

**The RESPOND Project Study Series:
Contributions to Global Knowledge**

Report No. 4

**Baseline Assessment of the
Readiness of Health Facilities
to Respond to Gender-Based Violence
in Guinea**

**Ashley Jackson, The RESPOND Project/EngenderHealth
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The assessment was led by Dr. Camara Moussa Kantara of Donka Hospital and Dr. Camara Havanatou of the Minière Medical Center in Conakry, Guinea. Ashley Jackson led the finalization of this report, with expert review by several EngenderHealth colleagues: Moustapha Diallo, Joseph Ruminjo, Hannah Searing, Fabio Verani, and Nancy Yinger. The report was copyedited by Michael Klitsch and was formatted by Elkin Konuk.

Executive Summary

Gender-based violence (GBV), understood as interpersonal physical or psychological violence resulting from normative gender roles and unequal power relationships based on sex, is a pervasive problem worldwide. Sexual violence (SV), one component of GBV, is associated with significant reproductive health risks, including unwanted pregnancy and the transmission of HIV and other sexually transmitted infections (STIs). Results from a 2009 national survey in Guinea show that, depending on geographic region, between 13% and 52% of women aged 15–64 had been raped since the age of 15.¹ Nevertheless, Guineans and international observers alike were shocked by the brutal rapes that were perpetrated on September 28, 2009, following a political demonstration in a stadium in Conakry. Many organizations and service providers have noted that the events of September 2009 underscored the urgent need for more services and better quality services to prevent and respond to GBV throughout the country.

Given the high prevalence of GBV in Guinea and the inadequacy of the current GBV response, USAID/Guinea provided the RESPOND Project with approximately \$825,000 in field support funds to partner with the Ministry of Social Affairs and the Promotion of Women and Children and the Ministry of Public Health and Hygiene over a 12-month period to provide support and services to survivors of SV during the September 28 political violence and to implement a broader strategy for a comprehensive response to GBV in three regions of Guinea (Conakry, Kissidougou, and Labé). Project work began in January 2011 and is being implemented in collaboration with two local nongovernmental partners: the Coalition Nationale de Guinée pour les Droits et la Citoyenneté des Femmes (CONAG-DCF) and the Association Guinéenne des Assistantes Sociales (AGUIAS).

The project activities focus on three objectives:

1. Providing ongoing medical care, psychosocial services, and social and economic reintegration support to survivors of the September 28 GBV
2. Building the capacity of local partners to implement effective GBV prevention efforts
3. Improving the health sector's response to SV

To achieve the third objective, RESPOND will conduct a series of SV trainings for health providers and other health facility staff. The training curriculum will cover medical and psychosocial services for SV survivors, as well as the ethical management of client data. The training curriculum will be informed by the results of this baseline assessment, which gauged the readiness of 21 health centers to respond to SV in terms of services, equipment, supplies, standard operating procedures (SOPs), and provider knowledge, attitudes, and skills.

The assessment team conducted interviews with 21 facility managers and 120 health care providers at 21 health facilities in Conakry, Kissidougou, and Labé. The providers interviewed were those identified by their facility managers as the most likely to treat survivors of SV. They

¹ Ministère des Affaires Sociales, de la Promotion Féminine et de l'Enfance. 2009. *Enquête nationale sur les violences basées sur le genre : La violence à l'égard des femmes et des hommes*. Conakry, République de Guinée.

included doctors, nurses, midwives, and health technicians. Three-quarters (74%) of providers interviewed were female.

Fewer than one-third (28%) of the providers interviewed had ever received training on GBV, and most of those trainings were less comprehensive than the curriculum adapted by RESPOND. Although half of the providers interviewed (51%) said they knew the meaning of the term “gender-based violence,” they offered a range of different definitions of it. After hearing a definition of GBV, 48% of providers could not name any laws relating to it. Most providers self-reported attitudes that are supportive of GBV survivors, such as the view that no one ever deserves to experience GBV.

SOPs and/or protocols for addressing SV are not systematically available and in use across health facilities. Currently, many facilities fail to take important measures to protect the confidentiality of SV survivors, such as keeping their files in locked file cabinets and obtaining informed consent before sharing client data with providers at referral sites. When listing the steps in the care of rape survivors, providers generally omitted many important steps, such as testing the survivor for pregnancy. It appears to be particularly rare for providers to take preventive steps to respond to SV, such as assessing client safety and suicide risk. Furthermore, the referral system for nonmedical services, such as legal assistance and social services, appears to be very weak.

Most facilities lack the essential commodities, equipment, and supplies to respond to SV effectively. For example, fewer than half of the facilities offer postexposure prophylaxis (PEP) against HIV. During the three months prior to the survey, PEP was consistently in stock at only 29% of facilities, and emergency contraception (EC) was consistently in stock at only 19% of facilities. In addition, providers and facility managers identified a need for management tools, such as registers, referral forms, and medico-legal forms.

