



Spotlight Initiative
To eliminate violence against women and girls

Papua New Guinea

A Baseline Assessment of Family Support Centres 2021



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Acronyms

A&E	Accidents and Emergencies
CIMC	Consultative Implementation and Monitoring Council
CSO	Community Service Organisation
DFAT	Department of Foreign Affairs and Trade, Australia
DfCDR	Department for Community Development and Religion
DHS	Demographic Health Survey
FSC	Family Support Centre
FSV	Family and Sexual Violence
FSVAC	Family and Sexual Violence Committee
GBV	Gender Based Violence
Hep B	Hepatitis B
LPA	Lukautim Pikinini Act
MSF	Médecins Sans Frontières
NCD	National Capital District
NDOH	National Department of Health
NOCFS	National Office of Child and Family Services
O&G	Obstetrics and Gynaecology
PEP	Post-Exposure Prophylaxis
PHA	Provincial Health Authority
PNG	Papua New Guinea
RPNGC	Royal Papua New Guinea Constabulary
VAC	Violence Against Children
VAW	Violence Against Women

Introduction

UNFPA And The Spotlight Initiative

UNFPA expands the possibilities for women and young people to lead healthy and productive lives. UNFPA supports countries in using population data for policies and programmes to reduce poverty and to ensure that every pregnancy is wanted, every birth is safe, every young person is free of HIV and AIDS, and every girl and woman is treated with dignity and respect. Advancing gender equality and promoting the empowerment of women is a key programme priority of UNFPA defined in the UNFPA Strategic Plan 2022-2025.

The Spotlight Initiative is a global, multi-year partnership between the European Union and the United Nations to eliminate all forms of violence against women and girls by 2030. Launched in 2018, the Spotlight Initiative in the Pacific prioritises a focus on addressing and preventing Intimate Partner Violence (IPV) as a leading form of violence against women and girls in the region. The initiative aims to drive transformation to end IPV through work across six pillars: laws and policies; strengthening institutions; prevention of violence and social norm change; delivery of quality services; gender-based violence (GBV) data availability and capacities; and supporting the women's movement and civil society. Complementing this work, Zonta International Foundation (Zonta) launched a two-year initiative focused on strengthening national capacities of the health sector in Papua New Guinea and Timor-Leste to deliver survivor-centred specialised healthcare to Gender Based Violence survivors. Both programmes prioritise improving and expanding GBV response services through health system strengthening, understanding health facilities as a key entry point for survivors. This includes a focus on support for Family Support Centres (FSC) and their accompanying hospitals for a cohesive all-of-facility approach to establishing a 'one stop' service model for specialised services.

GBV in PNG and Health Sector Response

According to the national Demographic Health Survey (DHS) of Papua New Guinea (2016-2018) 59 percent of women and girls have experienced physical and sexual violence at the hands of their intimate partner/s in the last 12 months.

Only 35 percent of women who have ever experienced physical or sexual violence have sought help, of which a majority sought help from family and friends and a very small percentage sought help from formal service providers—10 percent from the police, and three percent from social work organisations and another 3 percent from doctors/medical personnel¹. Data indicates the strong intersections between violence against women, adolescent girls, and children both in

GBV Prevalence in Papua New Guinea

63% women and girls have experienced any form of intimate partner violence (physical/sexual/emotional)

59% have experienced physical and/or sexual violence

57% among those who have experienced spousal physical/sexual violence have sustained injuries

Only 35% women victims of IPV have sought help

Of these, only 10% have sought help from police and 3% from social work organisations and 3% from health workers.

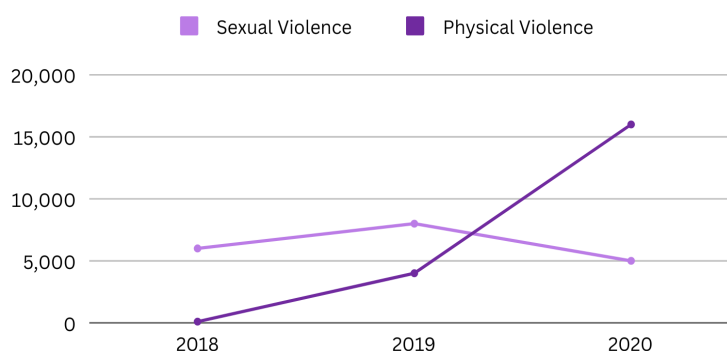
¹ Demographic Health Survey PNG, 2016-2018

terms of drivers, protection factors and responses to violence. For example, increased help-seeking behaviour for intimate partner violence by women with children (34-40%) compared to women without children (27%); and reported the highest rates of spousal violence (physical, sexual, and/or emotional) among females aged 15-19 years old².

Low uptake of services is a feature of demand and supply side limitations that feed into each other. Low demand for services can at least partially be attributed to normalisation of gender-based violence as indicated by the DHS—70 percent of women and 72 percent of men agree that wife beating is justified under specific circumstances—and partially by limited access to and awareness about services³.

Between 2018 and 2020 a total of 18,759 survivors of sexual violence and 20,609 survivors of physical violence were provided medical care at the health facilities⁴. Estimates on the number of GBV survivors accessing services of health facilities over the last three years suggest an upward trend—with 2020 seeing a steep rise in survivors of physical intimate partner violence seeking formal support in the wake of COVID-19 pandemic. Part of the increase may be understood as expansion of GBV related health services for survivors.

Figure 1. Trends in health services sought by GBV survivors, 2018-2020.



Family Support Centres - One Stop Service Centres in Papua New Guinea

Hospital-based Family Support Centres (FSC) have been set up by the National Department of Health (NDOH) across the country to operate as one-stop service centres for providing integrated GBV response services to survivors. The development of the FSC approach in PNG was first recommended as part of a report commissioned by the national Family and Sexual Violence Action Committee (FSVAC) which analysed family and

One-Stop Service Centres

One-stop service centres are a model of delivering integrated services to victim/survivors of GBV. The rationale for such a model is to provide multi-sectoral services in one place to the survivors rather than having them travel from one service provider to another.

First established in a public hospital in Malaysia in 1994, this model has been replicated in many countries. While the model is usually set up in tertiary health facilities (hospitals), in some countries, one-stop centres have been established in police stations and safe houses or are set up as stand-alone centres.

The WHO has recognised and promoted this model as part of the health sector response to GBV.

² UNICEF Report on ending VAWC in PNG

³ Demographic Health Survey PNG, 2016-2018

⁴ National Department of Health: Special Parliamentary Committee Inquiry into GBV - Health Sector Submission – 21st June 2021 (Available at <https://www.unitedforequalitypng.com/may-2021-gbv-inquiry>)

sexual violence in PNG⁵. This report recommended the establishment of a health-based 'one stop shop' model for the provision of multi-sector specialized GBV response services (health, case management, mental health and psychosocial support, legal aid) recognising health as a key entry point for survivors. The FSC model was also established to strengthen referral pathways by creating a 'safe space' for women and children to seek care and access other services through safe and comprehensive referral. The first FSC was established in Lae in 2003 with support from Soroptimists International. Additional FSCs were then established with support from MSF, DFAT, UNICEF, FHI360, USAID, UNFPA and the NDOH.

At present, a total of 18 FSCs exist within provincial hospitals. NDOH and health partners have pushed for the decentralisation of FSCs from provincial through to district levels in recognition of the significant barriers many communities face accessing provincial capitals. However, at present this has had limited success, with Southern Highlands being a notable exception to this.

Normative framework: In October 2006, the Secretary for Health issued a circular that required all Provincial Hospitals to integrate Family Support Centres into their operations. In 2009, all hospital boards were directed by the Secretary of Health to allocate sufficient budgetary funds to enable the establishment and operation of Family Support Centres (FSCs) in all main health centres. This was followed, in 2009, by a further circular directing all hospitals and health centres to remove fees that were being charged for treatment and medical reports for domestic violence, sexual violence and child abuse cases.

In 2013, the NDOH published its National Department of Health (NDOH) Guidelines for Provincial Health Authorities (PHA) /Hospital Management establishing hospital-based Family Support Centres (2013) which affirms them as the preferred approach to health-based one stop shop models for the provision of multi-sector response services for GBV survivors.

Normative framework for Family Support Centres

1. National Guideline on the PHA/Hospital Establishment of Family Support Center (FSC), 2013.
2. The National Health Plan, 2011-2020: Objective 7.1: to increase health sectors response to prevention of injuries, trauma, and violence with an impact on families and the communities. Priority 7.1.2: to increase the roll-out of and access to family support centers to reduce the impact of violence in the home and community.
3. Circular instructions (12th December 2009) and reinforced on the 18th July 2016, directives from the Secretary for Health to all Provincial Health Authorities (PHA's) for the:
 - Removal of fees/charges for GBV, Sexual Violence and Child Abuse at all Hospitals, health centers and health facilities;
 - Establishment of Hospital Based FSC as a "One Stop Shop" model to respond to Sexual & Gender Based Violence and integrated GBV response services to all lower - level health facilities;
 - Inclusion of GBV Program activities and FSC Operations in Annual Implementation Plan.
4. Sexual & Gender Based Violence (SGBV) Clinical Practice Guideline for Health Workers, 2020

The guidelines lay down objectives, principles, and list of services that the FSCs must deliver:

Objectives:

- Provide client-centred care for the medical and psychosocial needs of survivors
- Create strong linkages and improve access to justice for survivors

⁵ Kaybryn, Jo & Butcher, Kate. (2016). Independent Formative Evaluation of Family Support Centres in Papua New Guinea. 10.13140/RG.2.2.19239.50089.

- Assist in the prevention of violence through advocacy and community education.

Principles: The Guidelines explicitly set client-centred care as the guiding principle for the provision of GBV services; 'FSCs must:

- Affirm that violence against the person....men, women, or children.... is neither acceptable nor inevitable
- Be safe, welcoming, non-judgmental, private, confidential, respectful, and sensitive to the feelings of the client
- Be gender sensitive and, where possible, provide services by health workers of the client's gender choice (evidence shows that this is generally a woman in the case of women and child survivors)
- Be available 24/7 and free of charge
- Ensure that all clinic staff agree to and are bound by a specific Code of Conduct (Annex 1) relating to all FSC-related work

The normative framework for the FSC sits within the broad health sector framework. The 2007 Provincial Health Authority Act decentralised the health system by awarding provinces power to manage health budgets and programmes (curative and public). The introduction of the PHA Act and ongoing decentralization, in particular, the staged establishment of Provincial Health Authorities, continue to be highly consequential for FSC who largely fall under the authority and management of PHAs through their respective provincial-level facilities. It is important to note, as elsewhere, that donor funding for FSCs is a primary source of support notwithstanding this formal governance structure.

Guidelines for PHA/Hospital Management establishing hospital-based Family Support Centres (2013)

A Comprehensive Care package for survivors of family and sexual violence includes medical treatment which involves:

- the acute management of mental and physical (if any) injury as well as
- the early provision of the correct emergency medications to reduce the chances of contracting sexually transmitted infections (STIs- including HIV & Hepatitis B) and
- the timely provision of emergency contraception (for those at risk) to avoid a possible conception from an episode of rape.

Comprehensive Care also entails providing the survivor with:

- Early and on-going psycho-social support through appropriate emergency counselling to help them deal with the trauma, and
- Assisting survivors in accessing legal assistance to the Justice system of PNG. (if they so choose)

Services: The FSC guidelines breakdown FSCs services into the following categories:

- Safety/security/ comfort: FSC must ensure safety of the client including through security (preferably female) guards, referral accompaniment for safe dispatchment and referral.
- Physical health interventions: First aid as needed; Pregnancy prevention; STI prevention; HIV prevention; Tetanus prophylaxis; Hep B immunisation; Referral and follow-up as indicated:

- Within hospital (A&E, O&G, Family Planning Clinic, Paediatrician, Psychiatrist, Social Worker, Surgical services, STI/HIV clinic, etc)
- To other higher level health facilities if required by the severity of the case.
- Psycho-social services: Psychological first aid: Emotional support, Counselling (Basic, trauma, medication adherence, etc), Referral when needed, Follow-up.
- Medico-legal support: Advice regarding options, provision of timely medical reports where required, representation as a witness may be required if there are court proceedings.
- Follow-up arrangements, as appropriate or requested by client: adherence counselling and support, emotional support, follow up management of lesser injuries (sutures, plaster checks, wound dressings), OPD if patient has been referred to a specialist and requires specific follow-up, psychiatry, paediatrics, O&G etc, private practitioner if this is their choice.

Five Essential Services

In PNG, the clinical management of intimate partner and sexual violence is commonly referred to as the '5 essential services' including in national clinical guidelines. These include:

- Treatment of Injuries
- Psychological First Aid (PFA)
- Prevention of:
 - HIV and STI
 - Pregnancy
 - Hepatitis B
 - Tetanus
- Safe Referral
 - Internal to other specialist medical care providers
 - External to other service providers (welfare, legal, safe house, police, child protection, counselling, repatriation)
- Supportive Follow-Up

The '5 essential services' overlap with FSC responsibilities outlined in the National Guideline on the PHA/Hospital Establishment of Family Support Center (FSC), 2013. This summary has been included here for clarity.

Infrastructure and Physical Space: The FSC guidelines suggest that ideally, the FSC should be located close to the main services of the Hospital, such as Accident and Emergency (A&E), Outpatients, and Obstetric & Gynecology (O&G) Department. If this is not possible, it should be located so that clients can access it securely and discreetly. It should not be located next to the main entrance (because of security issues), the morgue, or in the STI/HIV clinic (to avoid possible stigma).

FSCs are advised to have at least 6 different types of rooms, in addition to reception, triage, storage, waiting and office space, fixed phone line/s, mobile phone 2-way radio to communicate with security and ideally, with email/web access.

The 2013 guidelines for FSCs advise that at a minimum, a provincial level FSC should aim to provide the following physical space:

- A private reception area, a triage area, a registration area; a big office space (for administration); a private, shaded, and secure client waiting area, a children's play area/crèche
- 6 different types of rooms as follows:
 - A separate counselling room,
 - At least 1 interview/examination room
 - A room (preferably with a separate entrance) where police can conduct interviews with clients choose to report the assault
 - "Transit stay" rooms/space to provide short-term accommodation (for up to 48 hours if necessary)
 - 2 rooms for staff; one for the FSC Coordinator, and one "staff room"
- Bathroom with shower, and separate toilet(s) with adequate hand basins and a laundry room

Challenges: Although a systematic review of the quality and impact of services provided by FSCs has not been conducted, two assessments, one by Médecins Sans Frontières (see box)⁶ and one by UNICEF suggest that while important gains have been made in making available GBV services to survivors, FSCs face several challenges.

A formative evaluation of FSCs commissioned by UNICEF in 2016⁷ validated the importance of Family Support Centres by concluding that Hospitals with FSCs were better equipped to respond to women and child survivors of violence than facilities without FSCs. The Evaluation overall findings affirmed the FSC model as 'unique and critical service to survivors of family and sexual violence'. Despite this it noted 'confusion about the goals of the FSC with regard to their reach at District level, their role in primary prevention of family and sexual violence' and the need for a 'clear strategy, which goes beyond the operational guidelines to outline the purpose, goals and desired indicators for the centres'. The evaluation found the following barriers preventing FSCs from meeting their objectives:

- **Provision of all services in one site:** The criteria to be a 'One Stop Shop' was not comprehensively met by any of the sites. Although all of the sites were aware of the five essential services, no FSC were found to be offering the complete suite of services on site. Only two out of 14 were able to offer the five essential services on site, most relied on internal referrals across hospital departments, and none were offering legal and justice advice in situ.
- **Availability of medical supplies:** Hepatitis B vaccinations, for example, were not routinely available at Kundiawa FSC or at the hospital itself. Kundiawa FSC had no cold chain, so tetanus jabs were provided through A&E.
- **Feedback and support network:** While the hospital sites provided a welcoming and pleasant environment across all the sites, there were only two FSCs that systematically sought feedback from service users to improve the service, and only one which attempted to establish a survivor support network.
- **Human resources:** Only 3 out of 14 met the stipulated requirement for human resources to ensure consistency of services. Staff capacity building is hampered by high staff

⁶ Lokuge K, Verputten M, Ajakali M, Tolboom B, Joshy G, Thurber KA, et al. (2016): Health Services for Gender-Based Violence: Médecins Sans Frontières Experience Caring for Survivors in Urban Papua New Guinea. PLoS ONE 11(6): e0156813. doi:10.1371/journal.pone.0156813

⁷ Kaybryn, Jo & Butcher, Kate. (2016). Independent Formative Evaluation of Family Support Centres in Papua New Guinea. 10.13140/RG.2.2.19239.50089.

turnover and poor integration of FSC staff into the health sector human resources system.

- **Follow up** was a challenge for all FSCs particularly for Post Exposure Prophylaxis. A major obstacle to follow up is the cost of transport to and from the clinic, and the provision of transport fares has greatly increased follow up and adherence to PEP protocols.
- **Access:** There was relatively low client load, from 1.1 (Kundiawa) cases per day to a maximum of 7.9 cases per day (Angau); attributed to low awareness about the FSC among communities as well as health workers in different parts of the facilities. Consultations with a Maternal and Child Health nurse at one of the FSCs revealed that many women with injuries are seen during outreach and MCH clinics but their injuries are ignored 'as they have come for child vaccinations or other reasons' and because these clinics are very busy there is no time to address the matter properly.
- **Reaching the most vulnerable:** While all FSCs will treat anyone who self-refers as long as their case is related to family and sexual violence, there was scant evidence to suggest that any of the FSCs have set priorities for responding to the needs of marginalised groups by articulating specific criteria or guidelines; and they are not resourced to respond to the barrier of distance and transport costs. Gaps remain in responding to the specific needs of women, including older women, vulnerable children, transgender people, and people with disabilities.
- **Data collection and management** systems were not in place or not used for decision making and compounded by lack of standardization.
- There was **no evidence that the FSC approach has contributed to primary prevention of violence** because their current functions focus on response services rather than changing social norms

When free, confidential, accessible medical and counselling services are provided, many survivors will present for care. Those who do present receive best-practice medical care and counselling, in particular if they present in a timely way and are retained in care. The majority who received two or more sessions of counselling had improvement in self-reported functioning, with the most improvement seen in those reporting non-partner SV. However, high levels of IPV and child sexual violence by known perpetrators suggests that effective policing, protection, and legal services will also be required alongside health services if survivors are to escape the cycle of violence.

Evaluation of FSC services provided in Lae, between 2010-2013, MSF

In 2021, in a submission to the Special Parliamentary Committee on GBV, the NDOH noted that inadequate financial, material, and human resourcing present a major challenge to providing accessible, appropriate services for survivors of violence⁸. Few Family Support Centres are functional beyond a Provincial level while services have limited operating hours, despite the fact that most violence occurs at night and on weekends. Limited access to adolescent and youth-friendly services exacerbates risk of GBV especially for adolescent girls and women who are ill-equipped to negotiate intimate relationships including use of family planning.

⁸ NDOH Submission on health sector responses to GBV, 30 June 2021

Global evidence on one-stop service centres

Across the world, one-stop centres (OSCs) have been established to provide multi-sectoral services using an integrated model, where all of the needs of the survivor are met within one facility. There are three primary types of institutions that have implemented one-stop centres: medical or health facilities, justice (police), and women's centres. For example, a hospital or clinic provided medical care as well as psychosocial and legal support by relying on an integrated network of psychologists, social workers, and volunteers, all of whom had office space and could see patients and clients in the hospital or clinic.

Health facilities are a preferred location for one-stop centres across the world, not only because they can provide essential life-saving health services to survivors, but also because health care providers (such as nurses, midwives, doctors, and others) are likely to be the first professional contact for persons who have been subjected to intimate partner violence or sexual violence. Women and girls often seek health services, including for their injuries, even if they do not disclose the associated abuse or violence. Studies show that women who experience violence use health care services more than women who have not experienced violence. They also identify health care providers as the professionals they would most trust with disclosure of abuse⁹.

Challenges faced by FSCs in Papua New Guinea mirror experiences from across the world on barriers that prevent the one-stop model from providing high quality, accessible, acceptable, multisectoral care. A review of one-stop centres in over 24 countries concluded that while they make a difference in the communities where they are located, there are several barriers that prevent one-stop centres from fulfilling their purpose¹⁰. In hospital or medical clinic settings, for instance, one-stop centres are able to provide survivors of GBV with much-needed medical attention to address acute injury and exposure to diseases, most notably STIs and HIV; however, hospital based one-stop centres were weak in creating access to legal and justice pathways.

Of the 15 barriers faced by OSC, 3 were found to be at the root of all other barriers: insufficient staffing, basic equipment, and lack of sustainable funding.

Good governance of multisectoral response service, political will, availability of on-site psychological services, knowledgeable and sensitive staff have been identified as key enablers for effective one-stop services across the world

Health care settings have been the preferred choice for situating one-stop service models in many countries, including in low resource settings/developing countries in Africa, including in Zambia, Tanzania, Kenya, the Democratic Republic of Congo, and South Africa; Asia-Pacific, including Afghanistan, Nepal, Mongolia, India, Sri Lanka, Philippines, and so on.

Barriers of one-stop centres in low- and middle-income countries

- Lack of staff training in providing psychosocial support
- Limited operation of OSC during nights and weekends
- Not equipped to provide follow-up services
- Lack of private consultation rooms
- Survivors had to pay user fees
- Failure to address inequities in care for LGBTQ survivors
- Poor multisectoral collaboration
- Services at several OSCs are 'fragmented' and 'not truly one-stop'
- Lack of knowledge on GBV among health workers
- Many OSCs provided no training on how to care for survivors.
- Insufficient staff, high staff turnover and lack of dedicated staff for the OSC.

⁹ UN Women, UNFPA, WHO, UNDP & UNODC (2015): Essential Services Package for Women and Girls Subject to Violence: Core Elements and Quality Guidelines, Module 2: Health.

¹⁰ Olson RMcK, García-Moreno C, Colombini M. The implementation and effectiveness of the one stop centre model for intimate partner and sexual violence in low- and middle-income countries: a systematic review of barriers and enablers. *BMJ Global Health* 2020;5:e001883. doi:10.1136/bmjgh-2019-001883

Barriers identified include:

- Lack of staff training in providing psychosocial support to survivors affects quality of care;
- Limited operation of OSC during nights and weekends, which is the time when most violence occurs, was perceived to be a major barrier by survivors, OSC staff and OSC stakeholders;
- Many OSCs were not equipped to provide follow-up services such as long-term counselling or follow-up medical care’;
- Lack of private consultation rooms security personnel or systems often violated patient confidentiality and privacy, and survivors and staff expressed fear for their safety;
- Free services at the OSC facilitated access to survivors, however in many OSCs in over 20 countries, survivors had to pay user fees and survivors from rural areas are prevented from accessing OSC due to high cost of transportation;
- OSCs have largely failed to address inequities in care for LGBTQ (lesbian, gay, bisexual, transgender and queer) survivors who may be excluded, discriminated and revictimized when seeking services;
- Poor multisectoral collaboration is one of the most common barriers to OSCs across the world, weak partnerships with the police, legal and justice services, shelters and NGOs have been reported;
- Services at several OSCs are ‘fragmented’ and ‘not truly one-stop’, with survivors required to move from different departments within the hospital, as well as between hospitals and other service providers (for police, legal, shelter, for e.g.);
- Lack of knowledge on GBV among health workers at the OSC is a major barrier, with some OSC staff unaware of the different services available at their facility, many staff of OSC (including on and off-site police officers) holding victim-blaming attitudes, and insensitive behaviour towards survivors (e.g. scolding rape survivors).

Many OSCs provided no training on how to care for survivors and little instruction on OSC policies. OSCs also lacked mechanisms for sustainable knowledge acquisition such as follow-up trainings and evaluation of trainings; Insufficient staff was a barrier key; many OSCs faced staff shortages and high staff turnover and in some there are no dedicated staff for the OSC. Provision of good quality psychosocial support has been found to be the tipping point for the success of one-stop centres in other reviews, for instance from Kenya and Zambia ¹¹.

Psychosocial support provided by the one-stop centres was perceived to be highly effective by all survivors and caregivers (of child survivors) who were interviewed. They reported going back to OSCs for follow-ups, supportive counselling, and support group meetings, where these were available (Review of one-stop service centres in Kenya and Zambia).

¹¹ Jill Keesbury, W. Onyango-Ouma, Chi-Chi Undie, Catherine Maternowska, Frederick Mugisha, Emmy Kahega, Ian Askew. 2012. A Review and Evaluation of Multi-Sectoral Response Services (“One-Stop Centers”) for Gender-Based Violence in Kenya and Zambia. Population Council: Nairobi, Kenya.

Methodology

Purpose

As part of UNFPA's commitment to strengthen specialised GBV service provision through Family Support Centres, a baseline assessment of FSC functionality and service readiness was conducted in 2021. Primary data collection for the assessment was carried out by a team of national consultants between August and October of 2021.

The baseline builds on the formative assessment conducted by UNICEF in 2016 and seeks to document changes to FSCs over the five-year period and revisits its findings to determine their continuing relevance. The baseline used the Gender-Based Violence (GBV) Quality Assurance Tool developed by the World Health Organisation in partnership with Jhpiego and the U.S. Centers for Disease Control and Prevention (CDC) as the primary assessment tool (more on this below). The assessment tool documents the functionality and service readiness of FSCs and in doing so, provides a foundation for a monitoring framework for FSCs henceforth. In this way, the baseline design speaks to the findings of the prior evaluation (a more detailed methodological summary is included in the next section). The assessment was conducted simultaneously with regional consultations with FSCs, relevant frontline providers and provincial health administrators. Reflections from the consultations have been included in the report where they are relevant to the findings generated from the assessment tool. This is referenced for clarity. Draft FSC Action Plans developed as part of these consultations have been included as an Annex 7. It is anticipated that these along with the baseline will assist in the development of the proposed National Action Plan for FSC.

The baseline was intended as the first of mixed method assessments of health sector response to GBV. It will serve as the basis for ongoing monitoring of FSC functionality for UNFPA programming as well as inform subsequent qualitative research to complete and further investigate its findings, particularly in relation to quality of care. It is also hoped that the assessment will assist in strengthening the coordination and cohesiveness of support for FSCs and health-based specialised services for GBV survivors more broadly across development, government, community, and private sector partners.

Tools

The Gender-Based Violence (GBV) Quality Assurance Tool¹² developed by Jhpiego in partnership with the World Health Organisation and the U.S. Centers for Disease Control and Prevention (CDC) is organised by 10 thematic areas that list 28 standards, elaborated by 133 verification criteria for each area:

- 1) Availability and Appropriateness of Services
- 2) Facility Readiness and Infrastructure
- 3) Identification of Patients Who Have Experienced IPV or SV
- 4) Patient-Centered Clinical Care and Communication
- 5) Forensic Examination and Handling of Evidence
- 6) Referral System and Follow Up of Survivors
- 7) Training and Quality Improvement
- 8) Health Care Policy and Provision

¹² Jhpiego, the U.S. Centers for Disease Control and Prevention, and the World Health Organization 2018: Gender-Based Violence (GBV): Quality Assurance Tool. Standards for the provision of high-quality post-violence care in health facilities.

