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Skosana, Brenda Sulile

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Provider perceptions of the quality of post-rape care in Ekurhuleni District

Brenda Sulile Skosana
Student Number: 747099

Supervisors: Prof Lenore Manderson
Dr Nicola Christofides

Date: 06 June 2016

A research report submitted to the School of Public Health, University of the Witwatersrand, in partial fulfillment of the requirement for the degree of Master of Public Health in Social and Behavior Change Communication.

Declaration

I, Brenda Sulile Skosana, declare that this research report is my own work. It is submitted in the partial fulfillment of the requirements for the degree of Master of Public Health, in the field of Social and Behavior Change Communication in the University of the Witwatersrand, Johannesburg. It has not been submitted before any degree or examination at this or any other University.

Signature:

06 June 2016

Dedication

This report is dedicated to my daughter Hloniphile Skosana and my mother Sbongile Skosana. Thank you mom for taking care of Hloni since her birth, from when I started my Masters of Public Health until today. I have managed to do this because of your unwavering support. Thank you Hloni for understanding and behaving during my years of study.

Abstract

Background

Rape and HIV are major public health issues in South Africa. Rape has negative short and long term health impacts, both physically and psychologically. Survivors are at high risk of sexual transmitted infections, including HIV. Health care services have two important roles in caring of survivors: attending to their physical and psychological health needs, and collecting evidence for court purposes. The national government has put measures in place to improve the quality of care for rape survivors; this includes a clinical guideline on management of sexual assault survivors. The guideline outlines a process of HIV testing and the provision of Post Exposure Prophylaxis (PEP) to prevent the transmission of HIV for survivors who report within 72 hours. South Africa has also implemented One Stop Centres, called Thuthuzela Care Centres (TCC), that enable survivors to access all medical, legal and social services. However, the PEP completion rate remains poor and health care providers often lack the training and confidence to manage rape survivors. As a result the needs of survivors remain unmet.

The aim of the study was to explore the knowledge, attitudes and experiences of Clinical Forensic Medical Services health care providers from three facilities in Ekurhuleni district, and to assess the quality of post rape care and related post rape exposure prophylaxis (PEP) services provided to rape survivors, in accordance with the National Department of Health Rape and Sexual Assault Policy and Clinical Management Guidelines. The research was conducted in 2015.

Methods and materials

A qualitative case study approach was used in three clinical forensic medical services in Ekurhuleni District in Gauteng. A total of 17 participants were interviewed, including different categories of staff doctors, professional nurses, enrolled nurses, auxillary nurses and lay counsellors. Participants were interviewed by the researcher using a semi-structured interview guide. All interviews were audio recorded and transcribed verbatim. A thematic content analysis was carried out. Themes and subthemes were developed from the objectives and from the transcripts. Quarterly registers and statistics generated from the centres were reviewed and compared.

Results

Most participants were female (82.3%). All professional nurses and doctors had been trained on the management of rape. Participants viewed the training on sexual assault management as informative and recommended it for all clinicians who examine rape survivors. All participants who were interviewed demonstrated professionalism and confidence in managing rape survivors. However, most participants were uncertain about policy and clinical management guidelines and when asked, described patient flow rather than policy. Each centre had its own patient flow and record system. The provision of PEP differed among interviewees: although most participants gave the full 28 days course, some participants did not give PEP unless the survivor had agreed to HIV testing. Participants raised issues relating to the impact of caring for rape survivors on health care providers, and identified lack of psychosocial therapy for survivors, limited psychotherapy for health care providers, and lack of support from other departments as challenges that they experienced when caring of rape survivors.

Conclusion

Although Gauteng has developed dedicated centres and allocated dedicated staff who have attended training, the management and record system of sexual assault/rape survivors is not standardized. Most dedicated health care providers of Clinical Forensic Medical Service (CFMS) demonstrated confidence in managing sexual assault survivors, but they were uncertain about the sexual assault policies. However, there are still challenges in providing quality care to rape survivors due to lack of resources and lack of support from non CFMS staff who work in the hospital in association with CFMS health care providers. This results in other needs of rape survivors continuing to be unmet.

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Contents

Declaration ii

Dedication iii

Abstract iv

Acknowledgements vi

Abbreviations xi

Chapter One: Introduction 1

1.1 Background 3

South Africa National Management Guidelines for Sexual Assault Care 3

HIV Counselling 4

Thuthuzela Care Centre Model Survivors Flow 4

1.2 Literature Review 5

Legislation on management of rape survivor 5

Training health care providers on management of rape and sexual assault 6

PEP and challenges around provision of PEP 6

PEP and factors affecting adherence and completion 8

1.3 Problem Statement 10

1.4 Justification 10

1.5 Research Question 11

1.6 Aim and Objectives 11

Chapter Two: Methodology 12

2.1 Study Design 12

2.2 Study Site 12

2.3 Population 13

2.4 Sample 13

Table 1: Sample of participants who were purposively selected for the study 14

2.5 Data collection 14

2.6 Scope of study 15

2.7 Data management and analysis 15

Chapter 3: Results 17

3.1 Sociodemographic characteristics of Ekurhuleni Clinical Forensic Medical Service (CFMS) health care providers 17

3.2 Guidelines and Policies of Clinical Forensic Medical Services 18
Knowledge and attitude of health care providers on national and provincial guidelines 18
Attitudes of health care providers 19
3.3 Processes of management 19
History taking and counselling 19
Knowledge of Health care providers on PEP to rape survivors 21
3.4 Challenges providing comprehensive care to post rape survivors 22
Lack of resources 22
Poor planning, infrastructure and organization of Clinical Forensic Medical Services .. 23
Shortage of staff 23
Language barriers 24
Lack of psychosocial therapy for survivors 24
Lack of medication 26
Challenges in Initiating PEP 27
Perception of health care providers on adherence and statistics 29
Comparing the CFMS records and statistics 30
3.5 Liaising with Other Departments and Sectors 32
Lack of commitment from other departments 32
3.6 Impact on Self 34
Stress due to traumatic events 34
Emotional draining 35
Coping mechanisms 35
3.7 Training Received by Providers 36
Summary 38
Chapter Four: Discussion 40
4.1 Process of survivors' management 40
4.2 Challenges to providing comprehensive care to post rape survivors 40
4.3 Shortage of Staff 43
4.4 Impact on Self and Coping Strategies 44
4.5 Knowledge of Health Care Providers of National or Provincial Sexual Assault Policies 45
4.6 Attitude of Health Care Providers 46
4.7 Training 47
4.8 Limitations 48

Chapter Five: Conclusion and Recommendations 49

Recommendations 49

References 53

Appendix 1 57

Appendix 2 59

Appendix 3 60

Appendix 4 61

Appendix 5 62

Appendix 6 63

Appendix 7 64

Appendix 8 65

Appendix 9 66

List of tables

Table 1 Interviewees…….14
Table 2 Characteristics of Clinical Forensic Medical Services Health Care provider……..18
Table 3 Patient flow……..20
Table 4 Centre Statistics…….31

Abbreviations

ART	Anti-Retroviral Treatment
LC	Lay counsellors
CFMS	Clinical Forensic Medical Service
DOH	Department of Health
DR	Doctor
FERCC	Far East Rand Care Centre
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome
IMI	Intramuscular Injection
J88	Department of Justice and Constitutional Development Form for recording medico-legal evidence
MTCC	Masakhane Thuthuzela Care Centre
NGO	Non-Governmental Organization
NPA	National Prosecuting Authority
PEP	Post Exposure Prophylaxis
POWA	People Opposing Women Abuse
PRN	When necessary
RN	Registered Nurse
SAPS	South African Police Service
SOCA	Sexual Offence and Community Affairs Unit
STCC	Sinakekelwe Thuthuzela Care Centre
TCC	Thuthuzela Care Centre
VAO	Victim Assistant Officer
WISN	Workload Indicators Staff Needs

Nomenclature

Adherence: The extent to which a person's behavior, e.g. taking medication, corresponds with health care provider's recommendation (Sabaté, 2003).

Completion Rate: Percentage of patients who have completed medication (World Health Organization, 2003)

Post Exposure Prophylaxis: Any preventive medical treatment started immediately after exposure to a pathogen, in order to prevent infection and the development of disease (World Health Organization, 2003)

Rape: Any unlawful and intentional act of sexual penetration without person's consent (Artz and Roehrs, 2009).

Sexual assault: Unlawful and intentionally sexual violation of a person without her or his consent (Artz and Roehrs, 2009)

National: Something that belongs to a typical or particular country or nation (Harper, 2011).

Provincial: Territorial unit within a state or country (Provincial government South Africa, 1 April 2011).

Chapter One: Introduction

Sexual assault is defined in the law as an "unlawful and intentional sexual violation of a person without her or his consent" and rape is defined as any "unlawful and intentional act of sexual penetration without person's consent" (Artz and Roehrs, 2009). Sexual assault and rape is a human rights violation.

HIV and rape are significant public health issues worldwide. In a country like South Africa with high prevalence of both, there is a risk of contracting HIV during rape (Smith et al., 2013, Christofides et al., 2005). There is a higher risk of contracting HIV during rape depending on the extent of injuries, number of perpetrators and site of penetration, as in the case of anal rape and unprotected sex with those who are HIV positive (Jewkes et al., 2002, Abrahams et al., 2010). The risks are 0.1%-0.2% for receptive vagina penetration exposure, 0.8% -3% for receptive penile anal exposure (Chacko et al., 2012). South Africa has the largest number of people living with HIV infection and the highest worldwide annual prevalence of rape (Bärnighausen et al., 2008, Jewkes et al., 2006). The highest prevalence and incidence of HIV infection is found among women below 30 years of age in South Africa, who make up the largest percentage of rape survivors (Makubalo et al., 2001, Shisana et al., 2009, Simbayi et al., 2014).

At least one in three women worldwide, during her lifetime, has been either physically or sexually abused, 38% of all women murders are committed by intimate partners and 7% of women are sexually assaulted by non-intimate partners (Ellsberg et al., 2008, Organization, 2013, Devries et al., 2013). South African police service statistics indicate that 66,196 cases of rape (55.63 per 100,000 population) were reported for the two month period 1 April 2010 - 31 March 2011 (Phaswana et al., 2013), compared to the United States, which has a rate of 31.8 per 100,000 (South African Police Services, 2004, Interpol, 2004). In response to this, as I describe in this thesis, changes in the care of rape survivors in Gauteng were developed to encourage people to report assault and seek appropriate care.

Rape incidence varies, and legal definitions of sexual assault, sexual violation, and rape also vary from country to country, making it difficult to compare figures on sexual assault in most

studies. Further, the law criminalises according to the offence; for example, in the Republic of Congo, Kenya and Nigeria, unlike in South Africa, rape in marriage is not an offence (Kilonzo et al., 2009a). Even so, a comparison of incidence of assault highlights the particular challenges in South Africa. In the United States, 25% to 30% of women and 13% to 16% of men reported that they had experienced sexual abuse before the age of 18 years (Martsolf et al., 2010). In Kenya, at least 24% of women had been raped in their life time and 4% of HIV infection in adolescence was attributed to rape (Chacko et al., 2012). In Gauteng Province in South Africa, 25.3% of women reported rape or sexual assault in their life time, with 7.8% experiencing rape in the previous year (Machisa et al., 2011). Non-consensual sex in marriage and dating relationships are not always reported as rape or sexual assaults in surveys (Jewkes and Abrahams, 2002), and this suggests that prevalence is even higher. Rape has a negative health impact, physically and psychologically, in both the short and long term. Among other things, it places the victim at high risk of psychological morbidity, unplanned pregnancy and sexually transmitted infections including HIV (Jina and Thomas, 2013).

In South Africa, HIV prevalence had increased from an estimated 4.09 million in 2002 to 5.51 million by 2014 (Statistical South Africa, 2014). An estimation of HIV prevalence by 2012 by Shisana and colleagues (2012) was 12.2%. However, in 2014 the estimated HIV prevalence was 10.2% of the total population (Statistical South Africa, 2014). The National HIV/AIDS and STI Strategic Plan 2007-2012 had two goals related to HIV reduction: firstly, to increase the uptake of anti-retroviral treatment (ART) by 80% of those people who need it, and secondly, to reduce HIV incidence by 50% by increasing the roll out of prevention programmes for high risk populations and increasing the accessibility and availability of Post Exposure Prophylaxis (PEP), psychological support and comprehensive care to sexual assault survivors (Rehle et al., 2010, South African National AIDS Council, 2011). The National Strategic Plan on HIV, STI and TB 2012-2016 retained as an objective the prevention of new HIV infections to achieve the long term goal of zero new HIV infections. These included the use of social and behavioural change communication to promote health seeking behaviour, and the provision of PEP to people who were exposed to HIV (South African National AIDS Council, 2011). PEP is a short-course of anti-retroviral drugs prescribed for a 28 day period which, based on observational evidence, reduce transmission of HIV after exposure (Smith et al., 2005, Pretorius et al., 2010).

A combination of antiretroviral treatment can reduce HIV incidence and AIDS mortality (Pretorius et al., 2010). In order to prevent the transmission of HIV, PEP must be prescribed within a short window of time after exposure (72 hours) and must be adhered to by people who may have been exposed from needle prick, unprotected sexual intercourse, or accidental exposure during a health care procedure. Antiretroviral treatment is also prescribed to pregnant women to prevent transmission from mother to child (Pretorius et al., 2010). The South Africa National Management Guidelines for Sexual Assault Care in 2002 recommended HIV testing and the provision of PEP within 72 hours to rape survivors if the survivor tested negative, to reduce HIV incidence. If the rape survivor tested positive, then a blood specimen was to be collected for a CD4 count and the person would be referred to a HIV clinic for further management (Department of Health, 2005, Kim et al., 2003). In an observational study conducted by Smith et al. (2005), in which 48 women were initiated on PEP 96 hours after the rape occurred, one woman seroconverted and tested HIV positive after six weeks. Another woman in the same study who was seronegative post rape and sought treatment after 12 days, and was not given PEP, seroconverted after six weeks. However, the rate of acceptance, adherence and completion of PEP is generally lower for rape survivors than among those who sought PEP after consensual sexual exposure, due to stigma and psychological trauma after rape (Chacko et al., 2012). A study conducted in 2005 in two sites in South Africa found that the health care needs of rape survivors were unmet, and there are gaps in service delivery (Christofides et al., 2006). Therefore, there is a need to strengthen these services (Jewkes et al., 2009a).

