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PEPFAR special initiative on sexual and gender-based violence: Baseline report

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PEPFAR SPECIAL INITIATIVE ON SEXUAL AND GENDER-BASED VIOLENCE

BASELINE REPORT

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PEPFAR SPECIAL INITIATIVE ON SEXUAL AND GENDER-BASED VIOLENCE

BASELINE REPORT

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EXECUTIVE SUMMARY

BACKGROUND

The PEPFAR Special Initiative on Sexual and Gender-Based Violence aims to strengthen care for survivors of sexual violence (SV) in 18 pilot sites in Uganda and Rwanda. Within these public facilities, implementing partners will support providers to undertake three sets of core interventions: 1) strengthening health services; 2) strengthening referrals from the health facility to other support services; 3) strengthening linkages between clinical services and other stakeholder groups to facilitate access to health services.

METHODOLOGY

The Initiative is expected to provide an evidence base for scaling up such efforts in the future and will be rigorously evaluated. This report contains results of the baseline assessment conducted between September and November 2009 in eight facilities in Rwanda and nine facilities in Uganda. It includes data from two sources: quantitative data from a Facility Inventory completed in 17 of the 18 intervention sites (data could not be collected from a military hospital for security reasons), and qualitative data from a series of focus group discussions (FGDs) conducted with health care providers from 13 of the intervention sites.

RESULTS

Services in both countries were generally weak, with facilities and providers in Uganda slightly better prepared to provide services than those in Rwanda.

Key findings from Rwanda include:

- While 100 percent of facilities had dedicated rooms or spaces for providing SV services, none of them contained the necessary equipment, supplies or drugs (including HIV post-exposure prophylaxis (PEP) or emergency contraception (EC)) needed to deliver comprehensive SV care.
- Only 38 percent of facilities had a doctor present at all times SV services were provided, despite legal requirements for doctors to participate in the examinations.
- Even though HIV PEP was not available in the exam rooms, it could be found in other areas in all facilities. EC, however, was only available in 62 percent of facilities, and only the Yuzpe method was offered (using Microgynon).
- Providers were aware of the medico-legal services required to report a case, suggesting that great emphasis is placed on legal documentation in the health care system. They were less aware of survivors' on-going health, legal and psychosocial needs
- Doctors were significantly more knowledgeable on the critical elements of SV care than nurses, suggesting a clear division in service delivery activities. Nonetheless, all providers indicated that the lack of trained staff was an important challenge in providing quality care.
- Lack of client follow-up was widely recognized as a challenge for the health care providers, especially for survivors who require follow-up HIV testing.

- Stigma, shame and a preference to settle cases at the community level were seen as key barriers to seeking care.
- Providers were largely unaware of other SV services offered in their communities.

Key findings from Uganda include:

- While no facilities in Uganda offered dedicated spaces for examining SV survivors, many of the wards or departments where SV services were given contained HIV kits (44 percent), PEP drugs (56 percent) and EC pills (89 percent).
- Because of this lack of centralized services, providers reported referring survivors to multiple locations within the same facility. Providers in one hospital indicated as many as five points of contact.
- Only 56 percent of facilities had a doctor present at all times SV services were provided, despite legal requirements for doctors to conduct and certify examinations. Providers indicated that, because of the lack of doctors in the country, such legal requirements served as a key barrier to providing care.
- HIV test kits and PEP drugs and EC pills were present in all facilities, even if they were not available in the area where SV services are provided. Facilities in northern Uganda had access to the dedicated EC pill Postinor-2, while sites in other areas of the country employed the less reliable Yuzpe method of emergency contraception.
- Providers widely believed that, in many cases, a survivors' behavior can lead to SV, although such negative perceptions did not affect providers' beliefs that all SV cases should be treated as an emergency.
- Although they reported limited training, providers were largely aware of the major injuries and risks associated with SV and demonstrated a good knowledge of the most critical components of care.
- Both doctors and nurses were aware of several other organizations providing SV services in their communities, but did not have formal procedures for referring survivors to them.
- Limited community awareness of SV issues and services was seen as a major barrier to seeking care.

RECOMMENDATIONS

Under the Initiative, implementing partners are encouraged to undertake the following activities to strengthen SV services and service utilization in the participating facilities.

Recommendations for Rwanda

Strengthen health services by:

- Ensuring that SV services are offered at all times when the facility is open and that communities know where to seek services when facilities are closed.
- Ensuring that SV exam rooms offer visual and auditory privacy.
- Providing HIV testing, prophylaxis and emergency contraception in the location where exams are performed.

- Introducing a dedicated emergency contraceptive pill.
- Ensuring that basic equipment and supplies are available in examination rooms.
- Training both nurses and doctors to provide comprehensive SV services.
- Developing facility-level protocols for managing and referring SV survivors.
- Ensuring all facilities maintain adequate records on SV survivors.

Strengthen referrals from the health facility to other support services by:

- Making providers aware of the other services that a survivor may require following medical examination.
- Conducting a mapping of the specific post-SV care services in each facility's catchment area.
- Developing and educating providers on systems and procedures for referring survivors to the other services available in their community.

Strengthening linkages with the community by intensifying community awareness-raising activities conducted by health advisors and during routine health talks in the facilities.

Recommendations for Uganda

Strengthen health services by:

- Centralizing SV services in dedicated service delivery rooms or spaces.
- Ensuring that SV services are offered at all times when the facility is open and that survivors know where to seek care when facilities are closed.
- Ensuring that a dedicated EC product is available to all health facilities.
- Training both doctors and nurses to provide SV services; sensitize all providers within the facility.
- Strengthening forensic evidence collection within health facilities.
- Developing facility-level protocols, algorithms for managing and referring SV survivors.
- Ensuring all facilities maintain adequate records on SV survivors.

Strengthen referrals from the health facility to other support services by developing more formal linkages with other community-based organizations providing SV services.

Strengthen linkages with the community by empowering health care workers to conduct community-level sensitization activities.

INTRODUCTION

The PEPFAR Special Initiative on Sexual and Gender-Based Violence aims to strengthen services for survivors of sexual violence (SV) though the implementation of a comprehensive model of care in participating PEPFAR partner facilities.

The Initiative's efforts are expected to expand SV services, improve service quality, increase service uptake, and provide an evidence base for scaling up such efforts in the future. Each implementing partner will pilot or enhance site-specific service delivery models based on the needs, preferences, and capacities within their health care setting and based on government policies and community practices. A standard set of core interventions will be undertaken at all sites. These include:

1. Strengthening health services
   - Health facility and infrastructure improvements
   - Logistics and supply management system improvements
   - Training and mentoring of health care workers to provide a full package for medical services including voluntary HIV testing and post-exposure prophylaxis (PEP); pregnancy testing and emergency contraception (EC); STI screening and treatment; psychological counseling
   - Training and strengthening of systems for collection and certification of forensic evidence
   - Development/strengthening of facility-level protocols and supervisory systems for medical services
   - Development/strengthening of record systems for case management.
2. Strengthening referrals from the health facility to other support services
   - Identification of support services within the health facility catchment area (e.g. police, legal, shelter, HIV care and treatment, other medical follow-up, longer-term counseling, economic and other social support)
   - Development/strengthening of systems for client referrals to these support services.
3. Strengthening linkages between clinical services and other stakeholder groups to facilitate survivors' access to health services
   - Engage communities and stakeholder groups to identify survivor barriers to health services and help design solutions
   - Sensitize community and stakeholder groups to the need for, and urgency of, seeking medical help for rape and other forms of SV, including the importance of HIV testing and the availability of PEP to prevent HIV transmission
   - Development/strengthening of protocols and standard operating procedures (SOPs) for referral of clients from the police and other local authorities to the health facility
   - Development/strengthening of protocols and SOPs for referral of clients from other support services to the health facility

- Consultations among representatives of health services, police and other local authorities, other social support services, and community stakeholder groups to inform development of these protocols and ensure their implementation.

PROJECT SITES

PEPFAR Country Teams in each country selected their implementing partners and directed funding to them through the corresponding agency (USAID, CDC, or DOD). Implementing partners then selected their participating sites. Site selection criteria included: the ability of each facility to provide SV services, including PEP; potential for creating linkages with police and local communities; and demonstrated need for SV services within catchment population or facilities. It is important to note that the intervention sites were not selected based on national representativeness; rather, they were selected as pilot intervention models. A total of 18 sites are included in the Initiative, 8 in Rwanda and 10 in Uganda (Table 1). All sites are public health facilities operated by the Ministries of Health in each country.

Table 1 PEPFAR SV Initiative Intervention Sites in Uganda and Rwanda

Country	Implementing Partner	Intervention Sites
Rwanda	International Center for AIDS Care and Treatment Programs (ICAP)/ Columbia University	Muhima District Hospital Gisenyi District Hospital
	IntraHealth HIV/AIDS Clinical Services Program	Byumba Hospital Kigogo Health Center
	AIDS Relief/ Catholic Relief Services	Muyange Health Center Kibogora Health Center Bungwe Health Center
	Drew Cares International (DCI)	Kanombe Military Hospital
Uganda	Northern Uganda Malaria, Tuberculosis and HIV/AIDS Program (NUMAT)/JSI	Gulu Regional Referral Hospital Lira Regional Referral Hospital Kitgum District Hospital Anaka District Hospital Amolatar Health Center Pajure Health Center Anyeke Health Center
	Mulago-Mbarara Teaching Hospitals' Joint AIDS Program (MJAP)	Mulago Hospital
	Uganda People's Defense Force	Bombo Military Hospital Gulu Military Hospitals

EVALUATION DESIGN

To provide the evidence base for future policy and programming, the evaluation will consist of a pre-post intervention design, complemented by the routine collection of service statistics to document trends over the life of the intervention period. Due to budgetary constraints, no comparison sites are included; rather, changes at each intervention site during the life of the project will be relied upon to gauge Initiative outcomes. Evaluation findings will be reported at the levels of intervention site, implementing partner, country, and initiative as a whole. Equivalent data will be collected at the intervention sites by the implementing partners and the Population Council, as described below.

Key components of data collection and reporting include the following. The Population Council will be responsible for collecting all of these data.

- At baseline, quantitative data will be collected on facility readiness to provide SV services, using a Facility Inventory form (see Appendix 1). Qualitative data on service providers' knowledge and attitudes will be collected through a series of Focus Group Discussions (FGDs) with doctors and nurses in intervention sites (see Appendix 3).
- Throughout the intervention, quantitative data will be collected through the use of the SV Client Assessment Form on a routine basis at each intervention site by the implementing partners.
- At endline, the baseline data collection will be replicated. Additional data on program acceptability and impact will be collected through Key Informant Interviews (KIIs) with Program Managers and Stakeholders.

This document includes data from the baseline assessment of health facilities in Uganda and Rwanda.

METHODOLOGY

Approval to conduct the study was granted by Rwandan National Ethics Committee, Uganda National Council for Science and Technology, the U.S. Centers for Disease Control/Atlanta, and the Population Council.

DATA COLLECTION TOOLS

As noted above, two sets of tools were used to collect the data contained in this report. First, a facility inventory was conducted to review the infrastructure, supplies, and services available in the facility. Its purposes are to assess: 1) the facility's readiness to provide services for SV clients (at baseline), and 2) changes in service quality over the intervention period (comparing endline to baseline). The Facility Inventory instrument is based on the following: a) Sexual Violence Research Initiative assessment guidelines[1], and b) IPPF/WHR SV programming toolkit[2].

Second, FGDs were conducted using the question guide contained in Appendix 3. The purpose of the FGDs is to assess the provider's perceptions and attitudes toward SV care. The Guide is drawn from the following sources: a) Improving the Health Sector Response to Gender-Based Violence: A Resource Manual for Health Care Professionals in Developing Countries, September 2004, International Planned Parenthood Federation/ Western Hemisphere Region[2]; and b) Rural AIDS and Development Action Research, Questionnaire for Health Care Workers[3].

Prior to participation in FGDs, all participants completed an informed consent form, which specified that all information will remain confidential, that participation will not have an impact on their professional duties, and that no compensation will be provided for completing the survey. To protect the identity of respondents, the signed informed consent forms and FGD transcripts are stored separately in the Council's offices.

FIELDWORK AND DATA COLLECTOR TRAINING

Baseline data were collected in both countries between September and November of 2009. In Rwanda, one senior consultant and two junior data collectors were hired to carry out the field work under the direction of the principal investigator. All data collection tools (the Facility Inventory form and FGD guide) were translated into Kinyarwanda prior to submission to the Rwandan National Ethics Committee. These translations were then reviewed by the partners, pre-tested and revised prior to implementation. FGDs were conducted in Kinyarwanda and tape recorded. Transcripts of the FGDs were prepared in English by the senior consultant, and sent to Population Council Nairobi for analysis.

In Uganda, a team of four consultants comprised two data collection teams. All FGDs were conducted in English, and typed transcripts of the FGDs were sent to the Population Council's office in Nairobi for analysis.

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[1]Christofides, N. et al. 2006. "How to conduct a situation analysis of health services for survivors of sexual assault." Johannesburg: SVRI, MRC.

[2]Bott, S. et al. 2004. *Improving the Health Sector Response to Gender-Based Violence: A Resource Manual for Health Care Professionals in Developing Countries*. New York: IPPF/WHR.

