

SEPTEMBER 2018

INTEGRATING GBV Services in Health Facilities

Experience from *Strengthening HIV/AIDS Services for Key Populations in PNG* program implemented by FHI 360



This report was made possible by the generous support of the American people through the United States Agency for International Development (USAID). The contents are the responsibility of FHI 360 and do not necessarily reflect the views of USAID or the United States government.



TABLE OF CONTENTS

Acronyms and Abbreviations	i
Introduction	i
Relationship Between Gender-Based Violence and HIV in Papua New Guinea	2
Benefits of Integrating Gender-Based Violence and HIV Clinical Services	3
Gender-Based Violence Screening.....	4
Process of Integration.....	5
Step 1: Gather information on (1) references and resources, (2) types of GBV, applicable laws and policies and (3) referral services.....	5
Step 2: Gather information on the readiness of targeted health facilities to offer GBV clinical services	7
Step 3: Develop a GBV screening protocol	7
Step 4: Build capacity of health care providers and Program staff	10
Step 5: Provide ongoing supportive supervision	10
Step 6: Plan for and collect GBV data	11
Step 7: Prevent GBV and build a bridge between the community and GBV services.....	11
Results	13
Lessons Learned and Challenges	15
Recommendations.....	16

ACRONYMS & ABBREVIATIONS

EC

Emergency Contraception

FSC

Family Support Center

FSVAC

Family and Sexual Violence Action
Committee

GBV

Gender-based Violence

IPV

Intimate Partner Violence

KP

Key Population

MSM

Men who have Sex with Men

NDoH

National Department of Health

PEP

Post-exposure Prophylaxis

SOP

Standard Operating Procedure

STI

Sexually Transmitted Infection

TG

Transgender

VCT

Voluntary Counseling and Testing

ACKNOWLEDGMENT

The work illustrated in this report would not have been possible without the support of National Department of Health (NDOH) that provided support for the integration through its Family Health Services unit. National Capital District Health Services (NCDHS) has provided unequivocal support in the piloting and roll out of the GBV integration in the clinics it manages directly or indirectly through other partners.

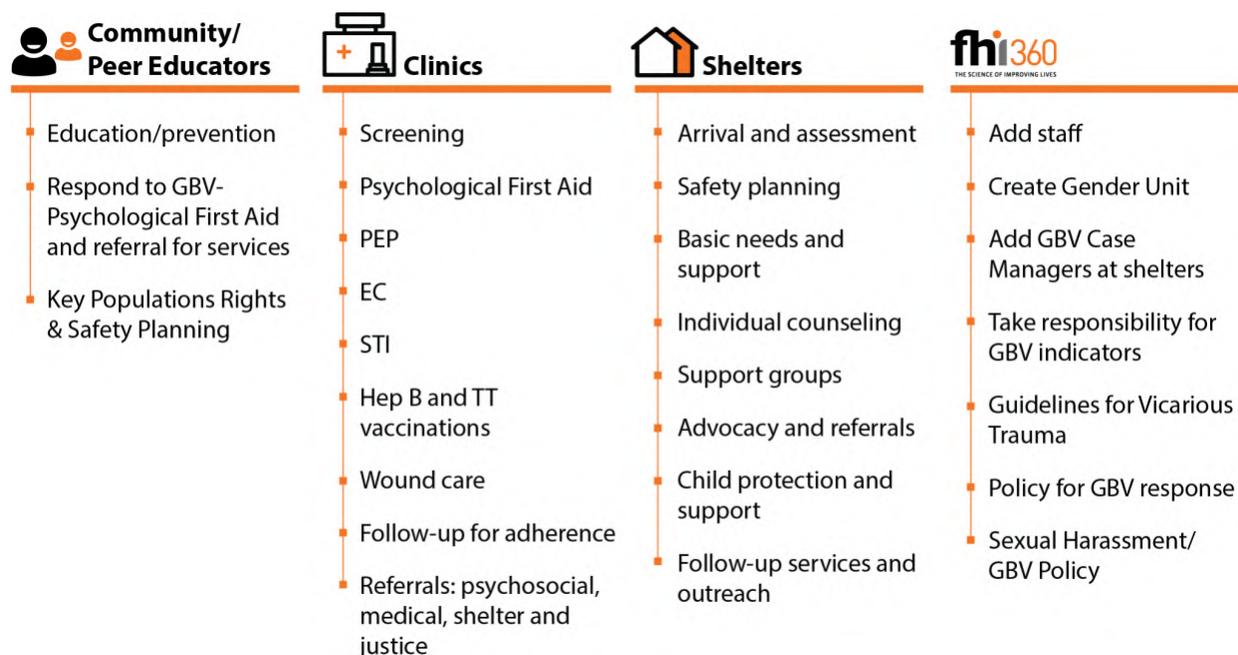
FHI 360 would like to thank the generous financial and technical support from United States Agency for International Development (USAID). FHI 360 would also like to acknowledge Salvation Army, Living Light Health Services (Four Square Church), Modilion General Hospital and Id Inad Clinic staff, Heduru Clinic management and staff, Hope Worldwide and Lawes Road and Nine Mile clinic staff and Takurara clinic staff for integrating GBV in their clinics. FHI 360 team member include Maryce Ramsey, Gender Advisor, Roselyn Nopa, Gender Officer, Dr. Ignatius Mogaba, Deputy Director, William Yeka, Monitoring and Research Advisor and Daniel Tesfaye, Country Director contributed to the compilation of the report. FHI 360 would like to thank Mirriam Dogimab, former gender project director for her contribution in the write up of the report.

