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An Examination of the Benefit of the Sexual Assault Care and Practice (SACP) Programme in Gauteng, South Africa

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A research report submitted to the Faculty of Health Sciences,

in partial fulfilment of the requirements for the degree of

MSc Med in the field of Bioethics and Health Law

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A research report submitted to the Steve Biko Centre for Bioethics Faculty of Health Sciences, University of the Witwatersrand, Johannesburg in partial fulfilment of the requirements for the Degree of Master of Medicine in the field of Bioethics & Health Law

Declaration

I, Claire Mooideen student number **W0454770,** registered for the degree of MSc Med Bioethics and Health Law.

I hereby declare the following:

- I am aware that plagiarism (the use of someone else's work without their permission and/or without acknowledging the original source) is wrong.

- I confirm that the work submitted for assessment for the research report is my own unaided work except where I have explicitly indicated otherwise.

- I have followed the required conventions in referencing the thoughts and ideas of others.

- I understand that the University of the Witwatersrand may take disciplinary action against me if there is a belief that this is not my own unaided work or that I have failed to acknowledge the source of the ideas or words in my writing.

- This work has not been submitted to any other institution or university for any degree or examination purpose.

Signature:

Date: 18/03/11

Dedication

I dedicate my dissertation to my late husband, and to my mother and siblings, to my children, and grandchildren for believing in me, and having faith that “I will conquer”! Their valuable support meant so much to me, especially during these last five years.

This dissertation is also dedicated to all the survivors of gender-based violence and the activists who have committed themselves to address this complex and devastating social issue.

Abstract

In the reflective section of this paper I show that healthcare for gender-based violence, especially sexual assault patients has largely been a neglected area of service delivery in South Africa. There are substantial gaps in service provision in many parts of the country with repeated reports that the process of seeking health care and justice exposes such patients to further trauma.

I suggest that in South Africa, as well as elsewhere, it is time for nursing to take the lead in building multidisciplinary partnerships in clinical practice, education, and research in the area of sexual assault and violence. It shows why it is imperative that the underlying intention of upholding and promoting patient advocacy and family health care remains a core value of nursing. It argues that the role of “forensic skill and knowledge” in the nursing sector is vital tool in the struggle against gender-based violence.

In the empirical section, a survey was conducted to examine and articulate the question of the Sexual Assault Care and Practice (SACP) programme being a benefit (or not) to Sexual assault caregivers; to determine whether there has been retention of the knowledge by nurses and doctors who participated in the SACP programme; to evaluate whether there is or is not an improvement in service provision for sexual assault clients, to evaluate if the participants felt the SACP programme to have been of benefit and to identify hindrances to programme implementation. As noted by this study, survivors of sexual assault and violence continue to be in need of expert forensic services, and knowledge concerning the management and care of survivors appears to benefit from a formal training programme. No determination could be made from this survey concerning the perceived benefits of the programme or hindrances to care. This may reflect the current status of the programme in South Africa and provides cause for reflection.

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Preface

My Personal Journey towards Activism against Gender-based Violence

We must accept finite disappointment,

but we must never lose infinite hope.

Dr. Martin Luther King

My personal nursing experience supports the above statement. This study draws on my personal experience as a clinical nurse, then as a nursing tutor and later as an activist against gender-based violence.

I commenced my nurse training in 1975 where as a young married woman I was exposed to women who were experiencing domestic violence. I felt hopeless to assist these women as domestic violence was not highlighted in the nursing curriculum at that time, and if it was included it was not a priority subject. Domestic violence at that time, was viewed more as a 'private matter' and public-private interventions were not the norm. Nonetheless, abused women would be seen in the emergency departments and they would request assistance. The abused women would receive medical care but I recognised early on that these women needed additional interventions to empower them to be able to overcome the abuse. Healthcare practitioners at that time (and often, even now) lacked sufficient training and expertise regarding the care, treatment and

management of patients presenting with gender-based violence including rape survivors. This was of great concern to me as nursing was my chosen career and to me a caring profession with a strong advocacy aspect. It was in this context that my personal journey in the prevention of gender-based violence began.

In 1992, after completing general nursing and midwifery at Northdale Hospital and psychiatry at Town Hill in Pietermaritzburg, I took a transfer to Addington Hospital in Durban. It was there I identified opportunities to join the active movement in the prevention of gender-based violence. As a Sister in Charge of the Polyclinic, (near Point Road - a known “red light” district) I saw abused women daily who came for assistance at the clinic.

My pivotal turning point was when a woman arrived at the Polyclinic following a vicious assault by her drug-dealing partner recently released from goal. She was medically treated and allowed to return home to the perpetrator without any social intervention. That same evening the women was found dead on the street. The assumption was that her drug-dealing partner threw from the flat, five stories down to her death. This unnecessary and brutal act was what prompted me to join the National Network on Violence against Women (NNVAW) as member, treasurer and eventually as a chairperson.

NNVAW seeks to challenge and eliminate all forms of abuse, oppression, and discrimination against women facing violence by empowering them choose to build better lives. NNVAW is a broad-based coalition of more than five hundred organizations and individuals that advocates for, provides services to, and assists victims of domestic violence, sexual assault, and trafficking. It is composed of survivors, advocates, activists, attorneys, educators and other professionals committed to ending violence against women.

NNVAW aims to:

- build capacity for women to become leaders against all forms of violence;
- promote an understanding of the complex realities of women facing violence;
- provide technical and training support to service providers, attorneys, community advocates and other professionals (both governmental and non-governmental) working with women exposed to violence at the local and national level; and to
- increase public awareness, education, and understanding of issues around violence against women.

In addition, the NNVAW is also involved in advocacy by promoting law and public policy reforms at the local and national levels that benefit women facing violence. An example of the advocacy work of the NNVAW was their submission of input into the Domestic Violence Act, 1998.

In 1994, following the development of the Constitution, there was a sense of hope; a climate of change in the new South Africa. People were becoming aware of their rights. Women were recognised as being equal before the law. “Gender equality” was a new term on everyone’s lips; people were seeing the links between violence and the past; violence and health, and health itself was looked upon as a human right.

It was during this exciting time that I obtained an Honors degree in Nursing Education and was offered a post as Head of Department of Social Science at the Addington Nursing College. Based on the knowledge and skills obtained from the association with the gender-based activism movements, I was able to advocate that gender-based violence became an integral part of the Addington Hospital’s nursing curriculum.

This is where an informal curriculum in forensics and management of victims of gender-based violence began - long before its ‘formalisation’ in 2005. Besides facilitating on gender-based violence in the classroom for trainee nurses, I obtained permission from the hospital management to invite the NNVAW to hold workshops on gender-based violence, especially on the management of rape survivors for Addington Hospital personnel. From these workshops, a core group of professional nurses interested in the prevention of gender-based violence was identified and a greater understanding of the need for a formal educational programme in forensic nursing was instilled.

One of the coalition organizations active in the prevention of gender-based violence was the *Advice Desk for the Abused*. Based in KwaZulu-Natal, the Advice Desk for the Abused was a leading NGO with 21 years of experience addressing domestic violence. Founded in 1986 by the present South Africa-Netherlands Programme on Alternatives in Development director, Anshu Padayachee and Judge Navi Pillay; the organization's focus remains on crisis intervention, counseling, training, advocacy and research for survivors and perpetrators. Empowerment of women was given priority, as women were seen as the main victims of human rights violations and historic discrimination, even in times of relative peace. The Advice Desk for the Abused assisted survivors to prepare in reporting cases of domestic violence. This organization also recognised the great and urgent need for perpetrators to understand abusive behaviour and empower them with knowledge on how to unlearn this "learned" behaviour. Grounding this approach is the understanding that much gender-based abuse is a vicious cycle. To break this cycle, women must be removed to a safe and secure environment where support (physical and psychological) is available. In such a "safe house", located in an "unknown" area, healing processes could begin.