Key recommendations for the development of a provider SV training program include:

- Selection of participants and trainers
 - Include all four cadres of health care providers (doctors, nurses, midwives, and health technicians) in the training.
 - Invite providers to attend even if they have received some prior SV training.
 - Train and support providers to conduct an SV orientation for other staff at their facilities.
 - Identify the handful of individual providers who have recently attended comprehensive trainings on SV, and assess their level of knowledge and skills; if appropriate, ask these providers to serve as assistant trainers.
- SV knowledge and skills
 - At the beginning of the training, clarify the definition of GBV, including specific definitions of different types of GBV (physical, psychological, and sexual). (It may be helpful ask providers to identify acts of GBV in fictional case studies.)
 - Cover the laws that relate to GBV, including the legal definitions of rape and other acts of GBV, address legal requirements, such as reporting requirements, for providers, and discuss laws that relate specifically to GBV involving minors.

- If feasible, train providers to carry out forensic examinations and fill out medico-legal certificates.
- Train providers to identify and treat the consequences of SV in survivors.
- Disseminate the Ministry of Health guidelines for SV response to facilities that lack them.
- During the training, invite providers to use a template to develop SV SOPs with the managers of their facilities.
- Develop job aids for SV response and include them in the training materials.
- Ensure that providers understand the specific steps for responding to SV or learn how to use job aids that cover these steps, and test providers on their recall of these steps through role plays.
- Return to the health facility 3–6 months after the training, to repeat the role play exercise and refresh providers on the steps they learned.
- SV attitudes
 - Engage providers in discussions of attitudes around SV, especially gray areas where providers' attitudes may diverge.
 - Engage providers in a discussion of how SV can affect survivors' health and treatment.
 - Engage providers in a discussion of how to respond in a supportive way when a client discloses that he or she has experienced SV.
- Confidentiality and consent
 - Highlight in the training the specific steps that providers should take to protect SV survivors' confidentiality.
 - Encourage providers to report what they have learned to their facility managers and to catalyze facility-wide change in confidentiality and consent practices.
 - Train providers to lead a half-day GBV cascade training, with a focus on confidentiality, for other staff at their facility.
- Referrals
 - Train providers to provide information on clients' rights and services, and to conduct safety planning with the survivors through role plays.
 - Discuss the value of treating clients as whole people, with a wide range of needs.
 - Develop lists of services available to SV survivors in each of the three regions, and share these lists with providers during the training.
- Commodities, equipment, and supplies
 - Include in the curriculum examples of registers, referral forms, consent forms, and other documents that providers could photocopy and use at their facilities.
 - Address the importance of keeping track of the levels of stock of commodities, such as EC and PEP, and placing timely orders.
 - Return to the health facility 3–6 months after the training for a guided tour, and discuss with the facility manager and the provider who received training ways in which to improve the facility's physical structure, commodities, equipment, and supplies.

Recommendations for the Ministry of Health and partner organizations include:

- Scale up SV training through in-service training in other regions of Guinea and/or preservice training.
- Ensure that the Ministry of Health's guidelines for responding to SV are available at every health facility.
- Develop and distribute simple job aids (such as an SV response flow chart and a listing of other services available to SV survivors) for response to SV.
- Disseminate registers, referral forms, consent forms, and other tools to assist providers in the management of SV cases.
- Invest in infrastructure and equipment, such as private examination rooms and lockable file cabinets, to improve SV response.
- Increase efforts to secure the supply chain for EC and PEP commodities.
- Invest in GBV prevention efforts at the national, regional, facility, and community levels.
- Institute and enforce sexual harassment and assault policies in health services.

Introduction

Background

Guineans and international observers alike were shocked by the brutal rapes that were perpetrated on September 28, 2009, following a political demonstration in Conakry. Human Rights Watch estimates that at least 109 women and girls were raped that day. With support from the United Nations Population Fund (UNFPA) and World Health Organization (WHO), local nongovernmental organizations (NGOs) quickly identified as many sexual violence (SV) survivors as they could and provided temporary support, through distribution of rice and cash and referral to health and psychosocial services. Approximately 50 women and girls were assisted in this way, but it is believed that many more never received help, as the profound stigma associated with rape prevented them from identifying themselves as SV survivors.

As in many countries in Africa, health, psychosocial, and protection systems in Guinea are stretched thin. While systems to respond to rape and other forms of gender-based violence (GBV) exist, survivors encounter access barriers, including cost, a referral system that is not yet fully coordinated, and limitations in service quality. Many organizations and service providers have noted that the events of September 28 underscored the urgent need for more and better quality GBV services throughout the country. Results from a 2009 national survey in Guinea show that, depending on geographic region, between 13% and 52% of women aged 15–64 years been raped since the age of 15.² Given the high prevalence of GBV in Guinea and the inadequacy of current GBV response, the U.S. Agency for International Development (USAID) Mission in Guinea identified the need to improve GBV prevention and response efforts across key sectors.

