

## ORIGINAL RESEARCH ARTICLE

# Knowledge and practice of health workers on sexual and reproductive health and rights and gender-based violence: Evidence from three municipalities in Senegal

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## Abstract

Adolescents in low- and middle-income countries face numerous developmental, sexual and reproductive health (SRHR) challenges, including exposure to multidimensional violence. Dealing with gender-based violence (GBV) is of great importance and health personnel are key players. The objective of this work was to study the knowledge and practices of health personnel on SRHR and gender-based violence in Guédiawaye, Kaolack and Kolda communities in Senegal. A descriptive and analytical cross-sectional study was conducted, which consisted of health professionals (general practitioners and specialists, nurses, and midwives) and community health workers (community relays, bajenu gox, matrons). All health facilities in the three communities were included. Data analysis consisted of univariate analysis and logistic regression modeling to investigate the factors associated with the knowledge and practice of health personnels. An alpha risk of 5% was taken. A total of 78 health professionals and 128 community actors were included in the study. More than half of the health personnel (56.3%) had good knowledge of policies, standards and protocols relating to sexual and reproductive health services for women (adolescents) and about 60% on conventions and laws. The level of knowledge was good among 51% of respondents and good practices among 54.9%. The factors associated with good knowledge were the municipality in which the profession was practiced, and the effects of training received in the social construction of gender. The factors associated with the practices were knowledge of policies, standards and protocols through training, training received in the provision of family planning services, and in medico-psychosocial management of cases of sexual violence. We conclude that the knowledge of stakeholders (health professionals and community health workers) about sexual and reproductive health and gender-based violence is important for better service provision and good management of cases of gender based violence. (*Afr J Reprod Health* 2024; 28 [8s]: 163-175).

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**Keywords:** Knowledge; Practice; Personal health; Gender-based violence; Sexual health; Reproductive health

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## Résumé

Les adolescents des pays à revenu faible et moyen (PRFM) sont confrontés à de nombreux défis en matière de développement, de santé sexuelle et reproductive (SSR), notamment l'exposition à une violence multidimensionnelle. La prise en charge des violences de genre est d'une grande importance et le personnel de santé en constituent des acteurs clés. L'objectif de ce travail était d'étudier les connaissances et les pratiques du personnel de santé sur la santé sexuelle et reproductive (SSR) et les violences basées sur le genre dans les communes de Guédiawaye, Kaolack et Kolda au Sénégal. Une étude transversale descriptive et analytique a été menée. La population était constituée des professionnels de santé (médecins généralistes et spécialistes, infirmiers, sages-femmes) et des agents de santé communautaires (relais communautaires, bajénu gox, matrones). L'ensemble des structures de santé des trois communes ont été inclus avec un choix raisonné des cibles. Une analyse univariée et une modélisation par une régression logistique a été effectuée pour rechercher les facteurs associés à la connaissance et la pratique du personnel de santé. Un risque alpha de 5% a été pris. Au total 78 professionnels de santé et 128 acteurs communautaires ont été inclus dans cette étude. Plus de la moitié du personnel de santé (56,3%) avaient une bonne connaissance des politiques, normes et protocoles (PNP) des services de santé sexuelle et reproductive des femmes (adolescentes) et environ 60% sur les conventions et Lois. Le niveau de connaissance était bon chez 51% des enquêtés et les pratiques bonnes chez 54,9%. Les facteurs associés à la bonne connaissance étaient la commune d'exercice de la profession, le fait de bénéficier d'une formation en construction sociale du genre. Les facteurs associés aux pratiques étaient la connaissance des PNP à travers la formation, les formations reçues en offre de services PF et contraception d'urgence, en prise en charge médico-psychosociale des cas de violences sexuelles. En conclusion, la connaissance des acteurs (professionnels de santé,

## Introduction

Violence against women is a global public health crisis of pandemic proportions. It has serious social and economic consequences for countries and societies<sup>1</sup>. Gender-based violence is a serious public health problem<sup>2</sup>, very widespread around the world. It affects around 30% of women aged 15 to 49 who have been married or cohabiting worldwide<sup>1</sup>. Most of this violence is committed by intimate partners. Worldwide, almost a third (30%) of all women who have been in a relationship have experienced physical and/or sexual violence at the hands of their intimate partner, family members or people they are with, and with whom they maintain intimate emotional relationships. In some regions, 38% of women have suffered violence from their intimate partner<sup>3</sup>.

In the Eastern Mediterranean region, 31% of ever-partnered women have experienced physical and/or sexual violence from their intimate partner in their lifetime. Sexual and gender-based violence has harmful consequences on the sexual and reproductive health and mental health of victims<sup>4</sup>.

Adolescents in low- and middle-income countries face numerous developmental, sexual and reproductive health and rights (SRHR) challenges, including exposure to multidimensional violence. Gender-based violence (GBV) is highly prevalent in these countries and is strongly linked to poor SRHR outcomes. However, GBV interventions have not yet been adequately integrated into SRHR due to individual, social, cultural, service, and resource barriers<sup>5</sup>.

