month intervention the team found significant barriers for children accessing care which they were unable to fully explore because of the short time frame for the intervention and because it was not the focus of the intervention. However, it is the belief of the evaluator that had the mission taken this proposal forward it would have been an opportunity to learn about addressing child related sexual violence. A focus on this issue could have been mutually beneficial to both the Solomon Islands given the gap identified and an important learning experience for MSF for the Pacific Islands more generally.

Moving MSF advocacy from the national to the FSC level

The focus of the November conference and subsequent plans of identifying specific actions tailored to different locations addressing survivors' barriers to accessing care and their long term protection needs, although never materialized, made sense as a next step in MSF's advocacy work. The logic of this plan took the focus of the advocacy to local level and coincided well with MSF second advocacy goal of "ensuring access to referrals for other-sector services (law and justice, social welfare or protection) or broader mental-health services." It was also consistent with the messaging used in *Service for Survivors* advocacy document provided to participants at the November conference. In any future interventions, ensuring there are staff and resources available such as an HAO or IEC officer dedicated for these tasks should be prioritized to ensure that project level advocacy takes place.

Stronger more focused advocacy on the experience of children is needed.

MSF has strong and compelling data on child survivors of abuse and sexual violence from all of the projects. IEC activities highlighted the importance of ensuring that children have access to services and as a result MSF saw a steady increase in children accessing services. The organization took steps to improve the health response for children through training health staff in child related counseling and equipping at least one center with staff with specialized skills. However, the long-term protection concerns of children at risk of recurring violence and child abuse remained a major gap.

In future interventions simultaneous to strengthening the health response steps should be taken by MSF to play a stronger role in finding solutions for survivor's long-term protection needs through using their data to advocate. Advocacy, mapping services, and/or making links locally are a starting point. For advocacy along with collecting information on numbers efforts should be made to understand the experience of the children through interviews and focus group discussions with children and their caregivers. Follow up in the community should also be practiced and while this is labor intensive it does provide the organization with a better understanding of the experience of the children to be in a better position to advocate on their behalf through not only knowing realistically what to advocate for but how and who to advocate to. These same strategies can apply to all survivors. A greater focus on understanding the experience of men and boys is also needed.

Introducing the 5 ES model to resource poor countries outside the region including in Africa, the Americas, and Asia should be considered.

There are a number of countries around the world that could benefit from ensuring that survivors receive the basic minimum of care such as the 5 essential services offered by MSF. Additionally, given the lack of human resources in hospitals in many countries in Asia, Africa, the Middle East, and the Americas, and that incidences of family and sexual violence remain high introducing an approach that trains one medical staff to be able to provide survivors with lifesaving care should be introduced elsewhere. This would assist Health ministries in many countries to respond to SGBV and help thousands of survivors by increasing their access to quality, available, accessible, timely, and appropriate healthcare services. MSF would need to start much the way that it did in Lae or Tari with first demonstrating how it works by doing it themselves and showing that it is possible.

BACKGROUND

An exploratory mission in 2006 to PNG highlighted high levels of violence especially against women and children. The mission found a lack of services, lack of understanding of the problem especially of child abuse and the effects on children, a weak health care system, and a general lack of care for survivors of family and sexual violence notably derived from a lack of expertise, knowledge, and political will.³ After much debate within MSF-OCA as to whether it justifiably fit into the MSF mandate, a decision was made to intervene.

When MSF entered PNG in 2007 the reason for its presence was:

MSF's role in PNG is to provide quality medical and psychosocial services to women and children suffering from domestic and social violence, and advocate to the National Department of Health and other relevant actors to not only acknowledge the issue, but actively seek and implement strategies for the provision of appropriate and effective services for the victims."⁴

Family and Sexual Violence (FSV) in PNG is pervasive and widespread, centered within the family and the extended family (*wantok*), and manifests itself as physical or emotional abuse, sexual abuse, and social isolation. Children are a particularly vulnerable group also because of their inability to seek care independently of a parent especially if the perpetrator is a family member. Another major challenge in children reporting is the stigma attached to young survivors. The endemic nature and high rates of violence within the family impact women and children most dramatically.

Along with the high level of violence there is a lack of understanding of the health consequences of sexual violence and abuse, including but not limited to: serious injuries, unwanted and early pregnancy, unsafe abortion, sexually transmitted infection including HIV, sexual dysfunction, infertility, increased vulnerability to disease, mental trauma, and/or death. Although the scale of the violence is well documented, the medical and psychosocial needs of survivors are almost completely neglected when it comes to healthcare provision in PNG.⁵

MSF's decision to intervene came with ambivalence within the organization given that PNG is a development context and not an emergency or natural disaster where MSF would normally intervene without reservation.⁶ However, the widespread nature of the violence, the widespread lack of understanding of the health consequences of the violence, and the lack of appropriate and available services to address the violence were factors that ultimately compelled MSF to intervene.

Between 2007-2015 the focus of the mission evolved and changed and in the most recently updated country policy (2012) it states:

That MSF-OCA is present in PNG in response to the chronic humanitarian crisis created by endemic levels of family, sexual and general violence. The mission has developed a clear regional agenda of increasing awareness of and response to the (usually ignored) medical and psychosocial needs of patients who have experienced rape, child abuse and other forms of family or sexual violence, through model demonstration and advocacy messages. MSF's presence in PNG since 2007 has led to increased commitment from the National Department of Health (NDOH) and other actors to providing medical and psychosocial care to survivors of FSV. The response to FSV and general violence in Hela Province is decreasing the mortality rate and creates access to healthcare for the population.

It prioritizes the following health and policy responses:

- **Medical and psychosocial care for survivors of Family & Sexual Violence (FSV)**
- **Medical response to survivors of tribal and general social violence**

³ MSF-H PNG 2006 Explo Part 1 Assessment

⁴ 2007 Country Policy PNG

⁵ MSF PNG Report Hidden and Neglected November 2011

⁶ According to 0611ESD reflections on 2006 PNG Explo there was significant ambivalence noted and a lack of a clear fit into the Health and Operations Policy.

- Attempting specially to understand and respond to the situation and needs of sexually and physically abused children
- Demonstrate models of care that are adapted to the local context, for the purpose of creating a sustainable model that can be exported and adopted virtually anywhere in the region with minimal local adjustment, so as to ensure greatly increased access to care for the most vulnerable and at-risk survivors
- Our ambition is to be the driving force in a greatly increased Pacific-regional response to the needs of patients affected by FSV, ultimately influencing the response to unmet needs in the Pacific region⁷

Since the project began in 2007 there have been four major projects including in Lae 2007-2013, Tari 2008-2016, the Regional Treatment and Training (RTT) project 2013-2015 (represented by PMGH and Alotau in this report) and the Solomon Islands 2014, all related to addressing FSV in PNG and the Solomon Islands.

Table 1:MSF-OCA’s history in the country/context

Year	Lae	Tari	RTT	Solomon Island	Country wide
2006					Assessment
2007	Project opens in Lae Provincial hospital				
2008	Took over the FSC completely in Lae Provincial hospital	Project opens project in Tari District hospital			
2009					
2010					Concept of Family Support Centre is born.
2011		Hela becomes its own province			2011 Hidden and Neglected Advocacy Report launched
2012					
2013	MSF hands over the Lae project		In June Mile 9 opens In August Lawes Rd opens In November Maprik opens ⁸	In May assessment team determines that an intervention is warranted	In November the conference: A comprehensive response to Family and Sexual Violence in PNG takes place. In Port Moresby bringing people from nine provinces throughout the country.
2014		Decision to close Tari made at the September Co-Days This decision was linked to the fact that Oil Search expressed interest in taking over the management of the hospital but later it changed its mind.	In January PMGH opens In May Lawes Rd closes In September Maprik closes In November Alotau Opens	Reassessment done in May determining that an intervention is not warranted- Technical mission goes in for three months	Decision is made to close RTT and hand over Tari FSC to Oil Search Foundation and the hospital back to the health authorities
2015		Handover of staff to NDoH begins	MSF’s intervention in	MSF assessment team goes in determining that a treatment and	

⁷ Country Policy 2015

⁸ Mile 9, Lawes Rd. and Maprick were all a part of the RTT project. The evaluator did not look at these projects at all.

EVALUATION METHODS & LIMITATIONS

The evaluation uses a mix of document review, qualitative research methods, and collection of quantitative data with a view to triangulating data from at least two different sources.

1) *Two meetings* took place at the end of the field research in Tari with the Tari team and also at the end of the field visit with the Coordination and Management Team (CMT) in Port Moresby. The purpose of these two meetings was to provide feedback to key members of MSF staff and to receive initial feedback as a means to validate initial findings.

2) *Semi-structured individual interviews*. This was the main data-gathering tool for the project. Individuals who were interviewed are listed in an annex and include past and present MSF project staff that worked on the various projects and other key government and community stakeholders.

3) *Group meetings or focus group discussions* took place. This was primarily used as a strategy in Tari Hospital in discussions to ensure a wide array of staff were consulted and interviewed for the project in the most time efficient manner.

4) *Direct observation* at the Tari Hospital FSC, PMGH FSC, and Alotau FSC and the respective hospitals that took place to deepen the evaluator's understanding of the context in which FSV survivors were seeking care. Especially important is to understand the quality and availability of services there.

5) A *document review* supplemented all of the methodological strategies described above. The project documentation has helped to both contextualize evaluation questions properly, as well as help the evaluator understand challenges/obstacles and changes in programmes. It has also been essential to corroborate SP findings drawn from the interviews. Where possible, quantitative data has been drawn largely from MSF medical data to corroborate SP and support overall findings.

Field Visit

The evaluator spent between 25 September and 10 October 2015 on the field visit to PNG. During this period the evaluator carried out interviews with both national and international MSF staff, hospital staff, community stakeholders, and patients. The evaluator spent approximately one week in Tari, one week in Port Moresby and two days in Alotau, Milne Bay.

Key limitations the evaluator noted are:

As is often the case when conducting final evaluations or during periods when programmes are closing, much emphasis in the discussions especially with MSF national staff in Tari was concern about the fact that MSF was handing over the project to the government and the uncertainty about their future. This made it challenging at times to focus on the content of the subject matter being evaluated.

Although feedback from the beneficiaries of the services is critical in order to understand key aspects of the intervention, this was done quite extensively in Tari with IPV survivors; however little to no patient feedback was conducted in Port Moresby and Alotau. There was no patient feedback at all from children or survivors who suffered from sexual violence. The necessary feedback for this type of information was drawn in other ways. This includes taking into account MSF staff attitudes about survivors/patients, secondhand accounts outlined in reports drawn from patient testimonies. It is unfortunate that the evaluator was unable to conduct first-hand patient and family member interviews as it denies patients and survivors the opportunity to participate in giving feedback about a project that was designed to address their needs.

The evaluator only visited PMGH, Tari, and Alotau. The evaluator did not visit Lae, the Solomon Islands, Maprick, or any other location in National Capital District (NCD). It was emphasized that the focus of the evaluation should be on Tari, Alotau, and PMGH. The analysis of the Solomon Islands and Lae comes only from the available documentation and through staff that were involved with those projects.

Data-analysis and validation and presentations of findings

Once the data-gathering phase was complete, qualitative data analysis took place, which was done by listing and coding data under each of the headings which included: 1) Effectiveness of the overall project, 2) Effectiveness, patient's views, 3) Advocacy, and 4) Sustainability and 5) Internal management of the project through the triangulation of information gathered from the range of qualitative and quantitative methods.

A discussion of findings and feedback with staff and other key stakeholders also formed part of the data analysis. A subsequent presentation of findings to MSF management and the broader MSF family was done and their feedback was incorporated. The final report will incorporate all feedback and follow an outline that is agreed between the evaluator and the MSF office.

MAIN FINDINGS

The purpose of this evaluation is to document and evaluate the interventions to address FSV in PNG with the overall aim of understanding which strategies worked the most effectively within PNG and those that can also be utilized in other similar contexts. Therefore, the purpose of the evaluation is to determine the effectiveness and sustainability of various strategies that MSF employed to address FSV in PNG. This includes looking at its structure and patient's level of access in its own right with the major focus on Tari Hospital and the RTT project in PMGH and Alotau and looking at the advocacy and administration of the project as well as looking at the intervention as a whole. Although the evaluator did not visit the Solomon Islands or Lae, references to these projects have been made in the evaluation based upon information gathered from interviews and documents reviewed.

The organization of the report are considered under these five main questions: ⁹

- The level of effectiveness of each intervention
- How effective each project was in terms of the accessibility and availability of care for FSV services
- How effective the advocacy was in reaching project goals and improving patient's access
- The level of sustainability of each of the projects
- How effective the internal management and coordination of each project was including support provided by MSF Berlin and OCA

The level of effectiveness of each intervention

Table 2: Overall theories of change by project

Strategies	Lae	Tari	PMGH	Alotau	Solomon Islands
Dates	2007-2013	2008-2016	2013-2015	2014	April 2014-July 2014
Theory of change/strategy	Catalyst for change MSF tried and tested essential services trained staff treating patients and set up a Centre of Excellence to train staff and institutions	MSF trained staff working in a hospital to respond to FSV main aim to build own capacity to respond in Tari	Once policy level change had been done treatment, training and capacity building were the main focus	Once policy level change had been done training and capacity building support to existing capacity.	No policy level change only training and coaching to existing health staff
Primary Objective for each project	Appropriate medical and psychological services for women and children who are survivors of sexual violence are provided by MSF and replicated by other actors	Decrease mortality and morbidity through access to quality emergency surgical care, as well as medical and psychosocial care for survivors of sexual, family and general violence in Hela Province	The mortality and morbidity of survivors of FSV in NCD and other targeted provinces in PNG is reduced due to improved access to quality integrated medical and psychosocial care	The mortality and morbidity of survivors of FSV in NCD and other targeted provinces in PNG is reduced due to improved access to quality integrated medical and psychosocial care	Increase the visibility and recognition of the crisis of FSV across the Solomon Islands through the provision and scale up of FSV services in Honiara and Guadalcanal Province, Solomon Islands

The overall goals of each intervention were to provide medical and psychological care to reduce morbidity and mortality. Each had an advocacy component aimed to serve as a catalyst for change. These interventions are clearly aligned with the overall Country Policy, which is also consistent with these two main goals

Table 3: Lae project

Lae
2013
Overall objective: Improved health status of survivors of sexual and intimate partner violence
Specific Objective 1: Improved quality of and access to medical and psychosocial care to survivors of SV, IPV in Lae District, and 9 main health district of Morobe provinces and throughout PNG.
Specific Objective 2: Increased awareness of the medical and psychosocial care available to survivors of SV/IPV in the community.

⁹ These questions are further elaborated in the evaluation matrix found in the TOR that is in the appendix.

Specific Objective 3: Increased access to medical and psychosocial care to survivors of SV/IPV through provision of services integrated in the basic health care units (health Centre's), with a specific focus on the most vulnerable women and children.

Specific Objective 4: Advocacy in relation to both the medical and psychological impact of SV/IPV on individuals, families and communities and the resulting necessity for availability of integrated services for survivors on a national level.

Background

Beginning in 2007 MSF opened up a project in Lae supporting the Soroptimist Foundation to run the Women's and Children's Support Centre (WCSC) in the Angau Memorial General Hospital and by 2008 MSF had taken over the entire programme. In early 2010 the Centre officially changed its name to the Family Support Centre (FSC) in line with national guidelines. MSF took overall financial, administrative, and technical support for the running of the FSC in partnership with Angau Memorial General Hospital.

There were several major components to the intervention in Lae. This included the provision of medical and psychosocial services to FSV survivors at both the hospital level and at four Health care centers, the testing of essential services that would eventually be adopted in PNG, the setup of a training school with staff from health facilities from around the country for training and medical data gathered from the project that has been effectively utilized for advocacy and change.

