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Health Care Providers in Uganda and Rwanda are Knowledgeable about Sexual Violence and HIV, but Few are Equipped to Provide Comprehensive Services

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Background

Sexual violence (SV) is increasingly recognized as an important driver in Africa's HIV epidemic due to the convergence of high HIV and SV prevalence rates in the region. To mitigate the HIV risks associated with SV, in 2008 PEPFAR launched a 2-year initiative to test the feasibility of integrating comprehensive SV services into existing HIV programs. This initiative is being piloted in 18 health facilities across Rwanda and Uganda. Interventions work to strengthen clinical care for SV, including post-exposure prophylaxis (PEP), and develop linkages with legal and community support 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 poster highlights results of the baseline assessment conducted between September and November 2009 in eight facilities in Rwanda and nine facilities in Uganda (Table 1). It includes data from two sources: quantitative data from a facility inventory (FI) 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. Separate FGDs were held for doctors and nurses. FI data were entered into EpiInfo and analyzed with SPSS 13.0; FGDs were manually coded and analyzed.

Table 1: PEPFAR SV Initiative Intervention Sites in Uganda and Rwanda

Country	Implementing Partner	Intervention Sites
Rwanda	Rwandan Ministry of Health	Project oversight
	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 District Hospital
		Bungwe Health Center
	Drew Cares International (DCI)	Kanombe Military Hospital
Uganda	Ugandan Ministry of Health	Project oversight
	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

Results

Services in both countries were generally weak, with facilities and providers in Uganda slightly better prepared to provide services than those in Rwanda. All respondents in both countries had a good level of knowledge of the risk of HIV infection associated with SV and were aware of the need for PEP.

Key findings from Rwanda include:

- While 100% of facilities had dedicated rooms or spaces for providing SV services, none of them contained the necessary equipment, supplies or drugs (including HIV PEP or emergency contraception (EC)) needed to deliver comprehensive SV care (Table 2).
- Only 38% 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% 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

  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. —Doctor

- 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.
- Delayed reporting at the health facility was the major challenge to provision of PEP to survivors of SV.

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

- 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.

  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. —Nurse

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

- Stigma, shame and a preference to settle cases at the community level were seen as key barriers to seeking care.

  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. —Nurse

- Providers were largely unaware of other SV services offered in their communities.

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

  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. —Doctor

Table 2: Summary of Facility Inventory Indicators, Rwanda and Uganda

	Infrastructure			Guidelines		HIV & Supplies				Records
	Facility open for 24 hour SV services (%)	Dedicated room for SV (%)	Doctor present at all times (%)	Guidelines for clinical mgt. available (%)	Guidelines for referrals available (%)	HIV rapid test kits available where exams conducted (%)	PEP drugs available where exams conducted (%)	Have 15 of 20 essential pieces of equipment where exams conducted (%)	EC pills available where SV exams conducted (%)	Records indicate SV clients (%)
Rwanda: Percent "yes" (n = 8 facilities)	13	100	38	13	13	0	0	0	0	63
Uganda: Percent "yes" (n = 9 facilities)	33	0	57	11	11	44	56	11	89	56

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%), PEP drugs (56%) and EC pills (89%) (Table 2).
- 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.

  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. —Nurse

- Only 56% 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.

  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. —Nurse

- 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.

  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 . —Doctor

- 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.

  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. —Nurse

- Limited community awareness of SV issues and services was seen as a major barrier to seeking care and for the provision of PEP.

  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. —Nurse

Conclusion

Although service providers in Uganda and Rwanda are aware of the HIV risks associated with SV, very few are equipped to provide the essential services.

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 are working 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.

References

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For more information about this study, please visit the **Population Council Booth #E–453**, our website, **www.popcouncil.org**, or e-mail: **jkeesbury@popcouncil.org**.