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CONTENTS

1. Introduction and Background 1
1.1 Introduction 1
1.2 Background 1
1.2.1 Magnitude of the problem of sexual assault 1
1.2.2 Health consequences 1
1.2.3 Factors influencing reporting cases 2
1.2.4 Sexual assault services 2
1.2.4.1 Standards and Norms for Primary Health Care 3
1.2.5 Objectives 4
3: Methodology 5
3.1 National Study 5
3.1.2 Characteristics of health providers interviewed 5
3.2 North West Province 6
Profile of interviewees 7
Health care worker profile 7
District Manager and MCH Director profile 8
Police, Social workers and NGOs 8
4. Findings nationally 10
4.1 Health providers: Length of service at sampled facility 10
North-West Health providers: Length of service at sampled facility 10
4.2 Age of health providers 10
4.3 Sexual assault services –facility characteristics 11
4.3.1 Structural barriers 11
North West: Characteristics of hospitals 12
Privacy and confidentiality 12
Availability of equipment and supplies nationally: 12
4.3.2 Availability of sanitary towels in the examination room 12
4.3.3 Availability of consent forms 13
4.3.4 Availability of sexual assault evidence collection kits 13
4.3.4.1 ..... Problems experienced with the sexual assault evidence collection kit 14
4.3.5 Keeping evidence locked away 14
4.3.6 Availability of treatment in examination room 15
Availability of tests and treatment 15
4.4 Where people who have been raped first present 15
4.5 Reasons for delays in examination of patient 16
4.6 Where patients wait 17
4.7 Waiting time by province 17
4.7.1 Reasons patients wait 18
North West: Waiting for transport after examination 18
North West: Where patients are examined 19
4.8 Who examines patients 19
North West: Who conducts the examinations 19
4.9 Workload 20
North West: Workload – variability within a province 20
4.10 Sending clothing for forensic evidence 21
4.11 Giving evidence in court 21
4.12 Attitudes towards rape 22
4.12.1 Is rape serious? 23
North West: Attitudes towards rape 24
4.13 Referrals 24
4.13.1 Why providers do not refer patients for counselling 25
4.14 Concerns about pregnancy, STIs and HIV, testing and treatment 25
4.14.1 HIV risk, testing and counselling 26
4.14.2 Post-exposure prophylaxis to prevent transmission of HIV 26
North West: HIV risk, testing and counselling 27

4.14.3 Pregnancy risk, contraceptive use and pregnancy test 27
4.14.4 Emergency contraception and abortion counselling 28
North West: Health workers action regarding pregnancy risk 28
4.14.5 Risk of STIs, treatment and referrals 28
4.14.6 Correct STI treatment 29
4.15 Protocols 30
4.16 Training 31
4.16.1 Training by level of facility 31
North West: Training of doctors and nurses 32
North West: Records of trained staff and deployment 33
4.16.2 Topics that were covered in training 33
4.17 Intersectoral collaboration 34
North West: Intersectoral collaboration 36
4.18 Factors that are associated with quality of care 37
4.19 Discussion 38
Recommendations 39
List of abbreviations 40
References 41

Executive Summary

Women often receive very poor quality medical care after sexual assault. This has been highlighted in work done by Human Rights Watch, Suffla and others that explored services in some provinces. No systematic investigation of services in all provinces had been carried out. In 2001, the National Department of Health prioritised improving sexual assault services and the research presented in this report was conducted to inform this process. The aim was to investigate sexual assault services provided by health sector in South Africa with an in-depth look at North West province. Two district hospitals; a regional hospital and a tertiary hospital (where they existed) were randomly sampled in all provinces. The total number of hospitals in the sampling frame varied from province to province. This was adjusted for in analysis through weighting. At each hospital, we interviewed two doctors and two nurses who examined or assisted in the management of a patient who presented at the hospital after rape. A primary health care clinic, which referred patients to the sampled hospital in each district, was identified and a nurse at the clinic was interviewed. A total of 155 providers were interviewed. A facility checklist was completed at each hospital. In North West Province, 199 nurses and doctors were interviewed from 20 hospitals and a primary health care clinic that referred patients to these hospitals. In addition, district managers, police, social workers and representatives of NGOs addressing gender-based violence were interviewed.

There were many systemic problems that were identified. These included structural inadequacies such as not having a private room with walls and a door where examinations could be conducted. Sexual assault services were typified by long waits – this resulted from health care providers not being available (either because they were too busy or on call), sexual assault not being prioritised and the current system where the police bring the sexual assault evidence collection kits and if the patient did not present first at the police this means waiting for the police to bring the kit. Problems with kits were experienced ranging from kits being incomplete or unavailable to health providers being inadequately trained to use the kit.

This study highlighted the need for standardised clinical management guidelines for sexual assault service delivery. Results indicated that there was significant provincial variability in sexual assault service delivery. Providers' attitudes towards sexual assault as well as the availability of a protocol in the facility differed significantly between provinces. The provider's awareness of the presence of a protocol in the facility was significantly associated with higher quality of care. There is no one province that was found to be better in *all areas* of sexual assault services when considering all aspects explored in this study.

In some hospitals there were designated providers who saw sexual assault cases whereas in other facilities any casualty doctor could examine a patient. This was particularly notable when looking at the variation within North West province where many of the doctors interviewed had seen fewer than five patients in the previous six months. Seeing a larger number of patients was significantly associated with higher quality of care. This finding supports having designated providers.

Just over a quarter of all providers had received any training on sexual assault and about half of these had received the training while they were undergraduates or undergoing basic training. The content of the training concentrated largely on medical treatment and conducting examinations in order to collect forensic specimens. Little attention was paid to addressing provider attitudes, the psychosocial aspects of sexual assault or gender issues.

In exploring the management of sexual assault we found that providers were sensitive to the risks of STIs, HIV and pregnancy. The majority of providers raised these risks with the patient. Offering STI prevention/treatment and emergency contraception happened quite uniformly. However, STI treatment provided to patients was not always correct or providers did not know what the correct treatment was. This raises a broader issue around the quality of treatment that is being provided in primary health care and hospitals. Tertiary institutions were not more likely to provide correct treatment.

About two thirds of providers offered patients an HIV test. This may be because post-exposure prophylaxis was not available at all facilities during fieldwork and providers did not want to offer a test if they could not provide the drugs or because finding out your HIV status after being sexually assaulted was considered too traumatic.

Referrals for counselling occurred much less than any other aspect of the management of sexual assault. Providers across the country were unlikely to have any relationship with NGOs and therefore seldom referred patients to them for counselling. Nearly one in ten providers had no relationship with social workers. There is a need for providers to be given a list of institutions and providers that they can refer patients to. As alluded to earlier, the psychosocial impact of sexual assault should be integrated into training.

District managers' knowledge and attitudes towards sexual assault need to be addressed. Supervision of the service is recommended as a way to ensure greater consistency and to familiarise managers to the gaps and shortfalls in how services are being delivered.

The study further suggested that intersectoral collaboration was inadequate. While most health providers had an average relationship with the police, up to a third of providers described their relationship as poor depending on province. Some police also described poor relationships with health providers in the North West Province where we interviewed police in each district. Providers across the country were unlikely to have any relationship with NGOs and therefore seldom referred patients to them for counselling.

1: Introduction and Background

1.1 Introduction

At a workshop held by the National Department of Health and the South African Gender-Based Violence and Health Initiative[1] in March 2001, the current status of sexual assault services was discussed. One of the priorities emerging from that workshop was the need to systematically describe and analyse services in all provinces in the country. This report presents findings from a study undertaken by the South African Gender-Based Violence and Health Initiative[2].

Sexual assault is acknowledged as a public health issue in South Africa. The physical and psychological health consequences can be severe. The level of rape reported in community-based surveys is substantially higher than that reported to the police. This points to major barriers to reporting rape to the police. Such barriers include fear of further trauma, especially lack of confidentiality, stigmatisation and not being believed, fear of retaliation by the perpetrator, and a perception that such reporting would be unlikely to result in punishment of the perpetrator.

Health care providers have an important role to play in the management of the sexual assault patient after sexual assault. The WHO in their guidelines on the Medico-legal Care for victims of Sexual Violence state that the "overriding priority is the health and welfare of the patient. The provision of medico-legal services to victims of sexual violence assumes a secondary importance to the provision of general medical services."

1.2 Background

1.2.1 Magnitude of the problem of sexual assault

In the year 2000, 52,550 cases of rape and attempted rape of women were reported to the South Africa police, 21,438 of which were of minors under the age of 18 years and of these 7898 were under the age of 12 years (mostly between 7 and 11 years). Prevalence rates of reported rape vary between provinces. In addition 2,934 cases of indecent assault of men were reported, 1,627 of which were of minors. The highest risk group for sexual assault are teenagers and young women (CIAC, 2002).

The rate of rape reported to the police in 1996 was 240 cases per 100 000 women. Research suggests that this represents the tip of the iceberg of sexual assault in the country. A representative community-based survey found that in the 17-48 age group there are 2 070 such incidents per 100 000 women per year (Jewkes & Abrahams, 2002). Sexual assault among men has not been the subject of much research and may be equally or more under-reported. It is particularly a problem in prisons.

1.2.2 Health consequences

Sexual assault can profoundly affect the physical, emotional, mental and social well being of women, men and children. Whilst genital and other bodily injuries often result from the force used in the rape, many patients have no visible injuries because they are threatened and, particularly when weapons are used, their strategy for self-protection is to offer no physical resistance. In a series of 432 cases of rape examined in Johannesburg, 37% of rape survivors had evidence of non-genital injury and 38% had evidence of genital injury (Martin, 1999). These findings are similar to those from the United States and Canada. Similarly whilst many patients demonstrate very visible signs of distress after sexual assault, some respond to the trauma with extreme composure or numbness. This should not be interpreted as a sign of lack of impact. It is very important that lack of injuries and lack of overt distress are not interpreted as indications that a sexual assault complaint is unfounded or impact was insignificant.

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[1] Funded by the MRC

[2] Funded by the Rockefeller Foundation

Irrespective of signs immediately after sexual assault, patients are at risk of a range of medium and long-term health problems. These include pregnancy, sexually transmitted infections including HIV, urinary tract infections, pregnancy-related problems and mental health problems including depression, post-traumatic stress disorder, sleep difficulties and (attempts at) suicide (WHO, 2002). Women who have experienced sexual assault have been shown to experience problems related to the assault for many years afterwards, including post-traumatic stress, depression, substance abuse, chronic pelvic pain, and they are at greater risk for a repeated sexual assault than other women. Adult survivors of child sexual abuse have been shown to be at greater long-term risk of substance abuse, mental health problems and unsafe sexual practices than the general population (WHO, 2002). Victims of sexual violence are also at risk of stigmatisation in their communities. Research on the health impact of men is not available, however rape of boys has been shown to result in very similar mental health consequences as that of women (WHO, 2002).

Mental health problems, primarily post-traumatic stress disorder, depression and substance abuse have profound social consequences. They may result in dropping out of school or other education, loss of function at work, difficulties in sexual expression and diminish the range of activities which the person feels comfortable doing. The family and raped person's partner often do not cope very well and family units may break down in the aftermath of sexual assault. These issues highlight the need for careful attention to the mental health of patients who have been sexually assaulted and for health workers to have specialised training in their management.

1.2.3 Factors influencing reporting cases

Whilst the overwhelming majority of rapes reported by women to the police are perpetrated by strangers or men known by sight, research indicates that women are much more likely to be sexually coerced by an intimate partner than by a stranger (Dunkle et al, 2003). The majority of women experiencing sexual coercion do not currently come forward to health services or the police.

Barriers to reporting cases include not being believed. This is a very important source of further trauma for sexual assault survivors. Others are difficulties with physical access, fear of the examination, fear of being blamed, fear of retaliation by the perpetrator, and fear of the legal processes, including experiencing rudeness and poor treatment. Many women and men are concerned that if they seek care after sexual assault their reputations will be ruined because health workers and facilities do not respect confidentiality.

Many women do not go to the police because they anticipate that ultimately their action will not result in their perpetrator being punished. At present this is the most likely outcome of sexual assault complaints. Police data indicates that in the year 2000 only 45% of cases were referred to court, 47% of cases referred to court were withdrawn in court and only 16.5% resulted in a guilty verdict. A woman, man or child laying a rape or indecent assault charge had a one in 13 chance of seeing their rapist jailed (CIAC, 2001).

1.2.4 Sexual assault services

Until recently, District Surgeons who were employed by the State for this task undertook sexual assault medical examinations. They were usually general practitioners, a few of whom had attended a short course in forensic examination. Some District Surgeons were highly motivated and took a special interest in sexual assault cases, however there were many complaints that they were hurried, disinterested in sexual assault patients, judgmental and insensitive (Human Rights Watch, 1997). Patients were usually given very little information about the medical examination, particularly about procedures and how they relate the court process, about pregnancy, HIV/AIDS and the reasons for medication given (Stanton et al., 1997; Francis, 2000). The examination was often cursory and documentation of evidence was poor. Many District Surgeons did not like to attend court because delays in procedures resulted in their being taken away from other work for substantial periods of time. In a given area there were few District Surgeons, which often contributed to women having to wait many hours before being examined.