INTRODUCTION

Strengthening HIV/AIDS Services for Key Populations in Papua New Guinea is a six-year (2012–2018), \$19.4-million Program funded by the U.S. Agency for International Development. The Program aims to reduce HIV incidence among key populations (KPs), including men who have sex with men (MSM), transgender (TG) people and men and women engaging in transactional sex. Using a continuum of prevention to care and treatment model, the Program works to achieve its goal by (1) increasing demand for HIV/AIDS services among KPs, their sexual partners and their families, (2) increasing the supply of quality HIV/AIDS services for KPs, their sexual partners and their families, (3) increasing the use of facility- and community-based gender and gender-based violence (GBV) interventions and (4) strengthening health systems for HIV/AIDS service delivery. To increase the use of facility- and community-based GBV interventions, the Program directly supported four clinics run by faith-based organizations and four government-run facilities in integrating GBV clinical services into HIV services.

This document includes information on the relationship between GBV and HIV, the rationale behind GBV screening, the steps taken to integrate GBV programming across the Program in general and into HIV clinical services, lessons learned and recommendations, as well as resources and references for integration. Separate annexes contain additional materials and tools created by the Program. The diagram below summarizes the Program’s activities related to GBV:

Figure 1. Strengthening HIV/AIDS Services for Key Populations in Papua New Guinea – Program activities related to GBV.



RELATIONSHIP BETWEEN GENDER-BASED VIOLENCE AND HIV IN PAPUA NEW GUINEA

Papua New Guinea is facing twin epidemics of HIV and GBV with limited data available especially on GBV. With a population of 7,800,000, Papua New Guinea has 32,744 people living with HIV and an estimated HIV prevalence of 0.8 percent.¹ The data available on GBV is scarce but daunting. GBV primarily affects women, girls and individuals who do not conform to societal norms and expectations related to masculinity and femininity. A cross-sectional survey conducted in 2009 that covered four provinces found that two-thirds of the female respondents had experienced physical or sexual GBV.² An integrated bio-behavioral survey conducted in three provinces in 2016, 2017 and 2018 showed that more than one in three women engaging in transactional sex in Port Moresby, Lae and Mount Hagen (34.2 percent, 40.5 percent and 40.4 percent respectively) had been forced to have sex, while approximately one in four MSM and TG people in Port Moresby (24.1 percent) and Lae (23.7 percent) had ever been forced to have sex.³

The relationship between GBV and HIV in Papua New Guinea echoes global findings:⁴

- Direct transmission of HIV via forced sex
- Reduced ability to negotiate for safer sex due to GBV in intimate relationships
- Sexual relationships at earlier ages and increased sexual risk-taking and vulnerability to sex work among victims of child sexual abuse
- Women, MSM, TG people and women engaging in transactional sex afraid to test, disclose test results, access services or adhere to treatment

The 90–90–90 global target for HIV/AIDS programming calls on countries to reach three goals by 2020: 90 percent of people living with HIV will be diagnosed, 90 percent of diagnosed people will receive antiretroviral therapy, and 90 percent of those who receive antiretroviral therapy will have viral suppression. GBV is one of the most significant barriers to each of these goals in Papua New Guinea.⁵

¹ National AIDS Council Secretariat National Department of Health. Country Progress Report, Papua New Guinea. Reporting Period January 1 to December 31, 2014; April 15, 2015.

² Ganster-Breidler M. Gender-Based Violence and the Impact on Women's Health and Well-Being in Papua New Guinea. *Contemporary PNG Studies: DWU Research Journal*. 2010; 13. Available from: www.archive.org/details/Ganster.

³ Kelly-Hanku A, Willie B, Weikum D, Boli Neo R, Kupul M, Coy K et al. Papua New Guinea Institute of Medical Research and Kirby Institute, UNSW Sydney. *Kauntim Mi Tu Multi-Site Summary Report 2018: Key Findings from the Key Population Integrated Bio-Behavioural Survey Papua New Guinea*; 2018. Available from: www.aidsdatahub.org/sites/default/files/publication/PNG_Kauntim_mi_tu_Multi-Site_Summary_Report_from_the_Key_Population_IBBS_2018.pdf.

⁴ United Nations Development Programme. Rapid Assessment of Institutional Readiness to Deliver Gender-Based Violence and HIV Services in Five Provinces of Papua New Guinea; 2013. Available from: www.aidsdatahub.org/sites/default/files/documents/hiv-2013-rapid-assessment-gbv-hiv-png.pdf.

⁵ Ramsey M. President's Emergency Plan for AIDS Relief. Gender Analysis, Papua New Guinea; 2016.

BENEFITS OF INTEGRATING GENDER-BASED VIOLENCE AND HIV CLINICAL SERVICES

Accessibility : given the high levels of GBV against KPs and the significant barriers KPs face in accessing health services, especially in relation to GBV, integrating GBV services into Program-supported HIV services would be the best way to ensure that more GBV survivors can access appropriate care.

Utilization of existing services : Of the five essential GBV services – psychological first aid, emergency contraception (EC), post-exposure prophylaxis (PEP), prophylaxis for sexually transmitted infections (STIs) and vaccination against tetanus and hepatitis B – most are already provided by trained staff at HIV/STI clinics. Given the training requirements for providers to conduct HIV counseling and testing or to dispense PEP, using existing services and adding missing services (EC and tetanus and hepatitis B vaccines) where needed makes the integration of GBV services cost-effective and logistically easier.

