Intimate Partner Violence against Women:
A Review of Current Response in Papua New Guinea Challenges and Opportunities

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Intimate Partner Violence against Women: A Review of Current Response in Papua New Guinea Challenges and Opportunities.'

A thesis submitted in partial fulfilment of the requirement of the degree of Masters in International Health.

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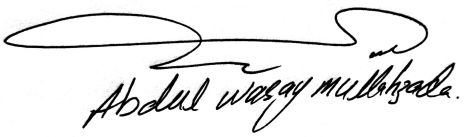
Signature: 

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Table 1: Injuries Definition per MSF-Data base

Abbreviations

A&E- Accident and Emergency

AIDS- acquired immunodeficiency syndrome

CEDAW- Convention on the Elimination of All Forms of Discrimination against Women

DV- Domestic Violence

DFAT- Department of Foreign Aid and development (Australian Aid)

FSV- Family and Sexual Violence

FSC- Family Support Centre

FSCAC- Family Sexual Violence Action Committee

FHI360- Family Health International-360

GBV- Gender Based Violence

GESI- Gender Equity and Social Inclusion

GDP- Gross Domestic Product

HIV- Human immunodeficiency virus

IPV- Intimate Partner Violence

IPO: Interim Protection Order

LIMC- Low and Middle-Income Country

MSF – Medicines Sans Frontiers/Doctors without Borders

MTDP- Medium Term Development Plan

NDOH- National Department of Health

NGO- Non-Government Organization

OPD – Out Patient Department

O &G- Obstructive and Gynecological department

ODW- Office for Development of Women

OSC- One Stop Centers

PEP - Post-Exposure Prophylaxis

PID- Pelvic inflammatory disease

PTSD- Depression, post-traumatic stress disorder

PNG- Papua New Guinea

PNGDSP- Papua New Guinea Development Strategic Plan

PFA- Psychological First Aid

RCT- Randomized Control Trail

STIs – Sexually transmitted infections

SDG- Sustainable Development Goal

SGBV- Sexual and Gender Based Violence

UNDP - United Nations Development Program

UNICEF - United Nations Children's Fund

UN- United Nations

WHO - World Health Organization

Glossary

Gender-based violence (GBV) is an umbrella term for any harmful act that is perpetrated against a person's well, and is based on socially ascribed (gender) differences between males and females. Acts of GBV violate a number of universal human rights protected by international instruments and conventions(1).

Sexual violence: Any act, attempted or threatened, that is sexual in nature and is done with force – physical, mental/ emotional, or social – and without the consent of the affected person/survivor. This includes any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic a person's sexuality, using coercion, threats of harm or physical force, by any person regardless of relationship to the victim in any setting, including but not limited to home and work. Includes rape, attempted rape/ sexual assault and sexual exploitation(2).

Intimate partner violence is used to describe people who have been physically, sexually or emotionally harmed by someone they are in an intimate relationship with. This includes current or former spouses or partners, such as boyfriends, girlfriends, same-sex partners or dating partners, whether they are living together or not(1,3).

Family violence: People who have been physically, sexually or emotionally harmed by another member or members of the family, regardless of the age or sex of the victim or perpetrator(1,2). "As family has a very broad definition in the context of Papua New Guinea, MSF defines family members as people who live within the same household or compound; this can include blood relatives, co-wives and members of extended family such as in-laws"(2,3).

Domestic violence versus family and intimate partner violence: MSF also treats survivors of family violence and intimate partner violence**.** These types of violence fall under the more general term domestic violence, which is generally agreed to include any act of physical, sexual or emotional abuse perpetrated by a spouse, partner or family member(2).

Note on terminologies used in the context of PNG:

- In Papua New Guinea, MSF uses the terms 'family violence' and 'intimate partner violence', as they are more widely understood, and they more accurately reflect the violence inflicted on our patients and reflect their medical and psychosocial needs(2,3).
    - "Family violence and intimate partner violence (IPV) fall under the more general term domestic violence, which does not have a universally agreed upon definition but is generally agreed to include any act of physical, sexual and emotional abuse perpetrated by a spouse, partner or family member"(1,3).

Referrals: in general describe the processes of how a Survivor encounters an individual or institution about her or his case, and how professionals and institutions communicate and work together to provide her or him with comprehensive support(4,5). Partners in a referral network usually include different government departments and agencies, women's organizations, community organizations, faith-based organizations, medical institutions and others(6,7). An important prerequisite for the design and implementation of effective referrals is the existence of an institutionalized referral mechanism(8,9).

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Abstract

Problem: Intimate Partner Violence (IPV) and violence against women is a global public health and human rights problem. It is happening in every society irrespective of culture, race and belief. Worldwide 30% of women have experience physical and/or sexual violence by their intimate partner, while intimate partners are accounts for 38% of murders of women worldwide. Health and social consequences of IPV is significant that includes acute and long-term physical, mental and socio-economic.

IPV is the most common form of violence against women in Papua New Guinea (PNG); according to multiple studies around 67% of women in PNG experienced family and sexual violence. The prevalence of IPV against women remains very high. While policy context has improved yet the implementation of those policies is not materialized.

Objectives and Method: This thesis reviews the current system response to IPV against women in PNG, identifies gaps and opportunities in the light of a literature review for best practices from around the word using system model approach. Data from the two-family support centers was used to further illustrate the characteristics, magnitude and current health response to IPV.

Findings and Result: In the light of this review, the government of PNG in response to IPV has taken a range of measures in development of polices and strategies that are conducive for women survivors of IPV. Several policy documents emphasize multi-sectorial response, effective community dialogue & referral and networking. However, these policies are not fully implemented neither materialized, due to lack of standardized protocols e.g. clinical guideline, referrals and standard reporting mechanism are among the challenges in response to IPV including lack of technical skills, trainings, and awareness about IPV is key constraints in response to IPV across all sectors. Lack of services particularly social and protections is another challenging factor in response to IPV.

Furthermore, lack of primary prevention programs, lack of ownership and investment from government in sustaining of limited primary prevention programs that are initiated by partners has also contributed to high level of IPV over decades. Most of the IPV intervention across all the sectors are donor depended that could be the reason for slow progress in the implementation of the current policies due to conflict of interest, donor

pressure. Family support center so called one stop shop centers (OSC) is evidence based approach, however current system response is limited to provincial hospitals, neglecting primary health care services (PHCs).

Conclusion and Recommendations: Response to IPV is complex, it nearly impossible for one sector to meet the demand. There is a need for a system model response where all sectors work together under a multi-sectoral response strategy. Primary preventions programs must be priorities and sustained in order to break the cycle of violence, while health sector should scale IPV care in PHC settings. Strengthening referral system, reinforcement of law and protection services, in addition to establishment of national data collections system and further research on IPV must be prioritized. Involvement and strengthening of the provincial and district level authorities need to be priorities in order to have a sustainable programs and also to booster the implementation of the current policies.

Keywords: Intimate partner & against women violence, Papua New Guinea, System response, prevention programs, best practices.
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Introduction:
The author of this thesis is working as medical coordinator for an international humanitarian Organization. The organization I worked with for the last ten years is known as Médecins Sans Frontières/Doctors without Borders **(MSF).** The author has worked in several low and middle-income countries. Prior to this course, the author has worked in Papua New Guinea **(PNG**) during the years 2015-2016, in the capacity of mission medical coordinator responsible for medical programs in the country. The subject has appealed interested because of following reasons.

Firstly, the subject is very much linked to my current work and I am interested to work in the field sexual and gender-based violence **(SGBV)** and violence against women. Secondly, there is a growing political will in response to violence against women particularly in PNG, given that SGBV remain a major obstacle in achieving development goals. Thirdly, the finding of this study will be useful for MSF to develop future interventions in the light of system response model. Fourthly, the findings of this study will help me in my future assignments and carrier to develop sound SGBV interventions.

Intimate partner violence (IP) and other forms of SGBV are very common in PNG since long. The prevalence study on family and sexual violence (FSV) conducted by the Law Reform Commission in 1982 which remains the key evidence. This study found as high as 67% of women in PNG experienced FSV. The terms FSV and IPV are used interchangeably in the context of PNG. The issue has been recognized and it has been since the birth of PNG on the table of the government to response. Papua New Guinea has signed several conventions including the Convention on the Elimination of All forms of Discrimination against Women (CEDAW), followed by Istanbul convention(10–12). These conventions were guiding the formulation and development of national legislation, policies and good governance through multi-sectoral response. Several initiatives including development of Family Protection Act that criminalizes IPV, and set new penalties for family violence, making it a punishable crime for the first time in PNG. Establishment of family support centers (FSC) was initiated by the health sector; several policies such as NHP and gender policy 2014 have been developed. However, the implementation these polices are hugely lacking behind. A number of factors contributed to poor implementation of these policies e.g. lack of financial, human resources, lack of standard guidelines.

These limitations resulted to a variation of services offered by multiple partners in a non-unified and un-sustainable manner.

This thesis is based on a descriptive analysis of IPV data from MSF-supported FCS, together with review of effective interventions from around the globe. The thesis aims to formulate evidence-based recommendation to boost the development of preventive and curative policy guidelines and improve practices and interventions for survivors of IPV in a comprehensive and holistic system approach.

This thesis is divided into five chapters:

Chapter 1: Provides background information on PNG, stressing on geographic, demographic, health systems, and social cultural norms in relation to IPV in PNG.

Chapter 2: Provides information on scope, magnitude of IPV and description of the study including objectives and method.

Chapter 3: Describes the study findings and results two sections. Section 3.1 presents quantitative findings on the characteristics of IPV survivors using facility-based data from MSF supported family support centers (FSC) in PNG. Section 3.2 describes and reviews IPV response in PNG, identifies gaps and potential opportunities of current response, in the light of best practices, prevention and response to IPV from around the world mostly low and middle-income countries (LMIC).

Chapter 4: This chapter will cover the discussion of the study results and findings to highlight the best feasible options for PNG.

Chapter 5: Concludes findings of the review and provides feasible recommendations in the light of evidence.

Chapter 1: Background Information on Papua New Guinea

1.1 Geography:

Papua New Guinea(PNG) is one of the largest nations in the Pacific Region and is a home to over seven million people(13). With an area of 463,000 square kilometers, PNG neighbors Australia, West Papua and Solomon Islands. Papua New Guinea has a democratic government with a decentralized political system, which allows provincial and local level decision-making authority to prioritize and implement policies, per their local context(14). The country is administratively divided into 22 provinces, with 89 Districts, 313 Local Level Government areas and 6,131 wards(14). The landscape of the country splits the country into main coastal and highland areas. The capital of the country is Port Moresby, which is unreachable by road from most parts of the country, and particularly from the highlands.