In response to the problems with the District Surgeon system, it was phased out in most provinces over the period from 1996 to the present time. Sexual assault medical services are currently provided by all doctors in the public health system and can be provided by any private practitioner. The system was revised without taking account of the necessity for formal training or evidence of competence. The overwhelming majority of doctors who currently provide sexual assault care have had no specific training. Service delivery is further complicated by the rapid turnover of doctors in the public sector and emigration. Rape patients still often have to wait a long time before getting care, their health needs beyond the medico-legal examination are not well met and the quality of the facilities in which the examination takes place is often poor (Suffla et al, 2001, Human Rights Watch, 1997). These problems with the current service represent an injustice to the patient. In Northern Cape nurses were trained to do sexual assault examinations in a pilot project, however, deployment of these trained nurses has not been optimal. Other provinces have started training nurses to do sexual assault examinations however, it is still too early to assess whether this cadre of nurse will be appropriately deployed.

In an attempt to address the quality of sexual assault care minimum standards and norms were developed by the National Department of Health.

1.2.4.1 Standards and Norms for Primary Health Care

In 2000, the National Department of Health brought out a document entitled “The Primary Health Care Package for South Africa -- a set of norms and standards”. One of the sections highlights PHC responsibilities with regard to domestic violence and sexual assault. The document recognises the need for inter-departmental and intersectoral collaboration in delivering services. The responsibilities outlined in that document include that:

- Every clinic should establish working relationships with the nearest police officer and social welfare officer by having visits from them at least twice a year.
- A member of staff of every clinic must have received training in the identification and management of sexual, domestic and gender related violence. The training should include gender sensitivity and counselling.
- The clinic staff are required to fast track in a confidential manner any rape victim to a private room for appropriate counselling and examination.
- All cases of sexually transmitted disease in children are managed as cases of sexual offence or abuse.
- When a person presenting at a clinic alleges to have been raped or sexually assaulted the allegation is assumed to be true and the victim is made to feel confident they are believed and are treated correctly and with dignity.
- A detailed medical history is recorded on the patient record card and a brief verbal history of the alleged incident is taken and noted - with an indication that these are not a full account. These notes are kept for 3 years.
- Staff explain that referral is necessary to an accredited health practitioner and arrangements are made expeditiously and while awaiting referral emergency medical treatment is given with the consent of the victim: prophylactic treatment against STD and post-coital contraception.
- The victim is given information on the follow-up service and the possibilities of HIV infection and what to discuss with the accredited health practitioner at the hospital or health centre.
- Victims are not allowed to wash before being seen by an accredited health practitioner.
- Women who have been raped or abused are attended to by a female health worker and if this is not possible (e.g. a male district surgeon comes to the clinic) then another women is present during the examination.
- The victim is given brief information about the legal process and the right to lay a charge.
- If the victim now indicates a desire to lay charges the police are called to the clinic.

The document emphasises that all patients should be referred to the next level of care when their needs fall beyond the scope of competence of clinic staff. The document also states that referral is necessary to a trained and accredited health provider.

Conducting a situation analysis of how sexual assault services are being delivered in different provinces in the country will assist the Department of Health in determining whether the minimum standards set out in this document are being met. This study was conducted against this background.

1.2.5 Objectives

The overall aim of the research was to investigate sexual assault services provided by health sector in South Africa with an in-depth look at North West province. Specific objectives were as follows:

- To describe how sexual assault services are being delivered
- To determine the sexual assault case load of health care providers
- To determine the nature of training of health care providers who examine sexual assault patients
- To determine quality of care provided by facilities after sexual assault
- To assess attitude of staff who have contact with sexual assault patients
- To determine the availability and accessibility of provincial protocols and guidelines for rape
- To explore factors associated with the delivery of high quality sexual assault services
- To determine what referral pathways exist

3: Methodology

3.1 National Study

A cross-sectional study of facilities in all provinces of South Africa was carried out. Two district hospitals; a regional hospital and a tertiary hospital (where they existed) were randomly sampled in all provinces. The total number of hospitals in the sampling frame varied from province to province. This was adjusted for in analysis through weighting.

At each hospital, the medical superintendent or equivalent was approached and asked to identify two doctors and two nurses who would examine or assist in the management of a patient who presented at the hospital after rape. In some facilities there were designated providers who would examine sexual assault patients while in others any casualty doctor was expected to conduct the examination. A facility checklist was conducted at each hospital included in the study. Drawing from the Thuthuzela Centre[3], a basic checklist of equipment required for conducting a rape examination was developed. Equipment included an examination couch, working angle lamp, table, lockable cupboard (for storing completed sexual assault evidence collection kits), drug cupboard with treatment required for post-rape care, and emergency clothing. We conducted an inspection of all hospitals to determine whether they met basic requirements for conducting rape examinations. A nurse or doctor we had interviewed accompanied us to the room or area where examinations were done.

A primary health care clinic, which referred patients to the sampled hospital in each district, was identified and a nurse at the clinic was interviewed.

A quality of care score was developed for the purposes of data analysis and interpretation. This is shown in the table. According to the current protocol of the National Department of Health, sexually transmitted diseases should be treated (syndromic management based on WHO guidelines) pre-emptively with three drugs. Sending away clothing was taken as a marker for the quality of forensic examination as this could not be assessed in an interview. At the time data was collected it was not national policy to prescribe anti-retrovirals to rape victims but offering a private prescription was recognised as good practice.

The analysis took into account the complex sampling design. Data was analysed using Stata 6.0.

The open-ended questions were transcribed and thematic analysis was carried out.

Ethical approval for the study was obtained from the University of Pretoria. All provincial departments of health were approached for permission to access the sampled health facilities in each province.

3.1.2 Characteristics of health providers interviewed

One hundred and fifty-five health care providers were interviewed. Thirty-eight percent were doctors and 39.3% were nurses working in the hospital; 20% were primary health care nurses based in clinics and 2.6% described themselves as GPs – session doctors. For the purposes of this study we have grouped the GPs with the hospital doctors partly because there numbers are small but more importantly because they function as session doctors in the hospital. Table 1 shows a breakdown of staff interviewed by province. 71.6% of respondents were female and 28.4% were male. Most of the male respondents were doctors; only 4 of them were nurses.

[3] Based at GF Jooste Hospital, in Western Cape.

Table 1: Professional categories of health providers by sex and province

Frequency Column %	Sex	Health Care providers interviewed			Total
		Doctor in hospital	**Nurse in hospital**	**PHC nurses**	
North West	Female	2 (33.3%)	5 (83.3%)	3 (100%)	15
	Male	4 (66.7%)	1 (16.7%)	0	
Western Cape	Female	2 (25%)	8 (100%)	4 (100%)	20
	Male	6 (75%)	0	0	
Gauteng	Female	3 (37.5%)	7 (87.5%)	4 (100%)	20
	Male	5 (62.5%)	1 (12.5%)	0	
Mpumalanga	Female	3 (50%)	5 (83.3%)	3(100%)	15
	Male	3 (50%)	1 (16.7%)	0	
Limpopo Province	Female	2 (33.3%)	6 (100%)	3 (100%)	15
	Male	4 (66.7%)	0	0	
Northern Cape	Female	2 (28.6%)	4 (80%)	3 (100%)	15
	Male	5 (71.4%)	1 (20%)	0	
Eastern Cape	Female	1 (16.7%)	6 (100%)	3 (100%)	15
	Male	5 (83.3%)	0	0	
KwaZulu Natal	Female	3 (37.5%)	8 (100%)	4 (100%)	20
	Male	5 (62.5%)	0	0	
Free State	Female	5 (62.5%)	8 (100%)	4 (100%)	20
	Male	3 (37.5%)	0	0	
TOTAL		59 (40%)	61 (40%)	31 (20%)	155

3.2 North West Province

In the in-depth study of North-West Province facilities, all districts were included in the study. Of the 37 hospitals in the province, interviews were conducted in 20. A primary health care clinic that referred to the hospital in a district was also included in the study for all 20 districts. A facility checklist of the 20 hospitals was completed.

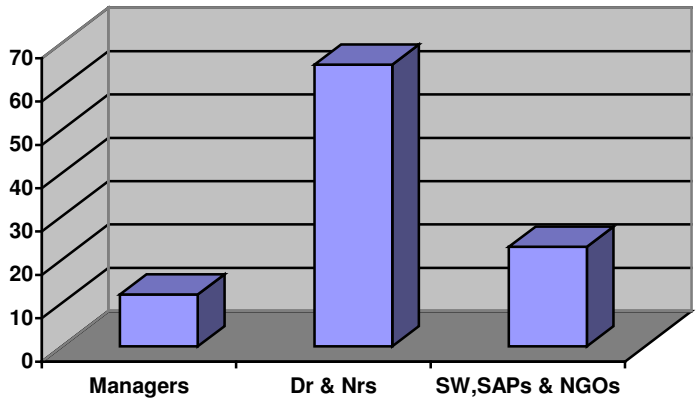
Standardized interviews were conducted with 2 doctors and 2 nurses per hospital. Providers were identified in the same way as described above for the country as a whole. In North West a police officer, social worker, and NGO staff member was interviewed to gain insight into the extent of intersectoral collaboration and effectiveness of referral pathways. In the national study, only the sampled districts from NW province were included in the analysis.

Fourteen district managers, the provincial human resources manager and MCWH director were interviewed.

Profile of interviewees

We interviewed 93% (153) of our total sample (164). Figure 1 provides a breakdown of the total sample.

Figure 1: Interviewees by sector



Health care worker profile

There were two GPs interviewed who worked as session doctors. The two GPs have been include and analysed with the hospital-based doctors. Table 2 shows that nearly two-thirds, (60.6%) of health care providers were women and 39.4% men. 26.8% of the doctors were women and 73.2% men. Among hospital nurses, 82.1% were women and 17.9% men and among PHC nurses 89.5% were women and 10.5% men.

Table 2: Staff category of health care workers by sex

STAFF		SEX		Total
		Female	Male	
Doctors	N	11	30	41
	%	26.8%	73.2%	100%
Hospital nurses	N	32	7	39
	%	82.1%	17.9%	100%
PHC Nurses	N	17	2	19
	%	89.5%	10.5%	100%
Total	N	60	39	99
	%	60.6%	39.4%	100%

Nearly thirty-seven percent (36.6%) of doctors were 30 years of age or younger, 43.9% were aged between 31 and 40 years and 19.5% were 41 years or older. For hospital nurses 56.4% were in the 31-40 year age bracket and 33.3% were 41 years or older. PHC nurses tended to be older than doctors and hospital nurses with 57.9% 41 years or older and 31.6% between the ages of 31 and 40 years.

Table 3: Staff category of health workers by age

STAFF		AGE			Total
		<30	31-40	41+	
Doctors	N	15	18	8	41
	%	36.6%	43.9%	19.5%	100%
Hospital nurses	N	4	22	13	39
	%	10.3%	56.4%	33.3%	100%
PHC nurses	N	2	6	11	19
	%	10.5%	31.6%	57.9%	100%
Total	N	21	46	32	99
	%	21.2%	46.5%	32.3%	100%

District Manager and MCH Director profile

Thirteen district managers, and one MCH director, were interviewed. For the purpose of analysis the data from the MCH director has been aggregated with district managers. Nearly twenty-nine percent (28.6%) of respondents were female and 71.4% male. Half were in the age category 31-40 years and the remainder was over 41 years of age.

Table 4: Proportion of district managers and MCH director by sex and age

		Frequency	Percentage
Sex	Female	4	28.6
	Male	10	71.4
	Total	14	100.0
Age	31-40	7	50.0
	41+	7	50
	Total	14	100.0

Police, Social workers and NGOs

All the NGOs interviewed were women and 75% were between the ages of 31 and 40 years while the remainder was under the age of 31. All the police interviewed were women, 41.7% were under the age of 31 years and the remainder was between 31-40 years. Among social workers, 46.7% were female and 53.3% were male, 60% were between 31 and 40 years and the remaining 40% were over the age of 41 years.