- 9) Outreach
- 10) Reporting and Information Systems

The three methods for verification of standards as recommended in the tool were used to collect data on these standards: interviews with service provider; observation and review of documents

The tool was adapted for use in PNG by UNFPA. Some of the modifications to the original tool include the following:

- **Number of respondents per facility:** Each verification criteria in the tool lists the most appropriate respondent for asking questions on the specific criteria—1) Doctor/Nurse/Midwife/Health Worker, 2) Social Worker/Counsellor/Psychologist; 3) Facility Manager/GBV Supervisor; 4) Police. At a minimum, the tool recommends that at least two respondents from the facility are interviewed for the assessment. However, given the context of FSCs in PNG—including the types of services offered at the FSC (5 essential *health* services and not multi-sectoral services) and the fact that in several FSC there is only one dedicated staff attached to the FSC, the assessors mostly only interviewed one staff from the FSC. Interviews with other relevant staff were incorporated into regional consultations.
- **Standards and Verification Criteria:** All 28 Standards prescribed by the Quality Assurance Tool have been included in this baseline assessment and an additional standard on Human Resource has been included as the 29th Standard. Of the 133 verification criteria listed in the tool, 7 were excluded and an additional 28 were included to reflect the context of PNG. For the additional standard on human resources, 7 verification criteria have been included. Hence a total of 29 standards and 161 verification criteria were assessed (all criteria are listed in tables accompanying findings under each standard). Key modifications are presented below:
 - Standard 2: 1 additional criterion has been included in the area of IEC responsive to diverse PNG audience
 - Standard 3: 14 additional criteria have been included in the area of facility readiness and infrastructure
 - Standard 10: criteria 10.1 has been excluded due widespread conflation of term case management, counselling and advocate which commonly include mediation and other harmful practices; ongoing service monitoring and parallel review of case management practices to complement this assessment. Relevant findings regarding health-based case management and psychosocial support captured elsewhere in this assessment. [Provider contacts a trained social worker or advocate to be present throughout the examination and during any interaction with law enforcement]
 - Standard 14: an additional criterion has been included (14.2 Are there FSC staff certified/authorised to provide EC)
 - Standard 15: an additional criterion has been included [15.2 Are there FSC staff certified to provide HIV PEP (i.e., received IMAI training and registration)]
 - Standard 17: criteria 17.3 has been excluded due to complete absence of service verified through ongoing service monitoring [Provider offers referrals to long-term mental health care and/or support groups]
 - Standard 19: 4 criteria in the area of forensics related to chain management have been excluded (19.8 to 19.11). After completion of data collection, Standards 18 and 19, pertaining “Forensic Examination and Handling of

Evidence” were dropped as per instructions in the Quality Assurance Tool (“if facility has no forensic system in place, mark “n/a” in the comments section and do not score this section”¹³)

- o Standard 20: 5 additional criteria have been included in the area of referrals
 - o Standard 21: 2 additional criteria have been included in the area of multi-sectoral coordination
 - o Standard 26: 2 additional criteria have been included in the area of data collection and management
 - o Standard 27: 2 additional criteria have been included in the area of data safety
 - o Standard 29: new standard on Human Resources with 7 verification criteria have been included (XI thematic area).
- **Scoring:** The tool provides for scoring each criterion with a hard yes or no, with the option of not applicable(n/a where relevant). Criteria scored as n/a were not included in the final tally. An additional score of “referred” has been included. This reflects services that are not provided at the FSC but possibly outside the FSC through other providers/units in the hospital, such as the OPD, ED, STI/HIV clinics. In such cases, the FSC staff who responded to the assessment could not speak to that criterion and/or quality of service. Such instances were found in standards pertaining Patient-Centered Clinical Care and Communication—in particular standards 8, 10,13, 15, 16.

For example, for criterion 13.3—*“If a patient has been strangled or choked, provider tells patient to return to the clinic if experiencing any new onset of: difficulty breathing, voice changes, or signs of respiratory distress up to 72 hours after the assault, as this may be related to possible swelling in the tissue surrounding the trachea”*—the interviewed FSC staff reported that they themselves did not tell the patient what to do in such circumstance and that this would *probably* be done by the relevant department attending to the injuries/patient FSC. But since this particular service was not provided at the FSC, it was scored as referred.

After all criteria were scored as yes, no and referred, the percentage of “yes” under each standard became its aggregate score.

Challenges in data collection and scoring of responses illustrate a larger issue with FSCs in PNG. While FSCs are intended to provide stipulated services at one location ‘under one roof’ (ie. FSCs), in reality services are commonly provided by different units including FSC, A&E, OPD. Critically, where this is the case these services are not *integrated or well-coordinated*. For instance, the head of the FSC, usually the nurse of the FSC, could not speak of the services provided outside of the FSC through other wards. This has implications for quality control and ultimately impacts the experience of, and outcome for the survivors. These concerns are addressed in the findings and discussed in the chapter on conclusions, where a whole-of-hospital approach is recommended for FSCs in Papua New Guinea.

¹³ See p28 of Jhpiego, the U.S. Centers for Disease Control and Prevention, and the World Health Organization 2018: Gender-Based Violence (GBV): Quality Assurance Tool. Standards for the provision of high-quality post-violence care in health facilities.

The scores for all standards are converted into 4 broad ranks		
Colour	Grade	Description
Green	A	Meet Basic Standard (100%)
Yellow	B	Above average (75-99%)
Orange	C	Average (65-74%)
Red	D	Fail (Below 65%)

Sample

A sample of 11 FSCs from across PNG were selected for the assessment. FSCs were selected as they are supported through the Spotlight Initiative, Zonta International and emergency response funding, the primary UNFPA funding for GBV health response work. However due to movement restrictions imposed in response to the COVID-19 pandemic, not all FSC's could be visited for this assessment. In the end, 9 out of 11 selected FSC's were assessed.

In this report the FSCs are referred to by the name of the city/town where they are based (for FSC at Lae, FSC at Buka, etc.)

Table 1: List of FSCs included in the Assessment

	City/Hospital	Province
1)	Alotau	Milne Bay
2)	Arawa	Autonomous Region of Bougainville
3)	Buka	Autonomous Region of Bougainville
4)	Goroka	Eastern Highlands Province
5)	Lae	Morobe Province
6)	Mendi	Southern Highlands Province
7)	Mt. Hagen	Western Highlands Province
8)	Port Moresby	National Capital District
9)	Rabaul	East New Britain

Figure 2: Locations of Surveyed Family Support Centres



Respondents

In a majority of the FSC where there is only one staff appointed (nurse), functioning as the appointed or de-facto FSC in-charge, she was the only respondent to the interview. In FSCs where there are more than one staff, all staff, including the Officer-in-Charge (OIC) were interviewed together. In group interviews, respondents were encouraged to agree on a collective response, this was particularly significant where FSCs have both clinicians and social workers, for example in the FSCs at Alotau and Port Moresby. Supplementary information was garnered from regional consultations, as noted previously.

Limitations

- The assessment relies on self-reporting from respondents, who are staff of the FSCs. Accordingly, an inherent aspect of the design is its reliance on the experience and interpretation of individual staff which may not be a full and accurate account of the situation. For instance, in Buka the nurse at the FSC had only been in this role for 9 months at the time of this assessment and struggled to respond to many of the standards. To every extent, this has been mitigated in the report by explicit notes highlighting the need for further investigation and clarification including through subsequent service quality assessment.
- The length and depth of the questions posed a challenge. The time necessary for a thorough review

Most caseload figures included in the report are approximations, due to hesitancy in sharing data, lack of possibility to triangulate.

Length and depth of assessment tool made significant demands on time/availability of FSC staff respondents.

Staff of FSC were overburdened with demands from various surveys.

COVID-19 related movement restrictions caused delays and ultimately for 2 FSCs to be dropped from the assessment.

of all questions was often beyond what individual staff could reasonably commit. This is especially true in the majority of FSCs that are staffed by one person. The assessor prioritised the non-interruption of services. Accordingly, interviews halted when the participants had to respond to a client. However, this required them to stop as well as return to the respondent for follow up multiple times.

- In some locations, lack of clarity on the role of FSC and prioritisation of GBV in facilities as well as high workloads limited the availability of other relevant, non-FSC based staff for interviews. FSC staff participating in assessment could not respond accurately to some of the standard criteria. In such cases the response has been marked as “referred” service and not included in the final tally of the scores. Regional consultations attempted to provide another source for data collection however the report acknowledges it could have been strengthened with the participation of other relevant non-FSC staff.
- Due to travel restrictions relating to the COVID-19 Delta variant wave in PNG, 2 sites were not able to be included in the assessment and assessments had to be conducted with limited exposure to the assessors and respondents as FSC staff.
- Impending travel restrictions due to the fluctuating COVID-19 emergency limited the amount of time data collectors could spend in each location, which in part contributed to the prioritisation of FSC staff as primary respondents. Remote assessment through phone-based interviews were explored however significant limitations were identified and thus this was not a preferred modality.
- In the case of the FSC at Port Moresby (in Port Moresby), because there are many other development partners/NGOs coming through and asking various information and conducting various assessments, there was hesitancy at first to participate in this exercise unless clear of the outcomes. However, other needs of the FSC outside the standard tool assessment were also discussed and captured and assessment was completed with some gaps in data. The hesitancy may have resulted in misrepresented data.
- In general, across the referral pathway, there remains a hesitancy to share information and data. In part, this reflects a concern about confidentiality which should be commended. However it also reflects the lack of clarity along the referral pathway between providers on responsibilities for the delivery of specialised health, case management, safety and justice services, which contributes to distrust and concerns/antagonisms regarding perceived competing mandates. In this context, providers are resistant to sharing information. The lack of a formal referral pathway standard operating procedures, and as part of this information sharing protocols is both a cause and a product of this dynamic which inhibits accurate, ethical and safe data management. For this reason, most caseload figures included in the report are approximations.
- Older facilities who kept data were able to provide more accurate representation of data whereas the facilities that were new or had only 1 staff had limitations in maintaining records.

Findings

1. Overview of the FSCs

Of the FSC's included in this assessment, the oldest established FSCs are the ones in Lae, established with the support of Soroptimists International in 2003, and in Port Moresby, established with the support of UNICEF in 2004. The most recently established FSC is the one in Rabaul, East New Britain (2016), with the support of MSF (See brief summary of each FSC below and overview in Annex 2).

Four of the 9 FSCs included in this assessment are located outside the main hospital building—Arawa, Buka, Goroka and Mt Hagen. In the case of the FSC at Goroka, it is located at a substantial distance from the main hospital building and in Buka, the FSC shares space with HIV/STI clinic (which is against the recommendation of the FSC guidelines). Of the 5 FSCs that are located within the hospital, 2 share space with other departments: Accidents and Emergency department in Alotau and Diabetics Frangipani Clinic in Rabaul.

There is a wide disparity in the number of rooms dedicated for the FSC at each of the locations, with the fewest rooms in Rabaul, that too shared with a diabetes clinic and the highest number, 13 in Lae. Only 4 of the 9 FSCs have a separate room for overnight stay for survivors and their caregivers—Arawa, Goroka, Buka and Port Moresby. The FSC guidelines advise at least 6 different types of rooms for each FSC at the Provincial level, including one for overnight/temporary stay.

Figure 3: Floor Plan for FSC at Arawa

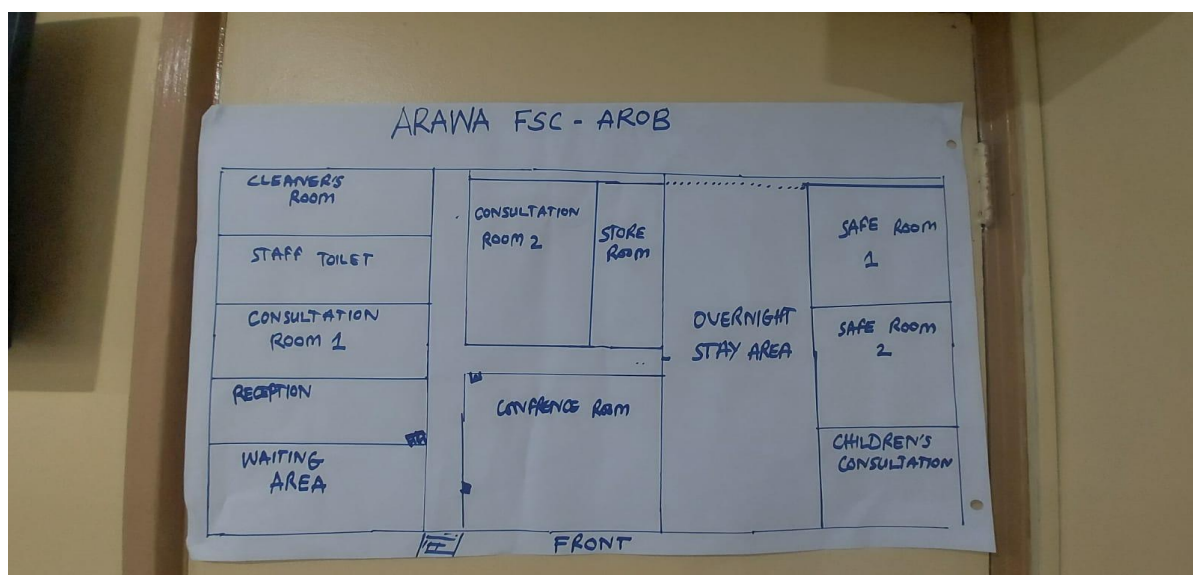
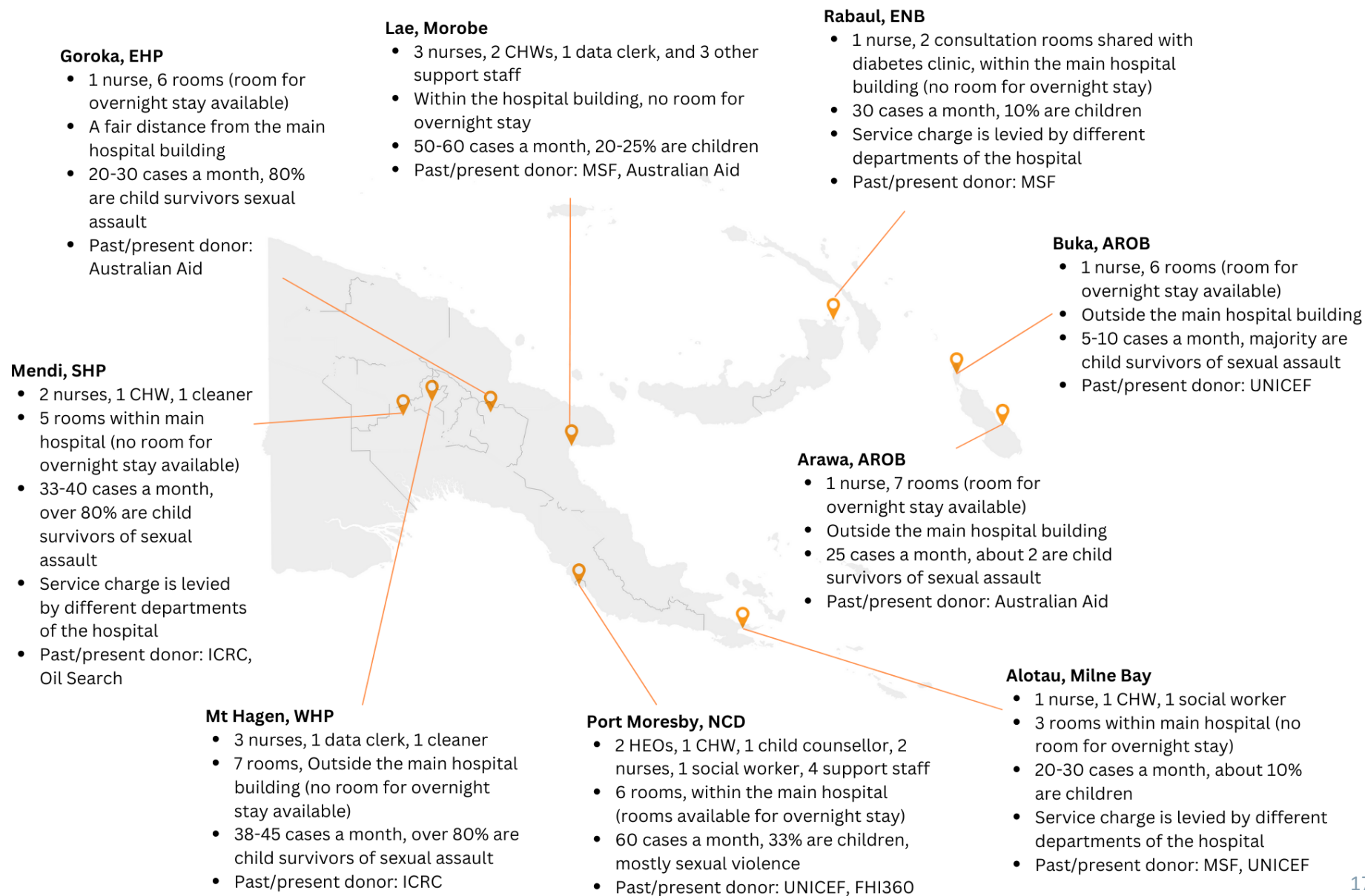
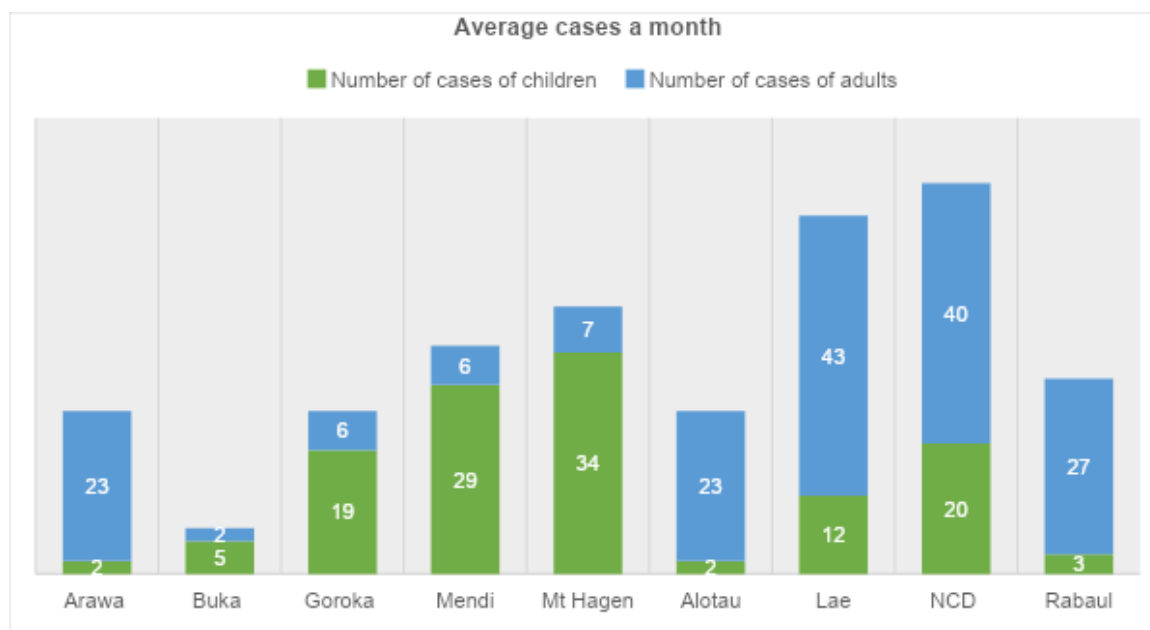


Figure 4: Capacities of Family Service Centres, 2021



2. Brief Profile of Service Users

Number of cases¹⁴: The FSCs at Port Moresby, Lae and Mt. Hagen reported the largest number of service users in a month (60, 55 and 41 at an average respectively), while the FSC at Buka, receives between 5-10 cases in a month. FSC at Mendi reports an average of 35 cases a month followed by FSCs at Alotau, Goroka and Arawa who report an average of 25 cases a month.



Age: While 5 of the FSCs reported that the vast majority of their service users were adult women, 4 FSCs reported that a vast majority of their service users were children (between 60 to 80 percent) and the majority of the cases of violence against children were related to sexual violence (Mt Hagen, Mendi, Goroka and NCD). Majority of the cases of violence against women were noted as intimate partner violence. The baseline has not explored the reasons FSCs have different profiles of service users¹⁵.

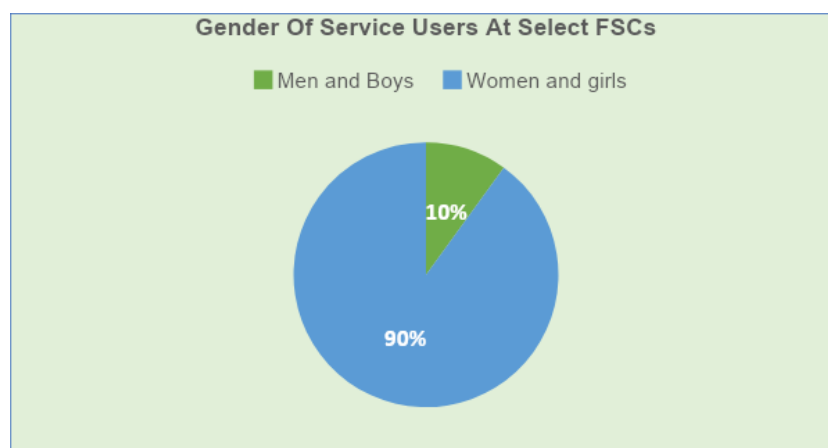
Gender: All FSCs report that the majority of their service users are women and girls, presenting with different types of violence, including intimate partner physical and sexual violence; and in the case of children, almost always related to sexual violence. The FSCs did not share precise disaggregation of the types of violence by age and gender but shared broad estimates.

Men and boys form a very small proportion of their users. Where boys are service users, it is usually a case of sexual violence. Adult men's presentation at FSCs varied. Reports received included men presenting as caregivers in cases of child welfare/protection, for STI treatment for themselves and some in some cases after experiencing intimate partner violence (physical) themselves. Men also attended FSCs for 'couple's' counselling, which involves an FSC staff member 'counselling' the abusive male partner and the female partner (survivor) to address marital discord. FSC's in Mendi and Mt. Hagen shared that men were sometimes invited for 'couple's counselling'. While not referred to as such, this is mediation. Mediation is not

¹⁴ Caseloads are based on estimates provided by the FSCs. They have not been verified, triangulated by assessors for reasons explained elsewhere in the report.

¹⁵ No data from Port Moresby on age and gender disaggregation.

recommended in GBV given the harm it poses to survivors. In locations where ‘couples counselling’ involved the participation of abusive male partners at the FSC site, either the survivor had requested this and/or the FSC staff had ‘recommended’ it as a relevant service. Alotau reported the highest numbers/proportion of men and boy survivors as their service users (18 percent at an average in a month); while FSCs at Rabaul, Mt Hagen, Goroka, Mendi and Arawa reported that between 9-12 percent of their service users were men and boys. The diversity of reasons driving male attendance and the risk posed by adult male, and in particular abusive adult male, presence at FSCs critically requires clarification to ensure FSCs remain client/survivor-centered service sites (elaborated further in subsequent sections).



Persons with disability: FSCs report very little to no presentation of persons living with disability seeking their services. While FSCs at Rabaul and Mendi report that they receive one to two cases a month (respectively) from persons living with disabilities, Lae, Alotau and Goroka report that they receive one or two cases of persons living with disability every 2 to 3 months. Buka reported having had only one case of a person with disability in 9 months, Arawa reported that they have not had a single case of a person living with disability (challenges and recommendations regarding accessibility and quality care for persons with a disability are included in subsequent sections) .

Trends in cases: FSCs at Goroka, Mendi, Mt. Hagen, Lae and Alotau shared that cases peak just after Christmas, around the Independence celebrations on the 16th of September and around the time of celebrations for State of Origin. While a majority of the FSCs shared that number of cases coming to the FSC dropped during the COVID-19 (related to lockdowns), the FSC at Rabaul reported that they saw unprecedented rise in cases, especially of child sexual assault during this period.

During the COVID-19 lockdown period in the province, there was an increase in cases, particularly Incest and other sexual violence. When victims are at home and exposed to known perpetrators. There was an increase in cases of child sexual abuse. After COVID-19 related lockdown, the FSC received cases of 6 boys who had been sexually harassed, abused, and molested through oral sex or anal sex, which has not been previously recorded. –FSC, Rabaul

Issues with data: While respondents from FSCs said that they maintain records of their service users by age and gender, they were not able to provide precise figures or share physical

records of the data during the interviews. They shared that they store raw data in physical forms that have confidential information on survivors, hence they could not be shared with assessors. They do not prepare periodic summary of caseloads and data is only compiled once a year to feed into the annual planning process of the hospital. Except for the FSC at Port Moresby, none of the FSCs have a system to maintain records with a coding system. Even so, the FSC at Port Moresby did not share their records.

Classification of violence by type of violence also varies between FSCs, and several overlaps are noted. IPV, marital rape, physical violence, sexual violence, emotional violence seems to be used as separate categories and it is quite possible that a survivor presenting with more than one type of violence is reported to the assessor under each of the different categories. Issues with data are further elaborated in the following section, under analysis of the standard on Reporting and Information Systems.

3. Achievement Against Standard Criteria

The baseline assessment found that none of the FSCs meet the standards and criteria for quality provision of post-violence care in the health facilities.

A majority of the FSCs perform significantly below standards, meeting less than 65% of all criteria: Arawa, Buka, Goroka, Alotau and Rabaul. Three FSC's perform at an average level, meeting between 65-74 percent of the criteria: Mendi, Mt. Hagen, and Lae. The FSC at Port Moresby performed above average, meeting 79 percent of the criteria¹⁶.

The poor performance is not a reflection of poor efforts on part of the FSC staff but rather due to insufficient resourcing—supplies, staff and lack of a systematic approach, procedures, protocols, and training. Overall, the lack of a “whole-of-hospital” approach and siloed approach to FSC and GBV services, which is indicative of the low priority to GBV in general, is at heart of poor achievement of standards. FSC staff demonstrate appropriate soft skills required for the task but are restricted by systemic gaps in the health sector response to GBV.

An overview of overall scores is presented in Table 2, followed by detailed breakdown of achievement of each standard criteria (except 18 and 19¹⁷) under the 11 thematic areas.

Table 2: Overall achievement against all standard criteria

		Arawa	Buka	Goroka	Mendi	Mt Hagen	Alotau	Lae	Port Moresby	Rabaul
	OVERALL SCORES	64	52	61	67	69	54	74	78	52
	Standard ¹⁸									
1	Accessible, affordable, appropriate	100	83	100	83	100	67	100	cc ¹⁹	67
2	Visible IEC materials	50	50	50	50	50	50	50	50	50
3	Appropriate infrastructure, equipment	68	59	59	73	68	23	77	77	18
4	System for survivor identification	25	25	25	25	25	25	25	25	25
5	Appropriate communication with survivor	80	80	80	80	80	60	80	80	60
6	Addressing immediate risk	67	67	67	67	100	100	100	100	67

¹⁶ Each verification criterion was scored as a yes/no and n.a or cc where information was not applicable or not verifiable. In the case of the latter, denominators matched only those criteria that were scored. Where the criteria pertained a service provided outside of the FSC (by other departments of the hospital) they have been noted as “referred” and scored as a “no”

¹⁷ As explained under Methodology, Standards 18 and 19 pertaining to Forensic Examination and Handling of Evidence were not applied for this assessment.

¹⁸ Although the WHO tool lists 28 standards and all 28 have been investigated in the baseline assessment, 2 standards pertaining to the thematic area of forensics which scored n/a for all FSC's have been dropped from this aggregate presentation. And a 29th Standard pertaining to Human Resources has been introduced.

¹⁹ FSC at Port Moresby did not provide a response to most of the criteria under this standard. It has therefore not been scored.

7	Obtaining informed consent	100	100	100	100	100	100	100	100	100
8	Management of injuries	60	40	20	0	0	0	60	100	40
9	Knowledge to prevent further trauma	100	100	100	100	100	100	100	100	100
10	Special considerations for child survivors	83	67	80	83	67	50	83	100	67
11	Privacy and confidentiality	80	60	80	80	80	75	80	80	60
12	Respectful care to prevent further trauma	80	60	80	33	33	33	60	100	67
13	Medical examination of injuries	75	75	50	50	50	50	50	50	50
14	Emergency contraception	75	50	50	75	75	75	50	75	75
15	HIV counselling, testing and PEP ²⁰	38	13	50	100	100	13	100	89	13
16	Medications and/or vaccinations	33	33	33	100	100	33	100	100	33
17	Mental health care	100	50	100	100	100	100	100	100	100
20	Referral system	70	40	80	40	40	40	70	70	40
21	Follow-up services	90	70	60	30	40	40	90	60	60
22	Relevant training	0	0	0	0	0	0	0	100	0
23	Systems for quality improvement	0	0	0	80	80	0	40	20	0
24	Protocols for standardized care	17	17	67	83	83	100	50	100	17
25	Awareness internal referrals, outreach	100	50	50	100	100	50	100	0	50
26	Information collection	100	100	100	100	100	100	100	100	100

²⁰ Most of these services are not provided at most of the FSCs, they are provided by other departments of the hospital

27	Analysis of GBV program data	20	0	80	60	60	50	80	80	50
28	Data informed improvement	56	56	56	67	67	56	56	89	56
29	Human Resource	57	50	29	57	57	57	86	86	43

4. Availability and Appropriateness of Services

Table 3: Achievement against Standard 1

Standard 1	Facility offers GBV services that are accessible, available, affordable and appropriate								
Verification Criteria	1) Facility offers GBV essential services 24 hours a day OR facility helps patients to access alternative facilities that provide essential care during off-hours whether through referrals (A&E) or staff on call 2) Facility offers GBV essential services without requiring GBV patients to report to the police 3) Facility keeps medical reports on site (e.g., patients do not have to go to the police station to obtain forms). Medical reports are available free of charge and persons authorised (eg. HEO and/or doctor) to sign them is available 24/7 4) Facility maintains patient privacy during triage/intake process 5) Facility provides services to GBV survivors free of charge 6) Facility prioritizes patients who have experienced sexual assault to ensure they receive care and support as soon as possible 7) Facility ensures all patients have equal access to care, regardless of sex, language, gender identity, sexual orientation, marital status, age, disability, race, religion, ethnicity, etc								
	Arawa	Buka	Goroka	Mendi	Mt Hagen	Alotau	Lae	Port Moresby	Rabaul
	100	83	100	83	100	67	100	cc	67

- GBV services are available to survivors 24/7 through a combination of services provided by the FSC and other departments of the hospital.
- None of the FSCs are required to or practice mandatory reporting to the police for either adults or child survivors.
- Medical reports are available on-site at all the FSCs, however, all FSCs require the police to approve that a medical report can be provided to the survivor/guardian through the use of a request form.
- All services at the FSC are free of charge but not all GBV services provided by other departments of the hospital are free of charge (reported by Mendi, Milne Bay and Rabaul)
- 6 out of 9 FSCs are able to maintain privacy during triage/intake but 3 FSCs do not have sufficient space or appropriate location to ensure such privacy (Buka, Alatau, Rabaul)

²¹ This criterion was not scored due to insufficient information provided by the FSCs.