By the end of the project, MSF was successful in treating a total of 13,305 survivors including 2800 child survivors between December 2007 and June 2013¹⁰. MSF provided support and training to clinical staff from 28 hospitals throughout PNG on how to set up and run much needed medical emergency services for survivors creating Angau Memorial Hospital FSC as a Centre for Excellence. One major success was following a month long training with staff in Mt. Hagen in July 2010, in November the same year Mt. Hagen opened a FSC. Today Mt. Hagen is still considered a fully functional FSC.

Feedback on the project

An evaluation conducted in 2012 found that the FSC had been effective in providing quality medical and psychosocial care and serving as a catalyst for change. It highlighted that the majority of the survivors had suffered from Intimate Partner Violence (IPV) and that large numbers of children that were accessing services. It questioned if the response largely designed for the needs of SV survivors was sufficient to address the needs of IPV survivors. The need to focus on the long term protection needs of the survivors was also highlighted. It found that while MSF had engaged with other stakeholders such as the police and legal services there was no systematized referral pathway that had been developed to support FSV survivors but rather done in an ad hoc way.¹¹ Without a clear referral system were many women and children were falling through the cracks. MSF saw a number of cases returning to the FSC as these women and children had no other option than to return to the dangerous and unsafe environment they had come from and face abuse again¹². The lack of a formal referral system was later partially addressed with the introduction of the Case Management Committee (CMC) that is currently operating and is seen as a model for case management work in the country.

Table 3: Tari Project

Tari, Hela Province	
2013-2014	2014-until the end of 2016
Overall Objective	Overall Objective
Decrease mortality and morbidity through access to quality emergency medical and surgical care, as well as medical and psychosocial care for survivors of sexual, family, and general violence in Hela Province	Decrease mortality and morbidity through access to quality emergency surgical care, as well as medical and psychosocial care for survivors of sexual, family, and general violence in Hela Province
Specific Objective 1	Specific Objective 1
Access to quality integrated medical and psychosocial care for survivors of sexual, family, and general violence in Hela province	The population of Hela Province has access to quality emergency surgical (including caesarean sections) services in Tari Hospital
Specific Objective 2	Specific Objective 2
Increased service uptake through acceptance of the importance and value of medical and psychosocial care for survivors of sexual, family, and general violence	Access to quality integrated medical and psychosocial care for survivors of sexual, family, and general violence in Hela province
Specific Objective 3	Specific Objective 3

¹⁰ MSF Brochure: Service for Survival, 2013

¹¹ Evaluation of MSF PNG Sexual and Family Violence Project: Lae October 2012

¹² Data from the PC hand over report highlight that out of a total of 10,305 survivors, 1092 or 11 % received care twice and there were also others who received care up to 20 times. 1307 Lae PC Final Report

The population of Hela province has access to services for life threatening medical, obstetric, and gynecological emergencies, delivered by NDoH with the support of MSF

Advocacy and lobbying with NDoH and Provincial Department of Health to provide staff and supplies in order to assume responsibility for FSC and surgical emergency services currently fully supported by MSF, which includes obstetric and gynecological emergency cases

Background

In 2008, a second project in Tari, Hela Province, considered to be one of the most volatile regions within PNG opened, and by 2009 MSF was offering emergency medicine and surgery for survivors of general violence and FSV, as well as a Mental Health (MH) component specifically for FSV survivors a similar package to what had been offered at the Angau Memorial General Hospital in Lae. In Tari Hospital, which was a district level hospital at the time, MSF co-existed alongside the NDoH. MSF ran two wards at the hospital, including both the Family Support Center (FSC) and surgical ward, and also provided support to the NDoH's gynecological department on caesarians. The provision of caesarians sections was a critical aspect of MSF's intervention given that there was not a national surgeon at the hospital. In 2010 Hela upgraded to a Province but without many substantial changes resource-wise, and it was only in 2015 that Tari Hospital was upgraded to a Level 5 hospital.

Meeting the objectives

Overall between the period of 2008 and the end of 2015 approximately 8,000 survivors accessed services. Like in Tari the majority of the cases were women and children and survivors of IPV. By 2015 the FSC caseload averaged to over 100 per month with numbers steadily increasing over time. These increases demonstrated that MSF maintained a high quality of service and it met its broad objective of decreasing mortality and morbidity through access to quality surgical, psychological, and medical care to survivors of both general violence and FSV.¹³

Unique to Tari project was the FSC MSF national staff that was trained to administer the 5 ES working in the Hospital as a completely separate structure. Links with the surgical department was a critical component to the intervention given the significant numbers of men, women and children who presented with physical and often life threatening injuries. In Tari, 99 % of survivors had been physically injured during their attacks and of these more than a quarter (28 %) needed treatment by a surgical team according to data gathered between 2008-2010. All non-emergency surgical cases were referred to the neighboring hospitals of Mendi and Mt. Hagen. Elective surgeries were also done however this was dependent on the existing staff including the profile of the expat surgeons and the corresponding Medical Team Leaders. Given the very high number of cases of FSV patients in need of surgery and the fact that there has not been a national surgeon recruited to date is a concern once MSF leaves given that it has filled that major gap since 2008.

Success/Challenges

The intervention in Tari suffered from on again off decision making throughout 2014 that started when there was speculation that Oil Search Foundation was planning on taking over the management of the hospital. The lack of clarity lasted throughout 2014 and had an impact on programming decisions within the project. With the Oil Search Foundation still in the picture, it took over the management of the FSC in December 2015 and an overall handover of the hospital to the Provincial Health Authorities (PHA) by MSF is scheduled to take place at the end of March 2016.

MSF's main achievements in Tari have been maintaining a high quality services and building the skills of 13 MSF national staff on treating FSV and providing minor and major surgical support and gynecological support to survivors in PNG. Protection from further violence once FSV survivors come for treatment, like in Lae, was a major concern. There is no safe houses or other services available to protect survivors from further harm. This resulted in a large number of survivors repeatedly seeking care.

IEC activities were in place beginning in 2013. However, despite that this was already being carried out repeatedly in trip reports taking steps to understand the community and/or engage with it in a meaningful way and developing a strategic approach to raising awareness was not carried out until close to the end of the project in 2015 when the expat IEC officer arrived in the middle of the year. Additionally, despite the overwhelming needs in Tari advocacy was not focused on the lack of referral services. The focus of the advocacy has been on security and lobbying the Provincial Health Authorities for recognition of the FSC and to encourage them to see FSV as health priority. Medical data collected in the Tari project was used to lobby for changes nationally. Sustainability is also a major concern dealt with at length later in the report.

Table 4: RTT

Regional Treatment and Training Programme	
2013 Overall Objective The mortality and morbidity of survivors of FSV in the NCD and targeted provinces in PNG is reduced due to improved access to quality integrated medical and psychosocial care.	2014/2015 Overall Objective The mortality and morbidity of survivors of FSV in NCD and other targeted provinces in PNG is reduced due to improved access to quality integrated medical and psychosocial care.
Specific Objective 1 Survivors of FSV in PoM/NCD have access to and use timely (<72H), quality integrated medical and psychosocial care.	Specific Objective 1 Survivors of FSV in NCD and other targeted provinces have access to and use timely (<72H), quality integrated medical care and psychosocial first aid (PFA).
Specific Objective 2 Survivors of FSV in targeted provinces have access to and use timely (<72H), quality integrated medical and psychosocial care.	Specific Objective 2 Survivors of FSV in NCD and targeted Provinces have access to mental health further support, with a specific focus on childcare.
Specific Objective 3 Increased general awareness and acceptance of the importance and value of medical and psychosocial care for survivors of FSV.	Specific Objective 3 Increased general awareness and acceptance of the importance and value of medical and psychosocial care for survivors by community and main referral partners (law & justice, protection, child welfare, etc.).
Specific Objective 4 Health authorities, policy makers, health professionals and partners are informed and aware of the importance and need for timely integrated medical and psychosocial care for survivors of FSV and cooperate actively on a country-wide multi-sectorial response to needs of survivors of FSV.	Specific Objective 4 Monitoring and evaluation system in place to facilitate continuity of integrated quality care by FSCs established with RTT support in NCD and other provinces through follow up visits.

Background

In 2013 once policy level change had taken place in the country, MSF carried out an assessment in Port Moresby and found that there was not a functioning FSC and access to care was both inadequate and inaccessible to FSV survivors in National Capital District (NCD). MSF launched a new intervention called a Regional Treatment and Training (RTT) programme to address this gap. The main focus of the intervention was in NCD with Port Moresby General Hospital (PMGH) central to the intervention with the health centers, including Mile 9 and Lawes Rd also part of the intervention. Alotau, Milne Bay, and also a district hospital in East Sepik in Maprick¹⁴ were also targeted for the intervention. Vanimo was also considered but never fully took off because of the lack of support from the NDOH. (As the evaluator was asked not to assess Mile 9, Lawes Rd or Maprick, when writing about the RTT will refer only to PMGH and Alotau).

Learning from the past

The approach used in the RTT was a departure from both Lae and Tari which was possible because the government had committed to addressing FSV at the policy level due to the advocacy carried out to get it on the government agenda. MSF provided hands on support to medical staff and treated patients hand in hand with the NDoH clinical staff, and trained them on efficient and quality medical and psycho-social care provisions.¹⁵ Data collection systems were also set up that are now uniform across the FSCs that MSF supported and that has allowed monitoring of caseloads across the board.

Given that MSF was working hand in hand with the NDOH, it required that hospital management dedicate NDoH staff for FSV work which was recognized as difficult to find because of the generally low healthcare staffing levels in PNG and because of the difficulty in freeing up medical staff for FSV work.¹⁶

In the case of PMGH, in order to be able to work within the PMGH, MSF was required to provide fifty per cent of the health staff and some other initial investments.¹⁷ Built into this agreement from the beginning hospital management at PMGH also contributed by providing dedicated human resources in the clinics to work alongside MSF in providing services for FSV survivors. Also as part of the agreement, the NDoH was committed to hire the MSF and national staff as part of the handover. The entire intervention took time to get started, as there was significant resistance from the FSC itself to work with MSF in this way. Once the collaboration was underway the intervention went smoothly as the FSC staff began to see the benefits of the interaction with MSF. Overall the intervention lasted about 9 months and was

¹⁴ Although Mile 9 and Lawes Road clinics had not originally been planned they were opened due to the lack of access to PMGH

¹⁵ 2013 ACP_POM_RTT_Project Proposal

¹⁶ 2013 ACT RTT Project Proposal

¹⁷ 2013 ACP POM RTT Project Proposal

finally handed over in June 2015 ¹⁸

Feedback from PMGH FSC staff in PMGH highlighted that partnering with MSF had a profound impact on the FSC. They said there was 1) increase of FSV survivors from 10 cases per month to between 100-200 per month, 2) awareness raising activities with village courts and police was effective in the uptake in services, 3) not only nurses but social workers were trained in providing 5 ES which they found to be hugely revolutionary and beneficial, 4) medical reports were completed in a much faster time than ever before from 2-3 months to 3-5 days 5) Child protection training was provided to all staff improving their skills with children, 6) MSF data collection tools were adopted in the FSC and utilized, and finally 7) as a result of the collaboration with MSF, the Australian government was funding the upgrade of the FSC.

Alotau differed as the FSC was already established and had been set up several years earlier with a social worker, a nurse, and two community health workers (CHWs). MSF provided training support and capacity building to the existing FSC staff, provided training to referral pathway partners, and introduced and trained FSC staff on data collection. The entire intervention lasted three months.¹⁹ Hospital management staff had specifically requested for MSF to support the FSC and their support for the intervention was a critical factor in its success. In fact they were so happy with it that they wanted MSF to assist in providing training to a health centre in one of islands to increase the overall uptake of services.

A 'flying' Information Education Communication (IEC) officer was hired for the mission and spent the bulk of her time carrying out the IEC component for the RTT. The main aim of the IEC work was to increase service uptake at the FSCs.²⁰ A major success of the RTT was the approach to the IEC work that effectively helped to increase access to services over time. As part of the awareness-raising activities carried out by MSF, referral partners underwent awareness training that resulted in their increased understanding of the urgency of referrals to FSC for treatment of FSV. The impact of this training was immediate with cases doubling in both Alotau and PMGH each month.

Strong outcomes

As of mid- 2015 both the PMGH and Alotau operate as fully independent FSCs with trained staff that provide the minimum package of 5 ES with options for other care through referrals. PMGH sees approximately 120 survivors of FSV, SV, IPV per month and in Alotau, approximately 30. Survivors in these locations also have access to mental health support beyond the psychological first aid provided as part of the minimum package of care. In total since the RRT began in 2013 there have been hundreds of FSV survivors that have received care with close to 80 per cent of this caseload treated at PMGH FSC. As will be discussed later the RTT project saw large number of cases of child survivors of sexual violence. These were even higher than in either Lae or Tari. In fact, in a six-month period between January and June 2015 reportedly over 60 per cent of the cases seen at PMGH FSC were girls under the age of 15 years old and in Alotau it was as high as 65 per cent²¹. In both PMGH and Alotau, the FSCs had child-friendly counseling rooms and PMGH had a child counselor.

One of the major concerns about this intervention was the leadership and decision-making process that went into closing the RTT. There was significant resistance from the RTT MSF staff with regard to the closure of the project that resulted in a full-fledged crisis impacting the entire project. The crisis around the RTT was extremely damaging to MSF internally. There were major concerns among those that did not support closing the project that the project had been closed too quickly not really allowing for all of the projects to fully develop.

Table 5: Solomon Islands

Solomon Islands	
2013 Overall Objective Improved health status for survivors of FSV in Honiara and Guadalcanal, Solomon Islands, with a specific focus on children	2014 Overall Objective Increase the visibility and recognition of the crisis of FSV across the Solomon Islands through the provision and scale up of FSV services in Honiara and Guadalcanal Province, Solomon Islands
Specific Objective 1 Survivors of FSV have access to and use timely (<72H) and quality integrated medical and psychosocial care, with special attention to child and adolescent survivors.	Specific Objective 1 Survivors of FSV have access to and use timely (<72H) and quality integrated medical and psychosocial care.

¹⁸ 2013 ACP POM RTT Project Proposal

¹⁹ MSF-PNG Regional Treatment and Training Project Coordinator Handover report

²⁰ 2013 ACP POM RTT Project Proposal

²¹ MSF PNG Mid-year report 2015

Specific Objective 2

Health authorities, policy makers, health professionals and partners are informed and aware of the importance and need for timely integrated medical and psychosocial care for survivors of FSV, especially for child and adolescent survivors, and act to make this care available and accessible

Specific Objective 2

Health authorities, policy makers, health professionals and partners are informed and make the necessary policy and operational commitments to ensure timely integrated medical and psychosocial care for survivors of FSV, especially for child and adolescent survivors, and to make it available and accessible in the Solomon Islands as well as across the Pacific region

Background

In an attempt to fulfill the organization’s commitment, set out in the Country Policy to be “the driving force in a greatly increased Pacific-regional response to the needs of patients affected by FSV, ultimately influencing the response to unmet needs in the Pacific region” in 2013 MSF carried out an assessment in the Solomon Islands. The assessment recommended that MSF set up an intervention there. After a year and no mission set up a second assessment mission was conducted and found that there were needs but an intervention by MSF was not justified as it may do more harm than good and be detrimental to local capacity²². In the end, a very modified form of the RTT programme focused on training and capacity building, with technical recommendations helping to establish links with the NDoH in PNG was set up. The main aim of the project was to increase awareness of the problem of FSV while increasing access to essential services for survivors through a three-month focused intervention.