Table 5: Proportion of NGOs, social workers and police by sex

STAFF		SEX		Total
		Female	Male	
NGOs	N	4	0	4
	%	100%	0%	100%
Social Workers	N	7	8	15
	%	46.7%	53.3%	100%
Police	N	12	0	12
	%	100%	0%	100%
Total	N	23	8	31
	%	74.2%	25.8%	100%

Table 6: Proportion of NGOs, social workers and police by age

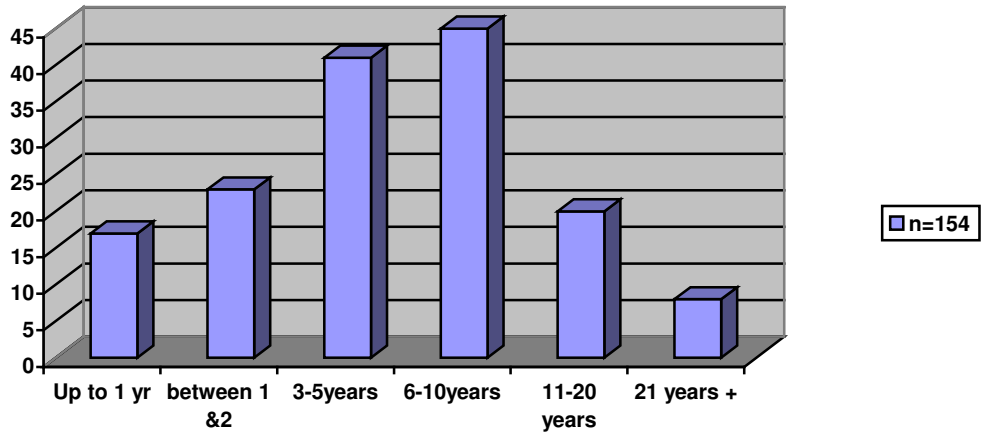
STAFF		AGE			
		<31	31-40	41+	Total
NGOs	N	1	3	0	4
	%	25.0%	75.0%	0%	100%
Social workers	N	0	9	6	15
	%	.0%	60.0%	40.0%	100%
Police	N	5	7	0	12
	%	41.7%	58.3%	0%	100%
Total	N	6	19	3	31
	%	19.4%	61.3%	9.7%	100%

4: Findings nationally[4]

4.1 Health providers: Length of service at sampled facility

The mean duration of work at the current facility was 7.02 years (95%CI 5.91-8.12). Figure 2 shows that 11% of the respondents had worked at that facility for 1 year or less, 15% had been there for between 1 and 2 years, 26.6% between 3 and 5 years, 29.2% between 6 and 10 years, 13% between 11 and 20 years and 5.2% for more than 21 years. So, just over half (52.6%) of the health workers interviewed had been working at that facility for 5 years or less

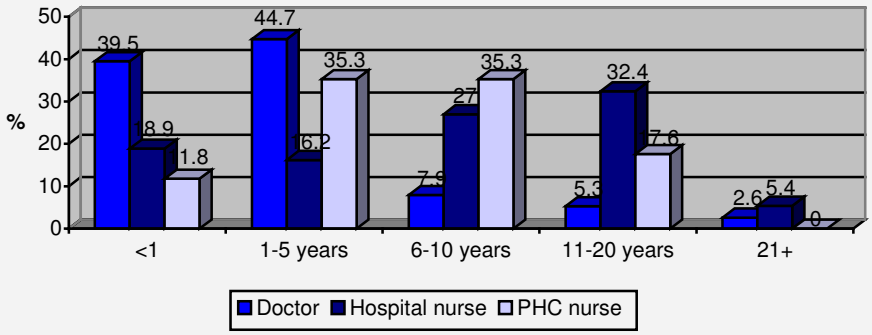
Figure 2: Length of service at the health facility of providers interviewed



North-West Health providers: Length of service at sampled facility

Health providers interviewed had worked at the facility for a minimum of 1 month and a maximum of 32 years with a mean of 6.2 years and a median of 5 years. The mean length of service was slightly shorter for NW compared to the national findings. Doctors had generally worked in the facility for a shorter period of time than nurses with 75.2% have spent 5 years or less at that facility. Among hospital-based nurses 72.8% had been at the hospital for six years or more.

Figure 3: proportion of providers by length of service and staff categories



4.2 Age of health providers

Most of the health providers interviewed were under the age of 40, 13.7% were 30 years or less, 40.3% were between 31 and 40 years of age while 46% were 41 years or older.

[4] The complete North West Report is available upon request. In this report of national findings some aspects of the North West in-depth study have been used to show variability in a province or some of the findings from the district manager and police, social worker and NGO interviews.

Table 7: Frequency of providers by age (adjusted for province)

Age of provider	%	95% CI
30 + under	13.7	8.2-21
31-40	40.3	31.6-49.5
41+ over	46	37-55.2

4.3 Sexual assault services –facility characteristics

4.3.1 Structural barriers

Structural barriers to quality of care were identified through the facility checklist. Nearly six percent (5.7%) of facilities in the Northern Cape had a private examination room, this was the lowest proportion nationally. Gauteng (15%) followed and then Limpopo Province (20.9%). KwaZulu Natal facilities had the highest proportion of private examination rooms (96%) followed by Western Cape (93.2%). While there were private examination rooms in many facilities, no province as a whole was fulfilling the current minimum standards set by the National Department of Health in 2000 which required staff "to fast track in a confidential manner any rape victim to a private room for appropriate counselling and examination". Some provinces were close to fulfilling this minimum requirement for example KZN and WC, however this is not the case for other provinces.

In many provinces, private examination rooms were kept locked after hours and thus were not available. In the Western Cape, 93.2% and North West Province, 81.8% of facilities reported that the examination room was be available at all times of the night.

Given concerns for the patients' safety, privacy and the need to be able to wash after the examination, access to a toilet, basin, bath/shower and hot water were explored in the facilities. If these amenities were located in the ward or some distance from where the patient was examined they were recorded as not being accessible. Access to these was not readily available in most cases. In Mpumalanga for example a basin was accessible in 20.8% of facilities while none of the other amenities were available. Gauteng also had poor access to these with 30% having access to a basin and 15% to hot water. Access to a toilet was easiest in Limpopo Province (60.5%), access to a basin was good in both Western Cape and North West Province (100%) while the likelihood of the patient having access to a bath or shower was best in Western Cape (56.8%) followed by KwaZulu Natal with 39%.

Table 8: Weighted proportion of facilities with private examination rooms, 24 hour service, access to toilets, basins, baths/showers or hot water and a working angle lamp by province

	Structural aspects of facilities											
	Private room		24 Hours		Access to toilet		Access to basin		Access to bath/shower		Access to hot water	
Province	%		%		%		%		%		%	
North West	59.1	27-91.2	81.8	17.5-100	40.9	8.8-73	100	-	0	-	100	-
Western Cape	93.2	71-100	93.2	72-100	56.8	28-85	100	-	56.8	28-86	93.2	72-100
Gauteng	15	0-50.4	15	0-50	0	-	30	*	0	-	15	0
Mpumalanga	60.4	24.8-96	0	-	0	-	20.8	0-92	0	-	0	-
Limpopo Province	20.9	0-92.4	0	-	60.5	25-96	20.9	0-92	0	-	20.9	0-92
Northern Cape	5.7	0-30	5.7	0-29	52.9	41-64	52.9	41-65	5.7	0-29	10.8	0-52
Eastern Cape	56.9	31-82.8	0	-	56.9	31-83	56.9	31-83	13.9	0-66	13.9	0-66
KwaZulu Natal	96	83-100	18	0-72	57	31-83	57	31-83	39	9-69	18	0-72
Free State	80	24-100	0	-	40	12-68	83.3	32-100	0	-	43.3	19-68

- too few observations to have meaningful confidence interval

North West: Characteristics of hospitals

Privacy and confidentiality

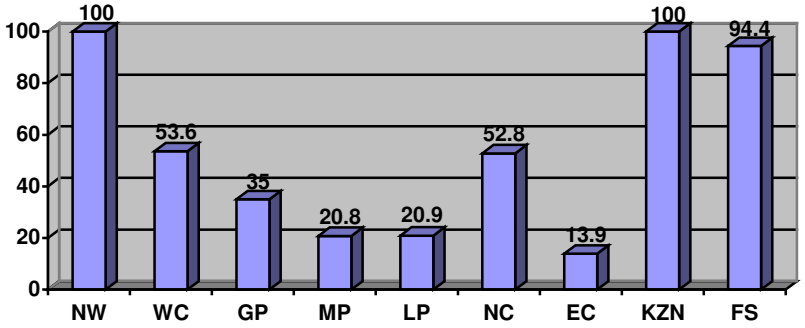
From our facility checklist we found that five (25%) of the 20 hospitals had a private room with walls and a door for rape examinations. Even when there was a private room it was not always used for rape examinations. In exploring managers' knowledge about health facilities we asked where rape examinations were done in health facility. 66.7% of district managers stated that rape examinations were done in a private room (with walls and doors), 16.7% stated that examinations were done in a public examination room and 16.6% stated that it was done in a private room with screens.

Most district managers apparently did not know where rape examinations were performed in their facilities. According to 88.2% of them, rape examinations were done in private room (with walls and screen), 5.9% stated that they are done in private room with screen and 5.9% stated that they are done in cubicles. It should be noted that rape examinations were not done in any of the clinics we visited.

Availability of equipment and supplies nationally:

A working angle lamp is considered to be a basic prerequisite for conducting a sexual assault examination. North West and KwaZulu Natal had a working angle lamp in all the facilities and Free State had a working angle lamp in 94.4% of examination rooms. The Eastern Cape only had a working angle lamp in 13.9% of examination rooms. Mpumalanga and Limpopo Province had working angle lamps in 20.8% and 20.9% of facilities respectively.

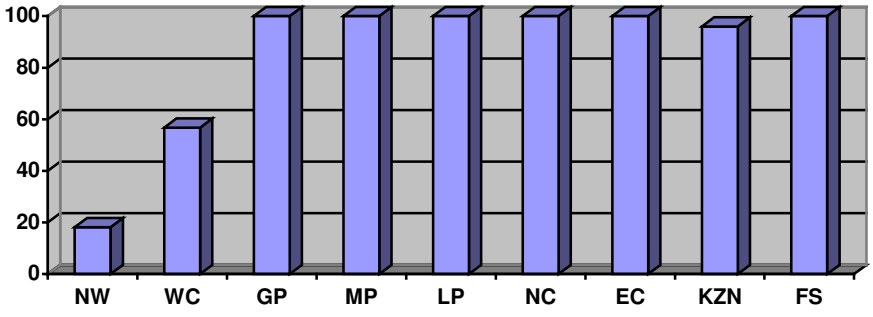
Figure 4: Proportion of facilities that a working angle lamp in the examination room by province



4.3.2 Availability of sanitary towels in the examination room

Most provinces had sanitary towels available in the examination room. North West had sanitary towels in 18.8% of facilities and Western Cape in 56.8%.

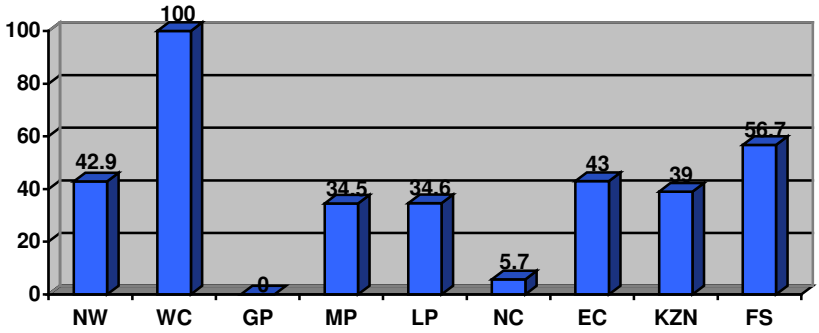
Figure 5: Proportion of facilities that had sanitary towels in the examination room by province



4.3.3 Availability of consent forms

Obtaining consent from patients is not only a legal requirement in order to conduct a sexual assault examination; it is also a way to ensure that the patient has some sense of control over the examination, testing and treatment that they are offered. The availability of consent forms in the examination rooms varied from province to province. In NW all of the facilities had consent forms while in Gauteng none of the facilities kept consent forms in the examination room. In the Northern Cape 5.7% kept consent forms while in the remainder of the provinces between a third and half of facilities had consent forms available. Many facilities seem to rely on the police to bring the consent forms (308) with them. The lack of easy access to consent forms could affect the quality of care for patients who present to the health services before going to the police. Needing the consent form may motivate a health provider to send the patient to the police before examining or waiting for the police to arrive. Lack of consent forms in the examination room may affect the management of a patient who has decided not to open a case and lay charges at that time.

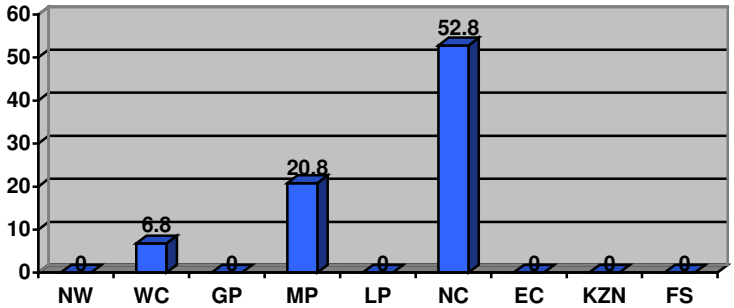
Figure 6: Proportion of facilities that had consent forms in the examination room by province



4.3.4 Availability of sexual assault evidence collection kits

Forensic specimens are collected in order to prove or exclude a physical connection between individuals. A specially designed sexual assault evidence collection kit is used in South Africa. The kit was designed to ensure that evidence would not be lost through deterioration or contamination. At this point in most provinces the sexual assault examination kits are kept by the police and not at health facilities. In the Northern Cape, 52.8% of facilities had kits. Kits were found in 20.8% of facilities in Mpumalanga and 5.8% in Western Cape. In six provinces there were no sexual assault examination kits found at the facility. This places an emphasis on the reporting of cases to police and reinforces the practice of patients presenting first to police stations. If a patient were to present first at a hospital and wanted to have a medico-legal examination they would have to wait for the police to bring the kit.