[3]Kim, J., et al. 2007. "Developing an integrated model for post-rape care and HIV post-exposure prophylaxis in rural South Africa." New York: Population Council.

Prior to conducting field work, all data collectors participated in a one-day training conducted by the principal investigator. This training covered the following topics: data collection tools and procedures; ethical issues and confidentiality; techniques for conducting focus groups; and data handling and submission. The training was followed by a pre-test of the FGD guide.

DATA COLLECTION PROCEDURES AND PARTICIPATION

Implementing partners facilitated data collectors' access to the participating sites. Facility Inventories were conducted by the data collector who was accompanied by staff from the facility; 53 percent of inventories were led by the facility in-charge. Data collectors were instructed to visually verify the presence of all equipment, supplies and guidelines indicated on the form. All facilities apart from one, Uganda's Gulu Military Hospital, participated in the facility inventory. Data collectors were not granted access to the Hospital due to national security concerns. Details for each focus group are given in the results section below. Table 2 summarizes the number of Facility Inventories and FGDs collected in each country.

Table 2 Summary of Completed Facility Inventories and FGDs

Country	No. of intervention sites	No. of facility inventories completed	No. of FGDs conducted	No. of sites where FGDs conducted
Rwanda	8	8	13	8
Uganda	10	9	7	7

Due to the limited number of staff at most sites, all health care providers (defined as doctors, nurses and clinical officers) who treat SV clients were eligible to participate in the FGDs. The size of the FGDs ranged from 5–10 participants. When possible, separate FGDs were conducted for doctors and nurses to minimize bias due to power differentials among the two cadres of providers. In some sites, especially those in Northern Uganda, only one FGD could be conducted with the available nurses. In other sites, providers from neighboring facilities were brought together to participate in the FGDs.

DATA ANALYSIS

All data was sent to the Council's office in Nairobi for storage and analysis. The following data analysis procedures were undertaken:

- Quantitative data from the Facility Inventories were entered using EPIDATA and analyzed using SPSS version 13. Descriptive statistics were calculated for all evaluation questions and indicators listed in Appendix 2, by facility and implementing partner to provide data relevant for programming.
- Qualitative data from the FGDs were analyzed by country, partner and cadre of providers to help inform program implementation. All data were analyzed manually by the individual analysis themes (Appendices 2 and 4) and by a 3-point Likert scale for each evaluation question to classify provider responses as "positive," "neutral" or "negative." The Likert Scales are included in Appendix 5.

RESULTS

The results of the baseline are first presented individually for each country, followed by a concluding section that draws cross-country comparisons. Within each country section, comparisons are made between facility categories, locations and cadres of staff and throughout, the individual facilities and their implementing partners are identified to assist with future programming. The analysis is structured by the Initiative evaluation questions outlined in Appendices 2 and 4.

RWANDA

FACILITY INVENTORIES

The Facility Inventory was completed for all eight of the intervention facilities in Rwanda. All rated poorly, with none of the sites scoring higher than 50 percent on a composite index that included the basic services, infrastructure and supplies needed to provide quality SV services. The best prepared to provide SV services were the sites supported by ICAP—Muhima and Gisenyi hospitals—closely followed by the site supported by CRS, Kibogora hospital. The least prepared sites were Kigogo and Bungwe health centers. Table 4 describes each quality of care indicator; positive (or "yes") responses are highlighted in red.

Has adequate infrastructure at the intervention sites been established?

Only one facility, Muhima hospital, provided 24-hour SV services. However, 100 percent of the surveyed facilities did have a dedicated room for examining SV survivors. The majority of these (88 percent) offered visual privacy, but only 50 percent provided auditory privacy.

Only 38 percent of the facilities reported that there is there a doctor available at all times that SV services are provided. Surprisingly, these three facilities were health centers, which offered SV services at limited hours. Specialized services, however, were only available at the hospital level.

Muhima and Gisenyi hospitals have a pediatrician and an obstetrician/gynecologist providing SV services, while Kanombe has an obstetrician/gynecologist and Kibogora a pediatrician. None of the other facilities have these specialists. Half of the sites have counselors providing services to SV survivors (Muhima, Gisenyi, Byumba and Kibogora).

None of the facilities have specific aides for examining children.

Do standardized care and referral guidelines exist at the intervention sites?

Kibogora hospital is the only facility with standardized guidelines or protocols for both clinical management of SV survivors and for referrals. It is important to note that these are facility-specific guidelines, as the national guidelines for SV management were not adopted until early 2010.

Are the necessary HIV drugs and supplies available at the intervention sites?

While all eight facilities have HIV rapid test kits and PEP drugs in the facility, none of them have the test kits or the PEP drugs in the areas dedicated for SV examinations. This suggests that survivors

are referred to another location for HIV services, although referral guidelines and procedures to these locations were not routinely available in the facilities.

Are other essential equipment and supplies available at the intervention sites?

The Facility Inventory form lists 20 types of essential equipment and supplies that each facility must have to provide quality SV services (see section 4 in Appendix 1). The minimum standard is to ensure that at least 15 of the 20 types of supplies are available in the area where SV exams occur, to minimize survivor referrals to multiple service delivery points and to ensure that all time-sensitive drugs are provided as quickly as possible.

As Table 4 indicates, none of the intervention sites met this standard. Table 5 highlights specific types of supplies and equipment that were available in the facilities surveyed, with positive responses ("Y") highlighted in red. While all of the examination rooms contained couches and examination gloves, only about half had basic equipment such as a working lamp and speculum. Less than 40 percent of the facilities had the capacity to conduct diagnostic tests and forensic evidence collection in the SV examination room, given the lack of swabs, blood tubes and lockable evidence cupboards. The data also indicate that drugs are routinely provided in another area of the facility, as PEP drugs, EC pills, analgesia and anti-emetics, were not available in the SV exam room.

None of the facilities offered a dedicated EC pill, which is more effective in preventing pregnancy and has fewer side effects. When offered, providers used high doses of the oral contraceptive pill Microgynon using the *Yuzpe* method of emergency contraception. Although these contraceptive pills should be widely available, only five facilities (63 percent) indicated that they could be found elsewhere in the facility.

Table 4 Summary of Facility Inventory Indicators, Rwanda

Facility	Partner	Infrastructure								Guidelines		HIV & supplies			Records		
		Facility open for 24-hour SV services	Dedicated room for SV	Visual privacy	Auditory privacy	Doctor present at all times	Obs/gyn provides service	Pediatrician provides service	Counselors provide service	Guidelines for clinical mgt. in SV room	Guidelines for referrals in SV room	HIV rapid test kits in SV room	PEP drugs in SV room	Have 15 of 20 essential pieces of equipment	Records show SV clients	No. of SV clients last month	Composite index score (%) (15 indicators)
Kanombe Military Hospital	DCI	N	Y	Y	Y	N	Y	N	N	N	N	N	N	N	N	—	27
Byumba Hospital	IH	N	Y	Y	Y	N	N	N	Y	N	N	N	N	N	Y	11	33
Kigogo Health Center	IH	N	Y	Y	N	Y	N	N	N	N	N	N	N	N	N	—	20
Muhima Hospital	ICAP	Y	Y	Y	N	N	Y	Y	Y	N	N	N	N	N	Y	13	46
Gisenyi Hospital	ICAP	N	Y	Y	Y	N	Y	Y	Y	N	N	N	N	N	Y	43	46
Kibogora Hospital	CRS	N	Y	—	—	N	N	Y	Y	Y	Y	N	N	N	Y	4	40
Muyange Health Center	CRS	N	Y	Y	Y	Y	N	N	N	N	N	N	N	N	Y	1	27
Bungwe Health Center	CRS	N	Y	Y	N	Y	N	N	N	N	N	N	N	N	N	—	20
% "yes" (n = 8 facilities)		13	100	88	50	38	38	38	50	13	13	0	0	0	63	—	

Table 5 Selected supplies and equipment available in SV examination rooms, Rwanda

Facility	Exam couch	Exam gloves	Consent form	Working angle lamp	Speculum	Swabs	Blood tubes	Lockable evidence cupboard	EC pills	Analgesia
Kanombe Military Hospital	Y	Y	Y	Y	Y	N	N	N	N	N
Byumba Hospital	Y	Y	Y	N	N	N	N	N	N	N
Kigogo Health Center	Y	Y	Y	N	N	N	Y	N	N	N
Muhima Hospital	Y	Y	Y	Y	Y	Y	Y	Y	N	N
Gisenyi Hospital	Y	Y	N	Y	Y	Y	Y	N	N	N
Kibogora Hospital	Y	Y	Y	Y	Y	Y	N	Y	N	N
Muyange Health Center	Y	Y	Y	N	N	N	Y	N	N	N
Bungwe Health Center	Y	Y	N	N	N	N	N	N	N	N
% yes (n = 8 facilities)	**100**	**100**	**75**	**50**	**50**	**38**	**38**	**25**	**0**	**0**

Do adequate record-keeping procedures exist at the intervention sites?

Five sites maintained records on the number of SV clients. The number of clients in the last month prior to data collection ranged from one at Muyange to 43 in Gisenyi. At the time of the baseline data collection, none of the sites had started using the SV client assessment forms to track services provided to survivors.

FOCUS GROUP DISCUSSIONS WITH SERVICE PROVIDERS

As summarized in Table 6, a total of 13 FGDs were held in the five hospitals and three health centers. In each hospital, two FGDs were held, one with doctors and one with nurses. The health centers only have nursing staff. The number of participants ranged from only 4 doctors in Kanombe hospital to 10 nurses in Byumba hospital.

The qualitative data from the FGDs was analyzed and coded using a three-point Likert scale, with a value of 0 being given for a negative response, 1 for a mixed response and 2 for a positive response. Details of the responses and scales are provided in Appendix 5.

Table 6 Summary of FGDs held in Rwanda

	Facility	Location	Partner	Cadre	No. of participants
1	Kanombe Military Hospital	Urban	DCI	Doctors	4
2	Kanombe Military Hospital	Urban	DCI	Nurses	8
3	Byumba Hospital	Semi-urban	IntraHealth	Doctors	8
4	Byumba Hospital	Semi-urban	IntraHealth	Nurses	10
5	Kigogo HC	Rural	IntraHealth	Nurses	8
6	Muhima Hospital	Urban	ICAP	Doctors	7
7	Muhima Hospital	Urban	ICAP	Nurses	7
8	Gisenyi Hospital	Urban	ICAP	Doctors	9
9	Gisenyi Hospital	Urban	ICAP	Nurses	7
10	Kibogora Hospital	Rural	CRS	Doctors	8
11	Kibogora Hospital	Rural	CRS	Nurses	6
12	Muyange HC	Rural	CRS	Nurses	7
13	Bungwe HC	Rural	CRS	Nurses	8

Table 7 presents the results of this analysis, with negative responses (less than 1.0) highlighted in red. Overall, the data demonstrate that providers held relatively favorable attitudes toward survivors of SV, but did not feel they had the skills to provide appropriate care. All providers ranked uniformly low on the identification of survivors' needs beyond immediate medical treatment and on strategies for referring survivors to other services or strengthening community linkages. The following discussion highlights specific provider responses and comments on these issues, and is structured by the analysis themes outlined in Appendix 4.

Provider knowledge of SV cases in the community

All of the respondents had a good understanding of what constitutes SV, and all providers felt that it was increasingly common in their communities. They also reported that SV has always been present, but it has been customary to conceal cases for fear of family shame and stigma. Now, they believe more survivors are reporting as a result of government efforts to raise awareness of SV, which encourage people not to conceal cases but to seek medical attention and legal redress. As nurses in Muhima hospital noted:

This existed even in old times but it was entrenched in the customs of the people. For instance, someone would have sex with a child and his people covered it up in order not to bring shame over the whole family. —Muhima nurse

Due to the media, all people have got to know the wrongness of sexual abuse so that they accuse or disclose those who do this. In the old times, people covered this up and it was something like a custom. Today, they accuse seeking for justice. —Muhima nurse

Table 7 Summary of Likert-Scale results for the FGDs, Rwanda

Facility	Partner	Cadre	Awareness		Attitude			Capacity					Other needs			Linkages			
			SV knowledge	SV prevalence felt to be increasing	Consider SV a medical emergency	Believe survivor behavior causes SV	Believe entitled to same care	Sufficient number of providers trained	Training content felt to be sufficient	Trained in last 12 months	knowledge of Injuries & risks	knowledge of components of care	Awareness of other needs	Referrals & protocols	Knowledge of support in community	Knowledge of barriers to SV services	Community outreach	Knowledge of partners	Client feedback sought
Kanombe Military Hospital	DCI	Doctors	2	2	2	1	2	0	0	2	1	1	1	0	0	-	0	1	0
Kanombe Military Hospital	DCI	Nurses	2	2	2	1	2	0	0	-	1	0	0	0	0	2	0	0	0
Byumba Hospital	IntraHealth	Doctors	2	0	2	1	-	0	0	-	1	-	1	0	1	1	0	1	0
Byumba Hospital	IntraHealth	Nurses	2	2	2	1	2	0	-	2	1	1	0	0	0	2	1	0	1
Kigogo Health Center	IntraHealth	Nurses	2	1	2	2	2	0	0	-	1	1	0	0	0	1	1	0	0
Muhima Hospital	ICAP	Doctors	2	1	2	0	2	0	0	2	1	1	1	0	0	1	0	0	0
Gisenyi Hospital	ICAP	Doctors	1	2	1	1	-	0	0	-	2	2	0	0	0	1	0	0	0
Muhima Hospital	ICAP	Nurses	2	2	2	1	2	0	0	0	1	1	0	0	0	2	0	1	0
Gisenyi Hospital	ICAP	Nurses	2	2	2	1	2	0	-	0	2	2	0	0	0	1	0	1	0
Kibogora Hospital	CRS	Doctors	2	2	2	0	2	0	2	2	2	2	0	1	0	0	1	1	1
Kibogora Hospital	CRS	Nurses	2	2	2	0	2	0	0	2	2	1	1	1	0	1	0	0	1
Muyange Health Center	CRS	Nurses	2	2	2	1	2	1	-	2	2	2	0	0	1	2	0	1	2
Bungwe Health Center	CRS	Nurses	2	2	2	1	2	1	-	-	2	2	0	0	0	1	1	0	0
Number of responses = 1 or 2 (of 13 FGDs)			13	12	13	10	11	2	1	8	13	11	4	2	2	11	4	6	4
Average of responses (min 0, max 2)			1.92	1.69	1.92	0.85	2	0.15	0.22	1.4	1.46	1.33	0.31	0.15	0.15	1.25	0.31	0.46	0.38

0 = negative, 1 = neutral, 2 = positive

Other factors that were said to be responsible for the perceived increase in cases included the belief that sex with a virgin will cure HIV, the phenomenon of youngsters having 'sugar daddies and mummies', the increased use of drugs and alcohol particularly amongst youth, children being able to watch adult-rated movies in public places, lack of proper supervision by parents who are often working long hours and young girls being allowed to walk alone at night.