²² The FSC at Port Moresby was not scored on this standard due to incomplete response.

- Aggregate scores for this standard are not entirely accurate since criterion on equal access could not be measured because of lack of information/verification on this score. Those scoring 100% must not be read as FSCs that ensure equal access to all (eg. persons with a disability)

24×7 Services

All FSCs scored positively on this criterion, even though none of them are open 24/7 and operate from Monday to Friday, 8am – 4pm (with the exception of the FSC at Lae which is open on weekends as well), for the following reasons:

- 8) The FSCs themselves do not provide the whole suite of GBV services, a bulk of the medical/clinical services are provided by other departments of the hospital, such as the A&E and OPD.
- 9) The A&E is open 24/7 and both, the A&E and OPD are typically the first point of entry for survivors
- 10) FSC staff shared that they are available on call during weekends and after hours (except at Port Moresby and Rabaul)

The reliance on other hospital wards for after hours and weekend care for survivors is in line with the standard and relevant criteria. Hence, the assessors have concluded that GBV services are available to survivors 24/7 through a combination of services provided by the FSC and other departments of the hospital.

However, concerns were raised during consultations with the FSCs regarding the standard of care provided outside of the FSC at the various departments of the hospital (A&E, OPD, etc) and the need to invest in a 'whole of facility approach'. Concerns included whether non-FSC staff have requisite training relevant to their interactions with survivors (eg. safe response and referral, psychological first aid and/or clinical management of rape) and because of this, the risk of stigmatisation and retraumatisation of survivors by health staff, who may not be adequately trained.

Other concerns included an already overburdened health system combined with the normalisation of GBV resulting in the de-prioritisation of GBV cases at non-FSC entry points as well as the charging of survivors for essential services which should otherwise be free of charge at the FSC (see more below).

Similarly, the reliance on FSC staff on call after hours and on weekends aligns with the standard and relevant criteria, however, raises concerns regarding timeliness of care to survivors as well as staff care and wellbeing.

Mandatory reporting to the police

All the FSCs reported offering GBV essential services without requiring cases of adult or child survivors to be reported to the police. There is no legal obligation in PNG for mandatory reporting of GBV cases for either adults or children. This adheres with international best practice for survivor-centred care. FSCs reported that most of the cases are referred to them by the police in any case, and in other cases, FSC facilitates contact with police only if the

survivors (or guardian in case of a child) ask for it, or when there is a threat to the life of a survivor and/or third party, like a child.

Where there is a risk to the life of the survivor (e.g. mother and/or child) as identified by the doctors at the ED or as shared by the survivor, the FSC would inform the police to intervene with the perpetrator - FSC, Goroka

We only call the Police directly during severe consequences when the life of the survivor is at risk such as during Sorcery Accusation Related Violence- FSC, Mendi

In the case of child survivors, the relevant legislation (*Lukautim Pikinini Act, 2009*) compels all service providers, including health workers, to report to the Office of Child and Family Services—through their designated Child Protection Officers when they have “reason to believe that the child is a child in need of protection”; however, in practice this occurs inconsistently. Resourcing is one factor; either the absence of a Child Protection Officer or understaffing prevents this.

In many cases, there is only one Community Development Officer who oversees all areas under the Department for Community Development and Religion’s (DfCDR) mandate; including but not limited to youth, the elderly, GBV, child protection, economic empowerment. This person may also function as the Child Protection Officer. Providers were often not confident in the quality and safety of services provided by the Child Protection Officer. Overwhelmingly assessment respondents as well as those who participated in consultations pointed to the complexity of mandatory reporting in the socio-cultural context and the strong norm of children ‘belonging’ to their kinship. Safety concerns relating to the child, reporting family members and/or service providers were also noted in small communities, in part at least arising from the Child Protection Officers and/or police’s relationship with perpetrators. Assessment respondents gave conflicting answers regarding the determination of GBV cases involving adolescents. In some cases, providers respected the evolving capacities of the child to make informed decisions regarding their care and seemed to exclude them from mandatory reporting for Child Protection Officer obligations. In other cases, young women over the age of 18 were still perceived to be ‘children’, with guardians being included as a matter of course, although admittedly no formal reporting to state service providers was done. The treatment of adolescent survivors is expanded upon in the discussion on informed consent in following sections.

Medical reports-free and on site

All the FSCs share that medical reports are available on site. Where they are provided by or as part of the service provided within the FSC, they are free of charge. However, where they are generated as part of a service provided by health staff in other wards, they must be purchased. As expanded upon below, at many sites at least some of the essential health services are provided outside FSCs through other wards, which has concerning implications of

Legal Framework and Mandatory Reporting in PNG

Summary reporting obligations as per CP and GBV legislation

The legal framework for children does not require mandatory reporting to the police. However, the (*Lukautim Pikinini Act, 2009*), requires service providers to report child protection cases to Child Protection Officers.

The legal framework for GBV comprised the *Criminal Code* and *Family Protection Act*, neither compel service providers to report cases of GBV to police.

the genuine availability of free medical reports (more on this included in the subsequent sections). FSCs lack of basic office materials raised concerns about their ability to continue to provide free medical reports, with a few anecdotal reports suggesting survivors had to provide their own materials for report generation (paper, printing, etc.).

The nurse usually fills in the medical report and it is signed by the HEO or the doctor of the hospital. However, all FSCs require the police to approve that a medical report can be provided to the survivor/guardian through the use of a request form. Processes for this vary across sites; in some cases, the survivor is given the request form by the police to take to the FSC herself and is then given her report to take back to the police. In other cases, the police directly communicate with the FSC and/or receive the medical report directly from the hospital. This process is intended to prevent misuse of the medical reports, especially by the survivor and/or her family/*wantok*/collective group to claim compensation as part of customary justice practices. The use of medical reports for this is reported to be very common. Health staff have also raised safety concerns about the release of medical reports, citing cases where community members affiliated to either the survivor or perpetrator have targeted health staff (HEO or Nurse) who have signed the medical report. FSCs at Mt Hagen, Mendi, Lae and Rabaul shared that the police have to request for the release of the medical report to the survivor. This request in the form of an Affidavit is required by the courts.

Medical reports are stored on site but there is a new policy about sharing of the medical report. A request form has to be provided by the police and the perpetrator put behind the bars before a medical report is provided. This is to ensure that there is compliance with court requirements. The reason why the policy was changed is because the victims usually use the medical report for compensation claims outside of the formal justice system. – FSC, Mendi

Survivor privacy during triage/intake

All but three FSCs maintain privacy in their physical layout for survivors during the triage/intake process. The FSCs at Buka, Alotau and Rabaul are not able to maintain privacy during the intake process because they share space with other health departments/clinics in the hospital (HIV/STI clinic in Buka, Accidents and Emergency department in Alotau and Diabetics Frangipani Clinic in Rabaul).

Free of charge services

In a majority of the FSCs (5 of 9), GBV services are provided for free at the FSC and all entry points in the hospital—Arawa, Buka, Goroka, Mt. Hagen and Lae. FSCs at Mendi, Alotau and Rabaul reported that while no charges are levied for services provided directly by the FSC, fees are charged for medical services provided by other departments of the hospital. In Alotau, the A&E Department charges a fee of K10 for services; in Mendi, survivors are possibly charged for surgeries and in Rabaul, the A&E department charges K10, the outpatient department charges K2 and medical reports provided outside the FSC cost K25. This information could not be collected from the FSC at Port Moresby.

Survivors still pay an after-hours fee at the Accident & Emergency Department at K10, and outpatient is K2 for a day. Medical reports provided outside the FSC, cost a K25 fee. —FSC, Rabaul

Respondents at FSCs in Arawa, Goroka, Mt Hagen and Lae shared that circulars are shared across the hospital departments to create awareness on not charging fees from GBV survivors.

Prioritizing survivors of sexual assault

All the FSCs (except at Port Moresby, who did not respond) reported that they prioritise patients who have experienced sexual assault to ensure they receive care and support as soon as possible. In general, FSCs reported receiving more sexual violence cases than other forms of GBV, so that the prioritisation of sexual violence.

Services provided to men and boys

FSCs at Mt Hagen provide services to men and boys through a men's desk and referrals to male social worker at the hospital (who has recently been laid off).

FSCs at Goroka and Lae refer men and boys to the male social worker of their hospitals.

FSCs at Mendi and Rabaul do not have a men's desk but provide services to men and boys: Mendi provides couple's counselling to men (as husbands of survivors accessing FSC services) and Rabaul has provided services to boys in cases of incest or neglect.

Equal access to care

This criterion was not scored since there was insufficient information to verify whether the FSC ensures access for all GBV survivors regardless of their sex, language, gender identity, sexual orientation, marital status, age, disability, race, religion, ethnicity.

A majority of the FSCs do not maintain and/or compile data disaggregated by various demographic categories—at most they include information on age, gender and disability. When asked to respond to this indicator, respondents generally spoke about access for men and boys (they were asked if they have a men's desk). All FSCs shared that they provide services to men and boys, regardless of whether they had a men's desk or not (Arawa, Buka, Alotau do not). However, many respondents conflated male survivors and males involved in GBV cases where the subject was a female survivor (eg. through mediation with husband and wife). This points to a deeper challenge throughout on the lack of survivor-centred values and practices amongst respondents. For example, in some cases 'couples counselling (ie. mediation) was done by FSC staff in an effort to find out 'whose fault it really was' and/or in consideration of the perpetrator's real or perceived needs (this is expanded upon in following sections) in an attempt to balance them with that of the female survivor.

5. Facility Readiness and Infrastructure

Table 4: Achievement against Standards 2 and 3.

	Arawa	Buka	Goroka	Mendi	Mt Hagen	Alotau	Lae	Port Moresby	Rabaul
Aggregate Score	59	55	55	61	59	36	64	64	34

Standard 2	Facility has visible GBV information, education and communication (IEC) materials
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Verification Criteria	<ol style="list-style-type: none"> 1) Facility has visible IEC materials for patients (e.g., posters and/or pamphlets on what to do in case of GBV, GBV laws and rights, and available services) in high-traffic areas (i.e., lobby, waiting areas, consultation rooms, restrooms, etc.) 2) IEC is clear and tailored to all audiences - including for persons who cannot read and diverse cultural and language groups 								
	Arawa	Buka	Goroka	Mendi	Mt Hagen	Alotau	Lae	Port Moresby	Rabaul
	50	50	50	50	50	50	50	50	50

Standard 3	Facility has appropriate infrastructure, equipment and commodities in place to provide appropriate 5 five essential services as per SGBV clinic guidelines
Verification Criteria	<ol style="list-style-type: none"> 1) Facility offers 5 essential services in a location that is close to main services at the Hospital (eg. A&E, Outpatients, O&G) 2) Facility location is in a in a non-stigmatising location which affords privacy (eg. consider proximity to STI/HIV clinic) 3) Facility ensures that signs inside and outside the facility are discreet and well-lit (e.g., instead of "Rape Center" signs could say "Wellness Center" or "One-Stop Center") to increase the safety and privacy of patients and providers 4) Facility has adequate lighting for safety and security 5) Entrance has gate and lock 6) Facility has a fence to afford privacy and security 7) Facility has own security guard 8) Facility and rooms can be locked from the inside 9) Facility's rooms/areas where psychosocial counseling and clinical services are provided are private, clean and comfortable 10) Facility has an emergency exit 11) Entry of non-relevant people, in particular males is restricted, with this enforced by security guard and where required and safe, staff 12) Facility has a room where the patient can rest and/or recuperate that is private, quiet, clean and comfortable (eg. short stay room/observation room) 13) Facility has separate consultation and/or counselling rooms for adults and children. 14) Facility has a child-friendly room for child counseling 15) Where facility provide services for male survivors (men's desk), male and female survivors have their own separate private, confidential space including separate entrances 16) Facility has all essential infrastructure, furniture, equipment, supplies, documents, and commodities available. This includes medical equipment suitable for children. 17) Facility has a system in place to check on a quarterly basis whether medicines, vaccines, and tests are within validity/expiration date, and safely discard those that have expired 18) Facility integrates essential GBV supplies, commodities, vaccines, tests and equipment within the facility's essential supply chain (List of essential items included as assessment attachment) Facility has not had a stock-out of essential GBV supplies, vaccines, tests or medicines in the past three months, and there is a system in place for emergency orders 19) Facility has not had a stock-out of essential GBV supplies, vaccines, tests or medicines in the past three months, and there is a system in place for emergency orders 20) Facility has running water and proper sanitation for clients and staff

	21) Facility has a sink in consultation room/s								
	22) Facility has timely access to forensic laboratory facilities either on site or via transport ²³								
	Arawa	Buka	Goroka	Mendi	Mt Hagen	Alotau	Lae	Port Moresby	Rabaul
68	59	59	73	68	23	77	77	18	

Some critical challenges common among FSCs surveys are detailed in the section below, including that:

- IEC materials are mostly in English and are not suitable for those who cannot read
- In 6 of the 9 FSCs, the other units of the hospital providing GBV services are close enough to FSCs which allows survivors a short walk to or from but in 3 FSC's they are not—Goroka, Mt. Hagen and Rabaul.
- Infrastructure, equipment, and commodities are lacking in all FSC and are most undersupplied in FSC's at Alotau and Rabaul
- Two FSCs do not meet any of the standard criteria for safety and security of survivors: Alotau and Rabaul.
- All FSCs have experienced stock out of essential GBV vaccines, tests, or medicines (except in Mendi)

Visible and tailored IEC materials

While IEC materials are displayed in all FSCs, they are not tailored to all audiences - including for persons who cannot read and diverse cultural and language groups. Except for the FSC in Port Moresby, in all other FSCs the IEC materials are only available in English and not in the local language and neither of the 9 FSCs have IEC materials that can be easily understood by those who cannot read.

All 5 essential services in one location

All 5 essential services are provided within the hospital but not necessarily within the FSC. Most FSCs do not have an examination room for instance and all clinical interventions are done in departments of the hospitals outside of the FSC. In 6 of the 9 FSCs, the other units of the hospital providing GBV services are proximate to FSCs which allows survivors a short walk to or from but in 3 FSC's they are not—Goroka, Mt Hagen and Rabaul.

The FSC is very far from the main services in the Hospital. This has been identified as a reason for a decline in cases coming through. – FSC, Goroka

It is quite a walk to different services even within the hospital. Referrals are made to other facilities within the Hospital, e.g., referral for GBV related eye injury to eye clinic or tooth injury to dental clinic. –FSC, Rabaul

More generally, the requirement of survivors to walk to other wards for service, whatever the distance, compromises the quality of care including their safety and confidentiality.

²³ Scored as n/a since there is no system/provision for forensics at the hospitals

Safety and privacy of survivors

Most FSCs are located in a non-stigmatising location which affords privacy, except in 2 locations: Alotau where the FSC is located in a busy area of the hospital; Rabaul where it is located in a separate area. Although the FSC at Buka is a stand-alone facility within the hospital, at the time of this assessment it had been converted into a makeshift facility for COVID-19 and the FSC was temporarily sharing space with the 2-room STI/HIV clinic in the main Hospital. Even if temporary, this arrangement runs the risk of exposing survivors to stigma.

While all facilities have discreet signage for the FSC, in three of the FSCs the signs are not well lit or clearly visible. There is insufficient lighting at the FSCs in Goroka, Alotau and Rabaul.

Patients are exposed to stigma as the FSC is located right in the middle of a busy area. Facility needs to change access to the back so it is separate from the Accident and Emergency Area. –FSC, Alotau

Two FSCs meet all standard criteria for safety and security of survivors: Lae and Port Moresby—they have a dedicated security guard for the FSC, have a fence, gate and lockable rooms. They have an emergency exit and a system to restrict entry of non-relevant persons to the FSC.

Two FSCs do not meet any of the standard criteria for safety and security of survivors: Alotau and Rabaul. They do not have guards, lockable rooms, emergency exits or a system to restrict entry of the non-relevant persons. These FSCs also share space with other units of the hospital (A&E and Diabetes) that makes it more challenging to ensure privacy for consultations with survivors. Even though the FSC in Buka was temporarily sharing space with another clinic (STI/HIV) they score well on privacy for consultations because within the shared space they have a separate room for consultations with GBV survivors; and their usual location (pre-COVID-19) allows for privacy.

The challenge is that the triage area is also shared with the Frangipani Clinic, there is no security guard to screen people coming into the shared entrance. The doors of the shared clinic also remain open and not locked for diabetes patients to walk in. –FSC, Rabaul

Quality of rooms for survivors

Only 4 FSCs have a room where the survivor can rest and/or recuperate that is private, quiet, clean and comfortable (Arawa, Buka, Goroka and Port Moresby); 6 FSCs have separate rooms for counselling for children but of these only 4 are child-friendly rooms; the former being standard rooms that are used for counselling children, compared to the latter which are equipped with child-friendly materials (ie. toys, child-friendly IEC, etc.). Except for the FSC at Mt. Hagen, none of the FSCs have gender segregated rooms/spaces for consultations with women and men help seekers.

The facility has 2 rooms available one for 24 hrs and one for 72 hrs rest—FSCs at Arawa, Buka and Goroka

The children's counselling room has been converted into a COVID facility—FSC, Arawa

Essential infrastructure, equipment, supplies

None of the FSCs meet the checklist of standard requirements for infrastructure, equipment and supplies, including medical equipment suitable for children as stipulated by the Quality Assurance Tool (see Annex 3 for essential items in the checklist).

Of the 9 FSCs that were assessed, only 1 FSC had access to a phone, only 3 had a blood pressure machine and stethoscope, only 2 had an angle lamp or flashlight for pelvic exam, only 5 had bandages. Only 5 had emergency contraceptives, 4 had simple pain relief medication and only 1 had a pregnancy test kit available. 3 FSCs did not have lockable storage for keeping documents/records of survivors.

GBV supply stock out at FSCs

Arawa and Buka: Gonopack Probinocide stock out since the beginning of 2021

Goroka: Stock out up to 2 months at a time for acetromycne.

Mt Hagen: Stockout of Children's PEP for over 6 months

Lae: stock out of Hepatitis B vaccination has been since 2017

Port Moresby: Ran out of painkillers and other essential supplies a few days last month. No system for emergency

Rabaul: stock out of HIV and Hep B Test Kits and Vaccines

Table 5: Essential infrastructure, equipment and supplies (% items available)

	Arawa	Buka	Goroka	Mendi	Mt Hagen	Alotau	Lae	NCD	Rabaul
Infrastructure	57	57	57	71	71	14	57	57	14
Furniture	55	55	44	38	77	5	50	44	0
Admin Supplies	71	57	85	85	85	57	71	85	57
Clinical Supplies	69	69	46	27	42	42	38	4	23
Essential drugs and commodities	50	63	25	44	13	44	25	cc ²⁴	63

All the FSCs integrate their requirements for essential GBV supplies, commodities, vaccines, tests and equipment within the hospital's supply chain. However, not all FSCs are able to store the required supplies because they do not have storage space or refrigerators, for example for storing vaccines—the FSCs supplies are stored in other units such as the outpatient or HIV/STI clinics.

Most FSC's have a system for weekly or monthly checks to discard supplies that have passed their expiry date except Mt. Hagen and Port Moresby. In Mt Hagen, a new policy by the PHA to manage limited drug supply in the province has centralised drug procurement and distribution with the hospital-based pharmacy and so the FSC no longer has a role in checking supplies for expiry.

All FSC's except the one at Mendi have experienced stock-out of essential GBV supplies, vaccines, tests or medicines in the past three months, and only a few have a system in place for emergency orders (see box).

²⁴ Could not compute due to incomplete response

Water and sanitation

All FSC's have running water and proper sanitation facilities for clients and staff, except in Buka—where staff and clients use general toilets available in the hospital. All FSC's have water sinks except Alotau and Rabaul.

Timely access to forensic laboratory facilities

This verification criteria was not applicable to any of the FSCs because no hospital in PNG has the capacity or systems for forensics. Forensics are managed centrally by the Police through a specialised department in Port Moresby who in turn outsource forensics laboratory services from out of the country. Nurses at the FSC do collect vaginal swabs and blood samples for STI/HIV testing by the hospital laboratories.

6. Identification of Survivors Who Have Experienced IPV or SV (Standards 4-6)

Table 6: ACHIEVEMENT AGAINST STANDARDS 4, 5 and 6

	Arawa	Buka	Goroka	Mendi	Mt Hagen	Alotau	Lae	Port Moresby	Rabaul
Aggregate Score	57	57	57	57	68	62	68	68	51

Standard 4	Facility has an appropriate system in place for providers to identify patients who have experienced GBV
Criteria	<p>i. If patient presents with common signs and symptoms for IPV or SV the provider asks about violence (based on suspicion of violence) in the appropriate manner</p> <p>ii. Facility has a standard process to ask about IPV or SV (e.g., job aid, algorithm, etc.) which aligns with national guidelines, or if no national guidelines are available, aligns with WHO guidelines Facility's policy is to conduct routine clinical enquiry about IPV or SV ONLY IF services meet all of the following WHO minimum requirements for routine enquiry:</p> <ul style="list-style-type: none"> • A protocol or standing operating procedure exists for providing post-GBV services • A questionnaire, with standard questions where providers can document responses, exists • Providers offer first-line support • Providers have received training on how to ask about IPV or SV • Private setting, confidentiality ensured • A system for referrals or linkages to other services within the facility is in place <p>If any of these minimum requirements is missing, or GBV services are considered inadequate, providers do not conduct routine enquiry or universal screening</p>

	iii. Provider conducts routine enquiry when assessing patients in other clinical environments as appropriate (ANC, HCT, FP, ICU/emergency, outpatients, PMTCT, etc.) IF minimum requirements are met								
	Arawa	Buka	Goroka	Mendi	Mt Hagen	Alotau	Lae	Port Moresby	Rabaul
	25	25	25	25	25	25	25	25	25
Standard 5	Provider asks about IPV or SV in an appropriate manner								
Criteria	<p>i. Provider never asks about IPV or SV unless the patient is alone (even if another family member is present, since that person may be the abuser, or a relative of the abuser) AND in a private consultation room (patient cannot be seen or heard from outside)</p> <p>ii. Provider brings up the topic of GBV carefully by making some general statements about GBV before asking the patient directly about her/his situation.</p> <p>iii. Provider does not require patient to talk about her/his experience of IPV or SV if s/he does not want to</p> <p>iv. Provider explains that s/he will ask the patient detailed questions to assess his or her safety and to make sure s/he gets the right treatment and support</p> <p>v. Provider asks simple and direct questions about specific acts of violence to enquire about IPV or SV and documents responses</p>								
	Arawa	Buka	Goroka	Mendi	Mt Hagen	Alotau	Lae	Port Moresby	Rabaul
	80	80	80	80	80	60	80	80	60
Standard 6	Provider assesses and addresses any risk of immediate violence or harm when IPV or SV is disclosed (i.e., safety planning)								
Criteria	<p>i. Provider asks simple and direct questions to assess immediate danger to the patient's life for all GBV cases not just repeat presentations</p> <p>ii. If patient responds "yes" to 3 of the questions above concerning immediate danger, or if the patient requests shelter, the provider offers appropriate referrals to shelter or safe housing, or works with the patient to identify a safe place where s/he can go (e.g., a friend's home, church, etc.)</p> <p>iii. Provider helps patient to make a safety plan</p>								
	Arawa	Buka	Goroka	Mendi	Mt Hagen	Alotau	Lae	Port Moresby	Rabaul
	67	67	67	67	100	100	100	100	67

- Patients are identified as survivors of IPV/SV at different locations in the hospital whether the staff (FSC or other departments) have guidance or training for doing so
- FSC staff demonstrate soft skills for making appropriate inquiry on IPV/SV but do not have training and guidance on asking direct questions
- All FSCs are able to identify immediate risks to survivors and are able to discuss about and refer to shelters or alternative safe places but only 4 do safety planning with survivors.

Standard 4: Identification of patients who have experienced GBV

Identification of patients as GBV survivors may happen in 3 different locations/situations in the hospitals:

- i) The A&E department is the most typical first point of contact for survivors of IPV/SV. In most instances, they are accompanied by the police and “brought in” as IPV/SV survivors, i.e., already identified.
- ii) At the FSC, for cases that usually do not involve aggravated physical injuries and not requiring medical stabilisation.
- iii) At the OPD, other clinics in the hospital where the identification of patients might be done by health workers of the OPD/clinic and/or by the FSC staff invited by the clinic. These are rare instances.

The WHO requires that 6 minimum requirements must be met before which any facility can conduct routine enquiry or universal screening for identification of IPV/SV survivors (See box below). Regardless of whether the FSCs or other departments of the hospital meet the prerequisites, they are all engaged in making enquiries and providing services to IPV/SV survivors. The FSC’s themselves meet few prerequisites for making inquiries with patients/survivors on their IPV/SV experience and the other departments meet even fewer of these requirements.

For instance, all FSCs reported that they use a standard intake form developed by MSF for guiding their inquiry on IPV/SV (See Annex 4), although they have not been trained on how to ask questions of survivors. In the absence of a whole-of-hospital approach, it is unlikely that these forms are also used by the A&E and other departments to make inquiries with patients. Likewise, all FSC report that they are able to provide first line of support²⁵ to survivors (some have training in this, some don’t) but the same cannot be said for the other departments. While all FSCs except the ones at Alotau and Rabaul have private settings to communicate with survivors about their IPV/SV experience, it is unlikely that the busiest departments of the hospital—the A&E and OPD are able to provide privacy to survivors, especially in the absence of clear guidelines and protocols for GBV response that are applicable across the hospital. In this context, the first persons in contact with the survivor are usually not the FSC staff and there is no system to ensure that these first contacts are trained in and follow the guidelines (MSF intake form for ex) for making inquiries of the survivors and ensure privacy and confidentiality for survivors. By the time the survivor meets with the FSC staff (after a referral from A&E/OPD or after an on-call consultation), the tone of their experience with GBV response service at the hospital has been set.

As elaborated in later sections, in the absence of SOPs for internal referrals for GBV survivors and requisite training for all staff (FSC and non-FSC) involved in the care of survivors, the FSC staff (and indeed other departments of the hospital) rely on routine referral system for general patients and /or ad hoc referrals at their hospitals.

WHO minimum requirements for routine clinical enquiry about IPV or SV	
All FSCs have	None of the FSCs have
✓ A questionnaire, with standard questions where providers can document responses, exists (MSF form, Annex 4)	× A protocol or standing operating procedure exists for providing post-GBV services

²⁵ The WHO defines “first-line support” using the acronym “LIVES”: Listening, Inquiring, Validating, Ensuring safety, and Support through referrals. (WHO, 2014, Health care for women subjected to intimate partner violence or sexual violence: A clinical handbook.

<ul style="list-style-type: none"> ✓ A system for referrals or linkages to other services within the facility is in place ✓ Providers offer first-line support 	<ul style="list-style-type: none"> ✗ Providers have received training on how to ask about IPV or SV <p>Some have: Private setting, confidentiality ensured</p>
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Despite not meeting the minimum requirements for making clinical enquiries on IPV or SV, FSC staff are using resources that they do have for making such enquiries. For example, with children, the FSCs in Lae, Mt. Hagen and Mendi report that they use toys, story-telling and drawings as methods to help children “open up”.