Crisis situations and the resulting response measures often exacerbate the difficulties and human rights violations faced by adolescent girls. Women and girls are disproportionately affected. The main effects highlighted by studies are the increase in physical, psychological and sexual abuse, the increase in the number of teenage pregnancies, poor management of menstrual hygiene and the appearance of early marriage<sup>6</sup>. Results show low

contraceptive coverage, moderate access to prenatal care, a high prevalence of sexual and gender-based violence and low use of sexual and gender-based violence prevention and support services among vulnerable women<sup>4</sup>.

The consequences of gender-based violence on women's health lead them to seek out the health centers closest to their homes, demanding answers<sup>7</sup>. Primary health care is recognized as an appropriate space to welcome women in situations of gender violence, because this model of attention is based on the link between the professional and the user<sup>8</sup>.

Furthermore, it was noted that professionals' knowledge of the definitions, epidemiology and management of violence ranged from reasonable to good. When it comes to what to do, professionals who receive assistance and training obtained safer results. Therefore, it has been suggested that educational activities be provided to support the actions of professionals against gender based violence<sup>9</sup>.

Professional training on violence is very important and professionals report having received instructions on this subject in their workplace<sup>9</sup>. In relation to the conduct of professionals in the face of situations of gender violence, there is evidence that working in health services for less than 10 years provided better knowledge on ways to provide services to individuals experiencing GBV. In addition, professionals who have received training in the services recognize violent situations and the behaviors to adopt<sup>9</sup>.

When dealing with cases of violence, some health professionals feel inhibited about addressing issues that go beyond traditional care<sup>10</sup>. Raising awareness at work from a biopsychosocial perspective of the health/disease process is essential<sup>11</sup>, given the complexity of gender-based violence. The lack of knowledge on how to act leads the professional not to directly address the subject, even in the event of suspicion of violence<sup>10</sup>. Adequate training of these professionals increases the likelihood of detection of gender-based

violence<sup>11</sup>. Another study, carried out among nurses in Spain, also revealed that the lack of adequate formal training of health workers in this area is the main difficulty in identifying these cases of violence<sup>9</sup>.

In the Senegalese context, few studies have been carried out on the knowledge and practices of health actors on GBV and SRHR. However, knowledge and practice guide the management of gender-based violence, which is of great importance, and health professionals are the key players. The objective of this study is to explore the knowledge and practices of health actors (health professionals and community actors) on gender-based violence and sexual and reproductive health and rights. We believe data will be relevant to designing policies and programmes for improving the services offered in health facilities and at the community level.

## Methods

The study was quantitative. A descriptive and analytical cross-sectional study was carried out in the regions of Dakar (communities of Guédiawaye), Kaolack (communities of Kaolack) and in the region of Kolda (communities of Kolda). The selection of these regions was made taking into account the indicators linked to the health of adolescent girls and also the presence of the partner Non-Governmental Organization called the Center for Infant and Family Guidance (CEGID) which has solid partnerships there and is responsible for the implementation of related interventions.

The population consisted of health professionals (general practitioners and specialists, nurses, midwives) and community health workers (community relays, bajénu gox, matrons). All health facilities in the three municipalities (Guédiawaye, Kaolack and Kolda) were included using purposeful sampling. At the health centre level, the following practitioners were interviewed: district doctor, the doctor responsible for the general consultation, paediatrician, gynaecologist, health centre major, paediatrics, midwives or reproductive health coordinators, community relay and bajénu gox (neighborhood godmothers). In addition, at the health post level, the head nurses, midwives,

matrons, community relays and bajénu gox were interviewed.

Data collection was done with pre-coded questionnaires to answer the research questions, based on a search of the literature on the theme of gender-based violence, and access to reproductive health services to adolescent girls. The collection tools were administered through face-to-face interviews. The tools included questions on providers' knowledge of Policies, Standards and Protocols (PNP) for SRHR services for women (adolescents); sources of information on PNPs for adolescent SRHR services; knowledge of conventions and laws relating to men, women (adolescents), among other themes.

The data were analyzed with R 4.2.1 software. A univariate analysis (quantitative variables described through the mean with its standard deviation and qualitative variables by absolute and relative frequencies) and a multivariate analysis by logistic regression were carried out to identify the factors associated with the knowledge and practices of health providers. Knowledge was assessed through an accumulation of scores making it possible to classify actors with a score greater than or equal to and lower than the median. Each knowledge item was scored 1 if the actor knew it and 0 if the actor did not know it. A cumulative score of 1 for each item was made.

The present work falls within the scope of a study and the protocol received approval from the Research Ethics Committee (CER) of the Cheikh Anta Diop University of Dakar (bearing the reference number SEN21/48 at the date of 04/08/2021) before the start of activities. Free and informed consent was requested from the study participants before the data collection began. Data collection was done anonymously.