1.2 Demography:

According to the 2011 census, PNG has an annual population growth of 3.1% with the fastest growth in urban areas. Multinational companies such as LNG and Oil Search are involved in natural resources projects, which results in labor migration within the country to different main cities. However, most of population still lives in rural areas, with a total over 85% living in the highlands region. Despite the amount of natural resources, the level of poverty in relation to neighboring countries is high. Papua New Guinea ranks 156 out of 187 on the United Nations Human Development and 40% of the population has no formal education(15).evidence shows that unemployment increases the risk for IPV. 40% of the population is below the age of 15 years(16). Most of the citizens are Christians, with wide presence of Catholic, Protestant and Seventh Day Adventist churches(17).

1.3 Socio Cultural:

Papua New Guinea is comprised of over 1000 tribes and 800 different languages are spoken. Traditions and cultural practices are very different among the tribes. Culturally the country has been divided in to four regions, Lands, Southern, Mommas and Highlands's(18). Over 80% of the population lives in the highlands regions. The clear majority of community structure in

PNG is patriarchal particularly in the highlands regions. The society is patriarchal, in which the father or eldest male is head of the family and decisions are taken through the male line(19). Traditionally, the marriages are arranged by Wantok ("one talk" is a local social system; it is meaning those who speak the same language). Bride price negotiation is a key factor in which there is involvement of a Wantok(20).
The society structures are the foundations for nearly all forms of gender inequalities, which results in men's having control of over resources more than women. This poor control over resources means limited access to health, education and even child marriages not being able to choose. The use of physical and sexual violence against their partners by men is socially acceptable, justifiable and normalized(19,21).Several studies highlighted the fact that violence against women particularly domestic and IPV are to large extend accepted as normal. These evidences indicated that IPV is acceptable or justifiable by women and men, 85% of men and 75% of women stated that women should obey their husband, while up to 60% of men and 45% of women accepted the use of punishment by husband(22,23). Another studies unpacked the socio cultural factors contributing to IPV, such as bride price (22.67%), followed by low income, unemployment, lower level of education, joint family system, having children from another wife(11,15,17). In the highlands, women have even less societal power, but the land can be handed down matriarchal or patriarchal lineages, though the control over the land remains with the men. Currently in the highlands, there is women representation in the newly instituted village courts, where small offenses are seen. The women representation is a result of a successful policy put in place that requires these courts to have at least 2 women on the committee. Unfortunately, the experience is that their presence is often perceived as merely to satisfy a legal requirement and their voices remain unheard in the committee(20).

In Bougainville, one in five men had 2-3 partners(22), Countrywide about 18.3% families are polygamous, According to the National Demographic Survey (2006), polygamy is more prevalent among men of ages 20-24, especially those with higher education, living in highlands or are divorced(16). Having multiple partners is another contributing risk factor in IPV(24).Early marriage is another well-known risk factor for IPV, in the highlands region the average age for married 28.6(16).

A study in Bougainville found that IPV is to a large extend accepted by both men and women. Participants agreed that the husband is entitled to beat/punish their wives in case of mistake, with 45% women and 60% of men agreeing to this perspective. Furthermore, 85% of men and 75% of women suggested that women should obey their husbands(22).

1.4 Government Policy:

The government of PNG has committed to addressing violence against women and gender inequality through development of national strategies, polices and plans. This includes a constitution which has two specific goals guiding the governments work on gender equality: Integral Human Development, and Equality and Participation(25). In 2016, PNG adopted a set of goals of the 2030 Agenda for Sustainable Development. While the SDGs are not legally binding, governments are expected to take ownership and establish national frameworks for the achievement of the goals. Goal 5 on gender equality and the empowerment of women and girls includes ending violence against women and harmful practices, as target areas 5.2 and 5.3(26)

Papua New Guinea remains a signatory of the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW). This treaty has guided the development of national legislation, policies and good governance through multi-sectoral response. Papua New Guinea has initiated the Family Protection Act, a law initially drafted in the early 1990s, criminalizing domestic violence and setting new penalties for family violence. However, the implementation of the act is questionable partly due to lack of financial, human resources but also due to lack of guidance on the implementation (9-12).

Papua New Guinea has developed several policies in addressing GBV in line with national legislations, such as Government of PNG Public Service Gender Equity and Social Inclusion Policy (GESI) in 2013(10). This policy promotes equity and inclusiveness in the public sector irrespective of gender. This policy aims to improve awareness among public servants regarding the amendments to Public Service General Order 20 and advocates for improvements in public service human resource policies and practices to support gender equity and social inclusion throughout government. While National Policy for Women and Gender Equality 2011-2015 policy identifies

GBV as the priority action area. Papua New Guinea ranked 140 out of 146 countries with regards to gender inequality(15).These gender inequalities are some of the key driving factors behind IPV (11,15,27).
The national department of health(NDoH) focuses on implementation of the National Health Plan 2011-2020 (NHP) and the unequivocal zero tolerance for any form of gender based violence as per the Papua New Guinea Vision 2050(28). This NHP is also aligned with the work of the National Strategy to prevent and Respond to Gender Based Violence 2015-2050(NSPRGBV), which was informed by the Regional Action Plan for Violence and Injury Prevention in the Western Pacific 2016–2020. The NHP recognizes the need to improve the health sector in response to IPV, which impact on families, communities and society. Strategy 7.1.2 of the NHP aims to increase the roll out of Family Support Centers (FSC) across the country at the provincial hospitals.
The strategy is in line with regional plan of action for violence and injury prevention that PNG signed at Western Pacific conference 2016-2020, which calls for immediate and sustainable steps to reduce high national burden of violence and injuries and highlights the importance of inter-sectorial partnership(13). The sexual and gender based violence health sector response is coordinator through an independent body known as Family and Sexual Violence Action Committee (FSVAC) with other sectors. The mandate of the FSVAC is to work with all sectors and streamline the coordination and response to reducing the occurrence of and suffering caused by physical, sexual and psychological violence, including IPV. However, FSVAC is participating in development of policies in the line of country wider vision(29).

The national department of health (NDoH) with the development of FSC establishment guideline in 2013 assumed the ownership of the FSC approach. This operational guideline is the key policy document guiding the implementation of hospital based one stop center, which describes FSCs part of the Government's strategy to provide multi-sectoral and integrated support to survivors of violence. This guideline provides details of services offered in the FSC are specific to the medical and psychological first aid needs of its target population(29).

These policies are crucial in developing, strengthening and scaling up the contribution of public health towards the achievement of the sustainable

development goals (specifically SDG 5). However the implementation of these policies are lacking hugely behind, in addition to the above constraints lack of clinical guideline, national data collections system to streamline and standardize the health sector response including referral guideline remain a key challenges.

All mentioned strategies and policies emphasis on multi sectorial response to SGBV including IPV through implementation of gender sensitive and inclusive interventions in health, protection, social and legal sectors for all survivors' women, men and children. It is quite evident that policy context has made some progress. However the implementation of these policies particularly at provincial and district level are poor. This disparity between the current national level commitment in implementation of these policies are attributed to several factors etc. poor law enforcement and lack of clear policy framework to guide the implementation at the provincial level and lack of commitment in general(10,11,13).

1.5 Health System:

The health system of PNG is decentralized, where the provincial authorities have the decision-making power over the budget, priority setting and planning, implementation and monitoring of the activities. The National Department of Health (NDoH) remains responsible for policy and strategy development and shall support technically the provinces. This decentralized health system means that implementation of policies and strategies are dependent on local health system capacity and political commitment.

The health system of PNG faces numerous challenges and constraints in general including: inconsistent provincial institutional capacity, shortage of health care workers, limited funding, donor dependency(30–32).

There is a dire shortage of healthcare workers throughout the country, especially in rural areas where 87% of the population lives. PNG has less than 400 doctors of which only 51 works outside Port Moresby. The ratio is 1 doctor per 17,068 people. There is also a critical shortage of health workers – just 0.58 per 1,000 people, compared to WHO's standards which specify 2.5: per 1,000 people simply to maintain primary care. The shortage of trained healthcare workforce(30) resulted in closure of rural health facilities in some parts of the country(33).

Papua New Guinea's total expenditure on health has increased from 82 to 109 USD per capita between the years 2010 to 2014. Health expenditure is 4.3% of the Gross Domestic Product (GDP), ranking even lower than most of South East Asian countries according to WHO health expenditure in 2014(34).

The government of PNG funds 70% of the health budget while the rest of the funds are donor dependent(34,35). The government of PNG attempts to take the lead in response to SGBV through a sector wide approach in resources allocation, prioritization of interventions. However, due to lack of institutional capacity, in practice, international and national Non-Governmental Organizations (NGO) including medicines Sons frontiers (MSF), family health international-360(FHI), and other UN agencies. The main donors for most part of health sector specifically in response to IPV, establishment of FSCs, primary prevention interventions are coming from Department of foreign Affairs and Trade-Australia (DFAT) previously called Australian Aid, Oil Search Health Foundation, remain influential partners in delivery of health services. Health services are in principle free at point of care but there are small fees for some services. In 2009, a circular was sent to all primary health care facilities, instructing that all SGBV survivors including IPV, were exempted from all forms of user fee and charges including provision of free medical certificate(36).

The current health system response to IPV includes establishment of family support centers (FSCs) at the provincial level. Under this response, FSC are providing medical and psychosocial services less than one physical place, the model is called one stop shop (OSS) for more detail on type of services provided in the FSCs and other OSS clinics see annex 1. The FSC so called OSC is an evidence based approach, countries are more and more adopting this approach(6).

Currently, there are fifteen FSCs in thirteen provinces(32). Several international and local development partners, such as UNICEF, MSF, and FHI-360, have worked with NDoH and FSVAC on the establishment and running of 9 of these centers. Four FSCs have been supported through public-private partnership with Digicel Foundation. Where FSC are established, survivors of IPV are offered essential services per FSC

guidelines, which include: medical first aid to stabilize any immediate physical threats and Psychological First Aid and methods to prevent HIV and STIs, Hepatitis B and Tetanus, unwanted or unintended pregnancies; or other life threatening medical conditions. After receiving the initial treatment, they are referred to social services, if needed(12,30,32).

Where there is no FSC, survivors of IPV seek care from accident and emergency department (A&E), Obstetrics and Gynecological department (O&G) and outpatient's department (OPD), and mostly are documented as accident and injuries except sexual violence cases. If any women are identified by health workers as survivors, they are referred to FSC for further specialized care or to the reproductive health units(22,30).