There are even people today who perform this action in order to recover from some diseases like AIDS. —Muyange nurse

…due to development, today's movies, these facts have increased. —Muyange nurse

Although the numbers were said to be increasing, not one facility actually mentioned having records of SV cases that they could refer to.

This is not easy to answer. They're random cases. We have no effective estimates. —Muhima doctor

Where numbers were mentioned, they were anecdotal and ranged from 8 per month in Kibogora hospital to 10 per day in Kanombe Military Hospital.

As far as I am concerned, there is time when I received about 10 per day, and they come every day. They are actually many and you would not miss at least 2 in one day. —Kanombe doctor

Survivors tended to report at all times of day or night and ranged in age from babies to adults, but respondents felt there was an increase in the number of young children being reported.

It is in these last days that I heard a man raping a one-year-old child, so that we find that this is worrying because formerly maybe only mature girls would be raped. —Kibogora doctor

Provider attitudes toward SV survivors

Provider attitudes towards SV survivors are likely to impact the quality of care they receive. In cases where providers believe that the survivor has brought the assault on themselves, often through "loose" behavior or inappropriate attire, providers may be less willing to prioritize the case. To assess this attitude, FGDs examined providers' beliefs regarding how SV is instigated and how that related to care. Provider beliefs and attitudes ranged widely but only in one facility, Muhima hospital, did the doctors strongly believe that the behavior of young girls can be responsible for their attacks.

There are behaviors that cause them to be raped, especially mature girls. Those are like indulging in alcoholic drinks (the case of Muhima road for example). —Muhima doctor

Morals are loose in the city. This sometimes depends in which city someone has been raised (girls going home through the night are really exposed to rape). —Muhima doctor

In most facilities the respondents, both doctors and nurses, were divided or did not feel strongly about the issue. Only in Kigogo health center did the nurses unanimously disagree that any survivor can be responsible for the attack.

There is no such behavior which would be the reason for aggression. Even if some people say that this is due to the way clothes are put on or the excess of alcohol, on my side I find that this is a pretext. —Kigogo nurse

Whatever the cause of the violence, all respondents believed that SV cases should be treated as an emergency and provided the same level of care as any other emergency case.

Provider capacity: Training

The majority of respondents did not feel they had received sufficient training, either in terms of numbers trained or the content of the training. The only exceptions were Muyange and Bungwe health centers, both CRS sites. Providers in five facilities reported that they had received training in the last 12 months. Gisenyi hospital is the only site which reported not to have received any training in SV.

Table 8 summarizes the numbers and cadres of health worker reported to have been trained and the approximate date of the training.

Table 8 Health Workers Reported to have been Trained, Rwanda

Facility	Nurses	Social workers	Doctors	Laboratory technicians	Details
Kanombe	4		1		2 days, Oct 09
Muhima	1	1	1		
Byumba		1	2	1	4 days, May 09
Kigogo	2				3–5days, 08/09
Bungwe	15	4		2	3 days
Kibogora	2		1		3 days, June 09
Muyange	2	1			3 days, 07 & 09

Provider capacity: knowledge of injuries and risks

Service providers in all facilities were able to describe some of the major injuries and risks associated with SV. The three CRS sites, Kibogora, Muyange and Bungwe, together with the ICAP site, Gisenyi, had the best responses. The latter is surprising considering their claim to not have received any training.

Providers in most facilities mentioned the most serious injuries and risks including HIV and STI infections, the risk of pregnancy and the psychological trauma, the loss of self esteem, loss of value and living in permanent fear. Very few providers described physical injuries. Some respondents felt that all injuries qualified as serious, but those that listed the least serious/important injuries mentioned torn clothing, scratches and bruises.

The greatest wound is the emotional one. —Kanombe nurse

We should not minimize anything because all the consequences are all the very serious. —Kibogora doctor

Provider capacity: knowledge of the most critical components of care

The descriptions given of the care provided to survivors of SV were varied but tended to be brief, with the best knowledge being in Kibogora, Muyange and Bungwe and Gisenyi. The poorest response was given by nurses at Kanombe Military Hospital.

Most respondents identified a clear division in the elements of care provided by the nurses and the doctors. Only the doctors are eligible to perform the examinations, collect forensic evidence and

specimens for tests, prescribe medicines and complete the police forms. The nurses receive the clients and provide counseling to prepare them for the examination. Thus, often nurses were not fully aware of all elements of care. Only providers in three facilities, Byumba, Bungwe and Kigogo, mentioned the need for prophylaxis for HIV.

Providers from health centers also identified that clients should be referred to the nearest hospital for many services.

It is clear from the responses that great emphasis is placed on the legal aspects of collecting forensic evidence and completion of police forms. As described by one doctor, the health care provider's responsibility primarily involves the collection and reporting of evidence to the police.

We have a police office [in the hospital] and in our case we perform the diagnosis and when we get them we write a report and we send it to the police. When this has been done with, things look as if we have finished with the patient. That is how we end. —Muhima doctor

Some providers expressed concern that the current emphasis on legal services and retribution undermined the survivor's access to health care.

As far as [the survivors] are concerned, they would like the wrongdoer to be punished straightaway for them to go back home or be fined as they do not care about the future consequences on the one who has been raped. —Bungwe nurse

Challenges faced in providing SV care

All of the facilities described many challenges that they face in providing care for SV survivors. The most frequently mentioned challenge was that of the attitude of the survivor and/or the family, followed by the trauma of the survivor and/or family (Table 9).

Table 9 Challenges Faced in Providing Care, Rwanda

Challenge	No. of respondents mentioning issue	Facilities where issue mentioned
Attitude of survivor or family	12	By, Bu, Kig, Gi, Kib,Muy
Trauma of survivor and family	9	Ka, By, Bu, Kig, Gi, Kib
Lack of follow up	8	Ka, Mu, By
Delayed reporting	8	Ka, Muy, By, Gi, Kib
Lack of trained personnel	7	Ka, Mu, Muy, Kig, Kib
Bureaucracy	5	Ka, By, Kib
Poverty	4	Ka, Mu, Muy
Lack of equipment, supplies & medicines	4	Bu, Gi, Mu
Lack of community awareness	3	Muy
Lack of access to perpetrator	3	By, Gi, Kib

Ka = Kanombe Military, Gis = Gisenyi, By = Byumba, Bu = Bungwe HC, Mu = Muhima, Muy = Muyange HC, Ki = Kibogora, Kig = Kigogo HC

The attitude of the survivor or the family reflects the social stigma associated with reporting SV crimes. Providers noted that survivors, especially those who may be already sexually active, are reluctant to identify sexual assault as the cause of their injuries.

There are the ones who refuse to tell their news; so, the one who has been assaulted is reluctant to tell what happened because she is accustomed to the fact, such as when she does this with one who gives her valuables. —Byumba nurse

The case of a child accustomed to this so that the doctor consulted and said: "The vagina has been visited and not violated" —Byumba nurse

Providers observed that SV among children was particularly difficult to identify, with parents and children often providing conflicting stories. Parents' interest in receiving compensation for the violation of their child was often cited as a reason for this discrepancy.

Some say that there was not any violence while her parents say that there was some. So, the very victims sometimes declare that there was not any violence; in this way statistics are scrambled. —Kibogora doctor

The trauma of the survivor and family makes it very difficult for health workers to provide complete care, including obtaining a full history and conducting an examination.

When rape has occurred, the family of the victim would come with such commotion that the counseling aimed at helping them becomes a problem. They come in an overpowering mood wanting the problem to be settled straightaway. —Bungwe nurse

To be crying a lot, so that she cannot speak. There is a case of a child who was 9 years old and refused to enter the consultation room and was all in tears. —Byumba Nurse

Lack of follow-up of survivors was described as the norm. Despite health workers explaining that the survivors need to take another HIV test after 3 months, they very rarely return. There is no mechanism to trace survivors and no follow-up counseling facilities in the community to refer survivors to.

We are not able to assure them because there is no follow-up; when they get out of here, everything is like we are finished with them, and they do not come any more. —Kanombe nurse

We do not see them coming for a medical test after 3 months. Normally another test ought to be performed after 3 months. —Byumba doctor

Another major issue is that many providers felt that survivors reported to a health facility too late for comprehensive prevention services to be provided. Ideally, survivors should seek medical help within 72 hours of the incident for forensic evidence, PEP and emergency contraception to be efficacious. However, many survivors report much later, either due to the survivor's or family's reluctance to report the case, wanting to settle the issue at home or due to delays caused by reporting first to the police. It is national policy for the police to be the first point of contact. Often the SV is only reported when the survivor becomes pregnant or has contracted an STI.

[They] come to health facilities very late as they begin the proceedings in their families. —Muyange nurse

Another thing is, for example, children who fear to reveal this and tell this very late because they would have afraid her saying that they will kill her if she tells this, and then this would be known if she begins to get pus on her sex or when they can see that she is wobbling and would bring her to the health facility after evidences have been erased. —Kanombe doctor

We wish them to pass by the health center first instead of being late thinking that they should begin by seeing the police or any other place. —Kanombe nurse

Referrals to other support services

Although respondents were asked about their knowledge of procedures for screening survivors for their 'other needs', most respondents were not even aware of 'other needs'. None of the facilities have formal screening procedures or protocols for referrals and very few have any knowledge of support services available in the communities or are aware that there are no such services. Providers at only four facilities, Kanombe, Muhima, Byumba and Kibogora, mentioned the need for ongoing counseling and follow up, although they recognized that care was not widely accessible.

We do not see the victim after [examination] in order to get her oriented to psychological services [because] we do not have them. —Muhima doctor

Respondents most frequently mentioned onward referrals in the context of other health facilities and the police.

Provider knowledge of potential barriers to accessing SV services

The respondents varied in their awareness of barriers to survivors accessing health care, ranging from the doctors at Kibogora who all felt there are no barriers at all, to the nurses of Kanombe, Byumba, Muhima and Muyange, who noted multiple and significant barriers. Table 10 highlights the most frequently identified barriers to reporting.

Table 10 Barriers to Accessing SV Services, Rwanda

Barriers	No. of respondents*	Facilities where issue mentioned
Family cover up due to stigma & shame	16	All except Kib
Police corruption	5	Ka, By, Muy
Preference for community-level settlement	2	Muy

Ka = Kanombe Military,By = Byumba, Mu = Muhima, Muy = Muyange HC, Ki = Kibogora
* number of respondents who mentioned each issue

The most frequently mentioned barrier was families attempting to hide the incident for fear of bringing shame on the family.

Another thing is the parents who do not want the events to be known, for example, if the events took place in families or were perpetrated by grandfather, cousin or uncle and the parents would not want that awkwardness to be known. —Byumba nurse

Police corruption was mentioned by five respondents, who felt that survivors will be put off from reporting an incident, particularly if the perpetrator was a wealthy or well-known person, since they would pay off the police for the case to be dropped.

If the man who has abused the child is a rich person while the child is a poor one, the man can go and see the authorities in order to silence them and the child would get nothing in compensation. —Muyange nurses

In Muyange, providers also mentioned that families prefer a community-level settlement in order to extract compensation from the perpetrator due to their poor economic status.

As an example, a girl student would get pregnant from someone who has a job and this happened to get known that man would take the girl apart and give some money to her or to her family and they would cover up the fact. —Muyange nurse

Linkages to the community: health facility outreach

Respondents consistently observed that their facilities did not conduct any community outreach activities to raise awareness on SV services. Nurses at Bungwe HC and Byumba hospital mentioned that community-based Health Advisors are present in every cell and have some responsibility for performing this outreach.