## Results

### *Sociodemographic characteristics*

A total of 78 health professionals were included in this study, including 34.6% (27) in Guédiawaye, 44.9% (35) in Kaolack and 20.5% (16) in Kolda, the majority of whom were female (83.3%) with an

**Table 1:** Socio-demographic characteristics of the health providers

Personal characteristics	Health professionals <i>n=78</i>	CHWs <i>n=128</i>
<b>Sex</b>		
Female	65 (83.3)	115 (89.8)
Male	13 (16.7)	13 (10.2)
<b>Age</b>	39.6 (6.9)	44.7(11.7)
<b>Instruction</b>		
Primary	1 (1.3)	26 (20.3)
Average	1 (1.3)	32(25.0)
Secondary	17 (21.8)	59(46.1)
Superior	59 (75.6)	5 (3.9)
<b>Profession of service providers</b>		
Midwife	37 (47.4)	
Nurse	35 (44.9)	
Doctor	5 (6.4)	
Other	1 (1.3)	
<b>Profession of ASCs</b>		
Bajenu Gox		39 (30.5)
DSDOM		17(13.3)
Matron		29(22.7)
Relay		43(33.6)
<b>Doctor function (N=5)</b>		
District Chief Medical Officer	2 (40.0)	
General practitioner	3 (60.0)	
<b>Function of nurses and midwives (N=72)</b>		
Other	5 (6.9)	
SR coordinator	3 (4.2)	
Head nurse	32 (44.4)	
Mistress	2 (2.8)	
Midwife		
Service Major	3 (4.2)	
Health post midwife	27 (37.5)	

average age of 39.6 (SD +/-6.7) years. The community health worker (CHWs) represented 128 including 24.2% (31) from Dakar, 58.6% (75) from Kaolack and 17.2% (22) from Kolda, predominantly female (89.8%) (Table 1).

### ***Knowledge of policies, standards and protocols, conventions and laws***

Most health professionals in the three communes knew the policies, standards, and protocols (PNP) of sexual and reproductive health services for women (adolescents) on family planning (97.4%), adolescent and young people reproductive health (94.9%), the fight against gender-based violence (82.1%) and psychosocial care (80.8%). The sources of information for policies, standards and protocols (PNP) were from the training received at school or in service delivery points (PPS) (87.2%). More than 50% of ASCs knew about PNPs. The conventions and laws were known by more than 60% of health professionals, as well as the ASCs. The main source of knowledge of the types of violence was documentary research (81.2%) (Table 2, 3 and 4).

The level of knowledge of policies, standards and protocols was good for 56.3% of all health actors studied. This level was also reached on conventions and laws for 60.2% of health workers. Overall, we note a good level of knowledge at 51.0% (Table 9).

### ***Training of health professionals***

Concerning the training of health professionals on sexual and reproductive health, and the fight against GBV, 93.6% of them received training on a family planning service compared to 78.9% for community actors; 84.6% on the Integrated Management of Childhood Illness (PCIME) approach and the prenatal consultation (CPN) service package, finally, 83.3% had knowledge of the management of obstetric fistulas. Only 29.5% and 52.6% respectively benefited from training on the management of Female Genital Mutilation (FGM) and the treatment of sexual assault. More than a quarter of CHWs were trained in these areas (Table 5). With respect to sexual and reproductive health and rights (SRHR) aimed at adolescents/young people, the majority of providers (89.7%) had benefited from training on referrals to

**Table 2:** Knowledge of Policies, Standards and Protocols (PNP) for women's (adolescent) sexual and reproductive health services

<b>Knowledge of Policies, Standards and Protocols (PNP) for women's (adolescent) sexual and reproductive health services</b>	<b>Health Professionals n=78</b>	<b>CHW n=128</b>
Fight against gender-based violence	64 (82.1)	91 (71.1)
Reproductive health of adolescents and young people	74 (94.9)	120 (93.8)
Family planning	76 (97.4)	123 (96.1)
Psychosocial care	63 (80.8)	69 (53.9)
Other PNPs	3 (3.8)	1 (0.8)
None	1 (1.3)	2 (1.6)
<b>Source of information on Policies, Standards and Protocols for adolescent sexual and reproductive health services</b>	<b>Health Professionals</b>	<b>CHW</b>
Training (School / PPS)	68 (87.2)	76 (59.4)
Health providers (health facility)	34 (43.6)	42 (32.8)
Internet search	23 (29.5)	3 (2.3)
Social networks	17 (21.8)	7 (5.5)
Peers	18 (23.1)	67 (52.3)
Literature search	15 (19.2)	3 (2.3)
None		2 (1.6)
Others (media)	5 (6.4)	45 (35.2)

**Table 3:** Other sources of knowledge of PNPs for community stakeholders

<b>Other sources</b>	<b>45 (35.2)</b>
Chat	39 (86.7)
Teen center, in the media, NGO	1 (2.2)
Experience	4 (8.9)
Media	1 (2.2)

competent services when necessary and on the offer family planning (FP) and emergency contraception services. More than 40% of CHWs were trained in these areas (Table 5).