Figure 7: Proportion of facilities that had sexual assault evidence collection kits in the examination room by province



4.3.4.1 Problems experienced with the sexual assault evidence collection kit

Many providers mentioned that the kits were incomplete or had already been used. Providers frequently mentioned that the police forgot to bring the kit; brought the wrong one or that the evidence collection kits were unavailable.

> "Police come to see if they need it [kit] – so you get police who turn up if they are near the hospital and check out if it is an emergency rape"

> "…some police stations don't even have them."

The doctors frequently mentioned lack of training to use the kit. They mentioned that the new sexual assault evidence collection kit had been introduced without training and they often did not know what the different components were meant for.

> "Crime kits are difficult to use, doctors should be trained on how to use them."

> "We haven't been orientated and introduced to the new crime kit"

> "With the new kit no one explained it and there are many things inside. The old one was simple. Even senior doctors can't help, we need training on it."

A few mentioned that the new kit meant that the examination took a long time, up to an hour. Interestingly, experts say that the examination done thoroughly should take at least two hours and doctors felt that even a one-hour examination was too long.

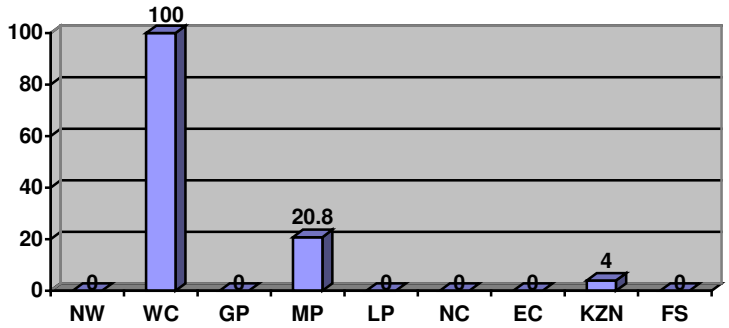
> "It takes a long time and I feel it is not practical. We are not forensic doctors and there are other patients to see, it takes about one hour …"

> "It takes long to work with 30 minute – 1 hour while there are other [patients] waiting"

4.3.5 Keeping evidence locked away

Maintaining the chain of the evidence involves ensuring that no tampering of evidence is possible. In order to ensure this, evidence should be locked away until the police collect it. The facility checklist explored whether there was a lockable cupboard for the storage of evidence – six of the provinces were found not to have one. In KZN 4% and in Mpumalanga 20.8% of facilities had a cupboard that locked. In the Western Cape all facilities had a lockable cupboard. In one facility in North West province the completed SAECKs were left on the nurses' desk in the casualty department for collection at a later time by the police.

Figure 8: Proportion of facilities that had a lockable cupboard where Sexual Assault Evidence Collection Kit (SAECK) could be stored for collection by province



4.3.6 Availability of treatment in examination room

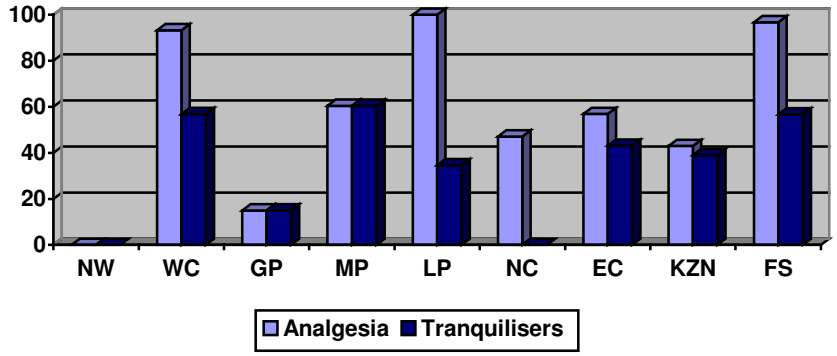
One of the aspects of quality of care that is frequently considered in the management of sexual assault is to avoid secondary trauma. Having patients wait in long queues to receive treatment where their safety may be jeopardized should be avoided. It is recommended that all tests and treatment should be available in the examination room. North West province had the lowest proportion of facilities with tests and treatment in the examination room with only 18.2% of facilities having pregnancy tests available. It should be noted that the government's policy on the provision of post exposure prophylaxis to prevent the transmission of HIV after rape changed during the period when the fieldwork was undertaken. All NW data collection happened before the change in policy and some of the data collection in other provinces shortly after the announcement. The availability of PEP shows the initial response with Gauteng and Mpumalanga responding quickly to the changes in policy.

Table 9: Weighted proportion of facilities with tests and treatment in the examination room by province

	Availability of tests and treatment in the examination room				
	HIV test	Pregnancy test	EC	PEP	STI
Province	%	%	%	%	%
North West	0	18.2 (0-83)	0	0	0
Western Cape	20.5 (0-78.9)	100	100	100	100
Gauteng	15 (0-50)	37.5 *	30	15 (0-50)	15 (0-50)
Mpumalanga	100	34.5 *	60.4 (24.8-96)	20.8 (0-92.1)	20.8 (0-92.1)
Limpopo Province	100	100	60.5 (24.7-96.2)	0	20.9 (0-92.1)
Northern Cape	52.9 (41.2-64.5)	52.9 (41.1-64.6)	94.3 (71-100)	0	47 (35.5-58.8)
Eastern Cape	100	100	100	0	56.9 (31.1-82.8)
KwaZulu Natal	70.5 *	100	82 (28-100)	0	78 (18.8-100)
Free State	40 (12.2-67.8)	100	56.7 (32.4-80.9)	0	96.7 (85.5-100)

* Too few observations to have meaningful confidence intervals

Figure 10: Proportion of facilities that had analgesia and tranquillisers in the examination room by province



4.4 Where people who have been raped first present

Nearly three-quarters (72.3%) of all providers interviewed said that a person who had been raped would go to the police first. Interestingly, there was a different pattern in the Eastern Cape where providers reported that someone who had been raped would be more likely go to

a health facility first (68.6%). More than one-third (37.7%) of the Northern Cape respondents reported that patients presented at the hospital first. It was only in the Western Cape that providers reported that patients ever went to a social worker first (14.5%) although they were much more likely to first go to the police (66.8%).

Table 10: Weighted proportion of service patients first present at after rape by province

	Where health care providers interviewed said patients went first after rape				
	Hospital	Private doctor	Police	Social worker	Other
Province	%	%	%	%	%
North West	11.8	3.6	76.4	-	8.2
Western Cape	11.4	-	66.8	14.5	7.3
Gauteng	25	10	62	-	3
Mpumalanga	-	-	92.1	-	7.9
Limpopo Province	15.8	4.2	80	-	-
Northern Cape	37.7	-	62.3	-	-
Eastern Cape	68.6	-	31.4	-	-
KwaZulu Natal	15	7.8	76.4	-	0.8
Free State	4.7	-	87.3	-	8

4.5 Reasons for delays in examination of patient

Another cause for delay in the management of sexual assault is the perception by providers that the patients should report sexual assault to the police first. Pressuring patients to report the case to the police is also a violation of rights. The patient should be entitled to complete management of sexual assault whether they choose to report the case to the police or not.

In the Free State 83.3% of providers reported that they would send the patient to the police before examining. Other provinces that reported this were Mpumalanga (82.2%) and the Western Cape (72.5%). Provinces where a lower proportion of providers reported sending patients to the police included Northern Cape (44.3%), North West (51.5%) and Eastern Cape (54.2%) While there were differences between provinces, these were not statistically significant.

Table 11: Weighted proportion of providers who send patients to the police before examining them by province

	Send to police before examining	
	%	95% CI
North West	51.5	27.1-75.9
Western Cape	72.5	3.1-100
Gauteng	60.4	37.9-82.9
Mpumalanga	82.2	69.8-94.6
Limpopo Province	65.7	31.9-99.4
Northern Cape	44.3	27.7-61
Eastern Cape	54.2	38.7-69.7
KwaZulu Natal	68.8	52.9-84.7
Free State	83.3	74.9-91.7

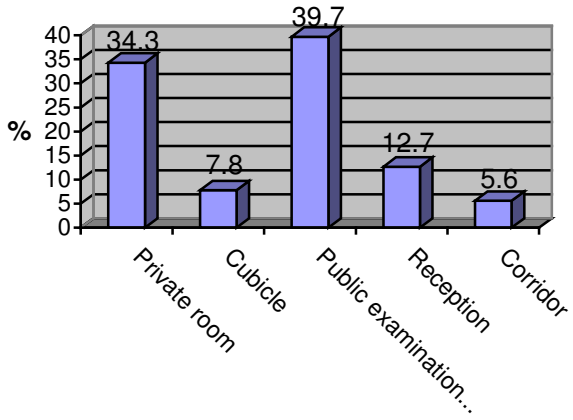
Overall, 94.8% of health care providers interviewed reported that they would advise patients who have not reported to report to the police even if they did not insist that they did so before the examination.

4.6 Where patients wait

The WHO guidelines on the Medico Legal Care of victims of Sexual Violence highlight that the patient should be able to see a health care provider when they present at a health facility and that they should not be left alone in the waiting room.

In the 31 facilities investigated in this study, 39.7% of providers reported that patients waited in a public examination room, 12.7% said patients waited in the reception, 5.6% in the corridor and 7% in a cubicle. 34.3% of providers indicated that patients waited in a private room. While this increases the safety of the patient, patients often wait alone. Patients waiting in public areas risk having further contact with their rapist who may either attack them again or allow the defence to argue that any DNA evidence could have resulted from contact between them in the facility.

Figure 11: Where patients wait before being examined

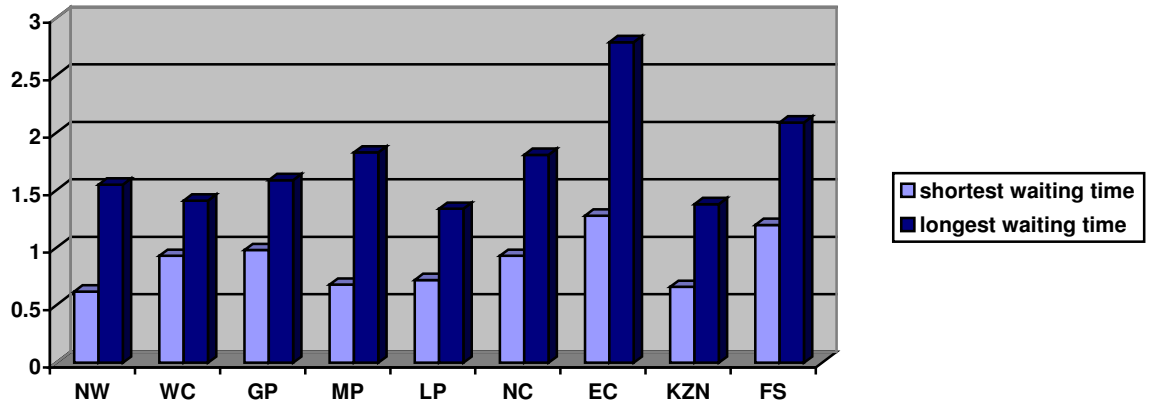


Nearly fifteen percent (14.8%) of patients were reported to come to the health facility alone, 43.9% came with police and 41.3% with family or friends. The police usually do not wait with the patient at the hospital so it is estimated that more than half of patients wait alone.

4.7 Waiting time by province

It is recommended in the WHO guidelines that the examination be performed as soon after presentation at a health facility as is possible. The reasons for this include the loss of therapeutic opportunities such as the provision of emergency contraception, changes to physical evidence and loss of forensic material. Waiting time varied between provinces. About half of the provinces reported that it was possible for a patient to be seen in less than an hour but most provinces reported that patients often waited a lot longer with Eastern Cape reporting waits of nearly three hours. It should be noted that providers reported these waiting times; actual waiting time may be longer or shorter.

Figure 12: Shortest and longest waiting time in hours by province



4.7.1 Reasons patients wait

The most common reason given for why patients wait was the availability of a doctor to do the examination. Sometimes there was mention made of staff shortages e.g. "I am the only doctor" but others mentioned that if a patient came in after hours then the doctor would be on call and that could take some time especially if the doctor was not on the premises. Another reason that was frequently mentioned was the number of patients that were waiting and rape was not prioritised above anything else. A couple of providers mentioned that a person who has been raped does not always present herself immediately. There was also mention made of that if a doctor does not feel competent to do an examination they may wait for a more experienced doctor. Police not bringing the kit was also mentioned as a reason why patients waited.