It is health advisors who help those people within the community; they are the ones who accompany those people who are found to be better than the other usual ones. —Byumba nurse

These nurses also indicated that they conducted some awareness sessions on SV in their routine health talks within the facility. Respondents at Kibogora hospital, Kigogo and Bungwe health centers mentioned that some HIV prevention outreaches touch on SV issues but do not deal with it in depth.

Here at the health facility we teach them to get to know how their children have spent the day. —Byumba nurse

Linkages to the community: partnerships with other groups

Very few of the respondents in any of the facilities were able to identify any partnerships between the health facility and community or stakeholder groups who aim to overcome the barriers to accessing health services. Only one NGO, ICAP, was mentioned as providing SV services by nurses at Muhima. Providers at Kanombe Hospital, Muhima, Byumba, Gisenyi and Muyange health centers mentioned other government institutions, primarily in the justice sector, including the police, the Ministry of Defense, the Ministry of Health, health advisors and community police.

We know the police only and nowhere else. I could see the list of many people in charge of fighting aggression but those who invest themselves in this action are few. —Kanombe doctor

Assessing client satisfaction

In most facilities, providers noted that there are no formal procedures for seeking client feedback on the services they have received. Some describe that it is obvious that a client is not satisfied as they get angry and upset, for instance those kept waiting for long periods.

The way we receive them does not please them because when they come they find only one nurse the other being busy with other emergencies such as surgical emergency so that they would not be received immediately. —Gisenyi nurse

However, Kibogora, Byumbe and Muyange have 'suggestion boxes' throughout the facility. The providers state these are regularly checked, comments reviewed and changes made to services when appropriate. They have not yet seen a comment regarding SV services.

There is a suggestion box everywhere, and in analyses that we make…there aren't any tokens about rape. —Byumba nurse

Suggestions for improving SV services

All of the providers in the FGDs were keen to offer suggestions on how their SV services could be improved. Table 11 outlines the most common responses to this question; suggestions highlighted in red correspond with key interventions that will be undertaken as part of the Initiative. This confirms that these interventions are in line with the needs identified by the providers.

Table 11 Provider suggestions for improving SV services, Rwanda

Suggestion	No of respondents mentioned each issue	Facilities where issue mentioned
Conduct community awareness campaigns	20	All
Provide training & job aides	20	All
Testing of the perpetrator	11	Ka, Gi, BY, Bu,
Follow up survivors	11	Ka, Mu, By, Gi, Muy
Improved collaboration & networking with police & others	9	Ka, Gi, By, Kib, Mu
Improve availability of psychological support in facilities	6	Ka, Mu, By
Provide free services & medicines for survivors	6	By, Gi, Muy, Mu
Provide suitable equipment (especially for children)	6	Ka, Mu, Bu, Muy
Ease the paperwork	5	Ka, Mu, By
Provide more personnel	5	Ka, Bu, Gi, Kib
Decentralization of services to nurses & HCs	4	By, Kig, Mu
Improve HMIS and QA	4	Mu, By, Gi

Ka = Kanombe Military, Gis = Gisenyi, By = Byumba, Bu = Bungwe HC, Mu = Muhima, Muy = Muyange HC, Ki = Kibogora, Kig = Kigogo HC

The most frequently mentioned strategy was to conduct community awareness of SV, the procedures to follow and where to find services. As noted, above this is a key element of the Initiative's interventions, and it is expected that community outreach activities facilitated by the partners will increase service utilization.

[We would like] to go to the community for sensitization pertaining to harassment - To help the family as well as the environmental society to receive the victim. —Bungwe nurse

Together, politicians, citizens and other levels, we should work in unison to fight those events and sensitize the population about issuing such harmful acts. —Kibogora nurse

Another frequently given suggestion was to provide training of many more health workers along with health advisors and social workers. As observed above, only a limited number of providers reported having been trained to provide SV services. This is also a key element of the Initiative's planned interventions.

Respondents felt that nurses should be trained and allowed to conduct all procedures relating to SV to enable decentralization and remove the necessity to have a doctor attend to the survivors. This is especially true for health centers, which must currently refer survivors to hospitals which may be far away.

T*he doctors who are in the country are few. They [should] get trained in SGBV and train the nurses because these ones are many. So that when the one who has been raped comes, the nurse would receive her in case the doctor is busy with emergency cases because then she has all the skills. —Gisenyi nurse*

Many respondents requested good job aides to assist those who have attended trainings to then teach their colleagues. Suggestions included "a *manual pertaining to SGBV which would help even those who did not attend the training." —Kibogora nurse*

To assist in the care of the survivor, many respondents also felt it was important to test the perpetrator for HIV and other STIs. This testing was recommended to ensure the proper provision of prophylactic services for the survivors, including PEP, to assist in correct identification of the perpetrator, and if the survivor tests positive, to provide the suspect with PEP.

The presumed rapist must be examined because this can also help him, especially if the so-called victim has got illness from somewhere else, like AIDS or gonorrhea and so on. —Kanombe doctor

Because follow-up of survivors is completely lacking in all facilities, many providers recognized the need to improve this element of care through community-based interventions.

Motivation is needed in a manner that those victims could return for feedback and follow-up. —Byumba doctor

Providers suggested the introduction of mobile field teams, which include counselors and social workers. These teams would work with communities to identify survivors and either offer services there or accompany them back to the facility. Two respondents suggested collaborating with other units of the Ministry of Health and partners to provide on-going support at home.

That there should be one mobile team that would work together with two persons at the health center or at the hospital, and even below where the problems happen, in order that there should be some follow-up and assistance, and feedback the doctor's reports. —Gisenyi nurse

This suggestion was associated with that of improved psychological support**,** in which providers specifically mentioned improving the availability and quality of counseling services within the facilities. This would enable survivors to be properly counseled before and after examination and testing and before leaving the facility to improve the chances of returning for follow-up.

Counseling is something they do not care for although this is useful and there are people who can help. We desire this domain to be cared for in all the hospitals in the country. —Kanombe nurse

Other respondents mentioned improving collaboration and networking between the health facilities and police to provide SV care. Two respondents specifically suggested having a police person stationed permanently in the health facility to enable survivors in minimizing points of contact and reducing

delays in receiving medical attention. Conversely, one respondent suggested a nurse should be stationed at the police station.

If possible, there should be nurses at the police station, who would make the diagnosis; or else funds ought to be put at the disposal of hospitals so that if a case should happen with the rapist being retained at the Sector, it would be possible to go there and get him tested for HIV and other sexual diseases and come back straightaway. —Kanombe nurse

The improvements in paperwork suggested by providers were mostly related to having the police forms available in the health facilities, allowing nurses to complete them and improving their quality.

The other improvements providers suggested included providing SV services 24 hours a day, being better organized with space, not referring survivors to many departments and out to the police or other organizations such as CHUK (Muhima), caring for the survivor rather than being focused on the legal aspects and collecting forensic evidence and having a store of clothes to give to survivors in need.

Differences between categories of facilities and cadres of staff

There was little difference in the responses given by providers in hospitals and health centers and between urban and rural facilities. Only providers in rural facilities mentioned the challenges of lack of community awareness, lack of designated space, distances to the facility, difficulty of obtaining forensic evidence and families covering up the incident in the hope of compensation or preventing the survivor feeling shame.

The nurses in the one military hospital, Kanombe, demonstrated much lower levels of knowledge SV care than nurses in any of the other facilities.

A few differences were seen in the responses of doctors and nurses. The nurses seemed slightly more aware of the barriers survivors may face in seeking assistance and also requested more equipment, particularly for use with children. Nurses in health centers mentioned the need for designated space for SV survivors. It was mostly doctors who described screening survivors for other needs, needing to test the perpetrator and needing to improve the documentation in the SV services.

RECOMMENDATIONS: RWANDA

Overall, SV services in Rwanda are relatively weak and tend to emphasize prosecution over health care. Under the Initiative, implementing partners are encouraged to undertake the following activities to strengthen SV services and service utilization in the participating facilities.

1. Strengthening health services

    - *Ensure that SV services are offered at all times when the facility is open, and that communities know where to seek services when facilities are closed.* Only one of the 8 participating facilities provided SV services on a 24-hour basis, although providers observed that survivors tended to report after hours and on weekends. Hospitals that operate on a 24-hour basis should make an effort to ensure that trained staff are available at all times to respond to SV cases.

    - *Ensure that SV exam rooms offer visual and auditory privacy.* While 100 percent of the facilities surveyed indicated that there was a space dedicated for SV examinations, not all took precautions to guarantee that survivor exams were not overheard. This could potentially contribute to the survivors' reluctance to disclose SV, as reported by providers, and undermines confidentiality within health facilities.

- *Provide HIV testing, prophylaxis and emergency contraception in the location where exams are preformed*. Providers noted that a barrier to care was ensuring proper referrals within and outside of the health facility. However, the Facility Inventory suggests that as policy, health facilities do not provide HIV services in the SV exam area, nor do they offer the even the most basic drugs such as analgesics. Of special concern is the fact that time-sensitive treatments, such as PEP and emergency contraception, require referral.

- *Introduce a dedicated emergency contraceptive pill*. Dedicated EC pills are not offered in any of the surveyed facilities, although they are more effective in preventing pregnancy, have fewer side effects and are easier for a variety of providers to dispense. The Ministry of Health is encouraged to make dedicated emergency contraceptive pills, such as *Postinor-2* or *Pregnon*, available for SV survivors.

- *Ensure that basic equipment and supplies are available in examination rooms*. While a dedicated space may be available to provide the services, the quality of exams are severely limited by a lack of basic medical equipment such as specula, lamps and swabs. Despite the emphasis placed on the forensic elements of the examination, facilities were routinely missing the basic tools needed to collect necessary samples.

- *Train both nurses and doctors to provide comprehensive SV services*. All cadres of providers noted the need for more and better training on GBV, and demonstrated limited knowledge of the core elements of care beyond forensic evidence collection. This training, they recommended, should be afforded both to nurses (who are more plentiful) and doctors (who are legally permitted to report the cases).

- *Develop facility-level protocols for managing and referring SV survivors*. In early 2010, the Rwandan Ministry of Health adopted national guidelines on SV services. To ensure that these guidelines are properly implemented, facilities should explicitly (and in writing) identify the internal procedures required to comply with national guidance. They also need to include facility-specific referral information, including the names and telephone numbers of contact people at referral sites. These guidelines should be readily accessible to all providers who provide SV services, and should be visible in the room where exams are conducted.

- *Ensure all facilities maintain adequate records on SV survivors*. Maintaining adequate records on SV survivors is critical for ensuring that survivors receive appropriate care and follow-up services, and for documenting changes in demand and service utilization. While most facilities kept records of SV clients, three did not: Kanombe Military Hospital, Kigogo health center, and Bungwe health center. Collection of such data is necessary for gauging the Initiative's impact in the short term and ensuring on-going quality services.

2. Strengthening referrals from the health facility to other support services

    - As a first step in strengthening referrals, *make providers aware of the other services that a survivor may require following medical examination*. The majority of providers who participated in the FGDs did not indicate that survivors required on-going health, legal or psychosocial services following the initial medical exam. Of those who recognized that survivors needed other services, few were able to identify how to access them. Efforts at health facilities, therefore, need to focus on educating providers on the types of follow-on care that might be required and where to refer survivors in need. These issues should be covered in the training courses discussed above, but can also be discussed at regular in-house information-sharing sessions.

- As a second step, *each facility should conduct a mapping of the specific post-SV care services in their community*. To ensure that survivors are referred appropriately, they need to be aware of where other services are available in their community and how a survivor can access them. This can be most effectively done through a community mapping exercise carried out by staff from the health facility or by the community-based health advisors.

- Finally, each facility must develop and educate providers on systems and procedures for referring survivors to the other services available in their community. This may include providing transportation for the survivor, alerting staff at referral points, or simply informing a survivor of how to access these services if they choose. These procedures must be codified in the facility-level protocols and available to all SV service providers.

3. Strengthening linkages with the community

    - Intensify community awareness-raising activities conducted by health advisors and during routine health talks in the facilities. Providers consistently noted that community members were not aware of the health implications associated with GBV, the services facilities provided, and the need to seek health care as soon as possible. They identified the community-based health advisors as one key partner in raising awareness, but did not feel that they were adequately informed about SV. Once trained, health care providers can educate the health advisors on SV, providing them with the knowledge needed to communicate key messages on SV. At the facility, providers can raise awareness by fully integrating SV issues into their regular health talks.

UGANDA

As with the data from Rwanda, results from the facility inventories are reviewed first followed by the results of the FGDs. Cross-country comparisons are presented in the final section of this report.

Due to restrictions on access to military sites, data for the two UPDF sites were collected by uniformed soldiers from the military's research department. These data collectors were trained by the study's in-country supervisor and completed all facility inventories and FGDs alone. Only data from Gulu Military hospital has been provided and the study team is unable to verify its quality.

FACILITY INVENTORIES

The Facility Inventory was completed for 9 of the 10 intervention sites in Uganda. Data was not provided by the UPDF for Bombo Military hospital.

All sites rated relatively poorly on the evaluation questions, and only three sites scored higher than 50 percent on a composite index of service preparedness indicators given in Table 12. The best prepared facility was Lira hospital, closely followed by Gulu Military hospital and Mulago Hospital (the national referral hospital). The least prepared were the sites in northern Uganda, including Anaka hospital, Kitgum hospital and Pajule Health Center. Table 12 provides an overview each facility's performance on key indicators measured by the Facility Inventory, with positive (or "yes") responses highlighted in red.