In October 2009, USAID/Guinea provided the RESPOND Project with approximately \$825,000 in field support funds to partner with the Ministry of Social Affairs and the Promotion of Women and Children and the Ministry of Public Health and Hygiene over a 12-month period to provide support and services to GBV survivors of the September 28 political violence and to implement a broader strategy for a comprehensive response to GBV in three regions of Guinea (Conakry, Kissidougou, and Labé). Project work began in January 2011 and is being implemented in collaboration with two local NGO partners: the Coalition Nationale de Guinée pour les Droits et la Citoyenneté des Femmes (CONAG-DCF), and the Association Guinéenne des Assistantes Sociales (AGUIAS).

The project activities focus on three objectives:

1. Providing ongoing medical care, psychosocial services, and social and economic reintegration support to GBV survivors of the September 28 violence
2. Building the capacity of local partners to implement effective GBV prevention efforts
3. Improving the health sector's response to SV

² Ministère des Affaires Sociales, de la Promotion Féminine et de l'Enfance. 2009. *Enquête nationale sur les violences basées sur le genre : La violence à l'égard des femmes et des hommes*. Conakry, République de Guinée.

Overview of the Package of Interventions

At the onset of the project, RESPOND formed a multisectoral steering committee of stakeholders from key ministries and NGOs, to oversee the project activities. The steering committee includes representatives from the Ministry of Social Affairs and the Promotion of Women and Children, the Reproductive Health Division of the Ministry of Health, the Ministry of Security and Civil Protection, UNFPA, and the NGOs Plan Guinea, AGUIAS, and CONAG. RESPOND worked with the steering committee to identify a package of interventions informed by EngenderHealth's Supply–Enabling Environment–Demand (SEED™) programming model, with interventions in three areas: **supply**, to support delivery of quality services that are accessible, acceptable, and accountable to the clients and communities served; the **enabling environment**, to facilitate the policy, program, and community environment, including social and gender norms; and **demand**, to help individuals, families, and communities acquire increased knowledge and capacity to prevent GBV and to seek care, if necessary.

The package of interventions comprises:

- Immediate care for survivors of the September 28 GBV:
 - Medical and psychosocial assessment, referral, and follow-up
 - Social and economic reintegration services and support
- Training and ongoing technical assistance and support to community-level committees to lead GBV prevention efforts
- A baseline assessment of 21 health centers, including recommendations for specific actions needed to improve medical and psychosocial services for SV survivors and ensure the ethical management of client data
- Training of health care workers and posttraining follow-up and support at referral sites
- Monitoring and documentation of results

Methodology

Study Objective

The baseline assessment was conducted to gauge the readiness of health centers to respond to SV in terms of services, equipment, supplies, SOPs, and provider knowledge, attitudes, and skills. The results will inform the development of a curriculum that RESPOND will use to train health care providers on SV prevention and response.

Methods

In June 2011, a team of researchers conducted interviews with facility managers and health care providers at 21 health facilities in three administrative regions of Guinea. Eight of the facilities are in Conakry, six are in Kissidougou, and seven are in Labé:

- *Conakry*: National Hospitals of Ignace Deen and Donka, Jean Paul II Hospital, and communal health centers of Ratoma, Minière, Yimbayah, Coleah, and Matam
- *Kissidougou*: District Hospital and its five satellite urban health centers
- *Labé*: Regional Hospital and its six satellite urban health centers

Facilities were selected based on the size of their catchment populations; the largest facilities in each region were included in the sample.

At each facility, the researchers conducted a structured interview with the facility manager. The researchers then asked the facility manager to identify the provider(s) at his or her facility who are most likely to treat survivors of SV. These providers were invited to participate in individual structured interviews. In total, 120 providers were interviewed. Prior to each interview, the researchers obtained the informed consent of the participant.

The researchers used EpiInfo and Excel to analyze the data.

Results, Discussion, and Recommendations

Provider Background

Results

The 21 facilities ranged from a hospital with 190 doctors on staff and a catchment population of more than 1 million to a health center with no doctors serving fewer than 5,000 people. Overall, the most common cadre of health care provider on staff was a health technician (36%), followed by a doctor (30%), a nurse (26%), and a midwife (8%) (Table 1). The distribution of providers by cadre different slightly for those interviewed compared with the overall distribution at facilities, since interviewees were selected based on the likelihood that they would treat survivors of SV. Most interviewees were health technicians or doctors, mirroring the distribution at facilities. Unlike the distribution at facilities, however, midwives were more common than nurses in the sample interviewed.

The sex distribution of providers varied greatly by cadre. While only 24% of doctors were female, 80% of nurses, 100% of midwives, and 98% of health technicians were female (Table 1). The two lab technicians interviewed were also female. Overall, 74% of providers interviewed were female.

The majority of facilities in the sample had no medical specialists. Across the 21 facilities, there were 24 gynecologists, half of whom were at one hospital. Only two facilities had surgeons, and only one had a urologist. Surgeons and urologists are necessary to treat some of the sequelae of SV, such as fistula.