> "[Waiting time depends on] whether there is a doctor available and sometimes if there is an emergency case and I am the only doctor then they have to wait"
> "During the night we have to call a doctor depending on his/her whereabouts if outside the hospital it will take long"
> "It depends if there are many people in the hospital then they have to wait longer."
> "It depends on my previous patients. I also do post-mortems. If you are busy with a post-mortem you can't jut leave it and just see to [the rape case]"
> "if she does not come out and say then she will wait in the queue like everyone else."

North West: Waiting for transport after examination

Patients who used transport provided by police or hospital wait for transport at the hospital. 80.7% of health workers stated that rape victims waited in public room for transport and 19.3% stated that they waited in private room. Nearly three quarters (74.5%) of health workers stated that patients wait for one hour for transport and 17.6% stated that they wait for two hours. The longest waiting time was five hours for police or hospital transport.

According to health workers, lack of transport is a factor that prevents women from reporting rape and getting medical treatment.

'If people want to come to hospital, they have to pay. If you are raped you sit at home and pray you don't fall pregnant. To pay at the hospital, then another for the police, its too much if you don't work." [Nurse, PHC]

Similarly, social workers and NGOs mentioned problems of transport for rape survivors. Where they have to wait a long time for police transport or they would have to pay their own money for transport from facility to facility.

North West: Where patients are examined

Rape examinations are usually done in hospitals and in some areas in clinics (particularly in rural areas). 16.7% of district managers stated that rape examinations are done in primary health clinics (PHC). However, district managers stated that nurses operating in PHC have no training on rape examinations and that few doctors undertake visits at PHC. Nearly a quarter (22.2%) of district managers further stated that rape examinations are done in GP's rooms and 33.3% stated that district surgeons would do examinations.

4.8 Who examines patients

Respondents reported that a doctor in the facility (73.5%) or a doctor associated with the facility such as a local GP (0.7%) or district surgeon (14.2%) conducted most of the examinations. Nurses conducted the examination as well (9.7%). It was unusual for a specialist to do the examination and this was reported to happen in 1.9% of examinations. Provincial distribution of nurses doing examinations reflects expansion in forensic nurse training: 26.7% of nurse examinations happen in both Free State and Northern Cape, 20% in KwaZulu Natal and 7% in Eastern Cape, Mpumalanga and Limpopo Province.

Table 13: Who examines sexual assault patients

Health care provider	**%**
Doctor in facility	73.5%
Nurse	9.7%
District surgeon	14.2%
Local GP	0.7%
Gynaecologist	1.9%

North West: Who conducts the examinations

Similar to the national findings, 78.9% of doctors and nurses stated that doctors conducted examinations, however, 21.1% stated that district surgeons conducted examinations many more than were found nationally. In places where district surgeons were still in operation, they were designated to conduct examination by the hospital. In one district, the hospital referred us to a designated 'district surgeon' who was the 'only person to conduct rape examinations'. The doctor operated out of his consulting rooms where examinations were done. He explained that if a rape survivor goes to the hospital, she would then be taken to his office, where he would attend to her after completing the previous consultation. In another district, the district surgeon had a private office at the hospital, which he used for rape examinations. In this district the hospital and the police were setting up a 'one-stop centre'.

Half of the district managers stated that doctor with forensic training would do rape examinations and 27.8% stated that casualty doctor would examine rape survivors. Doctors and nurses at hospitals and clinics also reported that nurses do 'superficial examinations'. Superficial examinations involve a nurse examining for bleeding and providing treatment where patient has to wait for doctor or district surgeon.

Some nurses do examinations to 'check if patient has been raped' and during examination they would 'cross-examine what the patient was doing at night'.
Some nurses reported on superficial examinations believing that they were assisting rape survivor,

'take history of what happened, examine thoroughly, ask person who brought victim what happened, give treatment and then call doctor'.

'if there is laceration, we must check if it is deep, if the doctor is not here, we have to do it'.

Responses were obtained from questions about their main responsibility when rape survivors come to the facility. None of the nurses doing these examinations were working as forensic or sexual assault nurses.

4.9 Workload

Overall, the mean number of patients seen in the previous six months was 28 with a minimum of 1 and maximum of 390.

There was variability between provinces with regard to the number of sexual assault patients seen by each examiner over the previous 6-month period – KwaZulu Natal providers saw the fewest sexual assault patients, the mean number was 11 (95%CI 4-18) while the Northern Cape saw the most patients, with a mean number of 41 (95% CI 30-53).

Table 14: Weighted average of sexual assault patients seen in the previous six months by province

	Number of patients seen	
	Mean	95% CI
North West	24	12-35
Western Cape	22	8-41
Gauteng	17	7-28
Mpumalanga	13	8-18
Limpopo Province	33	22-44
Northern Cape	41	30-53
Eastern Cape	30	*
KwaZulu Natal	11	4-18
Free State	29	19-39

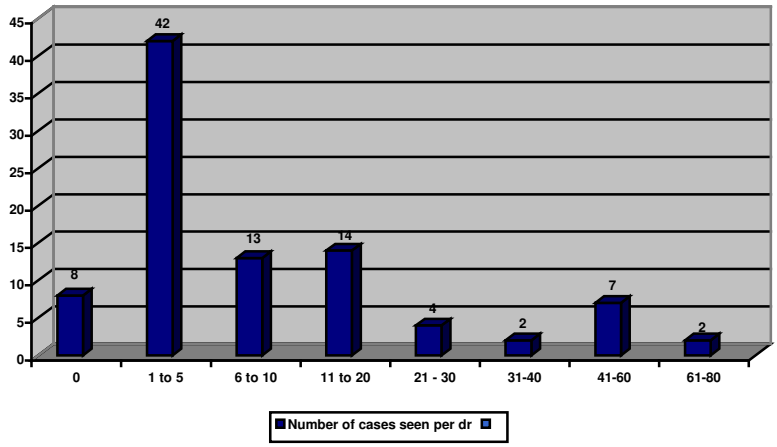
* Too few observations to have meaningful confidence intervals

North West: Workload – variability within a province

Respondents were asked how many rape cases seen over the previous six months. In most facilities, no official records were kept of rape cases.

Eight of the health care providers interviewed reported that they had not seen a single case in the previous six months. Forty-two had seen between 1 and 5 cases, 13 had seen between 6 and 10, 14 between 11 and 20, 4 between 21 and 30, 7 between 41 and 60 and 2 between 61 and 80.

Figure 13: Distribution of cases seen in the previous six months



4.10 Sending clothing for forensic evidence

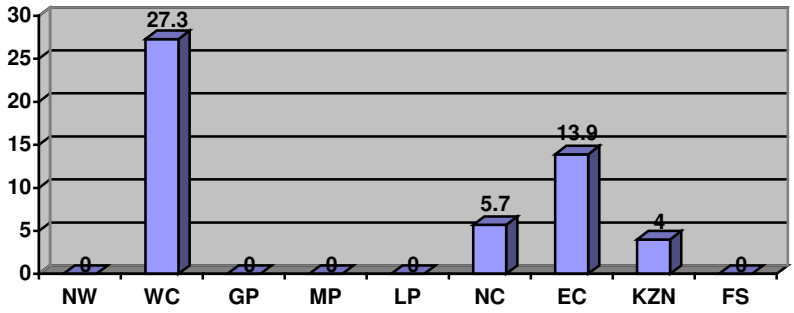
Forensic specimens can sometimes be obtained from clothing. Underwear in particular can contain seminal fluid or saliva. In all provinces except Gauteng providers said they had ever sent clothing for DNA evidence. The province where providers were most likely to have ever sent clothing was Mpumalanga, 32.5% (95% CI 0-75.2%) followed by Northern Cape, 28.3% (95% CI 28.3%-35.3%).

Table 15: Weighted proportion of providers who ever sent clothes away for forensic evidence by province

	Ever sent clothes for forensic examination	
	%	95% CI
North West	3.6	0-16.5
Western Cape	15	0-53
Gauteng	0	0
Mpumalanga	32.5	0-75.2
Limpopo Province	7.9	1-15
Northern Cape	28.3	21.3-35.3
Eastern Cape	8.3	0-39.3
KwaZulu Natal	15.6	4-27.4
Free State	8.7	3.8-13.5

One of the possible barriers to sending clothes to obtain forensic specimens is the lack of emergency clothing in facilities. In the Western Cape (27.3%), Eastern Cape (13.7%), Northern Cape (5.7%) and in KZN (4%) of facilities had emergency clothing. None of the facilities in the other provinces had any emergency clothing.

Figure 14: Proportion of facilities that had emergency clothing in the examination room by province



4.11 Giving evidence in court

Giving evidence in the previous year is an indicator of several aspects of sexual assault services including: workload – as it can be very time consuming to go to court; and quality of the completion of the J88 form and the collection of forensic specimens. Not giving evidence in court is an indicator of whether the quality is good or bad is difficult to determine as a clear, well-documented J88 with sufficient physical evidence may not require testimony while poorly documented forms with no evidence of sufficient quality to analyse may result in cases that do not go to court. Overall, very few of the providers interviewed had gone to court in the previous year the range was from 0% in the Eastern Cape to 19.3% in the Free State. None of the nurses interviewed had given evidence in the previous year despite reports that they had done examinations.

Table 16: Weighted proportion of providers who had given evidence in the previous year by province

	Given evidence in court in previous year	
	%	95% CI
North West	16.4	3.5-29.2
Western Cape	8.6	2.9-14.4
Gauteng	3	0-10
Mpumalanga	4.2	0-18.4
Limpopo Province	15.8	1.5-30.1
Northern Cape	2.3	0-11.6
Eastern Cape	0	0
KwaZulu Natal	16.4	5.6-27.2
Free State	19.3	17.1-21.6

4.12 Attitudes towards rape

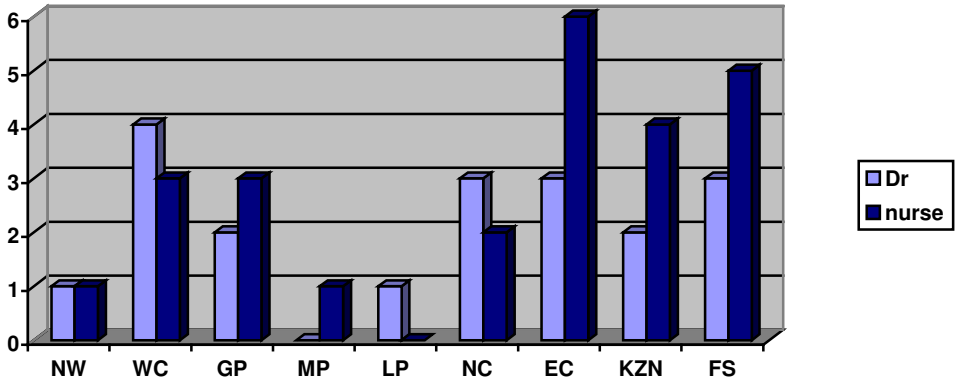
Overall, 28.4% of the respondents did not think that rape was serious. There was variation between provinces for example in the Eastern Cape 28.3% (95%CI 2.7% to 59.3%) of health care providers thought that rape was serious while in Limpopo Province 95.8% (95%CI 81.5%-100%) said that rape was serious. The difference between provinces was statistically significant $F_{3.45,44.82}$ =5.6 and p=0.0016.

Table 17: Weighted proportion of providers who considered rape to be serious by province

	Rape is serious	
	%	95% CI
North West	88.2	81.8-94.6
Western Cape	64.1	52.4-75.8
Gauteng	84	55.4-100
Mpumalanga	92.1	85-99.2
Limpopo Province	95.8	81.5-100
Northern Cape	69.4	67.1-71.8
Eastern Cape	28.3	2.7-59.3
KwaZulu Natal	64.4	52.6-76.2
Free State	62.7	53-72.4

Of the female providers 26.1% did not think that rape was serious, while 34.1% of the male respondents did not think that rape was serious. Nurses were more likely to say that rape was not serious than doctors. Fifty-nine percent of nurses believed that rape was not serious and 40.9% of all doctors (including GPs) shared this belief.

Figure 15: Number of providers who did not think that rape was serious by province and whether they were a doctor or a nurse



4.12.1 Is rape serious?

The health care providers who said that rape was serious gave a variety of reasons for their answer. Most often, providers mentioned that rape was serious because of the health consequences of sexual assault including the risk of HIV, STIs, and emotional or psychological consequences. Some felt that it was serious because it involved so many different dimensions including the medico-legal examination, testing and treatment. Other reasons mentioned included that rape was common in South Africa and that it was an infringement of human rights.