Time-sensitive services delivery : screened GBV survivors and people who are referred for GBV can access all GBV services in the same clinic and receive time-sensitive EC and PEP within the critical time frame.

GENDER-BASED VIOLENCE SCREENING

While there are Family Support Centers (FSCs) that provide GBV-related services, as the name suggests, these centers are primarily focused on intimate partner violence (IPV, also known as domestic violence) and sexual violence against women and girls. Those experiencing GBV outside of such parameters may not feel welcome at these sites. Additionally, there are only two FSCs serving Port Moresby.

While FSCs only provide services after a survivor has experienced GBV, GBV screening serves as both response and prevention. “When risk or exposure to past or current IPV [GBV] is assessed through ‘screening,’ the impact can be primary prevention for patients with no history or suspicion of exposure, secondary prevention for patients with past exposure, or tertiary prevention for patients with current or acute exposure.”⁶

As illustrated in the results section of this document, the majority of those who are screened do not report experiencing GBV. However, not all clients who are experiencing or have experienced GBV will report it during the screening, particularly the first time. GBV screening achieves other important aims in that it provides a safe space for clients, including KPs, to learn about GBV – what it is, how it impacts their health and where services are available – and to open a dialogue between the provider and the client, setting the stage for future disclosure.

Screened GBV survivors are assisted by trained providers to assess their current risks and make plans for safety, including knowing where and how to access community resources. Those who do not report GBV during the screening but may currently be experiencing GBV or might experience it in the future can connect with peer educators trained to use tools to help KPs assess their danger and plan for safety. Peer educators are also trained to prepare KPs to be screened as part of their regular clinic visits, increasing the likelihood of future disclosure and building a bridge between community and clinic.

Integrating GBV screening into HIV/STI services accomplishes five important objectives:

- Increasing the number of service points available to GBV survivors in a country with extremely high levels of GBV and where travel in, around and between neighborhoods can be dangerous and difficult for survivors
- Developing the first KP-friendly GBV service sites
- Serving as GBV prevention as well as response
- Offering an opportunity for KPs to be educated about what GBV is, how it impacts their health and where they can find services
- Assisting KP survivors to take the first, crucial steps toward safety planning

⁶ Decker MR, Miller E, Glass N. *Screening for GBV in Formal and Informal Settings: Where Are We and Where Are We Going?* Background paper submitted for NSF/NIJ Workshop: How Can Intimate Partner Violence be Prevented? A Workshop on Developing Effective Primary, Secondary, and Tertiary Interventions; 2014. Available from: www.citeseerx.ist.psu.edu/viewdoc/download?doi=10.1.1.882.1621&rep=rep1&type=pdf.

PROCESS OF INTEGRATION

This section details the seven steps in the process of integration.

STEP 1 Gather information on (1) references and resources, (2) types of GBV, applicable laws and policies and (3) referral services.

STEP 1.1 Gather information on references and resources

To begin the process of integration and screening, the Program relied on a selection of important reference materials:

World Health Organization. *Responding to Intimate Partner Violence and Sexual Violence against Women: WHO Clinical and Policy Guidelines*. Geneva, Switzerland; 2013.

Available from:

www.apps.who.int/iris/bitstream/handle/10665/85240/9789241548595_eng.pdf;jsessionid=8F10FE3A828D2C59A1A7BF27E41F0331?sequence=1.

Bott S, Guedes A, Claramunt MC, Guezmes A. International Planned Parenthood Federation, Western Hemisphere Region. *Improving the Health Sector Response to Gender Based Violence: A Resource Manual for Health Care Professionals in Developing Countries*; 2010. Available from:

www.ippfwhr.org/sites/default/files/GBV_cdbookletANDmanual_FA_FINAL.pdf.

Government of Papua New Guinea, National Department of Health (2014). *Medical and Psychosocial Care for Survivors of Sexual and Gender-Based Violence, National Clinical Practice Guidelines*, Papua New Guinea.

Betron M. U.S. Agency for International Development. *Screening for Violence against MSM and Transgenders: Report on a Pilot Project in Mexico and Thailand*. Washington, DC: Futures Group; 2009. Available from:

www.healthpolicyplus.com/archive/ns/pubs/hpi/1100_1_GB_V_MARP_Final_Project_Report_FINAL_4_27_10_acc.pdf.

World Health Organization. *Health care for women subjected to intimate partner violence or sexual violence: A clinical handbook*. Geneva, Switzerland: WHO Document Production Services; 2014. Available from:

www.who.int/reproductivehealth/publications/violence/vaw-clinical-handbook/en/.

These documents were critical in identifying the minimum requirements for screening, process steps for integration, tested tools, specific issues related to KP screening and government requirements for GBV clinical services. In the GBV screening protocol, the Program referenced the National Clinical Practice Guidelines rather than creating new protocols for clinical services and ensured that the GBV training for Program staff was complementary, thus enhancing rather than contradicting existing guidance and training.

STEP 1.2 Gather information on types of GBV, applicable laws and policies

Most screening materials available have been developed with a focus on identifying IPV against women. To develop a screening protocol and train providers appropriately, the Program needed to take into account all types of violence and perpetrators of violence against KPs as well as services available to survivors. Clinical data revealed that it is important to address not only the violence KPs experience in relation to their sexual orientation, gender identity and/or sex work as perpetrated by clients and strangers but also violence perpetrated by loved ones and partners.