1.1 Background

South Africa National Management Guidelines for Sexual Assault Care

The South African National Management Guidelines for Sexual Assault Care provides principles and guidelines for managing patients (Department of Health, 2005). These include that there is no obligation for health providers to report a sexual assault case to the police if the person is an adult, and a case number or laying a charge is not a prerequisite for attending to a patient's medical needs. At the time of consultation, the health care provider should listen to the survivor's fears, provide medical care, and provide HIV and trauma counselling. Vaginal, anal, or oral swab evidence should be collected and stored for six weeks if the incident happened within five days of presenting for care. If a survivor wants to be examined

but does not want evidence to be collected, any injuries should be documented on the sexual assault evidence form. Counselling and support should be provided to all survivors (Department of Health, 2005). However, appropriate counselling is not always possible at the acute phase. Therefore, information about examination, and packs on the examination process and the health risks after sexual assault, including in relation to STIs and HIV especially, should be provided to the survivor (Department of Health, 2005, World Health Organization, 2003).

HIV Counselling

According to National Management Guidelines for Sexual Assault Care, a rapid HIV test should be offered at the initial visit, or in the first three days after the rape incident, to all patients. If a rapid test is not available, blood should be collected and sent to a laboratory. HIV test results may be provided immediately to the patient who consented to the test, or may be done after three days when the patient is ready to know her (or his) status. PEP with anti-emetics to counteract side effects is to be prescribed to all patients presenting to the facility within 72 hours of sexual assault. A three day starter pack of these medications is prescribed to those patients who are not ready to test on their initial visit, and a seven day supply should be provided to those patients who test negative. The rest of the treatment for 28 days should be offered to patients who cannot return for a weekly supply due to financial constraints, and a follow up test should be done at six weeks, three months and six months after the initial test. If the HIV test results are positive after the three days starter pack has commenced, the treatment should be discontinued and the patiens should be referred for further counselling (Department of Health, 2005, World Health Organization, 2003). Patients should be referred for psychological support after the rape incident and should be referred appropriately for the further management of wounds/injuries if there is a need. Families also should be offered basic support care and emotional containment (Department of Health, 2005).

Thuthuzela Care Centre Model Survivors Flow

Rape survivors experience complex needs, and many countries have developed one stop centres that enable survivors to access legal, medical and social services (Kilonzo et al., 2009b). In South Africa, the Thuthuzela Care Centre (TCC) model is a one stop centre that was introduced and aimed to reduce the secondary victimization of the survivor, improve conviction, and seek to ensure a zero HIV seroconversion rate (Muthien, 2004). The

Thuthuzela model is run by the National Prosecuting Authority, Sexual Offences and Community Affairs Unit (SOCA), and comprises of representatives from the Departments of Justice, Police, Health, Social, Treasury, Education, Correctional Services and two non-governmental organizations namely Ekupholeni and People Opposing Women Abuse (POWA) (UNICEF, 2008).

According to Thuthuzela Care Centre protocol, when the survivor enters the facility, the site co-coordinator welcomes the survivor and offers her (or, less often him) (and those who are with her/him) a quiet place to rest. The nurse or survivor supporter must offer pre and post counselling to the survivor and obtain her consent to test for pregnancy, HIV and sexually transmitted diseases. If the survivor is found not pregnant and HIV negative prior the rape, emergency contraceptives pills and PEP are given. The doctor or registered nurse is informed about the survivor immediately to ensure prompt physical examination and collection of evidence. The survivor is given information about the procedures that will be performed, and a consent form is signed by the survivor for medical examination, collection of evidence, and blood to be taken for testing. If the rape occurred in the preceding 72 hours, then DNA is collected and PEP is provided to those survivors who qualify for it. Following that, the survivor is given a comfort pack with toiletries and clothes including underwear, and is able to bathe or shower and to change her clothing if they are dirty or torn. After examination and bathing, the nurse discusses the medical follow-up dates and psychological appointments for counselling, and writes the follow-up dates on an appointment card. The Victim Assistant Officer also discusses with the survivor the psychological appointments for counselling (National Prosecuting Authority, undated). Thereafter, the investigating officer on call obtains a statement from the survivor at the Centre, and she (or he) is transported home by a police officer in an unmarked car (if the survivor chooses to open a case with the police).

1.2 Literature Review

Policy and legislative frameworks

The national government in South Africa in the last decade has put measures in place to improve the quality of care to rape survivors by developing a new model of rape care and clinical guidelines, and to create a conducive environment for rape survivors (Department of

Health, 2005). Health care services have two important roles in caring for rape survivors: assisting with the collection of evidence for the police and court purposes, and attending to the survivor's physical and psychological needs (Jewkes et al., 2009a).

The legal definition of rape was broadened in the Criminal Law (Sexual Offences and Related Matters) Amendment Act 32 of 2007 (also referred to as the Sexual Offences Act) (Sexual Offences and Related Matters Amendment Act, 2007). The amendment to the legislation included all sexual crimes in one law, made all forms of sexual abuse and exploitation a crime, and ensured that the law was available to both women and men who experienced sexual crimes (Sexual Offences and Related Matter Act, 2007).

Training health care providers on management of rape and sexual assault

A standardized training curriculum for health care providers was developed in 2007 by the National Department of Health, and the government has since trained nurses and doctors to examine survivors and to provide supportive health care (Jina et al., 2013). In some facilities, the service has been moved to a specialized unit, although survivors could still present to and receive care at casualty departments in some hospitals and at primary health care centres (Jina et al., 2013, Christofides et al., 2006). Yet despite these initiatives, health care services for rape survivors in South Africa remain poor, resources are limited for the provision of services, and PEP adherence is low (Jewkes et al., 2009a).

PEP and challenges around provision of PEP

Sub-Saharan Africa is severely impacted by HIV/AIDS (Shisana et al., 2009). As already noted, South Africa continues to have the largest number (5.51 million in 2014) of adults and children living with HIV in the region (Bärnighausen et al., 2008), and there is therefore potential risk exposure of HIV among rape survivors (Arend et al., 2013a, Kim et al., 2003).

PEP provision remains the critical dimension in post rape care to prevent the transmission of HIV. However, it cannot be offered in isolation (Jewkes et al., 2009c). In Kenya a study of sexual assault survivors was conducted on post sexual assault care and 194 participants were followed up after 2 weeks of obtaining additional doses and counselling; more than half of

those participants completed PEP course (Arend et al. 2013b). A study conducted by Roland et al. (2012) also indicated that when nurses provided counselling, prescribed PEP, made appointments for follow-up, and referred the rape survivor for psychological support, the adherence and completion rates of PEP were high. This contrasts with the poor adherence rates of survivors who do not receive full care, or who seek care immediately after the rape incident when they are still traumatized and are unable to understand the benefits of PEP (Arend et al., 2013b). Obstacles to the provision of PEP are mostly institutional rather than patient driven. Health care providers lack training on the management of rape survivors and this leads to the poor collection of evidence, failure to provide timely HIV voluntary counselling, lack of counselling about drugs, and inappropriate referral (Kim et al., 2009a). Little is known about the extent and quality of trauma counselling and psychological referrals by health care providers, and survivors are often unable to absorb much of the information given to them at their first presentation due to their mental state (Vetten and Haffejee, 2005, Kim et al., 2003). Some facilities that initiate PEP refer rape survivors to specialized local clinics for follow up. However, there is no formal tracking system of clients by the clinic (Christofides et al., 2005, Garcia et al., 2005). In some facilities, counselling is provided in an unconducive environment where privacy and confidentiality cannot be assured (Vetten and Haffejee, 2005). In other facilities, health care providers were not adequately trained, lacked confidence in managing survivors of rape, and were not well informed about PEP protocol (Birdsall et al., 2004). People who tried to access PEP treatment at health facilities reported that they encountered negative attitudes from health care providers. Furthermore, rape survivors who reported to the facilities without a police case number were turned down by health care providers, and the case number was used as the criteria to qualify for PEP (Birdsall et al., 2004). Other health care providers shout at rape survivors who report late for PEP, causing distress among survivors and resulting in them not returning to the facility if they have missed a dose (Vetten and Haffejee, 2005). Negative attitudes shown by health care providers towards rape survivors compromise rape survivors' needs; this contrasts with health care providers who have a high level of knowledge in providing post rape care, and who have positive attitudes and are sympathetic to survivors (Kim et al., 2003, Jina et al., 2013) . Women who have been raped are willing to travel a long distance to a facility that has PEP and trained health care workers who understand rape and who can provide thorough counselling (Christofides et al., 2006).

A study conducted by Christofides et al. (2006) found that the completion of HIV prophylaxis was higher in Thohoyandou when a 28 day pack of HIV prophylaxis was given on the initial day, accompanied by anti-emetic drugs and information on HIV prophylaxis drugs, with home follow up visits provided by community workers linked to an NGO. This compared to the experience in Cape Town, where rape survivors were given a seven day starter pack and were expected to return to the centre weekly for HIV prophylaxis and the provision of anti-emetics, and where information on PEP was not widespread. However, anti-emetics alone do not result in better compliance, and in Thohoyandou, home visits with food parcels appeared to be crucial for adherence to medication.

PEP and factors affecting adherence and completion

The Refentse intervention study, conducted by Kim et al. (2009), entailed firstly two days of training of health care providers and other multi-disciplinary team members on caring for sexual assault survivors, including the importance of HIV prophylaxis and the health care worker's role in caring for women who have been sexually assaulted. Secondly, the training included formulating the hospital sexual assault and rape management policy, based on national management guidelines and treatment protocol to include 24 hour access to HIV counselling, provision of immediate PEP dose, and the provision of 28 days full course PEP treatment on the initial day. In addition, a private room was provided to examine rape survivors, with the required equipment for physical examination. Lastly a community awareness campaign was conducted about sexual abuse, PEP and the availability of rape services in the hospital.

Post intervention, police officers prioritized PEP treatment by bringing the survivors to the hospital prior to case opening. Counselling and testing survivors for HIV increased from 60% to 80% and provision of sexual transmitted infections increased from 88% to 92%. Survivors gained more insight into PEP and its side effects, and there was increased provision of anti-emetics. As a result, rape survivors were more likely to report that they had received 28 days treatment on the initial visit and had finished the course, resulting in improvements of completion rates (Kim et al., 2009). The inability of survivors to keep appointments for follow up treatment, as scheduled, has resulted in health care workers giving survivors the 28 days PEP (Vetten and Haffejee, 2005). However, the provision of a full 28 days PEP course without further counselling may result in poor adherence and a waste of drugs, and even when

given a weekly supply, if survivors were unable to come back for treatment, drugs were wasted. Other factors that affect completion and adherence rates include survivors' perceptions about the risk of contracting HIV after sexual assault, lack of support from family and friends, stigma, and the quality of the relationship between the survivor and health care worker (Vetten and Haffejee, 2005, Kistner, 2003). Support appears a critical factor.

A study conducted by Abrahams et al. (2010) on the impact of telephonic psychosocial support for PEP adherence showed that the survivors who were telephoned by health care workers were more likely than those not phoned to finish the 28 days course. However, there is a challenge in calculating the completion rate because some rape survivors were given weekly repeats, others were given a full 28 days treatment, and having received a full course does not ensure adherence. Therefore, the distinction between adherence, completing, and returning to the clinic needs to be made (Vetten and Haffejee, 2005). In order to deliver quality care and prevent secondary victimization to sexual assault survivors, South Africa needs to have an integrated multi-disciplinary model care. Resources need to be delivered by competent and compassionate health providers to survivors, and a proactive follow up system is needed to maximize the PEP completion rate (Kim et al., 2009b, Smith et al., 2005, Arend et al., 2013a).

The World Health Organization maintains that all countries should have policies and services provided to sexual assault survivors, and that the policy should include the provision of PEP (Du Mont et al., 2011). There is been an increase in sexual assault legislation and health interventions in sub Saharan African countries (Kilonzo et al., 2009a). For example, Liberia, Kenya, Namibia, Tanzania and South Africa all have laws specifically focusing on sexual violence (Kilonzo et al., 2009a). Yet a majority of providers (59.1%) in the study conducted by Christofides et al. (2005) in South Africa reported that there was no sexual assault policy and management guidelines in the facilities they reviewed. The South African Department of Health, as noted above, introduced a rape care policy which made provision for prescribing PEP to rape survivors (sexual assault survivors) who reported within 72 hours of rape in 2002 (Vetten and Haffejee, 2005, Christofides et al., 2006). Care of survivors of rape in health sector is recognized as a particular area of neglect internationally (Jewkes et al., 2009b). In South Africa, rape survivors receive few resources, resulting in substandard care and unmet health needs (Jewkes et al., 2009a).

1.3 Problem Statement

There is a gap in service delivery to rape survivors, and adherence to and the completion of PEP by rape survivors remains poor, despite the potential risk of contracting HIV as a result of sexual assault. Health care providers do not always give rape survivors adequate information on the side effects of drugs, and anti-emetics are not necessarily given on first consultation. Although most patients value having a sensitive health care worker who can provide counselling, this does not always occur (Vetten and Haffejee, 2005, Christofides et al., 2006).