> "High risk of disease, HIV, STDS…"
> "Serious medical, psychological and sociological case. Something very terrible to happen to anyone…"
> "Could be medical complications for example factors culminating in infertility that impact on her socio-economic status as a woman"

Some providers gave a conditional response. They felt that rape was serious under certain conditions for example if the patient was a child or if there were multiple perpetrators. Rape was not considered to be as serious if patients presented some time after the rape had occurred. Others said that the severity of rape depended on the nature of injuries. If there were severe injuries then rape was serious if there were no visible signs of injury then it was not. Several providers mentioned that women are raped when they are drunk implying that they were some how responsible for what happened to them. There were also some providers who said that rape was not serious because women lie about being raped

> "Sometimes you get women who have been raped and they were drunk it is not always clear whether they are for real or not."
> "You sometimes find women who have not really been raped"
> Women who are "not bleeding heavily then she can wait like others in the queue"
> "They are not often physically injured and thus in most cases we give preference to severely injured."

North West: Attitudes towards rape

Nearly ninety percent (88.9%) (88) of respondents stated that they viewed rape as a serious medical condition. There was slight difference between doctors, 90.2% (37) and nurses, 87.9% (51), viewing rape as serious medical condition. 90% (54) female respondents (doctors and nurses) were slightly more likely to regard rape as serious medical case, than 87.1% (34) male respondents.

Table 18: Proportion of providers who thought rape was serious by sex and age

			Is rape serious?		
			Yes	**No**	**Total**
SEX	**Female**	N	54	6	60
		%	90%	10%	100%
	Male	N	34	5	39
		%	87.2%	12.8%	100%
Total		N	88	11	99
		%	88.9%	11.1%	100.0%
AGE	**<30**	N	17	4	21
		%	81%	19%	100%
	31-40	N	42	4	46
		%	91.3%	8.7%	100%
	41+	N	29	3	32
		%	90.6%	9.4%	100%
Total		N	88	11	99
		%	88.9%	11.1%	100.0%
Length of work at the facility	**<1**	N	22	2	24
		%	91.7%	8.3%	100%
	1-5	N	25	4	29
		%	86.2%	13.8%	100%
	6-10	N	18	1	19
		%	94.7%	5.3%	100%
	11-20	N	15	2	17
		%	88.2%	11.8%	18.5%
	21+	N	3	0	3
		%	100%	0%	3.3%
Total		N	83	9	92
		%	90.2%	9.8%	100.0%

4.13 Referrals

Of those who refer patients for counselling, 78.5% referred to social workers and 21.5% referred the patient to NGOs. The intersectoral relationship between the health providers and social workers, NGOs and police is discussed later.

Table 19: Weighted proportion of providers who refer patients for counselling by province

	Refer patient for counselling	
	%	95% CI
North West	63.6	50.8-76.5
Western Cape	29.1	0-75.9
Gauteng	56	45.5-66.5
Mpumalanga	56.3	34.9-77.6
Limpopo Province	71.6	43-100
Northern Cape	61.1	56.5-65.8
Eastern Cape	13.9	0-65.6
KwaZulu Natal	48.8	25.1-72.5
Free State	87.3	80.4-94.3

Just over two-thirds (67.3%) of providers reported that the police transport the patient to the police station, social worker/NGO or home after the examination, while 30.2% said that patients used their own/public transport and in 2.5% of cases the hospital provided transport.

4.13.1 Why providers do not refer patients for counselling

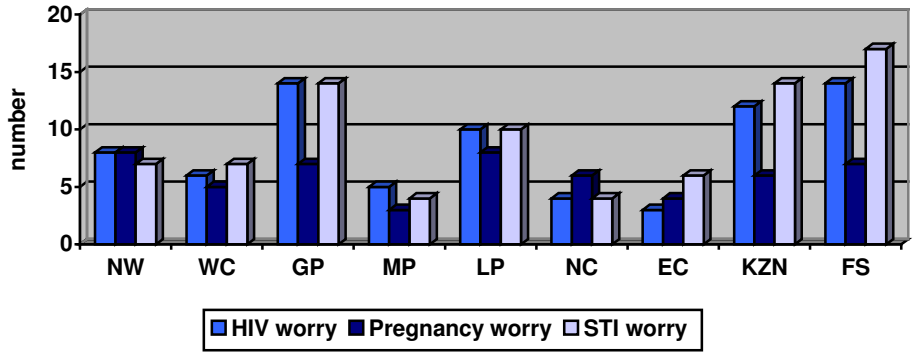
There were a variety of reasons given for not referring patients some providers mentioned that there was a lack of services or that they did not know who they could refer patient to. Others mentioned that it was not their role to refer a patient for counselling or that they were afraid that they might be overstepping their role if they were to refer patients. A few providers mentioned that they never thought about referring patients. Some felt that patient already knew where to go for counselling services while others felt that patients were not interested in counselling.

> "you can't offer help if people don't want it. Then you are getting in their business and over-stepping your job as a nurse"
> "I just never think of it."
> "Don't know who I can refer them to"
> "It is not my role"
> "… they are not interested in counselling"
> "… because they already know where to go"

4.14 Concerns about pregnancy, STIs and HIV, testing and treatment

Many patients presenting at health facilities after rape are concerned about STIs, HIV and /or pregnancy.

Figure 19: Number of providers who said that patients were worried about HIV, pregnancy and STIs most of the time



4.14.1 HIV risk, testing and counselling

Most providers raised the risk of HIV with patients after sexual assault. The proportion offering a HIV test was lower than the proportion raising the risk of HIV. In most provinces offering HIV counselling was lower than offering a test. It was in Free State (82% and 74%)and Limpopo Province (83.3% and 75.3%) that counselling was more likely to be offered than a HIV test. In the Northern Cape there was no difference in the proportion of providers who offered a HIV test and counselling. In the other provinces it is of concern that a HIV test may be offered without counselling especially after rape. However this may also be an indicator of different providers doing testing and counselling.

Table 20: Weighted proportion of providers who raise HIV, offer HIV test and offer HIV counselling by province

	Raise HIV risk		Offer HIV test		Offer HIV counselling	
	%	95% CI	%	95% CI	%	95% CI
North West	91.8	85.4-98.2	83.6	70.8-96.5	47.3	21.6-73
Western Cape	92.7	86-99.4	68.6	37.5-99.7	52.9	6.3-99.6
Gauteng	96	85.5-100	74	50.4-97.6	53	30.8-75.2
Mpumalanga	100	-	64.2	49.9-78.4	60.4	24.8-96
Limpopo Province	100	-	75.3	25.3-100	83.3	26.1-100
Northern Cape	100	-	51.7	44.7-58.7	51.7	44.7-58.7
Eastern Cape	100	-	68.6	63.4-73.8	51.4	46.2-56.6
KwaZulu Natal	92.2	86.3-98.1	45.2	31.8-58.6	32.4	0-66.7
Free State	84	72.9-95.1	74	59.4-88.6	82	72.3-91.7

4.14.2 Post-exposure prophylaxis to prevent transmission of HIV

As mentioned earlier, the fieldwork for the study took place over the period of time when the policy regarding the provision of ART as a post-exposure prophylaxis to prevent the transmission of HIV changed. North West data collection happened before the change in policy while data collection in the Eastern Cape happened a year after the new policy was introduced. Interestingly, while PEP was not offered in many cases providers did advise patients of about PEP. In the Western Cape where PEP had been provided for some time before the fieldwork we found that all facilities had the drugs available (see Table 4), however 68.6% of providers gave advice to patients about PEP and 55% offered PEP.

Table 21: Weighted proportion of providers who advise on post exposure prophylaxis and offer PEP by province

	ART advice		Offer ART	
	%	95% CI	%	95% CI
North West	31.8	25.4-38.2	0*	
Western Cape	68.6	37.5-99.7	55	
Gauteng	87	64.8-100	37	
Mpumalanga	92.1	85-99.2	36	
Limpopo Province	59.5	23.8-95.3	8	
Northern Cape	69.4	67.1-71.8	0	
Eastern Cape	28.3	0-59.3	3	
KwaZulu Natal	83.4	65.6-100	16	
Free State	56.7	46.5-66.9	3	

North West: HIV risk, testing and counselling

Data collection in NW happened before the change in the government's policy on providing post-exposure prophylaxis to prevent transmission of HIV. Therefore, in response to question about survivor's concerns about HIV transmission, some of the doctors and nurses were hesitant to respond. After reassuring them about confidentiality we were able to elicit responses.

Nearly three-quarters (72.5%) stated that they raised issue of HIV with rape survivors. Of those who did not raise issue of HIV, reasons were given such as "they did not want to further stress and worry patient" and that "patient would have too much to deal with".

More than two thirds (69.7%) of providers stated that they offered a HIV test. More than half (58.4%) offered HIV counselling, 33.3% gave advice about AZT, and 9.3% gave a prescription for antiretrovirals. This implies that health providers are quite motivated to provide or recommend PEP if it is available in clinics/hospitals.

4.14.3 Pregnancy risk, contraceptive use and pregnancy test

Most providers raised the risk of pregnancy with patients presenting after sexual assault. In all provinces but the Western Cape providers were less likely to ask about contraceptive use. In many provinces, a pregnancy test was most likely to be offered in Western Cape (81.4%), Northern Cape (80%), North West (70.7%) and KZN (70.3%). The Eastern Cape was the least likely to ask about contraceptive use (39.7%). Mpumalanga was least likely to offer emergency contraception (44.2%).

Table 22: Weighted proportion of providers who raise pregnancy risk, ask about contraceptive use and offer pregnancy test

	Raise pregnancy risk		Ask about contraceptive use		Offer pregnancy test	
	%	95% CI	%	95% CI	%	95% CI
North West	83.6	70.8-96.5	76.1	72.4-79.8	70.7	43-98.2
Western Cape	92.7	86-99.4	98.5	93.9-100	81.4	67.9-94.8
Gauteng	100	-	84	73.5-94.5	64	24.9-100
Mpumalanga	100	-	72.1	65-79.2	44.2	29.9-54.4
Limpopo Province	100	-	63.7	42.3-85.2	64.2	50-78.5
Northern Cape	100	-	71.7	64.7-78.7	80	80
Eastern Cape	91.4	86.2-96.6	39.7	3.5-75.9	62.8	52.4-73.1
KwaZulu Natal	96.4	85.6-100	87.3	79.8-94.9	70.3	68.1-72.6
Free State	100	-	79.3	77.1-81.6	64	48.9-80.3

4.14.4 Emergency contraception and abortion counselling

Most providers in most provinces offered emergency contraception again the Eastern Cape was the least likely to offer EC (56.9%). Abortion counselling usually happens when women present after the 72-hour period which was indicated for the provision of emergency contraception. There was great variability between provinces as to whether they gave counselled about abortion from 1.1% in Northern cape to 42.4% in North West province.

Table 23: Weighted proportion of providers who offer emergency contraception and offer abortion counselling by province

	Offer EC		Abortion counselling	
	%	95% CI	%	95% CI
North West	71.7	60.7-82.8	42.4	25.9-58.9
Western Cape	100	-	13.2	0-50.1
Gauteng	97	90-100	30	13.7-46.3
Mpumalanga	100	-	8.3	0-36.8
Limpopo Province	80	80	23.7	2.7-45.2
Northern Cape	70.6	68.2-72.9	1.1	0-58
Eastern Cape	56.9	31.1-82.8	16.9	0-42.8
KwaZulu Natal	91.9	86.6-97.2	30	2-57.7
Free State	84	72.9-95.1	32	9-54.2

North West: Health workers action regarding pregnancy risk

Nearly ninety percent (88.5%) would ask about contraceptive use, and 78.5% would offer pregnancy test. This is particularly interesting if you compare it to the proportion (15%) of facilities that did not have pregnancy test kits in the examination rooms. Nearly eighty-four percent (83.3%) of providers said that they would offer emergency contraceptives. *Doctors and nurses were asked what emergency contraceptives they gave. They mentioned Ovral, Triphasil, Nur-Isterate and Depo. From this list Ovral is the most effective emergency contraceptive. Nur-Isterate and Depo are not indicated as emergency contraceptives.*

4.14.5 Risk of STIs, treatment and referrals

Most providers in most provinces raised the risk of STIs with patients after sexual assault. In many provinces drugs were given. The province that was least likely to provide STI drugs was

KZN (75%). Very few providers referred patients for further STI counselling or treatment. The most likely to refer was KZN (26.2%).