As Papua New Guinea laws criminalize prostitution and sodomy, caution must be exercised when giving referrals. On the other hand, the constitution of Papua New Guinea contains almost all the rights and freedoms enshrined in the Charter of the United Nations and the Universal Declaration of Human Rights. The country is also a signatory to the Convention on the Elimination of all Forms of Discrimination Against Women. In accordance with the National Department of Health (NDoH) Guidelines, which require health care providers to apply a survivor-centered approach by prioritizing their rights, wishes and needs, all Program-supported GBV services are provided with due regard for human rights, and all GBV materials inform KPs of their rights.

STEP 1.3 Gather information on referral points – availability and challenges

Referral points for all KPs were identified by consulting KP groups and GBV providers and through ongoing participation in and support for local Family Sexual Violence Action Committees (FSVACs). While there are shelter, legal, police and medical service points for women, services for children, sex workers, MSM, male survivors of GBV and TG individuals are limited. Overall, organizations serving KPs are poorly resourced. Regular participation in multisectoral FSVAC meetings enabled the Program staff to build relationships that proved crucial in ensuring smooth referrals with cases requiring personal attention. While this system works on a case-by-case basis, it is not sustainable. Notwithstanding the challenges, referral cards were developed for each KP, each type of referral service and each clinic conducting GBV screening.

STEP 2 Gather information on the readiness of targeted health facilities to offer GBV clinical services

The Program engaged in a process of assessment of the initial five (and, later, the additional four) facilities on several occasions. The first readiness assessment gathered information for the development of the GBV screening protocol.

Utilizing the International Planned Parenthood Federation's complete management checklist,⁷ the team visited each clinic at least once to assess:

- The clinic's structure
- Providers' attitudes
- Staffing
- Client flow
- Ability to offer all five essential GBV services
- Confidentiality
- Security of records
- Existing data collection tools and other forms

The information gathered was used to develop the screening protocol, the training program, data forms and other materials. The checklist was subsequently modified and significantly scaled down for providers to assess their clinic's readiness and develop a clinic-specific work plan for the initiation of GBV screening (see annex 1 for the modified checklist).

Client flow was one of the key issues assessed, including identifying the best entry points to screen all clients, to respect the client's privacy and to minimize movement/referrals for survivors. Priority was given to ensuring confidentiality and privacy of persons, information and data as well as access to either a male or female provider depending on the client's choice. Availability of all required medications was also assessed, and the main challenges identified were adding EC in the list of medications and having cold storage for vaccines. Locked cabinets were purchased for data storage, and existing registers and forms were modified to capture GBV data.

STEP 3 Develop a GBV screening protocol

FHI 360 followed the guidance provided by the International Planned Parenthood Federation⁷ in developing and implementing a routine GBV screening policy, including:

- Assessing and improving the clinic's physical and human resources
- Identifying operational definitions of violence
- Developing screening questions, a data collection system and a written screening protocol
- Ensuring that providers are adequately prepared to screen, refer and care for those who have experienced violence

⁷ Bott S, Guedes A, Claramunt MC, Guezmes A. International Planned Parenthood Federation, Western Hemisphere Region. *Improving the Health Sector Response to Gender Based Violence: A Resource Manual for Health Care Professionals in Developing Countries*; 2010. Available from: www.ippfwhr.org/sites/default/files/GBV_cdbookletANDmanual_FA_FINAL.pdf.

- Addressing providers' concerns and training staff to implement the screening protocol
- Providing support to health care providers who routinely screen clients
- Monitoring and evaluating routine screening

For details on GBV definitions, screening questions and who, what, when, where, by whom and how to screen, see the protocol in annex 2.

The Program followed two additional guidelines: (1) survivors should be able to access all necessary services with minimum movement and (2) the GBV screening protocol and training should reference and utilize existing national resources and forms to ensure compliance with national laws and to avoid duplication or confusion.