One of the major roles of the Advice Desk for the Abused was training and education. The organization offered a three-day integrated theory and practice Crisis Intervention Training Workshop. It was a dynamic multimedia presentation using a variety of teaching-learning tools such as lectures on Power Point, educational videos, role-play and frank discussions. Participants were those who wished to volunteer their services to

The Advice Desk for the Abused, and included professionals from the legal, medical, education, media and business fraternities. This workshop then included a follow-up practical component of 40 hours of monitored in-service training at the Head Office and the three outlying satellite offices situated at Durban, Pinetown and Verulam Magistrates Courts.

The coordinator of the Advice Desk for the Abused was approached with a request for training for an identified core group of professional nurses from Addington Hospital. The three day training was undertaken by 13 professional nurses and this included the 40 hours of experiential learning. The experiential learning took place at district services under the supervision of the District Surgeons (where victims of sexual assault were managed). In addition, this learning included Family Courts were women experiencing domestic violence were assisted in filling charge sheets and applying for protection orders; as well as time spent at the Safe Houses where women and their children were housed and assisted with interventions to help them make decisions concerning their future. The trained staff were referred to thereafter as “interventionists”.

Once the training was completed, these “interventionists” took the decision to approach Addington management to provide a area off the accident and emergency unit. The unit was named *Sinothando* meaning “we have love”. It was in this unit that what the educational training of the course was implemented. Interestingly, this service was offered beyond the normal working duties of the nurses. A roster, based on a call out

system was implemented . The *Sinothando* unit still exists, now as the Crisis Centre operated under the Department of Health.

By the mid 1990's, various moves were made to address sexual assault and abuse, nationally and locally, but one area of great need remained - the education and role of nurses in such a programme's implementation. Now, much later, professional training programmes for nurses in forensic care have been implemented and disbanded. Nursing as a profession turned inward and faces numerous crises in understanding of its meaning, responsibility, and social value. I remain steadfast in my belief that nurses and the profession of nursing have a pivotal role to play in the forensic management and support of victims of gender-based violence. One thing that has remained consistent, if not increasing, is the senseless, needless, and so-damaging acts of violence against women and children that perpetuates in our society. It is in this context that I advocate for the return of caring and advocacy into the healthcare professions and for the implementation of forensic nursing programmes into the national nursing curricula.

This research report represents the research / thesis component of the MSc Med (Bioethics and Health Law) requirement. In the Steve Biko Centre for Bioethics, research reports may be reflective (e.g. on a social, medical or legal issue), and may or may not contain an empirical arm. I choose to present my work with both a reflective and an empirical arm.

Chapter One: A Brief History of Sexual Assault Care Nursing

> *Emergency room and other nurses long have been expected to identify, document and preserve legal evidence in cases of rape, domestic violence and other injuries suffered as the result of a crime or suspected crime … They've been expected to do it without formal forensic training and in a medical community where the prevailing philosophy is "we're here to save lives, not collect evidence. With proper training, we can do both*
>
> (Lynch 2003).

Sexual Assault Care Nursing is a sub section of the broader Forensic Nursing field. This is a relatively new field in terms of official recognition in modern nursing and originated in the United States of America. One of the earliest nursing services related to forensics appeared in the 13th century, and this practice was dedicated to examining women's virginity before they married into royal families as well as the examination of victims of sexual assault (Castro 2005).

The term *"Forensic Nursing"*[1] did not even exist until the early 1990's. and it was in this connection that that the application of Forensic Nursing in the field of sexual assault

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[1] The term forensic nursing was first coined in 1992. See the *History of Forensic Nursing* at http://www.theforensicnurse.com/History.cfm

arose. In 1992, 70 nurses from 31 various Sexual Assault Nurse Examiner (SANE) programs throughout the United States and Canada met in Minneapolis, Minnesota for the first “National Convention of Sexual Assault Nurses”. This convention was organized to discuss the roles of nurses and how they might promote their service better as an organization. This diverse group of professionals created a fellowship and formed a kinship in the field of nursing that had previously been largely unacknowledged and unsupported by its peers.

The first official role of what were to become “sexual assault forensic nurses”, were from SANE who worked primarily at rape crisis centers and in emergency rooms. According to Burgess,*et al.* (2004:34), a large number of these nurses were recognised from the 1970s to 1980s for their expertise and profound skills in volunteering their time, energy, knowledge and care to sexual assault victims.

It was during this time that a key figure in this field emerged. Professor Virginia Lynch is considered as the pioneer of forensic nursing.[2] She is known for her observation that doctors and nurses were often insufficiently trained to do medico-legal examinations and collect forensic evidence (1993: 14; 2005: 34). Moreover, she identified that many

[2] Dr. Virginia Lynch is regarded as the founder of Forensic Nursing and founded the International Association of Forensic Nursing (IAFN), serving as its first president. Currently, Lynch is involved in establishing forensic nursing courses at US national and international educational institutions. She was instrumental in setting up South Africa’s first training programme

healthcare practitioners lacked sufficient training and expertise regarding the care, treatment and management of rape survivors. Importantly, she identified the primary outcomes and objectives necessary in the training of “Forensic Nurses”.

Lynch defined forensic nursing as

> *The application of the nursing process to public or legal procedures, the application of the forensic aspects of health care to the scientific investigation of trauma and/or death related medico-legal issues … [and a forensic nurse is] … a nurse with specialized training in forensic evidence collection, criminal procedures, and legal testimony expertise.*

As Lynch (2007: 432-437) and others in this field have shown, there is no single definition of forensic nursing, and all the definitions are equally relevant to the different settings in which the practitioners apply their nursing practice. Some definitions apply to community forensic practice and others to nursing practice in secure environments or to nursing practice with victims rather than perpetrators, or both. Each has evolved as the role has evolved. Moreover, each is defined by the context in which it occurs. For example, Whyte (2000) and Cordess (2000) have provided definitions that are specific to their area of work in high security including the following “... the nurse specialises in the care, treatment, rehabilitation and management of individuals who have either violated criminal law or been deemed to pose a high level of dangerousness” (Whyte 2000 :15)

Lynch, however, foresaw the need for the forensic nurse becoming the liaison between the medical profession and the criminal justice system. In order to be certified as a forensic nurse, Lynch stated, a nurse needed to possess an active, valid, and unrestricted nursing license in the state in which you intend to practice. According to her position, all nurses function as forensic scientists daily in their profession because everything a nurse documents, can be used as evidence in a court of law. Anytime a patient injury becomes the basis for a criminal action or lawsuit, a nurse's forensic skills are put under scrutiny. Scrupulous documentation provides protection for the nurse, evidence for a client, and testimony for the court. As Jewkes, *et al.* (2009) point out, this is because medical practices in the documentation of injuries must be precise and meticulous in order to be meaningful. Professional judgment, intuition, actions, interventions, and documentation will be placed under the legal "microscope" for review. In reality, many nurses are practicing forensic nursing and do not realize it. In 2008 Vetten *et al* reported on the dearth of successful prosecutions in rape cases and they were able to make the link between the evidence trail that succeeded for convictions and the role of nurses. (Vetton, L; Jewkes, R; Sigsworth, R; Christofides, M; Loots, L; and Dunseith, O. *Tracking justice: the attrition of rape cases Through the Criminal Justice System in Gauteng* Johannesburg: Tshwaranang Legal Advocacy Centre).