1.4 Justification

South Africa has the highest rates of HIV/AIDS and rape in Africa, and among the highest in the world. There is a potential risk of HIV transmission during sexual assault (Kim et al., 2003). As a result, the Department of Health developed clinical policy and guidelines for managing sexual assault, including PEP and emergency contraceptives pills provision, in April 2002 (Christofides et al., 2006, Abrahams and Jewkes, 2010). There are two important roles that the health services have for survivors of sexual assault. Justice is the first; the second, on which I focus in this report, is to assist survivors with medical care including preventative therapy, psychological support, and treatment and rehabilitation. The preventative therapy includes interface with HIV services, HIV testing, the provision of PEP, emergency contraceptives pills, and adherence counselling (Kilonzo et al., 2009a). Studies conducted by Arend et al. (2012), Vetten et al. (2005) and Abrahams et al. (2010) have identified and analyzed the barriers, challenges and experiences of rape survivors on PEP. Because PEP adherence and completion rate remains low (Abrahams and Jewkes, 2010), there are recommendations that more research should be conducted to understand the challenges that result in this (Abrahams et al., 2010). This study was conducted to identify gaps in the health system, quality of care to rape survivors, the provision of PEP, barriers within the health system to implement the policy that includes the provision of PEP, and providers' attitudes, beliefs and experiences with regard to poor adherence. I have, in conducting this research, questioned how the health system can improve service delivery to rape survivors to enhance adherence and completion rates.

1.5 Research Question

What are the challenges encountered by Ekurhuleni District Health care providers when delivering PEP to rape survivors and supporting rape survivors? What is the competency level of health care providers on the implementation of sexual assault guidelines including PEP?

1.6 Aim and Objectives

The aim of the study was to explore the knowledge, attitudes and experiences of Clinical Forensic Medical Services health care providers from three facilities in Ekurhuleni District, and to assess the quality of post rape care and related post rape exposure prophylaxis (PEP) services they provide to rape survivors, in accordance with the National Department of Health Rape and Sexual Assault Policy and Clinical Management Guidelines in 2015.

The specific objectives of the research study, conducted in 2015, were as follows:

1. To analyze and describe the knowledge and attitudes of providers employed within the Clinical Forensic Medical Services from three facilities in Ekurhuleni District on national and/or provincial guidelines of rape survivors, including the provision of post exposure prophylaxis.

2. To describe the experiences and perceptions of health care providers in the Ekurhuleni District Clinical Forensic Medical Services on the implementation of the PEP service to rape survivors.

3. To describe the perception of Ekurhuleni District Clinical Forensic Medical Services health care providers on training and providing comprehensive care for post rape survivors.

4. To describe and compare the perceptions of health care providers on PEP statistics and reported adherence with recorded statistics at Ekurhuleni District in Clinical Forensic Medical Services.

Chapter Two: Methodology

2.1 Study Design

The study design is predominantly a qualitative study using a case study approach. The case study approach is one that focuses on gaining an in-depth understanding of an event at a specific time (Yin, 1981). The focus of the study was to understand how health care providers perceive post rape care and to describe practically what is offered to rape survivors. Therefore, the aim of the study was to explore the perceptions and experiences of Clinical Forensic Medical Services Health care providers on the quality of rape care in 2015.

2.2 Study Site

Gauteng Province has 26 facilities that provide post rape care. Of these, seven are Thuthuzela Care Centres (TCCs). The TCC model project was designed by the National Prosecutor Authority (NPA) through the contribution of stakeholders (Lawrence et al., 2007), and involves the Department of Health (DOH), National Prosecuting Authority (NPA), South African Police Services (SAPS), Department of Social Development, NGOs and mental institutes. The TCCs are one stop centres that provide a multi-disciplinary approach to the management of rape survivors. Ekurhuleni District has six post rape care centres, of which two are TCCs and four are Clinical Forensic Medical Services. The study was conducted in South Africa Gauteng Province at Ekurhuleni District in three Clinical Forensic Medical Service centres, namely: Sinakekelwe Thuthuzela Care Centre (STCC), Masakhane Thuthuzela Care Centre (MTCC) and Far East Rand Care Centre (FERCC). Clinical Forensic Medical Service sites are specialized units that deal with sexual assault cases. These facilities have been in operation for more than six years and they are busy centres. All operate 24 hours a day.

STCC is situated in the South Region of Ekurhuleni District at the new Natalspruit Hospital: Thelle Mogoerane Regional Hospital. According to STCC, based on figures for January to March 2015, more than 80 rape survivors were seen each month and about 60% were initiated on PEP each month; the completion rate was less than 65% according to centre statistics. MTCC is situated in the North Region of Ekurhuleni District at Tembisa Hospital. According to MTCC quarterly statistics, 54 survivors were seen each month and 55% were given PEP; their completion rate was below 60%. FERCC is situated in the East Region of Ekurhuleni.

At Far East, around 58 survivors were seen each month and 30% were initiated on PEP. However, according to FERCC's January to March 2015 quarterly statistics submitted to Ekurhuleni District Clinical Forensic Medical Services, the medico completion rate was less than 40%. All the above mentioned centres offer pre and post counselling to rape survivors who report before and after 72 hours, and consent for HIV testing is obtained. Survivors who report within 72 hours and are HIV negative are given PEP with weekly follow up dates for treatment and ongoing counselling. However, those who are unable to return to the centre are given a monthly supply of PEP medications. Completion rate statistics were used to monitor compliance. Gauteng Clinical Forensic Medical Services PEP completion rate target is 40% and Ekurhuleni district Clinical Forensic Medical Services PEP target is 70%. All three sites of Ekurhuleni were below the district target of 40% (Ekurhuleni Health District, 2015).

2.3 Population

In Ekurhuleni District, six facilities offer Clinical Forensic Medical Services. Two services are located at district one and regional three hospitals, and one is located at a primary health care facility. All facilities with TCC or Clinical Forensic Medical Service were eligible for selection as case studies. Within the TCC or Clinical Forensic Medical Service, there are health care providers who work at Clinical Forensic Medical Services including sessional doctors, permanent Clinical Forensic Medical Services service doctors, professional nurses, enrolled nurses, enrolled nursing auxiliary staff, and lay HIV counselors. These people comprised the population for this study.

2.4 Sample

Three facilities were purposively selected as cases for this study. These were the two Thuthuzela Care Centres and one other service. The reason for the selection of these facilities was that they had been in operation for a longer period of time and were busier centres than some of the other clinics. Three facilities were excluded. One was excluded because I work at the site. Another facility had been operating for less than two years and was only open 12 hours per day, with staff seeing fewer than 50 new rape cases a month. The last one was also new and operates only during weekday working hours, and at weekends and on public holidays it is closed.

Within the three selected facilities, I purposively selected permanent doctors and professional nurses who had received comprehensive training on sexual assault management and had seen more than 10 survivors in the last three months. I also interviewed enrolled nurses, enrolled auxiliary nurses, and lay counselors who had been working in the Clinical Forensic Medical Services for at least three months, had attended a trauma containment course, and had seen at least 10 survivors for last three months (see Table 1**).**

Table 1: Sample of participants purposively selected for the study

Facilities	Doctors	Professional Nurses	Auxiliary nurses	Lay counselors	Enrolled nurses	Total
A (STCC)	1	2	2	2	-	7
B (MTCC)	1	1	1	2	1	6
C (FERCC)	1	2	-	-	2	6
TOTAL	3	5	2	4	3	17

2.5 Data collection

I am an employee of the Clinical Forensic Medical Service, sit in Clinical Forensic Medical Services management meetings, and I am a member of the Gauteng Clinical Forensic Training Committee. There was a possibility that participants might have perceived me as an investigator sent by management to inspect whether the participant complied with sexual assault guidelines and protocols. However, I had no direct authority over any of the participants. During recruitment I explained to the participants the purpose, benefits and risks of participation in the study. I also made it clear that the research was for degree purposes and that the identity of participants would be kept confidential.

After a participant agreed to participate, she or he was given two consent forms to sign, one for participation and other one for audio recording (see appendix 2 and 3). All the interviews were conducted in the facilities and they took half an hour to one and a half hours. The interview guide and interviews were conducted in English as most of the participants were professionals and so spoke English fluently or as their first language, and lay counsellors always understood English. I reviewed the quarterly statistics and registers, and assessed the documentation.

2.6 Scope of study

Many factors hinder or enhance adherence and completion rates of PEP treatment. Therefore, the intent of this research was to identify the system dynamics with regards to PEP adherence and the accessibility of treatment, and to explore the confidence and competency of health care workers in implementing the guidelines of rape survivors. I analysed their perceptions of these factors in the context of the training that they underwent and the challenges that they experienced, including in relation to commencing PEP with rape survivors, and caring for rape survivors.

2.7 Data management and analysis

The interviews were audio recorded with consent, and transcribed word for word. The researcher transcribed all the interviews. After transcribing, the data were manually analysed. All transcripts were read multiples times and initial themes were identified. These themes drew on the objectives of the study. Memos were written during this process, noting the key themes that emerged from each transcript. Later, inductive codes were identified. These codes emerged from the data. The researcher designed a code book with codes extracted from the themes and subthemes with the definitions of code. Her supervisors reviewed the code book and worked through these, applying the codes to a transcript to ensure that there was agreement. The data were visualized using a mind map to look for patterns and to explore the relationship between the themes and sub-themes that had been identified. Findings from the different centres were compared to explore the similarities and differences in the patterns that were emerging. Different categories of health care providers were also compared. Memos were written throughout the process to document analytic thoughts.

For the objective that compared provider perceptions of the statistics and the actual facility statistics, the quarterly records and statistics from October to December 2015 of three sites were checked, and averages calculated. Both the statistics and clinic registers were compared to check the accuracy of the data that were reflected in the statistics.

2.8 Ethics

The protocol was approved by the WITS Faculty of Health Sciences, Human Research Committee Ethics and Ekurhuleni District Ethics Committee (M141147). Service delivery was not compromised by interviews, and participants were informed that their participation was voluntary and they could withdraw at any time. I reemphasized that the purpose of the study was academic. Furthermore, the participants were informed that their responses would be kept confidential and that in reporting the findings would be integrated in the report.

The participants were asked to sign the consent form for participating, after they received the information about the study (see Appendices 1 and 2). Separate consent for audio-recording was obtained. All audio recordings, transcripts consent forms are kept in password protected files and hardcopies are locked away. No unauthorized person had access to any of the information; only the two supervisors of the primary researcher accessed the raw data. All documents will be kept for two years after the publication of these findings. Thereafter all the information will be destroyed. Individuals signed for confidentiality. Codes were used on transcripts and records, and no true name was used. Copies of consent forms for the study and audio recording, as well as the completed demographic questionnaires with unique numbers, are kept locked away.

All transcripts were de-identified. In the results section, the following codes are used: C indicates lay counsellor, and so C1 for lay counsellor participant one, DR is doctor (hence DR1, DR2, etc.), N1 is nurse participant one, and RN 1 is a professional nurse participant one. The lower case letters are used to identify the site of the study: “a” indicates STCC, “b” MTCC and “c” FERCC. Hence N2c is nurse number two from Far East Rand Care Centre.

Chapter 3: Results

The results section is organised by six main themes identified during the analysis. Under each theme, various subthemes emerged. The main themes identified were: guidelines and policies that direct Clinical Forensic Medical Services; challenges in providing comprehensive care to post rape survivors; liaising with other departments and sectors; processes of management; training of health care providers; and impact on self.

3.1 Post rape care management

Post rape care needs to be comprehensive, and there are many processes and policies that need to be implemented to provide quality care to post rape and sexual assault survivors. The processes include obtaining a history of the event, trauma counselling, HIV counselling and testing, examination of the survivor and the collection of evidence, prescribing and commencing treatment to prevent HIV, STIs, and the provision of emergency contraceptive pills; and documentation of medical findings. In addition, the process should include referral to other departments for further management for those survivors who sustained severe injuries, referral for ongoing counselling to social workers, and handing the person over to the police to enable them to take their own history. Health care providers talked about the multiple difficulties and challenges that they faced during the process of managing rape survivors. To explore the extent to which health care providers were prepared to manage rape survivors, I also explored provider perspectives of the training which they received, and explored the knowledge and attitudes of health care providers on national and provincial policies of rape care and guidelines. I also compared the perception of health care providers on adherence with captured statistical data.

3.1 Sociodemographic characteristics of Ekurhuleni Clinical Forensic Medical Service (CFMS) health care providers

As set out in Table 2, most of the participants were female (82.3%) and married (58%). Participants were also categorized according to race, and 94% of participants were Black. Most of the participants had completed matric and had certificates and diplomas: all doctors (17% of all participants) had degrees, the 29% with diplomas were professional nurses, and the participant who had not completed matric was a lay counsellor. Around one quarter of participants worked less than 40 hours per week at clinical forensic medical services; these

were all lay counsellors receiving a stipend and not permanently employed by the Department of Health but by an NGO. The participants who worked 40 hours or more per week were nurses and doctors.

Table 2 Characteristics of the 17 Clinical Forensic Medical Services Health Care providers

Characteristics	Number	Characteristics	Numbers
Sex		**Level of education**	
Male	3	No school completed	1
Female	14	With a Certificate	8
		Diploma	5
		Bachelor's degree	3
Race		**Marital status**	
Black	16	Married	10
Indian	1	Single	7

3.2 Guidelines and Policies of Clinical Forensic Medical Services

Knowledge and attitude of health care providers on national and provincial guidelines

Clinical Forensic Medical Services have policies and protocols that guide the process of managing the rape survivor. Those policies and protocols include STI management protocol, HIV testing and counselling, Sexual Offences Act and the national sexual assault policy and clinical management guidelines.