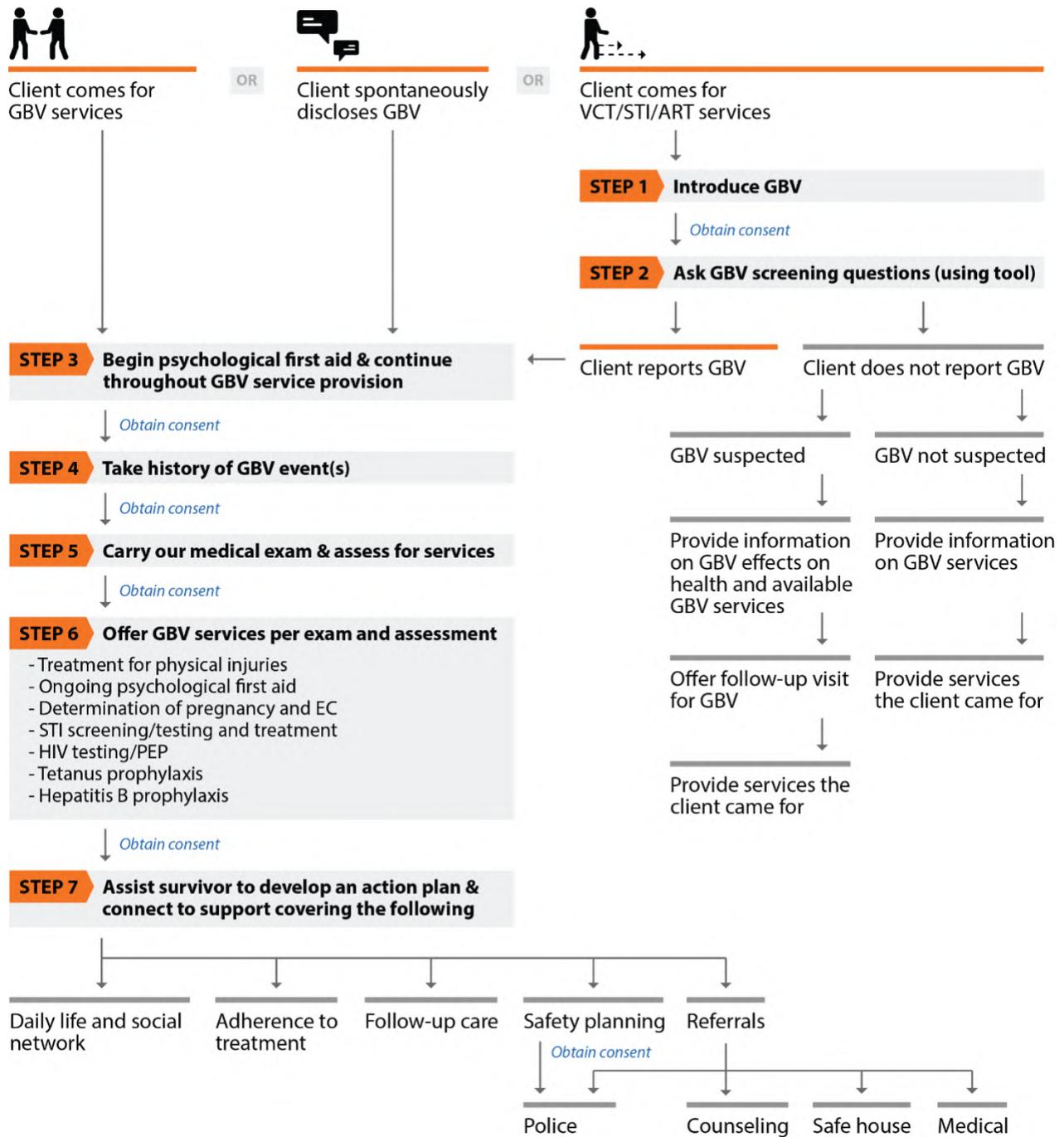
In the implementing clinics, survivors can access all services in the room where they are screened with the exception of survivors reporting GBV in the voluntary counseling and testing (VCT) room, who must move only once to access all services. The GBV screening protocol is simple and provides page references to the National Clinical Practice Guidelines, making it easier to find further relevant guidance for each step and ensuring that all providers are delivering GBV services according to national standards. Existing national GBV forms are also referenced according to the steps they should be used for.

JOB AIDS

All job aids created are simple, clear and easy to follow and use. They include:

- GBV screening and services flowchart depicting the sequence and pathways of the GBV screening protocol through service delivery (see figure 2)
- GBV survivor flowchart, checklist and internal service access cards to map out the flow of a survivor and avoid counting a survivor twice
- Wall chart with the screening questions as a visual reminder for providers
- Referral cards
- Posters in the waiting rooms and T-shirts worn by Program staff that read: "Talk to me about violence in your life, I can help."

Figure 2. Gender-based violence screening and services flowchart.



STEP 4 Build capacity of health care providers and Program staff

To be successful, the Program's GBV clinical services required extensive training for leadership, management, clinical services staff, monitoring and evaluation staff, researchers, social and behavior change communication staff and outreach staff, as well as governmental and non-governmental partners. Since the inception of the Program, all FHI 360 staff, implementing partners and clinic staff have attended multiple training sessions on gender every year, including KP sensitization, GBV sensitization, gender norms, and gender analysis and integration.

A five-day training course on GBV screening and clinical services developed health care workers' knowledge and skills to be able to provide ethical, quality and complete GBV services. In particular, the training:

- Followed the GBV protocol, building the necessary skills and attitudes to implement each step in the screening and services flowchart successfully
- Employed an experiential and practical methodology, incorporating existing forms, resources and training
- Focused on understanding personal values, including how those values create barriers to service use, upholding professional ethics and meeting KP human rights
- Utilized role-play to practice the skills required for each step; participants alternated between being the provider and being Josephine, a TG woman who experienced sexual GBV
- Introduced the facility readiness assessment tool for clinic teams to help them develop an action plan to initiate GBV screening and services in their clinics

The GBV clinical services training was carried out twice in 2015, and refresher sessions were carried out twice in 2016. For the complete training agenda, see annex 3.

STEP 5 Provide ongoing supportive supervision

The most delicate phase in rolling out GBV clinical services is right after the training, when providers begin to implement what they have learned. To facilitate this step, the Program provided supportive supervision to each clinic two to three times a week and mentored clinicians on interviewing survivors, conducting medical examinations, using the screening tool, capturing data correctly, coordinating referrals and compiling GBV reports. Random checks on charts, data tools and survivor charts were carried out to verify the data collected. Immediate on-site support was also provided for emergency case management.