Successes and Challenges

During the three months, the team focused on training and capacity building with designated nurses and clinical staff in both medical and psychosocial services, provided technical support and advocacy with a focus on recommendations on clinical guidelines and medical treatment protocols, established referral pathways inside the hospital and healthcare systems and carried out advocacy towards development partners to fill in gaps in care, and programmes and training to ensure sustainability of systems. Successes and challenges of the project, according to the closure report included increased access to care for survivors to services available for 24 hours, improvement in the identification of survivors through training nurses, increased focus on adolescents, and the recognition of need for a therapeutic counseling model.

The challenges highlighted included poor data collection and therefore difficult to know if care was being accessed, barriers to accessing care were not well understood, that the intervention was too short to see if desired changes took place, focus on young children remained a gap, low patient numbers did not give much opportunity for on the job training, training provided to nurses was not followed up due to time constraints, limited to Honiara, and a sense of missed opportunities by not doing any actual provision of care both as an opportunity for Solomon Islands as well as a learning opportunity for MSF²³.

Objectives not met

It appeared that the three-month intervention that focused most of its activities on training health staff was not the right approach to “Increase the visibility and recognition of the crisis of Family and Sexual violence (FSV) across the Solomon Islands through the provision and scale up of FSV services in Honiara and Guadalcanal Province, Solomon Islands.” as it has been written as the overall objective of the project. First of all, the project only took place in Honiara so there were limits to the approach geographically. Also in order to increase the visibility and recognition of the FSV and to achieve the second objective aimed at high level policy change it would require a very different approach than was implemented making the logic model inappropriate to reach the intended goal. It did however play a role introducing the idea of a combined medical and psychosocial response to FSV to health staff. However, beyond that, it seemed that the intervention was too short to have a lasting impact, which was evidenced by the follow up done in 2015 by two members of the CMT. Also it seems that specific objective 1 was not achieved which as the care provided in Honiara was not integrated and there were no reports of survivors accessing services under the 72 hours. While survivors may have done so, because of poor data collection it was difficult to show evidence of this.

In May 2015, approximately a year after the intervention had taken place, the 2015 CMT made a visit there. There had been a visit planned in December 2014 however had been postponed. This visit revealed that there were some services for survivors in Honiara although the overall approach was not integrated as counseling and medical services were in

²² Reassessment of the intervention in Solomon Islands-May 2014

²³ Solomon Island End of Protect report

different places and there were no services outside of Honiara. Essentially the assessment did not find a lasting impact and found a justification for MSF to again set up an intervention there²⁴.

Overall in a three-year period there were three assessment missions and a three-month intervention teaching and training health staff that in the end appeared to have had very little lasting impact. Two of the three assessments determined that MSF had an important role to play while the 2014 assessment recognized there was a need but that ultimately an intervention by MSF was not warranted. It is very unclear to the evaluator why the decision made in 2014 was not challenged and why in the end an intervention was done that was not realistically focused on policy change and only focused on providing training of health staff. It is not clear what the intervention hoped to achieve by doing that.

The 2013 assessment proposed to a focus on children. It is the belief of the evaluator that had the mission taken this proposal forward it would have been an opportunity to learn about addressing child related sexual violence. A focus on this issue could have been mutually beneficial to the Solomon Islands given that during the three-month intervention the team found significant barriers for children accessing care and to MSF’s understanding of providing support to child survivors of sexual and gender based violence both in the Solomon Islands and in the Pacific region more generally.

Effectiveness of each model based on patient’s access to care

Patient’s access to care: Timely availability, accessibility, appropriateness and quality of care

The measure of the effectiveness of a patient’s access to treatment for FSV is determined by the timely availability, accessibility, appropriateness and level of quality of health care that FSV patients have to services. These varied by location.

Availability of services

Table 6: Availability of care

	Lae	Tari	RTT-PMGH	RTT-Alotau	Solomon Islands
Availability of care					
Internal setup at the FSC level	24 hour Hospital based care with NDOH staff absorbed by FSC. Total of 10 staff working in the FSC	24 hour Hospital based care MSF staff only in both FSC and in hospital for referrals (surgery). 1 FSC supervisor and 13 nurse and counseling staff	During the week between 8-4 pm Hospital based care 1 Social worker who is overall in charge of four social workers, 1 Health Extension Officer (nursing supervisor), 3 nurses and 1 child counselor. 4 of the MSF health staff were absorbed	During the week between 8-4 pm Hospital based care FSC staff only-MSF playing a coaching role and training role only. Training including 1 coordinator /social worker and 2 CHWs	During the week between 8-4 pm Hospital based care provided

In Lae and Tari the FSC offers 24-hour service with full services available from 8-5 PM Monday through Friday with one FSC staff on call out of clinic hours. In PMGH and Alotau clinic services were being provided 8-4 PM Monday through Friday. After 4 PM and during weekends survivors are expected to seek out care at the emergency room of the respective hospitals with follow up with FSC the next day or after the weekend. The evaluator did have the opportunity to speak to the head of the maternity ward at PMGH during the field visit that said that during weekends if a FSV survivor came in she was directed to the maternity ward since this was a 24-hour service. It is difficult to know how this was working as no data was shared with the evaluator.

While the expat IEC officer was working with the RTT in 2014 and 2015, an emergency phone on a 24-hour basis was available. When she left the project this responsibility was transferred to a hotline managed by Child Fund.²⁵ It is unclear how this is working presently.

Accessibility of Services

²⁴ Follow up report in May 2015

Table 7: Accessibility of Services

	Lae	Tari	RTT-PMGH	RTT-Alotau	Solomon Islands
Accessibility of care					
Physical Accessibility	Transportation a challenge because of security	Transportation a challenge security and cost	Transportation a challenge	In Alotau not a challenge no access to much of the population in Milne Bay due to the fact of the Islands	Services only available in capital
Economic and psychological	Free, confidential and secure	Free, confidential and secure	Free, confidential and secure	Free, confidential and secure	Free confidential and secure

Physical accessibility

The ability of survivors to access FSV services was a major challenge in all projects; however, the reasons differed. This not only impacted the ability of FSV survivors to access services but also had a major impact on the ability of survivors to follow-up and for MSF to follow up their cases. In Lae as MSF had a decentralization strategy and through this they trained staff in four Health Centers making emergency medical FSV services available to survivors there.²⁶ Although unclear from the available data of the period of time that services were available at the Health Centres in total 601 survivors accessed services in these Health Centres²⁷. Major constraints due to a lack of human resources were cited and it was recommended that more could have been done through training and capacity building between the hospitals and the Health Centers to increase their capacity and motivation to work²⁸. Otherwise the only other option for medical and psychosocial services was hospital based care at the FSC. Transportation and security concerns were considered two main challenges accessing the hospital.

In Hela province the only available FSV services are in Tari Hospital. Transport is very limited, with the majority relying on public transport, foot or private vehicle. Few have access to an ambulance unless they can pay for fuel.²⁹ Since the beginning of 2015 a vehicle for FSV survivors is available and managed by a community police officer. FSC staff said that since this had been an option it has been used to transport survivors from the hospital to their home following care being provided at the hospital. Survivors to access the hospital did not use it. One of the main constraints with it was that the police officer was not always available. Papua New Guinea Australia Law and Justice Partnership (PALJP) who were slowly but increasingly showing commitment to addressing some of the referral gaps for FSV survivors in Hela province provided the vehicle.

In PMGH both the FSC and safe house staff highlighted lack of access to transportation as one of the most major challenges for patients to access care at the FSC. Although no ambulance service exists in National Capital District (NCD), reportedly there is G4S Meri Seif, an emergency hotline for survivors to call and they will be picked up at any time of day or night. Additionally, Population Services International (PSI) had reportedly started a referral transport from clinics to the hospital and FSC and police station between 9-5 PM;³⁰ and in 2015 the PMGH FSC had also received a vehicle to assist in the transport of survivors to the police and/or to safe houses.³¹ Despite these efforts made to address the challenges to transportation concerns accessing the PMGH FSC remained a major challenge.

In Alotau geographical challenges were the main issue preventing physical accessibility to the FSC, as over half the population of Milne Bay live in the 160 inhabited islands and access to the mainland is expensive and distant with few services outside of Alotau.³² Otherwise transportation within Alotau was not considered a major challenge. Discussions with hospital management revealed that they were interested in exploring how MSF could support them to further decentralize FSC services. It was suggested that the Health Center staffed by a doctor and medical staff was accessible to many of the other islands by boat be capacitated to provide FSV services.

Economic and psychological accessibility

²⁶ Although this did not include psycho-social care

²⁷ 1307 Lae PC Final Report in this report it highlighted that there was a mix of MSF staff and NDOH staff at the HC. It highlighted that in three of the HCs largely MSF treated patients directly while in one of the HCs they played more of a coaching role. A constraint identified by the Lae evaluation highlighted that a constraint was that there were insufficient NDOH human resources and there was no mention of the MSF staff treating patients.

²⁸ 130716 Kamalini Lae Assessment External + HOM.

²⁹ One patient who was interviewed said that she paid the fuel for the ambulance in order to get to the hospital to give birth. She said that the fact that the care was free made it affordable for her to pay for the fuel to get to the hospital. If the hospital had cost, then she said she would not have made it.

³⁰ MSF-PNG Regional Treatment and Training (RTT) Project Coordinator-Handover report

³¹ Interview PoM October 2015

³² Trip report Assessment –Alotau/Milne Bay September 2014

All MSF supported hospital based FSCs were secure, free of charge, and set up in a way that facilitates confidentiality. Accessibility of service was also facilitated by the fact that survivors are provided the most urgent medical and psychosocial services in one comprehensive medical session. This reduces the number of times that a survivor has to tell his or her story and reduced waiting time before getting lifesaving services.

FSCs varied by location. In Lae and Tari the FSC is integrated in the hospital so all patients are sent to a central waiting room. They are then triaged based on condition or injury. Patients in need of FSV services are sent to FSC waiting room, which is enclosed and separate from other patients. FSC services within Tari are well organized; child friendly, and counseling rooms are private. In Tari there is an overnight facility for survivors of up to 4 beds, kitchen and bathroom.

In Lae, PMGH and Alotau there are totally separate buildings from the hospital and set up with counseling rooms that are child friendly and separate rooms that are confidential. In both examples renovations were planned to make the facilities larger in 2016.

Free services

In all MSF locations free services were available. In 2009 the NDOH directed all hospitals to waive all fees for treatment of FSV survivors. While this was guaranteed in all facilities that MSF provided services in, it was not the case across the board as reportedly in other non-MSF supported FSCs this guideline is not always respected³³. In Solomon Island there was a policy of free care for survivors although it is unclear how well this was respected.

Interviews with patients in Tari Hospital overwhelmingly cited that having free services and security were the main reasons they were able to continually access services. A number of survivors talked about the fact that they were only able to access services because it was free, as they highlighted that there was no way they could pay for it. Another said that free service enabled her to spend the money on the transportation to get to the hospital as there was no way that she could have afforded both.

Quality and the Appropriateness of healthcare

Table 8: Quality and appropriateness of healthcare link

	Lae	Tari	RTT-PMGH	RTT-Alatou	Solomon Islands
5 ES Services available	Provincial hospital full range of services available and provided through nurse-based care used. MSF protocols ³⁴	5 ES fully available and provided through nurse-based care used. MSF protocols	Train NDoH staff on NDoH protocols for drugs and add a psychological first aid component	Train NDoH staff on NDoH protocols for drugs and add a psychological first aid component	Trained on MSF protocol however the services were not necessarily all provided in the same location by the same person. Not consistent medication available
Mental health	MSF counselors and nurses providing mental health support.	Nurse or counselor provided all 5 ES and if needed further mental health services would schedule second session or refer to MHO.	NDoH nursing staff would do all 5 ES and then sent to NDoH social workers for counseling and children were sent to MSF counselors trained how to deal with children.	Nurse and CHW do 5 ES and refer to FSC social worker for counseling, if too heavy would refer on to mental health department in hospital	Trained nurses and health staff in 5 ES including PFA
Availability of medical referrals	Yes, within hospital	Yes medical services such as surgery, minor operational theatre or	Yes, within hospital for both mental health and medical care	Yes, within hospital for mental health and medical care.	Medical referrals available within hospital

³³ MSF Brochure: Service for Survivors: A survivor centered medical response to family and sexual violence in Papua New Guinea: The experience of Medicines Sans Frontieres.

gynecological
No possibility
for further
mental health
support.

The 5ES Protocol³⁵ consists of medical first aid (including wound care and a medical exam), psychological first aid, post-exposure prophylaxis, and vaccines to protect against sexually transmitted diseases and other infections; and emergency contraception to prevent unwanted pregnancies. These services are provided in one location with a trained nurse or counselor providing all services, confidentially and free of charge.

This approach developed based on MSF's experience in Lae and Tari that took into account the scarcity of human resources in PNG (especially the fact that there are few available doctors and mental health counselors) and the urgent need to provide life-saving care to SV survivors. It is a survivor-centered approach to care that takes the popular one stop center concept a step further³⁶.

The survivor has only one place to go and only one health professional (instead of two or three) to recount his or her the experience. As a result, there is a reduced waiting time for the survivor, and even the turnaround time for the medical report is reduced in some places from up to a few months to not more than a week.³⁷

Survivors of SV and PEP

The 5ES comprehensively treats SV survivors, as the treatment protocol is geared towards preventing HIV-AIDs and unwanted pregnancies. In Lae data collected between 2008 and 2009 found that 83 % of all survivors of sexual violence and 65 % of those who came to the FSC within 72 hours and considered at high risk of HIV infection were prescribed PEP. In Tari data collected between 2009 and 2010 found that 70 % of all SV cases were considered to be at high risk of sexually transmitted infections and prescribed treatment. Sixty-five (65) % of the survivors who came into the FSC within 72 hours were considered high risk of contracting HIV and received PEP.

Lack of follow-up impacts on PEP adherence

The lack of follow up had implications for survivors who were provided with PEP and put on a 28-day treatment cycle. While MSF struggled to find solutions for it and put into place many initiatives such as calling survivors to remind them, providing them with the full cycle of PEP treatment and explaining the importance of following through on the full treatment, PEP adherence was generally low. Data collected between January and June 2015 highlighted that there was a high number of survivors defaulting with reasons cited that included lack of money for transport, inability to find transport and lack of understanding of the PEP treatment. Developing links with women's groups could be a way to understand better how to support survivors to improve adherence to PEP through seeking out advice and assistance.

Psychosocial support available in FSCs

In all the FSCs MSF supported, survivors had access to psychological first aid, counselling and (follow-up support to help patients find coping mechanisms in order to enhance their recovery). The amount of counselling time provided to each patient varied from individual to individual and the aim of the counselling sessions was to address symptoms related to anxiety, mood, and behavioural-problems.³⁸ In both Lae and Tari between 2008-2010 over 8,300 psychosocial care consultations were provided. The majority were provided at least one psychosocial counseling session and in Lae it was 90 % and in Tari 89 %. However, few came back for more even though it was available. The data showed that 72 % in Lae and 90 % in Tari who were discharged reported an improvement in their condition, and 66 % in Lae and 85 % in Tari reported an improvement in their daily activities³⁹. Although this data suggests that psychosocial assistance can be lifesaving, interviews with MSF mental health and PNG FSC staff highlighted that few seek out this kind of assistance beyond the first session where it is provided automatically. It was also highlighted as a challenge in MSF reporting documents. It seems in this case that more needs to be done to understand existing coping strategies so that they can

³⁵ There is a difference between the protocols that MSF uses and the ones the NDoH uses. For instance, PEP are different HIV testing protocols and NDoH require certifications that most MSF don't have.

³⁶ The one-stop center approach used in many countries around the world brings all the services to one place so the survivor only has to go to one place for their health care but normally the survivor would need to see more than one medical person to address their health care needs.

³⁷ Interview POM October 2015

³⁸ ASC Tari Project Proposal 2013

³⁹ Hidden and Neglected 2011

be further supported and stronger IEC messages on the benefits of psychosocial first aid after a traumatic event might be an important first step.