Forensic nurses serve both the living and the dead -- those who are victims, suspects, survivors, and those who are left behind. Their expertise combines nursing science,

forensic science, and criminal justice. Found in both traditional and nontraditional roles and practice settings, forensic nurses work in various locales including emergency departments, mental health settings, correctional facilities, and coroners' offices. Forensic nurses may collect evidence used by law enforcement or medical examiners, conduct death investigations, or provide crisis intervention for the victims and families of violence. Forensic nurses also know how to present themselves in court and provide expert testimony as a fact witnesses or expert witnesses.

At an international level, there is considerable diversity in forensic nursing roles. The following are some of the common forensic nursing roles; death investigator, nurse coroner; clinical nurse specialist; sexual assault nurse examiner; forensic psychiatric nurse and the forensic nurse educator/consultant. In South Africa, although forensic nursing is still in its infancy, there is a semblance in the form of the sexual assault nurse examiner; the forensic psychiatric nurse, as well as the forensic nurse educator.

Forensic nurses and physician assistants provide staffing 24 hours a day, 7 days a week and abroad are generally placed in Forensic Investigation departments or similar. In South Africa, forensic nurses are placed in Crisis Centers. They do not replace other forensic professionals; rather, they bring a unique nursing perspective to the multidisciplinary forensic team. Forensic nurses blend biomedical knowledge and critical thinking skills with their understanding of the principles of nursing medicine, law and human behavior.

In 1992, the newly established International Association of Forensic Nurses brought forensic nurses together under the leadership of founding President Virginia Lynch. The International Association of Forensic Nursing serves as the central unit to develop and promote forensic nursing nationwide and internationally. As of 1995, Forensic nursing has become a recognized specialty in many Western countries. In Africa, Lynch has been pivotal in establishing forensic nursing practices in Zimbabwe and South Africa at the invitation of the Attorney General, Minister of Health and Human Rights Organizations. Labrecque (1995) states that the new field of forensic nursing -- equal parts detective work, medical know-how, and compassion -- is taking off. Labreque quotes a nurse-turned-crime-fighter who says:

> *… nurses are in an ideal position to bridge these worlds … It's easier to train a nurse in the principles of evidence collection and preservation and crime scene analysis than it is to train police officers in health care principles.*

Obtaining accurate histories from crime survivors, for example, can be crucial to building a solid case. The empathy inherent to good nursing makes nurses particularly well-suited to this difficult, often emotion-filled, interviewing task.

In South African settings the observations and findings from abroad are even more apposite given our extremely high levels of gender based violence and sexual assault and the next Chapter will explore these aspects of the local context.

Chapter Two: The Need to Support Survivors of Sexual Violence

How long can you hear someone crying - how long can you hear someone dying - before you ask yourself why?

~Jackson Browne

2.1 Introduction to the Issue

Sexual violence, including rape, attempted rape, and sexual assault of women, children, (and increasingly) men, is a serious public health problem world-wide and particularly in South Africa. After 1990, when the hatred Apartheid system began to be dismantled, analysis began to take notice that the that In this society pioneering work on the impact, causes and costs of sexual assault to our social fabric have been conducted by Vetton, Jewkes, Christofides, Loots and others. Survivors of sexual violence have immediate and long-term health needs. Their immediate needs are for medical care, psychological support and information, prevention of pregnancy and STIs (including HIV), the management and documentation of any injuries, and collection of medico-legal evidence.

It is recognised that victims of sexual violence often receive a very poor quality of medical care (WHO a 2000; WHO b 2000). Healthcare for sexual assault patients has largely been a neglected area of service provision. Moreover, human rights organizations and others working in the field of gender-based violence support the claim that when seeking health care and justice many rape survivors are exposed to

additional or secondary trauma (see for example: HRW 2008; Christofides, *et al.* 2003; Francis & Baird 1999: 43).

2. 2 An Overview of Gender-based Violence in South Africa

Violence against women, especially sexual assault is the most pervasive yet least recognised human rights abuses in the world. It is also recognised as a major health problem - sapping women's energy, compromising their physical and reproductive health, and eroding their self-esteem (Campbell 2002: 1335-1336).

Research on violence against women in South Africa has proliferated within the last five years and all these studies highlight acts of violence as a human rights violation; with the underlying factor focused mainly upon the socially imbedded inequality between males and females.

The profound impact of the violence on women's personal, sexual, social and reproductive life reduces their autonomy and destroys their sense of personal safety and their quality of life (Christofides *et al*. 2003; CIET 2000:6; Francis 2000:37; Dangor 1996: 63).

South Africa has an unacceptably high incidence of sexual assault. According to the Crime Information Analysis Centre (CIAC 2000), there were 52,550 cases of rape and attempted rape reported in 2000 of which 21,438 were minors under the age of 18 years. There were also 2,934 cases of indecent assault of men reported. In 2003, the

South African Police Service (SAPS) reported 52,107 rapes and attempted rapes. Of these, more than 40 percent of rape survivors who reported their case between February 2002 and March 2003 were girls under eighteen, with 14 percent twelve years or younger (ibid). However, this figure certainly underestimates the true extent of the problem. The recent SAPS report (2009) titled *Total Sexual Offences in the RSA for April to March 2003 / 2004 to 2008 / 2009* indicates that 71,500 cases of sexual assault were reported in the latter. Gauteng province had the largest number of reported cases: 182.9 per 100 000 of the population.

The National Institute for Crime Prevention (NICRO) presents a more serious scenario estimating that only one in twenty rape cases are reported to the police (NICRO 2001: 12). Based on this estimate, it they calculate that one rape occurs every 83 seconds. The CIAC (2000) estimated that the SAP rates might even be worse with one rape occurring every 35 seconds. This is because many sexual assault survivors do not report to the police due to the perception that reporting the incident is unlikely to result in the conviction of the perpetrator (Jewkes, *et al.* 2009).

During the year 2000 and according to police data, only 45% of cases reached court, 47% of the cases referred to court were withdrawn in court and only 16.5% resulted in a guilty verdict. A woman, man or child laying a rape or indecent assault charge only had only a one in 13 chance of seeing the rapist convicted.

The medical system plays a critical part in obtaining substantiation of a rape. The accuracy of this evidence, its timeliness and its inclusion in every case reported can make a significant difference to the progress of a case. In addition, Christofides, *et al* (2002) reported a concern raised by police officers from a variety of police stations nationally regarding the time it takes a sexual assault victim to see a healthcare professional trained in the area of forensics.

Frequently *time* is a critical factor over which a victim has little control – sometimes it takes up to six hours before examination by a healthcare professional (*ibid*). This has implications psychologically and thus may influence the quality and type of forensic evidence. For example (and understandably) a raped woman may be psychologically impelled to rid herself of any ”evidence” of the crime and the longer the waiting, the more likely this compulsion will occur.

Research both in and outside of South Africa has identified that rape is not considered a priority healthcare issue. For example, some report that when a rape victim attended the accident and emergency unit for care, they often had to wait as long as 4 to 12 hours in a busy, public area. Moreover, their wounds were seen as less serious than those sustained by other types of trauma victims. In other words, rape victims competed unsuccessfully for staff time alongside the critically ill (Andersson and Mhatre 2003: 20; Hollaway & Swain 1993: 45).

In addition to the lack of expert and available medical staff, (thus problems with forensic examination and testing delays) prosecutors claimed the lack of training of police officers as the main cause of problems when taking the victim's statement, as well as a lack of evidence (Artz and Combrink 2003: 67). Cooperation and interaction with the legal system is vitally important. In keeping, another challenge is the psychological states of the survivors – people of all ages and sexes who have been raped are emotionally fraught – often frightened and embarrassed, and thus, easily intimidated by court procedures.

This is particularly the case in societies where gender inequality is rife. Without support and counselling (including the assurance of proper evidence collection), the trauma of court appearances often presents with additional understandable psychological anxiety.