Not all survivors that come through other entry points in the hospital are recorded and managed at the FSCs. In such cases FSC intervention typically is related to making referrals to safe houses where they exist. The services provided by FSC staff to survivors identified in other departments of the hospitals are usually treated as “consultation” provided by the FSC to that particular department. Such cases do not get “referred” to the FSC. A majority of the cases that come to the FSC are via the police or directly, not from the OPD or other departments. In fact, the referrals are more from FSC to other departments for (higher specialist) clinical care.

We use the consultation form when SV is identified in another section of the hospital. We are requested by the Doctor to consult in other higher service departments, especially O&G and Paediatric Children’s Departments. The Doctors request FSC staff to attend to the SV case within the wards rather than the survivor being referred to the FSC. –FSC, Lae

Standard 5: Provider asks about IPV or SV in an appropriate manner

All FSCs meet all but one criterion for this standard. They are all careful about not asking about IPV or SV unless survivors are alone and in privacy. Even in FSCs that do not have separate space for the FSCs such as in Rabaul and MB, staff either request to use a common consultation room privately when a survivor comes or draw curtains.

All FSCs are careful about bringing up the topic of GBV with survivors and start conversations with general statements and indirect questions before asking survivors directly about their situation—they use the intake forms developed by MSF to guide the flow of consultation with survivors. They also do not require survivors to talk about their experience of IPV and SV if survivors do not wish to—a consent form is part of their intake process. All FSCs explain to the survivors that they will be asked detailed questions to make sure they get the right treatment and support.

Start by building trust, tell a friendly story, offer some water or Milo or a biscuit to eat, give them time for those who hesitate and take their time. —FSC, Alotau

While the FSCs shared that they ask simple questions listed in the MSF intake form to guide their inquiry about IPV or SV and document the responses of the survivors, they do not ask direct questions about specific acts of violence. This is linked to the lack of guidance and training on how to ask direct yet simple questions on IPV and SV.

Just as for Standard 4, here too, it is not clear to what extent other departments of the hospital meet the criteria for making *appropriate* inquiries of survivors.

Standard 6: Assessing and addressing immediate risk of violence or harm

FSC respondents shared that they do not have specific guidelines or training on assessing immediate risk of violence or harm, including self-harm. They ask simple but not direct questions to assess immediate danger to the life of survivors and offer appropriate referrals to shelter (where available) or work with the survivor to identify a safe place where they could go. Where there are no safe houses, for example in Mt. Hagen, the service provider would discuss an alternate safe place for the survivor to go to. However only 4 FSCs help survivors make a safety plan—Mt. Hagen, Alotau, Lae and Port Moresby. The service provider at Rabaul shared that they would like to be trained so they could do safety planning for survivors.

Take immediate action depending on the needs of the survivor. In life threatening situations the survivors are kept at the facility for a maximum of 72 hours. We call the Police FSVU to help transfer the survivor to the safe houses in Arawa. There is a safe house for men and for women. Police FSVU have a vehicle that supports referrals. —FSC, Arawa

I (nurse) will ask the survivors if they would be safe returning home, and if their safety was guaranteed at home. —FSC, Rabaul

Limited awareness of GBV case management as a specialised service and the absence of it contributes to gaps in safety planning; safety planning is one aspect of the standard GBV case management process (further expanded upon in next section).

As for Standards 4 and 5 above, it is not clear to what extent other departments of the hospital assess and address immediate risks of violence or harm to survivors, especially in cases where referral to FSC is not made.

7. Patient-Centered Clinical Care and Communication (Standards 7-17)

Table 7: Achievement against Standards

	Arawa	Buka	Goroka	Mendi	Mt Hagen	Alotau	Lae	Port Moresby	Rabaul
Aggregate Score	75	59	68	75	73	57	80	90	64
Standard 7	1. Provider obtains informed consent from adult patients and informed assent from patients who are minors								
Criteria	i. Provider obtains written or verbal informed consent (or informed assent from children and young adolescents subject to determination of capacity) including explaining to								

	<p>the patient what the medical report entails and how resulting information may be used, prior to medical examination or procedure</p> <p>ii. Provider obtains written or verbal consent/assent for HIV counseling and testing</p> <p>iii. Provider follows facility guidelines for obtaining informed assent from children and adolescents if patient is deemed not to have sufficient maturity to provide consent</p> <p>iv. Provider never forces the patient, including children of any age, to undergo an examination against her/his will, unless the examination is necessary for medical treatment (e.g., if a patient may have life threatening internal bleeding)</p> <p>v. Provider makes it clear to the patient that s/he can decline any component of the examination or counseling session at any point, and seeks verbal consent at each stage of the examination</p> <p>vi. Provider respects the patient's decision about whether to involve the police at all times, if in accordance with national law.</p> <p>vii. After the child's safety has been secured and acute clinical care has been provided, the provider makes any reports to authorities guided by the least harmful course of action that takes into account the best interests of the child and his/her right to protection.</p>																		
	<table border="1"> <thead> <tr> <th>Arawa</th> <th>Buka</th> <th>Goroka</th> <th>Mendi</th> <th>Mt Hagen</th> <th>Alotau</th> <th>Lae</th> <th>Port Moresby</th> <th>Rabaul</th> </tr> </thead> <tbody> <tr> <td>100</td> <td>100</td> <td>100</td> <td>100</td> <td>100</td> <td>100</td> <td>100</td> <td>100</td> <td>100</td> </tr> </tbody> </table>	Arawa	Buka	Goroka	Mendi	Mt Hagen	Alotau	Lae	Port Moresby	Rabaul	100	100	100	100	100	100	100	100	100
Arawa	Buka	Goroka	Mendi	Mt Hagen	Alotau	Lae	Port Moresby	Rabaul											
100	100	100	100	100	100	100	100	100											
Standard 8 ²⁶	Provider manages injuries appropriately																		
Criteria	<p>i. Provider assesses and documents vital signs</p> <p>ii. Provider ensures patient is medically stabilized and treats serious injuries immediately</p> <p>iii. Provider takes a detailed medical history, as appropriate, from the patient (or from guardian/trusted companion if patient is unable to give a history and has consented to a companion being present, or the patient is a minor) I or tears</p> <p>iv. Providing appropriate bandaging and splinting as needed</p> <p>v. Providing follow up testing as indicated (e.g., XRay for bone fractures)</p> <p>vi. Provider manages genital and anal injuries appropriately (e.g., sutures deep vaginal, cervical, or anal lacerations or refers to higher-level facility if indicated, particularly in cases of female genital mutilation)</p> <p>vii. Provider manages minor injuries appropriately, after forensic evidence is collected (only if patient has given informed consent for collection of forensic evidence and capacity to process forensic evidence is present - refer to below sections on services to determine forensic functionality) including:</p> <ul style="list-style-type: none"> • Caring for minor wounds, lacerations 																		
	<table border="1"> <thead> <tr> <th>Arawa</th> <th>Buka</th> <th>Goroka</th> <th>Mendi</th> <th>Mt Hagen</th> <th>Alotau</th> <th>Lae</th> <th>Port Moresby</th> <th>Rabaul</th> </tr> </thead> <tbody> <tr> <td>60</td> <td>40</td> <td>20</td> <td>0</td> <td>0</td> <td>0</td> <td>60</td> <td>100</td> <td>40</td> </tr> </tbody> </table>	Arawa	Buka	Goroka	Mendi	Mt Hagen	Alotau	Lae	Port Moresby	Rabaul	60	40	20	0	0	0	60	100	40
Arawa	Buka	Goroka	Mendi	Mt Hagen	Alotau	Lae	Port Moresby	Rabaul											
60	40	20	0	0	0	60	100	40											
Standard 9	Provider demonstrates knowledge of appropriate communication techniques to prevent further traumatization of patient																		
Criteria	Provider demonstrates knowledge of empathetic and appropriate communication skills to use with all patients																		
	<table border="1"> <thead> <tr> <th>Arawa</th> <th>Buka</th> <th>Goroka</th> <th>Mendi</th> <th>Mt Hagen</th> <th>Alotau</th> <th>Lae</th> <th>Port Moresby</th> <th>Rabaul</th> </tr> </thead> <tbody> <tr> <td>100</td> <td>100</td> <td>100</td> <td>100</td> <td>100</td> <td>100</td> <td>100</td> <td>100</td> <td>100</td> </tr> </tbody> </table>	Arawa	Buka	Goroka	Mendi	Mt Hagen	Alotau	Lae	Port Moresby	Rabaul	100	100	100	100	100	100	100	100	100
Arawa	Buka	Goroka	Mendi	Mt Hagen	Alotau	Lae	Port Moresby	Rabaul											
100	100	100	100	100	100	100	100	100											
Standard 10	If patient is a child, provider takes special considerations, according to national guidelines																		

²⁶ The scores on this standard do not imply that injuries are not managed at all, but that they are not managed by the FSC.

Criteria	<ul style="list-style-type: none"> i. Provider offers compassionate, supportive counseling prior to history taking ii. If provider suspects home environment is abusive or dangerous, provider works to identify alternative shelter or appropriate course of action for child iii. For child patients, provider uses child-friendly communication techniques. iv. Provider permits child to have a trusted companion present during the exam, recognizing the companion may or may not be the caregiver or parent v. To avoid pain or serious injury, provider does not use a speculum to examine pre-pubertal girls, unless an internal vaginal injury or internal bleeding is suspected—in which case general anesthesia is administered prior to exam and a child-sized, small speculum is used²⁷ vi. Facility has child-appropriate dolls, toys or drawing supplies (paper, crayon/marker/pencil/paint) available 								
	Arawa	Buka	Goroka	Mendi	Mt Hagen	Alotau	Lae	Port Moresby	Rabaul
	83	67	80	83	67	50	83	100	67
Standard 11	Provider respects and maintains patient privacy and confidentiality								
Criteria	<ul style="list-style-type: none"> i. Provider does not share any information regarding the patient or the violent incident(s) with anyone who is not directly involved in the patient's care ii. Provider allows only authorized people into the consultation or exam (e.g., authorized people could be patient's preferred companion or staff involved in the patient's care) iii. Provider gives patient adequate time, space, and privacy in order to undress and dress for exams iv. Facility keeps patient files, medical report GBV register, forensic evidence (where relevant) and any other documents with identifying information about the patient securely in a locked cupboard, locker or locked room, according to national guidelines and facility protocols²⁸ v. Facility has a written policy in place to govern who can access patient files, medico-legal forms, and forensic evidence 								
	Arawa	Buka	Goroka	Mendi	Mt Hagen	Alotau	Lae	Port Moresby	Rabaul
	80	60	80	80	80	75	80	80	60
Standard 12	Provider observes the following aspects of respectful care to prevent further traumatization of patient								
Criteria	<ul style="list-style-type: none"> i. Provider takes care to minimize pain during exam²⁹ ii. Provider gives pain relief medication when requested or as necessary iii. Provider keeps patient's body covered with gown or sheet as much as possible throughout exam, so as to avoid unnecessary or traumatic bodily exposure³⁰ iv. Facility offers patients the choice of the sex of the provider to conduct the examination. If provider of preferred sex is not available, facility offers the patient to have a staff member of the same sex present in the examination room v. Facility offers inpatients and those staying in the on-site shelter/safe room simple food and fluids (to be given after medico-legal exam if patient has consented to one) 								

²⁷ Most FSCs do not provide clinical intervention, these services are provided by other departments of the hospitals and hence scored as "no". In Port Moresby, no response was received on this criterion, hence not scored.

²⁸ FSC at Alotau was not scored for this criterion because they do even have space for conducting medical exam, this criterion could not be applied to them

²⁹ Medical exams for survivors at Mendi, Mt Hagen, Alotau and Rabaul are not conducted by FSC but by the Hospital. This criterion could not be verified during the assessment, hence not scored. Port Moresby did not respond to this criterion and has not been scored for this criterion.

³⁰ Same as above

	Arawa	Buka	Goroka	Mendi	Mt Hagen	Alotau	Lae	Port Moresby	Rabaul
	80	60	80	33	33	33	60	100	67
Standard 13 ³¹	Provider conducts medical examination for genital and non-genital injuries								
Criteria	<ul style="list-style-type: none"> i. Provider documents findings from medical examination and treatment in patient's record in as complete and detailed manner as possible including document injuries on a body map/ pictogram/ traumagram, and observation and documentation of any petechiae¹⁴ on the scalp, behind ears, in the mouth, and in the sclera of eyes ii. Provider uses speculum only when appropriate and only if the provider has been trained on its proper use. iii. If patient has been strangled or choked, provider tells patient to return to the clinic if experiencing any new onset of: difficulty breathing, voice changes, or signs of respiratory distress up to 72 hours after the assault, as this may be related to possible swelling in the tissue surrounding the trachea iv. If patient is experiencing heavy or prolonged anal bleeding, trained provider uses anoscope for anal exam, or refers patient to higher level facility 								
	Arawa	Buka	Goroka	Mendi	Mt Hagen	Alotau	Lae	Port Moresby	Rabaul
	75	75	50	50	50	50	50	50	50
Standard 14	For female sexual assault survivors, provider offers emergency contraception								
Criteria	<ul style="list-style-type: none"> i. Provider offers oral emergency contraception (EC) within 5 days (120 hours) of the assault, according to national guidelines ii. Are there FSC staff certified/authorised to provide EC iii. Are there FSC staff certified/authorised to provide EC iv. If oral EC is not available, and if it is appropriate, a trained provider offers to insert a copper-bearing intrauterine device (IUCD) only if the patient is seeking ongoing pregnancy prevention v. If IUCD is selected, a provider trained in IUCD insertion inserts it within 120 hours (5 days) of sexual assault vi. If patient declines EC, provider gives information that EC is less effective as time passes, and emphasizes the importance of returning back to the facility for follow-up pregnancy testing and monitoring 								
	Arawa	Buka	Goroka	Mendi	Mt Hagen	Alotau	Lae	Port Moresby	Rabaul
	75	50	50	75	75	75	50	75	75
Standard 15 ³²	Provider offers HIV counselling, testing and HIV post-exposure prophylaxis (PEP) within 72 hours to sexual assault survivors								
Criteria	<ul style="list-style-type: none"> i. For sexual assault survivors, provider offers HIV counseling and testing as per national guidelines ii. Are there FSC staff certified to provide HIV PEP (ie. received IMAI training and registration) iii. If the patient tests negative for HIV and the assault occurred within the past 72 hours, provider discusses the various risk factors for HIV infection with the patient to determine the patient's need for PEP 								

³¹ For Standard 13, a majority of these services are not provided by a majority of the FSCs, but by other departments of the hospital.

³² Most HIV related services are not provided by the majority of the FSCs, but by HIV clinics in the hospitals, hence the low score.

	<p>iv. If patient tests negative for HIV AND the sexual assault occurred within previous 72 hours, provider offers full 28 day dosage of PEP in a two or three-drug regimen, or in accordance with national guidance (i.e. provider gives the full dosage so patient does not have to return for another visit)</p> <p>v. If patient is a child and tests HIV negative, provider prescribes appropriate paediatric PEP dosage according to national guidance</p> <p>vi. If PEP is given, provider counsels on side effects, the importance of adherence, and the importance of completing the full course of treatment to ensure PEP effectively reduces the risk for HIV infection</p> <p>vii. If PEP is given, facility has a tracking and follow-up system in place for ensuring and documenting PEP regimen completion</p> <p>viii. If patient tests positive for HIV and is interested in disclosing status to partner or family members, provider assesses for IPV and offers tailored guidance on how to disclose patient's HIV status to avoid disclosure-related violence, without pressuring patient to disclose</p> <p>ix. If patient refuses an HIV test and serostatus is unknown, and assault occurred within previous 72 hours, provider still offers PEP and encourages patient to return for HIV counseling and testing</p>																		
	<table border="1"> <thead> <tr> <th>Arawa</th> <th>Buka</th> <th>Goroka</th> <th>Mendi</th> <th>Mt Hagen</th> <th>Alotau</th> <th>Lae</th> <th>Port Moresby</th> <th>Rabaul</th> </tr> </thead> <tbody> <tr> <td>38</td> <td>13</td> <td>50</td> <td>100</td> <td>100</td> <td>13</td> <td>100</td> <td>89</td> <td>13</td> </tr> </tbody> </table>	Arawa	Buka	Goroka	Mendi	Mt Hagen	Alotau	Lae	Port Moresby	Rabaul	38	13	50	100	100	13	100	89	13
Arawa	Buka	Goroka	Mendi	Mt Hagen	Alotau	Lae	Port Moresby	Rabaul											
38	13	50	100	100	13	100	89	13											
Standard 16 ³³	Provider offers relevant medications and/or vaccinations for prevention and treatment of other sexually transmitted infections																		
Criteria	<p>i. Provider offers prophylaxis or treatment for sexually transmitted infections (STIs), and the choice of drugs and regimens follows national guidelines</p> <p>ii. Provider gives tetanus vaccination if patient has not had one in past ten years, or is uncertain about vaccination status</p> <p>iii. Provider gives Hepatitis B vaccination within 24 hours of assault if the patient is not already immune (determined through a blood test) according to the national guidelines (IF HEP B VACCINATION IS NOT AVAIL)</p>																		
	<table border="1"> <thead> <tr> <th>Arawa</th> <th>Buka</th> <th>Goroka</th> <th>Mendi</th> <th>Mt Hagen</th> <th>Alotau</th> <th>Lae</th> <th>Port Moresby</th> <th>Rabaul</th> </tr> </thead> <tbody> <tr> <td>33</td> <td>33</td> <td>33</td> <td>100</td> <td>100</td> <td>33</td> <td>100</td> <td>100</td> <td>33</td> </tr> </tbody> </table>	Arawa	Buka	Goroka	Mendi	Mt Hagen	Alotau	Lae	Port Moresby	Rabaul	33	33	33	100	100	33	100	100	33
Arawa	Buka	Goroka	Mendi	Mt Hagen	Alotau	Lae	Port Moresby	Rabaul											
33	33	33	100	100	33	100	100	33											
Standard 17	Providers offer mental health care to patients																		
Criteria	<p>i. Provider offers basic psychosocial counseling including active listening, empathy, reassurance, and identification of social support</p> <p>ii. Providers with a good understanding of violence deliver mental health care to patients, according to national or WHO guidelines</p>																		
	<table border="1"> <thead> <tr> <th>Arawa</th> <th>Buka</th> <th>Goroka</th> <th>Mendi</th> <th>Mt Hagen</th> <th>Alotau</th> <th>Lae</th> <th>Port Moresby</th> <th>Rabaul</th> </tr> </thead> <tbody> <tr> <td>100</td> <td>50</td> <td>100</td> <td>100</td> <td>100</td> <td>100</td> <td>100</td> <td>100</td> <td>100</td> </tr> </tbody> </table>	Arawa	Buka	Goroka	Mendi	Mt Hagen	Alotau	Lae	Port Moresby	Rabaul	100	50	100	100	100	100	100	100	100
Arawa	Buka	Goroka	Mendi	Mt Hagen	Alotau	Lae	Port Moresby	Rabaul											
100	50	100	100	100	100	100	100	100											

- All FSCs obtain consent/assent for survivors and their staff demonstrate knowledge of empathetic and appropriate communication skills to use with all survivors and knowledge of appropriate communication techniques to prevent further traumatization of patients.

³³ FSCs that do not provide vaccination/medication on-site have been scored with a no. These FSCs typically refer survivors to other departments for vaccination/medication. Since interviews were only conducted with FSC staff, this investigation cannot confirm/validate compliance with criteria by referred departments

- A majority of the FSCs are able to maintain patient privacy and confidentiality, except where they do not have sufficient and appropriate space (Buka, Rabaul) and a majority
- None of the FSCs have the capacity to manage injuries except at Port Moresby. Patients are usually medically stabilised at the A&E or other departments before being referred to the FSC.
- 6/9 FSCs provide emergency contraceptives on-site, the others provide prescriptions; 4/9 provide HIV PEP, the others refer survivors to HIV clinics and while all FSCs in offer prophylaxis for STI only 4 are able to administer Tetanus and Hepatitis B vaccinations while the others refer survivors to HIV/STI clinic.
- There is a general lack of clarity in the understanding of MHPSS interventions, a majority of the FSCs who report that they provide psychosocial counselling are provided basic emotional support and first-line of support and only a few have staff trained in providing psychosocial *counselling* (Mt. Hagen, Alotau, Lae and Port Moresby). Except Rabaul, Port Moresby and Alotau, no FSC reported providing health-based GBV case management services A majority services related to clinical care are provided by other departments of the hospital and their adherence to standard criteria could not be assessed

Standard 7: Informed Consent

All FSCs obtain informed consent from adult and child survivors of GBV. They obtain written or verbal informed consent (or assent) from child and adolescent survivors; written or verbal consent for HIV counselling and testing; and reported that they have never forced a survivor, including child survivor, to undergo an examination against her/his will. However, as noted elsewhere, it was unclear to what extent providers recognise an adolescent's right to provide consent based on their maturity and capacity; further investigation and investment in provider care for adolescents to reflect their distinct needs and evolving capacity is a recurrent finding. All FSCs use a standardised consent form for obtaining consent (see Annex 5). Service providers at all the FSCs confirmed that they clearly explain to the survivors that they can decline any component of the examination or counselling at any stage and that they respect the survivor's decision on whether to involve the police—although most FSCs shared that a majority of their cases were referred to them by the police. Even where child survivors were concerned, FSCs shared that child survivors almost always come to FSCs through the police and that the hospital and/or FSC attend to acute clinical care before they inform authorities such as child welfare/ child protection officers for further support to the child.

At the FSC in Port Moresby, child survivors' cases are attended to by the SCAN—Suspected Child Abuse and Neglect—team which comprises all Social Workers from the different wards at the hospital.

Given that the bulk of medical examinations and first point of contact are other departments in the hospital, it is not clear if and how these departments meet Standard 7.

Standards 8 and 9: Management of injuries and prevention of further trauma

Most FSCs scored poorly on Standards 8 and 9 because they do not provide these services, except the FSC at Port Moresby that does provide these services. It is not clear to what extent the departments that do provide these services meet the criteria for standards 8 and 9.

Management of injuries of survivors are usually not done at the FSC but by different departments of the hospital such as the OPD, Accidents and Emergencies or O&G³⁴. Only one FSC (Port Moresby) reported that they are able to perform all duties related to management of injuries; while 5 reported that they are only able to attend to minor injuries and simple suturing--Arawa, Buka, Goroka, Lae and Rabaul. 3 FSCs (Mendi, Mt. Hagen and Alotau) are not even equipped to manage minor injuries and perform simple suturing.

All FSCs report that they document vital signs of all survivors, regardless of whether they have examined the vital signs (only a few FSC) or where other departments have performed the examination. Where equipment for measuring vital signs is not available with FSCs (for example, only 3 reported that they have BP machine and stethoscope - Arawa, Buka and Mt. Hagen) they obtain and record information on vital signs from the OPD or emergency departments, where the survivors are stabilised in any case, before being brought to the FSC for further interventions. Survivors with serious injuries almost always first come to the OPD or emergency department where they are treated for injuries and stabilised. In cases where survivors have directly come to the FSC, they are first referred to the emergency or OPD for stabilising.

Detailed medical histories of the survivors are usually taken by the OPD or emergency departments where the survivors are first presented and then this medical history is made available to the FSC. While management of minor injuries and basic suturing is done by some of the FSCs that have a trained nurse, bed and an examination room, all FSCs refer survivors for suturing related to genital and anal injuries to the O&G or Accidents and Emergencies departments.

We refer survivors to the O&G department for examination and stabilisation to prevent re-examination from FSC and then O&G which may result in secondary trauma to the survivor. If the FSC had an HEO and a room for examination and such procedures, everything could be done at once in one place. –FSC, Alotau

Providers at all the FSCs demonstrated knowledge of empathetic and appropriate communication skills to use with all survivors. For instance, some providers shared that they use language that assures the survivors that they are in the right place for help and that the abuse/violence they experienced is not their fault; one provider shared that they use terms of endearment such as “my dear”, “my friend”, while addressing the survivors.

Standard 10: Special Considerations for Child Survivors

All service providers at the FSCs reported offering compassionate, supportive counselling prior to taking the history of the child survivor—they mention providing psychosocial first aid to child survivors before talking about the violence/abuse history. Almost all FSCs except the ones at Mt Hagen and Alotau, work to identify alternative shelter for the child if they suspect that the home environment is abusive and make referrals to existing safe houses. As noted elsewhere however, providers report particular difficulties responding to child protection cases in light of social, cultural and material contexts they operate in and related restrictions on removing children from abusive family settings, including finding alternative safe accommodation for children. The FSC in Mt Hagen (where there are no safe houses) did bring up discussions on alternatives, including family or community-based alternatives and the FSC at Alotau shared the case of a girl survivor of rape by her father who had to be kept at the FSC in the absence of

³⁴ The scores on this standard do not imply that injuries are not managed at all, but that they are not managed by the FSC.

safe houses for survivors, until such time that funds could be arranged to move the child with her mother to the mother's maternal home.

All FSCs shared that they use child-friendly communication techniques and allow a trusted companion of the child to be present during the exam, regardless of whether the companion is a caregiver or parent. They communicate with the child in the local language and use toys to gain the child's trust, although none of the FSCs have sufficient child appropriate toys and drawing supplies. The service provider at Alotau shared that they learnt some techniques for communicating with children by observing the Child Mental Health Specialist during their 2-week attachment with the FSC at Port Moresby. The FSC at Mendi shared that they use an SOP provided by the FSC at Port Moresby to guide their communication with child survivors, other FSCs do not have any such guidance.

I give them a few toys and we gain trust before we can talk to them, avoiding asking direct questions until trust is gained. Children in most observed cases are very apprehensive that they are in a hospital. –FSC, Rabaul

All clinical interventions to manage injuries of children are performed by different departments of the hospital. The FSC staff respondents to this assessment could not comment on how pain and serious injury is avoided during medical examinations of children—on whether child-sized speculums are used or general anaesthesia is administered prior to an exam because these clinical interventions are performed by health workers outside of the FSCs³⁵.

Standard 11: Survivor Privacy and Confidentiality

All FSCs maintain survivor confidentiality by not sharing any information regarding the survivor or the violent incidents with anyone who is not directly involved in providing care services to the survivor and they do not allow any unauthorised persons into the consultation or exam. All FSCs that conduct physical examinations provide adequate time, space and privacy to the survivor to undress and dress for the exams. While there are no national guidelines on secure management of files, medical records and other documentation on the survivors, most FSCs except at Buka and Rabaul keep all such records securely locked in a cupboard or locked room. In Buka cupboards do not have a lock and in Rabaul all records are kept in an open cardboard box. In Lae, although the cupboard storing the documents is locked, it is kept in a corridor outside of the FSC due to space constraints and in Goroka, although the files are kept in a locked cupboard, it is presently overflowing.

None of the FSCs have a written policy to govern who can access files and records pertaining to the survivors and only the FSC at Mendi has a written guideline on secure storage of records.

Standard 12: Respectful care and prevention of further trauma

The majority of the FSCs do not conduct medical exams because they do not have the facility to conduct a medical exam and medical exams are conducted by other departments of the hospital (Mendi, Mt Hagen, Alotau, Port Moresby and Rabaul)³⁶. The investigators could not assess compliance with these criteria.

³⁵ The scoring on this criterion as "no", implies it is a referred service, not delivered by FSC.

³⁶ The FSCs that don't perform medical exams have not been scored on criteria relevant to this standard.

Those FSCs that did report that they conduct physical exams (Aruwa, Buka, Goroka, and Lae) confirmed that they take care to minimise physical pain for the survivor during the exam and keep the survivor's body covered with a gown or a sheet as much as possible to avoid unnecessary bodily exposure. All FSCs provide pain medication as necessary or when requested by survivors, however as noted elsewhere commodity shortfalls and issues with ordering through centralised supply chain impact this. In FSCs where other departments of the hospital conduct the physical exam,

A majority of the FSCs are staffed only by women and so they are not able to offer a choice of sex of service provider to the survivors, except in Goroka, Port Moresby and Rabaul where they are able to offer the choice of a male service provider because they have male social workers or male mental health care providers in the hospitals.