Has adequate infrastructure at the intervention sites been established?

Only three sites provide 24-hour SV services; Gulu Military Hospital, Anyeke Health Center and Mulago Hospital. None of the facilities have a room or space dedicated specifically to providing SV services.

Over half of the facilities reported having a doctor present at all times. These included three of the four hospitals (Lira, Gulu Military, and Mulago), two of which offer 24-hour services. One health center, Anyeke located in Northern Uganda, also had a doctor consistently available.

Specialized services were less common, with only three facilities offering obstetric care and only one facility with access to a pediatrician. All facilities apart from one indicated that counselors were available for SV survivors. None had special aids for examining children.

Table 12 Summary of Facility Inventory Indicators, Uganda

Facility	Partner	Infrastructure						Guidelines		HIV & supplies			Records			
		Facility open 24-hours for SV services	Dedicated room for SV	Doctor present at all times	Obs/gyn provides service	Pediatrician provides service	Counselors provide service	Guidelines for clinical management in SV ward	Guidelines for referrals in SV ward	HIV rapid test kits in SV ward	PEP drugs in SV ward	Have 15 of 20 essential pieces of equipment	Records show SV clients	No. of SV clients last month	No of completed SV forms	Composite index score (%) (12 indicators)
Kitgum Hospital	NUMAT	N	N	N	N	N	Y	N	N	N	N	N	N	—	0	8
Lira Hospital	NUMAT	N	N	Y	Y	Y	Y	N	N	Y	Y	Y	Y	18	1	66
Anaka Hospital	NUMAT	N	N	N	N	N	Y	Y	N	N	N	N	N	—	0	16
Gulu Hospital	NUMAT	N	N	Y	Y	N	Y	Y	N	Y	Y	N	N	—	0	50
Pajule Health Center	NUMAT	N	N	N	N	N	Y	N	N	N	N	N	N	—	0	8
Anyeke Health Center	NUMAT	Y	N	Y	N	N	Y	N	N	N	N	N	Y	53	0	33
Ammolatar Health Center	NUMAT	N	N	N	N	N	Y	N	N	Y	Y	N	Y	—	0	33
Gulu Military Hospital	UPDF	Y	N	Y	N	N	Y	N	Y	N	Y	N	Y	2	1	58
Mulago Hospital	MJAP	Y	N	Y	Y	N	N	Y	N	Y	Y	N	Y	15	1	58
Percent "yes" (n = 9 facilities)		33	0	57	33	11	89	33	11	44	56	11	56	—	3	

Do standardized care and referral guidelines exist at the intervention sites?

Despite the fact that the Ugandan Ministry of Health has developed procedures for managing sexual assault, outlined in a 2007 national training manual, few facilities had these or other guidelines on site.[4] Of the three that did, all were hospitals. Gulu hospital did not report having any guidelines for care, but they did indicate the presence of guidelines for referring survivors to other service providers.

Are the necessary HIV drugs and supplies available at the intervention sites?

Approximately half of the sites had HIV test kits and PEP drugs in the location where SV services were provided. Of these, all but one had both HIV test kits and PEP drugs available in the SV examination areas; Gulu Military hospital reported having only PEP drugs in the examination area.

Are other essential equipment and supplies available at the intervention sites?

The Facility Inventory form includes 20 types of equipment and supplies that are essential for providing quality SV services (see section 4 in Appendix 1). The minimum standard is to ensure that each facility has at least 15 of these 20 available at the location where SV services are delivered. Only one facility, Lira hospital, met this standard.

Table 13 provides an overview of some specific equipment and supplies assessed in the Facility Inventory, with positive responses ("Y") highlighted in red. It demonstrates that although few facilities had everything they needed to provide quality SV services, many did have some key supplies.

Most interestingly, despite the drug's contentious history in the country, EC pills are among the most widely available supplies, and are found in the exam ward more often than PEP drugs. Five sites indicated that they relied on the *Yuzpe* method of emergency contraception, using oral contraceptives such as *Microgynon*. Another four sites in the north (Kitgum, Lira, Ammolator, Anyeke, Gulu hospital) reported access to the dedicated EC pill, *Postinor.*

Do adequate record-keeping procedures exist at the intervention sties?

Five sites maintained records on the number of SV clients they receive. Of those that did, the number of reported cases ranged from two at Gulu Military Hospital to 53 at Anyeke health center.

Three facilities reported having begun data collection using the SV form prepared for the Initiative. It is noteworthy that the number of forms does not correspond with the number of cases in the facility's records as observed by data collectors, indicating potential difficulties with ensuring the quality and quantity of data collected using the SV form.

[4] *Management of Sexual and Gender-based Violence Survivors*. Republic of Uganda Ministry of Health, April 2007.

Table 13 Selected Supplies and Equipment Available in Wards Where SV Examinations Occur, Uganda

Facility	Exam gloves	EC pills	Exam couch	Speculum	Swabs	Blood tubes	Analgesia	Anti-emetics	STI prophylaxis/ treatment	Working angle lamp	Lockable supply/ evidence cupboard
Kitgum Hospital	Y	Y	Y	Y	Y	N	N	N	N	N	N
Lira Hospital	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Anaka Hospital	Y	N	Y	N	N	N	N	N	N	N	N
Gulu Hospital	Y	Y	N	Y	Y	Y	Y	Y	Y	N	Y
Pajule Health Center	Y	Y	Y	Y	Y	N	Y	N	N	N	N
Anyeke Health Center	Y	Y	N	N	Y	Y	N	N	N	N	N
Ammolator Health Center	N	Y	Y	Y	Y	Y	Y	Y	N	N	N
Gulu Military Hospital	Y	Y	Y	Y	Y	Y	Y	N	N	N	N
Mulago Hospital	Y	Y	Y	Y	N	Y	Y	Y	Y	Y	N
% yes (n = 9 facilities)	89	89	78	78	78	67	67	44	33	22	22

FOCUS GROUP DISCUSSIONS WITH SERVICE PROVIDERS

A total of seven FGDs were held in six of the 10 intervention sites, all hospitals. FGDs were not conducted in the three health centers, located in rural areas, because of logistical and human resource constraints. Data was not provided by the UPDF for Bombo Military hospital, and the FGDs in Gulu Military hospital were conducted by uniformed personnel (Table 14).

Table 14 Summary of FGDs Held in Uganda

	Facility	Location	Partner	Cadre	No. of participants
1	Kitgum Hospital	Rural	NUMAT	Doctors	9
2	Lira Hospital	Semi-urban	NUMAT	Doctors	8
3	Lira Hospital	Semi-urban	NUMAT	Nurses	10
4	Anaka Hospital	Rural	NUMAT	Nurses	7
5	Gulu Hospital	Semi-urban	NUMAT	Nurses	10
6	Gulu Military Hospital	Semi-urban	UPDF	Nurses	10
7	Mulago Hospital	Urban	MJAP	Nurses	8

The qualitative data from the FGDs were analyzed and coded using a three-point Likert scale (Appendix 5). Table 15 summarizes the results of the scales with a value of 0 being given for a negative response, 1 for a mixed response and 2 for positive responses; negative responses (less than 1.0) are highlighted in red.

Overall, Table 15 indicates that providers have relatively high levels of awareness of SV and the basic elements of it management; nonetheless, they strongly indicated the need for further training. Providers tended to have less knowledge of the types of SV services provided outside the facility, and most facilities lacked referral procedures or feedback mechanisms.

The following section highlights specific provider responses, and is structured by the analysis themes outlined in Appendix 4.

Provider knowledge of SV cases in the community

All of the respondents were very knowledgeable of SV and in all but Gulu hospital, felt that it is increasingly common. Doctors at Kitgum hospital reported 4 to5 survivors per day, nurses at Mulago reported seeing 2 to 3 survivors a day (although the records reviewed in the Facility Inventory indicate one SV client every 2 days) while respondents at Lira and Anaka reported seeing 1 to 2 a week. They described survivors as ranging in age from a few months old to young adults, including boys but rarely older women.

We can't give you the percentage because there is no full analyzed research on SGBV, but through observation we think it's on a rise. —Mulago nurse

The respondents mentioned numerous factors contributing to a perceived increase in cases including: development and the "adoption of western culture" which has brought with it access to movies, internet, pornography, discos, alcohol and drugs. The availability of alcohol in small sachets in every village makes it easy for children to afford and has become a significant problem in schools. Others blame the lack of parental supervision as parents work long hours away from home and children walk long distances to school alone.

Table 15 Summary of Likert-Scale results for the FGDs, UGANDA

Facility	Partner	Cadre	Awareness		Attitude			Capacity					Other Needs			Linkages			
			SV knowledge	SV prevalence felt to be increasing	Consider SV a medical emergency	Believe survivor behavior causes SV	Believe entitled to same care	Nos. trained felt to be sufficient	Training content felt to be sufficient	Trained in last 12 months	Knowledge of Injuries & risks	knowledge of care	Awareness of other needs	Referrals & protocols	Knowledge of support in community	Knowledge of barriers to SV services	Community outreach	Knowledge of partners	Client feedback sought
Kitgum Hospital	NUMAT	Doctors	2	2	2	0	2	1	0	0	2	2	0	0	1	2	0	1	0
Lira Hospital	NUMAT	Doctors	2	2	2	0	2	0	0	0	2	2	0	0	1	2	1	1	0
Anaka Hospital	NUMAT	Nurses	2	2	2	0	2	0	0	0	2	2	0	1	2	2	0	1	0
Gulu Hospital	NUMAT	Nurses	2	0	2	0	2	0	0	0	2	2	0	0	1	2	0	0	0
Lira Hospital	NUMAT	Nurses	2	2	2	0	2	0	0	0	2	1	1	1	1	2	0	0	0
Gulu Military Hospital	NUMAT	Nurses	2	2	2	0	2	0	0	0	2	2	2	0	1	2	0	1	0
Mulago Hospital	MJAP	Nurses	2	2	2	0	2	1	1	2	2	2	1	1	2	1	1	2	0
Number of responses = 1 or 2			7	6	7	0	7	2	1	1	7	7	3	3	7	7	2	5	0
Average responses (m 0, max 2)			2	1.71	2	0	2	0.29	0.14	0.29	2	1.86	0.57	0.43	1.29	1.86	0.29	0.86	0

0 = negative, 1 = neutral, 2 = positive

Actually sexual violence is on the rise because sometimes people watch movies which can encourage them to do violent sex, people taking drugs, people drinking a lot and then peer pressure can make sexual violence go on increase. —Gulu nurse

Children, even elderly people, when you go, like, to internet café you find when they are surfing pornographic pictures and those are also motivating factors. —Kitgum doctor

Issues related to the conflict were also frequently cited by providers in Northern Uganda. In Gulu, respondents blame the war for habituating children to violence which they are continuing to carry out in villages. In Lira, respondents report a high incidence of SV cases within the IDP camps and in the towns by street children.

The northern zone was insecure—people were in the camps and they didn't have enough place to sleep—accommodation was a problem and if you run any how to live your life, you can chance to meet any body of any type of manner and can rape you. —Lira nurse

Provider attitudes toward SV survivors

While all respondents considered SV cases to be an emergency, they also believed that a survivor's behavior can be responsible for the attack. The respondents described many instances when the survivor could be perceived as inciting SV. These included situations where women were dressed in short skirts and low tops, drinking and accepting alcoholic drinks from men, taking drugs such as cocaine and marijuana, walking and talking provocatively, attending discos late into the night and visiting a man.

Yes some of them, it is especially those young girls like 14, 15 and 16 years, they also expose themselves to situations that encourage somebody to rape them like when we have dancing and the way they behave sometimes their behaviors itself the way they walk. —Kitgum doctor

As the sister had said, you find a young girl moving at night at 2am alone in the night that is one. And two, even how some people are dressed these days. —Mulago nurse

Despite these perceptions, all respondents believe that the survivor, even if she is perceived as having been responsible for the attack, should be treated the same as any other emergency case.

Provider capacity: Training

Providers uniformly noted that the number of staff trained and the content of trainings was not adequate to meet the increasing demand for services. Only a few of the doctors in Kitgum felt sufficient numbers of the staff had been trained in SV, but they did not feel that the training adequately prepared providers to deliver the services. Only at Mulago Hospital did the nurses indicate that they were satisfied with the numbers trained and the content of the trainings. Overall, respondents particularly felt the trainings needed more emphasis and time for counseling.

Table 16 Health Workers Reported to have been Trained, Uganda

Facility	Nurses	Social workers	Doctors	Midwives	Administration	Details
Kitgum Hospital	x		x			2008, 3 days
Lira Hospital	10		x			2007/08, 3 days
Anaka Hospital	10			x		2006/07, 3 days
Gulu Hospital						
Gulu Military Hospital					5	2006
Mulago Hospital			1 or 2	4		2008, 3 days

In Gulu Military Hospital, staff turnover was cited as a barrier to retaining trained providers. Nurses noted that of the five heads of department, administrators and women barracks leaders that were trained on SV, three of whom have since left. Table 16 summarizes the number and cadre of health workers reported to have been trained.