Ongoing supportive supervision and the review of GBV data are continuously providing information on the areas where additional training is required. For example, when the number of survivors identified through screening was lower than expected, the Program team surmised that

providers were having problems with the screening questions. The team addressed this issue in a refresher session on GBV screening that included the screening questions and how best to translate concepts into Tok Pisin. Training sessions on GBV case management were also provided for the clinicians as well as GBV sensitization training for the clinic security guards, receptionists and drivers, since these members of the staff are often identified as barriers to GBV survivors accessing the services.

STEP 6 Plan for and collect GBV data

The Program focused on collecting data to track screening, types of GBV, services received and referrals by population. Existing national HIV/STI intake forms, review and follow-up forms, daily log books, registers and survivor summary forms were updated and further developed before being distributed to all clinics to capture data as required by the Government and USAID. Emphasis was placed on the confidentiality and privacy of client records, and clear guidance was given on where data should be stored and who should be given access to it.

All data is stored in locked cabinets, and only two staff have access to the cabinet where the key for translating patient numbers into names is kept. In addition to random data spot checks, the Program staff supervises clinic staff in preparing the monthly GBV reports. This is done by checking screening data compiled from daily log books with the GBV survivor summary forms and by cross-checking the GBV register against the number of charts.

STEP 7 Prevent GBV and build a bridge between the community and GBV services

Working on prevention is difficult due to existing laws on sodomy and sex work, societal norms that cause stigma and discrimination, and programming predominantly focused on IPV or family and sexual violence. The long-term Program strategy includes working with the NDoH, Program peer educators, community programs and the family and sexual violence hotline to gradually transform the national (both governmental and non-governmental) GBV network of services and key resource materials to be more inclusive and welcoming of all GBV survivors, regardless of sex, age, gender identity, sexual orientation or profession.

SUPPORT TO THE NDoH

The Program staff provided technical support to:

- Integrate and create stand-alone sections on the disabled, elderly and KPs for the Referral Guidelines for Family and Sexual Violence Service Providers in Papua New Guinea
- Integrate and create a separate chapter on KPs for the Medical and Psychosocial Care for Survivors of Sexual and Gender-Based Violence, National Clinical Practice Guidelines

- Create a module on GBV against KPs for the national sexual and gender-based violence (SGBV) training curriculum

PEER EDUCATORS

Program peer educators only work with MSM, TG people, sex workers and other high-risk women and men. A GBV standard operating procedure (SOP) was developed to guide peer educators in (1) educating KPs about GBV, preventing GBV and safety planning, (2) preparing KPs for GBV screening and (3) referring KPs for GBV services. The SOP and the safety planning tools primarily focus on preventing and planning for safety with regard to IPV and sex-work-related violence. The GBV SOP training prepared the peer educators to (1) confidently use the GBV SOP, (2) help KP peers plan for safety, (3) provide accurate information on GBV, (4) respond appropriately to spontaneous disclosures of GBV by peers and (5) refer peers for GBV services. The GBV SOP, IPV safety tips and tips to prevent GBV against sex workers are available in annex 4, annex 5 and annex 6 respectively.

COMMUNITY PREVENTION

While extensive gender training for staff and partners was carried out (as illustrated in step 4), a limited budget and scope constrained the Program's ability to broadly impact public knowledge, attitudes and behaviors regarding GBV against KPs. Nevertheless, the Program developed resources and partnered with other programs to broaden its impact. In collaboration with the NDoH and FSVAC, the Program expanded "16 days of Activism Against GBV" activities to include GBV against KP and developed and disseminated the first "GBV against KP" posters, increasing awareness of the ways GBV impacts KPs and the specific needs of KPs experiencing GBV among multi-sectoral service providers. The Program also developed a half-day module on KPs and GBV which can be used alone or added to other training programs. This module has been incorporated into the ongoing "KP sensitization" community training project.

FAMILY AND SEXUAL VIOLENCE HOTLINE

In collaboration with ChildFund, FHI 360 supports a GBV hotline. Initially focused on IPV against women, phone counselors were trained to identify, support and refer KP GBV survivors and collect and track data on KPs. The phone counselors visited the Program-supported clinics that offer KP-friendly HIV/STI/GBV services. The hotline was added to the GBV SOP for referrals and targeted an SMS "blast" to KP hotspots. Both efforts worked to increase the number of KP GBV survivors accessing friendly services.

RESULTS

Data from five of the implementing clinics show that the number of clients accessing HIV/STI services who were screened for GBV increased from 718 in 2015 to 9,425 in 2018. The percentage of individuals screened and identified as survivors is still low compared to recent surveys on GBV in Papua New Guinea. However, the number of GBV cases (both screened and walk-ins) increased exponentially from 27 in 2015 (a partial year of implementation) to 287 in 2016 and 751 in 2017. As many as 607 cases have been seen by the third quarter of 2018.

The percentage of survivors (including walk-ins and referrals) receiving post-GBV care for both sexes increased sharply between 2015 and 2018 with a slight decline in 2017. The percentage of GBV survivors among KPs who received care increased significantly between 2015 and 2018 (MSM and TG: 0 percent to 100 percent; female sex workers: 33.3 percent to 92.4 percent). Overall, the number of cases of physical violence followed by emotional violence was higher than the number of cases of rape case and other forms of sexual violence.

Figure 3. Trends in GBV service uptake.

