TSHWARANANG
LEGAL ADVOCACY CENTRE
TO END VIOLENCE AGAINST WOMEN

Towards developing and strengthening a comprehensive response to the health care needs of rape survivors

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'Victims of sexual assault require comprehensive, gender-sensitive health services in order to cope with the physical and mental health consequences of their experience and aid their recovery from an extremely distressing and traumatic event'

Guidelines for medico-legal care for victims of sexual violence (World Health Organisation, 2003)

Sexual violence is primarily seen as a concern for the criminal justice system, requiring the development of legislation and policy guiding police and court procedures; the collection and interpretation of evidence; and the creation of support systems for victims[1] navigating their way through investigation and trial proceedings. Inevitably, such a focus subordinates survivors' broader health needs to the demands of the criminal justice system. Yet the health-related consequences of sexual violence are profound and long-term, permeating all aspects of life, sense of self, intimate relationships, sexuality, parenting, studies or employment, and the ability to cope. And while all of these adverse consequences cannot be prevented completely, many could be ameliorated by a comprehensive and multi-dimensional health sector response.

This brief policy note describes how sexual violence affects women's health and identifies the nature and type of health services women need after a sexual assault. It then summarises research examining access to healthcare services in the aftermath of a sexual assault, as well as the quality of such services. It concludes with implications for policy, service provision and advocacy.

The need for accessible, comprehensive and integrated health services is acute, given the extent of sexual violence in South Africa. In 2006/07, 52 617 rapes were reported top the South African Police Service (SAPS). These figures however, reflect only the number of cases reported to the police. StatsSA found that one in two rape survivors reported being raped to the police (Hirschowitz, Worku and Orkin, 2000), while the Medical Research Council (MRC) found that one in nine women reported being raped (Jewkes and Abrahams, 2002). Although their findings differ as to the extent, both studies clearly find rape to be under-reported. On the basis of the above studies it can be extrapolated that somewhere between the region of 104 000 and 460 000 rapes actually took place in 2006/07.

[2] The process of psychological reconstitution that follows victimization is irregular and difficult; on some days one may feel a victim, on others like a survivor. In acknowledgement of this process we use 'victim' and 'survivor' interchangeably in this document.

Sexual violence and women's reproductive health:

- sexually transmitted infections (STI), HIV and AIDS, pregnancy and infertility (Bollen et al 1999);
- a greater likelihood of miscarriages and induced abortions – this finding was reported in the 2005 World Health Organisation (WHO) Multi-country study on Women's Health and Domestic Violence Against Women by women who had ever experienced physical or sexual violence by their partners;
- teenage pregnancy - one study examining factors associated with teenage pregnancy in Cape Town found forced sexual initiation to be the third most-strongly associated factor with such early pregnancies (WHO, 2002).
- Other consequences include urinary tract infections, genital irritation, vaginal bleeding and infection, fibroids, chronic pelvic pain and pain during intercourse (WHO, 2002).

Sexual violence and women's mental health:

- Women who have experienced sexual assault, whether as children or adults, have been found more likely to attempt or commit suicide (WHO 2002:163).
- Depression, generalised anxiety, reduced self esteem, panic phobias (Astbury, 2006) and drug and alcohol abuse (WHO, 2002).
- Post-traumatic stress disorder (PTSD) - rape survivors are six times more likely to develop PTSD at some point in their lives in comparison to non-victimised women and also constitute the single largest group suffering from PTSD. Of all the traumatic stressors studied to date (including natural disasters like earthquakes, tsunamis and hurricanes), sexual violence most strongly predicts the likelihood of victims subsequently developing PTSD (cited in Astbury, 2006).
- Increased risk of revictimisation – both South African (Dunkle et al, 2004) and international research finds that girls sexually assaulted as children are at increased risk of being victimised again as adults. Forced first intercourse has also been associated with increased risk of physical and/or sexual partner violence (Dunkle et al, 2004).