Provider capacity: knowledge of injuries and risks

Despite limited training on SV, all respondents were knowledgeable of the injuries and risks associated with SV, including both physical and psychological trauma. Many felt all risks were equally serious and could not be rated above any others. As one nurse from Mulago hospital noted, "*they are all serious. There is no condition which is not serious."*

When providers did identify individual risks, contracting HIV was consistently identified. According to a doctor from Kitgum hospital, "*the most serious medical risk is for them to acquire HIV/AIDS."* One nurse in Gulu, also mentioned fistula "…*There is that injury where the whole perineum is torn up to the anus that one is possible and difficult to repair.*"

Provider capacity: Knowledge of the most critical components of care

Respondents from all facilities gave good, detailed descriptions of the procedures for managing sexual assault cases, including provision of HIV PEP and emergency contraception. The only exception was the nurses at Lira, who gave only a brief description, noting that most examinations are conducted by doctors who are present in the hospital at all times.

In all facilities, nurses were described as receiving the survivor, conducting immediate counseling and taking the history. The doctor then conducts the examination, takes specimens for investigation and forensic evidence, and completes the police forms. Providers consistently recognized the psychological impact of SV, and indicated the need for counseling prior to examination and treatment.

Even before doing the examination you do some counseling to make her comfortable that what you are going

to do to her is not harmful since she has been raped or defiled she might even think that you are going to do the same. —Lira doctor

Challenges faced in providing SV care

As highlighted in the facility inventory, none of the facilities had a dedicated space where SV services are provided, and only Mulago hospital has centralized care in a single ward (maternity). As a result, clients are referred multiple times throughout the hospital to receive all necessary services. For instance, a survivor may first report to emergency but is then referred to maternity followed by the laboratory for tests and to the ART unit for prophylaxis. This was especially pronounced in Gulu hospital, where nurses described as many as five points of contact within the same facility.

After the examination, this client will be either taken blood for HIV test from that unit or sent to ART clinic where she will be counseled and given a drug. —Gulu hospital nurse

Most of them to go to maternity to be seen by gynecologist, from there they go to ART clinic to be counseled or to be given this prophylaxis PEP, then others will come to antenatal here for family planning emergency contraceptives. —Gulu hospital nurse

Interestingly, providers did not see this series of referrals throughout the hospital as a barrier to providing quality care. They did, however, note that the process distorted the facility's ability to report accurately on the number of SV cases they receive.

Table 17 provides an overview of the most common challenges to providing SV services that were identified by providers. The most frequently cited challenge was the lack of properly trained personnel. As in most facilities in Africa, there is an acute shortage of staff so all facilities tend to have long waiting times and very full waiting areas, particularly in the emergency departments. These conditions are extremely daunting for an SV survivor, and limit a provider's ability to dedicate sufficient time to a SV exam. This is frustrated by shortages in higher-level medical personnel and the regulations which require that a doctor conduct the examination and complete required documentation.

…our doctor here, we have only one, and he has other administrative things to work on. Sometimes the technicians with other activities are not there so you find that some of the victims miss out some of these examinations. So in other words, personnel…we don't have enough personnel to do that. —Anaka hospital nurse

Demands on staff time also compromise the facilities' ability to provide follow up care, as described by nurses at Anka hospital "*Follow up we don't, because one we are few and we have to run many activities in the hospital so we don't make the follow up."*

Table 17 Challenges Faced in Providing Care, Uganda

Challenge	No. of respondents	Facilities
Lack of trained personnel	10	All
Lack of community awareness	7	Anaka, Kitgum
Delayed reporting	7	Anaka, Kitgum, Lira, Mulago, Gulu Military
Bureaucracy	4	Anaka, Gulu, Lira
Lack of equipment, supplies & drugs	4	Anaka, Kitgum, Gulu, Lira
Problems with communication	4	Lira
Lack of follow up	3	Gulu, Kitgum
Poor organization of services	3	Gulu, Kitgum, Lira
Disruption of prophylaxis	3	Mulago

The second most common challenge was the lack of community awareness of SV, its medical implications and the health services available.

One challenge is that some people are not aware of these services or in situations where they are aware, people don't know which one has to prioritize or to be done first. —Kitgum doctor

As a result, many survivors do not seek care at all, and when they do, they present too late to receive time-sensitive treatments such as HIV PEP and emergency contraception. Many report first to the police, which further under mines their access to medical care.

Sensitization of the community, that is very important because [I] find that since they are not aware that these services of the medical aspect is more important, they rush to the legal aspect so they leave the nearest center where they can get these services and they rush up to town sometimes like a very long distance so they end up coming very late. So sensitization is very important. —Kitgum doctor

Delayed reporting was another challenge mentioned in giving comprehensive care to SV survivors and was caused by survivors and families trying to settle the issue at home or first reporting to the police or local leaders.

Some of them take a lot of time at home trying to negotiate these issues at home so when they disagree they come to hospital late such that we cannot give them the PEP or these emergency contraceptive pills. —Anka nurse

The parents to these victims they are always compromised by the perpetrators, if the perpetrators are rich people they say lets settle it at home so that the issue does not go to police and they try to play it locally at home and mostly the children who are abused are normally lost in that way, the parents prefer getting the money to settle the issue from home without bringing them for treatment. —Kitgum doctor

The challenges related to policy requirements include the need for a doctor to perform most of the procedures for SV survivors and to complete the required police forms. This is compounded by the fact that there are limited numbers of qualified doctors in the country and they have very heavy workloads.

The major challenge we have been facing is that clients should be first examined by a gynecologist when you don't have a gynecologist around, it becomes a problem. —Gulu nurse

Referrals to other support services

Several providers were very aware that survivors require additional services following medical exams, although it was widely recognized that those services were not commonly accessible. The nurses in Gulu Military hospital had the best level of awareness of non-medical services for survivors, and mentioned the police and legal assistance.

It's important for us health service providers to know where somebody who has been raped should go. We can help them to identify the legal people like lawyers to help them in their cases, then we can also help them to know the procedure involved in case someone has been raped. —Gulu Military hospital nurse

Nurses in Lira, Anka, Gulu and Mulago had a more limited level of awareness, mentioning counseling and follow-up as the main needs. However, the facilities are not able to provide these due to lack of personnel and high workloads.

Psychosocial support should apply for them to become relaxed and adjust to the general needs like any other person. —Anaka hospital nurses

None of the facilities had formal systems for referring survivors for the other services. At least some staff for all facilities were able to name organizations providing support for SV survivors in the community, but they did not have formal arrangements for referrals. These organizations included: ARC, NRC and World Vision (Anaka), TASO and Red Cross (Gulu) and TASO and AIC (Lira).

The nurses at Gulu Military hospital mentioned that the police have their own clinical personnel to handle these cases, and if they do not have a doctor present, they will refer clients to the police for medical and forensic examinations.

Only in Kitgum did the providers mention a psychosocial support service and a youth center in the community to which they refer survivors.

We can also refer to any near psychosocial support group in the area where she comes from so that she can constantly go there and easily forgets what happened. It is always important to link them with those groups —Kitgum doctor

Provider knowledge of barriers to accessing SV services

With the exception of nurses at Mulago hospital, all respondents demonstrated a high level of awareness of the barriers to accessing SV services. The most commonly cited barriers are listed in Table 18.

Table 18 Barriers to Accessing SV Services, Uganda

Barriers	No. of respondents	Facilities
Preference for community level settlement	8	All
Fear of stigma	7	Anaka, Gulu, Kitgum, Lira, Gulu Military
Lack of awareness of services	5	Kitgum, Lira, Mulago, Gulu Military
Poverty & distances	4	Anaka, Gulu Military
Overcrowded facilities	3	Kitgum, Lira, Mulago
Threats by perpetrator	2	Gulu, Kitgum
Bureaucracy & corruption	2	Anaka, Lira
Lack of drugs & equipment	2	Lira, Gulu Military

The most common barrier mentioned was survivors the preference for settling the issue at home. As doctors in Kitgum noted, "*they tend to solve it from the villages so that it doesn't reach the authorities like the police and, by doing so, they keep the issue at home instead of accessing medical care."*

Often traditional leaders or the family encourage survivors to settle SV issues through this route, which it is a popular alternative among poor families because it frequently entails compensation.

The second most common barrier mentioned was the fear of being stigmatized in the community. This was identified in all of the northern facilities but not by providers at the urban Mulago hospital, located in Kigali.

Another issue is stigma related to being raped. People fear being associated with that name that so and so was raped by so and so and keep quiet. Sometimes they don't report to their own parents/guardians because they fear the stigma attached to it. —Kitgum doctor

Providers from all facilities, both urban and rural, identified barriers related to lack of community awareness regarding appropriate procedures to follow and where to find assistance.

In the communities, they are ignorant of services that are provided in the health facilities. They actually don't know that it is very important to access medical services immediately. —Kitgum doctor

The lengthy procedures and need for reporting to different offices which may be far apart before reaching the health facility also was believed to deter survivors from seeking medical care.

Corruption was also recognized as hampering efforts to provide services, as survivors are faced with various demands for payments which many cannot afford.

There is demand of money from those who are carrying out these activities like the police. When they want these forms, I hear those people always request for money and the person who is filling the form also. —Anaka nurse

Respondents reported learning about these barriers either directly from the survivors when they are taking the history or from the community since they live amongst them or during outreaches.

And then we don't just stay here at the health unit, we also move out do some outreaches so from there you get people who come and tell you stories and some of them we just read them from the news papers or even on radios. —Lira doctor

Linkages to the community: health facility outreach

While some providers reported conducting community outreaches, such activities were not common among the facilities surveyed. Respondents from Mulago and Lira hospitals most frequently mentioned these activities. While Mulago has a specific unit for outreach services, the respondents were not clear if SV is included in their activities. The majority of providers indicated that they would like to conduct outreach activities, but did not have the personnel or funding to do so.

Linkages to the community: partnerships with other groups

Providers from all facilities were able to mention a few groups who are working to sensitize communities on SV issues, but none of the providers knew exactly what these groups were doing in regard to SV and were not aware of any formal relationships between them and the health facility. Table 19 presents the SV organizations working in each hospital's catchment area, as reported by the providers.

Table 19 SV Organization Mentioned by Respondents, Uganda

Facility	Partners
Anaka	ARC, Baylor Children's Foundation, HIDO
Gulu	Red Cross Youth Centre (Ruyaga), ARC
Kitgum	CDO, IRC, ICRC, UNDP
Lira	UNICEF, CCF, AIC, TASO, FPA, Police
Gulu Military	NUMAT, CARE, ARC, Save the Children, government
Mulago	Police, Hope After Rape, Raising Voices, ANPCAN, Baylor Children's Foundation, the Infectious Diseases Institute

Assessing client satisfaction

Respondents indicated that none of the facilities had any formal system for obtaining clients' feedback on the services they have received. Only Gulu mentioned discussing any complaints received from a client to improve the services.

We always have meetings so during that time hint on this information when a client came she was mishandled like this, like this and let us not repeat it. —Gulu nurse

Suggestions for improving SV services

Surprisingly few respondents offered suggestions for improving SV services. Table 20 summarizes these suggestions, which came only from providers in Kitgum, Anka and Lira hospitals.

Table 20 Provider Suggestions for Improving SV Services, Uganda

Suggestion	No. of respondents	Facilities
Conduct community awareness campaigns	7	Anaka, Kitgum, Lira
Provide training	2	Anaka, Kitgum
Health services in police station	2	Anaka
Improve records/HMIS	2	Kitgum
Improve networking & collaboration	2	Kitgum

The most common recommendation was to conduct community awareness campaigns to sensitize people on SV issues and procedures; and the availability of services through radio, community meetings, community leaders and in schools.

To me, I think the other need is giving more information to the community. Where they should go to get services and when to come for services; not to be there at home. —Anaka nurses

Two respondents also felt that all health workers within a facility should receive an orientation on what SV services are provided at that site. This would strengthen the SV response overall by ensuring proper and timely referrals.

It is important to sensitize most of the hospital because you may have nurses around and they may not be able to provide the services directly but may know where to refer them. But it is important for them to know the importance of that patient coming at that time and the importance of the patient accessing them immediately because the patient might meet a busy nurse. If she doesn't know the importance of accessing the service immediately she may get angry and go away and we miss the patient. —Kitgum doctor

Other suggestions included training more staff in the health facilities. As one doctor at Kitgum noted, "*I think the major issue here is, if possible, if NUMAT could train most of the health care providers in SGBV, it is really important because we are getting so many clients."*

Two nurses at Anaka Hospital felt a doctor should be in the police stations to provide services immediately a survivor reports there. One noted "*I feel, well, the police should also have a doctor, their own doctor so that when these people are brought maybe late evening when the doctors here are not [on duty] the police doctor will have time to handle."*

The doctors at Kitgum felt record systems needed to be improved. This would allow them to better monitor SV case load, and allow for follow-ups and improve networking and collaboration with other SV stakeholders.

There is no data on these SGBV clients. If you could connect the health facilities to that ministry responsible so that they produce for us some sort of register to put the data of these SGBV clients it would really help us a lot such that when somebody needs data on it, he can access it. — Kitgum doctor

Differences between categories of facilities and cadres of staff

There were very few differences between the facilities. Overall, Mulago hospital was most unusual, due to the fact that it is the national referral hospital and was the only urban facility in the sample. Providers at Mulago demonstrated slightly better training, and greater knowledge of partners. At the

same time, Mulago nurses also seemed less aware of barriers to their services, or perhaps felt there were fewer barriers in their urban environment, and did not offer any suggestions for improving services. The nurses from Gulu Military hospital were no different from nurses in the civilian facilities.