Table 1. Providers at facilities, and interviews, by cadre and sex

Cadre of provider	Total no. (and %) at facilities	No. (and %) interviewed	% female among those interviewed
Doctor	405 (30%)	37 (31%)	24%
Nurse	357 (26%)	10 (8%)	80%
Midwife	116 (8%)	28 (23%)	100%
Health technician	490 (36%)	43 (36%)	98%
Lab technician	n/a	2 (2%)	100%
Total	1,368	120	74%

Of the 120 providers interviewed, 74 (62%) said that their facility gives SV survivors the option of having a female provider.

Discussion

The distribution of providers by cadre has implications for the design of the SV training program. If the curriculum were tailored to doctors or medical specialists, it would reach only high-level referral facilities. For all 21 facilities to benefit from having at least one provider trained, the curriculum should be designed for doctors, nurses, midwives, and health technicians alike.

The sex of providers is pertinent because the project has received anecdotal reports that some SV survivors in Guinea have experienced further SV perpetrated by male providers at health facilities. In some cases, for example, providers have reportedly subjected SV survivors to unnecessary and inappropriate examinations. In RESPOND's work with SV survivors, the project has observed a preference among female survivors to receive care from female rather than male providers.

RESPOND could train female SV advocates or providers to conduct counseling and safety planning for SV survivors before they are seen by doctors. If they have time and feel it is appropriate, female SV advocates or providers could offer to accompany SV survivors throughout the visit to the health facility, so that the client does not have to be alone with a male provider at any point.

Recommendations

- Design the SV curriculum to build on background knowledge that all four of the cadres of health care providers (doctors, nurses, midwives, and health technicians) would be expected to have.
- Train and support providers to conduct an SV orientation for other staff at their facilities. The orientation should cover the definition, causes, and consequences of SV and the protection of the confidentiality, safety, and dignity of SV survivors.
- In the curriculum, explain the importance of offering SV survivors the option to be seen by a female provider, when possible.
- Lobby to institute and enforce sexual harassment policies.
- Consider creating protocols to ensure that survivors have the option of being accompanied by a female SV advocate or provider during their health care visit, if they are to be seen by a male provider.

Training in SV Response

Results

Of the 21 facility managers, seven reported that their facility already has a program to respond to SV. According to facility managers, nearly half (10) of the facilities have at least one provider who has been specifically trained to respond to SV. A total of 39 providers—3% of the providers across all 21 facilities—received training on SV within the past three years, based on the report of facility managers.

Among the 120 providers interviewed—those at their facilities who are most likely to treat SV survivors—only 34 (28%) said they had ever received training on SV. Among interviewees with some SV training, most had attended a single training, while a handful had attended two or more trainings. Half of those with SV training were trained by UNFPA, one-third were trained by other NGOs, and the remainder were trained by the Ministry of Health. The majority (56%) of those with SV training were trained in the past year (2010–2011), likely in response to the September 2009 violence. Others received training as far back as 1986. The most common duration of training was four days. Table 2 shows the topics covered in past SV trainings, from most to least common, as reported by the 34 providers who attended.

Table 2. Among providers who received prior SV training, number and percentage reporting having been trained in various topic areas

Topics covered in prior SV training	No. (and %) of providers trained (n=34)
Confidentiality	33 (97%)
Provision of psychosocial support/reassurance to survivors	30 (88%)
Consequences of GBV	30 (88%)
Definition of GBV	29 (85%)
Causes of GBV	29 (85%)
Clinical management of rape	29 (85%)
Consent	28 (82%)
International standards for the care of SV survivors	25 (74%)
Collection and documentation of clinical evidence of rape	24 (71%)
SOPs for the care of SV survivors	22 (65%)
Special considerations when SV survivors are children/minors	20 (59%)
Legal requirements for providers	18 (53%)
Other	12 (35%)

Other themes covered in training included education of adolescents about GBV; female genital mutilation (FGM); measures to prevent GBV; regional offices; medical certificates; reproductive health; and the national Operational Action Plan on SV.

Discussion

Most providers have received no prior training on SV—even among those interviewed, who were identified by facility managers as the most likely to treat SV survivors. Based on the memories of providers who have receiving SV training, it appears that most prior trainings were not comprehensive. Therefore, even providers who have received some SV training in the past could benefit from attending a comprehensive SV training. A few of the providers interviewed had recently attended SV trainings that covered most of the key topics. If their level of knowledge and skills is high enough, these providers could be invited to serve as assistant trainers, to reinforce what they have already learned and improve the SV training program. In addition, the facility managers of the seven facilities that currently have an SV program could serve as valuable resources for identifying best practices and lessons learned in the health sector's response to SV in Guinea. The project should explore the possibility of inviting these managers to the training to discuss SV programs with the participants.

Recommendations

- In the SV curriculum, start from the basics; do not assume that the participants have any prior training on SV.
- Invite providers to attend the training program even if they have received some prior training.
- Identify the handful of individual providers who have recently attended comprehensive trainings on SV, and ask these providers to serve as assistant trainers.
- Return to the seven facilities that have an SV program to identify best practices that the Ministry of Health could scale up, and consider inviting the managers of these facilities to share their experiences with trainees.