Unfortunately, many rape survivors undergo "secondary traumatisation". This occurs when caregivers, police and others to whom the trauma survivor turns for emotional, legal, financial, medical, or other assistance respond in a negative or insensitive manner. Many rape victims perceive this secondary trauma as worse than the rape itself as it leaves them feeling betrayed by those that are designated "caregivers" in society. This insensitivity may be due a lack of training and awareness (Robertson 1998: 140).

From personal experience, there is also the difficulty of ensuring accurate documentation. In the current system, the police provide the sexual assault evidence collection kits which are necessary for the complete documentation of the rape incident. If the patient did not present first at the police station this means waiting for the police to bring the kit to the hospital or clinic. Most of the time the sexual assault evidence collection kits are unavailable and healthcare providers have to improvise. In addition, most healthcare providers do not have the necessary education concerning the proper procedures concerning the sampling and management of forensic evidence.

2. 3 The South African Government's Response to Violence

In 1994, the South African government made the prevention of violence and crime a priority area, following the approval of the *Constitution of the Republic of South Africa* by the Constitutional Court on 4 December 1996 (effective 4 February 1997).

The laws and policies addressing gender inequality from 1994 onwards provided an enabling environment for reproductive health reforms. For example, the Constitution of the Republic of South Africa, is said to be the most progressive on the planet with a Bill of Rights second to none. It guarantees the improvement of the quality of life of its entire citizenry and enshrines the values of human rights, dignity and freedom and security of the person as well as the prohibition against discrimination on sex, gender and sexual orientation (CRLP 1998).

To ensure freedom from all forms of violence, the South African government signed the *Convention on the Elimination of Discrimination against Women* (CEDAW) in January 1993 and ratified it on 15 December 1995. By signing and ratifying CEDAW, the South African government agreed to introduce measures to help protect the basic rights of women and to improve the status of women by trying to eliminate gender- based discrimination. Legislative and policy reforms followed aimed to address gender-based violence. Driven primarily by women's organizations, *The Domestic Violent Act* passed in 1998, is regarded as one of the most progressive in the world (Parenzee, *et. al.* 2001).

In medical-legal legislation, in 1999, the then-Minister of Health announced that District Surgeons (doctors designated to manage medical cases with legal implications) would be phased out and replaced by "accredited healthcare practitioners" – i.e. doctors or nurses. The requirements for these healthcare practitioners included specialized training and registration with the Health Professions Council of South Africa (HPCSA) or the South African Nursing Council (SANC). Consolidating medical services in one location, according to the then-Minister, would improve the chances of sexual violence survivors to receive both forensic examination and medical treatment in one place.

In practice, however, while the District Surgeons were phased out, insufficient training has been provided to the medical practitioners and nurses who were intended to replace them. Because of this, many sexual violence survivors' first contact with the

healthcare system is with the casualty (accident and emergency) department at a hospital, where treating doctors and nurses are often overworked, inexperienced, and untrained to do clinical forensic exams or manage rape cases (Cullinan 2000: 36; Artz and Combrink 2003). However, improving the quality of care for sexual assault survivors remains a high priority for the Government of South Africa. To this end, a South African *Gender-based Violence and Health Initiative* was formed in 2000.

The Gender-based Violence and Health Initiative is a partnership of fifteen organizations working on gender-based health issues. It's main aim is to encourage recognition of violence against women as a social and health problem, train health care providers in the care and management of those exposed to gender-based violence and conduct research to help to develop a policies and procedures on gender-based violence (HST 2000).

In 2004, the Department of Health (DoH) published a new *National Policy on Sexual Assault Care and Clinical Management Guidelines.* The aim of the guidelines is to sensitize relevant health care managers and others about sexual assault, improve and standardize training for sexual assault care practitioners, and to develop a national training curriculum in this regard.

In an address by the previous Health Minister Manto Tshabalala-Msimang (2002), reported a number of projects to reduce crime and violence. One of these projects was

the *Victim Empowerment Programme* which included the training of primary health care workers to respond better to survivors of violence. Another project by the DoH was the special training of health care workers to collect forensic evidence to assist the police and the courts to prosecute effectively offenders. In December 2004, the DoH produced the *National Management Guidelines for Sexual Assault Care.*

In 2005, the *Sexual Assault Care and Practice Program* was developed in Gauteng based on these National Management Guidelines. The development of the Sexual Assault Care and Practice training program followed extensive local research, study of international literature, training materials, and consultation with local stakeholders. The main aim was to sensitize and change the prevailing attitudes of health care professionals from indifference or ignorance to enlightenment concerning challenges in the provision of care, treatment, and management of rape and other sexual assault survivors.

Chapter 3: Sexual Assault Care Training for Nurses in South Africa

You cannot run away from awareness; you must some time fight it out or perish. And if you be so, why not now and where you stand?

~ Robert Lewis Stevenson

3.1 The Kimberley Experience

The international movement towards the need for and recognition of the role of nurses in forensics had an impact on South Africa. The decision to train forensic nurses was first taken in Kimberley, South Africa by the Institute for Studies in Forensic Nursing which was established in 1998. This was the result of an initiative taken by the Northern Cape Crime Prevention Committee. The main reason behind this stemmed from the escalating incidences of rape, elder abuse, domestic violence and child abuse, including low standards of forensic examination; mediocre testimonies by medical personal; untrained, inexperienced and unskilled investigating officers and prosecutorial personnel. All this lead to a poor conviction rate due to the inefficient services provided to the victim of abuse (Els 2000).

These reasons were the impetus for the decision by the Northern Cape Department of Health to train forensic nurses. The responsibility of forensic training was delegated to Dr.J. Els, Chief Medical Officer; Forensic Medical Services. It is worth noting here that the Deputy Director that initiated the training was one of the first cohorts of nurses

trained by Dr. Els in Kimberly. Financial support for the programme was procured from the American Embassy in Pretoria.

Professor Virginia Lynch who had continued to promote forensic nursing across the globe was invited to South Africa to present the first forensic course on the sub-continent. The first course consisting of thirteen nurses from the Northern Cape was offered in 1998, followed by a second course with an intake of nine nurses in 1999. The selection criteria was that the participants had to be a registered nurse with midwifery and psychiatry qualification, with five years clinical experience and show an interest in addressing women and child abuse .

Forensic nurses were trained to improve the treatment of rape victims, and ensure that sound medical evidence was collected to improve the chances of convicting violent criminals and improve the number of reported domestic violence assaults and rape cases.

Although the forensic training was supported by the Department of Health, the program was not sustainable due to lack of funding, communication and other problems such as stakeholder input. Thus the forensic nurses were not correctly utilized, rather they were placed in areas where they skills were not recognised as a specialty. This lead to the demise of the programme.

3.2 The KwaZulu-Natal Experience

In August 2001, the Forensic Services in the Department of Health and the Independent Medico-legal Unit (IMLU) now known as the Street Law Project from the Faculty of Law, KwaZulu-Natal University commenced a forensic training program for nurses.

At that time, I was a lecturer at Addington Hospital. I was approached by the above to assist with identifying a venue and in the selection of personnel from hospitals in the KwaZulu-Natal area to take part in the programme. The program was aptly referred to as “From trauma to trial” .This training was made possible by funding from the European Union.

Prof. Virginia Lynch and three members from the Sexual Assault Unit from the University of Colorado in the United States facilitated a five week course at the College of Nursing at Addington Hospital to 22 nurses from throughout Kwa Zulu Natal.

The program herald a new era of nursing practice in the province in which nursing, forensic science and the justice system all play a crucial role in securing evidence required to bring about successful convictions. The program was broader than managing sexual assault and gender-based violence.

McQuoid Mason, *et al.* in 2002 published a manual entitled *Crimes Against Women and Children: A Medico-legal Guide.* This was used as a training tool concerning

important South African medico-legal issues in the programme. The particular manner in which the subject matter was presented made it particularly accessible for members of the health & legal professions, justice and welfare personnel, NGOs and others involved in assisting women and children survivors of crime. .