The majority of professionals, more than 70%, had received training on contraception (96.2%); the management of sexually transmitted infections (STIs) and HIV/AIDS (93.6%) and the management of cases of infertility/infecundity (79.5%) on the management of cases of infertility/infertility (Table 6). Around half of the respondents, i.e. 48.7%, received training on the treatment of rape, 47.4% on the psychological treatment of sexual harassment and 44.9% no training on specific violence services based on genre. Around 30% of CHWs were trained in these aspects (Table 7). More than half of health professionals 69.2% were trained on gender, 57.7%

on the social construction of gender, 66.7% on human rights and 60.3% on inequality based on gender (Table 7). Health professionals (around 80%) knew that what to do in the event of GBV included a medical response, a psychosocial response, emotional support, and more than 60% of CHWs. Only 33.3% mentioned the safety and security response among professionals compared to 15.6% at the CHWs level (and 16.7% for listening and referencing among professionals (Table 8). The level of practice was also good for 54.9% (Table 9).

### ***Implication of the training of health actors on knowledge and practice***

We identified the factors that are associated with good knowledge. As shown in Table 10, participants in Kolda district had less knowledge than those of the Guédiawaye district, while those who had benefited from training in the social construction of gender had better knowledge (ORa=4.69 CI=2.03-10.86).

Sources of knowledge on policies, standards and protocols through training had a positive influence on good practices (ORa = 5.14 CI = 1.26-21.02). Participants who had received training in the

**Table 4:** Knowledge of conventions and laws

<b>Knowledge of conventions and laws</b>	<b>Health Professionals N=78</b>	<b>CHW</b>
Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) of 1979, ratified by Senegal in 1985	75 (96.2)	122 (95.3)
Additional Protocol to the African Charter on Human and Peoples' Rights relating to the Rights of African Women (1981) It was ratified by Senegal in 2004 and entered into force in 2006.	58 (74.4)	93 (72.7)
United Nations Convention on the Rights of the Child, which states that young people have a right to life, development, the highest attainable standard of health and medical and rehabilitation services	58 (74.4)	90 (70.3)
Convention 138 of the International Labor Organization (ILO) on the minimum age for admission to employment set at 15 years ratified by Senegal in 1999	60 (76.9)	80 (62.5)
Convention 182 on the Worst Forms of Child Labor (PFTE) ratified in 2000, defines a child as a person under the age of 18	65 (83.3)	103 (80.5)
Constitution of Senegal guaranteed Gender equality in law. Equal access for men and women to mandates and functions. Equal access for men and women to possession and property under the conditions determined by law.	66 (84.6)	110 (85.9)
Law No. 200518 of August 5, 2005 relating to reproductive health which emphasizes the services and care required, the rights of clients as well as the profile of PPS authorized to offer the services	71 (91.0)	73 (57.0)
Law No. 99-05 of January 29, 1999 which modifies the penal code with a view to penalizing pedophilia, domestic violence, female genital mutilation and sexual harassment	62 (79.5)	111 (86.7)
January 10, 2020, law 2020-05 amending law 65-60 of July 21, 1965 on the Penal Code made criminal sanctions on gender-based violence more severe by criminalizing rape and pedophilia and toughening related penalties. sexual harassment (Article 319 bis, 320 and 320 bis, of the Penal Code).	68 (87.2)	117 (91.4)
Law No. 2010-03 of April 9, 2010 which concerns the comprehensive care of people infected with or affected by HIV and prevention	64 (82.1)	106 (82.8)
Ratification, without reservation by Senegal, of all international and regional African instruments which provide that the legal minimum age for marriage is 18 years for boys and girls	63 (80.8)	103 (80.5)
None		2 (1.6)
<b>Sources of knowledge of conventions and laws</b>		
Training (School / PPS)	63 (80.8)	65 (50.8)
Health providers (health facility)	28 (35.9)	42 (32.8)
Internet search	30 (38.5)	8 (6.2)
Social networks	25 (32.1)	17 (13.3)
Peers	21 (26.9)	74 (57.8)
Literature search	21 (26.9)	7 (5.5)
Others (media)	11 (14.1)	54 (42.2)