Providers' Understanding of GBV

Results

Half of the providers interviewed (51%) said that they knew the term “gender-based violence.” The researchers asked these providers what the term means to them. Providers were allowed to give more than one response. Their most common answers were:

- Violence against women (23%)
- Sexual, physical, or psychological violence against women (13%)
- Sex without consent (11%)
- Labor forced on young girls (5%)
- Violence against men and women (4%)
- Female genital mutilation (3%)
- Discrimination against women (3%)
- Violation of women’s dignity (2%)

Discussion

In general, an understanding of the concept of GBV appears to be low among the providers. Even among the providers who knew the term, many offered definitions that do not capture its full meaning.

Recommendations

- At the beginning of the training, clarify the definition of GBV, including specific definitions of different types of GBV (physical, psychological, and sexual). It may be helpful to ask providers to identify acts of GBV in fictional case studies.

Providers' Knowledge of Laws

Results

Of the 120 providers interviewed, only 9% said that their knowledge of Guinea’s laws on GBV was very good, and just 20% said it was good. Most providers said that their knowledge was poor (45%) or very poor (27%).

The researchers offered providers a definition of GBV and asked what laws the providers know that relate to GBV. Half (48%) of the providers could not name any. One-quarter (24%) said there is a law against rape, 13% a law against FGM, 8% a law against forced marriage, 6% a law against physical violence, and 3% a marriage code.

Discussion

Providers’ knowledge of laws relating to GBV appears to be very low. Considering that only 24% of providers answered that there is a law against rape, it is possible that some providers did not understand the question. In particular, providers need information on their legal responsibilities, including when—if ever—they are required to report GBV to the authorities.

Recommendations

- Cover the laws that relate to GBV, including the legal definitions of rape and other acts of GBV, address legal requirements, such as reporting requirements, for providers, and discuss laws that relate specifically to GBV involving minors.
- If feasible, train providers to carry out forensic examinations and fill out medico-legal certificates.

Providers' Attitudes

Results

When asked if they believe that there are some cases in which a person deserves to experience GBV, 113 providers (94%) said “no.”

The providers were asked: “Imagine that a woman comes into the facility and reports that she was raped, but she does not want to disclose what happened to anyone besides you, her medical care provider. In private, her husband asks you what happened. In your opinion, should you tell her husband that she was raped?” In response, 116 providers (97%) said, “no,” indicating that they would not break confidentiality in the hypothetical case.

The providers were also asked: “If a man has sexual intercourse with a woman who says ‘no’ but does not physically resist, has he committed rape?” Of the 120 providers interviewed, 108 (90%) said “yes” and 12 (10%) said “no.”

Discussion

Overall, the vast majority of providers reported attitudes that are supportive of GBV survivors. However, their answers may have been affected by social desirability bias: They may have reported attitudes that they suspected the researchers would view favorably. To gain more insight into providers' attitudes, the project could ask training participants relevant questions from the Gender-Equitable Men (GEM) Scale, which was developed by the Horizons Project and Instituto Promundo to measure attitudes toward gender-equitable norms.³ The scale has the advantage of offering participants a range of possible responses rather than simply “yes” and “no,” which could lead to a more nuanced assessment of attitudes. To identify attitudinal changes over the course of the training, trainers could administer an adapted version of the GEM Scale during participants' pre- and posttraining tests. In addition, trainers could apply the Illinois Rape Myth Acceptance Scale to gauge attitudes specifically around sexual assault.⁴

Recommendations

- Measure changes in providers' attitudes from before training to after it.
- Engage providers in a discussion of the subtleties in attitudes around GBV. Rather than focus on the most clearly counterproductive attitudes toward GBV, the curriculum should address gray areas, where providers' attitudes may diverge.

³ Pulerwitz, J., and Barker, G. 2008. Measuring attitudes toward gender norms among young men in Brazil: Development and psychometric evaluation of the GEM Scale, *Men and Masculinities* 10(X):322–338.

⁴ Payne, D. L., Lonsway, K. A., and Fitzgerald, L. F. 2002. Rape myth acceptance: Exploration of its structure and its measurement using the *Illinois Rape Myth Acceptance Scale*, *Journal of Research in Personality* 33(1):27–68.

- Engage providers in a discussion of how GBV can affect survivors' health and treatment.
- Engage providers in a discussion of how to respond when clients disclose that they have experienced GBV (e.g., accept their version without interrogation, inform them of their rights and their legal and medical options, be supportive, respect their wishes).

Standard Operating Procedures

Results

According to facility managers, nine of the 21 facilities (43%) have written SOPs or protocols outlining how to care for SV survivors. One facility manager was able to show the interviewers the facility's SV SOPs, and eight were able to show the interviewers the Ministry of Health's guidelines for response to SV. No facilities had flowcharts for the care of SV survivors.