Table 24: Weighted proportion of providers who raise STIs, and treat STIs by province

	Raise STI risk		Treat STI		Refer STI	
	%	95% CI	%	95% CI	%	95% CI
North West	88.2	81.8-94.6	100	-	0	*
Western Cape	92.7	86-99.4	90.7	84-97.4	8.6	*
Gauteng	100	-	95.9	85.1-100	4	*
Mpumalanga	100	-	84.2	69.9-98.4	7.9	*
Limpopo Province	100	-	92.1	84.9-99.2	9	*
Northern Cape	100	-	100	-	0	*
Eastern Cape	100	-	82.8	72.4-93.1	18.8	*
KwaZulu Natal	96.4	85.6-100	75	60.5-89.3	26.2	*
Free State	92	86.4-97.6	80.7	78.4-82.9	19.3	*

* too many missing data in some provinces to obtain CI

4.14.6 Correct STI treatment

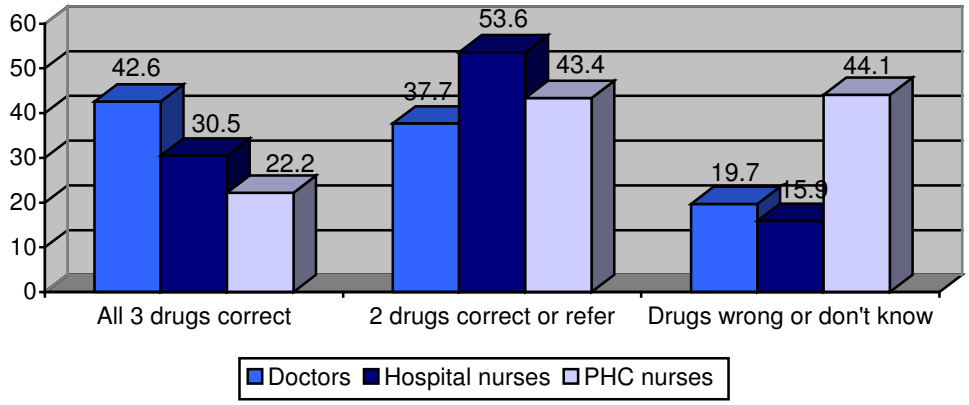
Providers were asked to name the drugs for the syndromic management for STIs. In most provinces less than a half of providers were able to correctly name all the drugs. The exception was the NW province where 71.8% of providers correctly named the drugs. Providers in KZN were most likely not to know the names of the drugs or to name drugs incorrectly (48.5%).

Table 25: Weighted proportion of providers who named correct syndromic management of STIs

	Correct STI treatment (syndromic)		
	3 drugs correct	2 drugs correct or refer	Wrong drugs/ don't know
North West	71.8	24.5	3.6
Western Cape	36.8	54.9	8.2
Gauteng	40.6	37.5	21.9
Mpumalanga	43.1	23.8	33.2
Limpopo Province	26.3	60.6	13.1
Northern Cape	37.7	22.3	40
Eastern Cape	23.8	65.8	10.4
KwaZulu Natal	23.8	27.7	48.5
Free State	20.7	46.3	33.1

There were statistically significant differences between categories of health professionals and whether they gave correct STI treatment. Doctors were more likely than nurses in the hospital who were in turn more likely than PHC nurses to correctly name the STI drugs (chi2 = 0.3792, F (3.14,40.85) = 2.9, P = 0.04).

Figure 20: Proportion of providers who named all drugs correctly, named 2 or referred or gave wrong drugs by professional category



4.15 Protocols

Nearly 93% of providers in the Western Cape and 80% in Mpumalanga reported that there were rape protocols in the facility. No provider in the Eastern Cape reported that there were protocols in their facility. There was a statistically significant difference between provinces reporting that there was a rape protocol in the facility where they worked, $F_{2.76,35.91} = 6.3217$, $P = 0.0019$.

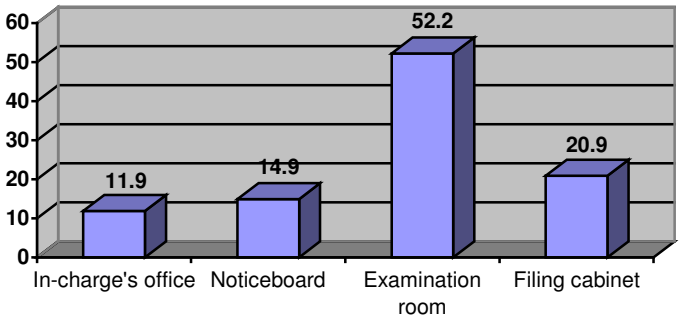
Table 26: Weighted proportion of providers said that there was a rape protocol at the facility by province

	Rape protocol in the facility	
	%	95% CI
North West	20	*
Western Cape	92.7	86-94
Gauteng	40	*
Mpumalanga	80	80
Limpopo Province	15.8	1.5-30.1
Northern Cape	49.4	47.1-51.8
Eastern Cape	0	-
KwaZulu Natal	26	10.8-41.2
Free State	43.3	0-94.2

* there were too few observations in some provinces for 95% CI to be meaningful

In the facilities where there were reported to be protocols, 52.2% were in the examination room, 20.9% in the filing cabinet, 14.9% on a notice board and 11.9% in the person-in-charge's office. This means that protocols were not always accessible.

Figure 21: Where protocols are kept



North West: *Case of the elusive protocol*
The district manager responsible for hospital X stated that there were no rape protocols in the district and province. Two doctors and nurses, working at hospital X , stated that there were protocols and that "were using them as they were kept on matron's board". None of the staff could show us a copy of the protocol.

4.16 Training

The minimum standards and norms document of the Department of Health refers to "an accredited health practitioner". This has clearly not been implemented anywhere in South Africa. Of the providers interviewed, 28.4% reported that they had received some training on rape. There was a statistically significant difference between provinces as to whether providers had received training $F_{4.46,58.01} = 2.74$, p=0.032. Nearly forty-three percent (42.3%) of providers in the Northern Cape had received training, followed by Free State (36.7%) then KwaZulu Natal (35.8%). Providers in the Western Cape had the lowest proportion of providers to have received training (14.1%) followed by Eastern Cape with 14.2% of providers having received some training. There have been ongoing training initiatives in both these provinces so it is likely that these proportions have changed since fieldwork.

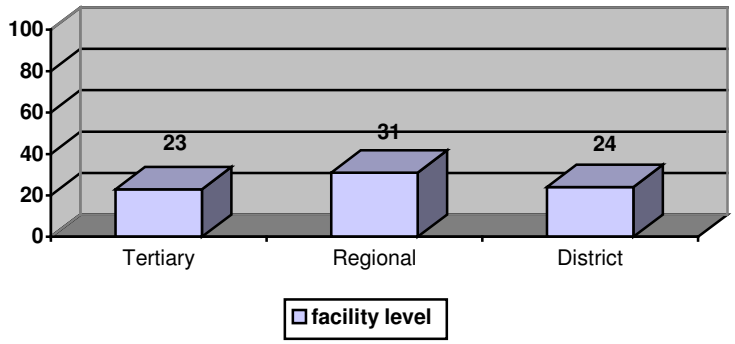
Table 27: Weighted proportion of providers who had received some training on rape by province

	Provider received some training on rape	
	%	95% CI
North West	23.6	10.8-36.5
Western Cape	14.1	4.4-23.8
Gauteng	19	5.6-32.4
Mpumalanga	23.8	2.4-45.1
Limpopo Province	20	
Northern Cape	42.3	33-51.6
Eastern Cape	14.2	0-29.7
KwaZulu Natal	35.8	19.2-52.4
Free State	36.7	26.5-46.9

4.16.1 Training by level of facility

Regional facilities had the highest proportion of trained providers (31%) while there was very little difference between the proportion of providers who had received training in district and tertiary institutions.

Figure 22: Proportion of providers who had received some training on rape by the facility level



North West: Training of doctors and nurses

We asked doctors and nurses if they had received training on rape, and if they had what the content and duration of training was. We also asked district managers questions about doctors and nurses training. 23.3% of all staff interviewed had received training on rape examination. Doctors (43.9%) were statistically significantly more likely than nurses to have received training; 10.3% of hospital-based nurses and 15.8% of PHC nurses had received training (Chi square = 10.1, p=0.001, 2 df).

Table 28: Proportion of staff who had received training on rape

STAFF		Trained on rape		Total
		Yes	No	
Doctors	N	18	23	41
	%	43.9%	56.1%	100.0%
Nurses in Hospital	N	4	35	39
	%	10.3%	89.7%	100.0%
PHC nurses	N	3	16	19
	%	15.8%	84.2%	100.0%
Total	N	25	74	99
	%	25.3%	74.7%	100.0%

94.4% doctors had received their training as part of their undergraduate medical course and only one (5.6%) had received postgraduate training, which was a week-long course provided by Medunsa (Medical University of South Africa). Of nurses who had received training, 4 nurses had received some training as part of their basic training and 3 nurses had received post-graduate 'victim empowerment training'.

Table 29: Proportion of staff who received training as undergraduates or post-graduates

STAFF		Where was training?		Total
		Undergraduate or post-basic	Post-graduate	
Doctors	N	17	1	18
	%	94.4%	5.6%	100%
Nurses in Hospital	N	3	1	4
	%	75%	25%	100%
PHC nurses	N	1	2	3
	%	33.3%	66.7	100%
Total	N	17	4	25
	%	84%	16%	100%

50% of district managers interviewed stated that they thought health workers who examined rape survivors had been trained, 44% thought that training was given during undergraduate studies at university, 22.2% thought postgraduate training was given and 33.3% thought that a course on forensic examination was given. District managers had different ideas on the length of courses. Estimates ranged from 1 day (16.7%) to 30 days (16.7%). 66.7% of district managers thought that training was not specialized and 33.3% thought that it was specialized training provided by Medunsa.

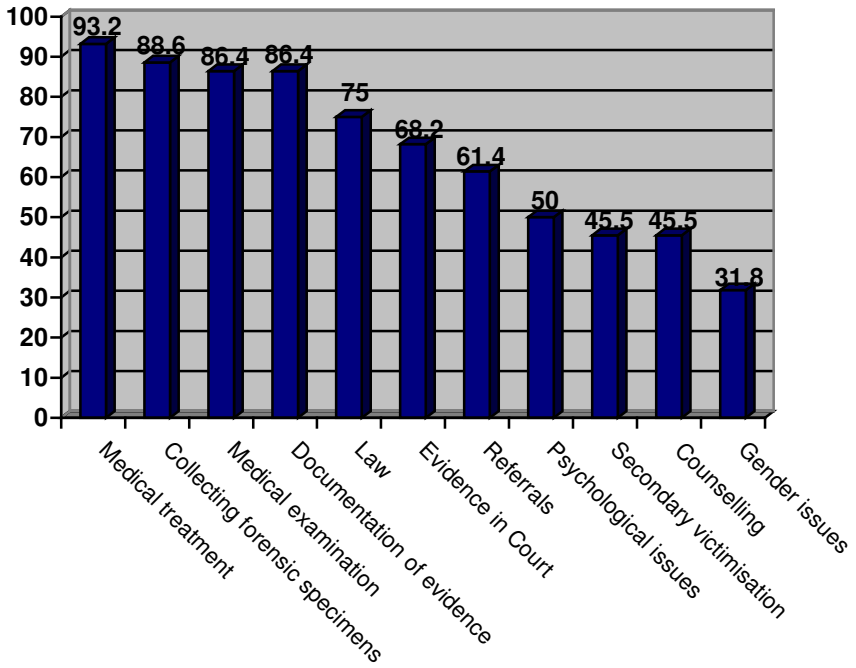
North West: Records of trained staff and deployment
In most hospital, records were usually kept of training by human resources department. These records were then submitted to district managers. We attempted to obtain statistics on trained doctors and nurses from the provincial health department, but this proved difficult. We asked district managers where records of doctors and nurses with rape training were kept and how those trained were deployed throughout the province. 88.9% of district managers stated that records were kept of those trained. 50% stated that records were kept at hospital where trained staff were based, 37.5% stated that provincial human resources kept records and 12.5% did not know where records are kept. According to 77.8% of district managers, trained staff were sent back to hospital or clinic and 11.1% were sent back with instructions to do rape examinations.

We found one nurse who had done forensic nursing course, at the Northern Cape Provincial health department, who was based at a clinic and not doing any rape examinations.

4.16.2 Topics that were covered in training

Most training covered medical treatment (93.2%) followed by the collecting forensic specimens (88.6%), documentation of evidence (86.4%), medical examination (86.4) and collecting forensic specimens. Fewer providers reported that psychosocial aspects of rape had been covered in training. Gender issues were only covered in 34.8%, secondary trauma in 45.5%, counselling in 45.5% and psychological issues in 50% of training.

Figure 23: Proportion of topics covered by training on rape



4.17 Intersectoral collaboration

The minimum standards and norms document prioritises intersectoral collaboration saying that "every clinic should establish working relationships with the nearest police officer and social welfare officer by having visits from them at least twice a year". While most of the providers interviewed had some relationship with the police this was not always a good relationship. In Northern Cape 37.7%, North West 24.5%, KZN 23.4%, Gauteng 16%, Mpumalanga 15.8% and Limpopo 8.4% of providers described the relationship as bad. The highest proportion of providers to describe their relationship with police as good (59.5%) were in Limpopo Province followed by Gauteng (58%) indicating that providers had very different experiences depending on where they were located and their individual experience. The Western Cape did not describe poor relationships with the police nor did the Eastern Cape although some providers there indicated that they did not have a relationship with police at all.