**Table 5:** Training in sexual and reproductive health and the fight against GBV

<b>Training in the areas of maternal, perinatal or neonatal health</b>	<b>Health Professionals</b>	<b>CHW</b>
Integrated Management of Childhood Illness (PCIME) approach	66 (84.6)	37 (28.9)
Prenatal consultation (CPN) benefit package	66 (84.6)	
Postabortion care (PAC)	58 (74.4)	
Emergency obstetric and neonatal care (SONU)	50 (64.1)	
Management of obstetric fistulas	23 (29.5)	
Family planning service	73 (93.6)	101 (78.9)
Newborn care	65 (83.3)	68 (53.1)
Management of Female Genital Mutilation (FGM)	23 (29.5)	26 (20.3)
Management of sexual assault	41 (52.6)	38 (29.7)
Management of other non-infectious genital conditions in women and men	54 (69.2)	
None	3 (3.8)	20 (15.6)
<b>Training in the areas of sexual and reproductive health (SRH) aimed at adolescents/young people</b>		
IEC/CCC activities on prevention and promotion of health-promoting behaviors	64 (82.1)	79 (61.7)
Disturbances and transformations of adolescence	59 (75.6)	50 (39.1)
Good behavior, healthy living practices, the rights and duties of adolescents	60 (76.9)	60 (46.9)
Importance of the premarital assessment	57 (73.1)	25 (19.5)
Voluntary, anonymous and free HIV testing	68 (87.2)	80 (62.5)
Distribution of condoms	69 (88.5)	85 (66.4)
Offer of family planning (FP) and emergency contraception services	70 (89.7)	83 (64.8)
Referral to relevant services if necessary	70 (89.7)	60 (46.9)
Fight against sexual violence and other violence	59 (75.6)	54 (42.2)
Medical-psychosocial care for cases of sexual violence and other violence	45 (57.7)	38 (29.7)
None	1 (1.3)	24 (18.8)

**Table 6:** Training on family planning services

<b>Training on the following family planning services</b>	<b>Health professionals</b>
Contraception	75 (96.2)
Management of cases of infertility/infertility	62 (79.5)
Management of STIs and HIV/AIDS	73 (93.6)
Other	1 (1.3)
None	1 (1.3)
<b>Training on the following contraceptive methods</b>	
Breastfeeding and Amenorrhea Method	74 (94.9)
Cycle collar or MJF	69 (88.5)
Male condoms	73 (93.6)
Female condoms	72 (92.3)
Progesterone Vaginal Ring (AVP)	34 (43.6)
Intrauterine device (IUD)	67 (85.9)
Spermicides	46 (59.0)
Progestin-only contraceptive pills	70 (89.7)
Injectable progestin contraceptives	74 (94.9)
Emergency contraception	72 (92.3)
Implants	70 (89.7)
Voluntary Surgical Contraception (CCV)	12 (15.4)
None	2 (2.6)

**Table 7:** Training on specific gender-based violence services

Specific gender-based violence services	Health Professionals N=78	CHW
<b>Training on specific gender-based violence services</b>		
Treatment of rape	38 (48.7)	39 (30.5)
Psychological support for sexual harassment	37 (47.4)	42 (32.8)
Management of female genital mutilation	24 (30.8)	25 (19.5)
None	35 (44.9)	78 (60.9)
<b>Training on specific theme</b>		
Gender	54 (69.2)	60 (46.9)
Social construction of gender	45 (57.7)	42 (32.8)
Femininities and masculinities	46 (59.0)	48 (37.5)
Gender-based inequalities	47 (60.3)	35 (27.3)
Link between gender and health	46 (59.0)	43 (33.6)
Exploring the links between gender and other determinants of health	44 (56.4)	33 (25.8)
Human rights	52 (66.7)	59 (46.1)
Gender and rights perspective in reproductive health research	46 (59.0)	34 (26.6)
Gender perspective for a critical look at health information	47 (60.3)	30 (23.4)
Development of a project more sensitive to gender and legal issues	41 (52.6)	36 (28.1)
Integration of social and gender dimensions in health program planning	39 (50.0)	38 (29.7)
None	18 (23.1)	56 (43.8)
<b>Training on the complaints management mechanism and case processing</b>		
Empathetic and non-judgmental listening to treat each survivor with respect and dignity so that they are able to tell their story in their own words, while guaranteeing them the possibility of keeping their story to themselves;	39 (50.0)	56 (43.8)
Do not re-victimize and re-traumatize survivors who are courageous enough to complain, contribute to their healing and empowerment;	36 (46.2)	46 (35.9)
Comprehensive, detailed information communicated in an easy-to-understand manner, on the services and the complaints mechanism, to be provided to victims;	38 (48.7)	48 (37.5)
Complaints management mechanism: who to contact, the different stages, whatever the entry point into the support circuit.	41 (52.6)	56 (43.8)
None	35 (44.9)	65 (50.8)
<b>Knowledge of GBV support guides</b>		
No	68 (87.2)	113 (88.3)
Yes	10 (12.8)	15 (11.7)
<b>Guide Name (N=10)</b>		
Building the future	6 (60.0)	
Guide the bridge		5 (33.4)
Don't remember	3 (30.0)	10 (66.6)
Reproductive health of young adolescents	1 (10.0)	
<b>Application guide in the practice of caring for victims of GBV (N=10)</b>		
No	2 (20.0)	11 (73.3)
Yes	8 (80.0)	4 (26.7)