Sixty-nine percent of providers interviewed said that their facility has SOPs, protocols, flowcharts, or other documents to remind them about how to care for SV survivors. The most common type of document was the Ministry of Health guidelines, which 7% of providers showed to the interviewers. Other documents included medical guidelines for the care of rape survivors, strategies for fighting GBV, UNFPA guidelines, and a national survey of SV, among others. Only one of the 120 providers showed the interviewers SOPs for how to respond to SV. When providers were asked how they know what to do when an SV survivor comes to the facility, only one said that she refers to SOPs.

About half (53%) of the 120 providers interviewed said that a staff person at their facility is assigned to respond to SV. Among the interviewees who have such a staff person at their facility, 24 (38%) reported that he or she is the person responsible for responding to SV. Not all of the providers interviewed fit this profile, because multiple providers were interviewed at the larger facilities in the sample.

Discussion

SOPs and/or protocols for addressing SV are not systematically available across health facilities. Even when these resources are available, providers may not use them if they are unclear or unwieldy. User-friendly SOPs are needed to ensure that providers take all critical steps in response to SV and the ethical management of client data.

During the training, providers could use a template to develop SV SOPs for their facility. This activity would allow them to apply the information they have learned and take ownership of the SOPs they will use. The SOPs could include a flowchart and/or job aid for the care of SV survivors. Providers could then work with their facility managers to finalize and share the SOPs at their facilities. In some cases, providers could train others at their facility on the SV SOPs.

Recommendations

- Disseminate the Ministry of Health guidelines for SV response to facilities that lack them.
- During the training, invite providers to use a template, based on international standards, to develop SV SOPs with the manager of their facility.

Confidentiality

Results

The researchers asked facility managers whether their facilities take certain steps to protect the confidentiality of SV survivors. About half said that they obtain informed consent before sharing client information and that their exam rooms ensure auditory and visual privacy (Table 3). None said that they use an identity code rather than the client's name or that providers are required to sign a code of conduct.

Table 3. Percentage of facilities currently taking certain steps to protect confidentiality

Step to protect confidentiality of SV survivors	No. (and %) of facilities (n=21)
Use identity code rather than client's name	0
Require providers to sign a Code of Conduct that addresses client confidentiality	0
Obtain informed consent before sharing client information with other providers for referrals	11 (52%)
Have examination rooms that ensure both visual and auditory privacy	11 (52%)

When asked the same set of questions, providers gave similar responses to facility managers. While three of the 120 providers said that they do use identity codes, only one could describe the coding system. A small minority (16%) said that they had signed a Code of Conduct that addressed confidentiality. Seventy-five providers (63%) obtain informed consent for referrals, and 90 (75%) reported that their facility has examination rooms that ensure both visual and auditory privacy.

According to the facility managers, seven facilities (52%) record the number of clients who come in as a result of SV. None of these facilities ask SV survivors for their consent to be included in these statistics. Of these seven facilities, three send the SV statistics to the Ministry of Health, two send them to UNFPA, and two do not report the data to anyone outside the facility.

Only 13% of providers said that the medical files of SV survivors are kept in locked file cabinets, while 57% said they are not and 31% did not know. At most of the facilities where file cabinets are locked, one or two people have the key.

Discussion

To the extent possible, facilities should take additional measures to protect client confidentiality. The introduction of identity codes has the potential to improve confidentiality if this practice is deemed feasible in the context of Guinea's health system. According to facility managers, no facilities currently require providers to sign a Code of Conduct addressing client confidentiality, which would be relatively simple to adopt. With training, SOPs, and consent forms, more facilities could ensure that providers obtain informed consent before sharing survivors' information in the context of referrals. Financial resources would be required to address other needs, such as for lockable file cabinets and for examination rooms that ensure both visual and auditory privacy.

Recommendations

- Highlight in the training the specific steps that providers should take to protect SV survivors' confidentiality.
- Encourage providers to report what they have learned to their facility managers and catalyze facility-wide change in practices regarding client confidentiality.
- Train providers to lead a half-day GBV cascade training, with a focus on confidentiality, for other staff at their facilities.

Services Offered

Results

About three-quarters of facility managers said that their facility provides services for gender-based physical assault, rape, and other types of sexual assault (Table 4). Four facility managers (19%) reported that their facilities do not currently provide services to respond to any type of GBV.

Table 4. Number (and %) of facilities offering services for various types of GBV

Type of GBV	No. (and %) (n=21)
Rape	16 (76%)
Other forms of sexual assault	16 (76%)
Gender-based physical assault	17 (81%)
Forced marriage	1 (5%)
Other, such as denial of resources or psychological abuse	0
No services for GBV survivors	4 (19%)

On the types of GBV treated, the responses of providers generally aligned with those of facilities, except for the last item: Forty-three percent of providers said that the facility offers services for other forms of GBV, such as denial of resources or psychological abuse.