The specific challenges to responding to IPV within the health system are Prioritization in response to IPV and resources allocation that varies from province to province, which by its turn depends on provincial resources and international partner's presence. Prioritization and implementation of national strategies are dependent on the provincial institutional capacity and political commitment, impeding decentralization. Most of the current FSCs are lacking the capacity to offer basic counselling; this is due to lack of national policy/guidelines on mental health and skilled human resources capacity in the country (13,14,30).

1.6 Health Status:

Papua New Guinea (PNG), like most of the developing countries, is facing a double burden of disease. While tuberculosis (TB), human immune deficiency virus (HIV), acute watery diarrhea and pneumonia comprise the main morbidities and mortalities in general, the burden of non-communicable diseases is as high as up to 45% of total disease burden. In 2008, accident and injuries were the third leading cause of hospitalization(13). A reason for such high number of accident and injuries could be GBV cases being reported under them in places without a functional FSC. Maternal mortality rate is 733/100.000 live births, the median age at first birth being between 19.5 and 21 years old.

1.6.1 Sexual Transmitted Infections and HIV:

The prevalence of STIs and HIV is very high in PNG in comparison to the Pacific region countries. According to a recent systematic and meta-analysis, the prevalence of HIV is estimated at 2% and up to 60% of new diagnoses with HIV are female(37). Moreover, STIs are prevalent and complement to the high burden of disease. Prevalence of syphilis is around 3-12 % (highest in the highlands), gonorrhea and chlamydia around 25%, trichomonas around 24-70%(37). Although the intersection between HIV and GBV is well acknowledged, and HIV policy and programs do call for integration of GBV services; there are few facilities at the primary health care level which offers HIV testing as part of VCT. Nonetheless, the National Health Strategy 2015-2020 and Gender Policy 2013 urges for a multi-sectorial response(32).

The current national prevalence study was conducted in 1982 pre HIV arena; there is not national study to clearly mark the burden of HIV and IPV: There are several evidence including a systematic review and meta-analyses showing significant association between HIV and IPV. HIV (+) men are more likely to perpetrate IPV, resulting to higher rates of HIV among IPV survivors compared to those not exposed to IPV(38,39).
A qualitative study from Tanzania shows that women with HIV/AIDS, are more vulnerable to experiences IPV, such as financial dependency (lack of transport money), restriction in mobility (permission is needed to attend the clinic), verbal abuse and mistrust(40). The association between IPV and the risk of HIV in Nepal found that women survivors of IPV are 1.68 times more likely to have STI, while these women are 2.27 times less likely to have knowledge of STI and 2.38 HIV compared to those with no IPV experience(41). The same study also found that women with sexual IPV are 2.89 times more likely to have multiple sex partners, while the likelihood of safe sex and using condom is 2.44 times less likely(41). However, the association varied depending on multiple factors such as education, wealth and employment of women and their partners.

Chapter 2:

2.1 Problem statement:

Intimate partner violence is a global public health problem, not only because of its acute and long term physical and mental health consequences but due huge negative socio economic impacts as well(23,42). Globally almost 30% of women who have been in a relationship have experienced physical and/or sexual violence by their intimate partner(23).
Intimate Partner Violence (IPV) is happening around the world irrespective of culture, race and belief and affect negatively survivors health and societies(43).
A WHO multi country study (2015) on domestic violence and women's health found a wide-ranging of lifetime prevalence of IPV among women aged 18-49 years who experienced physical and/or sexual violence. Japan had the lowest rate (15%) while Ethiopia had the highest rate of IPV (71%). The study also found that violence from intimate male partners was a major contributor to women's ill health(44). Both men and women can be perpetrators and survivors of IPV. However regional and global estimates of violence against women conducted by WHO, found that as high as 30% of women worldwide have experience physical and/or sexual violence by their intimate partner. The study also estimate that intimate partners are responsible for 38% of murders of women worldwide(44). Beside the fact that women are more vulnerable to IPV, the data from the two FSC were nearly all women which is a factor that in this review will be focused on women survivors of IPV and men are considered as perpetrators.

The most immediate medical consequences include injuries, STIs, HIV, hepatitis B, tetanus and unwanted pregnancies. The long-term medical consequences include complications in pregnancy pelvic inflammatory disease (PID), chronic pain and disability(45).The mental health consequences of IPV include anxiety, depression, post-traumatic stress disorder (PTSD), and suicide(23,45).

Women who have experienced physical or sexual abuse from their partners are twice as likely to experience depression and go through abortion in some regions, women who experience IPV are up to 1.5 times more likely to acquire HIV, to have up to 16% low birth-weight baby. Violence during

pregnancy has also been associated with miscarriage, late entry into prenatal care, stillbirth, premature labor and birth and fetal injuries(46).
Evidence from Guatemala shows that women survivors of IPV during pregnancy are more likely to experience miscarriage with odds ratio of up to 2.8 times higher(47)..

Survivors of IPV and their children witnessing violence are emotionally affected(3,48). The impact on children of IPV survivors include anxiety, depression, future male perpetration of IPV and female experience of IPV in later life, as well as children's negative health outcomes, such as lower immunization, higher rates of diarrheal disease, and greater infant mortality rates(49,50).

Moreover, survivors of sexual violence are often blamed and stigmatized, which prevent them from seeking health care and remain in isolation(43,51). IPV has significant negative economic and social impacts for individuals and society(23).

There are numerous risk factors that contribute to high rates of IPV such as poverty, unemployment, education, age, early marriages, polygamy etc. multiple studies including studies from WHO, have found a strong association between high levels of poverty, unemployment, poor or low education, conflict, dependency on male bread winner and IPV(49,52,53). A WHO multi country study found that harmful socio-cultural practices such as gender discrimination, early marriages, violence from extend family member specially in joined families, controlling women from accessing health and other social support services, lack of legal protection for women's rights and inaccessible police, legal and justice systems as contributing factors(54,55).
Evidence recognizes age as a risk factor for IPV.
There are correlations between the triple burden of IPV, HIV and mental health as they have shared risk factors. This study once again confirms a strong association between the three public health problems and calls for a multi sectorial response and strategy Intimate(58) partner violence (IPV) is known to be higher in societies with high levels of poverty, unemployment, conflict, violence, discriminatory cultural practices, strong views of family integrity, lack of legal protection for women's rights and inaccessible police, legal and justice systems(33,54).

It is important to underline that people with disabilities are at a greater risk of suffering from IPV(59).

The barriers to care are lack of capacity among the health and other services providers including trainings, barriers within structure such as space, privacy, supply including standardized forms/guidelines and lack of female staff. Including distance from health and other services, direct and indirect cost of the services including the trust on the system(32,60).

Intimate partner violence is very common in PNG, the law reform Commission study in 1982 found that 67% of women in rural areas across the country had experienced family and sexual violence in their homes(21,61). Subsequent studies around the country conducted since then have found consistently similar high rates of violence against women, usually by their partners(21,62–64).
In Bougainville, they found that 29% of women who were interviewed during the study had been forced into sex, while 17% had been beaten during pregnancy period. With the result that one in five had lost their pregnancy. Intimate partner violence is very common in PNG. Two thirds of women who experienced physical violence had been injured, usually on multiple occasions (22,42). Men can be survivors of IPV however, numbers show that women in general experience more IPV, as they are being subjected to higher degrees of control by their male partners(23,44). A WHO (2013) prevalence study from 30 countries found that the percentage of sexual violence by an intimate partner ranged between 6 and 59 % for all sites included in the study(65). The study found, South East Asia with the highest prevalence of IPV with 37.7%, while the Middle East has 37%, and the Western Pacific region24.6%(65).

Nationwide studies estimate that as many as two out of three women have experienced violence during their lifetime in PNG, most often by someone known to them, including an intimate partner or another male family member(63). This ratio is overwhelming when compared to the regional average which shows about 30% of women have experienced IPV during their lifetime(24,63). PNG has the highest level of IPV (family & sexual violence) among countries with no active war or conflict setting(66), though the level of violence varies between tribes and location(67). In South Asia and Pacific, it was found that around half of the men committed some form

of violence against their partners. While in Bougainville the figure was significantly higher, 87.6% of the men committed violence against their partners(24).

In Goroka, Eastern Highland province, the economic consequence of IPV leads to poor physical and mental health, which negatively affects their children. Over 90% of the participants, who were self-identified survivors of IPV (male and female), agreed that IPV affects their self-esteem and ability to work, increase financial dependency, increase the risk of future escalation of violence, ill health, lead to unwanted pregnancy, STIs, HIV from forced sex, pregnancy complications and miscarriage, and also increased the likelihood of depression and put the children who witness IPV at risk of mental health problems(42). Depression, suicide and post-traumatic stress disorder were much more common among women who experienced partner violence than women who did not (42).

The fast urbanization growth of PNG could be a contributing cause of high level of IPV linked with either: social issues that are linked with tribalism in PNG, and particularly the highlands region, which is going through a transition period where the society is moving from traditional leaving style to an industrialized life(68,69).

Social acceptability of violence, stigma and non-availability of services, poverty, gender inequality, inequity in access and control over resources are compounding factors leading women not to disclose the violence or abuse they have experienced. Majority of cases do not seek help from formal services unless they have sustained serious or life-threatening injuries(21,62–64). Reports also uncover how women and their children are often subjected to a lifetime of abuse(21,46)
Gairo et al. (2012), highlights the risk and consequences of IPV. The study found strong association of IPV with ages ranged to 20-40 years had high rates of IPV specially the in Eastern highlands), early marriages (41.33%) and alcohol intake (45.33%), marital conflict (42.67%), extramarital affairs (36%). Dependency 22.67% of the time influenced IPV, followed by low self-esteem, experience of violence during childhood, sex before marriage, unwanted pregnancies, and extended family member(42).

2.2 Justification:

When it comes to the development of evidence-based interventions, programs and reforms availability of data plays as central role. Currently there is no national level data and information on demographic, characteristics, types of injuries and health consequences of IPV in PNG expect sexual violence cases that are captured only by age and sex under the current health information system (2,70). Although there is data on IPV collected at some FSCs such as MSF and few other organization part of routine program data. As there is no national reporting mechanism the information are not utilized to general information. Furthermore, there is lack of knowledge on best practices that would best fits IPV services in the context of PNG.

A descriptive analysis of data collected from MSF supported FSCs in Tari-rural area and PMGH FSC in Port Moresby –urban area, and literature review on effective interventions provides an exceptional opportunity to deliver a contextualized evidence-based overview of IPV comprehensive system response in PNG. The study will also be evaluating strength and opportunities of current policies, programs and interventions, to improve IPV services at health and other social and legal support services in PNG.