When there is a male requiring counselling, there is a male mental health officer available to support the FSC. The mental health clinic is located adjacent to the FSC and provides psychosocial support to male patients where necessary. –FSC, Rabaul

A majority of the FSCs do not provide simple fluids and food to survivors who are staying on-site at the FSC, those who are kept in the -in-patient ward however, do get fluids and water as per the hospital's policy. Only the FSCs at Arawa and Port Moresby shared that they provide fluids and food to survivors staying on-site at the FSC.

Standard 13: Medical examination for genital and non-genital injuries

All FSCs document findings from medical examinations in as complete and detailed manner as required in the forms they have for such documentation (originally developed by MSF). However, in most FSCs such medical examinations are conducted by the A&E or outpatient departments that provide such documentation. Those FSCs that have the facilities for using speculums on adults, use it only when appropriate and by trained nurses (Arawa and Buka). For all other 7 FSCs, examinations are conducted by other departments and the investigators could not assess compliance on this criterion³⁷.

Medical examinations of genital and non-genital injuries are typically performed by other departments of the hospital—the A&E, outpatient or O&G departments. When a survivor presents with heavy or prolonged anal bleeding they would either be presented first to the A&E department or be referred by the FSC to the A&E department. Likewise, survivors who have been strangled or choked are examined and advised by the A&E about which symptoms they should watch out for and return to the hospital for.

Standard 14: Emergency contraception

Six FSCs (Arawa, Mendi, Mt. Hagen, Alotau, ND and Rabaul) reported that they provide emergency contraception (EC) to survivors within 5 days of the assault. In Buka and Goroka the FSC provides them with a prescription to obtain the EC from the hospital pharmacies and in Lae they are expected to purchase the EC from private pharmacies due to shortage of drug supplies at the hospital. Nursing staff at all FSC's are certified/authorised to provide EC; and if a survivor declines the EC, all FSCs advise them on the importance of the EC and emphasize that

³⁷ The FSCs that do not perform medical examinations for genital and non-genital injuries have not been scored on criteria relevant to this standard.

the survivor should return for follow up tests and monitoring for pregnancy. None of the FSCs provide IUDs

Standard 15: HIV testing, counselling, administration and management of PEP

HIV testing, counselling and administration of PEP are provided in all hospitals, with some FSCs providing all HIV related services directly and some FSCs referring survivors to the HIV clinics in their hospitals.

Six of the FSCs directly offer HIV counselling and testing to survivors (Arawa, Goroka, Mendi, Mt. Hagen, Lae and Port Moresby), however nursing staff in only 4 of these are trained in and administer and/or supervise administration of PEP (Goroka, Mendi, Mt Hagen, Lae). In the remaining 2 (Arawa and Port Moresby) PEP is administered by the HIV clinic.

In Rabaul, although HIV testing and counselling is provided through referrals to the HIV clinic, PEP is administered at the FSC by the nurse who is not yet trained and certified for administering PEP

All HIV related interventions (testing, counselling, and administration of PEP) at 3 FSCs is provided through referrals to the HIV Clinics for testing - (Buka, Alotau and Rabaul).

Only in 1 FSC (Goroka) is PEP administered by staff trained and certified by IMAI for administering PEP, however, as per hospital policy, PEP is only administered by the HIV clinic to circumvent the short supply of drugs. At 3 of the FSCs, a trained HEO or Office in Charge supervises administration of PEP by untrained nurses (Mendi and Mt Hagen and Lae).

At two of the FSCs even though staff are not trained in administering PEP, they are administering PEP (Rabaul and Alotau). In Port Moresby, staff were being trained to provided HIV PEP by FHI 360 at the time of the baseline assessment

When survivors test negative for HIV and the sexual assault occurred within previous 72 hours, survivors are offered full 28-day dosage of PEP in a two or three-drug regimen and followed up for regimen completion by 4 FSCs directly—Mendi, Mt Hagen, Lae and Port Moresby; while 5 of the FSCs refer survivors to the HIV clinic for administering PEP and follow up. Likewise, the FSC or the HIV clinics counsel survivors on side effects, the importance of adherence, and the importance of completing the full course of treatment to ensure PEP effectively reduces the risk for HIV infection.

Similarly, where the survivor is a child and they test HIV negative, the FSC or the HIV clinic prescribes appropriate paediatric PEP dosage.

When survivors who test positive for HIV are interested in disclosing status to partner or family members, only 1 FSC directly provides guidance to survivors on how to disclose the HIV status to avoid disclosure-related violence- FSC at Port Moresby. All other FSCs refer survivors to HIV clinics for such guidance. The investigating team could not verify whether HIV clinics are providing such guidance (hence this criterion was scored as cc for all the 8 FSCs that refer).

When survivors decline an HIV test and their serostatus is unknown, and assault occurred within the previous 72 hours, all of the FSCs still offer PEP and encourage patients to return for HIV counselling and testing.

Standard 16: Medication and vaccinations

All FSCs in principle offer prophylaxis or treatment for sexually transmitted infections (STIs), and the choice of drugs and regimens is as advised in the national STI treatment guidelines. Only 4 of the FSCs administer Tetanus and Hepatitis B vaccinations if required (Mendi, Mt. Hagen, Lae and Port Moresby); while the remaining 5 FSCs refer survivors to HIV/STI clinic for administering these vaccines³⁸. As noted elsewhere, the commodity shortfall due to FSC challenges in placing and receiving orders from a centralised supply chain, lack of storage capacity in FSCs as well as a generalise drug shortfall in the health system means that while FSCs may be able to provide relevant drugs, in many cases they do not have the adequate stock.

Table 8: Availability of Essential Drugs and Commodities

	Arawa	Buka	Goroka	Mendi	Mt Hagen	Alotau	Lae	NCD	Rabaul
HIV test kit	Yes	Yes	No	No	No	No	Yes	No	Yes
Pregnancy tests	No	No	No	No	No	No	No	No	Yes
Emergency contraception pills or IUCD (1x Levonorgestrel Tablet 0.75 mg)	Yes	Yes	No	Yes	No	Yes	No	No	Yes
HIV post-exposure prophylactics as per country protocol (1 tab daily for 28 days-DTG)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes
Drugs for treatment of STIs as per country protocol (Ceftriaxone 250mg Injection)/(Azithromycin 500mg/5 days)	Yes	Yes	Yes	No	No	Yes	Yes	No	Yes
Drugs for pain relief (e.g., paracetamol) #*	Yes	Yes	No	No	No	Yes	No	No	Yes
Local anesthetic for suturing	No	Yes	No	No	No	No	No	No	No
Broad-spectrum antibiotics for wound care	Yes	Yes	No	No	No	Yes	No	No	Yes
Tetanus Vaccine	Yes	Yes	Yes	Yes	No	Yes	Yes	No	Yes
HPV-Hep B	Yes	Yes	No	Yes	No	Yes	No	No	Yes
STI test Kits	No	No	No	Yes	No	No	No	nr	No
Hep B test Kits	No	No	No	Yes	No	No	No	nr	No
Hemoglobin test kit	No	No	No	Yes	No	No	No	nr	No

*nr: no response

³⁸ FSCs that provide vaccination/medication on-site have been scored with a yes; FSCs that refer survivors to other departments for vaccination/medication have been scored "no". Since interviews were only conducted with FSC staff, this investigation cannot confirm/validate compliance with criteria by referred departments

Standard 17: Mental health care

All FSCs reported that they provide psychosocial counselling and all but one (Buka, newly appointed nurse) reported that they have good knowledge of GBV related mental health issues— however none of the FSCs reported having guidelines on providing psychosocial counselling to survivors and many had received little to no training on MHPSS or GBV case management. Looking at the general lack of training and/or previous experience of working with GBV survivors, it is quite likely that FSCs where there are no qualified psychosocial counsellors, social workers or nurses trained in providing psychosocial counselling, a very basic level of emotional support is offered including active listening, empathy, reassurance, and identification of social support—for example, at Arawa, Buka. In 4 of the FSCs that have medical social workers who reported being trained, or where social workers were mobilised from other departments of the hospital- Mt. Hagen, Alotau, Lae and Port Moresby—more advanced psychosocial counselling may be provided. Although the social workers at Lae and Alotau reported that they were overworked with patients from other departments of the hospital and are often unavailable for survivors at the FSC. The attachment of hospital's medical social worker/s to FSCs for GBV care appears to occur on an ad hoc basis contingent on advocacy by FSC staff and/or the social worker's interest and commitment.

The FSC at Rabaul relies on a mental health care provider at the mental health clinic adjacent to the FSC, however it is unclear if this mental health provider has been trained on GBV specific care.

However, across the board there remains a critical lack of knowledge and skills for the provision of MHPSS across the care continuum from non-specialised to specialised support. This combined with the widespread absence of GBV case management services and the lack of familiarity with GBV case management as a specialised service in and of itself results in the use of the term 'counselling' to describe a wide variety of often basic emotional support actions and/or at times harmful practices (see prior section on practice of mediation). As noted elsewhere, except for Rabaul, Alotau and Port Moresby, none of the other FSC reported that they provide case management services to survivors whom they provide services to in other clinical settings of the hospital .

8. Forensic Examination and Handling of Evidence

Table 9: Achievement against Standards 18 and 19

Standard and Criteria	Arawa	Buka	Goroka	Mendi	Mt Hagen	Alotau	Lae	Port Moresby	Rabaul
Standard 18	Provider conducts a medico-legal examination and collects forensic evidence according to national protocol if available								
	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Standard 19	Provider collects, stores and/or transports forensic evidence securely, according to national protocol								
	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Standards 18 and 19

As per scoring guidelines in the Quality Assurance Tool, since there is no system for forensics in the hospitals in PNG, the two standards under this thematic area were not scored in the baseline assessment. Forensics are managed centrally by the Police through a specialised department in Port Moresby and forensic laboratory services are outsourced from overseas.

Notwithstanding, the assessment does find that some of the FSC are better prepared to take on forensics related interventions as the field expands in the country. For instance, all FSCs note physical presentations of the violence on the body of the survivor, in their medical records. All of them collect vaginal swabs and blood for testing for HIV/STI and other infections (and send them to their hospital laboratories for testing).

Staff at Alotau and Lae have received training in taking detailed forensic history as appropriate from the survivor or guardian—staff at FSC Alotau received this training when they worked with the FSC in Port Moresby; and staff at the FSC in Lae were supported by UNFPA to attend a training on forensics in India

9. Referral System and Follow Up of Patients

Table 10: Achievement against Standards 20 and 21

	Arawa	Buka	Goroka	Mendi	Mt Hagen	Alotau	Lae	Port Moresby	Rabaul
Aggregate Score	80	55	70	35	40	40	80	65	50
Standard 20	Facility has a referral system in place to ensure patient is connected to all necessary services								

Criteria	<ul style="list-style-type: none"> i. Hospital has clear, documented and functional procedure for internal referral of survivors from wards to FSC/from FSC to wards in line with their wishes ii. On call duty list from A&E, O&G, AOPD and COPD is available and visible at the FSC iii. GBV/FSC committee is established and functional at hospital/facility iv. Facility has up to date multi-sector service mapping v. Provider tells the patient about other external available services and makes written referrals to the following services if relevant and wanted by the patient (including community-based services): vi. Facility provides referrals to GBV case management service (if not, do they provide themselves?) vii. If a facility does not have a functioning laboratory, the provider offers a referral to a nearby laboratory (for blood and pregnancy tests, etc.) viii. Facility has a system in place to document referral linkage(s) through confirmation with the referral facility, patient, referral card system or other method ix. Facility informs stakeholders (police, community organizations, etc.) about the GBV services that are available at the facility, and during what hours they are provided. Facility makes clear that all survivors are welcome, and that seeking GBV care does not mean the survivor will have to pursue a legal case x. Facility has a list of support services that have been mapped at the local, district and provincial levels, and this referral directory is available for on-site review xi. Facility updates the referral directory at least once per year by calling phone numbers and/or visiting locations, adding newly-available resources, and deleting resources that no longer exist 								
	Arawa	Buka	Goroka	Mendi	Mt Hagen	Alotau	Lae	Port Moresby	Rabaul
	70	40	80	40	40	40	70	70	40
Standard 21	Provider offers the patient follow-up services								
Criteria	<ul style="list-style-type: none"> i. Provider gives as much information as possible and provides all necessary referrals to the patient on the initial visit, in case the patient does not return for follow-up ii. Facility has a system in place to follow up with patients iii. Provider or follow up team monitors the patient's clinical condition and treatment including HIV and pregnancy test results, and provides counseling and support over time iv. Provider asks patient if s/he consents to follow up by phone or SMS text message, and documents a number where patient can be safely and privately contacted v. Facility offers providers a budget, phone credit or mobile phone credit (airtime) to make follow-up phone calls or SMS text messages to patients who consent to being contacted this way vi. Facility has a focal point or team who help coordinate each patient's care, treatment, follow-up and linkages with referral services vii. Provider and/or focal point follow up with the patient at time intervals according to national guidelines, or at a minimum, 1 month after assault and again at 2 months after assault viii. Provider encourages follow up visits through strategies including issuing appointment cards, phone call or SMS reminders, home visits, transportation 								

	assistance (e.g., voucher, reimbursement), personal accompaniment to services if patient has consented to being contacted this way								
	ix. FSVAC is functional in the province								
	x. Monthly/quarterly multi-sector coordination meetings take place with health, legal, justice, social service, etc providers								
	Arawa	Buka	Goroka	Mendi	Mt Hagen	Alotau	Lae	Port Moresby	Rabaul
	90	70	60	30	40	40	90	60	60

- None of the FSCs have an internal referral *system* that is clear, documented and functional for referral of survivors from wards to FSC/from FSC to wards in line with their wishes. Routine referral procedures followed for other patients are used for GBV survivors as well.
- GBV/Family and Sexual Violence³⁹ committees have not been set up in any of the hospitals hosting the FSCs
- FSVAC's set up in the provinces of 6 FSCs play a significant role in referrals and multi-sectoral coordination; the two provinces that do not have an FSVAC meet fewer standard criteria on referrals and follow up.
- All FSCs obtain survivors consent for follow up and note phone numbers for follow up, however only 3 FSCs have a system for follow up with survivors—Arawa, Buka and Lae; where they follow up over the phone; In Buka they use their own private mobile phones and own credit to make these phone calls.

Standard 20: Referral system

Internal referral system

The typical entry point for a survivor is the A&E department. A majority of the survivors coming to the hospitals, present with sexual assault and/or aggravated physical injuries requiring immediate medical attention; and are mostly accompanied by/ or referred by the police, they are first received at the A&E or outpatient departments, where they are medically stabilised before being referred to the FSC, if at all. FSCs are not designed to provide clinical services for such cases, most do not even have an examination room as discussed earlier.

Most internal referrals from the FSC to other wards are usually for laboratory services, O&G, HIV clinics and the hospital pharmacy for drugs. FSC staff shared that sometimes, outpatient departments might ask for FSC staff to attend to survivors in their departments, in case, for instance, the survivors need referrals to a safe house. When FSC staff attend to survivors in departments other than the FSC, they are not counted as FSC clients (and therefore not GBV clients).

However infrequently, it appears more likely that FSC staff are called by other departments than doctors from different departments coming into the FSCs to attend to survivors—this direction of referral is rare. In the case of the FSC at Alotau, staff reported that the O&G doctor is only available to attend to FSC clients on Fridays and survivors who come into the FSC on other weekdays and need to see the O&G, are asked to come again on a Friday. Roughly half of the survivors do not return for this rescheduled referral.

³⁹ Family and Sexual Violence is commonly used term to refer to GBV although also may encompass child abuse and domestic violence by non-intimate partner family members

Possible internal referral pathways of GBV survivors at Hospitals

- Route 1 ▪ A&E/OPD ▪ Back home
- Route 2 ▪ A&E/OPD ▪ FSC ▪ STI/HIV and/or Pharmacy and/or laboratory and/or other clinics
- Route 3 ▪ FSC ▪ A&E/OPD/ STI/HIV and/or Pharmacy and or other clinics and/or external

None of the FSCs have an internal referral *system* in place to ensure survivors are connected to *all* necessary services within the facility. Clear, documented and functional procedure for internal referral of survivors from wards to FSC/from FSC to wards in line with their wishes is not available—there are no protocols for internal referrals for GBV survivors. The FSC guidelines acknowledge the importance of good internal linkages within the hospital to meet the “full suite of needs” of survivors but does not lay down guidelines or procedures for internal protocols. The Guidelines require the establishment of an internal committee on GBV/FSV to enable a coordinated approach, but these committees have not been established in any of the FSCs assessed.

In the absence of such systems, survivors are usually “referred” from one department of the hospital to another, for instance from A&E (most typical entry point) to other departments and/or FSC using existing procedures for *clinical* referrals between departments—referral cards used for regular patients are used for referring GBV survivors as well. There are no guidelines and procedures specific to GBV survivors that enable a systematic approach to meeting all the 3 objectives of the FSC for the survivors (see objectives described in the Introduction). While on call duty list from A&E, O&G, AOPD and COPD is available and visible at all the FSCs, except at Alotau and Rabaul, and FSC staff are report that they are available on-call after hours, there is no process to *ensure* that FSC is engaged in all cases of GBV arriving at the hospital and for all departments to coordinate with the FSC to deliver the “full suite of needs” of survivors. This is linked to the broader issue of the absence of a whole-of-hospital approach.

Many FSC staff report that it is up to the different departments whether they inform and engage the FSC about patients presenting with GBV and there is no system to ensure that all GBV survivors are met by the FSC staff. Often, especially in off hours and on the weekends, the GBV survivors who are attended to by the A&E are asked to return to the Hospital to meet with the FSC on a working day. The likelihood of survivors availing services of the FSC in such cases is much lower than those who come to the hospital during hours.

One of the most significant implications of this gap is that, especially in the context where the entry point for a majority of GBV survivors is not the FSC and all health workers are not equally trained and capable to respond appropriately to the different needs of GBV survivors, many survivors are likely addressed without regard to their needs outside of medico-clinical—while clinical/medical needs might be met, psychosocial needs and possible referrals to other services are missed if survivors do not come into contact with the FSC.

In the absence of clear guidelines and procedure for *GBV responsive* service, for instance, by mandating the presence of FSC staff/staff trained on GBV at any entry point; it is highly likely that the full suite of needs of survivors will not be identified and addressed. As has been noted elsewhere in this report, a majority of the GBV survivors first present to the A&E or OPD where FSC staff may or may not be informed or engaged, with many survivors perhaps leaving the hospital without even meeting the FSC staff. If the mandate of meeting all the primary

objectives of the FSC (safety, medical, psychosocial) rests with the FSC, their engagement for all cases of GBV coming to the hospital must be made mandatory through clear protocols.

External referral system

Only 4 of the FSCs—Arawa, Goroka, Lae and Port Moresby have an up-to-date multi-sector service map; other than Port Moresby, they all use the service map developed by the FSVAC. All 4 of them have the list of mapped support services available on-site for review and shared that they update their referral directory at least once per year.

FSCs at Buka, Alotau, Mendi, Mt. Hagen and Rabaul do not have an up-to-date multi sector service map.

Regardless of whether the FSCs have a service map or not, all of them shared that they inform survivors about external services that are available and make written referrals on a standard form as requested by the survivors. However, only 5 FSCs document referral linkages, most of them in a logbook or register where they document where the survivor has been referred to—Goroka, Mendi, Mt. Hagen, Alotau and Rabaul—but not whether these referrals have been successful.

Referrals and case management services are referred to and through the FSVAC in 5 of the FSCs—Arawa, Buka, Lae, Port Moresby and Rabaul. In Goroka, the FSC makes referrals to Kafe Urban Settlers' Women's Association (KUSUWA) for case management services.

As noted elsewhere, most FSCs do not provide GBV case management services. Some reported referring to external providers for case management; FSCs at Arawa, Buka and Lae make external referrals to the FSVAC provincial committee for case management; however concerns remain regarding the availability and quality of FSVAC provided case management given very limited training. FSCs at Mt. Hagen and Mendi do not provide case management services nor do they refer externally for case management (there is no FSVAC at the provincial level). As noted elsewhere, FSCs at Alotau, Port Moresby and Rabaul provide case management services on their own/and or with the support of FSVACs. The FSC at Alotau has recently been provided with training on case management.

All FSCs inform external stakeholders (police, community organizations, etc.) about the GBV services that are available at the facility, and during what hours they are provided. They make clear that all survivors are welcome, and that seeking GBV care does not mean the survivor will have to pursue a legal case. All but 2 FSCs (Mendi and Alotau) report that regular multi-sector coordination meetings are held with health, legal, justice, social service (mostly through the FSVAC) however not all FSC respondent staff had themselves participated in these meetings. Although the FSVAC Milne Bay is strong and works closely with the FSC, the staff respondent from Alotau was not aware of this and reported that they did not have coordination meetings. In Mt. Hagen, (which also does not have an FSVAC), FSC staff shared that they have a “very strong” referral network, supported by FHI 360 and meetings for clinical coordination are held every 3 months. However, the FSC staff noted that since donor funding has stopped, such regular meetings have been discontinued.

Standard 21: Follow-up services

A majority of the FSCs do not have a system for follow up but all FSCs provide some form of follow up service or the other. Only 3 FSCs shared that they have a *system* for follow up with

survivors—Arawa, Buka and Lae; and they monitor the survivor’s clinical condition and treatment including HIV and pregnancy test results, and provide counselling and support over time, mostly over the phone (although they do not have any guidance on providing safe phone support). The FSC at Lae uses Closed User Group (CUG) that comes at no cost to the user and appointment cards for PEP or HEP treatment for following up with survivors. The FSCs at Arawa and Buka shared that even though they have a system, it has been challenging for them to follow up because of a combination of factors: the FSCs do not have a phone connection and so the staff use their private mobile phones and staff use their own credit to make phone calls (Buka); there is poor network coverage where the survivors live and many survivors either lose their phone or do not provide the correct phone numbers to contact them.

The remaining 6 FSCs—Goroka, Mendi, Mt. Hagen, Alotau, Port Moresby and Rabaul—said that they do provide as much information as possible and necessary referrals to the survivors on their initial visit, in case they do not return for follow-up. All FSCs shared that they encourage follow up visits and all but Buka shared that they note down the information on follow up visits in an appointment card/ clinic book that is provided to the survivor. The FSC staff at Port Moresby shared that they follow up with survivors on the phone regarding their clinical conditions, HIV and pregnancy tests.

Regardless of whether FSCs have a system for follow up or not, all of them ask for the survivor’s consent for follow up by phone or SMS text message and documents a phone number where the survivor can be safely and privately contacted. But only one FSC (Arawa) has dedicated budget, phone credit or mobile phone credit (airtime) to make follow-up phone calls or SMS text messages to survivors who consent to being contacted this way; and only 2 have dedicated staff for doing follow up with survivors and coordinating with external referrals (Lae and Rabaul).

Only 3 FSCs reported that they followed up with survivors one month after assault and again 2 months after assault (Arawa, Buka and Goroka). Staff respondents from 2 FSCs shared that the responsibility of follow up is on survivors, unless they are on a vaccine regimen, in which case the responsible unit of the hospital or the FSC would follow up.

It is at the patient’s discretion to make contact unless they are on vaccination from injuries. – FSC’s Alotau and Rabaul

10. Training and Quality Improvement

Table 11: Achievement against Standards 22 and 23

	Arawa	Buka	Goroka	Mendi	Mt Hagen	Alotau	Lae	Port Moresby	Rabaul
Aggregate Score	0	0	0	0	0	0	0	100	0

Standard 22	All providers who deliver GBV care have received training relevant to their roles and responsibilities in the care of patients
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Criteria	<p>i. Providers receive training (ideally facility-based, on-site) relevant to their roles and responsibilities. Training should include most of the following elements:</p> <ul style="list-style-type: none"> • Patient intake • Obtaining informed consent and assent for post violence care • First-line support through LIVES (Listening, Inquiring, Validating, Ensuring safety, and Support through referrals). • Maintaining patient privacy and confidentiality • How to ensure the safety of patients, providers and staff • How to document relevant medical • Assessing, documenting, and treating genital and non-genital injuries • Preventing the re-experiencing of trauma during examination • Performing diagnostic tests and prescribing treatments for EC, PEP and STI prophylaxis for adults and children • HIV testing and counseling • Examination and treatment of children and adolescents • Providing referrals • National forms, policies and protocols, including mandatory reporting if applicable • Types, root causes and consequences of GBV including signs/symptoms of post-traumatic stress disorder (PTSD) • Addressing provider attitudes and values • Prevention of secondary trauma to providers • Addressing stigma and non-discrimination • How to ask in a sensitive and non-judgmental way about IPV • Routine enquiry if facilities meet minimum requirements listed in Standard 4 • Basic mental health counselling • Long-term, comprehensive mental health care according to national or WHO guidelines. • Collecting, sealing and securing forensic evidence and maintaining chain of custody and complete forms • Examination and treatment of key populations (e.g., sex workers, men who have sex with men, transgender persons, people who inject drugs, prisoners) • Providing follow up care (e.g., linkages to ART if patient is HIV positive, or to economic empowerment programmes, etc.) • Forensic examination and documentation of findings with trauma grams • Testifying in court 								
	Arawa	Buka	Goroka	Mendi	Mt Hagen	Alotau	Lae	Port Moresby	Rabaul
	0	0	0	0	0	0	0	100	0
Standard 23	Facility has systems in place to ensure continuous quality improvement of post-GBV care services								
Criteria	<p>i. Facility has a supervision plan in place that results in the direct observation of at least one patient provider interaction per year for each provider offering GBV care</p> <p>ii. Providers receive verbal or written feedback from a supervisor after each directly observed patient provider interaction</p> <p>iii. Facility has at least one feedback mechanism for patients to anonymously report their level of satisfaction or any grievances with services, including any violation of her/his rights (e.g., regular patient satisfaction surveys, community feedback forum, suggestion box, ombudsman or phone helpline)</p> <p>iv. Facility ensures that all staff providing GBV care achieve and expand competencies via an ongoing capacity-building plan with short, targeted skill building, regular team meetings, and other activities, and are supported on a personal level in this work</p>								

	v. Facility has mechanisms in place to support and promote self-care for providers who experience secondary trauma as a result of providing post-violence care								
	Arawa	Buka	Goroka	Mendi	Mt Hagen	Alotau	Lae	Port Moresby	Rabaul
	0	0	0	80	80	0	40	20	0

- Staff of only one FSC (Port Moresby) have received training on most of the elements listed in the Quality Assurance Tool; all other FSCs have received some training or the other but not on a majority of the elements
- Systems for continuous quality improvement are missing in a majority of the FSCs, with only Mendi and Mt. Hagen reporting that they have a supervision plan in place. 5 of the FSCs are staffed by only one nurse and they do not have any provision for supervision or ongoing capacity support by supervisors—Arawa, Buka, Goroka, Alotau and Rabaul
- None of the FSCs have mechanisms in place to support and promote self-care for their staff

Standard 22: Relevant Training

The Quality Assurance Tool lists about 24 areas of training that FSC staff must receive training on. These include training on topics such as first-line support through LIVES; Examination and treatment of children and adolescents; Types, root causes and consequences of GBV including signs/symptoms of post-traumatic stress disorder (PTSD); Basic mental health counselling; Examination and treatment of key populations (e.g., sex workers, men who have sex with men, transgender persons, people who inject drugs, prisoners) and so on.

While all FSCs have received some training or the other, only one FSC reported that their staff have received training on most of the 24 areas listed by the WHO—the FSC at Port Moresby.

Examples of some of the training received by staff of different FSCs

FSC at Arawa: In August 2021, FHI 360 provided training on GBV sensitisation at all entry points in the hospital; and in June 2021 the FSC nurse (only staff at FSC) attended a Rape Clinical Case Management Training in Buka organised by UNFPA.

FSC at Buka: In August 2021, FHI 360 provided training on GBV sensitisation at all entry points in the hospital; and in June 2021 the previous FSC nurse (who is now no more) attended a Rape Clinical Case Management Training in Buka organised by UNFPA; the newly appointed nurse at the FSC now shared that she has not received this training.

FSC at Goroka: Nurse has been trained on GBV and she is an IMAI trained and certified PEP counsellor. She will soon be retiring from service and there is no plan for her replacement yet.

FSC at Mendi: The OIC is the only GBV trained, IMAI trained and certified ART prescriber or PEP counsellor at the FSC. She offers onsite training and mentoring to the other nurses.

FSC at Mt. Hagen: As with the FSC in Mendi, the OIC is the only GBV trained, IMAI trained and certified ART prescriber or PEP counsellor at the FSC. She offers onsite training and mentoring to the other nurses.