In Lae, PMGH, Alotau, and the Solomon Islands there were some options for counselling and psychological care beyond what was provided in the FSC that were available in the respective hospitals. The quality of these activities varied across the board.

Counselling services available for children was almost non-existent across PNG, it was only in PMGH that child counselling was available as part of the FSC. According to data collected on available services counselling a child must be done in the presence of a guardian. It focuses on alleviating emotional distress, identifying strengths and risks within the family and social environment, emphasizing the message that children are not to blame for abuse and should not be physically punished as a result of the abuse they experience. Supportive and protective individuals within the network are identified and encouraging adults to take responsibility for protecting children (and helping them identify strategies to do so) is also key and done. Teaching children and their carers some basic personal safety rules and giving children information about their basic rights (including sexual rights) in order to facilitate them in being able to protect themselves. Children and their caregiver can attend as many sessions as they wish, however in the experience at the PMGH it was anywhere between 1-5 sessions and usually 3⁴⁰.

High rates of IPV

According to the findings of the Lae evaluation, the ratio of IPV to SV cases between 2009 and 2012 was 2.50 to 1.0 and, in 2012, 59 % were IPV cases while 14 % were cases of SV. Data collected in both Lae and Tari between 2008 and 2010 found that out of 6700 survivors, a total of 5500 were medical consultations for IPV and FSV cases and the remaining 1200 were rape and SV cases demonstrating high numbers of IPV⁴¹. The evaluation raised questions about whether available services met their needs. Therefore, one of the essential questions raised in the Lae evaluation was whether and how existing FSC services originally designed for SV survivors met the needs of the IPV survivor. As a result, MSF's protocol recognized this and it evolved from counseling all survivors to providing psychological first aid, which is in line with internationally recognized guidelines on the treatment of IPV survivors⁴².

Links between mental health and violence

Data collected in 2014 in the Tari project highlight that there is much to learn about the link between mental health and IPV as reportedly of 796 clients almost half, 343 (>43%), had suicidal thoughts following an incident. According to the data, of the 343 clients, 74 percent suffered IPV, 25 percent of the 343 had suffered from sexual violence, and 1 percent suffered both.

Recurring patients

Another major challenge in providing services is the few options available to the survivor for protection from potential recurring violence⁴³. As the pattern of domestic violence tends to be repetitive and escalates over time the need to have safe locations and options for survivors is pressing as they are at risk of repeated violence, injury, and even death. According to MSF data collected between January and June 2015 more than one in every twenty survivors attending the MSF FSCs were repeat patients and 24 (out of over 1300) had come in following three or more incidents⁴⁴. In Lae the CMC has been set up to address this gap to further understand this aspect and help survivors find longer-term solutions beyond the provision of medical care⁴⁵. There has not been anything as comprehensive set up as the CMC in Tari, PMGH, Alotau, or Solomon Islands.

Male survivors

While services were available to everyone including men, there seemed to be skepticism among members of staff particularly in Tari as to whether men could be survivors of sexual violence. The conception among staff members was that the main reason for even reporting these cases was to get some form of compensation through the village court. However, there were a number of male victims of physical violence that were treated in the FSC as their cases had a

⁴⁰ Mapping of available services for children in PNG May 2015

⁴¹ Hidden and Neglected-2011.

⁴² Based on feedback provided on the report in January 2016

⁴³ According to a previous staff member in the project, there was some attention to providing perpetrators access to anger management classes although unclear as to what the overall impact was of this intervention.

⁴⁴ MSF UPR Shadow report PNG 2015

⁴⁵ The CMC is a separate NGO that works on behalf of survivors to assist them in addressing their longer-term protection needs.

family related connection and this kind of violence seemed more understandable to staff members. There was some recognition that there were a growing number of boys that were also survivors also further discussed below.

Table 9: Focus on Children by project

	Lae	Tari	PMGH	Alotau	Solomon Islands
Focus on Children	Children presented in the hospital but no special focus on children. Both the ER and pediatric ward were trained to encourage more internal referrals in the hospital. Police also referred children to the FSC.	Large numbers of children presented but no clear strategy to encourage more children to come to FSC. Child friendly room and group therapy provided on an ad hoc basis.	Is mentioned in the project proposal and training pediatric counselor was allocated. Referral pathway for children within hospital working well. There was an increase in the number of children accessing services especially for SV. Up to 60 percent of girls under 15	Is mentioned in project proposal, child friendly room, with therapy dolls, and some linkage within the hospital provided a high number of referrals. High rates of CSV were reported which was up to 65 per cent in 2015 of girls under the age of 15.	Highlighted in 2013 proposal but not carried out as originally proposed. Gaps identified in understanding barriers to accessing care.

Emphasis for the need to focus on responding to children including for both abuse and sexual violence cases, began from the early stages of the intervention. It was included as a focus in the Country Policy from 2007 and continually highlighted throughout the various projects. However while MSF did focus on children both through its advocacy and did see a growing number of children seeking health care through its programmes especially through the RTT, the focus that MSF gave to this was not commensurate with the urgency of the call⁴⁶. To date efforts to reach children at risk of violence have centered around creating child-friendly spaces and through providing specialized training with health staff as part of IEC services. In RTT, the IEC strategy targeted schools, including training teachers how to detect child abuse and to make them aware of what services are available. It was not clear if these activities were part of a project focused on children that was directed at higher level or from the initiative of the IEC team themselves. These efforts did result in an increase in numbers of children that accessed service over time as is highlighted below.⁴⁷

In all of the projects except for Tari, children were highlighted in proposals as an at risk group. In the Solomon Islands the 2013 intervention proposed a focus on children and adolescents. The feedback from the actual intervention was that there was a major gap with regard to children's access to services and a general lack of understanding of their barriers to care. This may have been a missed opportunity for MSF to learn more about addressing the needs of children had they taken on this intervention. In the other projects the lack of protective services available once children leave the FSC and return to the same potentially abusive and dangerous situation while a major concern could have benefitted from strategic and targeted advocacy by MSF.

As MSF does not often work in the field of child protection, this may have been an area that they did not have the right level of expertise at the managerial level to make clear decisions about. In PMGH there was an effort to map available resources for children in order to have a clearer understanding of what the available options for children. However these efforts were made late in the project. Additionally understanding patient's experience including children through carrying out interviews after services are provided and follow up after referrals are made are also good practice in order to be able to effectively advocate for increased legal, social and protection services. However it does not appear that this was practiced on a regular basis.

Data with regard to children accessing services throughout the various MSF projects is available. For example, in Lae from 2008 to 2012, 36 per cent of all females presenting for sexual violence were between 5 and 15 years old and 9 percent were under 5 years old. Males under 15 were also survivors of sexual violence and these numbers were reportedly on the rise. In Lae the evaluation found that the majority of the male survivors were younger than 16 years old and that the majority were survivors of sexual violence.⁴⁸ In Tari between January and June 2015, 37 % of the SV cases seen at the FSC were under the age of 15, and this represented an increase of 5 % in comparison with the same period in 2014. Of the 37 %, 9 % of the SV cases were under the age of five. In PMGH and Alotau, the majority were female sexual violence cases⁴⁹. Between January and June 2015 in PMGH it is estimated that 60 % of all cases were female survivors of SV between the ages of 0-15 years old and in Alotau estimates of female child survivors were higher

⁴⁶ This urgency was highlighted in the Lae evaluation, in MSF's advocacy reports as a focus in the RTT project, in the original proposal for the Solomon Islands' intervention and in various trip and assessment reports.

⁴⁷ The evaluator basis this assertion on the fact that

⁴⁸ 130716 Kamalini Lae Assessment External + HOM.docx

⁴⁹ MSF PNG Mid-year report 2015

at 65 % in the same age group⁵⁰. It is important to remember also that this is just the tip of the iceberg given the lack of available services at the district level and health care centers and the fact that it is extremely difficult for children to report.

Table 10: Available data on Female SV under 15

Project	Time-frame	Between 5-15 (%)	Under 5 (%)	Totals under 15 (%)
Lae	2008-2012	36	9	
Tari	January-June 2015		9	37 (an increase of 5 from 2014)
PMGH	January-June 2015			60
Alotau	January-June 2015			65
Soloman Islands	NA	NA	NA	NA

Where there were dedicated IEC services and referral partners, such as in PMGH and Alotau, there have been high numbers of sexual violence cases reported including high numbers of cases of children. In Alotau, this could be attributed to the relatively well-functioning referral pathway within the hospital. Referral partners including the police and welfare (CDS) also referred cases. According to data provided by the FSC in Alotau in 2015, 36 % of the survivors the FSC received were from within the hospital, 21 % from the police, 15 % from CDS, and approximately 24 % were self-referred⁵¹.

The Lae evaluation from 2012 highlighted that the most striking difference of referrals between adults and children are the higher proportion of children referred from within the hospital and police. The increase in the number of children presenting for sexual violence as a result of IEC activities in PMGH and Alotau highlighted to MSF how ill equipped all actors in PNG are in addressing child sexual violence. There are no safe houses for children in PNG and an insufficient number of staff trained to provide psychosocial care for child survivors. Within MSF there is a lack of an ability to follow up to see if other children in the family are at risk. Also violence against children is often dealt with through compensatory mechanisms within the local village court with the unity of the wantok group as the primary concern, which keeps children at risk, as there is no impact on the perpetrator.

The medical report: a form of protection for a survivor

Beyond keeping FSV survivors safe while they are in the FSCs, MSF’s other direct role in protection of survivors is through the provision of a medical report, which is prepared for all survivors of sexual violence. Later this was also extended to other cases upon the request of survivors. These reports contain a description of what the health worker has observed during the clinical examination and the patient’s own account of the violence. These reports can and are used by the police or in court as supporting documentation but not as primary evidence that the survivor has been examined and received medical treatment. However, they cannot and should not be used to indicate or interpret who or what caused those injuries. It is only the survivor, perpetrator and any direct witnesses who can provide this information. Medical professionals are not in a position to speculate or make statements about alleged perpetrators. MSF counsels all patients on the meaning and usage of medical reports and have collaborated with actors in the FSC, law and justice sectors to provide training on the uses and limitations of the reports in places where this was possible⁵².

Attitudes of staff

Another factor linked to quality of services are attitudes of the staff providing the care. In Tari one survivor who had received services in the FSC said how much she appreciated the FSC staff and compared them to the NDoH staff that often yelled and said derogatory statements to her and other patients. Interviews with FSC staff talked about the training they received and the importance of being conscious of their own judgments of patients. In PMGH and Alotau FSC staff talked about how the counseling training they had received from MSF had really made an impact on their professional and personal life. A number of them stated with satisfaction that their communication with survivors had improved over time and they were finding easier to gain their trust. They also talked about how both challenging and satisfying the work was. They said that counseling survivors of FSV was not for everyone and that those that came more naturally to it stayed on for life but those that did not were more easily likely to burnout. The only area of concern that

⁵⁰ There was also data gathered in Lae and Tari in 2008-2010 that highlighted high rates of child sexual violence. In Lae between January 2008 and June 2010 there are estimates of 49 % of children under the age of 18 who received services for sexual violence. In Tari it was significantly higher at 74 % under the age of 18, and 56 % that were 12 and under (between September 2009 and September 2010) based on data from Hidden and Neglected November 2011.

⁵¹ Although was not made aware of during the evaluation, apparently there were cases of child on child sexual violence reported within the teams. It was however not reflected in any of the monitoring reports and not highlighted by any former or current staff during the course of the evaluation

⁵² However, despite significant training and discussion there was a lot of confusion with regard to the medical report.

the evaluator observed in discussion with FSC staff in Tari especially were judgments about men who sought out services from some of the FSC staff discussed further below

Staff as survivors

Documents provided about the Lae intervention revealed that there was not enough attention focused on the fact that the majority of the PNG medical and counseling staff had also been victims of violence them. There was concern that not enough attention was paid to this issue by expatriate staff and even though assistance from the MSF psychological care unit was available few PNG staff made an effort to access it. Instead they opted to keep their experiences to themselves and whatever secondary trauma they may have experienced through hearing others' stories was also seemingly not expressed⁵³. In Tari this appeared to be addressed and caring for the medical staff that care for the survivors had been taken very seriously by MSF. MSF's psychological care unit paid visits to Tari staff once or twice a year to provide psychological support to staff. Feedback from FSV staff in Tari also reported that they felt that they were getting significant support from MSF.

Uptake in services due both to good quality and IEC services

Table 11: Increase/decrease of use over time

	LAE	TARI	PMGH	ALOTAU	SI
Increase or decrease of patients over time	Overtime numbers increased likely linked to MSF good reputation and due to outreach.	Overtime numbers increased likely linked to MSF good reputation in Hela province. Outreach also had some impact	Significant increase in numbers prior to MSF's intervention and afterwards. Also training police was effective and impacted numbers of child survivors	Increase of patients when MSF was carrying out outreach and also as a result of awareness raising with referral partners. In hospital training also increased numbers/	Data not collected so no clear patterns established

An indication of quality health care is the increased use of services over time. There were increases in the numbers accessing services in all locations. According to data collected from Lae and Tari in the periods that both FSCs were fully operational from 2010 to 2013, there was an increase in number of survivors accessing services over time with a major peak in 2012 where a total of over 4000 survivors sought out services, which was a significant increase from 2011. Data gathered later in Tari between 2014 and 2015 also revealed an increase. For example, the 608 survivors who sought out treatment at Tari Hospital between January and June 2015 represented an increase of approximately 23 % in comparison with 2014 for the same period. This was especially notable considering that during that period there was insecurity due to tribal fighting in the beginning months of the year. This made it difficult for some to get to the hospital. However, despite this there was still an increase in the number of survivors seeking care.⁵⁴

Table 12: Outreach by project

Outreach by project	Lae	Tari	PMGH	Alotau	SI
IEC/Outreach	Had a dedicated IEC team from the beginning of the intervention but their effectiveness fluctuated with level of interest of each project team.	In planning proposal but modified version implemented with MHO overseeing, later IEC officer attached to programme	Integrated and integral to the programme. Expat IEC officer and outreach team assigned	Integrated and integral part of the programme IEC officer and outreach team attached to programme.	Focus heavily on training of medical staff and no IEC officer

Lae

Feedback on the Lae project revealed that while awareness raising work had been planned for and implemented from 2012. The level of consistently in which it was carried out and its effectiveness seemed to fluctuate depending on the various project teams throughout the project period⁵⁵. Training in gender awareness to village court magistrates was considered a useful community based awareness raising activity. Awareness raising with the police also had an impact

⁵³ 1307 PC handover report 2012

⁵⁴ MSF six-month report 2015

⁵⁵ This information came from feedback on the document itself provided in January 2016

on the number of cases of sexual violence that were referred. An evaluation of the project carried out in 2012 in Lae highlighted that uptake in services was mainly based on self-referral that demonstrated that as women heard about the services they were able to access them. Regarding children, the main referrals came from within the hospital and police, highlighting the importance of these targets for increasing the uptake of services for children.

Tari

Interviews with survivors in Tari Hospital revealed that the uptake in services was mostly through survivors who had heard about services from others, or from others who had become aware of them through hearing about it in the market from a neighbor or friend. In the 2013 project proposal for Tari there were relatively extensive plans in place for IEC activities including for an expat IEC officer (attached to the RTT project) to utilize part of the time for activities in Tari. This plan did not materialize in 2013. IEC activities reportedly did start in November 2013, but not in the manner envisioned in the 2013 proposal based on a decision by the CMT for the IEC officer to be attached to the RTT project only. Still however with the more modest approach carried out, there was reportedly an increase in the number of cases of SV presenting in less than 72 hours, which was attributed to the IEC activities.⁵⁶

In June 2015, an experienced IEC officer, who had already been working in PNG in the RTT project, was deployed to Tari on a full time basis to carry out IEC activities and manage a team. This request came in June 2015 following a field visit from the Medical Coordinator who felt that the project needed a more robust outreach strategy, and especially important was engagement with rural health care center staff on the referral pathway and assessment of their capacity in terms of staffing and skills.⁵⁷ There were a number of reasons given for not carrying out IEC services in the community including from concerns about security linked to the general violence that took place outside of the hospital structure, to not having the right staff and/or also the 'on again off again' approach to Tari impacting on programming decisions.