2.3 Study objectives:

This study aims to analyze the characteristics of IPV cases managed in FSC MSF-supported services in PNG. On a second stage effective interventions from similar settings will be reviewed aiming to formulate evidence-based recommendations to inform the development national policies related to IPV. The findings of the study will be shared with (NDoH) of PNG and SGBV technical working group members, to improve SGBV response particularly for women survivors IPV.

2.3.1 Specific Objectives:

- Analyze IPV survivor characteristics, health care seeking, and physical consequences, and health response in PNG using MSF sexual and

gender-based violence response from routine program data collected from Jan 2014 to Jan 2016.

- Review of effective IPV interventions from similar contexts to that would be feasible in PNG to replicate.
- To formulate recommendations for the development of national policies, guidelines and improvement of interventions and practices.

2.4. Study Methods:

2.4.1 Methodology:

This thesis is consisting of two parts. First part is focused in analysis of routine program data. This anonymous IPV data from routine program monitoring, treatment files, OPD data from GBV and mental health counseling services were used from rural Tari highlands and Urban Port Moresby FSCs costal area. The data analysis covered the period from January 2014 to December 2015(Tari) and Jun 2015 for PMGH. The program was handed over in July 2015 to NDoH in Port Moresby. The data was made available for the study under a signed agreement after approval from medical director of MSF OCA from the head office in Amsterdam, result of the data will be described in chapter three sections 3.1.

The second part of the study is based on a literature review that includes published and grey literature. The literature review was used for analysis of interventions and best practices under the themes used in the conceptual frame work of system model approach to IPV. Review of evidence for effective IPV system response. Reports, policies from PNG government and partners working in response to IPV in PNG were also reviewed for better understanding of current response.

2.4.2 Search Strategy:

Cochrane, Science Direct, and computerized search engines such as Pub Med, Pop Line and Google Scholar were used for articles related to GBV, violence against women, IPV, social, economic and gender influences on IPV, consequences, prevention, health interventions and responses.

Snowballing technique was used in selection of relevant articles from the references of index source. Due to limited studies in the field of interventions and quantitative data from PNG, the search was extended to websites of

multilateral and bilateral organization including government of PNG, FHI 360, WHO, UNFPA, FSVAC, UNDP, UNICEF, UNWOMEN, CEDAW for relevant documents.

Articles from year 2000 and onwards were selected –except on PNG law reform study, only English language articles were reviewed, articles relevant to the objective of study was selected after reviewing of abstract-conclusion.

2.4.3 Key words:

Intimate partner violence, family violence, domestic violence, violence against women, health response, prevention strategies, survivor's center care, community and extended family member role, community health education, referral pathways, PNG and developing countries, community development dialogue/empowerment, GBV, influences, consequences.

2.4.4 Conceptual Framework:

The system module framework is chosen because it allows describing the response to IPV in broad dimensions. This includes prevention, protection and prosecution in the form of medical care, psychosocial counselling, safe accommodation, police protection and/or legal assistance. An effective system response to IPV requires a comprehensive set of services. In the context of PNG, SGBV- particularly IPV- is widely accepted and there is huge gender and power inequality that need a strong primary prevention integrated in the system. This makes it virtually impossible for a single organization or department to provide all services in the required quality and specialization, a multi-sectorial primary, secondary and tertiary prevention and responses that coordinates the services by all relevant service providers helps to ensure the availability of comprehensive support for survivors.

The system model approach focuses in utilization and involvement of the entire health care environment that address IPV services and

prevention. The system model approach framework has five elements developed and tested in 1998-99 by Kaiser Permanente, a national NGO providing health care delivery system in USA(71). The five themes of this framework were used as below, which covers the elements of multi-sectorial and comprehensive response to IPV:

1- **Leadership and oversight**: under this section government commitment in the form of legislations, policy, protocols and strategy development and its implementation will be reviewed. Adopted strategies and approaches for the delivery of evidence-based interventions will also be reviewed to provide recommendations.

2- **On-site services**: under this section availability of essential medical and psychosocial services including FSC services will be reviewed.

3- **Inquiry and Referral**: under this section availability of referral system among various sectors and service providers will be reviewed in the light of effective evidence.
4- **Community Linkage:** under this section availability of effective social, legal and protection services will be reviewed including policies in response to IPV.
5- **Supportive environment**: under this section current primary prevention interventions and evidence of effective interventions will be reviewed.

2.4.5 Limitations:

It is well known that men can be a survivor of IPV from their women partners. The fact that the review is only focused on women survivors of IPV is considered as a limitation. There is couple of reasons behind it: firstly, a clear majority of the IPV survivors are women, secondly the data from MSF two facilities shows that around 99% of survivors of IPV who seek care from these facilities were women.to avoid bias in the review of seeking care, health consequences the focus remains on women survivors only.

The data reviewed in this study is a facility-based data, the data shows only those survivors who could access or utilize the services, knowing that access to health care is limited in general, the study cannot cover those who experiences IPV but did not seek care.

The search is limited to English, the information in other languages are missed. The study of the law reform commission is the only country national wide prevalence study, however this study was conducted pre-HIV arena, although several small-scale studies have shown similar results including HIV co-infections.

2.4.6 Ethical consideration:

The study is a descriptive analysis of routine program data in combination of literature review. The survivors are not the subject in this study. Since there is no primary data collection required, ethical review committee clearance is not required. Patients' personal identifications are replaced with patient's unique identification code. This code is a combination of facility, year and annual patient serial number. The topic is approved by the Royal Tropical Institute, and agreement is signed between MSF and the primary investigator.

Chapter 3: Study Result and Findings:

This chapter is devised into two sections; quantitative data results are presented under section one and section two presenting findings of best practices from around the world.

3.1 Quantitative data, Analysis of health care seeking, characteristics of IPV, and physical and mental consequences of IPV among those receiving care at MSF-supported FSCs.

3.1.1 Numbers seeking care:

In 2007, MSF started SGBV response in PNG. Based on the need the program was expanded from Lae to Tari and Port Moresby general hospital. Between the years 2014 and 2015 the two MSF supported FSCs treated 1524 survivors of IPV. From the 1524 cases, just over 62% (n=953) of the cases were treated in Tari FSC in the highlands region figure 1 and rest 38% (n=571 cases) were treated in Port Moresby General Hospital FSC costal area figure 2. Average number of cases seen at both FSC remains around 30 cases per month. However, during the same period MSF provided community sensitization and health education to raise awareness about

SGBV part of Tari project activities. It is hard to attribute but could have contributed to some extend to this gradually increased during 2015 see figure 2.

The number of cases significantly dropped between January and April 2015 in Port Moresby figure 1. It was not clear why, but it could have dropped due to changes in location of the building during the construction period. This corresponds to the period where MSF was negotiating handover of the program to PMGH management as per the MoU.

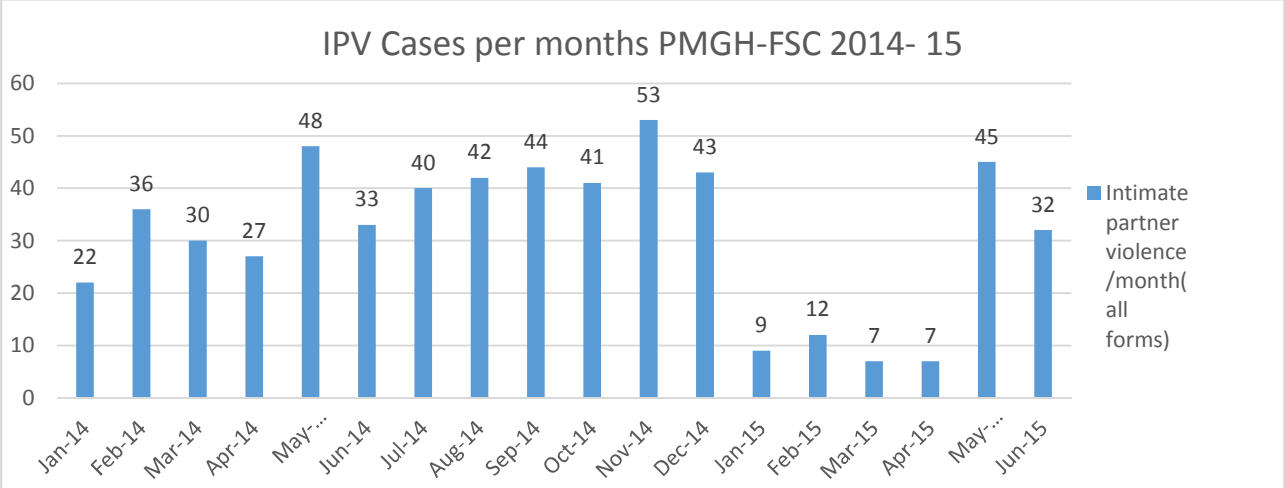

Figure 1: The trend of IPV cases - PMGH-FSC

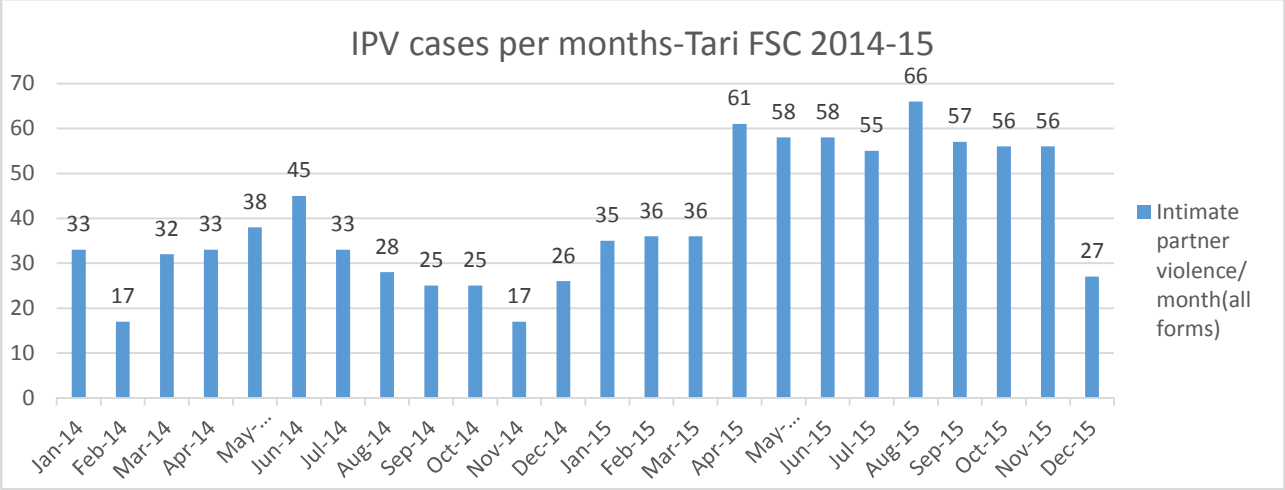

Figure 2: The trend of IPV cases -Tari-FSC

3.1.2 Demographics of Survivors:

Most of the survivors seeking for care at MSF services were between the age of 19-24 years old and 824 (86.4%) were women over 25 years old,

followed by 19 -25 years old, 120 (12.59%) in both locations. Data shows that almost (99%) of survivors seeking care from the two FSCs are women. Evidence suggests that a significant proportion of IPV survivors are women, yet evidence also shows that male partners could also be victims of IPV. However, number of male survivors who seek care remains very low in both locations (only 12 visits out of 571 cases were male).