There were also few differences in the responses given between doctors and nurses. Nurses, however, did seem to have a greater awareness of the other needs of SV survivors and the support services available in the community.

RECOMMENDATIONS: UGANDA

While providers tend to possess the basic knowledge necessary to provide SV services, their ability to deliver adequate SV services is undermined by a lack of supplies, equipment and linkages with other organizations and stakeholders. As part of the Initiative, implementing partners are encouraged to undertake the following activities to strengthen SV services and service utilization in the participating facilities.

1. Strengthening health services

    - *Centralize SV services in dedicated service delivery rooms or spaces.* None of the facilities surveyed had a dedicated space for providing SV services, and consequently, providers noted that survivors were referred to multiple service delivery points within the facility. This places an undue burden on the survivor, who is already traumatized, and undermines their ability to receive comprehensive and timely care. Establishing and stocking a dedicated room or space for such exams is not a costly endeavor, but it does require developing procedures for ensuring survivors receive all services in that space and that staff are aware of those procedures.

    - Ensure that SV services are offered at all times when the facility is open, and that survivors know where to seek care when facilities are closed. Only 1/3 of all facilities offered 24-hour services, despite the fact that 2/3 of the sites were hospitals that operate on a 24-hour basis. Sites must ensure that basic SV services are available at all times the facility is open, even if a doctor is not present. Time-sensitive services, such as PEP and EC, should be immediately available to all survivors.

    - *Ensure that a dedicated EC product is available to all health facilities*. While the majority of hospitals and health centers in the north had access to the dedicated product *Postinor-2*, facilities in other parts of the country reported relying solely on the *Yuzpe* method. A dedicated product is more effective, has fewer side effects, and is easier for all cadres of providers to deliver.

    - *Train both doctors and nurses to provide SV services; sensitize all providers within the facility.* Although providers who participated in the FGDs demonstrated relatively high levels of knowledge regarding SV care, they also indicated a need for more and better training. Given the limited number of doctors Uganda, it is critical that nurses also have also knowledge and skills needed to provide basic time-sensitive SV services, such as counseling, EC and PEP. Even providers who do not specifically offer SV services must be aware of when, where and how to refer survivors for further medical services within the facility. Nurses also indicated that they believe SV training programs should include more emphasis on trauma counseling.

- *Strengthen forensic evidence collection within health facilities.* While providers were generally knowledgeable of the critical components of care, they were not as conversant on the elements of forensic evidence collection as they were on clinical management. Many facilities also lacked the supplies needed to do collect such evidence, including blood tubes, emergency clothing and a lockable cupboard to store evidence. Providers also mentioned that the legal requirement for a doctor to complete all forensic examinations presented a barrier to care due to the limited number of doctors in the country.

- *Develop facility-level protocols, algorithms for managing and referring SV survivors.* Despite the existence of some national guidance on the management of SV survivors, only one third of the facilities surveyed had access to those or other guidelines in the area where SV services were provided. Only one site reported having any type of guidelines on referrals to services outside of the hospital, despite widespread recognition of survivor's on-going legal, health and psychosocial needs. Clearly specified procedures of care and referral pathways are needed to ensure that the survivor has the access to the best possible care. Facilities are encouraged to develop client flow algorithms that outline referrals within and outside of the facility, as well as facility-specific SV case management protocols.

- *Ensure all facilities maintain adequate records on SV survivors*. Slightly more than half of all facilities reported that they kept records on SV cases, but these records often disagreed with provider's perceptions of client load. Some respondents even noted that although they believed that SV was on the rise in their communities, their records could not provide that data. Accurately recording the frequency and nature of these cases is critical for ensuring that the facility is adequately equipped to respond to the demand, and allows providers to better understand the dynamics of SV in their community. Improved record-keeping can also strengthen forensic evidence collection, and ensure that more perpetrators are brought to justice.

2. Strengthening referrals from the health facility to other support services

    - *Develop more formal linkages between other organizations providing SV services and the health facility*. Providers generally recognized the survivor's need for on-going health, legal and psychosocial services, and had some idea of where those were provided in their community. There were, however, no formal linkages between these organizations and the health facility. Establishing such linkages is critical for creating an integrated network of care for the survivor, and can involve as little as identifying a point of contact within each organization to facilitate referrals.

3. Strengthening linkages with the community

    - *Empower health care workers to sensitize communities on SV services.* Respondents consistently noted that community awareness of SV was a key barrier to care, and that campaigns should be undertaken to improve that awareness. Healthcare workers expressed willingness to conduct such activities, but did not tend to see such outreaches as an important aspect of their job. Management of the health facilities should recognize that health care providers have an important role to play in promoting community health, and that such outreaches can be done with minimal resources. Regular health education talks, for example, provide excellent opportunities to address SV issues with waiting clients. Within Mulago hospital, efforts should be made to ensure that the community outreach department frequently and adequately includes SV in its activities.

CONCLUSION AND NEXT STEPS

The data presented above indicate that both countries can do much to improve their SV services, and that providers are willing to meet those demands. Under the PEPFAR Special Initiative on GBV, implementing partners will work closely with providers at these facilities to ensure that they have the tools to provide such services. It is expected that the final evaluation will document the impact of these strategies.

APPENDICES

I. FACILITY INVENTORY

Instructions to the data collector: Please request that the in-charge of each facility assist you in completing this form. The objectives of this process are to:

- Assess the facility's physical capacity to provide comprehensive SV services
- Assist the in-charge in identifying areas for improvement in the facility infrastructure

Remember that the objective of the inventory is to identify equipment and facilities that currently exist and are in working order—and not to evaluate the performance of the staff or clinic.

You are required to directly observe the conditions indicated on this form. In all cases you should verify that the items exist by actually observing them yourself—if you are not able to observe them, then code accordingly. For each item, circle the code most suitable response or describe as appropriate. Some questions will require additional information to be written in the indicated blank.

Section 1: Facility identification			
1.1	Name of data collector	Write name	
1.2	Was in-charge or HC manager present for entire observation?	No……..0 Yes……1	
1.3	Date of observation	____/____/_____ DD MM YYY	
1.4	Start time	____/_____ HH MM	
1.5	End time	____/_____ HH MM	
1.6	Type of observation	Baseline……0 Endline……..1	
1.7	Name of facility:	Write name	
1.8	PEPFAR Partner name	Write name	
1.9	Country	Uganda……..0 Rwanda……1 South Africa……..2	

Section 2: Service availability				
2.1	On WEEKDAYS, during what hours are SV services available?	Opening time ____/ ____ HH/MM Closing time ____/_____ HH/MM		
2.2	On WEEKENDS during what hours are SV services available?	Opening time ____/ ____ HH/MM Closing time ____/_____ HH/MM		
2.3	Is there a doctor present at the facility at all times that SV services are offered?	No……..0 Yes……1		
2.4	Is there a nurse present at the facility at all times that SV services are offered?	No……..0 Yes……1		
2.5	How many providers and of which type (qualifications) provide SV services in this facility?			
	Type of staff	Days a week available	Hours available per day working	
	Obstetrician/ gynecologist			
	Pediatrician			
	General practitioner			
	Medical resident			
	Medical intern			
	Trained/professional midwife A1			
	Trained/professional midwife A2			
	A1 nurse			
	A2 nurse			
	Counselor			
	Social worker			
	Nursing student			
	Police			
	Other _____			

Section 3: General infrastructure			
3.1	Is there a separate area where SV clients wait to receive services?	No……..0 Yes……1	
3.2	Is there one specific area or room dedicated for SV **medical services**?	No……..0 Yes……1	
	Is this area or room available at all times SV services are offered?	No……..0 Yes……1	
	Can conversations be heard from the outside?	No……..0 Yes……1	
	Can clients be seen from the outside?	No……..0 Yes……1	
3.3	Is there one specific area or room dedicated for SV **counseling**?	No……..0 Yes……1	
	Is this area or room different from the medical consultation area?	No……..0 Yes……1	
	Is this area or room available at all times SV services are offered?	No……..0 Yes……1	
	Can conversations be heard from the outside?	No……..0 Yes……1	
	Can clients be seen from the outside?	No……..0 Yes……1	
3.4.	Is the person who accompanies the survivor allowed to be in consultation/counseling room?	No……..0 Yes……1	
	Mother/Female parent of the child	No……..0 Yes……1	
	Father/Male parent of the child	No……..0 Yes……1	
	Spouse	No……..0 Yes……1	
	Adult accompanying the child	No……..0 Yes……1	
	Police	No……..0 Yes……1	
	Local authority	No……..0 Yes……1	
	Other (describe)		

Section 4: Essential equipment and supplies: **In the room/ward where examinations routinely take place:**			
4.1	Is there an examination couch?	No…….....0 Yes……..……1 Did not observe…..……9	
4.2	Is there a working angle lamp?	No…….…..….0 Yes……..…1 Did not observe……..…9	
4.3	Is there a speculum?	No…….…..0 Yes…….…1 Did not observe……..9	
4.5	Are there examination gloves?	No……..0 Yes……..…1 Did not observe……9	
4.6	Is there a sharps container?	No……..……0 Yes…….……1 Did not observe……9	
4.7	Is there a lockable cupboard for the storage of forensic/medico-legal evidence?	No……..…..…..….0 Yes……..…1 Did not observe…..……...9	
4.8	Is there a lockable medical supply cabinet?	No……..0 Yes……..…1 Did not observe……9	
4.9	Are there sanitary towels?	No……..……....0 Yes……..……...1 Did not observe……9	
4.10	Is there emergency clothing?	No…….……0 Yes……..…1 Did not observe……9	
4.11	Is there a consent form for the examination?	No…….…….0 Yes……1 Did not observe……9	
4.12	Are there swabs?	No……..0 Yes……..…...1 Did not observe……9	
4.13	Are there blood tubes?	No……..0 Yes……..…1 Did not observe……9	
4.14	Are there special aids for examining children (dolls, paper and pens for drawing pictures?)	No…….…..0 Yes……..…...1 Did not observe……9	
4.15	Is there a pregnancy test kit?	No…….……....0 Yes (in exam room)…..…..…..1 Yes (elsewhere in facility)…....2 Did not observe……..……9	

4.16	Are there emergency contraceptive pills?	No……..0 Yes (in exam room)……..1 Yes (elsewhere in facility)…....2 Did not observe……..……..….9	
4.16.a	If yes, what brand of emergency contraceptive pills are available?	*(write name)*	
4.17	Are there STI prophylaxis/treatment?	No…….…....0 Yes (in exam room)……..…....1 Yes (elsewhere in facility)…….2 Did not observe……..……..9	
4.18	Is there analgesia?	No……..…...0 Yes (in exam room)……..…..1 Yes (elsewhere in facility)…....2 Did not observe…….....……9	
4.19	Are there tranquilizers?	No…….0 Yes (in exam room)……..1 Yes (elsewhere in facility)……2 Did not observe……..……9	
4.20	Are there anti-emetics?	No…….…....0 Yes (in exam room)…….…1 Yes (elsewhere in facility)…....2 Did not observe……..……9	

Section 5: HIV services			
5.1	Is there a HIV rapid test kit?	No…….....0 Yes (in exam room)…….....1 Yes (elsewhere in facility)…….2 Did not observe……..……..….9	
5.2	Are there post-exposure prophylaxis (PEP) drugs to prevent HIV?	No…….……0 Yes (in exam room)……...…1 Yes (elsewhere in facility)…....2 Did not observe……...……9	
5.3	How many days of PEP drugs are provided during initial visit?	_____ number of pills	
5.4	Are children referred to another location for pediatric PEP?	No…….……0 Yes……1 Did not know……9	
5.5	When are PEP clients advised to return to the facility for a follow-up HIV test?	_____ weeks	

Section 6: Protocols and information for patients			
6.1	Does the facility have guidelines or protocols for **clinical management** of SV?	No……0 Yes……1 Did not observe..…..……9	
	Are the clinical management guidelines or protocols available in or nearby the examination room?	No……..……...0 Yes……..……..1 n/a……2	
	Do they include special provisions for examining and treating infants and children.	No……..……...0 Yes……..……..1 n/a……2	
	Are there leaflets or handouts on the medication?	No…….……0 Yes……1 Did not observe……..……..9	
	Are there leaflets on side-effects of drugs?	No……..……...0 Yes……..…..1 Did not observe…..……...9	
6.2	Does the facility have guidelines for **referral** of survivors to other services?	No…….…….....0 Yes……..……...1 Did not observe…….....9	
6.3	What services are included in the referral guidelines?		
	Police	No……..……0 Yes……..……...1 Did not observe…….…….....9	
	Safe house	No…….….0 Yes……1 Did not observe…….9	
	Legal services	No…….…….0 Yes……1 Did not observe……...…….9	
	Counseling/ psychosocial support	No…….…….0 Yes……..…1 Did not observe…….9	
	HIV/AIDS care and treatment	No…….…….0 Yes……..…1 Did not observe…….9	
	Other _____	No……..….0 Yes……..…1 Did not observe…….9	
	Are the referral guidelines or protocols available in or nearby the examination room?	No…….……0 Yes…….……1 n/a……..2	
	Do these guidelines include phone numbers and contact people at each referral point?	No…….……0 Yes…….……1 n/a…….……2	

	Do referral guidelines explicitly address procedures for removing a child from an unsafe domestic environment?	No…….……0 Yes…….……1 n/a…….…2	
	Are there leaflets and handouts on support services for rape survivors, such as NGOs?	No…….0 Yes……1 n/a…….....2	

Section 7: Supplies in unit where SV services are provided			
7.1	**Commodity**	**Number/** Did not observe 99	
	Number of HIV rapid testing kits		
	Number of PEP kits		
	Number of emergency contraceptive pills		

Section 8: Records and registry			
8.1	Do facility registers clearly indicate if a client presents for SV services?	No…….0 Yes……1	
	Number of SV survivors indicated in facility registers for past month	Number _____(indicate month)	
8.2	Number of completed survivor assessment forms for past month	Number _____	
8.3	Do facility records indicate if a client receives follow-up care?	No…….0 Yes……1	

Thank you very for your time and contribution to this survey!