Gaps with regard to a clear IEC strategy and dedicated resources were highlighted on a number of occasions including by the SV health advisor in 2013 in her trip report and then again by the Humanitarian Advisor in November 2013 during her visit to Tari. In her trip report, she writes, "Outreach provides an opportunity for two-way dialogue – we can listen to the community and learn from them to better adjust our own communication and strategy. Building stronger relationships with the community potentially also allows us to assess if there is any potential for community mobilization towards increased grass roots demand for services and perhaps even upwards pressure toward the CEO."⁵⁸

It is important to note that just knowing about services does not necessarily mean they are accessible, and it is this reason that a two-way dialogue is valuable as it helps to understand essential information about the community such as who is the first point of contact for women, for children, who can they trust with information, and where can they go for protection. Given the very few actors and few referral options in Tari, developing links with the community is critical. However, this more proactive approach did not really take place until 2015 when the Expat IEC officer came on board. The links that the IEC team was making with women's groups in October 2015 were invaluable as the women's groups had networks throughout Hela province that had significant potential to reach women and children with information. While it was extremely positive that this work was being done, the evaluator considers not getting involved in the community in this way earlier on as a missed opportunity for MSF.

RTT

The IEC work carried out in and around PMGH was very effective in increasing the uptake of services. It was estimated that after training with specific groups, including police and clinic staff, referrals to the FSC almost doubled. Between January and October 2014 before the training was carried out there were 17 referrals per month; after the training started in November they jumped to 36 and remained steady for at least the next six months.⁵⁹ With village courts the messages were to help them understand the referral pathway, the urgency of getting SV survivors to care within 72 hours and providing them with hotline numbers. Clinics that had access to SES were also targeted. Schools were targeted with a heavy emphasis on helping teachers detect signs of child abuse and awareness about the referral pathway.

According to data collected from Lae and Tari between 2008-2010 the majority of survivors presented within 72 hours of the violence they experienced. In PMGH over a six-month period between January-June 2015, out of a total of 498

⁵⁶ ACP Project Progress report

⁵⁷ 1505 Tari Medco 1st Field visit trip report (with comments)

⁵⁸ Humanitarian Advisor trip report November 2013

⁵⁹ Outreach Closing Report-2015

survivors treated in PMGH, 66 per cent presented within 72 hours. This also coincided with significant work done on awareness raising activities by the IEC officer and the team in PMGH with this message as central.

In Alotau IEC activities were prioritized. The IEC team was called in two months after the project in Alotau started, reportedly to help increase the uptake of services. Once IEC activities started in January 2015 the average monthly numbers of survivors accessing the FSC doubled from 7 to 14 while IEC work was happening, and reportedly decreased back to 7 once the IEC activities stopped.⁶⁰ During the evaluator’s field visit to Alotau, the FSC staff noted the impact that the IEC activities had had while MSF was providing support and highlighted that IEC activities had been a key component that was missing in their current activities.⁶¹ It may be important in any future intervention that IEC activities for FSV become attached to other health education or outreach activities of the hospital and/or to become part of the curriculum of community police in order to bring more sustainability to the overall programme.

Radio programmes that focused on simple messages were also used in Alotau and PMGH. In NCD however, it was limited because of the cost of Public Service Announcements (PSA).⁶² Radio programmes are often good interventions as they are resource friendly and help to continue to send messages long after the original support is gone. But it is also difficult to measure their impact unless specific data is collected on understanding this.

Engaging with the referral partners and the development of the referral pathway to impact the uptake of services were major priorities for MSF in PMGH and Alotau. A priority was to ensure that referral partners were not only aware of FSV services but saw the medical aspects of the response as lifesaving and therefore to ensure that survivors go to the FSC prior to going to the police or safe house. This concept seemed to be well understood among the various referral partners in Alotau and consequently referral numbers from partners reflected that understanding.

There were also high numbers of referrals from within the hospital, (especially useful in detecting cases of violence against children). In PMGH initially there was a lot of resistance to doing awareness rising in the hospital, with activities only starting in 2015, just months before MSF was no longer involved in the project. However, the cause of the resistance was addressed and referrals within the hospital are reportedly working well⁶³.

Referral partners in PMGH recognized MSF as being instrumental in helping to bring greater clarity on the referral pathway through training and provision of referral pathway sheets.⁶⁴ Additionally key stakeholders also acknowledged the role of outreach in PMGH as key in helping them understand the link between the medical parts of the response to the other needed services. Through workshops run by MSF and with the IEC team in particular it really helped referral partners understand the response fully, including their own role in it.⁶⁵

Table 13: Availability of Referral Pathway

Referral pathway	Lae	Tari	PMGH	Alotau	Solomon Islands
Referral pathway	Yes-safe house, police, legal, case management, later a CMC was developed to support survivors in finding long term solutions.	Only police but very limited, one MSF short stay unit, no legal, mostly village court with medical report for compensation	In June 2014 Family and Sexual Violence Action Committee (FSVAC) activated with agreement on referral pathway. Police, legal, safe house	Yes- police, legal, and limited safe house. FSVAC at capital and not involved in direct supervision of services.	Existence of referral pathway including police, legal, safe house, and community center

Government options for protection

Forms of protection available in PNG for survivors included reporting cases to the police, applying for interim protection orders through the court, repatriation of women back to their own families, taking cases to the village court for compensation and accessing safe houses. All of these options were available in varying degrees by location and also had varying degrees of impact that also varied by location. Overall however protection from reoccurring violence remained a major issue throughout the project period in all locations and across PNG.

⁶⁰ Outreach Closing Report-2015

⁶¹ Interview, Alotau October 2015

⁶² Outreach Closing Report -2015

⁶³ Interview POM September 2015

⁶⁴ Interview POM, October 2015

⁶⁵ Interview, POM, October 2015

The police have set up Family and Sexual Violence Units in selected police stations throughout the country. These units are supposed to be trained to deal with cases of family violence. Since the set up in 2007 their effectiveness has had mixed results.

The legal backing of Interim protection orders (IPOs) is court ordered protection orders that can be administered by the District Court directly to survivors. These are derived from the most recently adopted Family Protection Laws which criminalizes marital rape, recognizes domestic violence as a crime, and highlights and facilitates the use of IPOs as a temporary form of protection by a survivor. A medical report is not required but it can strengthen a case.

The welfare office is responsible for at risk children. However, they are chronically underfunded and not seen as a viable agency to protect children.

Safe Houses are a temporary location for someone to seek out safety for a short time from a few days to a week to provide some form of protection to FSV survivors. There are an insufficient number of safe houses in PNG. There are no safe houses available for children at all.

The effectiveness of the advocacy in reaching project goals

National level Advocacy

MSF's primary advocacy goal according to the country policy" is to create broader access to integrated care for survivors" and the secondary goal is "ensuring access to referrals for other-sector services (law and justice, social welfare or protection) or broader mental-health services."⁶⁶

MSF has been extremely successful with strong and effective advocacy done at the national level on getting the health response to FSV on the NDOH's agenda and effectively meeting its primary advocacy goal. With regard to its second goal of ensuring access to referrals for the other-sector services including (law and justice, social welfare, protection or broader mental health services; these results have had more mixed.

The success of the first advocacy goal is linked largely to the instrumental role MSF played ensuring the implementation of the operational guidelines that provide the framework for service provision in health facilities throughout PNG. The urgency for the adoption of the guidelines was a major focus of MSF's advocacy report "Hidden and Neglected" that was published and launched in November 2011. In 2013 the PNG government published the *Guidelines for PHA/Hospital Management establishing hospital based Family Support Centres*. These provided instructions on the levels of care and priority services in Family Support Centres. The full package of essential services for medical and psychosocial care, outreach services, referrals to other key services and safe dispatch of survivors⁶⁷

Another major achievement has been the role that MSF has played in the development of soon to be adopted *Clinical Guidelines for the Medical Care and Support of Survivors of Sexual and Gender-Based Violence* in Papua New Guinea, based on MSF protocols scheduled to be adopted in late 2015⁶⁸.

Feedback from stakeholders revealed that the positive approach used by the 2013 CMT team has been a crucial factor in MSF's achievement of both their programme and advocacy goals. Beginning in 2013 when the Head of Mission arrived in the country he consciously took on developing key relationships at the national level, with organizations such as the FSVAC and other key stakeholders. Simultaneously the Medical Coordinator worked closely with the NDoH at the technical level to influence the development of the clinical guidelines. A very high point in MSF's tenure in PNG was prior to and leading up to the November 2013 conference that MSF put together in partnership with FSVAC and NDOH.

Representatives of the police, the FSVAC, the diplomatic community, and safe house representatives from NCD and Alotau spoke glowingly of MSF's role during and in the lead up to the November 2013 conference. Actors referred to MSF as a major player on FSV including being referred to as" a team player" and" taking the lead both medically and through advocacy on FSV".

⁶⁶ Country policy 2013

⁶⁷ MSF-UPR Shadow Report PNG-2015

⁶⁸ The drafting and the approval process started in 2013 and since then have undergone a number of delays and by August 2015 no new draft had been approved or adopted according to the MSF PNG UPR shadow report.

The November 2013 conference: *A comprehensive response to Family and Sexual Violence in PNG* was considered a huge milestone by all actors involved. It really put MSF on the map as a major medical player on the issue of FSV in PNG. The conference was the first time actors from a range of different sectors and levels were brought together including health, legal, police, safe house, and social welfare at the national level. They were drawn from a total of nine provinces throughout the country. The aim of the conference was to start the process of setting up a proper referral system between providers with the hope of creating a better overall referral system within each province. The goal was to have concrete action plans from the 9 provincial delegations (including direct service providers from the health, child/social welfare or safe house, and law/justice/police sectors) to increase services and referral pathways in 2014 and 2015.

The next step in the advocacy work nationally, according to the RTT project proposal, was to set, advocacy activities in line with national strategy and according to the results and follow-up to the November 2013 conference's provincial roll-out strategies. Specific actions may include tailored advocacy for each location according to the barriers for survivors to access the 5ES (e.g., lifting fees for survivors). The other part of the advocacy work would be to select priority provinces for intervention based on the national advocacy strategy, conference outputs, and the likelihood of successful implementation of the MSF model of care⁶⁹

Yet this shift in focus did not materialize and the work of the HAO ended up staying at the national level, focusing on monitoring the results of provincial plans and trying to get the various Steering committees to function⁷⁰. After much effort by the HAO to carry this out with significant effort put in and little to show for it, in July 2014 the CMT made a decision to reduce involvement in these activities.

The work of the HAO then shifted to mapping the status of all FSCs countrywide with the aim to raise other actors' awareness on current gaps and to support RTT in the identification of future intervention sites⁷¹. It is important to note that the mapping was done based on information provided by NDOH and not gathered physically by MSF.

Project level advocacy

The focus of the conference and subsequent plans of identifying specific actions tailored to different locations addressing survivors' barriers to access to care, although never materialized, made sense as a next step in the advocacy work. This plan coincided well with MSF's second advocacy goal of, ensuring access to referrals for other-sector services (law and justice, social welfare or protection) or broader mental-health services, and was consistent with the messaging used in *Service for Survivors*, an advocacy document provided to participants at the November conference.

Service for Survivors reiterated key messages such as framing FSV as a medical and humanitarian emergency, the importance of the 5 ES as a key treatment for FSV survivors, and the importance of data collection in particular collecting data that not only includes the sex and age of the survivors but the nature of the violence experienced by survivors. MSF argues that reflecting this kind of information will help to motivate decisive action by a range of actors especially around the need for services to go beyond medical and psychological care including legal, access to safe houses, police, and child protection services.

Focus on advocacy again reemerged in 2015 with a new HAO joining the team. Again the HAO worked at the national level producing a report focused on the lack of services and safety for survivors of FSV. It highlighted that the true extent of FSV in PNG is still very unclear due to the lack of consistent data collection and available statistics, it highlighted the high instances of violence against children, and that despite the awareness now within PNG of the medical and psychological impact on FSV survivors and their need for services, there are glaring gaps in service provision both medically with insufficient numbers of FSCs functioning around the country and in terms of addressing women and children's long term protection needs. It highlights the lack of safe houses and the very few options for children's protection overall including insufficiency in the laws.

It appeared that MSF's advocacy has been strong and momentous since 2011 beginning with the release of *Hidden and Neglected* and in 2013 in the lead up and during the November 2013 conference as a major high point. In 2014 similar to other aspects of the mission, the project came to a virtual standstill including its advocacy. While the advocacy has

⁶⁹ 2013 ACP PNG RTT Project Proposal

⁷⁰ Based on Field Interview October 2015

⁷¹ 2014 ACP PNG COORDINATION

been extremely successful at the national level leading in policy and attitudinal change about Family and Sexual Violence, project level advocacy has been virtually absent. Although data was gathered from the projects the information was used for national level advocacy rather than at the project level to make any concrete changes for survivors.

Although there were plans to move the advocacy to the local level these plans never materialized. In fact, in Tari there was no engagement with the community outside of the hospital and none of the advocacy efforts focused on trying to help women and children address any of their long-term protection needs. Despite that the Family and Sexual Violence Action Committee (FSVAC) was not yet operational and the formal referral pathway in Tari comprised of only the police and MSF, MSF did not see a role in highlighting the gaps that existed at this level.

In PMGH and Alotau, MSF’s participation in the FSVAC and the IEC’s awareness-raising work made MSF more aware of the gaps in the referral pathway however the team did not develop any in depth plans to advocate on these issues.⁷² In the Solomon Islands the advocacy focused on getting development partners to fill in gaps in services and like other projects of the intervention it was too short without follow-up to have any lasting impact. In Lae although MSF had left the scene by the time the Case Management Committee (CMC) had been created, the need to develop a more systemic approach was drawn from the awareness that came about because of the existence of the FSC itself.⁷³ Prior efforts to address long-term protection needs had been done by MSF in Lae but only in an ad hoc way.

The sustainability of each mode of care and the impact on the project

Table 13 Level of Sustainability by project

	Lae	Tari	PMGH	Alotau	Solomon Islands
Sustainability	Lae remains sustainable and considered a Centre of Excellence for FSV in PNG	Lack of sustainable a concern. The FSC itself planned for referenced throughout; not prioritized and will result in a difficult handover.	Sustainability built in absorbing MSF into NDOH structure. The eventual support of the hospital management was critical in the long-term success.	Sustainability built in through having trained existing NDOH staff that is still linked to the project. Strong supports from hospital management also a critical factor in the success of the project.	Although there were plans for sustainability built into the programme by training of staff however after the three-month intervention there was no follow up by MSF. Therefore, gains made during intervention were not sustained.

Lae

In Lae there were initial concerns about the ability of the FSC to be sustained given the manner in which the intervention had been set up with MSF virtually taking over an existing structure? However, the establishment of a Centre of Excellence where medical staff from PNG came for training has ensured its sustainability as this has attracted donors ensuring greater sustainability. Additionally, the FSC continues to provide quality medical and psychosocial care to survivors. Also the CMC is...

Tari

The sustainability of the FSC in Tari Hospital is reliant upon the sustainability of the hospital itself. The sustainability of the hospital is therefore an issue that will impact the sustainability of the FSC. MSF will be handing over the surgical unit and the FSC to the hospital. Both international and national staff expressed concerns about the handover of the hospital with doubt expressed as to whether the Provincial Health Authorities will manage to keep the hospital secure and running smoothly to maintain quality services that are free of charge. If free care is not available, this would have a major negative impact on patient’s access to care including in the FSC.