**Table 8:** Practice of health actors faced with gender-based violence

Practice in front of a GBV	Health Professionals N=78	CHW
<b>What to do in the event of GBV</b>		
Medical response	63 (80.8)	77 (60.2)
Psychosocial response	63 (80.8)	86 (67.2)
Emotional support	76 (97.4)	124 (96.9)
Safety and Security Response	26 (33.3)	20 (15.6)
Others to be specified (listening and referencing)	13 (16.7)	8 (6.2)
<b>Reporting principles/procedures to follow</b>		
Guaranteed anonymity;	63 (80.8)	97 (75.8)
Confidentiality ;	72 (92.3)	111(86.7)
Security and residual risk assessment;	33 (42.3)	30 (23.4)
Guarantee of human dignity	50 (64.1)	58 (45.3)
Building confidence	60 (76.9)	97 (75.8)

**Table 9:** Level of knowledge and practice of health personnel

Characteristic	n (%)
<b>Level of knowledge of policies, standards and protocols</b>	
Good	116 (56.3)
Bad	90 (43.7)
<b>Level of knowledge of conventions and laws</b>	
Good	124 (60.2)
Bad	82 (39.8)
<b>Overall knowledge level</b>	
Good	105 (51.0)
Bad	101 (49.0)
<b>Level of practice</b>	
Good	113 (54.9)
Bad	93 (45.1)

provision of family planning services and emergency contraception (ORa = 6.14 CI=1.79-21.04]), in medico-psychosocial management of cases of sexual violence and other violence (ORa =

4.66 CI=1.55-14.03) and in Gender perspective for a critical look at health information (ORa = 10.68 CI=1.43-79.49) had better practices (Table 11).

## Discussion

The study showed a good level of knowledge of policies, standards, protocols, conventions, and laws among the participants Overall, the level of knowledge of the actors was good at 51.0% as was the level of practice at 54.9%. The factors associated with good knowledge were the municipality in which the profession was practiced, and the benefits obtained from training in the social construction of gender. The factors associated with practices were training on policies, standards and protocols, training in the provision of family planning services and emergency contraception, in medico-psychosocial management of cases of sexual violence and other violence and in Gender perspective for a critical look at health information.

Overall the level of knowledge of the actors was good. Other authors have found similar results. Martins L de CA et al<sup>9</sup> who was able to show that the knowledge of professionals on the definitions, epidemiology and management of violence ranged from reasonable to good, despite knowing little about the prevalence of violence or violence during pregnancy. In fact, more than 80% of professionals showed that they knew the concept of gender violence. Regarding the disclosure of violence, the knowledge of users' direct approach to violence was low. Most professionals showed that they did not know how to approach women about the violence they had experienced<sup>9</sup>.

Our work showed that less than half, or 48.7% of respondents, received training on the treatment of rape, 47.4% on the psychological treatment of sexual harassment and 44.9% no training on the specific gender-based violence services. These results are below compared to those of Martins L de CA et al<sup>9</sup> who found that among those questioned about professional training in matters of violence, 83.1% considered it to be very important and 66.0% declaring having received training and instructions on this subject at their workplace. They also found a good level of

**Table 10:** Factors associated with the level of knowledge of health personnel regarding SRH and gender-based violence

Features	Awareness Good vs Bad		P value
	Crude odd ratio (ORb)	adjusted odd ratio (ORa)	
<b>District</b>			< 0.001
Guédiawaye	1	1	
Kaolack	1.5 (0.79-2.87)	0.95 (0.42-2.16)	
Kolda	0.23 (0.09-0.62)	0.08 (0.02-0.28)	
<b>Source of knowledge of conventions and laws through social networks</b>			0.058
No	1	1	
Yes	1.77 (0.85-3.67)	2.39 (0.95-6.04)	
<b>Training in IEC/CCC activities on prevention and promotion of health-promoting behaviors</b>			0.060
No	1	1	
Yes	2.55 (1.4-4.64)	2.24 (0.96-5.21)	
<b>Training in family planning (FP) service provision and emergency contraception</b>			0.125
No	1	1	
Yes	2.66 (1.38-5.1)	1.95 (0.83-4.59)	
<b>Training in the fight against sexual violence and other violence</b>			0.168
No	1	1	
Yes	1.71 (0.98-2.98)	0.55 (0.23-1.3)	
<b>Training in Gender Social Construction</b>			< 0.001
No	1	1	
Yes	3.87 (2.13-7.02)	4.69 (2.03-10.86)	

knowledge of mandatory notification (70.5% of correct answers). In contrast, regarding the notification of cases, 50.1% of people answered correctly and 40.9% said they did not know, indicating a need for clarification regarding the execution of the procedure<sup>9</sup>. The results of a qualitative investigation showed the invisibility of violence in the service and the lack of awareness of the gender category and its complexity. Thus, adapting health care work processes to care for women in situations of violence constitutes a major challenge in providing assistance that can reduce gender-based oppression<sup>7</sup>. These results suggest a need for capacity building and awareness raising among health personnel in order to improve the level of knowledge about gender-based violence.

Nurses' scope of work includes organization and paperwork. In addition, they are well aware of

the protocol for assisting victims of sexual violence, which is the only one to have a specific protocol<sup>10</sup>.