Participants stated that the patient flow was based on how the survivor was managed in the centres, rather than in relation to sexual assault clinical management guidelines; few mentioned any protocols. Many were unfamiliar with the guidelines and policies. A few professional nurses had partial knowledge of the guidelines, especially in relation to the distribution of a PEP starter pack to survivors who refused to be tested. Most participants said they did not give a patient treatment if they refused to be tested, as they believed that they had to know the status of the patient before giving treatment.

> Okay (Laughing). The first is that when the patient, when they come, eh … eh!! Why this question is become so tricky? You said the guidelines of rape survivors? Like??? (RN1a)

> Maybe I saw it in the drawer, but I did not read it. (N2b)
>
> (Raised eyebrows) Guidelines? (Taking a deep breath). (DRc)

Attitudes of health care providers

Most participants raised the importance of being professional and non-judgemental when dealing with rape assault cases. As much as they had questions about why the survivor was at the tavern at that time of the night, for example, they did not ask survivors those questions. Participants reported that even with cases when they felt that the survivors were not being truthful, they treated them as genuine and followed the procedure as expected, and all the necessary investigations, examination, and treatment were given. They may subsequently hear from the police that the client had withdrawn the case. According to participants, most cases involving teenagers were not genuine, but they handled them professionally.

> But now the problem is that people are roaming around at night because most of our cases when you ask, the client will say, I was at the shebeen at night, 12 am. But you ask yourself, why are people roaming around at night? But you can't ask your client because you cannot judge; you can't say why you are walking alone at night in the street around 12 am? But what we do we teach them when we do outreach? Because if you find a group of boys or young girls, you must tell them. (N2c)
>
> You see, things like this make me ... Because we are not judgemental, we just take the story as it is. Okay, I know this situation; I dealt with this situation before, I dealt with it like that … (RN1a)
>
> Usually, you do not see them until they go to the police, we are not judging. If you come here and say you been raped, I can't say to you, you were raped because you were wearing this short skirt. We just take it as they say it because we are not judgemental. (C2b)

3.3 Processes of management

History taking and counselling

In discussing process, some of the participants described patient flow, which varies from centre to centre. This is the process of managing the patient from admission until discharge, and it is included in the TCC guidelines. The patient flow per centre is described in the table below.

Table 3 Patient flow for STCC, MTCC and FERCC

STCC Patient flow	MTCC patient flow	FERCC patient flow
FCS members are stationed at the Centre. **Walk in survivor from the community or brought by the police** FCS members are called to interview the **survivor** prior medical staff. After seen by FCS member the counsellor or nurse opens a file, obtains a history and carries out pre and post-test counselling and a HIV test, if consent is given. Nurses take vital data. However, if it is a counsellor, the survivor is post-test counselled and handed over to the professional nurse or a doctor (Clinician) for examination and treatment. After examination the survivor is referred to VAO for further counselling and scheduling of appointments and FCS are called to collect evidence and transport survivor home.	FCS members are not stationed at the centre. **Walk in survivor from the community or the scene** Uniformed police are called to take the survivor to police station to open a case and FCS members are called by the uniform police to transport **survivor** to MTCC. The FCS member hand over the survivor to MTCC staff, patient is seen by counsellor first for pre counselling and trauma containment, referred to the nurse or sister to, HIV testing is carried out, do vital data collected and post-test counselling is conducted, sometimes the post HIV counselling is done by the VAO and handed over the clinician for examination and treatment. After examination, the survivor goes to VAO and FCS are called to collect evidence and transport survivor home.	FCS members are not stationed at the centre. **Walk in survivor from the community or the scene** Uniformed police are called to transport the **survivor** to police station for case opening and FCS members are called by uniformed police to police station to transport the patient to FERCC. Patient handed over by the police to the FERCC staff, nurses open a file for survivor and nurse does trauma containment, collects vital data and pre and post counselling and HIV testing. After vital data collection the survivor is handed over to the clinician for examination and treatment and referred to local clinic for psychosocial therapy. FCS members are called to collect evidence and transport survivor home.

Health care workers talked about the whole process of counselling and debriefing the client who has experienced rape as emotionally draining, because during the trauma and HIV counselling session, they must obtain the history and hear the story of what transpired during the rape incident. The types of injuries sustained by survivors during a rape incident can also cause distress to health care providers. The counselling is time consuming, because survivors have to calm down before the provider can proceed with history taking or a clinical examination. According to participants, rape survivors respond to the situation in very different ways. Some clients find it easy to relate the story of the rape incident immediately;

others become hysterical, highly emotional, and need to take time to calm down before they can relate what happened. Others become numb and are unable to tell their story.

> What I have learnt is that consoling them is very difficult, because you find that some survivors come to the centre crying. Then you wait like for a lot of minutes before getting their history from them or before examining them. You have to be patient and very caring, because rape cases are very sensitive and you cannot judge them as well. (DRb)

The issue of trust and time was raised especially with reported cases involving children. Health care providers explained that it was especially difficult to get to the truth of what happened from a child, and working with children was seen to be especially time consuming. Participants mentioned that they felt more traumatized and frustrated working with children than adults, both because children take time to tell what happened to them, and sometimes because they are unable to explain what happened at all. Some health care providers have made it their obligation to get to the truth of what happened especially from a child, and when the child refuses or is unable to tell the story, they became frustrated. This contributes to more stress. There is a need to build rapport and so develop a relationship with the child to enable the evaluation. In this process, the child needs to gain trust of the provider to give information of what happened, and due to pressure of other patients waiting outside in the queue, health care workers see this as especially time consuming and stressful. Some became impatient.

> The child is very, very difficult to come out with the truth. Like earlier today, there was a child, I asked her what happened. She said nothing …When I was thinking about the child and what was happening, maybe I spent three hours to four hours with the child. Sometimes, I left and went out, and when I came back and asked her, sisi is still not changing anything and she said nothing, nothing. In the end the child was pregnant, was pregnant already. (C1a)

Knowledge of health care providers of PEP provision to rape survivors

Most participants including doctors reported that they did not give treatment to survivors who did not want to be tested. They believed that all survivors must be tested before prescribing treatment. Only two clinicians – a doctor and a professional nurse – said that they gave a three day starter pack if the patient reported within 72 hours and was not ready to test. All participants described pre and post counselling and testing procedures. Although most of the counselling is done by nurses and counsellors, this is not the case at all centres, and in some cases the doctor does the counselling. All doctors explained counselling and testing

procedures, even if they were not involved in counselling. Clinicians and nurses mentioned the new STI protocols, and only one professional nurse stated and still implemented the old protocol. All participants were knowledgeable of PEP treatment, although some of the lay counsellors did not know some of the names of the treatment.

> Okay, rape survivors need therapy (long pause and laughter). We refer them for counselling, like I said, we have got a social worker on site. We use hospital social workers, then for the kids we have a kids' clinic. Then that is for counselling. We have an HIV protocol that we follow; we do an Eliza HIV test, we give them a Prophylaxis, STI packs and condoms, and we involve the partners. If they do not have place to stay we involve South African Police Services (SAPS). They organize placement for the kids and shelters for adults. So we try and encourage them to come back for follow up, even if it is not like, if it is necessary (PRN). When there is a need, we encourage them to come back and to call us if they have any problem and we give them our cell phone numbers. Yeah, that's how we do it. (DRc)

> Iya, the point of the treatment is, I explain that, if you won't test, then you will never get the treatment. Because you are not going to get the treatment without knowing your status. You should know your status before getting treatment. If still the patient is in denial to get the results, obvious(ly) he cannot get the treatment, because how can you give treatment if there is no status? (C1a).

> We give them, eh!! To prevent STIs we give, like you know, the recent protocol is rocephine 250mg imi stats plus Azithromycin 1g stat, flagyl 2 g stats, Ovral tablets two stats and two after 12 hours. According to HIV results if it is non-reactive, we give Lamzid 1 tab twice a day to take at the same time. If she takes it at 7 h00, she will take again at 7h00 at night for 28 days, and if there is any injures, we treat according to any injuries. We also have hepatitis vaccine, three doses. One dose is 1 ml intramuscular injection (imi) to start on that day. Then the second what do we call it? When they come back on the six weeks and three months. (RN2a)

3.4 Challenges providing comprehensive care to post rape survivors

Lack of resources

Participants described providing post rape care as challenging and stressful, because of the lack of resources such as staff, medication and infrastructure to implement the sexual assault policy and guidelines.

Poor planning, infrastructure and organization of Clinical Forensic Medical Services

All three selected facilities for this study are located in stand-alone buildings and are far from casualty – the accident and emergency department - of the hospital that they are attached to. This raised concerns when a survivor needed to be transferred to casualty for further management. Referral or transfer to casualty of patients with severe injuries is a problem as some survivors need to be wheeled or taken on a stretcher to casualty, and others needed extra medical devices like oxygen cylinders. Distance from casualty depressed staff members of the study centres, because if there was an emergency, it was a challenge to reach casualty for immediately assistance and this was seen as delaying the provision of care to the patient.

> It's when there is difficulty in examining a patient … I was examining a 13 year old child who was vaginally and anally penetrated, iyo!!! And there was a fistula that was bleeding. When there are excessive injuries, whereby, ehhh … (Pause) There is no medical person who will assist you there and there. Whereby you have to take the child to casualty for further management (looking into the distance), neh!! And when you get there, they do not take that as a priority. That is a serious challenge, you know. You wish other people could sensitise or prioritise issues. I know that some of them do not understand what we are doing this side, as much as we have tried to go and educate them. But when there is bleeding with a child, was she 18? Not 18 – eight years. She was below, she was eight years. **(**RN1a)

Shortage of staff

Most participants raised shortage of staff as a serious challenge, with negative impact on their ability to provide comprehensive and quality care to rape survivors. Professional nurses were working alone and were often expected to do the whole process without assistance. Most professional nurses were overworked because they multi-tasked and undertook all the procedures when there were no doctors, counsellors or junior nurses. They start from opening the file, obtaining the history of the incident, provide counselling, testing, and taking vital signs, through to the collection of evidence. This was often difficult and they became overwhelmed. Junior staff members were also affected by staff shortages, as sometimes they undertook tasks beyond their scope of practice. For example, if there was no Enrolled Nurses or a sister to give medication or injections, a junior nurse or a counsellor was expected to commence and dispense treatment. In addition, sometimes psychosocial therapy was delivered by a professional nurse, enrolled or auxiliary nurse due to the demand for the services from survivors and the shortage of social workers. This added to the pressure on and

stress to nurses. Sinakekelwe Thuthuzela Care Centre at Natalspruit experienced this during the night when the NGO (Ekupholeni) offering counselling was closed:

> I would do the vital signs and do some counselling. Moreover, if we do not have the counsellors then the professional nurse does counselling. (RN1a)
>
> After the doctor examines the client, the client comes back to me and I give adherence and medication PEP. (C1b)
>
> They have different protocols. Here in Gauteng, counsellors concentrate on the counsellor's work, and in Klerksdorp we found that their counsellors were doing lots of things. They were doing the counsellors' job, they were cooking, cleaning, and helping the doctor when examining the client. They were doing the nurses' job. But they're a counsellor not a nurse. If you are a nurse at least you can counsel the patient. We were surprised at what other TCC's do. (C2b)

Language barriers

There are eleven official languages in South Africa, and many other languages and dialects are spoken by South African nationals and cross-border immigrants. Gauteng is a particularly diverse province, and many survivors are from elsewhere in the country or from outside of South Africa. This means that survivors cannot always articulate or express what had transpired in the incident. Health care providers may not be able to communicate and understand the language that the survivor speaks because they lack the capacity to speak non-South African languages and lack the capacity to speak all South African languages, and so they cannot always interview the rape survivor for linguistic reasons. This frustrates the rape survivor and the health care provider, and it compromises quality of care, as neither understands the other:

> Touching on this word of rape, you will end up in…like now, the challenge is we are having this mom, she does not know English, Sotho or Zulu. She just speaks seTsena and there is no-one here who knows that language; even now we are struggling to get someone to interpret. She cannot write and she cannot do anything, so she is still here since this morning, and I do not know what we are going to do. (C1a)

Lack of psychosocial therapy for survivors

The issue of psychosocial therapy for survivors came up strongly and was perceived as one of the most critical parts of post rape care. Survivors are emotionally wounded, and therefore

they are perceived to need psychosocial therapy to be able to restore their lives and to face the world. However, not all facilities had social workers assigned to the centres, and some hospital social workers were not willing to assist rape survivors. Even those who were willing to see rape survivors at times were overbooked. Therefore, nurses, doctors and lay counsellors sometimes ended up counselling the survivors. Participants reported that those survivors who received psychosocial therapy recommended it as an important part of their healing process. For example, the district hospital used to assist patients from the Far East Care Centre with counselling. However, that arrangement was no longer effective at the time of the study, because the social workers were reluctant to go to court to give evidence or to testify because they lacked training on how to give evidence in court. Therefore, clients are referred to the local health clinics or police stations for counselling.

> We used hospital psychologists, but now they refuse because they say they do not want to go court. We have that challenge now. Even the casualty does not want to see our patients because they are afraid that they might be called to court to describe the injuries that they document in for Justice form (J88) (N2c).

Sinakekelwe Thuthuzela Care Centre does have counsellors, victim assistant officers, auxillary workers and a social worker at Ekupholeni to provide counselling during the day, but at night they have a problem with patients who are hysterical or need intensive counselling. In such contexts, they have to wait till the morning for Ekupholeni staff.