Standard 23: System for continuous quality improvement

None of the FSCs meet all the standard criteria for continuous improvement in their care services. The 4 FSCs that are run by only one staff reported that they do not have any supervisor (Arawa, Buka, Goroka and Rabaul).

Only 2 FSCs (Mt Hagen and Mendi) reported that they have a supervision plan in place whereby at least one survivor-staff interaction is observed per year and written/verbal feedback is provided to the supervised staff, both also have at least one feedback mechanism for survivors to anonymously report their satisfaction or grievance.

Even where FSCs are well staffed (Port Moresby and Lae) there is no supervision plan, although staff at Lae reported that supervisors provide feedback and that there is a competency check done every year (not documented though).

FSCs at Mendi and Mt. Hagen, FSCs at Lae and Port Moresby shared that they have an on-going capacity building plan with short, targeted skill building and regular team meetings. None of the FSCs have mechanisms in place to support and promote self-care for staff who experience secondary trauma as a result of providing post-violence care.

Only 2 FSCs—Mendi and Mt. Hagen reported that they have a mechanism for obtaining anonymous feedback from survivors (feedback forms). The assessment did not look into the number and types of feedback or how this feedback was being used to improve service quality (out of scope).

11. Health Care Policy and Provision

Table 12: Achievement against Standard 24

Standard 24	Facility has protocols in place to offer standardized post-GBV care according to national or WHO guidelines								
Criteria	i. Facility has the following guidelines and documents available on-site for review:								
	<ul style="list-style-type: none"> a. FSC SOPs b. WHO PFA guide c. STI Treatment Manual d. National Guidelines for Minor Injuries e. National HIV/AIDS protocol f. Referral Pathways Guide 								
	ii. Providers know of and utilize these guidelines and documents								
	Arawa	Buka	Goroka	Mendi	Mt Hagen	Alotau	Lae	Port Moresby	Rabaul
	17	17	67	83	83	100	50	100	17

- Only 2/9 FSCs had the 6 guidelines and documents available on site: Alotau and Port Moresby. Arawa, Buka and Rabaul had only one such document available.

Standard 24: Protocols for standardised care

Protocols for providing standardised care were available at FSCs at Alotau and Port Moresby. FSCs with the fewest guidelines were Arawa and Buka, who had only one—the WHO PFA guide and National HIV/AIDS protocol, respectively (see below for list of guidelines available at the 9 FSCs).

All respondents shared that they knew how to use the guidelines/protocols that are available to them (whether or not they had received training on these guidelines/protocols).

The 2013 Guidelines for PHAs/Hospital Management for Establishing Hospital-Based Family Support Centres were initially developed during the adoption of the model by the NDOH. However, they have not been updated to reflect the current and intended future status of FSCs and in general, FSCs do not have them on hand.

The STI Treatment Manual is the most commonly available guidance document, with 7 out of 9 FSCs reporting it; followed by National HIV/AIDS protocol and Referral Pathway Guide (developed by FSVAC). The SOPs for FSCs and National Guidelines for Minor Injuries are the least available policy documents at the FSCs.

Types of policy documents available at the FSCs									
	Arawa	Buka	Goroka	Mendi	Mt Hagen	Alotau	Lae	Port Moresby	Rabaul
FSC Guidelines (2013) SOPs				✓	✓	✓		✓	
WHO PFA guide	✓		✓			✓	✓	✓	
STI Treatment Manual			✓	✓	✓	✓	✓	✓	✓
National Guidelines for Minor Injuries				✓	✓	✓		✓	
National HIV/AIDS protocol		✓	✓	✓	✓	✓		✓	
Referral Pathways Guide ⁴⁰			✓	✓	✓	✓	✓	✓	
# of policies	1	1	4	5	5	6	3	6	1

12. Outreach

Table 13: Achievement against Standard 25

⁴⁰ The Referral Pathway Guidelines developed by CIMC-FSVAC

Standard 25	Facility integrates GBV awareness raising and referrals into other health programs and outreach activities								
Criteria	i. Facility works with other services to integrate GBV enquiry and care into their programs (e.g., HIV, antenatal care, family planning counseling, etc.) if minimum conditions listed in STANDARD 4 are met								
	ii. Facility has a community liaison to raise awareness of GBV and the services that are available OR facility conducts outreach in local communities to raise awareness								
	Arawa	Buka	Goroka	Mendi	Mt Hagen	Alotau	Lae	Port Moresby	Rabaul
	100	50	50	100	100	50	100	0	50

- Only 4 FSCs are engaged in awareness raising within their hospitals (informing other departments about the FSC and its services) as well as in the local communities
- Port Moresby is the only FSC that did not report raising awareness within the hospital or in the communities
- Outreach to local communities is restricted because of limited budgets and human resources—there is no dedicated community liaison staff at the FSCs

Standard 25: Integrating GBV enquiry and care into other departments of the hospital

All but 2 FSCs (Mendi and Port Moresby) shared that they inform other departments of the hospital about GBV services and advise them to share information with clients on relevant services. However, given the low referrals from other departments to the FSC, it appears that such “awareness raising” is not sufficient. In the absence of SOPs that provide clear guidance to all hospital departments about their roles and the referral pathway and hospital-wide orientation and capacity development on GBV response, such isolated efforts by FSC staff to create awareness about the FSC are unlikely to yield the desired results (increased safe identification of GBV survivors among regular patients and increased referrals to FSC). FSCs at Mendi and Port Moresby shared that they do not need to inform other departments within the hospital because their internal referrals are already strong and working well. This approach is problematic because high turnover among health workers in hospitals means new recruits may not be as informed.

As described in the section on Standard 4, according to the WHO, routine clinical enquiry about IPV or SV should only be undertaken only if services meet all of the minimum requirements for routine enquiry: SOP for GBV services, standard guiding questions and training on how to ask these questions, ability of provider to offer first line support, private and confidential setting and system for internal referrals. Given that most of these prerequisites are not met in the 9 FSCs/hospitals, encouraging other departments to integrate routine GBV inquiry in their work could do more harm than good to the survivors.

Community outreach

Community outreach is not an integral part of the work of FSCs. At best, 5 out of 9 FSCs report that they conduct outreach in communities, mostly integrated with outreach events planned by the PHAs (Mendi and Mt. Hagen) or where funds are available through donor funding and development partnerships. For example, in Alotau the social worker is engaged with Church

arranged programs, Law and Justice sector and UN initiatives to conduct outreach and awareness. FSCs at Arawa and Lae shared that the biggest challenge to their ability to do outreach is lack of funding to meet fuel and travel costs; FSC Arawa, for instance, is therefore only able to conduct outreach within the town

Among those that do not have an outreach programme, the FSC at Goroka shared that they participate in outreach events only when development partners invite them. Where FSCs are staffed by only one person, for example Buka and Rabaul, outreach activities are not conducted. Costs of outreach work in communities is listed as a challenge by most who do not conduct any outreach in communities. Given challenges across the board in providing comprehensive services in response to GBV including staffing shortages, limited community outreach is both understandable and advisable to avoid increasing demand for services without the requisite strengthening of service capacity to meet increased numbers of presenting survivors.

13. Reporting and Information Systems

Table 14: Achievement against Standards 26 and 27

	Arawa	Buka	Goroka	Mendi	Mt Hagen	Alotau	Lae	Port Moresby	Rabaul
Aggregate Score	59	52	79	76	76	69	79	90	69

Standard 26	Facility has intake forms, chart forms, or registers that collect information about a patient's experience of GBV and the post-GBV care s/he received
Criteria	<p>i. Provider collects and documents the following information about a patient's experience of GBV and the post-GBV care s/he received, if available:</p> <ul style="list-style-type: none"> • Sex of the patient and perpetrator(s) • Age of the patient and perpetrator(s) (if known) • Number of perpetrators • Relationship of the perpetrator(s) to the patient • Time and date of assault/violence • Time and date of consultation • Type of assault/violence • Description of incident • For sexual assault, location(s) of penetration (vaginal, oral, anal) • For sexual assault, type of penetration (with penis, finger, object or mouth) • For sexual assault where penetration occurred, whether or not a condom was used • Pregnancy risk assessment • HIV and STI risk assessment • History of consensual intercourse within 5 days of assault (if DNA sample collected) • Documentation of the patient's injuries on a detailed diagram • Medications administered, offered, accepted and/or declined including PEP • Whether forensic evidence was collected or not • Current GBV signs and symptoms • Relevant medical history (e.g., pre-existing injuries, previous sexual or physical assault, if patient is currently pregnant, if HIV status is known, if patient has experienced female genital mutilation) • Vital signs • Referrals offered • Whether safety planning discussion took place • From where a patient was referred (if anywhere) • Whether the patient has returned for follow-up GBV care, and what services were received during the follow up visit <p>ii. Provider fills medical records and forms completely with all relevant information</p> <p>iii. Facility uses standardised data collection forms including:</p> <ul style="list-style-type: none"> -Informed consent form -Data summary sheet -Follow up sheet -Medico-legal proforma -Medical report (child and adult)

	<ul style="list-style-type: none"> -Drug/supply request form -Referral form (medical and external referrals) -Admission and discharge <p>iv. There is a follow up log book for:</p> <ul style="list-style-type: none"> - HIV and PEP - Pregnancy Test and Management - Vaccination - Basic counselling 																		
	<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 10%;">Arawa</th> <th style="width: 10%;">Buka</th> <th style="width: 10%;">Goroka</th> <th style="width: 10%;">Mendi</th> <th style="width: 10%;">Mt Hagen</th> <th style="width: 10%;">Alotau</th> <th style="width: 10%;">Lae</th> <th style="width: 10%;">Port Moresby</th> <th style="width: 10%;">Rabaul</th> </tr> </thead> <tbody> <tr> <td style="text-align: center;">100</td> <td style="text-align: center;">100</td> <td style="text-align: center;">100</td> <td style="text-align: center;">100</td> <td style="text-align: center;">100</td> <td style="text-align: center;">100</td> <td style="text-align: center;">100</td> <td style="text-align: center;">100</td> <td style="text-align: center;">100</td> </tr> </tbody> </table>	Arawa	Buka	Goroka	Mendi	Mt Hagen	Alotau	Lae	Port Moresby	Rabaul	100	100	100	100	100	100	100	100	100
Arawa	Buka	Goroka	Mendi	Mt Hagen	Alotau	Lae	Port Moresby	Rabaul											
100	100	100	100	100	100	100	100	100											
Standard 27	There is an evaluation system in place to collect and analyze GBV program data																		
Criteria	<ul style="list-style-type: none"> i. Providers have been trained in how to collect and enter data ii. Facility has a system in place to collect and analyze trends in GBV data (types of violence, sex of patients, age of patients, services utilized, etc.) and it is currently in use iii. Adherence to proper data collection methods is verified (e.g., supervisor periodically reviews a sample of charts to assess quality and consistency) iv. Survivor files and data are securely stored in lockable cabinets and/or password protected soft copies v. Survivor coding system is in place to ensure confidentiality 																		
	<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 10%;">Arawa</th> <th style="width: 10%;">Buka</th> <th style="width: 10%;">Goroka</th> <th style="width: 10%;">Mendi</th> <th style="width: 10%;">Mt Hagen</th> <th style="width: 10%;">Alotau</th> <th style="width: 10%;">Lae</th> <th style="width: 10%;">Port Moresby</th> <th style="width: 10%;">Rabaul</th> </tr> </thead> <tbody> <tr> <td style="text-align: center;">20</td> <td style="text-align: center;">0</td> <td style="text-align: center;">80</td> <td style="text-align: center;">60</td> <td style="text-align: center;">60</td> <td style="text-align: center;">50</td> <td style="text-align: center;">80</td> <td style="text-align: center;">80</td> <td style="text-align: center;">50</td> </tr> </tbody> </table>	Arawa	Buka	Goroka	Mendi	Mt Hagen	Alotau	Lae	Port Moresby	Rabaul	20	0	80	60	60	50	80	80	50
Arawa	Buka	Goroka	Mendi	Mt Hagen	Alotau	Lae	Port Moresby	Rabaul											
20	0	80	60	60	50	80	80	50											
Standard 28	GBV data are compiled and analyzed to understand trends, improve health services and systems																		
Criteria	<ul style="list-style-type: none"> i. GBV data are disaggregated by sex (male and female) ii. GBV data are disaggregated by age (0-4, 5-9, 10- 14, 15-19, 20-24, 25-29, 30-49, 50-59, 60+) iii. GBV data are disaggregated by types of violence experienced and whether the perpetrator was an intimate partner or non-partner: <ul style="list-style-type: none"> • sexual violence by a partner or non-partner • physical violence by a partner or non-partner • emotional violence by a partner or non-partner iv. GBV data includes the number of sexual assault survivors who received PEP at the facility within the 72 hour window v. GBV data include the number of people who completed the PEP regimen vi. GBV data note patient's key population classification if any (e.g., men who have sex with men, transgender persons, sex workers, persons who injects drugs, or prisoners) or other vulnerable population at risk (e.g., persons with disabilities) vii. GBV service data are linked to HIV and other health services data through common unique identifiers (such as a numeric code), a central filing system, or shared electronic medical records system viii. Data reports for GBV statistics (with no personal identifying information of patients) are available for sharing with management team, referral partners and other appropriate, relevant stakeholders, when safe and prudent to do so ix. Improvement plans for service delivery are made after GBV data are reviewed, including changes or updates to the services offered, approaches used, and commodities procured 																		

	Arawa	Buka	Goroka	Mendi	Mt Hagen	Alotau	Lae	Port Moresby	Rabaul
	56	56	56	67	67	56	56	89	56

- All FSCs meet the standard for collecting relevant information from survivors about their experience with GBV and care services they have received;
- Systematic approach to data management, including quality control on data collection, entry and analysis is missing in all FSCs. None of the FSCs except Port Moresby use a coding system to ensure confidentiality of the survivor whose information is stored (online and offline).
- While all FSCs report that they have a system to compile disaggregated GBV data for sharing with relevant stakeholders, none were able to share such reports during the investigation
- None of the FSCs reported that data is used to improve plans for service delivery

Standard 26: Collecting information from survivors

All FSCs report that they collect required information from survivors, including some demographic information about survivors and perpetrators; relationship with perpetrators; times and dates of assault; type of assault risk of HIV/STI/Pregnancy; documentation of injuries on a diagram, signs and symptoms; medical history; medications offered/accepted/declined; referrals and follow up. All FSCs use adapted versions of forms developed by MSF for documenting such information; adaptations vary across locations so that not all FSCs collect the same data. Some of the FSCs shared challenges in filling these forms.

Not all the sections of the reporting form are filled because there is confusion on how to fill some components of the form. –FSC, Arawa, Buka

The forms can be repetitive, quite cumbersome to fill and need to be condensed and simplified so it does not take too much time to fill. –FSC, Goroka, Lae

All FSCs also shared that they maintain medical records for all survivors that are usually filled by the various entry points/ departments of the hospital. Follow up logbooks are maintained by FSCs for tracking survivor's uptake of tests, medications, prophylaxis, vaccinations (even where these are administered by different units of the hospital) and to track basic counselling.

Standard 27: System to collect and analyse data

While all FSCs collect data from survivors, none of them meet the criteria for a *systematic approach* to collect and analyse the data (trained staff, proper method for collecting and quality control, data security and coding).

Staff of only 5 FSCs have been trained to collect and enter data (physical forms)—FSCs at Goroka, Alotau, Lae, Port Moresby and Rabaul—and most recognise the need for more training for their staff, including data entry clerk at Mt. Hagen.

Except for the FSCs at Arawa and Buka, staff of all other FSCs shared that they have a system in place to collect and analyse trends in GBV data (types of violence, disaggregated by gender, age, etc)—they shared that data collation was a monthly or quarterly exercise while analysis was an annual exercise. However, during the course of this baseline assessment, the

investigators found that the FSC did not have collated or analysed data readily available. Only 5 FSCs report that their data collection methods are verified by supervisors (where FSCs have only one staff member, overall supervision is lacking).

Of the 7 FSCs that store data in digital format only 5 report that their data is password protected—FSCs at Port Moresby and Buka do not password protect their digitised data. FSCs at Alotau and Rabaul do not have computers and therefore do not store data digitally.

The FSC at Port Moresby is the only FSC where a coding system is in place to ensure confidentiality of survivors—in all other FSCs, survivor data is stored in their name and with other identifying information

Standard 28: Data disaggregation

All FSCs shared that they disaggregate data by sex, age, types of violence, relationship to perpetrator (partner/non-partner); number of sexual assault survivor's receiving PEP within the 72-hour window and number of survivors completing the PEP regimen. However only 3 FSCs—at Mendi, Mt. Hagen and Port Moresby, note survivors' population classification (whether they are men who have sex with men, trans persons, sex workers and so on) and other vulnerabilities (such as persons with disabilities). The remaining FSCs shared that their intake forms do not have scope for noting such classification. None of the FSCs however, had such disaggregated data readily available to reference during the interview or share with the investigators—they provided broad estimates only, often with overlapping figures for different types of violence (for eg, the total did not add up to 100%).

Common Unique Identifiers

None of the FSC's except Port Moresby use common unique identifiers such as a numeric code or a central filing system or shared electronic medical records system with HIV and other health services data. The FSC at Port Moresby uses a numeric code for recording data on survivors and appropriate sharing across the hospital.

Data Sharing and Use

All FSCs except Buka shared that they maintain data reports on GBV that do not include identifying information of the survivors. They all shared that GBV statistics are available for sharing with management team, referral partners and other appropriate, relevant stakeholders, when safe and prudent to do so, but none of the FSCs were able to provide evidence of such data during this assessment. FSCs at Arawa, Mendi, Mt. Hagen specifically shared that they provide monthly reports to the medical records clerk/hospital authorities. Yet during the course of this baseline, none of the FSCs shared consolidated data, often citing confidentiality as a concern. This appears to be a contradiction—if non-identifying data is maintained and available for sharing with relevant stakeholders why would it not be available to share with the investigators of this assessment.

The FSC at Port Moresby is the only FSC that reported that they use GBV data to make improvement plans for the services, approaches and procurement of commodities. All other FSCs shared that they do not use the data for informing improvement.

14. Human Resourcing

Table 15: Achievement against Standard 29

Standard 29	Facility has sufficient trained staff to provide the 5 essential services									
Criteria	i. Facility has: Medical Officer; Health extension officer; Community health worker; Social worker; Mental health worker; Triage nurse									
	ii. Facility has support staff: Data encoder; Clerk/receptionist; Security guard (define gender); Cleaner									
	iii. Proportion of female staff in department									
	iv. FSC staff are aware of National GBV Strategy									
	v. FSC staff are permanent salaried position (receive regular/month salary)									
	vi. FSC staff are supported in light of risks of vicarious trauma, such as: "FSC staff are supported in light of risks of vicarious trauma, such as: staff rotation; given and take holidays; working hours are standard 8 hours per day; peer support mechanisms is in place; regular support groups/debriefing sessions provided weekly/monthly									
	vii. FSC is incorporated into Annual Action Plans for the Hospitals									
	Arawa	Buka	Goroka	Mendi	Mt Hagen	Alotau	Lae	Port Moresby	Rabaul	
	57	50	29	57	57	57	86	86	43	

- None of the FSC have all the required numbers and types of staff as prescribed by the WHO. 4 of the FSCs have only 1 staff member—a nurse
- The FSC at Goroka is at high risk of being shut down if staffing matters are not urgently addressed
- Lack of staffing structure, including appropriate salary grades for the FSC staff contribute to high staff turnover

Standard 29: Sufficiency of staff

The best staffed FSCs are the ones in Port Moresby and Lae, which are also the oldest established FSCs- with 7 and 5 staff each. They also have the highest support staff required for efficient working of an FSC. 4 of the FSCs have only 1 staff member—a nurse and no support staff—Arawa, Buka, Goroka and Rabaul. Mendi, Mt Hagen and Alotau have 3 staff each.

Interviewed staff shared several challenges with staffing at the FSCs.

- Staff grade levels: In Arawa for example, there is only 1 staff appointed at the FSC—a female nursing officer who oversees the facility. The permanent position assigned to the nursing officer for the FSC is at Grade 7 level which is lower than most other nurses in the hospital at Grade 8 level, which has led to a hesitancy among nurses to take on this role. Although there is a provision for an HEO, the position is not remunerated as other HEOs, and this has been a barrier to staffing this position.
- Repurposing of FSC as Covid Facility: In Buka for example, 3 staff were appointed to the FSC, however in response to the COVID-19 crisis, the FSC was repurposed as a COVID-19 facility; FSC services were moved to the HIV/STI clinic and 2 staff of the FSC

were moved to other departments of the hospital since there was no physical space for them at the HIV/STI clinic.

- Lack of staffing structure for FSC: In Goroka, the staff structure for the FSC is not part of the Annual Action Plan of the hospital/PHA (see more below). At the time of this assessment the staff nurse from the ED was managing the FSC and had been asked to voluntarily resign at the end of the year as she is approaching retirement age. Since there is no staff structure and plan for the FSC, it is not clear how the FSC will be run once the present nurse is retired from service. Just as in Buka, the FSC at Goroka was also temporarily repurposed as a COVID-19 facility.

In Rabaul, since the clinic was established in 2016, the nursing officer has operated as a support staff to the FSC, while holding a permanent position as an A&E nurse to the hospital. The PHA/hospital action plan does not provide for FSC staffing

Type of staff	Arawa	Buka	Goroka	Mendi	Mt Hagen	Alotau	Lae	Port Moresby	Rabaul
Medical Officer									
Health Extension officer								2	
Community health worker				1		1	2	1	
Social worker						1		1	
Mental health worker								1	
Triage nurse	1	1	1	2	3	1	3	2	1
Total Program Staff	1	1	1	3	3	3	5	7	1
Support Staff									
Data encoder					1		1	1	
Clerk/receptionist							1	1	
Security guard							1	1	
Cleaner/ Hospital hygiene staff				1	1		1	1	
Total Support Staff	0	0	0	1	2	0	4	4	0

Staff Caseload

Even recognising that caseload information provided by FSC staff are estimates, it appears that staff caseload per month is particularly worrisome in:

- Rabaul with one nurse attending to about 30 cases a month; the nurse is neither IMAI trained nor certified to prescribe PEP.
- Goroka with one staff nurse attending to about 20-30 cases per month, 3.4th of whom are child survivors of sexual abuse. The nurse is approaching retirement and her position is not included in staffing structure for the Hospital, leaving the FSC at high risk of closure once she leaves
- Arawa with one nurse who has little to no training on GBV response, attending to 20-30 GBV cases per month

	Arawa	Buka	Goroka	Rabaul	Mendi	Mt Hagen	Alotau	Lae	NCD
Number of program staff	1	1	1	1	3	3	3	5	7
Caseload per month	25	7	25	30	35	41	25	55	60

Incorporation of FSC in Annual Action Plan of the Hospital/PHA

Inclusion of FSCs in Hospital/Provincial Health Authorities' Annual Action Plans is inconsistent.. In Buka, the nurse responding to this assessment was newly recruited and could not confirm if the FSC was part of the action plan. The inclusion of FSCs in the action plans are central to sufficient staffing of the FSC and integrating of FSC staff in the human resource of the hospital. However, even where FSCs are included in the PHA/hospital action plan, they are often recruited at grade levels lower than nurses in other departments, and appointments to FSC are perceived negatively and as an end to their career.

Conclusions and Recommendations

This baseline assessment intended to serve as the basis for ongoing monitoring of FSC functionality for UNFPA programming as well as inform subsequent qualitative research to complete and further investigate its findings, particularly in relation to quality of care.

Comparison with previous assessments

The overall conclusion from the baseline assessment is that FSCs in Papua New Guinea remain a work in progress, with some progress since the formative evaluation commission by UNICEF in 2016. Although the scope and methodology used for both exercises, the formative evaluation and this baseline, are slightly different, several areas of investigation were similar. A comparative review of the findings of both exercises suggests that the most important gains made in the work of the FSCs pertain to efforts outside of the FSC: the activation of provincial FSVACs and their role in providing a clearer external referral pathway, better multi-sectoral coordination and case management services, where FSVACs have been established—6 of 9 FSCs assessed (although assessment of quality of referral services and outcomes for survivors for outside the scope of the baseline). There has been a nominal increase in the number of FSCs in the country—from 15 in 2016 to 18 in 2021.

For a majority of inquiry points, the findings of both exercises, suggests that little has changed in the intervening years.

- FSC's continue to not operate as one-stop; with the majority of clinical services provided outside of the FSC at different departments. Primary entry point for survivors is not the FSC but A&E.
- Case load remains low compared to the prevalence of FSV/GBV in the country, there is little effort to expand outreach in general and improve access for the especially marginalised.
- Staffing needs remain unmet, in number and capabilities, with majority FSC staff not integrated in the staffing structure for the FSC, affecting high turnover and job insecurity.
- Essential supplies and drug needs remain unfulfilled, with stock out reported by many FSCs
- Data management remains in need of systematisation; collection, collation, analysis and use in decision making remain poor.

Table 16: Comparing findings from Formative Evaluation 2016 to Baseline Assessment 2021

	Formative Evaluation UNICEF 2016	Baseline Assessment UNFPA 2021
Total number of FSCs in the PNG	15	18
Provision of all services at one-stop - FSC	None	None
Availability of medical supplies	Inconsistent, gaps	Inconsistent, gaps
Human Resources	3/14 met requirement	2/9 met requirement

	Poor integration with health sector staffing	Poor integration with health sector staffing
Follow up with survivors	Very limited, cost for survivor, cost for FSC	Very limited, cost for survivor, cost for FSC
Client load	Survivors at different departments/clinics not counted	Survivors at different departments/clinics not counted
Inclusion	No evidence of specific measures to prioritise or address most marginalised	No evidence of specific measures to prioritise or address most marginalised
Data collection, standardisation, management	Systems not in place, or data not used for decision-making	No evidence of systematic data management and use
Outreach for primary prevention/awareness on FSV	Not regular, only with external donor support	Not regular, only with external donor support
FSVAC multi-sectoral coordination	Inoperative	6/9 FSC reported referrals to FSVAC

The following sections elaborate on the key conclusions that can be made based on the findings of the baseline assessment and provide recommendations for strengthening the FSCs and indeed the health sector response to GBV in Papua New Guinea.

Services

- One or more of the five essential services are often provided through other departments which raises challenges with regards to the delivery of quality, timely, free and survivor-centred care*

The majority of the 5 essential GBV response services are not provided at the FSC itself but by different departments of the hospital. The first point of entry for survivors at the hospital is usually the A&E or OPD. This is the case during weekends, after FSC operating hours but also when the FSCs are open during the standard workday.

Most FSCs are not provided with adequate essential supplies, equipment, and trained/certified staff, to conduct examinations, treat injuries, provide vaccinations and skilled psychosocial support. Further, most are not open 24/7. Due to these reasons, injuries, whether during working hours or off hours, are mostly treated at the Accident and Emergency (A&E) or at the Out-Patient Department (OPD). Many FSCs do not provide vaccinations and medication on-site. FSCs provide prescriptions to survivors to obtain drugs from the hospital or external pharmacy and refer survivors to different clinics such as HIV and/or STI clinics for administering vaccines. None of the FSCs (or hospitals) have protocols for guiding internal referrals for survivors of GBV within the hospital, and the referrals for GBV survivors follow the same rules as for any general patient at the hospital. These are the implications of such a set up:

- A survivor presenting at an FSC is likely to move from one department to another to receive the full package of the 5 essential services. This carries the risk of re-traumatisation, delays and compromising safety, privacy, and confidentiality of the survivors. In hospitals where relevant departments are in different buildings and/or far from each other, these risks are compounded.

- It also appears that significant proportions of survivors who visit the hospital after hours, do not make it to the FSC at all. Its limited opening hours require them to make an additional visit during operating hours, which often deters continued help seeking. In many cases, health staff working outside the FSC may not have the skills to provide survivor-centred care or to deliver some essential services, such as psychosocial counselling, psychological first aid and referrals, which may not be offered to survivors at all; many of survivors who receive clinic services in response to GBV from departments other than the FSC are not captured clearly in GBV service data, thus underestimating the total number of GBV presentations⁴¹.

Reliance on other departments of the hospital is not in and of itself problematic. It may be a reasonable set up in low resource settings. In fact, the FSC guidelines acknowledge that “the complete suite of interventions required by a client may involve a number of staff and wards (eg A&E, theatre, ICU, Gynae, paediatrics etc)”. However, at present it results in the fragmentation of service delivery and contributes to poor quality services given the lack of training on GBV responsive services for all involved staff which raises concerns. Fragmented delivery of services through different departments poses significant risks to maintaining safety and confidentiality of survivors and puts them at greater risk of re-traumatisation by staff outside of the FSC who are not trained in protocols and skills in providing survivor-centered care.