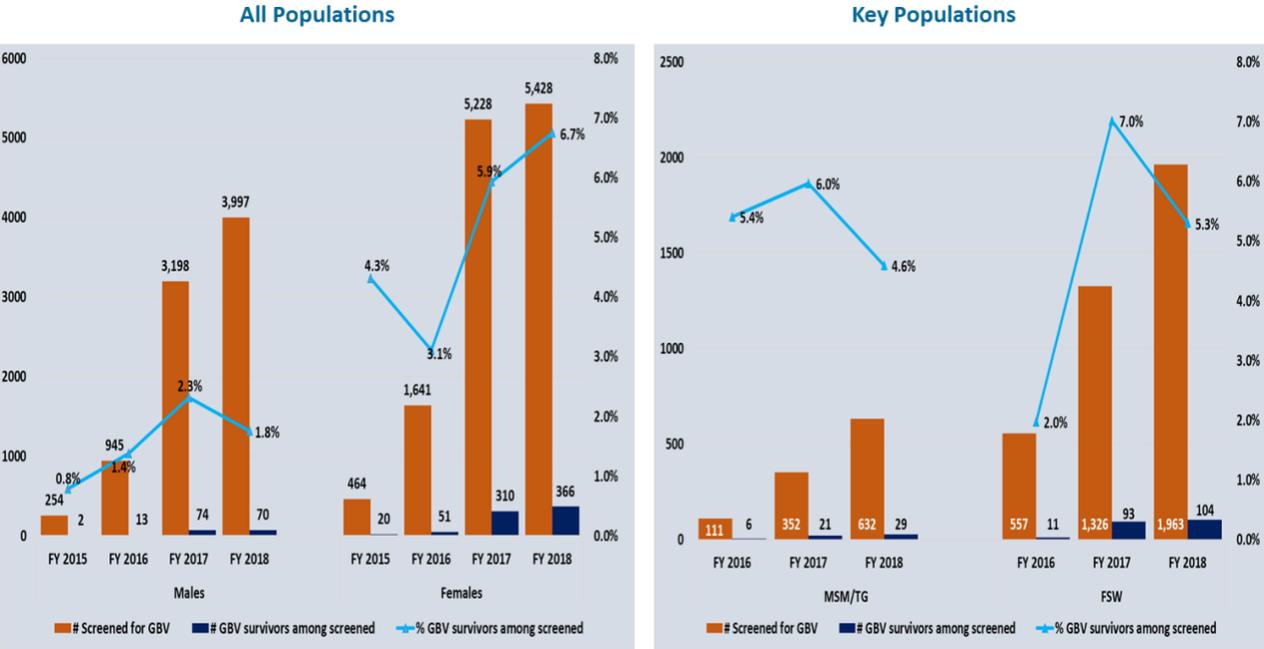


Figure 4. Distribution GBV cases seen by type of violence.

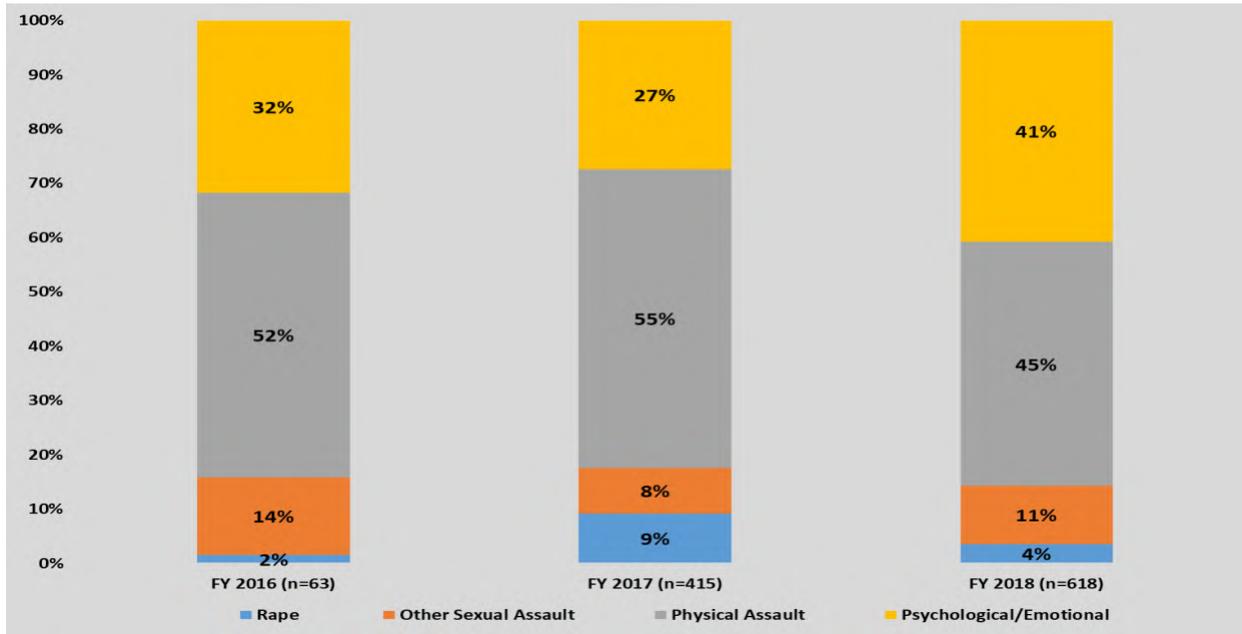
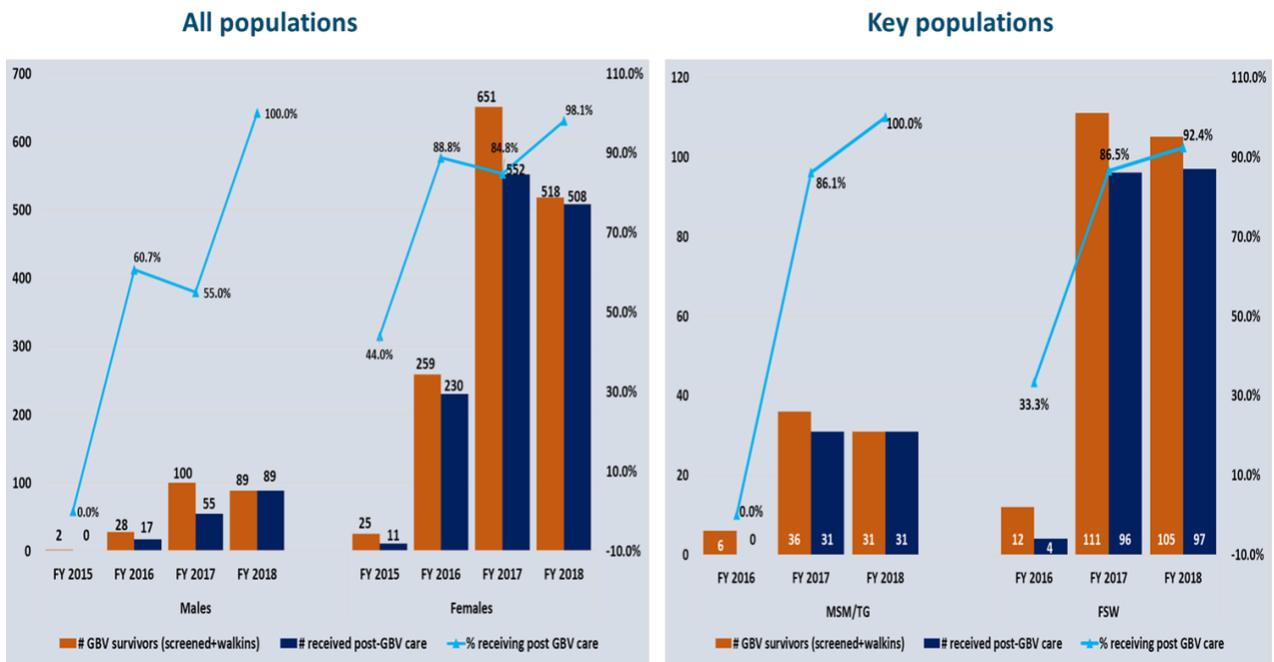