> Then you find that it becomes so difficult and painful, because you see that this person is staring at me and is emotional. When you ask, did you hear anything? - The victim will say "I am fine and I understand." At least they come during the day, unlike at night when Ekupholeni is closed. At least during the day the process will be done. We will counsel them while they are still hysterical, and when they go to Ekupholeni they become a little bit calmer. (C2a)

Tembisa Thuthuzela Care Centre has a victim assistant officer who assists medical staff to arrange counselling with hospital social workers. However, sometimes hospital social workers are overwhelmed because they have to see hospital clients. Sometimes rape survivors are given a future date that is available, based on the availability of the social worker or space, and so they are not prioritized. They wait like any other patient who comes to the hospital for social worker services.

> It depends. I remember I had another one, it was emergency case, and we used the hospital psychologists as we do not have our own social worker or psychologist. But they are responsible for the whole hospital, so it also depends on their bookings. (RN1b).

> Counselling … we refer our clients to the local clinics for counselling. As you know Far East is far from the townships, so we have transport problems. Then we decided that it is better for them to go to their nearest clinic for follow up as far as the therapy is concerned. (DRc)

Lack of medication

Lack of medication was also a concern as not all facilities had all the medication as stipulated in the policies and guidelines. Clinicians may be forced to prescribe substitutes that are available. Far East Rand Care Centre was the only centre that prescribed the treatment according to the policy. The two TCC centres did not have all the treatments as set out in the protocol. In Tembisa TCC, there was no third drug for children (Kaletra syrup). The participants did not know whether it was a "pharmacy problem" (related to stock-outs) or because the centre had not ordered the drug in the first place. They promised to find out from the chemist. This raised a concern, too, regarding how they managed rape survivors who were unconscious or who could not swallow tables, and with child survivors who were at high risk of contracting HIV. Sinakekelwe TCCS also reported challenges of the third drug (Aluvia); this was perceived as a supply chain management problem and was able to be resolved. Another concern was that in the two TCCs, some permanent clinicians were still prescribing according to the old protocol of treatment for STIs.

> Giving the third drug. When a person has been sexually, whether anally or vaginally penetrated by one or more people, or if one of those people is (known to be) HIV positive … sometimes we do not have the drug – (that's) challenge number one. (RN1a)

> We do have Aluvia in syrup. You know the Aluvia. We used to have it here in the centre, but now it is tabs (available in tablets). We give them one tab and it depends on the age of the child, we gave them the pill and I think it causes a problem, a pill in the little one. (DRb)

> The antibiotics that we give, we know that, nationally, so far we do not have cefixime, so we give ciprobay, here in our centre we give ciprobay 500mg, we give doxycycline as an antibiotic, and we give 100mg 12 hourly times seven days. We also give them flagyl depending on what we have on stock ….Before September it was, fixime 400mg stat, flagyl 2 g stat, the other one was ciprobay 500 mg stats, even Lamzid, ovrals 2 stats 2 after 12 hours, hepatitis three doses, what else? (Quietness) Yeah!!!! (RN1a)

Challenges in Initiating PEP

According to the sexual assault policies, rape survivors must be given ARV treatment if they test negative and have reported within 72 hours of the rape incident. A seven day weekly supply of ARVs is given to them, with a request that they monitor the side effects and adhere to the prescription. If the rape survivor cannot come back weekly for treatment due to transport difficulties, then a 28 day supply can be given. However, if the survivor not ready to test a three days starter pack is given and after three days if tested negative the rest of the treatment given weekly of same time. Despite these clear guidelines, health care providers experience some challenges in initiating ARVs to rape survivors.

The majority of participants at all centres raised concerns about giving rape survivors a weekly supply, as most of the survivors complain about transport challenges and the lack of transport money. Therefore at Far East, all survivors are given a 28 day supply of medication for the full course. STCC used to give seven days' medication until August 2014, when the centre and the hospital relocated to Vosloorus; most of the survivors come from Katlehong and face financial difficulties regarding transport. At present, to address these problems, STCC and MSCC staff interview survivors and give them a weekly or monthly supply based on their availability to present to the centre and their financial status. Other challenges raised by health providers from the two TCCs were that there was no telephone access to remind the survivor to come and collect her medication or to confirm adherence over the phone, and no opportunity therefore also to counsel the survivor about treatment. Most STCC nurses relied on counsellors at Ekupholeni to do telephonic follow ups.

> Because, at first when we used the same system, it did not work. (Survivors) never came back. So when we did some kind of verbal calling survey that was informal, most of them said, we do not have money, and there and there! And so we came together as a unit and decided that the best is for us to say to them, give them a full pack. (RN1a)

According to all doctors and a few nurse participants, initiating PEP to the rape survivor was not a problem, especially if health education was given to the survivor about side effects and the importance of taking treatment. However, some nurses and counsellors viewed the initiation of PEP as a difficult procedure, even if they tried to explain the importance of adherence to the medication and its side effects. One professional nurse thought that the

difficulties were because of the incident and its nature as violent and traumatic: survivors might be emotional and confused, and so unable to digest or recall all the information given to them on the initial day. Another nurse reported that some clients were not literate and therefore it was difficult for them to read the instructions written on the medication packs. Nurses and counsellors also said that rape survivors sometimes were misinformed about ARVs when they were initiated; occasionally rape survivors thought that health care providers were infecting them with HIV or they assumed that they (the survivors) had tested positive. One nurse from MTCC talked about communication as a particular challenge, as some survivors do not communicate to them that they were going to travel and they would not be able to attended an appointment on the scheduled date.

> Because some patients test negative and if you give them treatment, they say you are infecting them with the HIV. Why do you give them this treatment? (Even though) you have explained before giving her the treatment, that this treatment is for prevention … For the first time or the first day they come, some they forget what we have explained about PEP. I don't know, maybe it's because they have been hurt. Some they will say they are taking medication once a day and they hear that they have to take it twice day. Yeah those are the challenges. But they do take it. (C1a)

> So they don't understand what you are saying about the 12 hours apart story. They are ignorant and you are worried that they will not take that medication, yeah. It may come that the patient drank the medication but come back after six weeks positive. (N2c)

> No, most of them are always willing to take medication because they do not want to seroconvert, and I have never had a negative experience because I try to prepare them that it is not gonna be easy; you must know that sometimes you are going to feel queasy but you must be strong. It is better to safer for 30 days, you know. I told them to be strong and to take medication and most of them, they comply. (DRc)

> The genuine cases who have not had HIV tests before, first of all they are traumatized about the incident and when you explain to them about the risk, getting HIV, they are more worried and they know … definitely they know that this is something that they must do and when we tell them about pregnancy prophylaxis. I believe it is easy to initiate the rape survivor than initiating patient who was suddenly positive. (DRa)

A doctor and the registered nurse from STCC raised their concern that too much medication was prescribed for the patient, with the example of antibiotics plus a third drug. However, the new protocol has decreased the number and days of antibiotics and medication

that is taken immediately, as prescribed on the initial day. Thereafter the patient continues with ARVs. Some survivors also refuse to take treatment because they believe it is too much:

> Challenge number two is the survivors refusing to take so many drugs. Because when you look at the size of those drugs ... I will talk of one experience of a person … a well learned person who understood about the third drug. She said, she is not going to take it. Remember there is something that we give them. .. In other cases, survivors refuse the medication when the perpetrator is their boyfriend. (R1a)

> No, some victims don't want to take treatment even if we do a HIV test … there was this one patient who did not want to take treatment because she was living with this person who raped her, and we did all the tests and the HIV test was negative. But she refused to take treatment because she said, I sleep with this person every day. It is just that this day he forced himself on me, yeah. (C2a)

Perception of health care providers on adherence and statistics

Participants described health education and counselling as critical to ensure that survivors attend follow ups and comply with treatment. According to health care providers, clients who were given information on the importance of medication and side effects were more likely to come for follow up than those who did not receive such full information. However, some nurses still felt that some survivors would not come, irrespective of how much information was given to them. STCC participants reported that most clients came back because they were given a weekly supply. One professional nurse from MTCC reported that she had not yet reached a 100% return rate, but that most survivors returned. One participant raised the issue of adherence and statistics accuracy. In most cases, if they gave clients a full course of PEP, they could not be sure if the client would adhere to the treatment and based on that, they worried about how to keep records and generate their statistics, because the records would not be accurate.

> (Shaking head) Iya neh!!! That is something that actually I did not want to visit. But I'll say personally, it does not please me, to say that we calculate statistics according to the records. That we will say how many people came and we saw and we gave full packs. Not according to those who came weekly to say that definitely they came and they took (their medication) … So our completion rate is not statistically accurate. Then we that side, that side we will use our completion rate according to their visits when they come weekly. Whatever … So in that case we assume that will be completion rate. (R1a)

> Okay because, in the month of December, although we give clients health education and we do not give this only verbally, we also give them pamphlets to read. Because we understand that when they come on the first consultation, they cannot remember everything. But the other challenge is to remind them, we do not remind them because we don't have an open line to call them. So we have to call them through the switchboard, we use the switchboard line to ask for the line, so I think that one is also a challenge. (R1b)

> Adherence when they come back, we ask them and (do a) pill count, all those things, although it is not done as specifically as they doing it at the HIV Clinics. But we do it as we do it with other patient who are hypertensive on treatment. You know, this strict guidelines, but I don't know here if counsellors do adherence. (DRa)

Comparing the CFMS records and statistics

Different systems are in place in CFMS for record keeping and statistical purposes. Health care providers are expected to document all medicolegal findings and the procedures undertaken with the survivor in the records. One of these records is to keep statistics that are compiled daily and monthly, which should then be sent to the district office not later than the third of every month. The statistics forms have various elements which relate to consultation, medication follow up and HIV testing follow up. The consultation indicators are: the number of clients who reported sexual assault before and after 72 hours, number of clients who tested positive or negative after first HIV testing, number of clients not willing to receive PEP, and number of clients who are given the full 28 days course treatment. The medication indicators are: number of clients given PEP, first follow up, second and third follow up of PEP, and number of clients given first, second and third Hepatitis B vaccine. HIV testing element indicators are: number of clients who come back for six, 12 and 24 weeks HIV testing follow up and their status. The average for the three centres for six weeks follow up is 17.5%, three months follow up 10.1% and six months follow up 3.2%. The total number of new clients seen in all three centres from October to December 2015 was 662 and the completion rate was average 75.7% (Ekurhuleni Health District, 2015). Furthermore, the total number of new clients, average of completion rate and follow ups was calculated from October to December 2015 for each centre (see Table 4).

Table 4 Ekurhuleni Clinical Forensic Medical Services statistics for Sinakekelwe Thuthuzela (STCC) Care Centre, Masakhane Thuthuzela Care Centre (MTCC) and Far East Rand Care Centre (FERCC), October - December 2015.

Name of the facility/centre	Total number of patients	PEP Completion rate (%)	Six weeks follow up (%)	Three months follow up (%_	Six months follow up (%)
STCC	286	88.3	7	7.3	5.3
MTCC	153	65	32	6	5.3
FERCC	197	78	39	23.6	5.3

Different centres had different record books, and few books were similar. For example, all centres kept an admission book and South African Police Services book to maintain the chain of evidence collection and statistics forms for compiling monthly statistics. The TCCs are similar because of the National Prosecuting Authority.

At Far East Rand Care Centre, most participants reported that survivors adhere to ARV treatment, although it was difficult to determine how the completion rate was calculated, since clients were given a full course (all 28 days when they presented for the first time), and centre staff were not necessarily able to track clients to determine whether they had taken their medication. Health care providers said that they would ask clients about adherence at the six weeks' clinic visit when they came for a blood test follow up. However, fewer survivors came back at six weeks for follow up compared to the expected number. Moreover, the statistics at STCC, MTCC and Far East Rand did not correlate with the books, as some child patients of alleged sexual assault were not tested and the whole procedure was not followed. The clinician checked the child first, before undertaking an examination of the child. If there was no sign of penetration, then the child would not be tested for HIV. Another reason was that at MTCC, post 72 hours survivors were not tested for HIV. Another thing that came up very strongly was that at all centres, there was attrition of the numbers of people who returned for follow up, and many survivors did not report for follow up. At Far East, people who presented

post 72 hours were tested initially but they were not given a date for follow up. At MTCC and STCC, most clients came back for treatment and defaulters were recorded in the book.

3.5 Liaising with Other Departments and Sectors

Lack of commitment from other departments

One of the things mentioned by participants was a lack of commitment from other disciplines and the multi-disciplinary team, including police officers, for example, and other staff in facilities. CFMS staff members did not always have a good relationship with casualty and as a result, casualty staff did not understand the care centre's function and rape survivors were not prioritized irrespective of their condition. However, most of Far East Rand Care Centre participants reported that they enjoyed a good relationship with casualty staff at Far East Rand Hospital, and Far East Rand Casualty informed them when there were patients or managed patients who were referred for further management by FERCC. One nurse who was working night duty, who complained about Far East Casualty staff, stated that they were sent gender based violence clients who were brought by ambulance or who were classified as priority 01 due to the severity of their injuries, without them being stabilized at casualty first.

> Oh, yeah, we do send them to casualty and you find that they are attended to. Just like Casualty send clients to us after they have been stabilized or they call us to go and see our client there. We do have the relationship that works. (RN2c)

> I haven't had any bad experience or whatever with casualty; we communicate. We actually go to casualty and make sure that our clients are okay. Make sure that there is really a history of sexual assault because sometimes people sensationalize things, you know. If somebody comes in being robbed with no handbag, they always say the patient was raped, calling us and harassing us, saying there is a sexual assault case in casualty, and when you get there you discover that there is nothing. The patient was never raped. But we work very well together; the sisters are always helpful. (DRc)

As noted above, cases involving children can be especially difficult, as illustrated in the management of a 13 year old child who was penetrated vaginally and anally, and had a fistula that was bleeding. There are similar difficulties with other patients:

> Yoh!! Yesterday there was a client with laceration and Dr X referred the client to casualty, but casualty did not do anything. The patient went to Daveyton without being sutured. They just bandaged her and casualty is so ignorant because last time with the scar they just put on a bandage, and when I came in the morning, I saw the patient and the patient was dizzy. Dr Z

> had to put in a drip before examining the patient. And that patient was admitted almost for three months and taken to theatre for debridement and she was already discharged by casualty, you see casualty is afraid of sexual assault because they must go to court and they are afraid of court. (N1c)

Another challenge for implementing the sexual assault policies was that sometimes police officers did not see eye to eye with health care providers in terms of handling cases. Some of the police officers lacked interest in or were not committed to handling cases of rape and sexual assault. This was especially with cases of children, when the suspected perpetrator was relative young. Often the police officers attending would argue that there was no case or even advise the family to settle the matter out of court. This distressed the health care providers, because they had examined the child and had seen the injuries, and they ended up feeling like they had failed the child.