3.1.3 Characteristics of violence:

A clear majority of IPV survivors 1006 (66% of total cases) were hurt with an object such as, knife/machete and sticks causing severe physical injuries.

Survivors of IPV in Urban Moresby experiences more direct and indirect threats from their partners compared to rural Tari. Direct threat means personal threats and indirect threat refers to threats aimed at children, other family member or relatives. Five percent (5%) of the survivors were threatened directly, a personal threat, while indirect threat is reported among 8% of the cases, threats aimed at children, other family member or relatives. Majority of IPV cases happening at homes by intimate partners. The data analysis in Moresby shows 80% and 78% in Tari among those who seek care experinces IPV at home. This high rate of IPV cases happing at home are in line with high level of domestic violence rates in PNG.

3.1.4 Consequences:

The data clearly demonstrates that the majority (Tari 96 % and PMGH 90%) of IPV survivors who seek care experienced physical injuries. This is in the line with the evidence that suggests that physical violence resulting in injury is the most common reason why survivors IPV seek care (family and safety study & WHO study). Among the injured survivors 86% (n=818) had minor injuries followed by 11% (n=108) cases with major injuries that needed tertiary level care including surgery. Injuries classifications are based on MSF-data tool-see table 1. Among all the cases treated in Tari-FSC (n 953) nearly all (98%) of them needed medical intervention, of which 28% needed wound dressing, 18% stitching and 5% cast application to immobilize the fractures and dislocation.

Minor injuries:	Refers to all types of minor injuries that needs sutures but no Sphincter involvement e.g. Laceration, bruising, tears. The classification and definition are based on MSF-SGBV data base.

Major trauma	Refers to injuries such as permanent injury, infection, sphincter involvement, requiring surgery under general anesthesia, fractures

Table 1 Injuries definition per MSF-SGBV-data base-2014

3.1.5 Time to Seek Care:

Time of presentation to health facility is crucial in prevention of STI, HIV, unwanted pregnancies including prevention of Tetanus and Hepatitis B infection. Equally timely seeking cares to treat physical injuries are important for survivors of IPV. To seek care soon is undoubtedly beneficial. According to "WHO Clinical Guideline for Prevention and Treatment of IPV", if survivors present to health facility within 72 hours of the incident, most of the complications and consequences could be prevented, including sexually transmitted infections, HIV/AIDS and unwanted pregnancies. According to the data, over 82% of IPV survivors in Tari presented within 72 hours of which 44% presented within 24 hours (See figure 4). PMGH-FSC data shows similar pattern in general, however on a monthly base the number of IPV survivors seeking care within 24 and 72 hours fluctuated (see figure 3). This irregularity in presentation could be to a large extend influenced by factors such as distances from the FSC, availability and functionality of free referral transport services that was not reliable at times. However, there is no significant change between the two communities, both in seeking care or number of survivors presenting to health facility. On average, the number of survivors presented within 24 or 72 hours is the same.

According to MSF and WHO guidelines following visits are crucial in order to complete the treatment particularly prevention of unwanted pregnancy, HIV/AIDS and vaccination's. However, follow up visit remain very low in both locations, in total 31%, of survivors visited FSCs within one week (first follow up visit) of which 16% came for second follow up visit. Influencing factors to delayed health care seeking could be the distance, decision-making power, knowledge and indirect cost involved such as travel and leaving children/gardening work behind.

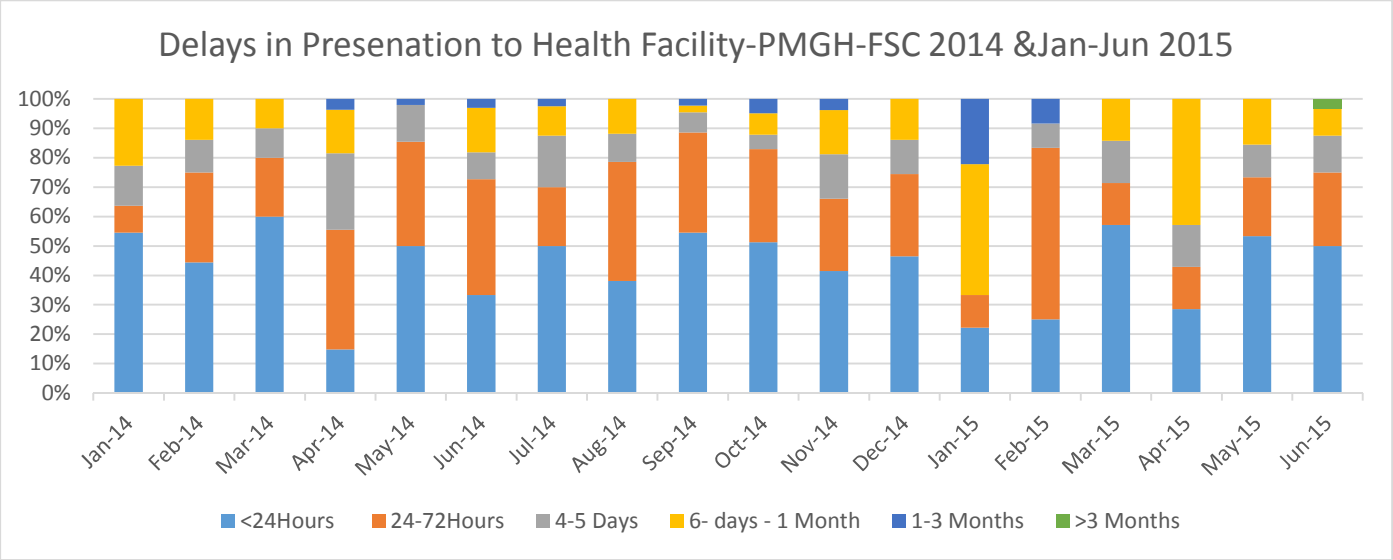

Figure 3: presentation of survivors to the health center from the time of incident over time-FSC-PMGH

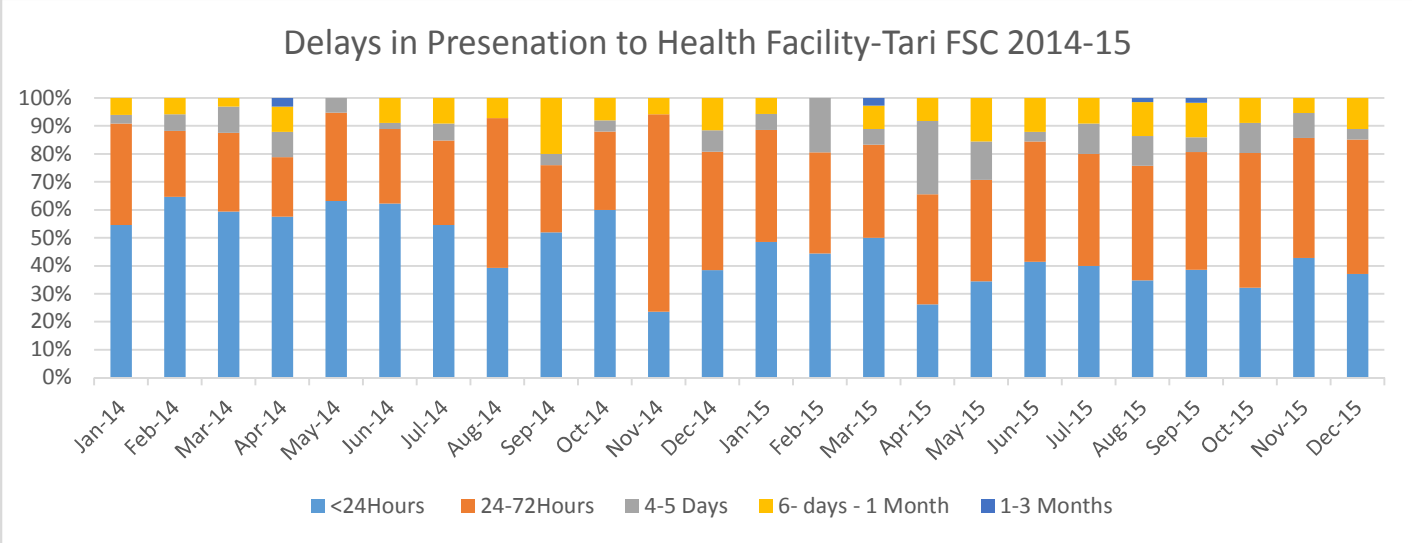

Figure 4: presentation of survivors to the health center from the time of incident over time-FSC-Tari

3.1.6 Referral to health care:

In Moresby, 83% of the survivors who visited the FSC were referred by the police department, followed by health services provider at 21%. NGOs, community leaders, MSF health education team and friends/relatives were also referring survivors to FSC. However, in Tari 65% of the survivors presented to the FSC by themselves; followed by 23% of them referred by

MSF outreach health education team. Referral from police, health centers and other local government departments such as village court-education remains very low in Tari. This low referral is also in the line of the evidence that indicate services are limited in these sectors.
Although MSF team have provided several trainings session for police, village courts and civil society organizations in Tari and Moresby, the limited number of referral from partners indicates several constraints such as availability, functionality and lack of capacity of legal and social services. This was in line with reports launched by Human Rights Watch from PNG" bashed up" in November 2015, which stated that referral pathways did not exist, or it was inconstant in rural areas(12).
Knowing that FSC services are limited to provide medical and psychosocial care, referring survivors to other social and legal services is important. The data shows referrals from FSC to specialize health care and to legal, social and protection services was very low in Tari. Due to non-availability of social, legal and protection services, including non-existence of any safe houses, 84% of the case was not referred. This high number of not-referral is also influenced by the fact that MSF was able to provide short stays (from 24 hours up to 72 hours) within the FSC.