Figure 5. Trends in GBV service uptake.



LESSONS LEARNED & CHALLENGES

- It is possible to integrate GBV services into HIV services at both government and faith-based facilities using the current workforce without hiring more staff.
- Participation in the broader GBV provider community, primarily through the FSVACs, helped address complex cases and provided opportunities to broaden the definition of GBV survivor, thereby increasing access to services for the affected populations.
- Training all clinic staff ensured that GBV survivors could access services from either a male or a female provider, based on whichever sex they felt most comfortable with.
- When GBV is added after HIV or other clinical services, providers may see it as extra work or not part of their responsibilities. This can be used to justify late reporting or refusal by some providers to screen.
- Training peer educators on the GBV SOP increased referrals for both KPs and the general population.
- Adding GBV awareness to Antenatal, Well Baby and Tuberculosis clinic days increased individual GBV disclosure and GBV walk-ins.
- Implementing partners' staff were more disciplined, committed and organized when their senior management demonstrated leadership and commitment to GBV services through capacity building, allocation of resources, supervision and follow-up.
- Some clinic staff fully implement screening, some screen partially and a few do not screen at all. Those who partially screen may only ask one question covering all GBV, only ask about one or two types of violence (usually physical or emotional) or only ask new patients or patients they suspect might have experienced GBV. The few who refuse to screen primarily cite workload as a justification.
- Despite hepatitis B being one of the five GBV essential services, challenges remain for adult rape survivors to access hepatitis B vaccines at the clinics, since the country only procures pediatric vials for the Expanded Program for Immunization.
- A lack of clear guidance on GBV data collection caused issues with reliability of data, including screening double counting; multiple revisions of the data collection tools were required.
- Lack of a KP-specific safe house or drop-in center remains a challenge.
- Over time, staff attitudes and behaviors with survivors and fellow staff have improved as a result of ongoing gender training and supportive supervision.

RECOMMENDATIONS

- Conduct consultations and “buy-in” meetings with key partners, such as National Capital District Health Services, the Port Moresby General Hospital, the Gerehu General Hospital and Anglicare PNG, as well as clinic managers to ensure acceptance of GBV integration.
- When post-GBV services are integrated into HIV/STI services, ensure that added responsibilities are reflected in the job descriptions of the current workforce under “roles and responsibilities” to raise a higher sense of obligation among the staff.
- When adding GBV to HIV or other clinical services, the management will need to balance the workload and continuously assess the quality of both services.
- To ensure balanced workload, the management should keep in mind that GBV survivors can pick the sex of the provider they wish to see. Female providers may end up with many more GBV cases than male providers and therefore more work overall. To address this issue and even out the workload, the Program staff allocated STI reports to male providers and GBV reporting to female providers.
- When rolling out GBV services, sensitize not only all staff at the clinics but also peer educators and the communities to build a bridge for referrals.
- To ensure consistency with the GBV screening and services protocol, process and data collection, conduct regular supportive supervision and spot checks. This also serves to encourage staff and motivate better performance.