The nurses were taught to identify crime scenes; interview victims of crime; present forensic evidence in a court of law, and become familiar with courtroom procedure as well as investigate trauma and death. Prof. Lynch said it made sense for the forensic nurse to be the first "port of call" for victims of abuse as the district surgeon was not always available for an emergency and nurses were on duty 24 hours of the day.

The KwaZulu-Natal training was officially opened by the then KwaZulu-Natal Minister of Health, Dr Zweli Mkize (2001) who stated

> *Nurses will be trained to acquire excellent observation skills, clinical communication skills, collection and preservation of forensic evidence, prevention and rehabilitation expertise in dealing with violence, raped and abused women and children. In line with national objectives of improving health status of women and children, it is our responsibility to ensure that quality health care is maintained.*

The aim of the project was to forge an improved partnership between health care and the criminal justice personnel Following the completion of the training, the then Minister of Health established forty Siyanakekela Crisis Care Centres, staffed by the newly trained nurses at public hospitals throughout KwaZulu-Natal Province. The Crisis Care Centres are available 24 hours a day, every day and provide a caring environment where survivors of abuse and rape can go for help and medical attention.

The Crisis Care Centres have two main functions. The first is to provide care and medical treatment for those who survived violence, rape or other forms of abuse, Their second function is to collect and preserve medical evidence so that the perpetrators of theses crimes can be prosecuted and convicted in a court of law. Of the 22 nurses trained, the majority were from hospitals where the Crisis Centres were established. A small number were nurse educators, who would be responsible for sustaining the training program.

Both trainings, in the Northern Cape and in KwaZulu-Natal, were not recognised by the Nursing Council, who stated that the training could not be accredited retrospectively as a curriculum was not presented to them before the training was delivered. The nurses who completed this program were never recognised academically or financially and the momentum was lost, although forensic trained nurses are still employed at the crisis centres within KwaZulu-Natal.

3.3 Different Roads to a Common Purpose

Following the demise of the forensic nursing program in both Kimberley and in KwaZulu-Natal, I then decided to further my studies to prepare myself to play a constructive role in the field of gender-based violence. I enrolled for a Masters Degree in Gender Studies at the University of Natal where one of the electives was Forensic Medicine, which I successfully completed in 2002.

In 2003, I took up a position as a training manager at the Reproductive Health, HIV and Research Unit in Johannesburg, an affiliate of the Witwatersrand University. The Reproductive Health Research Unit (RHRU) is a South African academic centre; a research and training institution with an agenda that focuses on sexual and reproductive health and HIV.

> *Sexual and reproductive health is a central aspect of overall health throughout the life cycle, and is thus critical to human development. Healthy sexual and reproductive behaviour sets the stage for good health before, during and beyond the reproductive years for both women and men, and has a significant impact on the health of the next generation* (Rees 2008)

The RHRU is recognised as one of the leading international organizations working in the sexual and reproductive health field, and has been awarded the status of a World Health Organization Collaborating Centre. It is also a regional coordinator for AMANITARE which is an African organization campaigning for women's and children's

health rights. The RHRU responds to sexual and reproductive health priorities through research, training, and capacity building in partnership with governments, communities and other organizations. I believed that I was in the right place where I could share my passion and continue to work in gender-based issues.

The RHRU was very supportive of my interest in the prevention of gender-based violence and encouraged me, as the training manager, to include gender-based violence in training programs being offered at Esselen Center. In 2005, Nicola Chistofides, a member of the Medical Research Council approached the RHRU training unit and requested to undertake a study to introduce gender-based violence screening into the Voluntary Testing and Counselling (VCT) services at the Esselen Street Clinic.

The purpose of the study was to explore the feasibility of integrating Gender-Based Violence (GBV) screening into VCT services. Esselen Street Clinic has been offering VCT services for 14 years, and approximately 512 clients are seen per month, 273 females & 239 males. For this project, 16 lay counselors were trained in two sessions (6 men and 10 women). The study design was done in two phases. [3]

[3] **Phase 1:** Adaptation of training material for VCT counselors and training. The Vezimfihlo training program was adapted. A three-day training that included skills development as well as raising awareness and addressing attitudes was implemented. Pre and Post test consisting of 18 questions was conducted to assess knowledge and attitudes.

Phase 2: This was followed by data collection where a qualitative study was conducted with 20 – 25 women who presented for VCT at the Esselen Street Clinic between May, June and July 2005. Three in-depth interviews were conducted with each woman who participated in the study. The first interview took

The Medical Research Council published a report of the findings of this study. This example demonstrates how my interest and training in forensic nursing education, practice and activism once again had relevance.

It gave cause for me to reflect on the forensic nurse programme in which I was the most deeply involved: The Sexual Assault Care and Practice Training in Gauteng.

3.4 The Sexual Assault Care and Practice Training In Gauteng

It was through the Medical Research Council that contact was made with the Deputy Director of the Gauteng Provincial Forensic Services (who happened to be one of those trained in forensic science by Professor Virginia Lynch and Dr. Els in the Northern Cape).

This opportune meeting was the catalyst for the development of the Sexual Assault Care and Practice (SACP) programme where, due to my forensic training, I was invited to be one of the facilitators on gender-based violence. By the end of 2005, the program was up and running and my own work in this field was beginning to be established. Although many hurdles remain to invigorate the forensic nurse training programme to be a recognised nursing specialty in South Africa, I often wondered what impact, if any, the SAPC training had on the practice of the remaining ”forensic nurses”.

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place before the women attended the VCT services, the second after she had received the post-test counselling and the third 10 to 15 days after she attended the clinic.

As part of the research report aspect of the Master's Degree in Bioethics and Health Law, I undertook a short survey to see if there was any long-term impact of the SACP programme on the management of victims of sexual abuse and violence. The following section overviews this endeavor.

Chapter Four: Empirical Analysis

An Examination of the Benefit of the Sexual Assault Care and Practice (SACP) Program in Gauteng, South Africa on Service Provision for Sexual Assault Clients

4.1 Initiation of the Programme

In 2005, the Deputy Director of the Gauteng Provincial Forensic Services was instrumental in the development the Sexual Assault Care and Practice Program in Gauteng. This was in consultation with local stakeholders e.g. medical officers and professional nurses from the Department of Health; personnel from the South African Police Services; district surgeons from the Forensic Services; prosecutors and magistrates with the Judiciary System; South African Human Rights Commission, the Medical Research Council (MRC) and civil rights groups and Non Government Organizations. The development of the program followed extensive local research and the study of international literature and training materials.

RHRU and the Gauteng Provincial Forensic Services entered into a partnership to provide this training with funding from the Presidents Emergency Fund for AIDS Relief (PEFAR). The program was offered twice a year until 2007 when I relocated to the Durban RHRU.

4.2 Description of the Programme

This was a 15 day intensive programme that combined 10 days of classroom-based didactic theoretical learning and 5 days of intensive hands-on clinical practice at designated Crisis Centres in Gauteng. Dedicated health professionals were the target audience and this is the group that materalised. A pretest and post test was conducted of each participant. The pre test was done on day one to identify gaps in knowledge and skills and the post test was completed on the last day of the training to validate if learning had occurred. The group met twice in a calendar year to ensure completion of the programme.

4.3 The Scope of the Training Program

The scope of the training program was very broad and included the following topics and was facilitated by the relative experts: the functioning of the Legal System including the Domestic Violence Act and the Sexual Offence's Act by the DPP; Law Enforcement by the South African Police Services and the FCS; Human Rights by SAHRC; child sexual abuse by Child Care Practitioner from the Teddy Bear Clinic; ballistics by the forensic Science Laboratory and role play of a mock trail.