Court attendance also caused stress, because sometimes the health care providers were not prioritized in court and there was a poor communication; sometimes health care providers were told after lunch that a case had been postponed. Hence, health care providers who were not based in Clinical Forensic Medical Services, e.g. casualty officers, did not want to assist with rape cases and the patient ended up being neglected or mismanaged. This resulted in poor quality care. This also caused stress among health care providers who worked at Clinical Forensic Medical Services:

> But another challenge is our police officers are doing favours, especially when the child is a minor and the parents are not willing, because mostly they will talk and the perpetrator's family will talk. They resolve the matter among themselves and the police do not follow it up, they condone that situation. It has become a habit now, if it is a minor, they will just tell us that, no, the family will just resolve or talk about it and it won't go anyway (RN1b).

> The difficulties of subpoena, you know, you go there and they will just keep you there for hours, especially in Kempton Park. You just wait until after lunch, and after lunch they will say the case will not go in, then they postpone it. Hmmmm (DRb).

3.6 Impact on Self

Stress due to traumatic events

Most health care providers who participated in the study described their work as stressful and traumatizing, due to the nature of the cases that were reported, including gender-based violence and cases of children who had been raped.

> It's bad sometimes, and sometimes you feel emotional when they explain what happened to them, so it is really hard to work with them. Yeah!! Because it is painful when you hear the stories, what they are talking about, what happened to them. (C1b)

> It is tough one. We really, really need to prepare your mind so that, you know, I will try to be supportive and caring as far as I can because it is draining emotionally. It takes a lot out of us … With rape survivors, you cannot predict that the next person who is going to come here, is going to react this way. Each person reacts differently, some reactions will really surprise you. (RN2c)

Health care providers consider their work to be unlike other jobs, insofar as it influenced their own life and relationships, and caused vicarious trauma. They are extra careful or overprotective of their own children because of the stories that they hear from rape survivors, and this has also made them distrustful. They take work issues to their home and always worry, wanting to know what is happening with their children or in their children's lives during their absence. They believe that they need an opportunity to debrief in order to cope with their work and in their everyday lives:

> It is traumatic to me as well. It is not the nice thing to do, to see people crying all the time. It is even worse when it is a very small child, it is very traumatic. That is why we need to go for debriefing in order to keep ourselves insane. (DRb)

> To be honest, I never knew how hectic this thing was until I started working here. I used to hear about sexual assault on the radio, but I never knew how it was till I started working here. As a result, my whole life has changed and I don't know if I have become paranoid or what. (RN2c)

> Yeah, it is stressful and you do not become popular. Sometime we do take it home and sometime you dream about this. (RN1b)

Emotional draining

According to health care providers, not all cases are genuine. However, as health care providers, they are expected not to judge but to render services to all cases that are reported to Clinical Forensic Medical Services as rape cases, and to follow all the protocol and perform all necessary procedures. Health care providers viewed these cases in particular as emotionally draining because they need to spend time and apply their mind to the case, working through the process, despite a shortage of staff and limited resources. Then after some time, when everything has been done, the client may verbalize that there is no case and state the reasons for not telling the truth initially. This contributes to burn-out, and when genuine cases come, health care providers are already exhausted.

> But when you counsel them further or try to get history further, then eventually you have examined them, when they said they want to open a case, when you have done everything a crime kit. Eventually at the end of everything, then they will say to you "No!!! We actually do not want to open a case. All we wanted is that this man must come and pay." (R1a)

Coping mechanisms

Different types of strategies are utilized by health care providers to deal with stress. A debriefing session is provided once a year to doctors and nurses by the Department of Health. Normally the Department of Health takes the CFMS health care providers, primarily doctors and nurses, for an outing for three days and two nights to a lodge or hotel, and there, activities are provided by a psychologist and other professionals. The other form of debriefing is case presentation or case sharing, whereby health care providers sit and present cases to their colleagues; this does not have a time frame and whether it occurs or not depends on the availability of staff.

Some health care providers just decided to block out stress from work and to act as if nothing had happened, as they are expected to counsel other patients. They consider that they have to be strong for their patients, and as a result, they don't have the time to debrief in between and deal with their emotions. Some console themselves by saying there are those cases that they laugh about when thinking about them, and others believe that they can handle the trauma since they have received training on trauma debriefing.

> Yeah, some, there are days whereby it is very tough, and like today, I was so touchy about this little girl, but then it is not always raining or bad, there are days whereby you laugh. But

> as you work and get experience or acquire experience, you get used to your job. But there are those cases that are very touchy. (RN1a)
>
> One day I said hayi, I wanted to quit from this centre, hey, because of the trauma. Like you feel like crying but we do not have to sympathise, we are binded by the ethics and you go outside. But at least, we are receiving the training that trains us on trauma. (C1a)
>
> So imagine if you take on the emotions of the patient that you saw personally, and also we need time, I need my own time to focus on other patients and not let this emotion get it me, because I am here most of the time. (N1a)
>
> Hayi, you like, iya … Neh!!! This is difficult, it is like okay, I must be strong because I am a counsellor. But when you are sitting (here), really, it is hard for me. But you act like nothing is happening. (C1a)

Although debriefing is viewed as a very important aspect for coping, lay counsellors are not prioritized when it comes to debriefing. Doctors and nurses get first priority, and only if there is space, then the CFMS managers may consider including counsellors. However, counsellors also demand to go to debriefing because they believe they deserve it, since they are also working with traumatic cases.

> Only sisters and doctors receive it, but sometimes we just force our way to go there because really, we need it. Sometimes we say, ah!!! Put us in that debriefing because really we need it, guys (laughing). It is not only the sisters and doctors. Let us go there. (C1a)
>
> Yes, debriefing, it is very important. It is one of those things that needs to happen. (DRc)

3.7 Training Received by Providers

All participants – doctors, nurses, and lay counsellors – appreciated the trainings provided by the department. All clinician participants (Doctors and Professional Nurses) had undergone a Sexual Assault Care Practitioners Training (SACP), a ten day course provided by the Department of Health. However, the department has increased it to 14 days to include simulation. The training covers anatomy, types of injuries (trauma), legislation (Sexual Offence Act) and treatment, for example, the STI protocol. This is additional training, separate from their undergraduate degree or diploma. The topics that were covered in undergraduate studies, for example, anatomy, are not provided in the detail that is provided in the sexual assault course. Therefore, the doctors and professional nurse participants described the course as very valuable, emphasising that every clinician who works at the Clinical Forensic Medical Services needs to have it in order to be capacitated and to be able to provide

quality care to survivors. Furthermore, clinician participants viewed it as one of the vital things that gave them confidence in managing rape survivors. Most professional nurses attended a HIV and counselling course that was provided by the Department of Health, and they also acquired skills on counselling. This was important, for, as noted above, at times when they were no junior nurses or counsellors, a professional nurse would offer the counselling services.

> I have attended a SACP training organized by the Department of Health Province, the ten day course, twice. And the first time I attended the course, it was 2011 while I was not full time here but I was seeing cases and it was a practical process. And then after I joined the services in 2013, I attended again the course in 2014 to refresh myself and went for theory and practical. I did it here because it is necessary to do it in order to get a certificate. But it helped a lot to refresh to understand initially and to also hear different topics that were presented by other departments and I strongly believe that anybody who works in department has to be exposed to that. (DRa)

> They start with the rights, they teach us about the rights of the client, HIV testing, examination of the anatomy of the client, vaginal part, and court attendance, PEP Post Exposure Prophylaxis treatment, and how to communicate, the importance of communication, the way you talk and sit. Yes … I would know the difference between a hymen that is intact and a hymen that is not intact and even a hymen that has clefts or new tears and all that. So I have gained a lot. (RN1b)

Lay counsellors and nurses also received HIV and trauma counselling training courses, some provided by Aurum Institute, a public benefit organization, and some by the Department of Health. Some 90% of junior staff members who were interviewed had received training on HIV Counselling and Testing (HCT) and trauma, while 10% had not yet been trained by Aurum Institute. One nurse participant who had not received the HCT training stated that in most cases, counselling is done by a counsellor or a professional nurse, and he was still waiting for the next course. He had received the course much earlier, when it was provided by Far East Hospital. Therefore, he needed a refresher course just like other junior nurses. Lay counsellors and nurses described the courses offered by the Department and Aurum Institute as important, as these really strengthened their ability to care for survivors with confidence, and it increased their knowledge in counselling and testing survivors.

> Yes HIV, even trauma, I did attend for trauma counselling; We were doing trauma counselling; they were teaching us about trauma counselling and stress and how to handle or

> manage the person who is traumatized or how you see if the person is traumatized or stressed. (C2a)

Most clinicians who went to SACP training also received training on collecting statistics as this was one of the topics that was covered. Two sisters or professional nurses, from STCC and FERCC, had not received the training on statistics because they had attended the SACP ten years ago and had not attended a refresher course. Therefore, they used their skills acquired from other departments to complete the monthly statistical records. The clinic books differ according to the clinics, but the daily registers (admission records) were more or less the same, and health care workers were either oriented on how to complete a clinic register or they taught themselves. Junior members were taught by senior staff members and data capturers (Clerk Administrators) on how to compile statistics and complete a daily clinic register, because data capturers did receive training on the completion of statistics. All lay counsellors from MTCC and STCC reported that they kept their own statistics and registers that they submitted to the department and to their supervisors on a monthly basis. The documentation of the POWA and lay health counsellors differs. Lay counsellors have a green personal register where they document all the clients they see individually to generate their statistics for the month:

> There is no course for those things. If you are working, the sister just teaches you how to write in the register. But there is no administration course, we just running by getting information from the sisters. (C1b)

> (The doctor), he showed us this, he showed us how to do stats and all the loop holes and everything about stats. It was a very nice module I enjoyed it. (DRc)

> We are doing it through our previous experience where I was working in Pholosong, because I was expected to write statistics every month so I am still using that experience. But the formal training on how to write stats, no … Okay I was trained at Chris Hani Baragwanath as a registered nurse D4, NIMART course ... trauma counselling, sexual assault in 2004 and after doing the sexual training, it was conducted in Johannesburg . . . in 2006 I started practising as a sexual assault practitioner … (RN1c)

Summary

Most participants are trained by the department on the care of sexual assault survivors. All categories of employers had received relevant training accounting to their expertise, and all valued the training. Although many lacked information on guidelines, they were confident in

managing rape survivors. The participants raised many challenges on caring for rape survivors and the impact on them of caring for rape assault survivors. Lack of support from other departments and resources were described and identified as a gap in service delivery to rape survivors.

Chapter Four: Discussion

The qualitative study reported in this thesis was conducted in three Clinical Forensic Medical Services at Ekurhuleni, and aimed to explore the health care providers' perceptions on the quality of care provided to post rape survivors. This included looking at the health care providers' attitudes and knowledge regarding PEP adherence of rape survivors, their familiarity with national and provincial policies and protocol, and their access to training and skills development.

4.1 Process of survivors' management

The study has highlighted many challenges faced by health providers in their efforts to provide quality care to rape survivors, and at the same time, it draws attention to the variation and similarities in the management of survivors of sexual assault between the centres. Each centre has its own system of patient flow, and even the TCC centres differ in how they manage survivors. The two TCCs have Victim Assistant Officers from the National Prosecuting Authority; however, their job descriptions differ. At STCC, there are two types of lay counsellors, one from the Ministry of Health and other one from POWA, an NGO, and each has different roles. However, their jobs are similar to MTCC lay counsellors: counsellors collect the history of the incident, offer counselling in relation to the assault, provide HIV counselling and trauma containment, and sometimes give medication. Furthermore, the registers and documentation differ; each of the two TCCs has its own way of documenting the data. Only a few books or records are the same. All centres have people responsible for capturing data; however, the data within each centre that are kept as statistics, and the registers that are maintained, do not correlate. This also suggests that patient flow differs, as the centres capture data according to the procedures that are delivered to survivors. This highlights the need for the standardization of the services. These centres are dedicated and specialized units for gender based violence survivors; however the main focus is sexual assault and rape cases and the services that they provide to the survivors have to be the same to prevent secondary victimization and to avoid compromising the provision of care. Regardless of centre, all survivors need the same treatment.

4.2 Challenges to providing comprehensive care to post rape survivors

At the new Natalspruit Hospital at Sinakekelwe Thuhuzela, there are discrepancies in terms of the management of the Survivor Care Centre compared to that at the old Natalspruit Hospital,

where casualty and the care centre was under one roof, and so transporting patients from the centre to casualty for medical management was easy. Although the space was not particularly suitable for the TCC model, it was better than the new Natalspruit centre, when during the study, its operation and communication with care centre staff was demotivating. The hospital is addressing this in terms of giving the STCC more space to render the comprehensive services according to TCC model. Once this occurs, the centre will be a stand-alone centre like the other two centres. Although this may make it difficult to transport patients to casualty for further management, participants felt that this was preferable to having the designated centre next to casualty, since their separation promoted privacy and access to other services that are needed immediately. This idea of separating the centres from casualty, but in a place where there is optimal access to a range of other services, is supported by the World Health Organization guidelines for medicolegal services to rape survivors; these guidelines recommend that the setting of the services have rooms designated for the examination of survivors that ensure privacy and security, and that these services are patient centred (World Health Organization, 2003, World Health Organization, 2013).