Table 30: Weighted proportion of providers who described their relationship with police as good, average, bad or nonexistent by province

	Relationship with police			
	Good %	Average %	Bad %	Non existent %
North West	48.2	27.3	24.5	-
Western Cape	49.5	50.5	-	-
Gauteng	58	26	16	-
Mpumalanga	24.2	60	15.8	-
Limpopo Province	59.5	32.1	8.4	-
Northern Cape	10.6	51.7	37.7	-
Eastern Cape	19.7	71.7	-	8.6
KwaZulu Natal	32.4	44.2	23.4	-
Free State	49.3	46.7	4	-

The minimum standards and norms document also refers to relationship with social workers. Some providers in all provinces except Gauteng said that they had no relationship with social workers what so ever. This ranged from 43.1% in the Eastern Cape to 7.9% in Limpopo Province. In many provinces relationships were described as good – 75.8% in Limpopo Province, 67.3% in North West, 65% in Gauteng. Only the Western Cape and Northern Cape had some providers who described their relationship with Social workers as poor.

Table 31: Weighted proportion of providers who described their relationship with social workers as good, average, bad or nonexistent by province

	Relationship with social workers			
	Good %	Average %	Bad %	Nonexistent %
North West	67.3	16.4	-	16.4
Western Cape	32.3	37.3	8.6	21.8
Gauteng	65	35	-	-
Mpumalanga	40.4	20	-	39.6
Limpopo Province	75.8	16.3		7.9
Northern Cape	21.1	58.9	9.4	10.6
Eastern Cape	8.3	48.6	-	43.1
KwaZulu Natal	28.8	55.6	-	15.6
Free State	50	38.7	3.3	8

Most provinces had high proportion of providers who had no relationship with NGOs at all. This was as high as 91.8% in North West, 88.9% in Eastern Cape, and 82,6% in KZN. The province that had the highest proportion of providers describe a good relationship with NGOs was Free State and two provinces described their relationships with NGOs as bad – Mpumalanga 4.2% and Northern Cape 9.4%.

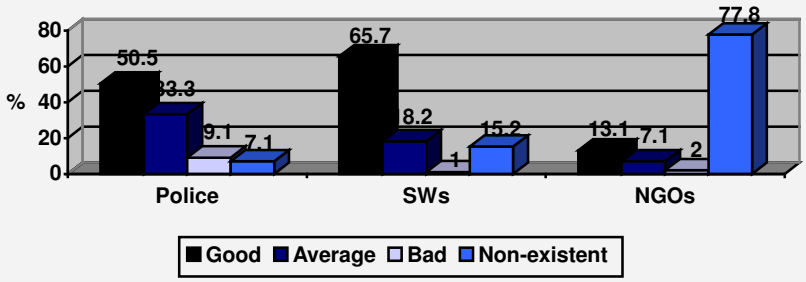
Table 32: Weighted proportion of providers who described their relationship with NGOs as good, average, bad or nonexistent by province

	Relationship with NGOs			
	Good %	Average %	Bad %	Non existent %
North West	8.2	-	-	91.8
Western Cape	16.8	36.8	-	46.4
Gauteng	22	24	-	54
Mpumalanga	8.3	7.9	4.2	79.6
Limpopo Province	23.7		-	76.3
Northern Cape	-	11.7	9.4	78.9
Eastern Cape	5.6	5.6	-	88.9
KwaZulu Natal	9.6	7.8	-	82.6
Free State	27.3	25.3	-	47.3

North West: Intersectoral collaboration

About half the health care workers reported having a good relationship with the police, 23.3% reported that their relationship with police was average, 9.1% reported a bad relationship and 7.1% said that they had no relationship with police at all. Nearly three-quarters of respondents reported that their relationship with social workers was good, 18.2% said it was average and 1% said it was poor while 15.2% reported that they had no relationship with social workers at all. Among health care workers, 77.8% reported having no relationship with NGOs while 13.1% reported a good relationship, 7.1% that their relationship was average and 2% that they had a poor relationship.

Figure 24: Proportion of health care workers who described their relationship with police, social workers and NGOs



There is only quantitative data available from social workers about their relationship with health facilities. All of the twelve social workers describe their relationship as good.

In response to an open-ended question the police and NGOs reported mixed relationships with the health facilities. Some said that doctors were available when they were needed and that they were helpful. Where problems with the health services were described, police said that the doctors and ambulances were not available or that they take their time attending to patients.

> "If an incident concerning rape occurs, the doctor is always available. Rape victims don't spend much time waiting for doctors"
> "There is a rape case we call a doctor and she comes out to the crisis centre and give medical examination and treatment. We never get disappointed by doctors."
> "They pay attention to policemen and rape victims because it is a serious case".
> "The hospitals usually help us in getting crime kits completed on time. We can also go back and get information from a doctor to help us with the case".
>
> "Sometimes the doctors are not available when we get there. We drop the patient at the hospital so that she waits for the doctor and then we leave to continue with other work."
> "If you call an ambulance at the station they don't come. We have to use police vehicles even if we don't want."
> "There is no sense of co-operation between the parties: the police and the health sector."
> "They take their time with patients making them wait. Doctors are insensitive or rude."

Police, NGOs and social workers were asked how many rape cases they saw per month. They reported seeing a mean of 12 with a range from 2 to 120.

4.18 Factors that are associated with quality of care

Analysis that explored factors that were associated with quality of care was conducted for the whole country. A quality of care scale was developed and is presented in Table 33.

Table 33: Quality of care score

Calculation of quality of care score	STI Treatment: -3 drugs correctly named 2 -2 correct drugs named or referral for treatment 1 Clothing/panties ever sent for forensic testing 1 Victims always referred for counselling 2 Raises issue of HIV with rape victims 2 Offered HIV test (or advice on where to get one) with HIV counselling 2 Offered HIV test (or advice on where to get one) without HIV counselling 1 Advised on anti-retrovirals 2 Discussed pregnancy testing if necessary 2 Asked about contraceptive use 2 Offered emergency contraceptives 2 Provided abortion counselling or information 2
Mean (SD) quality of care score	10.16 (8.02-12.30)

Staff who were older (over 41years of age) and had seen a higher number of sexual assault patients, working in a facility with a rape management protocol and who perceived rape to be a serious medical problem provided better care. The best management was associated with the highest quartile of caseload. Those who had been working for longer in the facility had a poorer quality of care score, possibly due to burn out. Training, whether at an undergraduate medical/basic nursing or postgraduate level made no difference to care. This may be because too few staff had received it or it had not been provided in enough depth. Figure shows that very few providers had received any training that dealt with the psychosocial dimensions of rape.

The findings suggest that services in South Africa could be improved by developing and disseminating clinical management guidelines, and ensuring care is provided by staff who gain experience by seeing larger numbers of cases and believe that this activity is an important part of their medical role. This may be ensured through having designated providers as suggested in the Standards and Norms document of the National Department of Health. Training on sexual assault needs to prioritise its social context and the importance of medical management of cases.

Table 34: Multiple regression model showing factors which were found to be associated with higher quality of care

Multiple regression model exploring factors associated with higher quality of care			
	Coefficient* **	95% CI	P value
Rape is a serious medical problem	2.12	1.05-3.19	0.001
Protocol available	1.37	0.04-2.69	0.044
Age: 30 + under 31-40 41+ over	1.00 1.35 2.39	- 0-3.38 0.44-4.35	- 0.172 0.020
Duration of work at facility	-0.13	-2.43- -0.13	0.032
No. of victims seen in last 6 months	0.019	0.007-0.031	0.004

* model adjusted for province

** F (12,2), p=0.0311

5. Discussion

This study highlights the need for standardised clinical management guidelines for sexual assault service delivery. Results indicate that there is significant provincial variability in sexual assault service delivery. Providers' attitudes towards sexual assault as well as the availability of a protocol in the facility differ significantly between provinces. The provider's awareness of the presence of a protocol in the facility was one of the factors that was significantly associated with higher quality of care. There is no one province that was found to be better in *all areas* of sexual assault services when considering all factors explored in this study.

The model of service provision in the different facilities to a large extent influences providers' workload. In some cases there were designated providers who saw sexual assault cases whereas in other facilities any casualty doctor could examine a patient. This was particularly notable when looking at the variation within North West province where many of the doctors interviewed had seen fewer than five patients in the previous six months. Seeing a larger number of patients was significantly associated with higher quality of care. This finding supports having designated providers.

Training was not statistically associated with higher quality of care. This could be explained by poor quality of training that providers had undergone and the fact that training did not address provider attitudes. Just over a quarter of all providers had received any training on sexual assault and about half of these had received the training while they were undergraduates or undergoing basic training. The content of the training concentrated largely on medical treatment and conducting examinations in order to collect forensic specimens. Little attention was paid to the psychosocial aspects of sexual assault or gender issues.

In exploring the management of sexual assault we found that providers were sensitive to the risks of STIs, HIV and pregnancy. The majority of providers raised these risks with the patient. Offering STI prevention/treatment and emergency contraception happened quite uniformly. However, STI treatment provided to patients was not always correct or providers did not know what the correct treatment was. This raises a broader issue around the quality of treatment that is being provided in primary health care and hospitals. Tertiary institutions were not more likely to provide correct treatment.

About two thirds of providers offered patients an HIV test. This may be because post-exposure prophylaxis was not available at all facilities during fieldwork and providers did not want to offer a test if they could not provide the drugs or because finding out your HIV status after being sexually assaulted was considered too traumatic.

Referrals for counselling occurred much less than any other aspect of the management of sexual assault. Providers across the country were unlikely to have any relationship with NGOs and therefore seldom referred patients to them for counselling. Nearly one in ten providers had no relationship with social workers. There is a need for providers to be given a list of institutions and providers that they can refer patients to. As alluded to earlier, the psychosocial impact of sexual assault should be integrated into training.

Sexual assault services at present are typified by long waits – both with reference to treatment and with reference to the police bringing the sexual assault evidence collection kits if the patient had not presented first at the police. Problems with kits ranged from kits being incomplete or unavailable to health providers being inadequately trained to use the kit.

Other than gaps in services attributable to the lack of training of individual providers, the study also highlights the systemic problems. These include structural inadequacies such as a private room with walls and a door where examinations can be conducted. Furthermore, district managers' knowledge and attitudes towards sexual assault need to be addressed. Supervision of the service is recommended as a way to ensure greater consistency and to familiarise managers to the gaps and shortfalls in how services are being delivered. The study further suggests that intersectoral collaboration was inadequate. While most health providers had an average relationship with the police, up to a third of providers described their

relationship as poor depending on province. Some police also described poor relationships with health providers in the North West Province. Providers across the country were unlikely to have any relationship with NGOs and therefore seldom referred patients to them for counselling.

If sexual assault services are to meet the minimum standards outlined in the 2000, National Department of Health policy document entitled “The Primary Health Care Package for South Africa -- a set of norms and standards”; most provinces will have to invest resources to address the gaps in service provision.

6. Recommendations

- We recommend that the sexual assault management policy and clinical management guidelines as well as the finalisation of provider training modules be prioritised and implemented as soon as possible.
- Training should address psychosocial aspects and gender issues as well as the treatment and examination of patients after sexual assault. There should be a focus on attitudinal shifts as well as increased knowledge and skills.
- District managers need to be trained as well as providers. Mangers should be responsible for the supervision of service within the facilities.
- Hospital superintendents should explore where a private examination room can be set up in the hospital (if there is not one already). Thought should also be given to putting a system in place that will allow sexual assault patients to be moved to the front of the queue and their care prioritised.
- Refresher courses or ongoing training on the management of STIs and the provision of emergency contraception is recommended for all providers irrespective of whether they manage sexual assault.
- Intersectoral collaboration between health providers, police, social workers and NGOs should be facilitated at all levels.
- NGOs that provide support and counselling for patients after sexual assault should build a relationship with service providers at local hospitals and encourage referrals.

List of abbreviations

1.	AIDS	Acquired immune-deficiency syndrome
2.	ARV	Anti-retroviral therapy
3.	AZT	Zidovudine
4.	CIAC	Crime Information Analysis Centre
5.	CI	Confidence Interval
6.	DNA	Deoxy-ribonucleic acid
7.	EC	Emergency contraception
8.	EC	Eastern Cape
9.	FS	Free State
10.	GP	Gauteng Province
11.	HIV	Human immuno-deficiency virus
12.	KZN	KwaZulu Natal
13.	LP	Limpopo Province
14.	MP	Mpumalanga Province
15.	MRC	Medical Research Council
16.	NC	Northern Cape
17.	NGO	Non-governmental organisations
18.	NW	North West Province
19.	PEP	Post-exposure prophylaxis
20.	PHC	Primary Health Care
21.	SAECK	Sexual assault evidence collection kit
22.	SAGBVHI	South African Gender Based Violence and Health Initiative
23.	SAPS	South African police service
24.	STI	Sexually transmitted infection
25.	SW	Social Worker
26.	VCT	Voluntary counselling and testing
27.	WC	Western Cape
28.	WHO	World Health Organization

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