Providers were asked to describe, step-by-step, what they would do if a client who had just been raped arrived at the facility. The interviewers did not prompt the providers with answers; they simply recorded the steps that the providers identified. Some providers may normally take steps that they did not mention in the interview; others might have mentioned steps that they do not normally take. Therefore, the responses in Table 5 give an indication of the steps generally taken by providers. Providers' responses are listed from most to least common, not in the order in which providers listed them.

Two-thirds of the providers would perform a physical examination and treat any wounds, and more than half would ask the client to describe what happened. Only about one in four would assure the client of confidentiality, provide psychosocial support, or test the client for HIV infection.

Table 5. Number (and %) of providers reporting various steps that they take when responding to rape

Step	No. (and %) (n=120)
Perform a physical examination	77 (64%)
Treat any wounds, if applicable	75 (63%)
Ask the client to describe what happened, any symptoms, and relevant medical history (e.g., HIV status)	70 (58%)
Assure the client of confidentiality	35 (29%)
Provide psychosocial support/comfort the client (e.g., explain that he or she is not at fault for experiencing rape)	31 (26%)
Test for HIV, if applicable	31 (26%)
Refer the client to another provider at the same facility for examination and care	9 (24%)
Refer the client for other services, according to his or her needs and wishes	29 (18%)
Provide postexposure prophylaxis, if applicable	13 (11%)
Test for pregnancy, if applicable	11 (9%)
Establish a medical certificate documenting the rape, according to the client's wishes	10 (8%)
Offer emergency contraception, if applicable	9 (8%)
Test for other STIs, if applicable	8 (7%)
Treat STIs, if applicable	5 (4%)
Administer other vaccines, if applicable (e.g., tetanus, Hepatitis B)	5 (4%)
Inform the client of his or her right to accept or refuse any of the services offered	4 (3%)
Discuss the client's safety (e.g., if he or she is in danger of continuing SV)	1 (1%)
In cases of domestic violence, ask whether children in the family are at risk of violence	0
Assess whether the client may be at risk of depression or suicide	0

Other steps that a handful of providers mentioned included welcoming the client, giving advice, setting up an appointment, and alerting the authorities.

Discussion

In some cases, the facility manager or provider may not have recognized certain services as a response to GBV. For instance, it seems likely that every health center treats cuts, which could come from gender-based physical assault, yet only 81% of facility managers said that their facility offers services for survivors of gender-based physical assault.

Even if some providers take more steps than they reported to the interviewers, the interview responses are cause for concern. For example, only 9% providers said that they would give a rape survivor a pregnancy test, and only 8% said that they would offer emergency contraception, if applicable. It appears to be particularly rare for providers to take nonmedical steps to respond to GBV, such as assessing client safety and suicide risk.

Recommendations

- Train providers to identify and treat the consequences of SV in survivors.
- Develop job aids for SV response and include them in the training materials.
- Ensure that providers memorize the specific steps to respond to SV or learn how to use job aids that cover these steps, and test providers on their recall of these steps through role-playing.
- Train providers to offer information on clients' rights and services, and to conduct safety planning with the survivors through role-playing.
- Return to the health facility 3–6 months after the training, to repeat the role-play exercise and refresh providers on the steps they learned.

Referrals

Results

Most facility managers referred SV survivors to legal assistance or law enforcement, when applicable, and two-thirds referred clients to psychosocial counseling (Table 6). Fewer referred clients to shelter or to an agency focusing on economic or social reintegration.

Table 6. Number and percentage of facilities offering various types of referrals, and the institutions to which they refer clients

Type of referral offered	No. (and %) of facilities (n=21)	Type of institution receiving referral
Legal assistance or law enforcement	18 (86%)	<ul style="list-style-type: none"> • The courts—7 • A forensic doctor—4 • A hospital—4 • The police—3
Shelter or a safe house	7 (33%)	<ul style="list-style-type: none"> • A hospital—3 • Security—2 • The agency for social affairs—1 • A guest house—1
Psychosocial counseling	14 (67%)	<ul style="list-style-type: none"> • The psychiatric ward—6 • A hospital—4 • The agency for social affairs—2 • Wise people (sages)—1 • UNICEF—1
Social reintegration	9 (43%)	<ul style="list-style-type: none"> • A hospital—3 • The agency for social affairs—2 • The courts—2 • UNICEF—1 • The community—1
Economic reintegration	5 (24%)	<ul style="list-style-type: none"> • A hospital—2 • NGOs—2 • Lawyers—1

Discussion

It appears that many facilities are missing opportunities to connect survivors of SV with services that may help them. In addition, some of the institutions where providers refer SV survivors appear unlikely to be able to directly meet the needs of survivors, as in the case of the three facilities that refer SV survivors to a hospital for shelter or social reintegration. The results also signal that appropriate referral services may not be available.

Recommendations

- Discuss the value of treating clients as whole people, with a wide range of needs.
- Develop lists of services available to SV survivors in each of the three regions, share these lists with providers during the training, help providers think of other resources to add to the lists, give providers copies of the lists for wider distribution in their facilities, and help providers plan how they will create a referral relationship with the services.