According to the South African national sexual assault policies and the World Health Organization, rape survivors must be given a combination of two drugs for ARV treatment and a third drug for post exposure prophylaxis to prevent HIV infection for high risk survivors, provided they have tested negative and have reported within 72 hours of the rape incident. Survivors should be provided with a seven days' supply of ARVs, during which period they should monitor the side effects while strictly adhering to the protocol. If the rape survivor cannot come back weekly for treatment due to transport difficulties, then a 28 days' supply can be given to them. Despite that, health care providers have some challenges in initiating ARVs to rape survivors. In this study, both TCCs had problems with prescribing some of the required PEP treatment due to the unavailability of the drugs in the centres. Therefore, clinicians were required to prescribe substitutes that were available, and survivors were given treatment based on the availability of different drugs in the facility.

A challenge with initiation of PEP is adherence. Many studies have found that PEP adherence is low, especially in resource limited areas such as sub-Saharan Africa (Chacko et al., 2012). However, Christofides et al. (2006) found that the completion of HIV prophylaxis was higher in Thohoyandou when a 28 day pack of HIV prophylaxis was given on the initial

day, accompanied by anti-emetic drugs and information on HIV prophylaxis drugs, with home follow up visits provided by workers with an NGO. We found that most health care providers from STCC and FERCC reported that the full 28 days course was given to survivors. The reasons for this were transport problems and fees, as nurses believed that most survivors would not come back for treatment follow up if they were given a weekly supply only. Unlike the study in Thohoyandou, providing the one month supply was not accompanied by follow up home visits by a NGO. It is therefore not possible to know what the actual completion rates of PEP are.

Vetten and Haffejee (2005) also reported that survivors experienced difficulties keeping appointments as scheduled for follow up treatment, which resulted in health care workers giving survivors the 28 days PEP. Some participants in our study stated that the reasons that survivors do not come back for treatment is because of lack of knowledge of the importance of treatment and because of poor counselling. They believed that the more information that is given to survivors about PEP and possible side effects, the more likely it is that survivors will adhere to treatment. These findings are consistent with a study conducted by Arend et al (2013) that has found that there is a need for Health care providers to discuss the challenges of PEP adherences, physical side effects and ways of accommodating the PEP into survivors' life regular medication counselling in order to increase the likely hood of adherence.

The inadequate follow up system complicates PEP administration (Chacko et al., 2012), and the calculation of the completion rate is problematic. The provincial completion rate target is stated to be 40%, but in the three study sites, the quarterly completion rate averaged 70%. The calculation of the completion rate is questionable when a full 28 days' supply of ARV medication is given, and even the weekly supply does not guarantee that survivors comply. According to the study findings, most survivors do not come back for a blood test follow up and there is no telephone access for people working at the centres to remind survivors about the treatment or follow up. Therefore, it cannot be guaranteed that the survivor adhered to the treatment as prescribed, took all medication, and did not HIV seroconvert.

Another challenge in managing sexual assault survivors is the lack of support from other departments and health professionals. Health care providers from other departments like casualty and social workers do not prioritize or take sexual assault as serious cases, and

appear reluctant to assist survivors because of the possibility of court attendance. This results in the poor management of sexual assault survivors, and various needs, for example psychosocial services, are not met. Sexual assault has negative physical and mental impacts, and prior research suggests that mental health needs are often not well met (Christofides et al., 2005). In the study settings, however, although psychosocial therapy is one therapy that is critical in the management of sexual assault survivors, two of the centres did not have social workers on site and survivors were referred to the local clinics and community health centres, which also have their work load of patients. Only STCC has its own social worker to offer ongoing counselling, but its social workers do not work at night. Furthermore, some of the social workers from the hospital and clinics are not willing to assist sexual assault survivors because, as noted above, they do not want to go to court. The findings are consistent with a study conducted by Suffla and colleagues (2001), evaluating medicolegal services, that showed that providers were often reluctant to attend to sexual assault cases because the implications of this legally in relation to evidence. This suggests the need to allocate a social worker from Clinical Forensic Medical Services in the centres, who understands that she or he is expected to give evidence in court. Other departments like casualty need to be sensitized to the Clinical Forensic Medical Services so as to give them support.

4.3 Shortage of Staff

According to the World Health Organization, the staff distribution is imbalanced between primary, secondary and tertiary facilities. Therefore, the World Health Organization published an approach called Workload Indicators of Staffing Need (WISN) in 1998, to adjust staffing levels to ensure a fair and optimal distribution of staff. In 2008, the document was reviewed and updated. The staff distribution according to WISN is calculated by looking at the statistics of the number of activities and support performed by all staff members and individuals according to category. It is also calculated by looking at health care workers' time available in one year and daily to do his /her job, taking into account also authorized and unauthorized absence. The purpose of WISN is to assess workers' work pressure and determine the volume and nature of work that can be undertaken by staff to cope in the facility and to minimize unnecessary pressure on workers (World Health Organization, 2010).

Study participants complained about shortages of staff. With the Clinical Forensic Medical Services, the issue is not about the number of survivors that are seen but about the activities

that are performed with survivors, unlike in other programs where the head count is considered rather than the activities. One survivor usually takes two hours or more for consultation in the CFMS due to all the processes that are undertaken. The other thing that was highlighted in the study is that professional nurses are most often overworked, because they are expected to multitask, performing junior staff work and clinical work if there is no one else to undertake such work. Although survivors prefer to be assisted by sensitive health care workers who can do all the procedures, health care providers prefer the opposite as they feel pressured and emotionally drained when they see a client and have to do all the procedures without assistance.

4.4 Impact on Self and Coping Strategies

Working with survivors of family violence and child abuse can be challenging (Pearlman and Saakvitne, 1995, Schauben and Frazier, 1995). However, while there is an extensive literature on its impact on survivors, the impact on the well-being of medical professional and staff is less often discussed (Gilbert, 2001). Most participants in this research reported vicarious trauma as one of the things that they experience when working with rape survivors. Vicarious trauma is "the transformation of the therapist's or helper's inner experience as a result of empathetic engagement with survivor clients and their trauma material" (Pearlman and Saakvitne, 1995) and results in profound shifts in the world view of the worker (Coles et al., 2013). Vicarious trauma can also result in disruptions in the workers' views of themselves (Stamm, 1995). Secondary traumatic stress results from knowing about a traumatic event experienced by another person and helping or wanting to help a traumatized person (Arvay, 2001). Most participants reported that their work was unlike any other work, because the rape cases that are reported and the history that is given by the survivors affect their own lives. They report that they are more alert and sometimes they feel they are more protective of their children and that they analyse everything. Some reported that they are more sympathetic with cases involving children, because the moment they see those child survivors they think of their own children at home. These findings are consistent with the study conducted by Coles et al. (2013), who found that physicians, nurse therapists, social workers and child abuse researchers reported similar experiences in an Australian setting.

Primary care professionals can find it difficult to deal with both survivor and perpetrator (Miller and Jaye, 2007). Therefore, professional support is needed for those who are caring

for alleged family violence perpetrators as well as caring for survivors (Coles et al., 2013)**.** More support is needed, including to ensure that health providers are working as a team to protect primary care professionals from secondary traumatic stress and burn out (Coles et al., 2013)**.** The participants of the study describe caring for survivors as difficult and that debriefing and case presentation or sharing strategies assisted them in coping with their work and their everyday lives. However, the debriefing session that is provided by the department is only held once a year, and because of this, doctors and nurses are targeted as the first priority. Once the department reaches the number, then lay counsellors and other staff members who are indirectly involved with survivors, like data capturers and cleaners, may then be considered. This study highlighted the importance of training on stress management and trauma debriefing, as most of the junior members reported that they use the skills that they have acquired from their training to manage stress and to support peers**.** These findings are also consistent with the study conducted by Coles et al. (2013), that indicated that supervision or support from trained or more experienced staff in response to traumatic cases can help staff manage distressing cases.

4.5 Knowledge of Health Care Providers of National or Provincial Sexual Assault Policies

According to the National Department of Health Sexual Assault Policy, if the survivor is not ready to test for HIV for any reasons, the survivor must be given a three days PEP starter pack and counselled on HIV. If the survivor comes back within the three days and tests HIV positive, the treatment is discontinued, relevant bloods are collected, and the person is referred to an HIV clinic. When the survivor comes within three days and tests negative, she/he is given the rest of the PEP: a seven day weekly supply or 28 days full course. Most doctors, professional nurses and junior nurse participants demonstrated knowledge of the STI protocol and HIV Testing and Counselling guidelines. However, some participants were not familiar with the latest information and still practicing the old protocol as during the interview they were referencing the old STI guideline. Patient process or flow specific to the centre was often described rather than the prescribed steps as outlined in the Clinical Management Guidelines for Sexual Assault (Department of Health, 2005). The flow that was being implemented at the centres had elements of the national guidelines but also had some features that were unique to the specific centre. For example, some participants believed that it was compulsory for a survivor to be tested for HIV prior to being given PEP: they believed that

irrespective of the survivor's state of mind, PEP treatment could not be given unless the patient tested. This practice contradicts the Clinical Management Guidelines for Sexual Assault.

Kilonzo et al. (2009) reported that in South Africa misunderstandings about the need to open a case of rape with the police prior to being able to access health care can be a barrier to accessing PEP within the required window of 72 hours. In Kenya, the legislation makes provision for the prescription of PEP in cases of rape but does not make any mention of any other aspects of the management of rape survivors including trauma, pregnancy prevention or STI management (Kilonzo et al., 2009a). However, our participants, unlike those reported by Kilonzo et al., believed that survivors have the right not to open a case and have the right to treatment whether a criminal case is opened or not. The sexual assault policy clearly states that survivors are not compelled to test for HIV, and so immediately after the rape incident a three day starter pack is given. Survivors are also not required to report the case to the police. These findings indicate that some of the participants are not knowledgeable about the guidelines and policies. All three sites have national protocols and policies for sexual assault management; however most participants were not aware of this. This underlines the need for regular in-service training on sexual assault policies and clinical management guidelines.

4.6 Attitude of Health Care Providers

Attitudes and beliefs are hard to change, and survivors prefer to travel the long distance just to be attended by sensitive, non-judgmental health care workers who will provide counselling and PEP (Christofides et al., 2005, Jina et al., 2013). Negative attitudes of health care providers contribute to poor quality care (Smith et al., 2013), and poor quality care can be a negative experience that contributes to secondary victimization and disempowers survivors (Gray and Gekoski, 2010). The results of the study demonstrated that health care providers who are dedicated to work in CFMS are mostly not judgemental, and they understand the consequences of being judgemental towards rape survivors. However, some participants, while stating that it was important to be non-judgemental, made comments that showed that there were situations where they believed that the survivor was putting herself at risk e.g. if she was out drinking until late at night. This demonstrated that there was still some evidence of judgemental attitudes. However, providers were aware of the importance of not expressing judgement by shouting at the survivors or blaming them for what happened. A limitation of

the study is that we did not observe the interactions between providers and survivors and therefore cannot comment on how the providers treated patients in reality. Irrespective of the perceived merits of the case (i.e. whether the provider believed that it was a "genuine" case or not), they reported that they rendered the service to the survivors.

4.7 Training

Health care providers need training to provide quality post rape care to survivors (Jewkes et al., 2009b). A study conducted by Smith et al. (2013) showed that training can improve health care providers' respect for patient rights. This is consistent with our study findings: participants described training as the thing that most changed their behaviour and attitudes towards rape survivors. All doctors and professional nurse participants had received training on the management of sexual assault survivors, and they emphasized the value they placed on the training. They recommended that other colleagues receive such training also, as it is intense and covers most topics that are not covered in undergraduate training, including legislation, evidence collection, court attendance, anatomy, different types of injuries, treatment and statistics. Despite the finding that most of the participants were not certain about sexual assault policies. They were confident in managing rape survivors because they had attended trainings. These findings are similar to Jina et al., (2013) who reported that the confidence in managing sexual assault by health providers who were trained was high but knowledge was less than optimal. All participants perceived rape as a serious condition that needed immediately care. This demonstrates that there have been fundamental shifts in attitude since the situation analysis of post-rape services conducted by the Medical Research Council in the early 2000s (Christofides et al., 2005).

While all junior nurses and lay counsellors had received training in HIV testing and counselling, and most had attended a course on trauma containment, they had not attended specific training for the management of rape survivors. Lack of training can contribute to the poor management of rape survivors (Christofides et al., 2005).

In addition, it has been shown that working with the same condition or in one aspect of health care services e.g.in medico-legal services, for period of time improves clinical skills and increases level of confidence (Lunney, 2008). Therefore, it is suggested that all health care providers working with rape survivors be trained and receive continuous in-service training on caring of rape survivors in order to provide a quality care.

4.8 Limitations

My role as provider may have influenced the results, as participants may have responded in the way that reflected what they thought I wanted to hear, for fear of disciplinary measures if they did not practice what is expected of them. However, the participants did not directly report to me, and the centre that I manage was excluded from the study. Participants were reassured that the study was for the purpose of the degree. Another limitation is the limited number of interviews, and thus it is difficult to transfer these findings to other settings. We could not explore fully quality of services provided to survivors as we only included providers in the study, and we did not carry out observations of how they relate to clients.