Personnel from the forensic medical unit in the Department of Health instructed and demonstrated the clinical aspects of forensic care with emphasis on adult sexual assault especially rape; dynamics of sexual abuse and the health consequences; general principals of sexual assault care; consent; HIV counselling; psychological

support; evaluation of a patient of sexual assault with special emphasis on the collection of medico-legal evidence including history taking, the general and genital examination, investigations using the Sexual Assault Examination kit (SAEK); assessment, treatment and management of sexually transmitted infections including post exposure prophylaxis i.e PEP, HIV and the prevention of pregnancy; precise documentation and the accurate completion of the Sexual Assault Examination Form (SAEF) and the J88 form , referrals; maintaining chain of evidence and giving evidence in court. The *National Management Guidelines for Sexual Assault Care.2004,* developed by the Department of Health to guide the provision of health care services as well as to set the minimum acceptable standards for the provision of quality care to the survivors of sexual assault.

To effect the application of knowledge and mastery of clinical skills various training approaches were used. These included formal lectures with power point presentations, demonstrations, role play, diagramming, group discussion and problem solving of case studies, videos and formal lectures.

The theoretical component was followed by 5 days of practical, experiential learning at designated Crisis Centres. These Crisis Centres are overseen by the Deputy Director for Forensic Services at the Medico-legal Unit and a coordinator who does weekly site visits to monitor and evaluate the quality of service provision. The participants were allocated to designated Crisis Centers where experienced doctors and nurses coached

and mentored the participants in the implementation of knowledge, skills and attitudes taught during the program. Each participant was issued with a workbook into which they had to document and report on all cases that they observed, treated and managed.

4.4 Assessment and Evaluation of the Programme

Continuous assessment of the content was evaluated on the active participation of the individual in group discussions, case studies and role plays. Final assessment depended on the marks received after the marking of the workbooks. The pass mark was 75%.

The programme was evaluated by means of a programme evaluation form.

On completion of the programme, a certificate of proficiency was issued to the each successful participant. A register was kept of all the participants as a means of record keeping for the Department of Health and for validation for the funders .At the end of two years, and after four training sessions

4.5 Research Report Methodology

4.5.1 Aim

The aim of this survey was to examine and articulate concerning the benefits or not of the Sexual Assault Care and Practice (SACP) programme. To determine whether there has been retention of the knowledge by nurses and doctors who participated in the SACP programme; to evaluate whether there is or is not an improvement in service

provision for sexual assault clients, to evaluate if the participants felt the SACP programme to have been of benefit and to identify hindrances to programme implementation.

4.5.2 Rationale

Healthcare professionals should be able to respond appropriately to the emotional status of the patient, recognise and treat life threatening injuries and offer adequate emergency prophylaxis against pregnancy, STI and HIV. Health care practitioners should also be skilled and competent to document injuries and collect appropriate forensic evidence in such a manner that the courts are provided with high quality evidence to assist with the prosecution and conviction of perpetrators of sexual assault.

4.5.3 Objectives

Objective 1:

Determine whether there has been retention of knowledge as a result of participating in the sexual assault care and practice (SACP) programme.

Objective 2:

Assess whether, in their opinion, the participants are providing more sensitive care than prior to their having taken the SACP, to victims of sexual assault

Objective 3:

Determine whether the participants are implementing all or part of the training into their practice

Objective 4:

Determine whether there are challenges and limitations to the implementation of the training

Objective 5:

Examine whether the participants view the training as beneficial

4.5.4 Design

This was a descriptive, cross-sectional study that made use of a structured, self-administered questionnaire which includes closed and open-ended questions. (Annexure A)

4.5.4 Limitations

A limitation of this survey will be determined by the response rate of the participants.

The history of forensic nursing (rise and demise) in South Africa may prove to influence responses.

The inability to compare participant knowledge prior to programme implementation and after is another recognised limit.

4.5.5 Ethics Clearance

To undertake the study, permission was obtained from Dr M. L. Lekibe, Forensic Specialist and chief member of Research & Epidemiology Medical Unit, the Deputy Director of the Gauteng Provincial Forensic Services in the Provincial Department of

Health and the Crisis's Centers Provincial Coordinator, Provincial Medico-legal Unit (MLU).

4.5.6 Study Population

The target study population consisted of a random selection of both doctors and nurses. The population included was the 117 participants who had completed the program from 2005 to 2007. The population sample was obtained via the centralized database kept by the Deputy Director of the Gauteng Provincial Forensic Services.

Selection was done according to specific criteria; 1) those who were working at the Crisis Centres in Gauteng and 2) who had interest in gender issues, 3) they had to be 18 years or older and 4) must have completed the SACP course. 5) Doctors had to be qualified medical practitioners and registered with the Health Professional Council and nurses had to have a diploma or a generic degree in nursing and be registered with the South African Nursing Council as a general nurse.

4. 5.7 Site of the study

The study was undertaken at random Crisis Centers in Gauteng, supervised by the Clinical Medico-legal Unit, Provincial Department of Health. At the time, there were 26 Crisis Centers in the three Health Regions in Gauteng. Breakdown is as follows;

Region A = JHB Metro & West Rand (11 + 4 = 15)

Region B = Ekurhuleni Metro & Sedibeng (3+3 = 6)

Region C = PTA Metro & Metsweding (3+ 2= 5)

4.5.8 Development of the Questionnaire (Annexure B)

As part of the evaluation, a self-administered questionnaire was developed by the researcher specifically for this program. This occurred after intense collaboration with personnel from the Medical Research Council, the CSVR, and the Medic-legal unit. Advice was sought from a data statistician to assist with assembling-. The National Management Guidelines for Sexual Assault Care, used as the training manual, was used as a guide in the development of the questionnaire.

The self-administered questionnaire was divided into four parts

- *Part I - Profile of respondent*

Part one focused on the profile of the respondents and included socio- demographic data, educational qualification, gender-based violence related training and current work description. Participants were requested to please tick (✓) or mark with an **X** the box (❑) corresponding to their answer (s) or fill in the blank space provided if their answer is not among the choices.

- *Part II - Knowledge and skills*

Part two tested knowledge and skills and included questions on legal and human rights, post exposure prophylaxis, treatment dispensing for rape survivors and the management guidelines. Participants were requested to please tick (✓) or mark with an **X** mark the box (❑) corresponding to the best answer (s) you think best fit the question

asked or write on the blank space provided if your answer(s) is/are not among the choices.)

- *Part III - Vulnerable groups*

Part three evaluated participant's attitude towards vulnerable groups and consisted of questions on child abuse, elder abuse, sexual assault and the psychological impact of rape. Participants were asked from their personal experience with vulnerable clients, to tick (✓)or mark with an **X** the appropriate box (❑) corresponding to **TRUE** if they found the statement correct, **false** if it is not correct, or **not sure** if they are uncertain or not sure whether the statement is true or false.

- *Part IV - Myths, misconceptions and facts regarding rape*

Part four, enquired concerning commonly held myths, misconceptions, and facts regarding rape. Participant's were asked from their point of view, how they perceived the stated value clarification statement and then tick (✓) or mark with an **X** in the appropriate corresponding box. or ***mark*** **a** if they **agree** with the statement or **d** if they **disagree**,

- *Part V - Implementation*

Part five, assessed the correct completion of the sexual assault evidence collection kit form and the j88 form, the participants were also asked to reflect upon the sessions in the program and comment about challenges and constraints that they encountered when implementing the knowledge and skills learnt on the program.

Participants were requested to please tick (✓) or mark with an **X** mark, the box (❑) corresponding to the answer (s) they thought best fitted the question asked or write on the blank space provided if their answer(s) is/are not among the choices provided.)