An additional problem posed by this reliance on different departments without a systematic, “whole of the hospital” approach is that the rule of free services to clients of the FSC is not applied to the other departments of the hospital, which routinely charge fees from survivors for medical treatment of their injuries resulting from the violence. (The Secretary of Health circular of November 2009 instructs that “no fees should be charged to clients of the Centre: not for medical treatment, nor for medical reports”).

The reliance on other wards for the provision of at least one of the 5 essential services raises important questions regarding the intended design and execution of the FSC model. Efforts to ensure all 5 services are provided within the FSC would require greater investment in infrastructure, staffing and materials at minimum. Alternatively, continued reliance on care from complementary wards requires a clearer delineation of non-FSC roles regarding GBV health care, their functional relationship with FSC staff, internal referral pathways and treatment procedures as well as the relevant training and support for staff. More generally, the reliance on non-FSC services requires consensus on the prioritisation of GBV as a critical, life-threatening issue amongst health staff and across wards within the facility. This order must come from health administrators including hospital CEOs through to front-line service providers in order for the intended logic and outcome of the FSC to be embedded in care for survivors across wards, including but beyond the FSC.

⁴¹ Additional challenges with safe and quality data management including through FSCs are expanded upon elsewhere.

Recommendations to NDOH, PHA and Hospitals:

Adopt "whole of the hospital approach": The one-stop model is designed so that all of the needs of the survivor are met within *one facility*. In Papua New Guinea, given that the FSCs are not equipped to provide all the 5 essential services and different departments of the hospital are involved in providing different services, the *one facility*, the *one-stop* is the hospital and not the FSC. It is critical that GBV and child protection response is integrated across these departments and not conceived as a silo. The one-stop model in PNG therefore, needs to adopt a "whole of the hospital" approach, strengthening the health sector response to survivors, firmly embedding and integrating GBV services across the hospital and not just in the FSCs.

Establishment and implementation of facility-level SOPs for health-based GBV response, clearly delineating responsibilities for GBV care to all health staff at all entry points for survivors, guiding internal referrals and instructions for GBV health data management. These SoPs must embed a "**systems**" approach to ensure coordinated and skilled delivery of services such that the strain on survivors for moving from one department to another and associated risks of re-traumatization are significantly reduced.

Inculcate the principles of survivor-centered approach among all staff of the hospital, especially those at the different entry points (competency-based training as per the NDOH guidelines). Educate all staff of the Hospital on how unequal power and social norms perpetuate violence against women and children and how survivor centered care can improve health and social outcomes for survivors.

Adequate human resourcing (numbers, qualification, and regular training) for GBV services should be institutionalised in annual plans and budgets of the hospital and PHA. Where staff have additional responsibilities in the hospital (eg social workers), ensure that GBV and CP survivors are prioritised.

Services to survivors must be free of charge at all departments/units providing services (A&E, OPD, Gynae, Dental, Pharmacy, etc.) not just for services provided by the FSC

Any future assessments of the FSC services must include all departments of the hospital engaged in providing GBV response services and not just the FSC and its staff.

2. *FSCs are often not providing the full suite of services only partially meeting the three objectives of safety, medical and psychosocial support (objective 1), the prevention of further violence (objective 2) and creating access to justice through external referrals (objective 3)*

The FSCs are not meeting all of the 3 objectives as outlined in the National Guidelines. FSCs/hospitals have been geared towards the partial provision of only one of the objectives, i.e., medical services. Capacities and mechanisms for meeting psychosocial needs (objective 1) and for facilitating prevention of further violence (objective 2), and for creating access to justice through strong external linkages with other service providers (objective 3) are limited or absent. Among the 5 essential services, FSC/Hospitals are most equipped to provide 2 (treatment of injuries and prevention of infection, pregnancy), and least equipped to provide 3 psychological first aid, referrals (internal and external) and safe follow up.

As per the national guidelines, FSCs are concerned not with the mere provision of services but with impacting the cycle of violence and to this end, the FSCs are required to provide *comprehensive* health care, addressing not only the "victims" immediate physical needs but also their *psychological and social needs* as well as facilitating *prevention of further violence* within that family/relationship. They are required to provide linkage services *beyond the provision of health care alone*, where the reporting of assaults is facilitated, and guidance can be given to *impact the cycle of violence*.

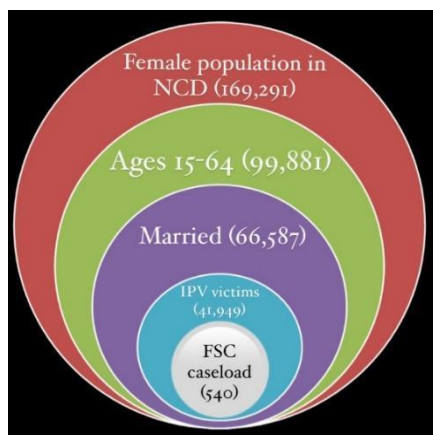
- a. Psychosocial counselling is only provided where there are trained staff at the FSC (such as social workers or nurses trained in providing psychosocial counselling) and only to survivors who make it to the FSC. However, all FSC staff, trained or not, self-reported providing a basic level of emotional support to survivors. Training on psychosocial counselling for survivors is rarely provided to FSC staff and it is unlikely that non-FSC staff at the hospital (A&E, OPD, etc), who treat the majority of survivors for their medical injuries, have any training on psychological first aid and actually provide it to survivors.
- b. The role of FSC in providing case management remains unclear. Based on respondents' feedback, few FSCs provide case management services however all engage in some kind of safety planning with survivors. Despite this, as is commonly the case, FSC workers often take on some case management responsibilities in the absence of adequate case management services outside the health system, including informal assessment and action planning. In some cases, the hospital medical social worker works closely with the FSC to provide case management, but in most cases the FSC and medical social work departments/actors are not collaborating. The health system, and FSCs and medical social workers in particular presents an under-utilised resource for case management and mental health and psychosocial support. While cautious to avoid overburdening FSC staff, the provision of some clinical care in other wards may allow for FSC to strengthen this complementary aspect of care.
- c. External referrals are likely stronger where FSVAC or similar multi-sectoral coordination bodies exist and where the FSC and hospital are strongly linked with these bodies. Present practice of external referrals is at best, limited to informing the survivors of the options that are available and providing contact information for referral service provider or FSVAC where available. There is no mechanism to ensure that survivors can access those referral services. High out of pocket costs for survivors to access referral service partners might also be an obstacle.
- d. Lack of capacities to follow up—lack of access to phones and budget for making phone calls hinder the ability of FSCs to check on the safety of the survivors and the use of referral services. Only 1 of the 9 FSCs covered in this assessment was equipped with a phone and FSC staff routinely rely on their personal mobile phones to connect with survivors (if at all), which in addition to cost implication, exposes the FSC staff to risk of harm. While FSCs who conduct phone-based follow up cited taking informed consent before doing so, they do not have guidance and training on conducting safe follow ups.

Access

3. *Access to FSCs remains limited overall with small caseloads: FSCs are being accessed mostly by women survivors of sexual and physical violence (intimate partner violence included) and child survivors of sexual violence, most of whom are brought in or referred by the police.*

Survivors of other types of gender based and family violence are not accessing FSC services; it is not clear if the services are accessible to members of the LGBTQI community⁴² or persons living with disability who are also at high risk of family and sexual violence. Most survivors whose entry points are different departments of the hospital, are not referred to the FSC.

Information on monthly caseloads at the FSCs indicates that only a very small proportion of all survivors of violence against women and children are accessing services of the FSC. Assuming



the best case scenario at the FSC in NCD that has reported the highest case-load of 60 cases a month (about 3 cases a working day), 75% of whom are adult survivors of IPV (not triangulated with hard data records), and applying rough calculations based on population data from the Census 2011 and data on IPV prevalence from the NDHS 2016; it appears that only 1 percent of the survivors of spousal violence in NCD have accessed services from the FSC at the Port Moresby General Hospital⁴³.

Data shared by FSC does not provide information to indicate if the most marginalized are accessing services of the FSC—record keeping and data management is poor overall, and user information is at best disaggregated by

age and binary gender identities. While all FSCs report that they provide services to anyone who comes to the FSCs (passive access), they have not applied any special measures to improve access for general or especially disadvantaged populations (active access), such as the LGBTQI community, persons with disability and others.

The following factors explain low access to FSC services and barriers that survivors face:

- There is limited to no outreach in the communities and therefore low awareness of the services available for survivors at the FSC/hospital. Most of the cases that come to the FSC are through the police, so only those survivors who are already in contact with the police, which is also generally a low proportion of all survivors (ref DHS 2016), make it to the FSC. The hesitancy of FSCs to conduct awareness raising is a reasonable response to challenges of being under-resourced, especially where there is only one staff at the FSC. Health staff and donors are cautioned not to over-commit FSCs and relevant actors to awareness raising without balancing investment in services to avoid increasing the caseload on staff without additional support, which in turn risks impacting the quality and safety of services.

However, together with external referrals, community outreach for primary prevention and for raising awareness on the services available for GBV survivors, is an important component for an ecological model to GBV prevention and response. Outreach must be understood not only in terms of creating awareness about services at the FSC but making

⁴² Gender-based violence was perpetuated against sexual minorities from a wide variety of sources, including one's own family members and sexual partners, transactional sex clients, and community members. Two key sources of GBV were police officers and healthcare providers. violence perpetuated against MSM/TG communities including physical assault (57%), sexual abuse (58%), blackmail (18%) and being refused medical treatment (13%). Sources of GBV included police, *raskols* (street gangs), regular sexual partners and relatives ([Source](#): Ref: FHI 360, 2013: Exploring gender-based violence among men who have sex with me, male sex worker and transgender communities in Bangladesh and Papua New Guinea: Results and Recommendations).

⁴³ These figures are rough estimates based on the following rough calculations: 1) 63% of ever-married women have experienced spousal physical, sexual, or emotional violence in PNG (DHS 2016); 2) NCD 2011 Female population in NCD (2011 Census): 169291; 3) of which 59% are in the age group 15-64 = 99,881 (<https://www.statista.com/statistics/731755/age-structure-in-papua-new-guinea/>); 4) of which 2/3rd women (15-49) are married= 66587; 5) of which 63% are victims of IPV=41949; 6) FSC at NCD reports max 60 cases a month, assuming these are all new cases, its 720 cases a year of which 75% are VAW (rest children)= 540 cases of IPV. 540 is 1% of total estimated survivors of IPV in NCD.

FSC services available at the community level by integrating with, for instance, primary health care providers and community-based health campaigns such as for family planning.

- Poor integration of FSC services with other entry points of the hospital that attend to survivors—whereby a larger proportion of survivors are first attended to by A&E or OPD and not all of them are referred to the FSC for provision of the full suite of essential services. The lack of referrals from other wards to FSCs, even after the identification (safe or otherwise) of survivors raises concerns regarding the comprehensiveness of care and functionality of internal referrals. The reliance on (on-request) FSC ‘consultations’ in other wards with survivors, and lack of subsequent referral to FSC for fuller care requires further investigation: why are such referrals to the FSCs not taking place; did the patient refuse and if so, why? Was it determined that the FSC did not provide relevant services and thus the referral was not offered? If this was the case, is the FSC perceived to not be relevant, and why? The lack of referrals from other wards in the hospital to the FSC highlights a lost opportunity for survivors who present for care (GBV related or otherwise) to access GBV-specific services.
- High out-of-pocket costs for survivors to access the hospital/FSC, especially for survivors who live far from FSCs in rural areas (e.g. travel costs) are likely to affect accessibility for survivors.
- Services to survivors are not entirely free of cost. Hospitals routinely charge survivors for medical treatment such as surgeries for harm caused by their violence; survivors are required to pay general costs of OPD, and A&E services and survivors are required to purchase their own drugs from external pharmacies when supplies run out in the hospitals (which is quite frequent).
- Lack of FSC services at night and on weekends have likely reduced access to GBV services for survivors in general, and even those who do manage to get medical treatment for their injuries through other departments, are therefore unable to access psychosocial support and referral services of the FSC.
- Navigation challenges within the hospitals, where survivors are required to go to different units to receive different services, such as STI, dental, pharmacy, might affect access to specific services.
- Long wait times between different services, for instance delays in releasing of medical reports have resulted in survivors not returning to collect their medical reports
- Mandatory requirement for police clearance to access medical reports, however well-intentioned, is a violation of the right of survivors to their medical report. While potential misuse of medical reports is understandably concerning, the requirement of police requests to obtain medical reports is a critical barrier to survivors’ access to justice. This not only compromises quality of care in terms of confidentiality and timeliness, but in practice functions as mandatory reporting without regard to the survivor’s wish to pursue legal recourse or not. Charging for medical reports, in particular those issued through non-FSCs wards is again a primary barrier to survivor’s access to legal recourse and should be rectified.

Recommendations to NDOH, PHA and Hospitals:

Meaningfully improve access to all 5 essential services for the most affected

Health authorities at the provincial and district levels must create greater awareness at the community level on the services available at the FSC through **targeted awareness programmes** as well as integrating awareness on FSCs as part of their ongoing public health awareness and campaigns (for vaccinations, and other community-based health initiatives). Non-FSC staff engaged in outreach should be trained and provided the relevant materials to integrate GBV awareness raising into their existing activities.

Strengthen **referral pathway from the community to the FSC**, by collaborating with NGOs, community-based organisations, network of community based human rights defenders and other community-based mechanisms for women and children's protection. Partner with 1-Tok Helpline to raise awareness about services available to survivors at hospitals and FSCs.

Strengthen internal referral protocols for hospitals/health facilities to ensure that multi-sectoral services of the FSC are made available to all survivors regardless of their entry point at the facility (A&E, OPD, others) and assistance to survivors with navigation of the different service points in the hospital.

Greater training, sensitization, and **accountability of all health workers** across the health facility on FSV, GBV, VAC, and the role of FSCs and need for integrated services

Build **capacities of primary health care facilities** on identification of survivors and provision of **first line of support**/first response (PFA and management of injuries) and referrals for specialized care as required. This will help avoid delays in response to all forms of GBV and violence against children, as well as contribute to secondary prevention.

Eliminate mandatory requirement for police clearance to access medical reports; instead, focus on **empowering survivors through psychosocial counselling** so they can make an informed choice about how they use the medical report.

Investigate the practice of mandatory reporting for adolescent GBV survivors and in cases which involve an adult GBV survivor and Child Protection case, both in terms of legal obligations as well as functional practice and reality to ensure informed quality of care which balances survivor-centered care with best interest of the child in the varied contexts of PNG.

Recommendations for DFCDR, National GBV secretariat, PHA and provincial FSVAC

Nurture a **network of community based first responders**, including community-based child protection mechanism, to provide PFA to survivors/caregivers, inform them about their rights and services, including services of the FSC, and refer survivors to appropriate service providers, including the FSC. Include community-based first responders in the referral pathway.

Mobilise youth networks for expanded outreach and awareness and community-based referrals to adolescents and young people which should be utilised by FSCs and multi-sector services more broadly.

Human Resourcing

- 4. Human resourcing at FSCs is inadequate—most FSCs have insufficient staff and face frequent staff turnover. While staff demonstrate empathy and compassion, training, certification and guidance to staff to deliver age-appropriate and survivor-centered medical and non-medical services is inadequate. There are no mechanisms for sustainable knowledge acquisition, including supervision, follow-up training and evaluation of training.*

Central to provision of good quality and survivor-centered response services is the availability of adequate, empathetic, compassionate and competent staff⁴⁴ that can respond to the specific needs of their clients. Most of the FSCs do not have an adequate number of staff and many have appointed only 1 nurse. In many FSCs non-medical staff such as social workers are shared with other departments of the hospital and are not always available when survivors come to the FSC. Nursing staff at the FSC are not fully integrated in the staff plan of the hospital, often employed at a lower grade and on the lookout for other opportunities. FSC staff have received some training or the other but none of the FSCs reported that they have received training in all of the relevant topics. For example, while FSC staff shared that they provide psychosocial support to survivors; a majority of them do not have any training on providing psychosocial counselling. Lack of support for mental health and wellbeing of FSC staff (and non FSC staff delivering services to survivors) is concerning given the significant risk of vicarious trauma related to their role.

While the staff of FSCs demonstrate knowledge of appropriate communication techniques and the principles of survivor-centred approaches such as respecting the privacy and confidentiality of survivors; taking care to prevent further traumatisation (emotional and physical); they do not necessarily have the wherewithal (equipment/infrastructure; guidance and/or training) to apply these principles (see more in conclusion 5). Well-meaning staff, whether at the FSC or in other departments, cannot be expected to deliver competent services without sufficient guidance and training (in addition to equipment and mechanisms). Competency deficit in the FSCs is a result of several factors:

1. Current pre-service training of doctors and nurses does not equip them with competencies for providing trauma-informed, survivor-centered care that is tailored to the distinctive experience of women, children, and adolescent survivors of violence. Such competencies need to be carefully built and strengthened through training, mentoring and clear guidelines. Given that non-FSC staff are involved in providing the bulk of medical services to survivors, such competencies need to be developed for all health staff of the hospital, definitely for those at the FSC and all entry points for survivors.
2. Since the establishment of FSCs, different development partners such as INGOs and UN agencies have organized and provided different types of training at different FSCs but there isn't a comprehensive and standardized plan for strengthening capacities of health workers in providing GBV and CP response. Sporadic training or training during the period of collaboration with NGOs/development partners do not sustain once partnerships have ended, partly due to lack of institutional memory and partly because of frequent staff turnover—many staff who received training have moved on and newer staff have not received any training.
3. Many FSCs are run by a single staff member and no supervisors have been appointed to provide mentoring and monitor quality of services.
4. Relevant protocols and guidelines are not always available at the FSCs and unlikely that they are available across the hospital at different entry points. The 2013 Guidelines for PHAs/Hospital Management for Establishing Hospital-Based Family Support Centres are now outdated.

⁴⁴ Department of Health, Papua New Guinea (2013): Guidelines for PHA/Hospital Management establishing hospital-based Family Support Centres

Recommendations to NDOH, PHA and Hospitals:

Develop a cohesive and comprehensive approach to training and capacity building for knowledgeable, competent, and compassionate provision of services

Urgently provide SOPs and standardised tools as well as training to relevant health staff and staff of FSC with for a) the safe identification of survivors including in non-FSC wards. This, at a minimum, is essential to avoid doing harm to survivors; b) provision of PFA for all survivors accessing services at any entry point; safety planning for survivors after they leave the facility.

Integrate knowledge and competency training on trauma informed, gender sensitised age appropriate and survivor centered care for survivors of GBV **in pre-service and in-service training** for health workers. In line with recommended whole of facility approach, non-FSC staff involved in health GBV response must also be included in all such in-service training and capacity building plans relevant to their role in care.

A structured system of **tracking and monitoring training and skills** must be established at a national and facility level. Structure supervision requires adequate staffing and supervisors should be provided standard supervision and monitoring templates to aid a more consistent supervision system across locations.

Develop **relevant and appropriate mental health and psychosocial care for staff** of FSC and those providing services to survivors.

Make relevant **policies and guidelines available to FSC** and non FSC staff; providing training in use of these guidelines.

Revise and update the 2013 Guidelines, aligning them with the recently finalised SGBV Clinic Guidelines

Supplies, Commodities and Equipment

5. *FSCs operate with poor and inconsistent availability of essential supplies and equipment. This significantly compromises their ability to provide survivor centered services exacerbates risks to dignity, safety, confidentiality of the survivors and compromises compliance rates.*

As mentioned above, FSC staff might be aware that physical re-traumatization of the survivor must be avoided through appropriate examination and/or they are not involved in conducting such examinations (they are done by the departments of O&G, A&E or by the OPD); they are aware of the need to provide privacy to survivors during consultations and to store confidential documents securely, yet they may not have the infrastructure that ensures privacy or for storing documents. Of the 9 FSCs that were assessed, only 1 FSC had access to a phone, only 3 had a blood pressure machine and stethoscope, only 2 had an angle lamp or flashlight for pelvic exam, and only 5 had bandages. Only 5 had emergency contraceptives, 4 had simple pain relief medication and only 1 had a pregnancy test kit available. 3 FSCs did not have lockable storage for keeping documents/records of survivors.

While the reliance of FSCs on different hospital departments for provision of more complex clinical care, such as for grievous physical injuries sustained by survivors may be reasonable given resource constraints, the lack of even basic equipment and supplies for FSC staff to attend to simpler injuries, perform a basic medical exam, provide privacy to survivor, provide

emergency contraception to survivors, or make a phone call to follow up on the survivor, significantly compromises the ability of FSC to deliver even the most basic care.

The prevalence of commodity shortages is very concerning. Without adequate commodities, the minimum care for survivors, especially sexual violence survivors, cannot be provided. This increases the chance of life-threatening health outcomes for survivors including HIV and high-risk pregnancies which in turn, places the survivor at higher risk for GBV. The drug shortage in particular related to emergency contraception, pregnancy tests and the treatment of STIs and HIV are highly concerning. In most locations FSCs provide survivors with a prescription to obtain these essential kits/drugs at the hospital pharmacy, heightening the risk to their safety and privacy and compromising the principle of confidentiality. These are known deterrents for compliance. The practice of giving survivors a script to buy emergency contraceptives at commercial pharmacies due to drug shortfalls at the hospital poses an even higher risk for survivors and impact on compliance rates. In addition to barriers related to distance, lack of confidentiality, privacy, safety and risk of stigmatisation for survivors, such practices also present a financial burden to survivors (EC generally priced at 50 kina).

Recommendations to NDOH, PHA and Hospitals:

Make available essential infrastructure, equipment, and supplies to enable FSCs to be self-reliant in delivering survivor-centered care and services that still fall under the FSC's exclusive responsibility. Prioritise items within the essential checklist and urgently make them available. For example, dedicated phone might be more critical than a computer, if genital examinations are being done elsewhere then at least stethoscope, thermometers, BP monitors, sutures bandages be prioritised for FSC to manage simpler injuries; EC, pregnancy kits and so on)

Urgently address commodity shortfalls to ensure the availability of required drugs for the clinical management of rape, and on-site availability of the relevant kits and medications.

FSCs should be equipped with the **necessary equipment to manage commodities**, such as stock fridges

Investment in a whole-of-facility approach should include **improving coordination and relationship between FSCs and the supply chain** to ensure FSCs are able to effectively order and receive goods from a centralized system. Where drugs and supplies need to be sourced from different departments, put in place a mechanism whereby the supplies might be delivered to the survivors at the FSC instead of the survivor having to go to the pharmacy

Access and Services for Men

6. FSCs do not have a clear strategy for addressing men as survivors and/or perpetrators, often conflating the two and potentially risking the safety of women survivors.

There appears to be an ill-informed understanding of equity in access to FSC services and what it means to make services of the FSC equitably accessible for all genders. In discussions with respondents when discussing males who sought help at FSCs, there was common conflation between male survivors of sexual violence and male intimate partners who had perpetrated violence and were perceived to need 'couples counselling' which, in practice, is often mediation. The practice of 'couples counselling' by FSC staff at the FSC raises critical concerns about the safety and quality of care for survivors.

There needs to be clear delineation of the role of FSCs with male survivors, male perpetrators and male third parties. Reports of providers balancing the interest of the perpetrator with that of the survivor speaks to the need for continuing, and ongoing coaching on the principles of survivor-centred care. FSCs must be supported to be able to provide alternative sources of mediation, should they be requested while maintaining their relationship with the survivor and the safety of the FSC space.

Recommendations to NDOH, PHA and Hospitals:

Develop **clear strategy survivor-centered approach for management of perpetrators who seek services of the FSC** or men who seek support of the FSC for marital discord/conflict. Provide clear guidelines for any interventions with couples, discouraging mediation.

Investigate the use of "men's desk" that have been established in the FSCs at Mendi and Mt. Hagen. Are these gender segregated rooms/space for consultations with male survivors of sexual violence or are these spaces where men access other types of services as well.

Annex 1: Brief Profile of Family Support Centres⁴⁵

1. Arawa: General Hospital in Arawa, Autonomous Region of Bougainville

Established at the General Hospital in Arawa, in 2014 with financial support from Australian Aid, the FSC in Arawa was opened for service in May 2015. All medical equipment, including for examinations, and furniture at the FSC were provided by Australian Aid. The FSC offers a free of charge service from 8 am-4 pm and for 5 days a week. Survivors who come after hours or on the weekend are attended by the Emergency Department, then referred to the FSC. FSC staff are available on call after hours and over the weekend.

The FSC is located within the compound of the General Hospital at a reasonable walking distance from the main building of the hospital that hosts key departments: the O&G, A&E and surgical wards. Survivors are typically accompanied to the FSC by a referring nurse from one of these departments.

The FSC has sufficient space and a design that ensures privacy and confidentiality for its users. It is well lit, fenced and gated with a grill door at the entrance, although it does not have a security guard. There is a waiting area with chairs and 7 rooms:

- a meeting room with tables, chairs and a white board—intended to be used for case conferencing but not being used at the time of the assessment
- a data entry room where details of the survivors are collected and entered into forms
- 2 examination rooms- one being used for examinations and another as the office for the nurse and for storage
- A toilet and shower for the staff
- An overnight stay area for survivors: with 2 self-contained rooms with beds, mattresses; a kitchen area with a fridge, utensils and dining table. Both rooms can be locked from inside. One of these rooms was not in use at the time of the assessment because the keys to the room were misplaced
- A storage room
- A consultation room for children, with an attached lounge area (consultation room was being used for administering COVID-19 vaccinations at the time of the baseline assessment).
- An outdoor laundry area and 2 water tanks are placed in a porch outside the kitchen

There are very few IEC materials displayed around the FSC, some of which are in *Tok Pisin*.

The FSC is staffed by one female nursing officer, the position of HEO has been vacant. There are no SOP, guidelines or standards for services at the FSC available with the nurse. The nurse is not IMAI trained, is not certified ART prescriber and does not have any training in providing psychological first aid.

The police generally refer survivors to the hospital where survivors are usually attended to by the A&E or OPD before being referred to the FSC. Onward referrals from the FSC are typically to the safe houses.

⁴⁵ Based on data collected from FSC staff respondents and observations made as part of visit to the FSC.

Case load at the FSC in Arawa is about 20-30 new and follow up cases of survivors in a month, including about 1-2 child survivors of sexual violence/rape. Majority of the cases of adult survivors of GBV are cases of IPV.

2. Buka: General Hospital In Buka, Autonomous Region of Bougainville

Established at the Buka General Hospital in 2013 with the support of UNICEF, the FSC at Buka is a standalone facility, within walking distance from different departments of the hospital such as the O&G, A&E, and surgery. At the time of the baseline assessment, the FSC was serving as a COVID facility (since 2020) and in the interim, FSC services had been relocated to the HIV/STI clinic of the General Hospital. The current space is one room that serves both as an office (with a desk) and an examination room (within an examination table). The FSC offers a free of charge service from 8 am-4 pm and for 5 days a week. Survivors who come after hours or on the weekend are attended by the Emergency Department, then referred to the FSC.

All necessary equipment and instruments for the FSC including forceps, complete range in sizes of speculums, and suture materials are sourced from the hospital when needed. All furniture and equipment and white goods were donated at the time of establishment of the FSC. A vehicle donated to the FSC by UNICEF is under the custodianship of the Health Secretary, Bougainville Department of Health, and is not available to the FSC.

The original FSC (the standalone facility) has sufficient space and a design that ensures privacy and confidentiality for its users. It is fenced and gated with a grill door at the entrance of the facility, although it does not have a security guard. All doors to the main entrances have security locks. The facility opens into a triage area and has 6 rooms (and an open kitchenette):

- A data entry clerk's office, with a computer
- Office space with desks, 1 desktop, shelves, and cabinets, now used as a COVID response storage room (lockable room). At the time of the baseline assessment there was no electricity supply to the FSC and the desktop had been moved to another building adjacent to the FSC.
- An office for the nursing officer
- A consultation room (faulty locks)
- 2 overnight stay rooms, with beds, a self-contained shower and toilet.

There were no IEC materials displayed in the shared facility at the time of the visit. The FSC staff shared that the main facility does have some IEC materials but not enough and all are in English.