Concerns about the sustainability of the FSC

⁷² RTT Handover report 2014

⁷³ Based on interview with Ume Wainetti of the FSVAC in October 2015.

There was also concern about Oil Search Foundation keeping their commitment of taking over the FSC as they had verbally committed to taking over the responsibility of paying staff salaries⁷⁴ Questions from current, mostly expat staff, were concerned about sustainability specifically concerned with how and why there had not been more integration or at least some steps taken by MSF at an earlier stage to integrate the FSC with the rest of the hospital. They observed that in fact “everything we do except assist in caesarian cases is separate—we don’t have joint trainings or meetings—there is nothing that brings us together.” In fact, one person described the set-up as the most difficult because handing over two wards in a hospital that has been operating separately from the rest of the hospital for many years—especially the FSC that did not reasonably conform to hospital standards—would be a major challenge. It was also noted “everyone from the CMT on down knew how difficult the structure would be to hand over, as these issues have been raised repeatedly.”

The sustainability of the FSC as a unit

Several staff made statements such as “The FSC is ready to be on its own—the staff are trained and can easily run on their own.” FSC staff made similar comments. Although while they did express their willingness and eagerness to work and to continue to work, they were concerned about their own safety and their ability to continue to work in the same way that they had been able to with the support of MSF in the future work. There was concern expressed for the safety of the FSC staff by MSF expatriate and national staff given the nature of the family violence in Hela province. One person said, “Having an FSC is dangerous because women are at the center of the conflicts and the war can play out in the hospital.” Several incidences of this had already occurred in the hospital, giving some real credence to this statement.

The aspects that are not necessarily sustainable are the size of the FSC team, linked to the difference in numbers of the NDoH structure in other FSCs. However as long as Oil Search Foundation keeps committed to taking the management of FSC and pays salaries, the size of the staff is less of a concern in the medium term. In the long term it could be a concern as other provincial hospitals in the Highlands, especially, have smaller numbers of staff in their FSCs. In Mende, a neighboring province, for example there is only two staff in the FSC as opposed to Tari’s fourteen. Additionally, caring for the medical staff that cares for the survivors has been taken very seriously by MSF. MSF’s psychological care unit paid visits to Tari staff once or two times per year to provide psychological support to staff. It is not clear who from Oil Search Foundation would take on this responsibility. Careful management of staff care is important in order to prevent staff burnout and if not addressed well could also impact on the sustainability of the project. This is also a concern for staff in the other FSCs however as they had greater integration in the hospital this is something that should be negotiated internally.

The RTT

In the RTT, the sustainability of the project was prioritized given the lessons that had been drawn from Lae and Tari. The PMGH and Alotau continued functioning once MSF handed over demonstrates a level of sustainability in these interventions that seemed to be well thought through from the planning stages. For instance, in order to be able to work in PMGH, MSF was required to provide fifty percent of the health staff and some other initial investments.⁷⁵ Built into this agreement was the NDoH’s commitment to provide dedicated human resources in the clinics to work alongside MSF in care provision for FSV survivors. NDOH also was required to hire the staff once the MSF project closed. This approach used proved to ultimately be successful as the staff that had been hired by MSF to work with the PMGH were retained.

The key elements that have led to sustainability of service was not only equipping staff with sufficient skills that helped them to feel confident in their work. One staff said, “I know exactly what to do when a patient comes in. This gives me so much confidence in myself. I really know how to help someone.”⁷⁶ The strategy of supporting staff to do the work on the job was key to the strategy rather than MSF doing the work they. Also noted was the data-monitoring tool that was provided was easy to adapt. It was also clear from discussions with hospital administrators who had initially requested for MSF to support the Alotau FSC that they were well aware of the activities, supported them, and understood the importance of the interventions. These were all critical factors that helped to sustain the services over time.

Solomon Islands

⁷⁴ On a number of occasions over the years, Oil Search Foundation had expressed interest in taking over the hospital but in the end failed to follow through on their intentions. In fact, for most of 2014 MSF was under the impression that Oil Search Foundation would take over the management of the hospital and finally in October 2014 they released a formal statement that they neither promised nor intended to take over the management of the hospital

⁷⁵ 2013 ACP POM RTT Project Proposal

⁷⁶ Interview Alotau October 2015

It appeared that the three-month intervention that focused most of its activities on training health staff without policy change at the national level was not the right approach to reach the intended goal. As a result, the impact was not sustained. The project only took place in Honiara so there were limits to the approach geographically. Also in order to increase the visibility and recognition of the FSV and to achieve the second objective aimed at high-level policy change it would require a very different approach than what was implemented making the logic model inappropriate to reach the intended goal. It did however play a role in introducing the idea of combining medical and psychosocial services to address FSV laying down the groundwork for future work with the staff. However, beyond that, it seemed that the intervention was too short to have a lasting impact, which was evidenced by the follow up done in 2015 by two members of the CMT.

The effectiveness of internal management and coordination

Table 14: Level of internal management by project

Internal set up	Lae	Tari	PMGH	Alotau	Solomon Islands
Set up	Full team with Project Coordinator, Medical Team Leader, MHO and outreach logistics	1 Project Medical Team Leader, nurse, surgeon anesthesiologist sharing support with hospital and logistics Mental Health Officer and outreach with full team. IEC officer-in-2015	1 Project Medical Team Leader, Information Education Coordination officer, MHO, and logistics	PC and MTL support from Capital and MHO, Nurse, 1 IEC Officer and logistics	3 experienced medical staff including nurse, psychologist and midwife and logistics.

Structurally largely like a classic MSF project

Largely the PNG project has been run as a classic MSF project with HOM, Medco, Finco, and Logco, based in Port Moresby providing support to projects through PC and MTL in Lae, Tari and RTT and to the Solomon Islands. The less usual addition to this set up has been the HAO at the national level as a relatively constant feature throughout the intervention period. Additionally, at the project level an IEC Outreach officer was initially assigned to the RTT project and then these resources were transferred to Tari when the RTT project closed.

At headquarters, along with the management support from the OD and OA in Berlin there were multiple advisors supporting and advising the project. These positions included the Health Advisor, a SV Advisor, a Mental Health Advisor, and two Humanitarian Affairs Advisors—one who had specific skills in understanding SV issues and another who specialized in medical advocacy. The support provided was split between Berlin and Amsterdam.

At the project level the set-up of the projects has varied quite significantly with more MSF-like conventional set ups in Lae and Tari while RTT and the Solomon Islands have used less of a conventional MSF approach. For instance, in the Solomon Islands three staff were deployed including a psychologist, a midwife and a nurse. Also in the RTT project staffing has been varied but with a PC for overall coordination and otherwise with a range of health and mental health staff deployed based on perceived needs. In Lae and Tari there were more conventional full-fledged project set-ups.

Another difference in the projects has been the use of existing NDOH or FSC staff in the case of Alotau and Solomon Islands and providing support to them through training and capacity building, while in Tari and initially in Lae and PMGH, MSF hired staff and implemented the project.

Interestingly one important requirement of the RTT and Solomon Islands projects was to ensure any staff deployed required sexual violence and clinical experience in providing medical care for survivors.⁷⁷ It is not clear why this was not required across the board or if this was a technical medical requirement. However, in any case, this same requirement should apply across all those working on missions that involve SV work, and that key management and support staff have some knowledge and interest in SGBV and community approaches.

As discussed in the chapter on advocacy, in 2012 and 2013 especially with the work done in the period during and in

⁷⁷ RTT project proposal SCP

the lead up to the November conference, MSF was playing a major role in PNG on FSV with strong leadership from the HOM and Medco. This was in sharp contrast to the 2014 CMT which was in contrast to the previous leadership in almost every way.

The situation that developed in 2014 coincided with the timing of a new HOM and Medco in PNG and the new Health Advisor and Operational Director at headquarters in Berlin. Early on in 2014 a crisis involving the entire coordination team in Port Moresby and the RTT project developed which eventually developed into a situation that had implications for the entire project, even the Tari project that was not centrally involved.⁷⁸ Headquarters staff also got pulled into it as the communication broke down at the field level. The crisis was centered on the disagreement with the decision and its rationale to close the RTT project especially and the overall mission in general. On top of that disagreement there were major personality clashes within the CMT and/or between RTT and the CMT.

Discussions about the closure of the RTT and the project as a whole started with the CMT in April 2014 and the decision was based on the interpretation that the criteria of, "Demonstrable and sustained accessibility of integrated clinical services for FSV survivors in 5 or more provinces without MSF involvement"⁷⁹ had been achieved.

Yet despite this fundamental difference of opinion that had huge implications for the project there did not appear to be any clear process for constructively discussing this issue as a team nor did there appear to be any clear and concrete evidence backing up this opinion that the mission objectives had been achieved. Although there had been a recommendation to carry out a physical assessment it did not appear that this recommendation was carried out in 2014. In 2014 the OST made a decision to close the mission.

The events of 2014 brought up a number of ongoing tensions that exist within the organization. First of all, it clearly brought out the tensions that exist within the organization about whether MSF should work in developmental contexts or rather stay focused on situations of natural disasters and armed conflicts. It also highlighted how important leadership is both at the field and headquarters level to manage team dynamics in order to prevent situations from getting out of hand. It highlighted the importance of ensuring that any MSF leadership and technical staff should have experience and interest in working on SGBV and community oriented projects.

CONCLUSIONS

The evaluation assessed the effectiveness of each of the projects based on project objectives, the availability and accessibility of patient's access to care, the effectiveness of the advocacy in reaching project goals and improving patient's access, the level of sustainability of the projects, and the effectiveness of the internal management and support.

Effectiveness of the intervention

Overall the projects in Lae, Tari, and the RTT effectively met the overall objectives of each of the projects. However, in the Solomon Islands the strategy designed for the intervention was not an appropriate approach to meet the goal and therefore not effective. This fact not only made it difficult to reach the goal but to have a lasting impact.

Overall between 2007 -2015 approximately 20,000 survivors of FSV, IPV, and SV were provided medical and psychosocial support. These interventions were carried out in hospital based FSCs, and in healthcare centres.

- In Lae between 2007-2013 approximately 11,000 FSV survivors accessed services.
- In Tari between 2008 and 2015 approximately 8,000 FSV survivors accessed services
- In the RTT and Solomon Islands between 2013-2015 approximately 1500-2000 FSV survivors accessed services⁸⁰

There was also evidence of increased use of services over time. By 2015 the FSC caseload in Tari averaged over 100 FSV survivors per month with numbers steadily increasing over time⁸¹. In the PMGH, staff highlight that following MSF's support, there was a massive increase, from 10 FSV survivors accessing services per month to 100-120 per month with these numbers being maintained today.

⁷⁸ The impact on the Tari team was indirect and centered around the fact that during this period they made a point of interacting with.

⁷⁹ MSF-PNG Regional Treatment and Training (RTT) Project Coordinator Handover report 30 November 2014

⁸⁰ This is a number estimated by the evaluator

⁸¹ In Tari survivors of both general violence and FSV also had access to surgical care.

Key to the Lae and Tari interventions were the show by doing aspects and the collection of data needed in order to do the advocacy. Additionally, in Tari where there was no existing structure MSF trained staff and did the implementation themselves. Also, in Tari and Lae, MSF had more control over the quality of care provided than in the other projects. For instance, it could guarantee 24-hour access to services while in PMGH and Alotau this was not available. It is also important to state that the RTT project was only possible following the policy change that took place in PNG as a result of the advocacy carried out by MSF based on what they learned from the Lae and Tari project. There is an important sequencing that was needed in PNG which MSF followed. Sustainability of the approach in Lae and Tari were a concern. However, in Lae this was ultimately addressed following the hospital hiring MSF staff that had been trained. In Tari the long-term viability is still in question.

Effectiveness in terms of accessibility and availability of care for FSV survivors

All survivors in all locations have access to free services, in a confidential and secure location provided by qualified and well-trained medical staff. In Tari, access to services are maintained at 24 hours a day and in the other locations between 8-4 PM during the weekdays and on weekends, survivors are referred to emergency room at the hospital. Toll-free hotlines are also available. Transportation was a concern in all locations limiting access due either to cost, security or both. FSC services remained at the level of the hospital as health clinics struggled to provide FSC services due to insufficient numbers of available health staff and a lack of dedicated FSC staff. It was only in places where dedicated FSC were available that it was possible.

MSF promotes a survivor-friendly approach to accessing FSV services. This approach was largely developed by MSF based on its experience in Lae and Tari that took into account the scarcity of human resources in PNG (especially doctors and mental health counselors) as nurses and counselors are trained and equipped to provide urgent life-saving care to survivors of FSV. The many advantages to the provision of care have been the reduced waiting time for the survivor, that the survivor only needs to tell his or her story one time in order to receive life-saving care. A medical report is also provided as evidence of the health impact of the violence to provide to the police, for compensation in the village court, or for an interim protection order.

While minimum package of 5 ES was available throughout all the projects, the range of other critical services varied by location. An overview of these are listed in the table below:

Table 1: Range of services available by location

Availability of FSV services	Lae	Tari	RTT-PMGH/Alotau	SI
Minimum package: 5 ES including Psychological First Aid	Yes	Yes	Yes	Not all in the same place
Other Mental health	Yes, within hospital	No	Yes, within hospital	Some access
Surgical	Yes, within hospital but not MSF run	Yes, within hospital and MSF run	Yes, within hospital but not MSF run	Some in hospital
Referral Services Police/Legal/Child/Safe House	Yes, to some degree	Only police and limited	Yes, police, legal, child welfare, but limited access to safe houses	Some within

IEC services were utilized in all locations and were considered especially effective in the RTT projects with a dedicated IEC officer attached to the project. In both PMGH and Alotau following awareness training workshops carried out with referral partners, referrals doubled in both locations and remained steady for several months after that. In both Tari and Lae, they could have benefitted from consistent and strategic approaches to IEC as their effectiveness fluctuated with the interest levels of the various teams in the project. However, across the board, following awareness raising activities numbers of survivors accessing services within 72 hours to obtain needed lifesaving treatment, especially children, increased in all the projects. Targeted awareness raising activities were considered more effective with increased numbers of referrals coming from police and within hospitals following the trainings.

Emphasis for the need to focus on responding to treat children for abuse and sexual violence began from the early stages of the intervention. It was included as a focus in the Country Policy (2007) and continually highlighted throughout

the various projects. And while MSF did provide some child friendly services to children including provision of staff with specialized knowledge in counseling children, the mission's response to the needs of child survivors did not meet the urgency of the original call and there was little to no advocacy focused on the situation of children. For instance, a 2013 assessment of needs in the Solomon Islands identified a need to focus on children and adolescents as central to the intervention. In 2014 upon a reassessment of the situation, an MSF intervention was deemed unwarranted except for some technical assistance. In the end it was a missed opportunity for MSF as barriers for children had in accessing care was highlighted as a key challenge.

Additionally, what still persists today are the few options available to survivors especially children for protection from potential recurring violence. As the pattern of domestic violence and child abuse repeats and escalates over time the need to have safe locations and options for survivors is pressing as they are at risk of repeated violence, injury, and even death. According to MSF data collected between January and June 2015 more than one in every twenty survivors attending the MSF FSCs were repeat patients and 24 (out of over 1300) had come in following three or more incidents. MSF plays a protection role through ensuring that medical reports are available free of charge for survivors to use in court, in a police case, in the village court for compensation, or for obtaining an IPO. However, more is needed for both their protection and for their protection in the longer term.

Effectiveness of advocacy to reach project goals

MSF's national level advocacy has been extremely effective. Their national level advocacy has made the health response to FSV central to the government's national agenda. It has been instrumental in pushing forth and influencing the content of two major policies that have transformed the response to Family and Sexual Violence in PNG.