II. FACILITY INVENTORY EVALUATION QUESTIONS AND INDICATORS

Evaluation question	Indicator	Numerator
Has adequate infrastructure at the intervention sites been established and maintained?	• Percentage of health facilities providing 24-hour SV services (open and staffed by doctor and/or nurse) • Percentage of health facilities with dedicated room/area for providing SV medical services • Percentage of health facilities with special aids for examining children	• Number of health facilities providing 24-hour SV services • Number of health facilities with dedicated room/area for providing SV medical services, including counseling • Number of health facilities with special aids for examining children
Do standardized care and referral guidelines exist at the intervention sites?	• Percentage of health facilities with guidelines or protocols for clinical management of SV • Percentage of health facilities with guidelines or protocols for referrals to (and/or from) at least one service (police, legal, counseling, HIV care/ treatment, other)	• Number of health facilities with guidelines or protocols for clinical management of SV • Number of health facilities with guidelines or protocols for referrals to (and/or from) at least one service (police, legal, counseling, HIV care/ treatment, other)
Are the necessary HIV drugs and supplies available at the intervention sites?	• Percentage of health facilities with HIV rapid testing kits in examination room/area (among those governed by national policy/protocol that includes HIV rapid test) • Percentage of facilities with PEP drugs in examination room/area • Percentage of facilities with HIV rapid testing kits in SV unit stores • Observed number of PEP kits in SV unit stores, by facility/ partner	• Number of health facilities with HIV rapid testing kits in examination room/ area • Number of health facilities with PEP drugs in examination room/ area • Number of facilities with HIV rapid testing kits in SV unit stores • Number of PEP kits in SV unit stores, by facility/ partner
Are other essential equipment and supplies available at the intervention sites?	• Percentage of health facilities with at least 15 of the other 20 essential equipment and supplies available in the appropriate examination areas (see list on FI form) • Average number of essential equipment and supplies available in the appropriate examination areas (see list on FI form)	• Number of health facilities with at least 15 of the other 20 essential equipment and supplies available in the appropriate examination areas (see list on FI form) • Number of essential equipment and supplies available in the appropriate examination areas (see list on FI form)
Do adequate record keeping procedures exist at the intervention sites?	• Percentage of SV clients presenting in previous month with completed client assessment forms • Percentage of intervention sites with procedures for recording follow-up care services	• Number of completed SV client assessment forms in the previous month • Number of health facilities with procedures for recording follow-up care services

III. GUIDE FOR FOCUS GROUP DISCUSSIONS WITH SERVICE PROVIDERS

NOTE TO THE FACILITATIOR:

After completing informed consent procedures, the facilitator will conduct a semi-structured discussion using the following questions as a guide. Prompting questions will be used to elicit an open-ended response, which can then be directed using probing questions as needed.

The note taker should include the following information at the beginning of each session's transcript

Country	Rwanda Uganda South Africa
FGD date	___/____/____ DD/ MM/YY
Facility/ facilities involved	
FGD facilitator/ note taker	1. 2.
Location of FGD	
Cadre of providers	Doctors _____ Nurses _____ Counselors _____
Total number of participants	
Start time	___/____ HH/ MM
End time	___/____ HH/ MM
Brief description of the FGD environment and location: *if people were enthusiastic to participate or seemed to be forced by the manager, if there were interruptions, etc.*	

General information and warm-up questions

- When we talk about SV, what do we mean?
  - Probe: does this include rape survivors, children, men, survivors of intimate partner violence?
- Do you think SV is on the rise?
  - Probe: why or why not?
- Does your (this) facility receive many SV clients?
  - Probe: how many is "many"? At what times are they most likely to report? What are their ages?

Informational statement: today, when we are discussing SV we are using the World Health Organization's definition as "any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic women's sexuality, using coercion, threats of harm or physical force, but any person regardless of relationship to the survivor, in any setting, including but not limited to home and work."

In other words, this includes rape and defilement (and attempts to rape and defile) that occurs to women and men, some of whom may be sexually abused by their partner, spouse, or other family members. Under your country's laws, rape is defined as (insert here); and defilement is defined as (insert here).

Capacity of providers

- Have providers in this project/facility ever received formal training in treating SV clients?
  - Probe: How many? What cadres? When was this training provided? What did it cover? Was it sufficient?
- What are the most common injuries and medical risks associated with the SV clients you see here?
  - Probe: which are the most serious? Which are the least important?
- Describe the procedure for managing a SV client.
  - Probe for: HIV testing and PEP provision, pregnancy testing and emergency contraception provision, STI prophylaxis, treatment of injuries and collection of forensic evidence.

What problems do you face in providing that care?

- Apart from medical care, what are the other needs of SV clients? How do you assess these needs? Do clients usually receive this other care? How do they know where to go for this care? Do you know where they can go for these services?
  - Probe for: protocols and practices for screening and referrals to police, legal services, shelter, psychosocial care, other services.

Provider attitudes toward clients

- Do you think SV should be treated as a medical emergency?
  - Probe: Should clients get treated immediately when arriving to the health facility? Why or why not?
- Thinking about the incident itself, are there times when a client's behavior causes the rape?
  - Probe: If yes, what are these behaviors (drinking alcohol, wearing revealing clothing, going out alone at night, etc)? If her/his behavior contributes to the rape, is s/he entitled to the same medical care as someone who might be less to blame?

Linkages with community/stakeholder groups

- SV survivors often face barriers in accessing medical services. Are you aware of any barriers members of this community face in getting medical care if they are raped or defiled? If yes, what are they? How did you learn about them?
- Do you or staff at this facility conduct outreach activities with the community in order to let them know rape care services are available here and to help get survivors to medical services?
  - Probe: If yes, please describe these efforts.
- Are you aware of any other groups (such as, government offices, civil society organizations, or social support services) that do community sensitization on SV?
  - Probe: If yes, please name the groups and what they do. Do their messages include information on your SV services and how to access them?
- Do you or staff at this facility ever work directly with clients or with other groups to find out how well your services are meeting SV client needs?
  - Probe: If yes, please describe this work. Have you used this information to improve your services?

IV. FOCUS GROUP DISCUSSIONS: EVALUATION QUESTIONS AND ANALYSIS THEMES

Evaluation question	Analysis theme
Have health care provider attitudes towards SV survivors and services changed?	• Provider beliefs that SV is a medical emergency • Provider beliefs that a survivor's behavior can cause rape
Has the capacity of health care providers to deliver quality SV medical care improved?	• Provider assessment of frequency and effectiveness of formal training in SV care • Provider recognition of the most common injuries and medical risks associated with SV • Provider recognition of the most critical components of health care for SV clients
Has the capacity of health care providers to refer clients to other support services improved?	• Provider practice of screening clients for other needs such as shelter, longer-term counseling, police services, legal services • Provider knowledge of health facility protocols for referrals to other services • Provider knowledge of support services available in the community
Have linkages between the health facility and community/stakeholder groups been strengthened to help facilitate access to services at the facility?	• Provider knowledge of community outreach activities managed by the health facility to facilitate survivors' access to health services • Provider knowledge of partnerships between the health facility and community/stakeholder groups that aim to overcome barriers to health services and/or improve quality of services

V. THREE-POINT LIKERT SCALES FOR FGD ANALYSES

Evaluation question	Analysis themes	Focus group responses	Scale
Has provider **awareness of SV** improved?	Provider knowledge of SV	The providers were very knowledgeable about SV	Positive
		The providers had some knowledgeable of SV	Neutral
		The providers were NOT knowledgeable about SV	Negative
	Providers belief of **SV prevalence**	The providers believe SV is increasing	Positive
		Providers were not sure whether SV is increasing	Neutral
		The providers believe SV is NOT increasing	Negative
Has the capacity of health care providers to **deliver quality SV medical care** improved?	Provider assessment of **formal training** in SV care	The majority of providers have received formal training in SV care	Positive
		Provider responses divided on formal training in SV care	Neutral
		The majority of providers have NOT received formal training in SV care and feel was NOT sufficient	Negative
		The providers felt formal training in SV care was sufficient	Positive
		The providers were divided on whether training in SV care was sufficient	Neutral
		The providers felt formal training in SV care was NOT sufficient	Negative
		Providers trained within the last 12 months	Positive
		Providers trained more than 12 months ago	Negative

	Provider **recognition of the most common injuries a**nd medical risks associated with SV	The providers correctly identified the most common injuries and medical risks associated with SV	Positive
		Providers only identified a few of the most common injuries and medical risks associated with SV	Neutral
		The providers did NOT correctly identify the most common injuries and medical risks associated with SV	Negative
	Provider **recognition of the most critical components** of health care for SV clients	The providers correctly identified the most critical components of health care for SV clients	Positive
		Providers correctly identified only a few of the most critical components of health care for SV clients	Neutral
		The providers did NOT correctly identify the most critical components of health care for SV clients	Negative
Has the capacity of health care providers to **refer clients** to other support services improved?	Provider **practice of screening clients** for other needs such as shelter, longer-term counseling, police services, legal services	The providers reported screening clients for other needs appropriately	Positive
		Provider responses divided on screening clients for other needs appropriately	Neutral
		The providers did NOT report screening clients for other needs appropriately	Negative
	Provider knowledge of **health facility protocols for referrals** to other services	The providers were knowledgeable of health facility protocols for referrals to other services	Positive
		Provider responses divided on knowledgeable of health facility protocols for referrals to other services	Neutral
		The providers were NOT knowledgeable of health facility protocols for referrals to other services or there are none	Negative
	Provider knowledge of **support services** available in the community	The providers were knowledgeable of support services available in the community	Positive
		Provider responses divided on knowledge of support services available in the community	Neutral
		The providers were NOT knowledgeable of support services available in the community	Negative

Have health care provider **attitudes** towards SV survivors and services changed?	Provider beliefs that SV is a **medical emergency**	Providers agree that SV is a medical emergency and client should be treated immediately.	Positive
		Provider responses divided on SV as a medical emergency	Neutral
		Providers do not regard SV as a medical emergency and do not think client should be treated immediately.	Negative
	Provider beliefs that a survivor's **behavior can cause rape**	Providers agree that a survivor's behavior can cause rape	Negative
		Providers divided on connection between survivor's behavior and rape	Neutral
		Providers do NOT feel that a survivor's behavior can cause rape	Positive
	Provider belief that client is **entitled to same care** as someone who may be less to blame for the rape.	Providers agree that client is entitled to same care as someone who may be less to blame for the rape.	Positive
		Providers are divided as to whether client is entitled to same care as someone who may be less to blame for the rape.	Neutral
		Providers agree that client is NOT entitled to same care as someone who may be less to blame for the rape.	Negative
Have **linkages** between the health facility and community/ stakeholder groups been strengthened to help facilitate access to services at the facility?	Provider **knowledge of barriers** to accessing SV medical services	The providers were knowledgeable of multiple barriers to accessing medical services	Positive
		The providers were divided on knowledge of barriers to accessing medical services	Neutral
		The providers were NOT aware of barriers to accessing medical services	Negative
	Provider knowledge of **community outreach** activities managed by the health facility to facilitate survivors' access to health services	The providers were knowledgeable of community outreach activities managed by the health facility to facilitate survivors' access to health services	Positive
		Provider responses divided on knowledge of community outreach activities managed by the health facility to facilitate survivors' access to health services	Neutral
		The providers were NOT knowledgeable of community outreach activities managed by the health facility to facilitate survivors' access to health services	Negative
		Descriptions of outreach activities	

	Provider knowledge of **partnerships** between the health facility and community/stakeholder groups that aim to overcome barriers to health services and/ or improve quality of services	The providers were knowledgeable of other groups that conduct community sensitization on SV services in this facility	Positive
		Provider responses divided on knowledge of other groups that conduct community sensitization on SV services in this facility	Neutral
		The providers were NOT knowledgeable of other groups that conduct community sensitization on SV services in this facility	Negative
		Other groups mentioned as conducting community sensitization of SV services in the facility	
	Provider awareness of **client satisfaction assessments** conducted by the facility	The providers were knowledgeable of client satisfaction assessments conducted by the facility	Positive
		The providers were divided in their knowledge of client satisfaction assessments conducted by the facility	Neutral
		The providers were NOT knowledgeable of client satisfaction assessments conducted by the facility or no such assessments are conducted	Negative
		Providers are aware that client satisfaction assessments are **used to improve services**	Positive
		Providers are divided or not sure that client satisfaction assessments are used to improve services	Neutral
		Providers were NOT aware that client satisfaction assessments are used to improve services	Negative

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