3.2: Evidence of Effective Interventions and Review of current IPV Response in PNG

3.2.1 Leadership and oversight:

A System approach in response to IPV emphasis on the training of health workforce, delivery of onetime free quality medical care, improvement of infrastructure including medical supplies, patients flow, privacy, legal framework, development of clear policy and protocols including ownership/leadership from the government etc(71,72). Multiple reports and evaluations suggests that, A clear strategy framework, such as guidelines, protocols, training of workforce , integrated SGBV response in all polices and responses, monitoring and evaluation standard tools, is needed for each sector to guide the local and provincial staff on how to integrate gender response intervention into practice, how to implement and monitor the progress finally how to maintain coordination in the light of multi-sectorial response strategy(2,3,5,70)According to WHO, national level and local level

leadership, governance and coordination in response to SGBV including IPV is one of the key pillars for a holistic system response(5,54,72).

There is limited studies on the governance and leadership however, evidence and experiences from countries such as Jordan sets a good example of good leadership and governance. They have developed policy as such that legally bounds all the partners from each sector responding to SGBV. Each partner is required to sign a memorandum of understanding (MOU), with the government which is partners commit them shelf to follow national polices, protocols and guidelines in all sectors including health, social and legal. This approach minimize conflict of interest, brings uniformity in response, avoids duplication of services, at last the response would be more sustainable(7).
Experiences from Kenya, Zambia and Uganda also shows progress in leadership, national standardized policies are implemented to a large extent. The government leads the response with the support of the partners(6). However, the governance and leadership from the governments are not as strong as Jordan ones when it comes to IPV and SGBV response and government ownership, which could be due to lack of funds and capacity.

Government of PNG together with partners have developed a number of gender sensitive policies as mentioned in chapter one under section government policy. This shows government commitment at the central level. However, there is huge gap and disparity between the national level policies and the enforcement of these policies at provincial and district level. Number factors such as lack of formal local coordination, institutionalization of training for workforce, monitoring and evaluation tools, funds are constraints that resulted in a lack of availability and access to health, legal and social services throughout the country and endangers lives(12,30,32). Reports and studies highlights that provincial health authorities have extremely limited capacity and resources to coordinate and take the lead in the implementation of multi sectorial response(3,32,70).
The above mentioned constraints resulted to poor access to health, social and legal services for survivors of IPV(2). As per national plan FSVAC is assigned to coordinate multi-sectorial response; yet, FSVAC provincial committees are operational in very few provincial capital with no presences or capacity to support the implementations and coordination at district levels(29,30,32) .

There is clear commitment and attention for IPV including other forms of SGBV at national level. However, the focus remains at national level policy development less attention is given to actual implementation and translation of these policies into practices(2,30). In the light of the above constraints and objectives of the current strategies that are emphasising on multi-sectoral response, elements of system wide approach are available but implementation part need more attention.

3.2.2 Services on site (Health Response to IPV in PNG & Review of Best Practices):

Health system plays an important role in response to IPV in the same line the role of health system in responding to IPV is growing in developing countries. However, most evidence of what works in relation to health system programming is still to be found in developed country contexts(73).

Several evidence from India and other countries also supports the integration of IPV responses through MCH programmes based on the gender sensitive and survivor centred principles(81,82). Evidence from South Africa suggests that integrating IPV care in primary health care increases early identification and referral to specialized health centers reducing delays in presentation of IPV survivor's and improves their wellbeing(79).Furthermore, WHO recommends that, as far as possible, care for women and girls who experience IPV should be integrated into primary care services(80). In the context of PNG, under the current approach where PHC are not prioritized in response to IPV remain as challenge. Currently where there are no FSC survivors of IPV are provided medical care at the out-patient's department (OPD), emergency room and MCH services, where most if these cases are recorded as emergency and accident cases except sexual violence as mentioned in chapter 1 section 1.5 & 1.6.

More in more the momentum is growing towards one stop centre approach, this approach is aiming to have medical care and as much as possible other support services such as legal or protection officers are based in the hospital or a short stay room is provided for survivors within the FSC or facility. The main reasons behind it are to reduce delays in provision of care also to reduce barriers(6).
Findings from a review and evaluation of three one stop centre (OSC) approaches from Kenya and Zambia shows; Approach A with a primary focus

on provision of clinical care in a standalone physical unite out of the hospital building in the same compound in some part of the country even in a separate compound. This approach was facilitating referral to other services. However, lack of social, legal and protection services and significant limitation in practical terms with referral services was the key challenges including referral to medical specialist for complicated cases that hampered the quality of care and adherence to follow up(6).

Approach B was only focused on provision of counselling legal and protection services hugely lacking medical services. While legal and social services was provided free of charge, however this approach largely depended to health care provider to send them survivors to them. This approach was not effective as survivors mostly first seek health care but the OSC did not provide health or psychosocial care. Approach C, a hospital based (OSC), although the primary focus of this approach was provision of medical services, but they did provide free medical certificate -medical evidence, provision of specialist care was much better, as it was government owned facility there was no competition or conflict of interest, guidelines and survivors cantered principles were followed. The OSC hospital based under the ownership and management of the government was considered the most effective model among the three. However, hospitals are not always accessible to all people particularly women survivors of IPV compared primary health care centres. Having said that, this approach is considered the best(6).

Evidence from several countries shows that (OSC) model of care where medical and as much as possible legal, social services are brought closer under one roof or one building to ensure survivors sensitive services provision. The type and variety of services are varying from context to context but to a large scale medical and psychosocial services are provided as minimum services in all settings good examples are Jordan(7), Kenya, Zambia and Uganda(6,74).

Family Support Centres (FSCs) so called one stop shop (OSP) approach in PNG was initiated by NGOs such as MSF operating at the provincial hospital, in close collaboration with NDoH in 2007 in Lae. The development of the FSC approach in PNG emerged since 2009 report analyzing family and sexual violence in PNG(13,75). Later, the concept was endorsed by NDoH and now included in the national health plan 2015-2020. It focuses on rolling out the FCSs at the provincial hospital level. FSC is a facility based OSC model

grounded on gender sensitive and survivor centered principle. The primary focus of the FSC is to provide medical and psychosocial services while facilitating referrals to legal, social and protection services with provision of free medical legal certificate(29,70). With the provision of medical and psychosocial care under one roof, it aims to reduce complexity, delays, maintain confidentiality and respect privacy in the line of survivor centered approaches and human rights principles(29,70).

There fifteen functional FSCs in PNG are all located at the provincial hospitals. The majorty of these facilities are managed by provincial health authorities with techincal and financial support from international donors, mainly funded by DEFAT(12,30). The hospital based FSCs has similar challenges and limitations to the OSC models. The primary focus of the FSCs are provision of medical and psychosocial care and facilitating referral services for legal and social services depending of the existing/functionality of referral path ways and availability and capacity of social legal sector. Although FSC services are for all survivors of IPV/GBV including men, however the structure of FSCs are limited to women and children, no services for men survivors of IPV are available(12,30,32)**.**

Secondly, the provision of mental health services is not prioritized under the current FSC services, neither current policies emphasizing on this gap. Mental health and counseling is not part of current training curriculum and there is no policy framework to systematically train and build the capacity of health workers to provide counselling both at FSCs and other primary health care facilities(30,32). Besides medical first aid and psychological first aid (PFA), medicines to prevent HIV and to prevent or treat STIs, vaccinations to prevent tetanus and hepatitis B and emergency contraception should be made available(3,70).

Evidence shows that interventions such a training of primary health care staff improves identification of women who experience violence and referral between primary health care and specialized SGBV service(76). According to UNDP assessment in 2013, both medical and legal service providers are lacking training in PNG. Without training and senstization, the staff cannot identify IPV survivors, which leads to not being able to facilitate a timely referral(30,32).The assessement also highlights that FSCs are providing great services but the approach has a serious limitations when it comes to

provision of care for women living in rural area, primary health centres including district hospitals do not have the capacity to provide GBV care(32).

Under the current policy and National Health Strategic Plan 2015-2020, the focus remains on the roll out of FSCs at the provincial level and is deprioritized in primary health care services(9,10,77). People living in rural areas have poor access to IPV care. In most of low and middle income countries, the capacity of national and provincial health authorities are limited to take the lead in coordination and implementation of multi-sectorial response(78).

3.2.3 Referral-Inquiry –Multi Sectorial Referral pathway:

A coordinated, multi-sector response is widely recognized as the most effective way of providing quality services to survivors of SGBV, most typically in the form of a robust referral system. In the absence of a functional referral system, survivors will not able to access other existing support services, leading to continual suffering that could lead to long-term physical, mental and social consequences, or even death(6). This approach also calls upon a community partnership and referral mechanism(60).

Referrals in general describe the processes of how a Survivor encounters an individual or institution about her or his case, and how professionals and institutions communicate and work together to provide her or him with comprehensive support(5,7). Partners in a referral network usually include different government departments and agencies, women's organizations, community organizations, faith-based organizations, medical institutions and others(6,7). An important prerequisite for the design and implementation of effective referrals is the existence of an institutionalized referral mechanism(8,80). A referral system is dependent on a legal framework. It is also reliant on the availability and capacity of other sectors, services and their commitment; and lastly, to the assistance- and health-seeking practices of the community. Therefore, the approach in setting up a referral system is, to a large extend, context specific(6,80).

A good example of multi-sectoral referral system is estalished in Jordan within a legal framework(7). Jordanian National Women Commisison (JNWC) leads the referral system, under OSC model approach offering 24/7 free services including free hotline, fax, email, phone calls for counselling, family reconciliation programs, shelter, social visits, legal consultations,

representations in courts, phsychosocial counseling , follow-up services, financial assistance to establish small project/business, scholorship, jobs, training opportunities, medical care, medical reports and family planning. However this approach requires a strong decentralized coordination and capacity to ensure services are provided and survivors confidentiality is maintained (7). This model of centralized referral system probably feasible in the context of Jordan. Knowing that law & justice, protection including community development sector are underfund, lack of training and technical skills and are not functional in most of the rural areas in PNG(2,12,30,32). makes this approach not feasible for PNG context. Also this approach requires strong leadership capacity at various level to ensure the quality of care, follow up and coordination among all the partners are sustained at this moment PNG is lacking this capacity.