Chapter Five: Conclusion and Recommendations

Rape is a public health issue. It has physical and emotional negative impact, and survivors of rape or sexual assault need comprehensive care to regain their normal state. South Africa has developed a one stop centre model of special centres for rape survivors to enable survivors to access medical, social and legal support. In addition, in Ekurhuleni, dedicated staff are appointed to work with rape survivors and training on caring for rape and sexual assault survivors is provided to doctors and professional nurses. Enrolled nurses, auxillary nurses and lay counsellors are trained on HIV counselling and trauma containment. In the findings of study, health care providers who were working in dedicated rape centres valued the training that was offered by the Department of Health on the management of sexual assault survivors, and they recommended that all health care providers working with rape survivors attend the training.

It was also discovered that health care providers who have attended the departmental training have acquired skills in managing rape survivors without expressing judgement. Lack of psychosocial therapy to survivors and limited debriefing sessions for health providers who render services to rape survivors emerged as the most critical issue. How adherence was measured and how the completion rate was calculated was also problematic, and the study gave insight into how rape survivors are managed and findings are recorded in the centres. Each centre has its own client flow and recording system. Most health care providers are knowledgeable about the process flow as compared to the policies on management of rape survivors.

However, there are still challenges in those centres to provide comprehensive care and to implement guidelines, due to resource constraints and poor supply chain management. These factors result in the needs of rape survivors not always being met.

5.1 Recommendations

Based on this study, I suggest the following:

Strengthening of National and provincial guidelines

1. Standardization of service delivery and recording system

The CFMS managers should develop a standard operating procedure that will guide health care providers when managing survivors, and make it available and visible in the centres and to all staff members. The recording system should be synchronized in all centres and the same documents should be used for recording findings.

2. Availability Revised CFMS clinical guidelines and policies

Revised clinical management guidelines and policy of CFMS must be finalised by the policy makers and National Department of Health, and should be disseminated to the provinces for implementation. The provinces will need to train all coordinators on the revised policy and ensure that all required resources for implementation of the revised policy are available and sustainable. Furthermore, universities and nursing colleges should ensure that sexual assault care forms part of their undergraduate curriculum.

3. Ongoing in-service training on policies, guidelines and statistics of CFMS by managers

In-service training on standard operating procedures, guidelines, policies and recording systems, including the capture of statistics, should be conducted by senior managers (coordinators) every month in the managers' meeting. Operational managers should conduct in-service training sessions or give feedback to junior staff members in the centres every week, and they should audit files and analyse statistics every month to assess the effectiveness of the in-service training. All trained CFMS clinicians should be encouraged to attend the short sexual assault care courses that are offered by various institutions. The department to offer refresher course for all the clinicians that have been trained on sexual assault care course.

Senior managers should audit files during site visits and assess the patient flow. All TCC health care providers should be trained on stipulated TCCs model of the National Prosecuting

Authority, and engage in challenges on implementing the model during stakeholders' meetings.

4. Training on CFMS policies and management of rape survivors for junior staff

The Department of Health should design and deliver a programme similar to the Sexual Assault Care Practitioners course that is attended by doctors and professional nurses for junior members. All districts should be represented, and relevant topics like policies of CFMS and duties of junior staff members in CFMS should be presented twice a year so that all CFMS junior members have an opportunity to attend.

5. Sensitization of other disciplines

The CFMS staff members should partner with the hospital and surrounding clinics by attending hospital and clinic management meetings in order to build a relationship. This could be achieved by them giving presentations on CFMS policies and procedures, and CFMS expectations of the clinics and hospitals. Operational managers in the facilities should build relationships with the skills and development manager and present information about CFMS services during the orientation of new staff. CFMS staff members should conduct in-service training in the wards to their peers or colleagues on a monthly basis. The CFMS senior staff and hospital managers should write and sign circulars on the management of sexual assault cases and circulate them. This will assist the casualty doctors and nursing staff to prioritise the needs of sexual assault survivors.

6. Provision of regular effective support of Health care providers

Support groups and regular debriefing should be offered to CFMS staff regularly. Staff members should choose a day each week to focus on themselves for one hour, discussing traumatic cases in which they were involved. During this discussion they should practise stress management techniques that they have acquired during debriefing sessions that were organised by department of health. After the sessions, the CFMS Staff members should organise refreshments to allow staff to eat together as the part of self-care and team building.

7. Human Resources for Effective CFMS services

It would be ideal for every centre to have a dedicated social worker trained on CFMS policies on site. Department of Health CFMS programme senior managers should motivate and advocate for social worker vacancies in CFMS, or negotiate with other programs to assist the CFMS with social workers who will be based at CFMS centres. If not possible for every centre to have social workers, the social workers who are available should rotate between all six centres at least once a week to ensure that a social worker is on site on a regular basis. The Department of Health should also motivate for additional nursing posts and use effective strategies for retention of staff. For example, if staff members elects to undertake further study and can do so without disrupting service delivery, the staff member should be recognised for his or her newly acquired qualifications.

8. Data collection and service statistics

Provincial managers should revisit statistics forms and consult with CFMS staff on the challenges of completing statistics, and assess the calculations of the completion rate with advice from statisticians. New statistics forms need to be designed and CFMS staff members should be trained on the completion of statistics.

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Appendix 1

Provider perceptions of the quality of post-rape care in Ekurhuleni district.

Information Sheet

Hello, my name is Brenda Sulile Skosana, I am a Masters of Public Health student in Social and Behavioral Change Communication through University of the Witwatersrand. As part of the course requirement, I will be conducting a research study to identify gaps in the health system, quality of PEP, barriers of the system to implement PEP, and providers' attitudes, beliefs and experiences with regard to poor adherence. I would like to invite you to participate in this research.

Procedure

During the research, I will be visiting your working place together with my team. The small demographic questionnaire will be self-administered, and an individual interview will be conducted on the first day. It is anticipated that the interview will take one to one and half hours.

Confidentiality

The interview will be audio recorded and I will keep all interview records of participants, together with transcription of those records. Your name will not be on those transcriptions to ensure confidentiality. All data will be stored in a secured place, and only the research team that comprises of researcher, researcher supervisor and research assistant will have access to your interview. The information will be kept confidential, but personal information may be disclosed if required by law or the organization for quality assurance and data analysis. Participants will have access to the results, I will set up a meeting with participants and the results will be presented to them. If the results are published, pseudonyms will be used to protected personal identification. I will also require your consent for audio recording.

Risk and benefits

No potential risk is identified for this study and there are no direct benefits for you. However, I may identify areas that may help in developing an intervention to improve PEP completion rates. It is hoping that providers will be empowered and supported according to the needs that will be identified during the study.

Participation is voluntary. You are under no obligation to participate. You have a right to withdraw at any time without penalty and loss of benefits.

For further information or enquiries about the study, please contact Brenda Skosana at (011)089-8522

If you have any concerns about your rights as a participant please contact Prof Cleaton-Jones, Chair of Ethic Committee at (011)7171234

Appendix 2

Consent form

I hereby confirm that Sulile Skosana has given me information to my satisfaction about participating in this study. She has explained to me the purpose, procedures involved, the risks and benefits and my rights as a participant in this study.

I have received the information sheet for the study and I have had enough time to read it on my own and ask questions. The questions I have asked about taking part in this study have been answered to my satisfaction.

Sulile has told me that the information I give and share in this study, together with information from other participants, will be anonymously processed into a research report and scientific publications. I am aware that this report, and any publications from it, will be shared with the other participants and she will keep me informed about the progress of the research.

I am aware that it is my right to withdraw my consent to be part of this study at any time and without any prejudice. I hereby, freely and voluntarily give my consent to participate in this study.

Investigator signature: Date:

Signature of participant: Date:

Signature of witness: Date:

Appendix 3

Consent form for audio recording

Title of the study: Provider perceptions of the quality of post-rape care in Ekurhuleni district.

Researcher's name and affiliation: Brenda Sulile Skosana, Student of Master of Public Health at Witwatersrand

This study involves the audio recording of your interview with the researcher. Your name and any other identifying information will not be associated with the audio recording or transcript. Only the research team will be able to listen to the recording, and audio records together with transcripts will be kept in a secure place in lockable cupboard.

The researcher and research team will transcribe and code the tapes, and then erase the audio recording once the transcriptions are checked for accuracy. The transcripts of your interview may be reproduced in presentation or in written products that result from this study. However, your name and all other identification will not be included in the presentation or written products resulting from the study.

I hereby give permission to the researcher to audio record me as part of this research. I also understand that this consent for recording is effective from the beginning of the study and the tapes will be destroyed two years, after the study has been published.

Participant's signature: Date:

Witness signature: Date:

Appendix 4

Demographic Questionnaire

Please indicate with a tick in an appropriate block below

What is your Sex/Gender

Female	Male	transgender	Not listed

Please specify Race/Ethnicity

Black African	White	Coloured	Indian	Other

What is your highest education /qualification

No schooling completed	High school completed no diploma	High school completed with certificate	High school with diploma	Bachelor's degree	Master's degree	Doctorate degree

What is your marital status?

Married	Single	Widow	Divorce	Not listed

How many hours do you work at clinical forensic per week?

1-10 hrs per week	11-20 hrs per week	21-30 hrs per week	More than 30 hrs per week

Appendix 5

Interview guide

1. Tell me about your job?
2. What has been your experience with caring of rape survivors?
3. What do you know about the guidelines of rape survivors?
4. Have there been any challenges in implementing them?
5. Tell me about your training.
6. Who provides it?
7. 8. What does it entail?
8. How long is the training?
9. Tell me about your training on completing the clinic registers and compiling monthly statistics?
10. How long was the training and what did it involve?
11. Please tell me how you implement pre and posttest HIV counselling and PEP adherence.
12. What has been your experience with initiating PEP to survivors?
13. What has been your experience with PEP adherence on rape survivors?
14. How many rape survivors come into your medicolegal services every week (on average)?

Appendix 6

Questionnaire

1. Does PEP statistics correlates with daily PEP register? yes /no
2. Is the register completed monthly? yes/no
3. Is everyone who reports to Centre for sexual assault tested yes/no
4. What is the HIV testing Statistics?
5. What are statistics for HIV and counselling?

Appendix 7

R14/49 Ms Brenda Sulile Skosana

HUMAN RESEARCH ETHICS COMMITTEE (MEDICAL)

CLEARANCE CERTIFICATE NO. M141147

NAME: (Principal Investigator)	Ms Brenda Sulile Skosana
DEPARTMENT:	School of Public Health Ekurhuleni District, Gauteng Province
PROJECT TITLE:	Providers Perceptions of the Quality Post - Rape Care in Clinical Forensic Medical Services in Ekurhuleni District
DATE CONSIDERED:	28/11/2014
DECISION:	Approved unconditionally
CONDITIONS:	
SUPERVISOR:	Lenore Manderson and Nicola Christofides
APPROVED BY:	Professor P Cleaton-Jones, Chairperson, HREC (Medical)
DATE OF APPROVAL:	16/02/2015

This clearance certificate is valid for 5 years from date of approval. Extension may be applied for.

DECLARATION OF INVESTIGATORS

To be completed in duplicate and **ONE COPY** returned to the Secretary in Room 10004, 10th floor Senate House, University.

I/we fully understand the conditions under which I am/we are authorized to carry out the above-mentioned research and I/we undertake to ensure compliance with these conditions. Should any departure be contemplated, from the research protocol as approved, I/we undertake to resubmit the application to the Committee. **I agree to submit a yearly progress report.**

Principal Investigator Signature

Date 2015-11-23

PLEASE QUOTE THE PROTOCOL NUMBER IN ALL ENQUIRIES

Appendix 8

UNIVERSITY OF THE WITWATERSRAND, JOHANNESBURG | FACULTY OF HEALTH SCIENCES

PLAGIARISM DECLARATION TO BE SIGNED BY ALL HIGHER DEGREE STUDENTS

SENATE PLAGIARISM POLICY: APPENDIX ONE

I Brenda Sulile Skosana (Student number: 747099) am a student

registered for the degree of Master of Public Health in Social and Behaviour Change Communication in the academic year final year 3rd .

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 above degree 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.

Signature: _____ Date: 25 February 2016

25/02/2016
1

Appendix 9

GAUTENG PROVINCE

EKURHULENI HEALTH DISTRICT
PUBLIC HEALTH UNIT

Enquiries: Dr Ronel Kellerman
Tel no: +27 11 878 8596/8617
Fax no: +27 11 876 1818
Fax2mail: 0866652447
E-mail:Ronel.Kellerman@gauteng.gov.za

MEMO:

To : To whom it may concern

From : Ms Mekgwe, Chief Director Ekurhuleni District (DOH)
Dr R Kellerman: Research Coordinator, Ekurhuleni District DoH

Date : 22 December 2014

SUBJECT: Permission to conduct research in Ekurhuleni District

In principle permission is granted to Ms Brenda Sulile Skosana, currently employed in Ekurhuleni in the Clinical Forensic Medical Services to conduct research in Ekurhuleni district for the following research topic: Provider perceptions of the quality of post-rape care in Ekurhuleni district. She is pursuing an MPH in Social and Behavioral Change Communication through University of the Witwatersrand.

The district Research Committee will only review the proposal and give approval once we have received the ethical clearance from the University of Witwatersrand.

The aim of this research is to explore the knowledge, attitudes and experiences of Clinical Forensic Medical Services health care providers from three facilities in Ekurhuleni district of the quality of post exposure prophylaxis (PEP) services they provide to rape survivors in accordance with the National Department of Health Rape and Sexual Assault Policy and Clinical Management Guidelines in 2014. Indepth interviews will be held with clinicians working in the Medico legal services.

Yours sincerely

Mekgwe

Mrs. N. Mekgwe
Chief Director Ekurhuleni Health District
Date: 24/12/2014

40 Cullin Street, Germiston, 1401 – Private Bag X 1005, Germiston, 1400