The first are the *Guidelines for PHA/Hospital Management establishing hospital based Family Support Centres* that provide instructions on the levels of care and priority services in Family Support Centres. The second major achievement has been the instrumental role that MSF has played in the development of the *Clinical Guidelines for the Medical Care and Support of Survivors of Sexual and Gender-Based Violence in PNG*. These use the 5 ES piloted by MSF in Lae and Tari as the basis for these guidelines.

The work done in Lae and Tari, the release of the advocacy report, *Hidden and Neglected* in November 2011 and the significant relationship building done in 2012 and 2013 by the CMT really centered MSF as a major player in PNG on FSV. The lead up and during the conference in November 2013 went even further as civil society more broadly began to see MSF as a major player and MSF gained significant respect from key community and government actors such as the FSVAC and the NDoH in PNG.

MSF along with community and government actors brought for the first time ever, representatives from around the country including medical, legal, psycho-social, and safe house partners to the national level to discuss increasing protective services for survivors at the provincial level to a national conference in November 2013. The goal was to have concrete action plans by each province for increased referral services by 2014 and 2015.

Coinciding with this, next steps in MSF's advocacy work were to move the national advocacy to the local level as a follow-up to the November 2013 conference's provincial rollout strategies. It was planned that tailored advocacy plans would be developed at the provincial level such as lifting fees for survivors or addressing transportation challenges. Although this seemed a national progression for the advocacy and made a lot of sense and a good plan, the shift in focus did not materialize and the work of the HAO ended up staying at the national level. The failure to shift the focus was a missed opportunity as both a learning opportunity for MSF to understand clearly what barriers exist for survivors at the project level and provide them tools for addressing them and as a way to help increase access to the services more substantially at the project level.

The level of sustainability of each of the projects

There is clear evidence of sustainability in the Lae and RTT interventions. In the RTT the sustainability of the project was prioritized given the lessons that had been drawn from the Lae project. Built into the agreement was the NDoH's commitment to provide dedicated human resources in the clinics to work alongside MSF in care provision for FSV survivors. NDoH was also required to hire the staff once the MSF project closed. This approach used proved successful as the staff that had been hired by MSF to work with the PMGH was retained. Additionally, utilizing an on the job training approach provided staff with practical skills with the opportunity to ask any questions or deal with any problems as they arose.

However, in Tari while the FSC staff were sufficiently trained and qualified to operate on their own without continued support from MSF by the end of the project, the long-term sustainability of the hospital in which the FSC was based was in question. It was unclear, if without the continued support of MSF, whether the hospital would remain secure and services would remain free of charge, including FSC services putting sustainability in question. In the Solomon Islands the intervention although introduced the concept of integrated care of medical and psychosocial care to nurses and medical staff, this did not lead to policy changes that were needed and as a result there was not a lasting impact. The Solomon Island intervention would have benefitted from an intervention that demonstrated to high level health officials the value of the 5 ES through setting up a Lae like intervention to demonstrate it.

The level of effectiveness of the internal management of the project

At the project level the setup of the projects has varied quite significantly with more MSF-like conventional set ups in Lae and Tari while RTT and the Solomon Islands have used less of a conventional MSF approach. For instance, in the Solomon Islands three staff were deployed including a psychologist, a midwife and a nurse. Also in the RTT project staffing varied but with a PC for overall coordination and otherwise with a range of health and mental health staff deployed based on perceived needs.

Following a strong and productive period between 2011-2013 where there were significant gains made on the project including MSF being recognized and respected as a key actor on FSV in the PNG, the project took a very different and unproductive direction when the Country Management Team changed in 2014. A crisis involving the entire coordination team in Port Moresby and the RTT project developed following the decision made to close the RTT project and the mission more broadly in September 2014.

There was a major disagreement within the team with the decision and the rationale behind it yet it was communicated as a decision and not a discussion, which led to a complete breakdown in communication within the team. Additionally, there were major personality clashes within the CMT and/or between RTT and the CMT that further exasperated the situation.

Headquarters were pulled into the crisis as communication broke down at the field level. Finally, headquarters acted and this resulted in a number of staff being let go and others leaving on their own accord. By early 2015 an entirely new coordination team was in place.

Although the decision to close the project in PNG was supported by the Management Team at headquarters the lack of support of this decision at the field level was not well managed and resulted in a serious crisis that impacted the entire intervention. While project closures are always difficult in any organization including MSF, the impression from some MSF staff was that there should have been action taken from headquarters to address the situation earlier at the field level that may be reduced the impact of what eventually took place.

MISSED OPPORTUNITIES, LESSONS LEARNED, and RECOMMENDATIONS

The successes have been highlighted and along with them there have been a number of lessons that should be acknowledged and learned from, good practice that should continue or be repeated elsewhere, and missed opportunities that should be highlighted

Table 2; Missed opportunities by location

Missed opportunities	Lae	Tari	PMGH	Alotau	Solomon Islands
Key issues	Maintaining closer links to Lae after 2013 in order to have a better understanding of the CMC in order to incorporating a CMC approach to protection	Working with the community earlier on in the intervention as an opportunity to learn about the culture and how to support locally developed protection strategies	Mapping of available services for children earlier on in the project. And then carrying out more advocacy around the lack of services for	Providing training to Health Centers that would provide access to services for the majority of the population of Milne Bay	Focus on children as a learning opportunity, introducing an integrated model of care, and making strong links with the NDOH in PNG

	outside of the health services.	especially through links with women and youth groups	children outside the FSC		
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Short and light intervention is preferable once policy change has taken place

One of the lessons learned from the RTT was that, if MSF was to support a short and light intervention of treatment and training, strict minimal criteria for intervention should to be in place. This included dedicated NDoH staff assigned to the FSC, available and motivated staff to continue after MSF’s departure and the hospital commitment to organize and prioritize the service and to refer patients from other wards. Additionally, having access to a referral network or at least some services available outside the hospital structure is a priority.

However, an important lesson to also take from the Solomon Islands’ intervention is that this approach is only possible after policy change has taken place at the national level with clear support from the government at the national level. In the Solomon Islands a short and light investment of training and capacity building was not effective because there had not yet been the needed change on the policy level first. Therefore, in any new location where MSF may consider introducing this minimum package of care, the organization needs to engage in policy level change as a first priority.

Availability, accessibility, quality, and timeliness ensures needed care

FSV services need to be provided in a secure environment and free of charge at the very least by a well-trained medical staff. Services should be available on a 24-hour basis and accessible. Services should be age and gender specific. The nature of the violence and the perpetrator should be understood and part of the analysis for a better response.

Awareness raising needs to be central to the project and strategic

Awareness raising strategies should be central components to all FSV interventions and strategies to raise awareness need to be adapted to the situation. Dedicated staff and resources should also be attached. Awareness raising and IEC support were provided in all projects, their effectiveness fluctuated and were dependent on the interests of teams and/or leadership at any given time. The strategies used in the project were also largely focused in one direction, which was extremely effective when engaging with referral partners and hospital staff with the aim of increasing the number of referrals to the FSC.

Some lessons from the IEC work include:

- A strategic approach that is targeted to specific groups had a greater impact than less directed non-strategic approaches such as carrying out general awareness raising in the market (IEC officer)
- Engaging police resulted in higher numbers of referrals of child survivors of sexual violence to the FSC (PMGH, Lae)
- Awareness raising to hospital staff on available FSC services resulted in higher numbers of referral of child survivors of sexual violence. (Alotau, Lae)

Two-way dialogue is also needed especially in places where there are no referral partners such as in Tari. Engagement with the community is critical. This can be done by ongoing focus group discussions in the community, small focused outreach activities, exit interviews with survivors and engaging with women, youth, or church groups to network and develop strategies.

Engagement with survivors should also go hand in hand to ensure their concerns, ideas and needs are also part of the awareness raising strategy. This includes ensuring that survivors understand the importance of seeking lifesaving care, know how to access vital services, and go beyond that to include developing an understanding of what prevents or constrains potential survivors from seeking care. Strategies should be sex, gender, and age friendly and take into account understanding the various points of contact in the community, their role in the community and then taking steps to engage with them.

Leadership should understand community approaches and SGBV projects

Evidence suggests that further intervention is needed to be guided by CMT leadership who embrace community approaches, have an understanding and interest in SGBV projects and feel excited and challenged by out of the box thinking. In fact, any staff working or supporting these types of projects should also have this understanding and interest.

Greater focus on provision of mental health services

In this project little was known about what happens to survivors once they leave the FSC except that there is a great likelihood that they will return to the same dangerous environment that they came from. This reality has been demonstrated by the high number of survivors returning for services in the FSC. MSF has also gathered compelling data on the mental health status of IPV survivors that should be further explored. The data suggests that those that seek out psychological services are benefitting from these services, however only a fraction of survivors are seeking these services out.

A Centre of Excellence should be set up in Tari, or a context like Tari, where there are a high number of IPV survivors and where there are few referral services available to meet their needs. This includes working with women's groups and other community structures to help try and address some of the protection and mental health services gaps especially for FSV survivors including children.

Testing a decentralization strategy: Milne Bay

In Alotau geographical challenges were the main issue preventing physical accessibility to the FSC, as over half the population of Milne Bay live in the 160 inhabited islands and access to the mainland is expensive and distant with few services outside of Alotau. Discussions with hospital management revealed that they were interested in exploring how MSF could support them to further decentralize FSC services. It was suggested that the Health Center staffed by a doctor that was accessible to many of the other islands by boat be capacitated to provide FSV services.

Understanding children's barriers to accessing care: Solomon Islands

The 2013 assessment proposal for the Solomon Islands focused on children. During the three-month intervention the team found significant barriers for children accessing care which they were unable to fully explore because of the short time frame for the intervention and because it was not the focus of the intervention. However, it is the belief of the evaluator that had the mission taken this proposal forward it would have been an opportunity to learn about addressing child related sexual violence. A focus on this issue could have been mutually beneficial to both the Solomon Islands given the gap identified and an important learning experience for MSF for the Pacific Islands more generally.

Moving MSF advocacy from the national to the FSC level

The focus of the November conference and subsequent plans of identifying specific actions tailored to different locations addressing survivors' barriers to accessing care and their long term protection needs, although never materialized, made sense as a next step in MSF's advocacy work. The logic of this plan took the focus of the advocacy to local level and coincided well with MSF second advocacy goal of "ensuring access to referrals for other-sector services (law and justice, social welfare or protection) or broader mental-health services." It was also consistent with the messaging used in *Service for Survivors* advocacy document provided to participants at the November conference.

In any future interventions, ensuring there are staff and resources available such as an HAO or IEC officer dedicated for these tasks should be prioritized to ensure that project level advocacy takes place..

Stronger more focused advocacy on the experience of children is needed.

MSF has strong and compelling data on child survivors of abuse and sexual violence from all of the projects. IEC activities highlighted the importance of ensuring that children have access to services and as a result MSF saw a steady increase in children accessing services. The organization took steps to improve the health response for children through training health staff in child related counseling and equipping at least one center with staff with specialized skills. However, the long-term protection concerns of children at risk of recurring violence and child abuse remained a major gap.

In future interventions simultaneous to strengthening the health response steps should be taken by MSF to play a stronger role in finding solutions for survivor's long-term protection needs through using their data to advocate. Advocacy, mapping services, and/or making links locally are a starting point. For advocacy along with collecting information on numbers efforts should be made to understand the experience of the children through interviews and focus group discussions with children and their caregivers. Follow up in the community should also be practiced and while this is labor intensive it does provide the organization with a better understanding of the experience of the children to be in a better position to advocate on their behalf through not only knowing realistically what to advocate for but how and who to advocate to. These same strategies can apply to all survivors. A greater focus on understanding the experience of men and boys is also needed.

Introducing the 5 ES model to resource poor countries outside the region including in Africa, the Americas, and Asia should be considered.

There are a number of countries around the world that could benefit from ensuring that survivors receive the basic minimum of care such as the 5 essential services offered by MSF. Additionally, given the lack of human resources in hospitals in many countries in Asia, Africa, the Middle East, and the Americas, and that incidences of family and sexual violence remain high introducing an approach that trains one medical staff to be able to provide survivors with lifesaving care should be introduced elsewhere. This would assist Health ministries in many countries to respond to SGBV and help thousands of survivors by increasing their access to quality, available, accessible, timely, and appropriate healthcare services. MSF would need to start much the way that it did in Lae or Tari with first demonstrating how it works by doing it themselves and showing that it is possible.

ANNEXES

ANNEX I: TERMS OF REFERENCE

1. Background and Context.

High levels of family, sexual and general violence occur in all regions of PNG and impact on most of population regardless of age and gender. The prevalence of rape and Intimate Partner Violence (IPV) in PNG is reportedly higher than almost anywhere else in the world. In 2008 a study found that 58% of those interviewed had suffered physical or emotional abuse in relationships; 47% reported financial abuse; 44% reported sexual abuse; and 38% reported social isolation. Child survivors of Family and Sexual Violence (FSV) are particularly vulnerable also because of their inability to seek care independently of a parent, and because of the stigma attached for young survivors.

The endemic nature and high rates of violence within the family impacts on women and children most dramatically and the government's lack of ability to address it adequately through state structures contributes to it being deemed a humanitarian emergency compelling MSF to respond. The government's inability to adequately respond to the medical and psychosocial needs of the population are influenced by lack of policing and protective or enforcement capacity, lack of social welfare systems and lack of legal or administrative capacity.

2. The Project's purpose

MSF Operation Centre Amsterdam (OCA) first came to PNG to explore the need to address FSV in mid-2006. Beginning in 2007 MSF opened up a project in Lae supporting the so optimist Foundation to run the Women's and Children's Support Centre (WCSC) in the Anjou Memorial General Hospital and by 2008 had taken over the entire programme.

In 2008, a second project in Tari opened and by 2009 was offering emergency medicine and surgery for survivors of general violence & FSV, and a Mental Health (MH) component specifically for FSV survivors. In 2013, MSF closed the project in Lae and handed it back to ANGAU NDoH hospital, and launched a new Regional Treatment and Training (RTT) project based in Port Moresby (PoM).

3. Objectives of the Assignment

MSF feels it is important for the organization to document and evaluate the interventions to address FSV in PNG with the overall aim of understanding which strategies worked the most effectively within PNG and those that can also be utilized in other similar contexts. Therefore, the purpose of the evaluation is to determine the effectiveness and sustainability of various modes of care that MSF has employed to address FSV in PNG. This includes looking at each mode of care in its own right and the intervention as a whole. This will include looking at the 2 different modes of care primarily which are: direct service provision and community supplied by MSF- The Tari and Lae Projects and working under the umbrella of the NDOH as the RTT. Training of health was carried out in the Solomon's Island, however the evaluator will not visit there. The assessment of this project will be done through the literature review and interviews with staff. For each mode of care and as a whole this intervention will include:

- Looking at how effective the theory of change met project objectives,
- Effectiveness of the various projects from the patient's perspective
- Purpose and effectiveness of the advocacy
- Level of sustainability
- Effectiveness of the internal management and coordination of each project and as a whole including support provided by MSF Berlin and OCA.

Criteria to consider for each intervention	Tari and Lae	RTT	Solomon Island	Project as a whole
Type of project	Direct supervision and	Working under the umbrella of the NDOH	Training only	Overall addressing FSV using a range of approaches in PNG

	community outreach			
Theory of change-did strategy meet projected outcomes				
Internal make up				
No of patients accessing care			Focus would be on numbers trained	NA
Level of sustainability projected				
Overall benefits				
Overall challenges				

The focus of this project is largely to understand the effectiveness and sustainability of the modes of care employed and how the project operated as a whole. The following questions will be used to guide the evaluation process including the development of data collection tools, identifying those who will be interviewed and the setting up of the field visit.