4. 5.9 Data Collection

A request was made by the researcher to attend a Crisis Center monthly strategic meeting prior to the study to explain the survey. Present at this meeting was the Provincial coordinator and the clinic coordinators. At the meeting, the researcher outlines the purpose of the study; that it was anonymous; how to complete the questionnaire; the expected timelines and the dispatching and collection process of questionnaire delivery and return.

It was agreed that one week prior to the survey commencing, A3 sized flyers with the relevant information pertaining to the study would be placed on the notice board at the Crisis Centre in order to create awareness of the study.

A random selection from the 26 Crisis Centers was made, the breakdown being five clinics from Region A; three from Region B and 2 from Region C. equaling a total of ten clinics. The Provincial coordinator together with the researcher delivered the questionnaires, to the clinic coordinators at the various random selected clinics during the monthly clinic inspections. One hundred questionnaires were circulated. The clinic coordinator at the crisis centers then disseminated the questionnaire to the potential participants. Participants were requested to complete the questionnaires and deposit

them in a pre-collection box at the crisis centre as explained at the meeting and according to the information sheet. The researcher collected the collection box after four weeks.

4.6 Data Management and Analysis

The data collection was done using a self administered questionnaire. The data management (capture and cleaning) was performed using the data entry programme. Epi-Info Version 3.3.2 was found to be a suitable data base programming system.

The data comprised both quantitative and qualitative aspects. The qualitative questions were re-coded according to the variability of responses. The quantitative questions utilized descriptive and analytical techniques. Descriptive statistics was performed on all the variables measured .For categorical variables, frequency distribution tables, pie charts and bar charts are reported. For continuous variables, the means, standard deviations and box plots are utilized. The statistical analysis uses STATA 9.0. Investigation of association between pairs of categorical variables is done using Pearson's Chi-square (or where appropriate Fischer's exact test) which is a non parametric procedure.

The participants' t-test was used to test for differences between two groups of a continuous variable or a non- parametric procedure such as Mann Whitney (e.g. when appropriate parametric assumptions are not met and sample size is small say less than

30). Expert advice from a statistician was sought at various stages of the research process.

4.7 Results

The following outputs represent data that was generated by the participants' responses to the questionnaire.

4.7.1 Response

Fifty questionnaires were distributed to health care workers based at three different metropolitan districts in Gauteng. Seventeen completed questionnaires were returned after a period of two weeks. These questionnaires were entered onto epi data and imported to STATA for analysis.

4.7.1 Demographic Data

The socio demographic elements of the data revealed that there were 15 females and 2 males of which the median age was 42 years with the youngest recipient aged 25 years and the oldest aged 63 years. Nine nurses and eight doctors completed the questionnaire with a 50% of the study population each possessing a degree or a diploma.

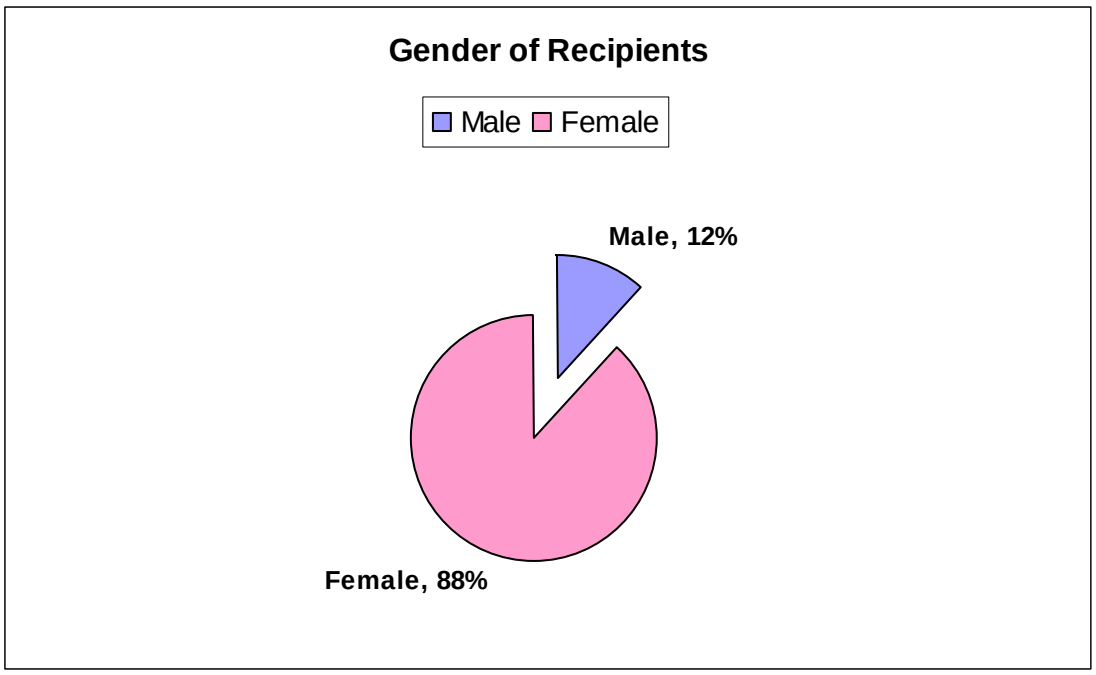


Table 1: Gender of Recipients Completing the Questionnaire

4.7.2 Continuing Education

47% of health care workers indicated that they attended courses in gender violence and these courses excluded the Sexual Assault Care and Practice (SACP) course.

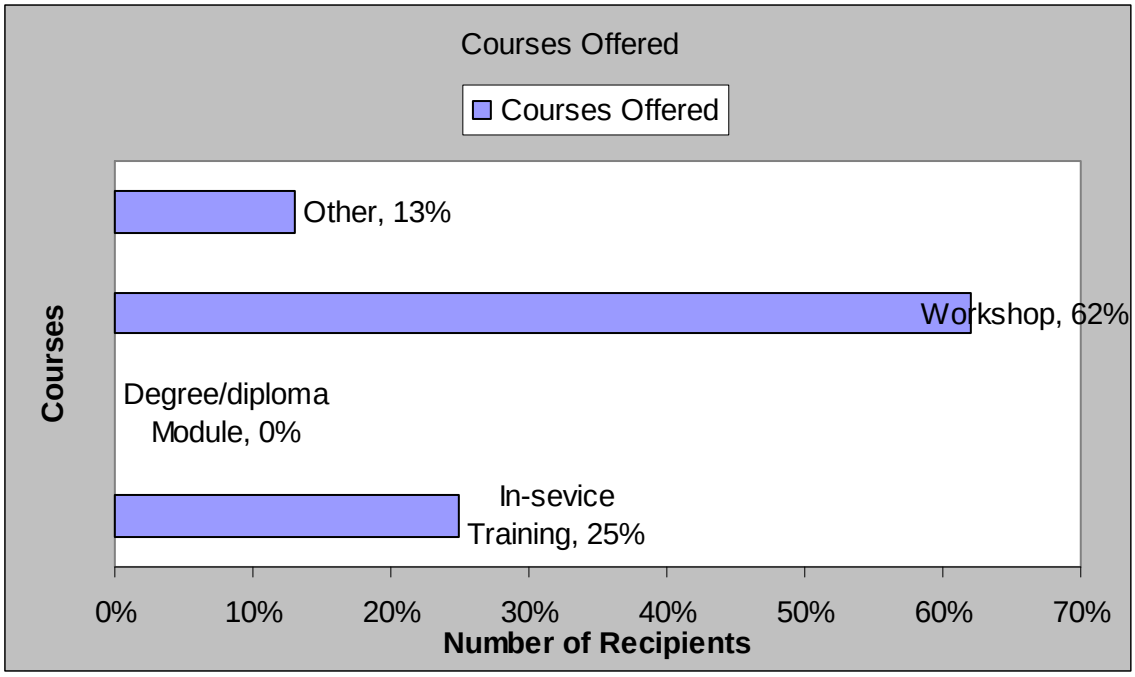


Table 2: Representation of the manner in which the gender violence courses were offered

4.7.3 Employment in Field

Seven percent of health care workers were employed for a period spanning less than 1 year. 13% represented the sample size for both those working between 1-3 years and 3 -5 years with 67% employed for more than 5 years.