A multi sectorial referral pathways seems to be feasible to duplicate in any context based on the available resources, this apporach is most comonly practiced among the partners in different contexts, it is a good example of a commitment that has not been materialized(78,79). Referral elements are present in every context, there is need for commitment, colloboration and sharing information under a clear agreed procedures(6,7).
The exisent FSC approach is evidence based yet there is a lack of of regulaton, guidelines such as referal protocols, networking with other partners, despite the emphasis in policies on a health response is guided within multi-sectorial approach. The limitation on non standardized referral mechanism for IPV survivors are attributed to the lack of social, legal and protection services particualry in rural areas(1,12). The current policies make emphasis on referral system but none of the strategies translate it into practices to ensure an effective and accessible service to survivors of IPV(9). There is no policy framework to guide multi-sectorial response and coordination in provision of comprehensive care including health, legal, justice, protection and social services provides and sectors(2,3,21,70). Gender Policy 2014,HIV strategy and National Health Plan 2011-2020 acknowledge the complexity of care and the need for a good referral system; there are only elements of a referral system and applied in a nonsystematic manner(2,30).Therefore, FSCs to have relationships with community development staff such as safe houses, protection officers, and other social services, including temporary shelter, where available, local police family and sexual violence unit, sexual offences squad, and/or the criminal

investigations unit, as well as District Courts and Office of Public Prosecution is critical. However, non-availability of referral guideline and protocol leads to disparities within the referral mechanism and unsustainable interventions leave IPV survivors with limited options but to return to abusive environment and lost in the chain of services(2,3,22,32,70).

3.2.4 Community linkage (Temporary shelter):

The need for specialized services for survivors of IPV extends beyond healthcare. evidence suggest that provision of temporary safe shelter and linkage through the safe houes to other social services are decreasing the risk of repeated violence, trauma, injury and even death(2).
A quality survivor-centered response to IPV is complex and requires commitment from multiple sectors including community development organization, NGOs, civil society protection and legal sector(4,5,84). community development with support from partner to prioritize development of safe house policy and the central government to fast track the endorsement of the policy/protocol.
Experience form a temporary shelter services offered to refugees in Lebanon by a local NGO called ABAAD, with financial support from UNHCR shows: following survivor-centered approach and human rights principles, the safe house offered a range of services including basic needs such as food, clothing, medical care, psychosocial counselling, case management, education, job placement safety and exit plan. The survivors could stay at least two months. This review shows that women survivors of IPV got jobs, survivors applied for legal prosecutions probably they felt more secure in the safe house rather than being in the same abusive environment; basic needs where cover so that survivors were no more dependent to breadwinner e.tc. however the review also shows that the establishment of safe houses require constant efforts in networking, support from community and civil society including law enforcement sectors(83).

Ugandan Women Network (UWONET) in a policy brief highlights the efforts that have been put together to provide safe shelter to survivors of IPV by NGOs offering similar range of services as Lebanon. However, lack of temporary shelter policy has contribute to inconsistency in provision of services provided by deferent partners. Furthermore, lack of standardized reporting mechanism and poor coordination resulted to lack of knowledge and evidence to analysis the effect of these services(74).

In PNG, policies including the medium term development plan (MTDP) 2010–2015 under strategy 7 emphasis on the need for establishment of safe houses for survivors of abuse cases including training of police force. However progress in the regards is hugely lacking behind(2,12).
The importance of community linkage in provision of temporary safe houses provision is acknowledged and legal sector as of 2016, has made commitment to establish family and sexual violence unit in police stations and so fare 17 police stations across the country have a function units, not enough but progress has been made in the right directions(12).

Currently there are few safe houses are operation in the country, most of them are located in bigger cities such as Port Moresby, Lae and Haggen(12,30). All the safe houses are funded by INGOs and run by local NGO or civil society. Services are offered varies a lot some offers food, counselling and reconciliation, some accept survivors with children under 5 years old some do not. None of the safe houses in PNG offers education for survivors or for their children, job placement and linking them with women empowerment programs. This is all linked with lack of national shelter policy, lack of ownership or prioritization from the government. Although several policies including Policy for Women and Gender Equality 2011–2015, Gender Health Policy 2014 and Gender Equity in Education (2009) list gender inequalities as a priority issue and emphasis on multi-sectoral interventions but fails to set out an action plan to develop a shleter policy to guide a uniform approach and standards(3,12)**.** Furthermore non-availability strategic framework, no policy to guide the establishment of safe house, are the key factors resulted to inconsistent in provision of services offered by NGOs in safe house**.**

3.2.5 Supportive Environment (primary prevention programs):

Primary prevention interventions are crucial in response to IPV. Evidence from a program in Uganda focusing on changing community attitude, norms and behaviour reduce gender inequalities and reduce the risk of IPV and HIV transmission(85).

Findings from 30 LMIC countries show the importance of primary prevention to break the cycle of ongoing IPV and other forms of SGBV. The study suggest primary prevention are most effective if initiated earlier; the

potential effect of intervention will drop by 62% and 33% if the program started 1 or 3 years after the marriages(57). These interventions need longer term commitment therefore it is wise to have them government owned/funded. PNG government with support with development partner must take the lead in implementation of such program which is not the practice at this moment. This evidence also suggests that prevention interventions focusing on changing gender norms among men are far more effective compared to changing behavior intervention that only focus on women(4). Currently the program is mostly focused on women and girls, while in most of the low and middle-income countries (LIMC), including PNG, gender inequities are pervasive in the society that limits women opportunity economically development of their society(4,78,84). The negative health, economic and social impact and consequence of IPV have been well acknowledged and has derived international and national attention to prevention of IPV right before it happens(84,87). Despite the growing commitment research in effective interventions and preventions strategies are limited for LIMCs(4,87), evidence from specific interventions has shown to be effective in terms of primary prevention are as follows:

The IMAGE Study: A program combining a microfinance revolving credit scheme with a participatory learning and action curriculum for gender and violence for women in loan meetings. A study of the program in Limpopo south Africa found that 2 years after the start of the intervention, experience of physical or sexual intimate partner violence in the past 12 months was reduced by 55% in women in the intervention group(51). Similar study in Bangladesh, women's experiences from a women microcredit program and skill development found that education increases women empowerment, improve decision making power and reduces IPV and violence against women(88). Microfinance intervention results from a randomized control trial study in South Africa shows no significant changes on controlling behavior but the intervention had a significant positive impact in reducing sexual and physical violence experience by their partners (55% reduction)(51). Subsequent studies (RCT) shows economic empowerment program shows reduction in acceptance of beating wife; reduce economical abuse even in the post conflict context(89). A RCT study shows that microfinance based intervention improve women empowerment resulting in reduction of violence in many ways such as being able to discuss and challenge the abuse by partner, possibility and ability to make decision without economically

dependency to leave abusive partner or environment(90). In the time of this review there was no active microfinance program in PNG.

Stepping Stones: An HIV participatory prevention program, seeks to improve sexual health by building gender equitable relationship. This process seeks to reduce gender-based violence. The program consists of critical reflection, role-play, and drama, and is delivered to single-sex groups for an average of 50 hours over 6–8 weeks. A study of the program in South Africa found it significantly reduced risk behaviors in men, with 38% fewer men in the intervention group than in the control group having reported perpetration of IPV at the 2-year follow-up, as well as a reduction in transactional sex and problem drinking at 12 months. Havening said that there is risk of bias in the study socially accepted answers by the participant. however, fewer men in the intervention group reported to have raped or attempted to rape at 12 months than men who did not participate in the program(38) National HIV and AIDS Strategy 2011–2015 recognizes GBV as a major factor in HIV vulnerability.

The HIV response in PNG includes a framework and guidelines for mainstreaming gender issues into design, planning, implementation and monitoring and evaluation through a multi-sectorial response. There is no prevention program that is initiated and sustained as national prevention program; however, there are initiatives and interventions on women empowerment and community level in response to violence against women. FSVAC and partners for prevention organization provide training on gender sensitization for different organization such a lifeline and help resources yet the impact and quality of these workshops to be evaluated(91).

SASA! In Uganda: a community mobilization intervention that seeks to change attitudes, norms and behaviors that drive gender-based violence, gender inequality and HIV. It was designed by raising voices and implemented by the Centre for Domestic Violence Prevention in Kampala. A recent cluster randomized control trial showed impressive results. The intervention was associated with significantly lower social acceptance of IPV among women and men; significantly greater acceptance among women and men that a woman can refuse sex; and a decrease in the experience of physical and sexual intimate partner violence among women(85). A similar program is implemented by FHI360 with financial and technical support from

Australian aid (DFAT) under the name of Komuniti Lukautim Ol Meri Project in Sandown province in PNG, the program is targeting at women and girls who experience violence, and men and boys who champion prevention of violence against women and girls, the program has three pillars: prevention, response and empowerment. Initial results of the survey from the two provinces shows promising results; however, sustainability of the programs questionable without government support(92). The program has been granted fund for two years, after which the future of the program is not clear.

One Man Can: was designed and implemented by South African NGO Sonke Gender Justice. It aims to (1) examine the links between gender, power, and health (alcohol use, violence, HIV/AIDS); (2) reflect on masculinities as these are practiced in relationships with women, other men, and the broader community; and (3) use a rights-based approach to reduce violence against women and HIV risks. The program works to achieve these goals by actively engaging with men and boys on the ground through the process of understanding, reflecting on, and reconfiguring masculinities and gender inequalities in their families and communities. OMC has been featured as an example of best practice by the World Health Organization (WHO), UNAIDS and the UN Population Fund (UNFPA). In the weeks following participation in OMC, 50% reported acting to address gender-based violence in their community and 61% reported increasing their use of condoms. A randomized control trial is currently underway in Mpumalanga to show the program's impact in preventing HIV and GBV. One the element of the Komuniti Lukautim Ol Meri program is also to engage men who could champion awareness on violence against women, the outcome, and effectiveness of this element is yet to be evaluated(92). This program is also short term (only two years funded), such interventions need longer term commitment both from the PNG government and development partners.

Most of the interventions in PNG are short term project based mostly funded by DFAT supporting gender mainstreaming through economic, infrastructure, small business, education and health sector yet due to non-availability of clear strategic framework and plan of action to guide a multi-sectorial intervention, the impact of these interventions remain very low or unknown due to unsustainable approach, government did not own these program, and NGO work on yearly bases depending on the availability funds. There is no

study and monitoring evaluation mechanism established through which the feasibility, accountability and acceptability of these programs and interventions are monitored. This could also be attributed to the lack of man power and technical capacity in various government sectors as discussed above also that government is pushed by donors interest rather than their own commitment (86).

Chapter 4: Discussion:

4.1 quantitative data analysis from MSF health facilities:

The data clearly shows that survivors of IPV who seek care from FSCs were nearly all women. As per evidence men can also be survivors of IPV, but the data shows poor access and utilization of services from the FSCs by men survivors. Yes in principle services are offered to men and women but in practices there are some barriers for men to access FSC services.

The high rates of women utilizing services could be influenced by several factors. Firstly, could be that women are mostly affected as evidence also shows women are mostly affected by IPV.