Evaluation Criteria and Questions	Targets	Methods/Tools	Verification
Theory of change			
How effectively did each model of care address the issue of FSV in the PNG context?	Project documents Patients MSF staff Other key stakeholders working on FSV	Literature review Workshop style meetings FGD Individual interviews	Analysis of the numbers of patients that were reached and the quality of care that was provided through interviews with patients and PNG government officials, and other key stakeholders.
How effectively did the theory of change for each strategy meet the projected outcomes?	Patients and former patients MSF staff and staff of other programs Government medical staff	Literature review Interviews FGDs Workshop style meetings	Analysis of theory of change and project outcomes compared with interviews with MSF Staff.
Internal set up			
How did the internal set up impact the effectiveness of the various modes of care that MSF set up?	Project documents Patients and former patients MSF staff and staff of other programs Government medical staff	Literature review Interviews Workshop style meeting	Analysis of staffing levels, qualifications, and overall management of project linked to each project
How effectively did the internal set up impact on the overall project work as a whole?	Project documents Patients and former patients MSF staff and staff of other programs Government medical staff	Literature review Interviews Workshop style meeting	Analysis of timeline linked to staffing, decisions about the project, and outcomes of projects be established

How did the support from MSF-OCBe, OCA impact on the effectiveness of the project?	Project documents MSF staff from both headquarters and project level	Literature review Interviews	Understanding perceptions or impressions through interviews and written documentation from MSF at the OCA, MSF-Germany with that of those at the field level from HOM on down to the project level
Patients access			
How effective was each approach to ensure patient's access to services?	Patients and former patients MSF staff Government medical staff	Literature review FGDs Individual interviews Workshop style meeting Participant observation	Feedback from patients cross checked with views of MSF and other government FSV service providers to gain a comparative view
What kind of impact did MSF's project have on the needs of the target beneficiaries?	Patients and former patients Family members of patients MSF staff and staff of other programs Government medical staff	Literature review FGD Individual interviews	Analysis of responses from patients, family members of patients and MSF staff
Advocacy			
How effective was the advocacy strategy in contributing to the project outcomes for each mode of care?	Project documents, advocacy strategy Patients and former patients MSF staff and staff of other programs Government medical staff	Literature review Individual interviews FGD Workshop style meeting	Analysis of the advocacy strategy in relation to achievements made by the advocacy
How did MSF's advocacy impact on addressing FSV in the PNG context?	Advocacy strategy, advocacy docs, and project documents Patients and former patients MSF staff and staff of other programs Government medical staff	Literature review Individual interviews FGD Workshop style meeting	Taking into account MSF, patients, government, and other FSV stakeholder's views
What kind of impact did the project have on other service providers that MSF partnered with?	Project documents Patients and former patients Staff of other programs Government medical staff MSF project staff	Literature review Individual interviews FGDs	This would be verified largely from discussions and feedback from government service providers, other service providers and patients.
Coherence/Sustainability			
How effectively will the different modes of care	Project documents MSF staff and staff of other programs	Literature review Individual interviews Workshop style meetings	Analysis of project documents, conversations with

be sustained once MSF leaves?	Government medical staff		MSF management and Government stakeholders
How effective were the strategies put in place to ensure sustainability of the projects?	Project documents Patients and former patients MSF staff and staff of other programs Government medical staff	Literature review Individual interviews FGD Workshop style meeting	Analysis of strategies put in place to projected impact of project.
How has MSF contributed to the national strategy to address FSV?	Project documents Patients and former patients MSF staff and staff of other programs Government medical staff	Literature review Individual interviews FGD Workshop style meeting	Analysis of national strategy and timeline of MSF interventions and outcomes
Lessons Learned			
What were the overall successes that should be replicated?	Patients and former patients MSF staff and staff of other programs Government medical staff	Literature review Workshop style meeting	Based on the overall analysis of the project
What were the challenges and how were they overcome?	MSF staff and staff of other programs	Literature review Workshop style meeting	Based on overall analysis of the project
What overall lessons can be drawn to be used in other similar projects?	Patients and former patients MSF staff and staff of other programs Government medical staff	Literature review Workshop style meeting	Based on overall analysis of the project.

4. Overall conduct of the evaluation

The participation of MSF in the evaluation

A key aspect of the approach that the evaluator will take is to work in a participatory manner along with MSF staff to carry out the evaluation.

5. Key targets

MSF-Germany

Norman Sitali
Musa Hamdan
Christian Katzer

MSF-OCA

Meggy Verputten
Giovanni Pintaldi
Pete Buthe

Former MSF-PNG staff

Paul Krugman
Pete Rinker
Elisa Galli
Jean Stowell
Emmanuelle Privat
Adele Springer
Sean Healy
Sebastian Dietrich

Christina Mach
Aleem Shah
Camillo Gomez
Bianca Tolboom
Ruth Lea Kaufman

MSF-PNG

Port Moresby MSF Coordination Team

HOM

Medical Coordinator

Non MSF-NDOH-Medical director

RTT

Port Moresby

Alotau

Tari

MSF-Project Staff-International and national staff

Project Coordinator

Medical Team Leader

Tari Hospital government health staff

Community Stakeholders

Patients and former patients (if there is a way to talk to them without a lot of effort made to organize them).

6. Methodology

The evaluation will use a mix of document review, qualitative research methods, and collection of quantitative data with a view to triangulating data from at least two different sources.

1) *Initial information gathering meeting* will serve as a key information gathering exercise to learn about the programme from the perspective of the staff and to ensure that expectations for the evaluation are clear.

2) *A validation meeting will take place* at the end of the field research with key MSF and other key stakeholders to validate findings. This will be followed by an overall presentation of findings to senior management staff of MSF prior to leaving. The agenda for that meeting will be put together during the course of the field research.

3) *Semi-structured individual interviews.* Semi structured interviews are the most reliable method for understanding behavior change as people are best placed to know, themselves, if there has been changes in their attitudes at the different stages of the project and what the catalysts were that led to those changes. Key informants will provide some of the richest sources of data through individual interviews.

4) *Group meetings or focus group discussions* will take place. These are used to gather a large amount of information quickly. Same sex groups of 5-7 people are grouped together.

5) *Participant observation* at police stations and medical centers will also take place to increase the understanding of attitudes more generally. It will also be useful to understand the environment in which survivors are seeking assistance and the quality and availability of services there. This will be done as a purely descriptive exercise through noting down what it observed.

6) *A document review* will supplement all of the methodological strategies described above. Project documentation will help to contextualize evaluation questions properly, as well as help the evaluator understand challenges/obstacles and changes in programmes. Relevant quantitative data from the MSF programs and government partners including police stations, health care centers, and village courts will also be used to corroborate and support overall findings.

Tari

The evaluator will arrive in Tari on the 25 September and leave on the 2 October 2015. During this period the evaluator will carry out interviews with MSF-staff, Government health staff, community stakeholders, patients and former patients (if possible). Prior to the visit it would be ideal if the team there identified key community stakeholder for the evaluator to interview and hold focus group discussions with. The main focus of the interaction with the community stakeholders is to understand the effectiveness of the approach and project from their perspective. She will also visit the hospital to observe the situation there.

Port Moresby

The evaluator will spend from 2 October to the 12 October in Port Moresby with a one-day visit to Alotau to visit the Family Support Center there. During this period, she will interview the MSF coordination staff to understand the project as a whole and MSF staff working more directly on the RTT. Additionally, the evaluator will interview the key stakeholders from the government and the community for their views on the project overall. She will visit FSCs to interview patients and former patients if possible. More details will be provided on the 24 September when the evaluator arrives in Port Moresby.

On the 10 October a validation meeting with key MSF staff and partners will be held. An overall presentation of findings will also be provided to MSF coordination prior to leaving on the 12 October.

7. Limitations and issues to take into account

As with all methodologies, this one has its limitations.

Key limitations the evaluator note is:

- Given the natural tendency for the implementers of programs to be wary of "evaluators" and cautious about the information that they share, every effort will be made by the evaluator to ensure this process is a learning experience. Therefore, as much as possible the evaluator will use participatory methods and be as inclusive as possible in her approaches to the evaluation. Additionally, it is expected that staff working closely with the evaluation will help to also spread this message throughout the entire process.
- Feedback from the beneficiaries of the services is critical in order to understand key aspects of the intervention. First of all, there are a number of questions that MSF is asking as part of the evaluation that could only be answered by speaking to beneficiaries and their family members (in the cases of children). Although it is important to be respectful of the privacy of those involved without asking their feedback it actually denies them the opportunity to participate in giving feedback about a project that was designed to address their needs if they are not included.

8. Data-analysis and validation and presentations of findings

Once the data-gathering phase is complete, qualitative data analysis will take place by listing and coding data under each of the headings of relevance, effectiveness, impact, and coherence/sustainability through the triangulation of information gathered from both the qualitative and quantitative methods.

A validation workshop with staff and other key stakeholders will also form part of the data analysis as findings will be presented and discussed. A subsequent presentation of findings to MSF management and the broader MSF family will also be done and their feedback will also be incorporated. The final report will incorporate all feedback and follow an outline that is agreed between the evaluator and the MSF office. The final report will be edited.

9. Detailed work plan is elaborated below

Phase 1:	ACTIVITY	WHO	Deliverables
Preparation			
1 September	Inception report drafted	Evaluator	Initial Inception report finalized

1 September	Literature review started	Evaluator	
18 September	Data collection tools created	Evaluator	Data collection tools finalized and submitted with inception for review and adoption
18 September	Final inception report provided	Evaluator	
21 September	Meetings with MSF-Berlin	Evaluator	Finalized inception report
Phase 2: Field Visit	ACTIVITY	WHO	Deliverables
21-23 September	Travel from Germany to PNG	Evaluator	
24 September	Initial introductory meetings in Port Moresby, Skype meetings with MSF-Amsterdam staff	Evaluator	
25 September -2 October	Field visit to Tari	Evaluator with HAO	
2 October	Fly back to Port Moresby		
9 October	Validation meeting at the end of the project	Evaluator	Validation workshop
10 October	Presentation of findings to MSF	Evaluator	Presentation of findings
12 October	Fly back to the USA	Evaluator	
Phase 3: Data Analysis	ACTIVITY	WHO	Deliverables
12-18 October	Follow up, data analysis and report writing	Evaluator	Draft final report submitted
19 October	Submit draft report for feedback	Evaluator	
26 October	Feedback provided to Evaluator on draft report	MSF-PNG,	
Phase 4: Final Report	ACTIVITY	WHO	Deliverables
26-30 October	Feedback incorporated in the final draft report	Evaluator	
31 October	Final report submitted	Evaluator	Edited report submitted

ANNEX II: LIST OF INTERVIEWEES

ANNEX II: LIST OF INTERVIEWEES

Interviews

Norman Sitali	Operations Advisor	MSF-Berlin
Christian Katzer	Operational Manager	MSF-Berlin
Pete Buth	Operations Deputy Director	MSF-OCA
Meggy Verputten	Specialist Advisor Sexual Violence	MSF-OCA
Giovanni Pintaldi	Specialist Advisor Mental Health	MSF-OCA
Angelika Herb	HOM-PNG	MSF-PNG

Abdul Wasay	Medical Coordinator	MSF-PNG
Laura Choon Cheng Lee	Humanitarian Affairs Officer	MSF-PNG
Konstantinos Antonopoulos	Project Coordinator-Tari	MSF-PNG
Thok Johnson	Medical Team Leader-Tari	MSF-PNG
Zaohua Ray Wei	Tech Log	MSF-PNG
Dr. Nicole Aube	Mental Health Officer	MSF-PNG
Dr. Bhavna Chawla	Surgeon	MSF-PNG
Dr. Renaldo Soria	Anesthesiologist	MSF-PNG
Aoife Siobhán Ní Mhurchú	OT Nurse	MSF-PNG
Christy Nichols	IEC officer	MSF-PNG
Susan Ferguson-Gender	Gender Advisor	Australian Embassy
Kerstin Newton	Gender Advisor	PALJIP
Ume Wainetti	Director	FSVAC
Isi Oru	Project Manager	FSVAC
Mary Njeri	Staff	Lifeline
Hazel Hopkos	Staff	Lifeline
Dr. Soikava Pauka	Director	Lifeline
Monica Haus	Director	Haus Ruth
David Kina	Director	FSVU Director-Police
Alice Arriga	Community Police	Police
Mary Arawi	Nurse	NDOH
Chelsea Magini	FSC Coordinator	Alotau
Ms. Gemma Lasema	CHW-FSC	Alotau
Ms. Sophie Pascoe	Volunteer	
Dr. Noel Yaubilin	Director Curative Health	Alotau
Dr. Perista Mamdi	Deputy Director Medical Services	Alotau
Mrs. Sorena Bagita	Principal Advisor Division of Community Development	Alotau
Ms. Did Nipuega	FSVAC	Kedu Seif Haus
Mrs. Thelma Sosthen	OIC-FSVU	Alotau
Mr. Stella Gilgero	Counselor	Milne Bay (MAVIMB) and Milne Bay Counseling Services Association (MBCSA).
Mrs. Tessie Soi	Head of POM FSC	PMGH
Lucy Sylvanus	Officer in Charge, Maternity	PMGH
Paul Hilai	Administration	MSF-PNG

Paul Brogman	Former HOM	MSF-PNG
Pete Rinker	Former PC-RTT	MSF-PNG
Elisa Galli	Former PC-RTT	MSF-PNG
Jean Stowell	Former PC-Tari	MSF-PNG
Emmanuelle Privat	Former HAO	MSF-PNG
Adele Springer	Former HAA	MSF-PNG
Aleem Shah	Former PC-Tari	MSF-PNG
Christina Mach	Former MEDCO	MSF-PNG
Musa Hamdan	Health Advisor	MSF-Berlin
Dr. Kamalini	Former MSF Staff-Lae	MSF-PNG

Focus Group 1 Tari hospital
Julius Ipayya-Physio department
Rodney Nasnas-OT department
James Nangu- OT department
Gibson Hauwane OT nurse
Paul Poka-Yakimb-Physiotherapist

Focus Group 2
Joyce Gambolo-Surgical Department Supervisor
Nancy Kipo-OT Supervisor
Claire Lembo-FSC Supervisor Anita-nurse
Leonie Angai-FSC Counselor
Roselyn Pele-RNO
Erina Piawe-Triage
Jenny John-Registered Nurse
Agnes Juba-CHW

Focus Group 3
FSC Team

Patients from Tari Hospital
Female, 30, Back three times for counseling, IPV
Female, 15, IPV
Female, 30, IPV-stab wound by second wife but husband supported her.
Male, 50, IPV-stabbed by wife,
Female, 28, IPV, most serious case of the bunch
Female, 40, not IPV Patient-C-section baby died-paid 100 kinas for the ambulance
Male, 60, Head wound-should have died-will give donations to hospital

ANNEX III: INFORMATION SOURCES

Observation

Outreach sessions with outreach team
Hela council of women-a total of 17 women from all over the province.
Village court officials in two communities
FSVAC meeting to draw up the referral pathway with PALJIP, MSF, and Women Representative
Oil Search team and MSF

MSF Medical meeting in Tari
CMT in Port Moresby

Documents accessed

Country Policy 2007, 2008, 2009, 2012, 2013
Evaluations

Lae Evaluation 2012

Assessments

Pre project assessment, 2006

Trip reports

GD MSF-UK, 2010
HAA MSF-OCA, 2011
HA-SV and Mental Health, 2013
HAA MSF-Berlin, 2013
HA MSF-Berlin, 2013

Hand over Reports

RTT Handover report 2013

Final reports

End of project report Solomon Island 2014
Final Report Lae
Outreach Final Report

Project Planning

Tari-2013, 2014
RTT-2013, 2014
Solomon Island-2013, 2014

Project Monitoring

Tari-2013, 2014
RTT-2013, 2014

Advocacy documents

Hidden and Neglected 2011
MSF Brochure: Service for Survival, 2013
MSF PNG UPR Submission 2015