The police generally refer survivors to the hospital where survivors are usually attended to by the A&E or OPD before being referred to the FSC. Onward referrals from the FSC are typically to the safe house networks by Nazarene Sisters. The nurse does not participate in the FSVAC meetings.

The FSC is staffed by one female nursing officer who has only been in this role for 9 months. The nurse is not IMAI trained, is not certified ART prescriber and does not have any training in providing psychological first aid.

Case load at the FSC in Buka is about 5-10 new and follow up cases of survivors in a month, including about 5 cases of child survivors of sexual violence/rape. Majority of the cases of adult survivors of GBV are cases sexual violence.

UNFPA has been working to strengthen internal referrals at the FSC in Buka—a training was held in June 2021 in Lae, after which the FSC nurse organised a meeting with all Sisters in Charge (SICs) of clinics and outpatient entry points. According to the nurse, this has increased the number of cases referred from different entry points in the hospital to the FSC in the last 2 months.

3. Goroka: General Hospital in Goroka, Eastern Highland Province

Established at the General Hospital in Goroka, Eastern Highland Province, in 2014 with financial support from Australian Aid, the FSC opened for service in May 2015. All furniture, equipment and medical instruments at the FSC have been donated by the Australian Aid. It is a standalone unit which is located at a considerable walking distance from other departments of the hospital such as the O&G, A&E and Surgery, which has limited its accessibility. Up until 2 weeks before this assessment, the FSC had been repurposed to serve as a COVID facility.

The FSC offers free of charge services from 8am-4pm for 5 days a week. Survivors are attended by the A&E or OPD during off hours and weekends.

The FSC has sufficient space and design that ensures privacy and confidentiality for its users. There is adequate lighting within and around the FSC and all doors to the entrances have security locks. The FSC is fenced and gated with a grill door at the entrance that opens into a service desk for screening users and a triage waiting area with 2 chairs. It has a kitchen and 6 rooms:

- 2 office spaces for the Officer in Charge and data entry.
- A meeting room
- A consultation room
- An examination room
- One storage room
- One room for overnight stay, with a toilet and shower facility.
- Separate toilets for staff and visiting (drop in) users of the FSC

There are very few IEC materials displayed in the FSC that describe its services, even fewer are in *Tok Pisin* or pictorial for easy understanding for those who cannot read.

The police generally refer survivors to the hospital where survivors are usually attended to by the A&E or OPD before being referred to the FSC. Internal referral card system used by the hospital is also used for referrals to and from the FSC. External referrals are facilitated through the provincial FSVAC that meet regularly and support case management.

The FSC is staffed by one female nursing officer who is approaching retirement age and has been asked by the hospital to retire voluntarily by the end of 2021. She is IMAI trained and a certified PEP prescriber but does not have training on providing psychological first aid. The nurse often invites the male social worker at the hospital to share office space at the FSC and to provide psychosocial support to survivors accessing FSC (this is an ad hoc arrangement).

The FSC at Goroka receives between 20 to 30 survivors in a month, 3/4th of whom are child survivors of sexual violence.

4. Mendi: General Hospital in Mendi, Southern Highlands Province

Established at the General Hospital in Mendi, Southern Highlands Province, in 2014 with support from the International Committee of the Red Cross (ICRC), the FSC is located within the General Hospital. Furniture, equipment, and medical instruments at the FSC have been donated by Oil Search Limited as the private sector support.

The FSC offers free of charge services from 8am-4pm for 5 days a week. Survivors are attended by the A&E or OPD during off hours and weekends and are charged by these departments. FSC staff are available on call after hours and over the weekend.

The FSC has sufficient space and design that ensures privacy and confidentiality for its users. There is adequate lighting within and around the FSC and all doors to the entrances have security locks. The FSC does not have separate security arrangements as it is located within the Hospital which is fenced and gated and with a stationary security guard.

There is a grill door at the entrance that opens into a service desk for screening users and a triage waiting area with 1 lounge chair, a table, and water cooler. The facility has 5 rooms:

- 1 office space for the Officer in Charge.
- 1 consultation room
- 1 examination room
- 1 storage room
- 1 Children's room

There are very few IEC materials displayed in the FSC—all are in English and not easy to understand by those who cannot read.

Typical referral pathway for survivors is from the various entry points in the hospital to the FSC and/or from the police to the FSC. The police generally refer survivors to the hospital where survivors are usually attended to by the A&E or OPD before being referred to the FSC. Internal referral card system used by the hospital is also used for referrals to and from the FSC.

The FSC is staffed with one CHW and 2 female nursing officers, one of whom serves as the Officer-in-charge and has received some training on GBV, IMAI trained and is a certified ART prescriber and PEP counsellor. She provides onsite training and mentoring to the other staff of the FSC.

The FSC at Mendi received about 33-40 cases a month; over 80 percent of whom are child survivors of sexual assault.

5. Mt Hagen: General Hospital, Mt Hagen, Western Highlands Province

Established at the General Hospital in Mt. Hagen, Western Highland Province, in 2009 with financial support from the International Committee of the Red Cross (ICRC), the FSC opened for service in 2010—then known as the Well Women's Clinic. The facility is located within the PHA Administration fencing, about a 5-minute walk from the main departments of the hospital—A&E, OPD and other clinics.

All medical equipment for the FSC was donated by ICRC when the facility was opened in 2010. However, the FSC did not have a medical examination room and all donated equipment for medical examination were redirected to other sections of the hospital, especially the A&E department. All furniture, computers, printers, shelves, and white goods currently available at the FSC have been donated by ICRC, the Australian Government through partnership with FHI 360 and local business houses such as the BSP Bank.

The FSC offers free of charge services from 8am-4pm for 5 days a week. Survivors are attended by the A&E or OPD during off hours and weekends.

The FSC has sufficient space for client privacy and confidentiality and although they do not have a dedicated security guard, the entrance to the FSC can be locked. On either side of the entrance to the FSC, there are 2 wooden benches that serve as waiting areas for users—the roof of this waiting area is covered with wooden panels. Inside, there are 7 rooms and 2 toilet and shower facilities for staff and service users, respectively:

- A reception for data entry prior to triage. It has a desktop computer and printer. A small storage area is attached to this room.
- 2 consultation rooms- common for children and adults, with desks and shelves
- Office of the manager of the FSC
- A storage room
- Counselling room for children—it is child friendly, has toys and chairs for children
- A staff tea room with a small kitchenette, couches, and a coffee table.

There is no dedicated space or arrangement for service users to stay overnight at the FSC.

Some IEC materials in English are displayed, none in the local language or pictorial/easily understood by those who cannot read.

Survivors are typically referred to the A&E department for medical examinations and stabilised before they are sent to/ back to the FSC for further services. The hospital's existing internal referral card system is used for referrals to and from FSC. External referrals are facilitated through an extensive network that was established under an FHI 360 project whereby community *lukautim ol meri*, or community mobilisers and other partners of FHI 360 supported external referrals.

The FSC has 4 staff members: 3 Nurses and 1 Data Clerk. A male social worker was appointed under a project with FHI 360 funded by DFAT, but this position was terminated when the project ended. The Nursing Officer who serves as the OIC of the FSC is IMAI trained and certified ART prescriber and counsellor.

The FSC at Mt. Hagen sees an average case load of 38-45 new and follow up cases a month, a majority (over 80 percent) are child survivors of sexual violence. The hospital has been out of PEP doses for children for over a year.

6. Alotau: General Hospital in Alotau, Milne Bay Province

Established at the General Hospital in Alotau, Milne Bay Province, in 2014 with support from MSF, the FSC at Alotau is located within the main Hospital building. Furniture, equipment, and

medical instruments at the FSC have been donated by UNICEF. The FSC is open from Monday to Friday from 8am to 4pm, GBV survivors are attended by the A&E over the weekend and after hours; FSC staff are also available on call. While services provided by the FSC are free of charge, other departments of the hospital providing services to GBV survivors do charge.

The facility is located at one of the busiest areas of the hospital adjacent to the outpatient area, which runs the risk of compromising the privacy of the clients. There is no system to ensure security within this area. The facility does not have an adequately situated triage area where clients are registered and screened. 3 spaces in a row, that are partitioned with thin wooden panels that do not reach the floor, serve as the triage area, nursing station and an office space. There are no doors to these spaces and the FSC staff use curtains to provide some privacy. There is a separate room for storage. There aren't enough chairs for clients and shelves are used as desks by the staff. There is no separate designated area for attending to child survivors.

The facility has a good display of IEC materials in English providing information for clients, including on access to justice. None of the displays are in *Tok Pisin* or easy to understand for those who cannot read.

The police generally refer survivors to the hospital where they are usually attended to by the A&E or OPD before being referred to the FSC. Internal referral card system used by the hospital is also used for referrals to and from the FSC. External referrals are facilitated through the provincial FSVAC.

The FSC at Alotau has 3 staff members: A Social Worker who is in charge of the FSC, a CHW who is nearing retirement age and a nurse who is very new to work in the FSC and requires training.

The FSC receives between 20 to 30 cases a month, of which roughly 10 percent are child survivors.

7. Lae: General Hospital Angau, Lae, Morobe Province

The FSC at the General Hospital in Angau is the oldest FSC in the country, established within the hospital building, in 2003 with the financial support of the Australian Government and subsequent support from MSF. All furniture at the FSC has been donated by Theodist Limited, Lae and all white goods for the kitchen and laundry were donated by the Bank of South Pacific Limited. Some of the medical equipment for vital examinations such as beds and lamps are old and worn out. Unlike the most other FSCs, the FSC in Lae is equipped to provide basic medical stabilisation services.

The FSC offers free of charge service from 8am-4pm, 7 days a week, it is the only FSC that reported being open on weekends as well. Survivors coming after hours are supported on call and through A&E and OPD departments.

The present premises of the FSC are relatively newly built and have sufficient space for client privacy and confidentiality and has a good system for security including a dedicated guard for the FSC. It is fenced and gated and has a ramp to facilitate access to the top floors for persons with disability. A porch at the landing of the stairs has benches where service users are screened for security before being allowed inside the FSC. There are 13 rooms/designated areas in the FSC

- A triage room at the entrance, where all details are collected by a CHW
- A meeting room for case conferencing and discussions on emergency cases
- An open waiting room with benches, a TV mounted to the wall and a little play desk for children.
- A nurse's triage station, where forms are screened, and records are stored.
- An office space for the Officer in Charge of FSC
- 3 consultation rooms
- A consultation room presently used for storage and data entry, with computers and printers donated by Daltron.
- A storage room for drugs
- A children's consultation room, with an attached small play area
- An emergency treatment room,
- A room for sterilising equipment

The FSC also includes a toilet and shower for service users (enabled for use by persons with disability); toilet and showers for staff, a laundry facility and a kitchen area. There are no rooms for survivors to stay overnight. Some IEC materials in English are displayed, none in the local language or pictorial/easily understood by neo/non literate.

Due to stock out for several drugs including emergency contraceptives, pregnancy test kits, Hep B vaccines and broad-spectrum antibiotics for over a year, the FSC at Lae provides survivors with prescriptions to purchase these drugs and vaccines at a private pharmacy located at a distance from the FSC.

The police generally refer survivors to the hospital where they are usually attended to by the A&E or OPD before being referred to the FSC. External referrals are facilitated through the provincial FSVAC that also supports case management.

The FSC has 5 programme staff—3 nurses and 2 CHWs; as well as 4 support staff including a data clerk, a receptionist, a cleaner and a security guard. The nurse who serves as in charge of the FSC is IMAI trained and certified PEP prescribers.

The FSC at Lae receives 50-60 cases in a month, including new and follow up cases. About 20-25 percent of these are children, either survivors of sexual assault or cases of neglect.

8. Port Moresby: Port Moresby General Hospital, National Capital District

The FSC in Port Moresby is the second oldest FSC in Papua New Guinea, established at the General Hospital in 2004, as a joint initiative between Port Moresby General Hospital under the National Department of Health and the Family Sexual Violence Action Committee (FSVAC), with initial support from UNICEF. The FSC is managed under the department of Social Work.

All medical equipment for vital examination used by the FSC is sourced from the POM General Hospital. The FSC is well equipped in infrastructure and furniture. The facility is well staff and supported by partners such as FHI 360 who support the salaries of the HEOs

The FSC is open from 8 is mainly a referral to the POM Gen for specific medical care. The facility focuses a lot more on psychosocial aspects of care.

The FSC is well lit and has a good system for security including a dedicated guard. All clients are screened at a triage at the reception following which the FSC opens into 6 consultation rooms, including a separate consultation room for children. The FSC has space for clients to stay overnight and toilet and shower facilities for clients.

The FSC in Port Moresby has a good supply and display of IEC material around the facility, in English and *Tok Pisin*. The facility has other pamphlets providing information about law and justice services, particularly those produced by CIMC. IEC materials are not easy to understand by those who cannot read.

The police generally refer survivors to the hospital where they are usually attended to by the A&E or OPD before being referred to the FSC. The HEO provides for referrals to other sections of the Hospital and external referrals through their own network of service providers as well as through the provincial FSVAC.

The FSC has 7 programme staff: 2 HEOs, a CHW, 2 Nurses, 1 Child Counsellor and a Social Worker, all female and 4 support staff. 2 male social workers from the social work department also provide support with cases where preference is for a male service provider.

The FSC receives about 60 cases a month, of which 25 percent are child survivors

9. Rabaul: Nonga General Hospital, Rabaul, East New Britain Province

The FSC in Rabaul was established at the Nonga General Hospital in Rabaul in 2016 with the financial support of MSF. The facility is located within the main hospital building and twice a week they share their space with the diabetes and hypertension services clinic known as the Frangipani Friendly Clinic—FFC (Mondays and Wednesdays). For attending survivors during these shared days, the FSC nurse has to put in a request to use the shared consultation room. The FSC/FFC do not have an examination room or examination bed and hence no medical examinations or procedures are conducted at the FSC—all survivors are referred to other departments of the hospital for these services. All furniture used by the FSC belongs to the FFC and has been donated by different donors.

The FSC offers free of charge services from 8am-4pm for 5 days of the week. Survivors who come off hours or on weekends are attended by OPD/A&E. Survivors are charged for services provided outside of the FSC.

All service users who enter the shared facility are screened through a small window and FSC users are directed towards the FSC nurse who sits in a corridor outside the consultation rooms. There are also chairs along the corridor which serve as waiting area for service users. There is no guard or other security system in place at the FFC/FSC. The shared nature of the facility means that the privacy of the survivors cannot be ensured. The FCC and FSC have the following shared space:

- 2 consultation rooms (neither have functioning locks and are not well lit), one of the consultation rooms is also used for storage. Records of survivors are stored in an open cardboard box
- A toilet and a shower

There is no arrangement for overnight stay for survivors and no separate counselling space for children.

Some IEC materials in English are displayed, none in the local language or pictorial/easily understood by those who cannot read.

The police generally refer survivors to the hospital where they are usually attended to by the A&E or OPD before being referred to the FSC. External referrals are facilitated through provincial FSVAC that also provides case management support.

The FSC is staffed by one 1 nurse who has undertaken a 2-week secondment to the FSC at the General Hospital in Port Moresby. She is not IMAI trained or certified to prescribe PEP.

The FSC receives about 30 cases a month of which about 10 percent are child survivors, mostly presenting with pregnancy and/or asexual assault. Adult survivor cases typically pertain physical and sexual violence by intimate partners.

Annex 2: List of Essential Infrastructure and Supplies

Infrastructure

- Private consultation room
- Adequate and hygienic toilet/latrines lockable from the inside
- Adequate and accessible water supply
- Children's Play room
- Internet
- Computers
- Telephones

Furniture

- Chairs for patient, companion, and provider
- Table or desk for consultations
- Door, curtain or screen for visual privacy during examination!!
- Examination tables
- Washable or disposable cover for examination table**
- Adequate light source in examination room
- Angle lamp or torch/flashlight for pelvic exam
- Lockable cabinet, room or other unit for secure storage of patient paper files
- Password protected computer used for consultations and safe record keeping
- Lockable medical supply cabinet OR lockable room where medical supplies are kept
- Child friendly furniture-Kids table or couches
- TV in Kids rooms
- Drip stand
- Examination Tray
- Blood pressure Machine
- Emergency Trolley
- Wheel Chair
- Need a separate examination room

Administrative Supplies

- Job aids in language of provider (eg. referral flow chart)
- Relevant national guidelines, protocols and policies (eg. Family Support Centre Standard Operating Procedures, SGBV clinic guidelines)
- Patient intake form/patient assessment form**
- Medico-legal form/forensic examination form**
- GBV or post-rape care register**
- Consent form or standardized questions the provider uses to obtain verbal or written, informed consent for GBV examination and care**
- Consent form or standardized questions the provider uses to obtain verbal or written, informed consent for HIV testing**

Clinical Supplies

- Blood pressure cuff
- Stethoscope
- Clean bed linens and gown for each patient**
- Sink
- Hand soap and/or glycerine-alcohol hand rub for use by clinician before exam and by patient after exam***

- Resuscitation equipment (if the health facility where GBV services are located has this equipment, this is sufficient)
- Feminine hygiene supplies (sanitary napkins/pads or clean cloths)**
- Waste basket with cover and disposable liner for non-biohazardous materials**
- Biohazardous waste basket with cover and disposable liner for biohazardous materials**
- Needles/syringes and sharps container with cover**
- Instrument care and cleaning supplies (functioning autoclave to sterilize equipment, backup system for sterilization, disinfectants, bleach, detergent, brush)**
- Sterile tray for instruments
- Blood tubes**
- Sterile or clean urine containers**
- Disposable, powder-free exam gloves**
- Speculum
- Tongue depressor (for inspection of oral frenulum and injury)
- Surgical scissors
- Sutures**
- Bandages**
- Clock (to document examination start and end time)
- Forceps (Plain and tooth)
- Kidney Dishes
- Dressing tray
- Swab sticks

Essential Drugs and Commodities

- HIV test kit
- Pregnancy tests
- Emergency contraception pills or IUCD (1x Levonorgestrel Tablet 0.75 mg)
- HIV post-exposure prophylactics as per country protocol (1 tab daily for 28 days-DTG)
- Drugs for treatment of STIs as per country protocol (Ceftriaxone 250mg Injection)/(Azithromycin 500mg/5 days)
- Drugs for pain relief (e.g., paracetamol) #*
- Local anesthetic for suturing
- Broad-spectrum antibiotics for wound care
- Tetanus Vaccine
- HPV-Hep B
- STI test Kits
- Hep B test Kits
- Hemoglobin test kit
- Glucometer
- Bathroom scale
- Digital thermometer

Annex 3: Draft Action Plans for FSCs

23) Draft Action Plan for FSCs in the Autonomous Region of Bougainville (AROB)

Timeline	Action	Responsible
URGENT	1. Training hospital management on GBV	
	2. Training on the clinical management for sexual violence and intimate partner violence survivors for FSC, STI and OPD staff.	
	3. Prescriber workshop for CHN.	
	4. Equip FSC so it is able to treat survivors of sexual violence, intimate partner violence and PA under one roof.	
	5. Introduce accompanying survivors between wards to ensure safe and complete referral.	
	6. Call ahead to other clinics/wards for the prioritisation of GBV survivors to avoid long wait periods which compromise care including confidentiality and safety.	
	7. Ensure medical treatment for GBV survivors is free in line with NDOH directives. This includes ceasing charging for GBV services where provided through a different ward, for example OPD.	
	8. Advocate on behalf of survivors to other wards to ensure GBV services provided by other wards/clinics remain free.	
	9. Introduce correct forms and start accurate reporting and data collection.	
CRITICAL	1. Sensitisation and training of non-FSC staff in hospital on GBV, clinical guidelines and survivor-centred care. Include a focus on fostering survivor-centred attitudes.	
	2. Improve referrals including documentation between district health facilities and provincial FSCs to ensure timely completion of referrals.	
	3. Management to allocate additional staff to FSC. Recruit additional staff, including nursing officers.	
	4. Inclusion of data officer and social worker as standard FSC staff	
	5. Pharmacist to order emergency pill; FSC to provide quotation to expedite.	
	6. Establish internal hospital referral Standard Operating Procedure.	
	7. GBV training on SGBV Clinical Guidelines for senior management.	
IMPORTANT	1. Public Awareness on FSC services through partners and committees	
	2. Meeting with DPM on human resourcing of FSC.	
	3. Roll out of syphilis-HIV testing.	
	4. Organise out-of-hours care with hospital staff.	

	5. Introduce debriefing.	
	6. Introduce staff rotation and adequate leave to address burn-out.	
	7. Introduce giving medical reports directly to appropriate police (eg. Sexual Offense Squad) rather than to the survivor or other actors to avoid misuse.	
	8. Multi-sector referral pathway training to strengthen referrals and accountability for who is responsible for what.	
	9. Training of district and sub-district providers on GBV including accurate completion of medical reports.	

24) Draft Action Plan for FSC: Rabaul, East New Britain

Timeline	Action	Responsible
URGENT	1. Introduce electronic storage. Procure computer desktop, UPS and external hard drive.	
	2. Improve database management including standardised data collection, management and sharing within hospital and with external providers.	
	3. Data management training.	
	4. GBV information provided regularly in E-NHIS forms.	
	5. Strengthen FSC to ensure all services provided under one roof.	
	6. Meet with DOM on expanded and sustainable human resourcing for FSCs.	
	7. Ensure FSC structure into the PHA workforce**	
	8. Training for existing and new FSC staff as well as relevant staff from other wards/clinic. Introduce shadowing.	
	9. Sensitisation and training of non-FSC on GBV including survivor-centred care and attitudes.	
	10. Timely stock control of commodities following FIFO.	
	11. Inclusion of data officer and social worker in FSC standard staffing.	
	12. Training district health staff on GBV including the correct completion of medical reports.	
	13. Introduce accompanying survivors between wards to ensure safe and timely internal referrals.	
	14. Strengthen manual storage of case data. Procure lockable filing cabinets. Training for workforce on data management.	
CRITICAL	1. Work attachments at well established FSC (eg. Angau).	
	2. Introduce staff rotation and adequate leave to address burn out.	
	3. Medical reports to be simplified to ensure accurate completion.	
	4. Improve FSC accessibility including for persons with a disability.	
	5. Additional staff in new positions at FSC including HEO and 2 nursing officers.	
	6. Introduce debriefing.	
	7. Ensure 24 hours services. Establish on-call roster and coordinate with other wards that function 24 hours after FSC operating hours.	
	8. Sensitise PHA management and board on FSC, including its function, importance and plans.	
	9. Call ahead to other clinics/wards for the prioritisation of GBV survivors to avoid long wait periods which compromise care.	

IMPORTANT	1. Introduce provincial toll free number to provide information on and referrals to ENB-based services.	
	2. Introduce giving medical reports directly to appropriate police (eg. Sexual Offense Squad) rather than to survivor or other actors to avoid misuse.	
	3. Ensure medical treatment for GBV survivors is free in line with NDOH directives. This includes ceasing charging for GBV services where provided through a different ward, for example OPD.	
	4. Advocate on behalf of survivors to other wards to ensure GBV services provided by other wards/clinics remain free.	
	5. Subsidise costs of transport for survivors.	
	6. Training ward development committees on GBV so they are able to conduct awareness for FSC and facilitate linking survivors.	
	7. Improve referrals including documentation between district health facilities and provincial FSCs to ensure timely completion of referrals.	
	8. Prioritise procurement of materials and supplies so FSC has minimum required (eg. fridge).	
	9. Multi-sector referral pathway training to strengthen referrals and accountability for who is responsible for what.	
	10. Establish stand-alone (currently attached to existing clinic).	
	11. Training senior management on SGBV clinic guidelines.	
	12. Strengthen internal referral pathway.	
	13. Procurement of FSC dedicated vehicle by the PHA/Provincial Government.	
	14. Build additional safe houses in districts.	

25) Draft Action Plan for FSC Alotau, Milne Bay

Timeline	Action	Responsible
URGENT	Capture annual plans in Annual Activity Plan	FSC/FSVAC
CRITICAL	Build local health staff capacity to respond to GBV	DPM
	Improve referral pathways including feedback to referring provider	FSC/FSVAC
	Sensitise all partners on coordination and referral pathways for GBV	FSC/FSVAC/ Partners
	Train all health staff on confidentiality related to caring for GBV survivors	FSC/FSVAC/ DNOH
	Develop SOP for internal hospital referral pathway	FSC/FSVAC

	Integrated GBV response team as part of disaster emergency team.	FSC/FSVAC
	Develop SOP for external multi-sector referral pathways including removal/rehabilitation of child/trafficking/SARV survivors.	FSC/FSVAC/ Partners
IMPORTANT	Caring for child survivors training	FSC/FSVAC/ Partners
	Conduct awareness of GBV and FSC services for high school students (primary to high school)	FSC/FSVAC/ Partners
	Improve awareness on basic human rights including right to services amongst providers and community	FSC/FSVAC/ Partners
	Create adolescent friendly safe space within hospital for friendly services	FSC/FSVAC/ Partners/Hosp ital Management/ PHA
	Purchase vehicle	NGO
	Case management and counselling training for multi-sector service providers	UNFPA/partn er
	Training of trainings to support in-house capacity building for health staff	NDOH
	Renovate and extend infrastructure	Partner/FSC OIC
	Direct supply of committees to FSC from AMS	NDOH
	Train male advocates to deal with male survivors.	NDOH/FSVA C

26) Draft Action Plan for FSC Lae, Morobe

Timeline	Action	Responsible
URGENT	1. Establish FSC ledger in PHA account to ensure FSC is allocated its own separate funding.	
	2. Improve commodity management including strengthening coordination with pharmacy as well as separate funding for emergency commodity shortfalls.	
	3. Urgent procurement of a vehicle.	
CRITICAL	1. Procurement of materials and supplies. Specifically desktop computers, printers and stationeries.	
	2. Additional staffing. Critical need for a receptionist to relieve burden on data officers. Additional staff required also includes two counsellors and two nurses.	
	3. Introduce staff rotation and adequate leave to address burn out.	
	4. Reintroduce debriefing for FSC staff.	
	5. Shift data management to a paperless system.	
	6. Development of multi-sector Standard Operating Procedures.	
	7. Improve non-FSC staff skills in accurate completion of medical reports for GBV survivors to alleviate burden on FSC, in cases where non-FSC have provided service and thus are able to complete reports. Training of district and sub-district providers on GBV including accurate completion of medical reports.	
	8. Meeting with DPM on human resourcing.	
IMPORTANT	1. Expanded awareness including radio messaging, TV and brochures and pamphlets.	
	2. Training and accreditation for nurses and clinicians for administering HIV PEP, PICT and IMAI.	
	3. Additional counsellors for psychological first aid.	
	4. Training of FSC staff on wound and fracture management and x-ray reading (for those not already trained on these).	
	5. Training on SGBC clinical guidelines for senior staff/hospital management.	
	6. Circulate circular instructions advocating other units that SGBV cases and medical reports are to be issued free of charge.	

27) Draft Action Plan for FSC Mt. Hagen, Western Highlands Province

Timeline	Action	Responsible
URGENT	1. Rehabilitation for juvenile offenders	Com Dev
	2. Interim donor supported staffing positions	Partners
	3. Multi-sector legal training	Partners
	4. Expand safe houses designed to meet specific populations (women survivor safe house, unaccompanied children house, etc.)	PA
CRITICAL	5. Counsellor/social worker at FSCs	PA
	6. Minimum standards requirements/updated Family Support Centre Standard Operating Procedures	NDOH
	7. Training for health staff on adolescent friendly attitudes and services	Partner/PHA
	8. Support/train village health volunteers to safely refer survivors	NDOH
	Staff retreat	Partners
	9. FSC and front-line health worker debriefing	Partners
	1. Improved regulation of pharmaceuticals (in particular misoprostol)	NDOH
	2. Training and sensitisation on FSC and GBV for hospital management and PHA	Partners
	3. Advocacy to DPM for sustainable recruitment on FSC	NDOH
	4. Integrate GBV into outreach to communities and villages	PHA
	5. Database to assist tracking and follow up	Government
	6. Improved multi-sector GBV referral pathway coordination and monitoring	National Government
	7. Standardised database across all FSCs	NDOH
	8. Multi-sector training and workshops on GBV and referrals	Government
	9. Violence prevention to address root causes of violence	Multi-Sector Providers
	10. Analysis of GBV data collected through FSC	PHA/FSC/Partners
	IMPORTANT	1. Expand legal awareness information sharing
2. Education and awareness in schools on SRHR and GBV provided by health staff		PHA
1. Additional IEC on laws including punishments for GBV and child abuse for distribution		Government