The factors associated with good knowledge identified in this study was the municipality in which the profession is practiced, and the fact of benefiting from training in the social construction of gender. This suggests the need for capacity building for health actors. Furthermore, developing comprehensive, accessible and quality services for women victims of violence and their children will involve strengthening the capacities of service providers in all sectors (for example, health, justice, education, social services). Joint multisectoral responses must be strengthened to better respond to and prevent violence against women<sup>12</sup>. Martins L de CA *et al*<sup>9</sup> found similar results. When verifying information relating to the conduct of professionals in situations of gender violence, they found that

**Table 11:** Factors associated with the practice of health personnel in terms of SRH and gender-based violence

Features	Practical Good vs Bad	adjusted GOLD	P value
	raw gold		
<b>District</b>			< 0,001
Guédiawaye	1	1	
Kaolack	8.19 (3.65-18.38)	32.53 (8.66-122.26)	
Kolda	192 (23.26-1584.74)	1952.02 (106.58-35751.38)	
<b>Level of knowledge of PNPs</b>			0,086
Bad	1	1	
Good	1.4 (0.8-2.44)	0.4 (0.14-1.16)	
<b>Age</b>	1 (0.97-1.03)	1.06 (1.02-1.11)	0,005
<b>Type of health worker</b>			0,054
Community worker	1	1	
Professional	2.05 (1.14-3.67)	3.14 (0.96-10.29)	
<b>PNP Knowledge</b>			0,017
<b>Source/Training</b>	1	1	
No	2 (1.09-3.65)	5.14 (1.26-21.02)	
Yes			
<b>Source of knowledge of conventions and laws/Training</b>			0,001
No	1	1	
Yes	0.93 (0.52-1.64)	0.14 (0.04-0.49)	
<b>Training in family planning (FP) service provision and emergency contraception</b>			0,002
No	1	1	
Yes	3.99 (2.04-7.84)	6.14 (1.79-21.04)	
<b>Training in medico-psychosocial treatment of cases of sexual violence and other violence</b>			0,005
No	1	1	
Yes	3.4 (1.87-6.21)	4.66 (1.55-14.03)	
<b>Exploring the links between gender and other determinants of health</b>			0,077
No	1	1	
Yes	4.83 (2.5-9.2)	0.17 (0.02-1.28)	
<b>Training in Gender Perspective for a critical look at health information</b>			0,016
No	1	1	
Yes	7.05 (3.57-13.93)	10.68 (1.43-79.49)	

working in health services for less than 10 years indicates better knowledge of ways to act towards gender violence. In addition, professionals who had received training in the services were more likely to

recognize violent situations and the behaviors to adopt<sup>9</sup>.

Our study showed that around 80% of health professionals and more than 60% of CHWs

mentioned the medical, psychosocial response and emotional support as actions to take in the event of GBV. Only 33.3% mentioned the safety and security response among professionals compared to 15.6% at the ASC level and 16.7% of professionals for listening and referencing. Our study showed a good level of practice at 54.9%. According to Tetikcok R *et al*<sup>2</sup>, in addition to medical intervention, it is necessary to find a way to provide psychosocial and legal support to victims. When doctors encounter women who have experienced violence, assessing the violence in the context of a legal case helps identify the violence and prevents it from becoming a cycle passed down from generation to generation. Martins L of CA,<sup>9</sup> when assessing professionals' feelings towards gender-based violence, found that 52.0% of them felt uncomfortable asking if the woman was subjected to violent situations with their partner. Most participants agreed that the role of professionals in dealing with gender-based violence must be the same as in situations where children are victims (65.3%). The number of wrong answers (97.8%) regarding the use of protocols for violence case management was also notable. A contrast between the discourses of doctors and nurses was observed regarding the guidance and management of cases of violence. Nurses see themselves as responsible for orientation, referral and case reporting, which is not the case for doctors. In addition, nurses insisted that cases should be managed by a multiprofessional team. The differences in discourse between doctors and nurses are probably linked to the fact that nurses are obliged to participate in training for the implementation of notification, which is not the case for doctors<sup>9</sup>. Medicalization has been considered the most important limitation of professional practice.

Furthermore, there are possibilities linked to the link offered by the logic of attention. However, these possibilities are still limited by the limits of the biomedical model and the absence of specific technologies to deal with violence<sup>8</sup>. Additionally, several digital health strategies have also been identified that can be used to develop integrated GBV and reproductive health services to improve adolescent health outcomes<sup>5</sup>.

Our study found as factors that could influence practices, sources of knowledge of policies, standards and protocols through training, training received in the provision of family planning and emergency contraception services, in medico-psychosocial care for cases of sexual violence and other violence.

Vieira EM *et al*<sup>10</sup> found results suggesting that training is linked to a positive attitude towards violence among primary health care professionals in Catalonia and Costa Rica<sup>10</sup>. Professionals who received shorter assistance and training had safer results in terms of what to do. It is then suggested to carry out educational actions in services in order to provide support for the action of professionals against cases of gender violence<sup>9</sup>. Martins *et al*<sup>9</sup> found similar results. Concerns and uncertainties about what procedure to follow in the case of a patient suffering from domestic violence may well be linked to the usual practical orientation of doctors towards what might be called effective action<sup>9</sup>.