The low utilization rate of men IPV survivors could be due to lack of awareness non- availability of male staff, space, trust and supply and social stigma, health education programs that are deprioritized under the current response. Secondly, it could be that the FSC infrastructure is not gender sensitive enough that prevents men survivors from seeking care. As I worked in these FSCs myself, over 95% of the FSC staff was female.

The low number of men cases was also one of the reasons the review focused only on women survivors of IPV.

The data shows that the vast majority of these women survivors of IPV seek care for physical injuries, the use of sharp object in both MSF-supported FSCs was also high, however the rates of major injuries in Tari-highlands region was higher compared to those in the coastal region FSC. Knowing that a facility based data cannot be representative of the population. However, these data shows that physical violence's rates are high among those seeking care and could be the main reasons for IPV survivors to seek care. The high rates of injuries among those seeking for care raises the question about what happens to those survivors who do not have physical lesions but who are experiencing psychological, mental health and neglect or isolation. Are they simply do not seeking for care or simply they do not have access to FSCs. This is an area that needs more research and attention, knowing that counselling services are very limited in PNG.

Completion of treatment is essential in prevention of further health consequences such as HIV, hepatitis B, etc. follow of visit are therefore crucial. The data shows that rates of follow up visit remain low. The low follow up that hampers the quality of care could be influenced by factors such as, indirect cost, distances, restriction in women movement, stigma, lack of knowledge and awareness, and another area that is neglected need

further investigation. Having said that, the survivors seeking behavior, trust and underestimating the importance of follow up care also be one of the factors.
The data indicate that over time number of IPV cases seeking care gradually increased, although the average remain relatively low around 30 cases per month. However, the number of cases referred by police has increased significantly particularly in Port Moresby. This indicates that coordination and networking with police and other protections, social services provider are crucial. The increase of referral could be attributed with the fact that MSF-did a lot of trainings in nearly over 50 police stations in Port Moresby. Secondly, the police sector in the capital has more staff, resources including transport. However, referral from primary health care centers to the FSCs remain very low (below 5%), this also indicate that primary health care staff are not trained enough to identify IPV survivors and facilitate referral after stabilization

4.2 Review of Best Practices:

There is a political will at the national level when it comes to response to IPV and violence against women. The policy context has made some good progress in development of gender sensitive polices and strategies. Nearly all current polices are emphasizing on multi-sectoral response. However, the implementation of these policies is lacking hugely behind. A few factors contributed to including lack of capacity, skills and resources across the sectors. Secondly, there is a disparity between national and provincial level commitment this could be due donor pressure/interest. At the national level policies are develop with limited involvement of provincial authorities in the process. Trainings needs, capacity building or even initiatives are taken by the provincial authorities to establish FSCs, include FSCs into hospital regular budget, establishment of provincial FSVACs are not guided well neither taken into account. This has led to disparity lack of ownership resulted to poor implementation progress for those policies. All the above indicate a conflict of interest between donor agencies and PNG government.

These polices, and strategies are lacking supporting documents to help, guide the implementation process such as guidelines, framework. The above-mentioned constraints contributed to poor coordination, lack of standardization and leadership from the government side a crucial element for a system response.

Hospital based family support center approach is evidence based. This approach seems to one of the most effective modules according to the evidence. Where medical, psychosocial services are provided for all survives of IPV. Although FSC services are for all survivors of IPV/GBV including men, however the structures of FSCs are limited to women and children in practices. There is no male staff in the FSCs(29,32).

The second major limitation with current approach is neglecting primary health care services. The hospital based OSC is the most feasible suitable approach however it doesn't mean that FSCs to be placed at provincial hospital level where a clear majority of people do not have access, particularly in the context of PNG. While systems approach to delivering services requires training of all staff at all level of the organization from direct patient care to data collection, resources allocation program management, infrastructure (enough working space) to improve quality of care including staff capacity building(93). It is feasible to train a nursing officer from the PHC unit who could identify and provide immediate medical care and facilitator referral to FCSs. However this approach requires efforts in all the five themes of the system module response(see chapter 2,section 2.4.4) that included personnel, material and space within hospital settings specially in the context of the PNG (94,95).

Considering PNG context, it is a suitable option for health sector to build the capacity of the primary health care staff to be able to identify IPV survivors, who can provide essential care and facilitate referral. On the other hand, having FSCs at the provincial hospital, where most of the services are available, it is wise to get legal and protection elements closer in to one physical place like Kenya, a protection officer and a police officer from sexual violence squad to be based in the FSC or somewhere like E&C department.

Evidence and current PNG policies strongly emphasize the multi-sectorial response, the data above shows that where service providers collaborate and an established referral mechanism function to a certain level; maybe not as systematic as there are no clear guidelines, protocols and depending on their capacity. Elements of multi-sectoral referral system are present and practiced wherever possible. However, lack of guideline and standard operating procedure, has contributed to inconsistency in referral procedures. Lack of services particularly rural areas is another limitation for establishment of referral system. MSF data also shows that referral from

other sectors remain very low in Tari where there is less diversity of actors.
Papua New Guinea government recognizes the importance and need of temporary shelter for survivors of IPV, most of the policies and reports do emphasis gaps when it comes to safe houses availability. In general, there is lack of evidence across the world when it comes to standardized services or package of care to be offered in safe houses, type of services are varies from context to context. Currently services in the safe house in PNG offered are limited to accommodation, food and at most counselling. However, some of the safe house do offer some additional services such as referral to social legal services including medical care. These variations of services are due to lack of shelter policy to standardize the services across the safe house. Secondly currently all the safe houses are run by civil society organizations or NGOs bring uniformity in their services and approach need a strong leadership and commitment from the government side to enforce standardization.
Given the context of PNG, where development partners such as DFAT, USAID have commitment to response to SGBV including IPV. The Lebanon safe houses approach is feasible given that a clear shelter policy is develop and endorsed by the government.

Primary prevention interventions are crucial in response to IPV. Evidence from Uganda with a goal to change community attitude, norms and behaviour reduce gender inequalities and reduce the risk of IPV and HIV transmission study showed a significant reduction in acceptance of IPV, increase acceptance of women to be able to refuse sex and reduced the physical and sexual violence experience comparing the last years and women had more chance to receive support from the community.Key in success of the intervention was the involvement of the community activists, government employees from health, police, legal and local leaders. UNDP, UN-Women have projects focused on women empowerment, economic development, women leadership programs are championed working closely with the Office for the Development of Women (ODW) and National Community Development Department.
Most of the project are also funded by DEFAT supporting gender mainstreaming through economic, infrastructure, small business, education and health sector yet due to non-availability of clear strategic framework and plan of action to guide a multi-sectorial intervention, the impact of these interventions remain very low. There is no study and monitoring evaluation

mechanism established through which the feasibility, accountability and acceptability of these programs and interventions are monitored. This could also be attributed to the lack of man power and technical capacity in various government sectors as discussed above. However, this approach is feasible in the context of PNG complemented with a clear policy and guideline.

Chapter 5: Conclusion and Recommendations:

5.1.1 Conclusion:

Progress has been made in response to SGBV including IPV such as establishment of FSC establishment and FSVAC and FSVU-front desk at some police stations(12,91).Yet the coordination remains weak, availability of health services are very limited, primary prevention programs are limited and inconsistent, lack of guidelines insufficient allocation of resources are key challenges that hamper IPV current response. If PNG government will not sustain the program it will collapse, the cycle of IPV will continue, that will negatively affect progress in development of a gender equity and violence free society.

Hospital based FSCs approach, where essential services are offered in one stop shop with strictly following survivor centred principle is well utilized where it is available yet strongly donor dependent. The review clearly shows that access to health care in general is low while survivors of IPV have very limited access to minimum essential health services. The current response of the health department focuses only on the establishment of the FSC and has neglected the primary health care settings.

Provision of health care alone is not enough regardless if it is provided in a FSC or in primary health care facility. There should be a clear strong multi-sectorial response strategy frame work, where actors work towards ending violence against women at all levels.

Currently, the gender policy does not clearly specify the prevention and prosecution. Coordination is a further measure of efficiency and this is what lacking regarding the FSC. Provincial FSVAC are not established in most of the provinces leading to poor or no coordination in response to IPV as provincial level this could also be due to that fact that donors agencies have given more attend to national level in developing policies not engaged enough with authorities at the field level.

It is critical that multi-sectoral coordination is strengthened, particularly regarding primary prevention, to avoid the perception that the response to FSV belongs solely to the health and law and justice sectors. There is a considerable need for legalization of safe houses while there is a huge demand for safe houses particularly in the Highlands.

While systems approach to delivering services requires training of all staff at all level of the organization from direct patient care to data collection, resources allocation program management, infrastructure (enough working space) in order to improve quality of care including staff capacity building. The most feasible system model is to train a GBV (IPV) nursing officer to identify and provide immediate medical care and facilitator referral to FCSs. This model requires sector wide approach that included personnel, material and space within hospital settings especially in the context of the PNG Considering PNG context, it is a suitable option for health sector to build the capacity of the primary health care staff to be able to identify IPV survivors, who can provide essential care and facilitate referral

5.2 Recommendation:

5.2.1 Donor Agencies:

- Implementation of current policies at the field level to be priorities through empowerment and involvement of provincial and district authorities across the sectors.
- Sustainable and longer term funding mechanism for primary prevention programs as these interventions need longer time to have impact.
- Support the government health sector to focus on primary health care services strengthening in response to IPV.

5.2.2 Government of PNG:

- The government needs to implement a strategy to ensure multi-sectorial GBV-IPV response focusing on three Ps (prevention, protection and prosecution) with a strong coordination mechanism governed by national and provincial authorities.
- The government and development partners are to prioritize initiation of program to reduce IPV and mitigate the root cause of IPV community dialogues and other programs such as SASA.
- The finalization of national clinical and referral guidelines to be prioritize in order to streamline health response and improve multi-sectoral cooperation.
- National standardized reporting system together with training manual for in-services health and other sector staff focusing on SGBV/IPV together with education sector to be develop in the line of current policies.

- Revision of FSC establishment guide must be prioritized to provide guidance for all provincial health authorities and partners involved in rolling out the FSC establishment.
- Government particularly NDOH to reconsider inclusion of counseling services into the current FSC approach.
- National department of health, Gender and Men's Health unit must develop a short and long-term strategic plan where priorities are clearly outlined for the five year and 10 years. This will not only streamline gender health sector response, but also improve multi-sectorial response including streamlining services.
- Primary prevention programs must be prioritized by the government sectors such as education, community development.
- A national wide advocacy program must be established to fast track the implementation of prevention programs. These initiatives must be led by development partners such as UNFPA.

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