Commodities, Equipment, and Supplies

Results

Only 12 of 21 facility managers (57%) reported that their facilities offer emergency contraception (EC) to women who have experienced rape. Of these 12 facilities, eight (75%) had stock-outs of EC within the past three months. According to facility managers, only nine facilities (43%) offer postexposure prophylaxis (PEP) against HIV to those who have experienced rape. Of these nine facilities, three (33%) had stock-outs of PEP within the past three months. Overall, two-thirds of facilities had essential commodities, equipment, and supplies for STI testing consistently in stock over the three months prior to data collection, and fewer had consistent EC or PEP supplies (Table 7).

Table 7. Facilities with essential commodities, equipment, and supplies consistently in stock over the past three months

Commodities, equipment, and supplies	No. (and %) of facilities with (n=21)
EC supplies	4 (19%)
Materials for STI tests	14 (67%)
Materials with which to take samples for medico-legal purposes	0
PEP supplies	6 (29%)

When asked if their facility has the equipment and supplies to offer adequate services to SV survivors, four of 21 (19%) facility managers and 22 of 120 providers (18%) said “yes.” Those who said “no” listed the types of equipment and supplies they would need to adequately serve SV survivors. The most commonly self-identified needs were:

- Rape kits, including EC
- Lockable file cabinets
- Examination tables
- Materials with which to make sutures
- Management tools, such as registers, referral forms, and medico-legal forms

Discussion

Facilities' readiness to respond to SV is compromised by the lack of consistently available commodities, equipment, and supplies. To improve SV response in the health sector, commodity security issues need to be addressed. While individual providers and facility managers can take some steps to address these issues, many key steps are outside their purview. Therefore, it is essential to involve Ministry of Health officials and international NGOs or agencies, such as UNFPA.

Recommendations

- Identify funding sources to support the procurement of some of the missing equipment and supplies for SV response.
- Include in the curriculum examples of registers, referral forms, consent forms, and other documents that providers could photocopy and use at their facilities.
- In the training, address the importance of keeping track of the levels of stock of commodities, such as for EC and PEP, and of placing timely orders. Allow room for some discussion of stock-outs, since providers may have advice for each other about how to improve commodity security. Keep the duration of this discussion to a minimum, however, since it is a complex issue that could stimulate much debate, and it is not as relevant to SV response as other topics in the curriculum.
- Return to the health facilities 3–6 months after the training for a guided tour. With the facility manager and the provider who received training, discuss ways in which to improve the physical structure, commodities, equipment, and supplies.
- Discuss stock-outs and equipment needs with facility managers, Ministry of Health officials, and international NGOs and agencies, such as UNFPA.

Conclusion

The assessment identified a number of ways in which the Ministry of Health, RESPOND, and other partners could improve the health sector's response to SV, beginning with provider training. Overall, only six facility managers (29%) feel that providers at their facility have the necessary knowledge and skills to provide adequate care to SV survivors. All facility managers and 73% of providers see a need for additional provider training on SV. Specific recommendations for participant selection and curriculum development are listed in the Results, Discussion, and Recommendations sections above. Once RESPOND has piloted and revised the provider training program, the Ministry of Health should consider scaling it up through in-service training in other regions of Guinea and/or preservice training.

Currently, the health sector's response to SV varies widely across facilities, with many providers failing to take critical steps to protect client confidentiality, treat rape survivors, and offer referrals. One explanation for inconsistent response to SV across facilities is that the use of SV SOPs is not mainstreamed in the health sector. The Ministry of Health should ensure that its guidelines for response to SV are available at every health facility. In addition, the Ministry of Health and RESPOND should consider developing and distributing simple job aids for response to rape, domestic violence, and other forms of GBV. Job aids should include an SV response flowchart and a listing of other services available to SV survivors in each of the three regions. The Ministry of Health should also institute and enforce sexual harassment and assault policies in health services.

Many facility managers and providers identified a need for management tools, equipment, commodities, supplies, and improved infrastructure to adequately address SV. The Ministry of Health and RESPOND should disseminate registers, referral forms, consent forms, and other tools to assist providers in the management of SV cases. In addition, they should seek sources of financing to cover infrastructure and equipment, such as private examination rooms and lockable file cabinets, to improve SV response. Furthermore, the Ministry of Health should increase efforts to secure the supply chain of EC and PEP.

Efforts to respond to SV in the health sector should be accompanied by efforts to prevent GBV, including SV, in the community. Several facility managers and providers suggested providing facilities with information, education, and communication (IEC) materials on GBV and raising awareness of GBV in the community. In particular, the Ministry of Health, RESPOND, and/or partners should raise awareness of EC and PEP, indicate where they are available, and highlight that a rape survivor must present at a health facility quickly to benefit from them. RESPOND has established and trained community-level committees in Conakry to plan and carry out GBV prevention activities in their respective communities. The Ministry of Health should invest in GBV prevention efforts across the country.