4.7.4 Availability of Reference Guidelines

Seventy five percent of the participants reported possession a copy of the DOH ("National") Management Guidelines for Sexual Assault Care at their respective clinics; 25% reported that they did not have these guidelines at their Crisis Centre.

Rape or Sexual Assault Survivors seen in One Week	**Percentage**
Less than 5	40%
5 to 10	47%
11 to 15	13%
More than 15	0%

Table 3: Number of Rape and Sexual Assault Survivors seen in one week from Sampled Centres.

4.7.5 Rape and Sexual Assault Survivors seen in one week from sampled Centres.

As these results indicate, close to half of the responding Centres, cared for 5 -10 survivors of sexual violence in a one-week period. The work-load relating to the highest number of survivors of rape and violence was identified in the reporting in the rage of 11 -15 persons seen in only one week. Forty percent of the participants responded with

numbers of less than five cases in a week. Such results indicate that the need remains for trained and qualified forensic healthcare personnel.

4.7.6 Questions concerning retention of knowledge

The primary objective of the “test your knowledge” questions was to inform the accuracy of the actual counselling and thus reflect this to the service delivery provided by the Crisis Centers.

The following outputs were noted for these questions:

For Question 13, which observed the correct answers to questions answered by individuals who attended courses as an add-on to the SACP, the data was categorical, a Fisher’s exact test represented a significant value of 5 % confidence interval.

In terms of those that attended further courses besides the SACP, it was noted that 38% answered questions pertaining to the SACP incorrectly, whereas 63% answered correctly. Of those that answered correctly, the percentage observed was 80% with an expectant percentage of 88.8% for nurses and 20% percentage observed with an expectant percentage of 25% for doctors. The above is indicative of meeting objective 1 as well as object 3 as stated in “Objectives” .

4.7.7 Demarcation of Training

The training was demarcated as represented in the table below which indicates whether training and competency was conducted in those specific areas. It was noted that 43%

of individuals possessed skills in individual areas as opposed to the 57%, which were trained in sexual, domestic and child abuse.

Areas Trained	**% Trained**
Child abuse	14%
Domestic Violence and Child abuse	29%
Sexual, Domestic and Child abuse	57%
Other	0%

Table 4: Training and Competency Areas of Health Care Workers

The graph below represents the case reported as per area of violence and the frequency as seen by the health workers trained in the particular area and therefore is used as an indication to inform objective 1 and 3.

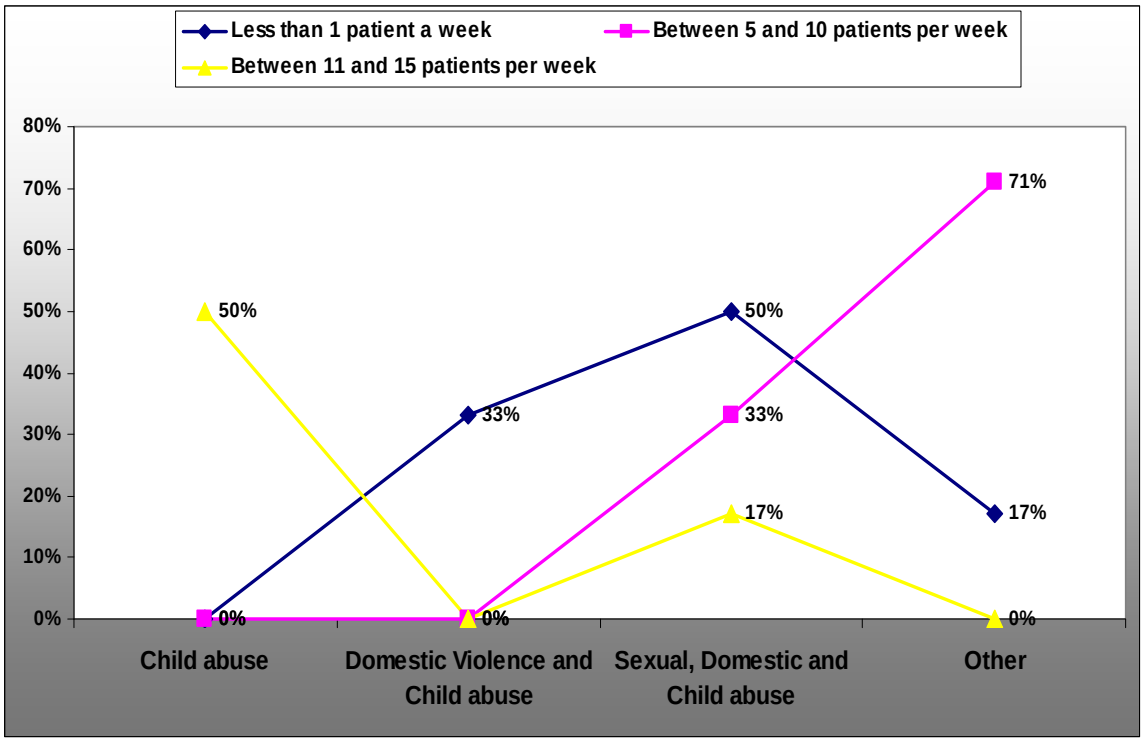


Table 5: Frequency of Categories of Violence as seen by Health Workers

4.8 Discussion

There were significant results which can justify the argument that those who attended the SAPC programme did retain the knowledge they gained from the programme. In addition, a determination can be made concerning the implementation of all, some, or no part of their training into practice. The training was very didactic in nature and could have drawn on more participatory and workshop style adult education formats especially after the necessarily content-heavy aspect of the first days had been established as a foundation. The facilitators could also have been better briefed upon or

drawn into the conceptualisation of the training could also have brought some concepts more fully alive.

A disappointing aspect of the study was the participants' vague or non-responses to questions pertaining to limitation and challenges. This implies this area should be further evaluated, e.g. the type of questions re-worked or the study redesigned in this regard. Unfortunately, the objective to assess the challenges and limitations to the implementation of the training could not be ascertained.

However, the objective to determine the benefits of training was supported by half of the participants requesting further training. It is noted that conversely, one could argue that one-half did not consider this necessary. I suspect that part of the problem lies in the study design in this regard and indicates a need for re-working. In addition, the questionnaire was unable to deal with the sensitivity of care delivered prior to the participants attending the course compared to those who attended.

Concerning the questions which remain indeterminate and unanswered, the unfortunate demise of the forensic programmes, the lack of recognition of forensic nursing as a specialty in its own right and its related financial implications may be considered as factors which lead to vague and non-responses to the questions concerning benefits, limitations, and challenges.

In spite of these flaws, this survey did highlight that the numbers of survivors of sexual assault and violence remain a grave area of concern, and that the knowledge imparted in the SACP programme appears to be retained and practiced. Overall, there are no results that are contrary to the premise that forensic nursing programmes have a vital role to play in the care and support of victims of sexual assault and violence in South Africa.

4.9 Recommendations

There still remains an ongoing need for the Department of

Health to raise awareness and knowledge of all health care personnel on gender-based violence, its health impact and issues related to patient care, the key staff to be trained as sexual assault specialists with the goal of identification, management, education and care for the survivors of gender-based violence and the final aim to eradicate this complex social problem.

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