## Limitation

As a limitation of this study, subjectivity was noted in measuring the level of knowledge and practice. Our calculation was based on an accumulation of scores making it possible to classify actors with a score greater than or equal to the median and lower. However, the sample was exhaustive across all structures with reasoned choice of targets, namely health professionals and community stakeholders.

## Conclusion

The level of knowledge and practices of health actors (professional and community) was good while the main factor linked to knowledge and practice was training. It is important to improve the knowledge and practices of health workers on sexual and reproductive health and gender-based violence. The management of GBV is of paramount importance among women, particularly adolescent girls. Health personnel are an essential element in this strategy. We conclude that the knowledge of stakeholders (health professionals, community health workers) about sexual and reproductive health

and gender-based violence is crucial for better service provision and good management of cases of violence.

## References

1. WHO, Department of Sexual and Reproductive Health and Research (SRH). Violence against women prevalence estimates, 2018 – Global fact sheet [Internet]. World Health Organization; 2021 March 5. [cited May 31, 2023]. Available: <https://www.who.int/publications-detail-redirect/WHO-SRH-21.6>
2. Tetikcok R, Ozer E, Cakir L, Enginyurt O, İscanli MD, Cankaya S, et al. Violence towards women is a public health problem. *J Forensic Leg Med.* 2016 Nov 1; 44:150-7. <https://www.sciencedirect.com/science/article/pii/S1752928X16301317>
3. WHO, Department of Reproductive Health and Research. Global and regional estimates of violence against women [Internet]. WHO, Department of Reproductive Health and Research, London School of Hygiene and Tropical Medicine, South African Medical Research Council; 2013 Oct [cited December 11, 2023]. <https://www.who.int/publications-detail-redirect/WHO-RHR-HRP-13.06>
4. Acharai L, Khalis M, Bouaddi O, Krisht G, Elomrani S, Yahyane A, et al. Sexual and reproductive health and gender-based violence among female migrants in Morocco: a crosssectional survey. *BMC Women's Health.* 2023 Apr 11; 23:174. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC10091612/>
5. Huang KY, Kumar M, Cheng S, Urcuyo AE and Macharia P. Applying technology to promote sexual and reproductive health and prevent gender-based violence for adolescents in low and middle-income countries: digital health strategies synthesis from an umbrella review. *BMC Health Serv Res.* 2022 Nov 19; 22:1373. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9675248/>
6. Shukla S, Ezebuihe JA and Steinert JI. Association between public health emergencies and sexual and reproductive health, gender-based violence, and early marriage among adolescent girls: a rapid review. *BMC Public Health.* 2023 Jan 17; 23(1):117. <https://doi.org/10.1186/s12889-023-15054-7>
7. Almeida LR de, Silva ATMC da and Machado L dos S. The object, the purpose and the instruments of healthcare work processes in attending to gender-based violence in a primary care service. *Botucatu interface.* 2014; 18(48):47–59. <https://www.scielo.br/j/icse/a/4msY5xCRYsRjcwHrJTVD95p/abstract/?lang=pt>
8. Guedes RN, Fonseca RMGS da and Egry EY. The evaluative limits and possibilities in the family health strategy for gender-based violence. *Rev Esc Enferm USP.* 2013 Apr; 47:304–11. <https://www.scielo.br/j/reeusp/a/cnnvPfnkz5pHCfM8kLHhY5S/?lang=en>
9. Martins L de CA, Silva EB da, Dilélio AS, Costa MC da, Colomé ICDS and Arboit J. Gender violence: knowledge and professional conduct of the family health strategy. *Rev Gaucha Enferm.* 2018 July 2; 39:e20170030. <https://doi.org/10.1590/1983-1447.2018.2017-0030>
10. Vieira EM, Ford NJ, De Ferrante FG, Almeida AMD, Daltoso D and Santos MAD. The response to gender violence among Brazilian health care professionals. *Ciênc Saúde Coletiva.* 2013 March; 18(3):681-90. [http://www.scielo.br/scielo.php?script=sci\\_arttext&pid=S1413-81232013000300014&lng=en&tlng=en](http://www.scielo.br/scielo.php?script=sci_arttext&pid=S1413-81232013000300014&lng=en&tlng=en)
11. Rojas Loría K, Gutiérrez Rosado T, Alvarado R and Fernández Sánchez A. [Attitude of primary care professionals to gender violence. A comparative study between Catalonia and Costa Rica]. *Aten Primaria.* 2015 Oct; 47(8):490-7. <http://dx.doi.org/10.1016/j.aprim.2014.10.008>
12. WHO Department of Sexual and Reproductive Health and Research (SRH). Violence against women prevalence estimates, 2018 – Global fact sheet [Internet]. World Health Organization; March 2021[cited April 25, 2024]. Available: <https://www.who.int/publications-detail-redirect/WHO-SRH-21.6>.