HEALTH CONSEQUENCES OF SEXUAL VIOLENCE

Sexual violence takes different forms, ranging from unwanted touching through to murder. It affects both women's physical health, as well as their emotional and psychological well-being. When sexual abuse is ongoing over a period of time it tends to have a more complex psychological impact.

Negative mental health consequences can be exacerbated by the ill-informed and judgemental treatment of rape victims by their families and communities, health care workers and criminal justice system personnel. Such blaming (termed secondary victimisation) essentially holds rape survivors responsible for their own harm and considerably worsens their psychological distress. Secondary victimisation is also perhaps the most preventable of harms arising from an incident of sexual violence.

Given these serious consequences, it is clear that a comprehensive response, delivered by trained, sensitive and knowledgeable personnel, is essential to meeting the many health care needs of rape survivors. At a minimum this includes the prevention, termination or management of pregnancy; pre- and post-test counselling for HIV, accompanied by post-exposure prophylaxis (PEP); antibiotics to prevent the possible transmission of any other STIs; treatment for any injuries to the body; and attention to the psychological needs of rape survivors, including PTSD. When rape survivors choose to report to the police medico-legal and forensic services are also required.

ACCESSING HEALTHCARE IN THE AFTERMATH OF SEXUAL VIOLENCE

To provide some insight into the nature and quality of healthcare services for victims of sexual assault, we have drawn in particular from the following three studies: a national survey of 31 facilities providing healthcare to rape survivors (Christofides et al, 2003; Christofides et al, 2006); an evaluation of 26 medico-legal facilities in Gauteng (Suffla et al, 2001); and a study examining rape survivors' adherence to PEP in Gauteng (Vetten and Haffejee, 2005).

The healthcare needs of rape survivors have not gone unnoticed. In April 2002 Cabinet announced that it was making anti-retroviral drugs to prevent HIV infection available to rape survivors. More recently, National Management Guidelines for Sexual Assault Care ("the Guidelines") and the National Sexual Assault Policy ("the Policy") were released by the Department of Health in 2005.

Both are important interventions on the part of government and demonstrate, on paper at least, commitment to addressing sexual assault. However, both the dissemination and implementation of these policies has been erratic and slow, with the result that many rape victims still do not have access to services.

Location of services

One of the objectives of the National Sexual Assault Policy is to establish accessible, designated, specialized 24-hour health care services for sexual assault patients. Currently, healthcare services for rape victims/survivors are based in a variety of settings nationally, including district, regional and tertiary hospitals as well as primary health care facilities. These services may be offered as part of health services generally; or they make take the form of specialist facilities catering to rape victims/survivors specifically and also include a range of other service providers in addition to health staff (such as the Thuthuzela centres established by the National Prosecuting Authority (NPA)). Less commonly, NGOs such as the Thohoyandou Victim Empowerment Programme (TVEP) in Limpopo, or the Refentse post-rape care project in Mpumalanga, offer health care from within health facilities. This wide variation in practice implies a wide variation in post-rape care, as research has found.

Presumably to ensure that they are available on a 24-hour basis, many services for rape victims are located in the casualty section of hospitals. But for a range of reasons, these are precisely the departments most unsuited to dealing with rape patients, being noisy, busy, chaotic, bloody, frightening and conflictual – hardly the ideal environment for someone in a state of shock. Further, unless rape survivors have suffered serious physical injury they will be bypassed in order to treat patients whose conditions are more immediately life-threatening.

While knowledgeable about emergency medical care, casualty staff have rarely received comprehensive specialist training around dealing with sexual assaults. Unless special measures are taken, the location of services in casualty seriously compromises the quality of care provided to victims of sexual assault, with casualty staff likely to see their services to rape survivors as an add-on (if not burden) and their work in casualty as their first priority (Vetten and Haffejee, 2005; Christofides et al, 2006).

Travel to facilities and waiting times

At almost all casualty-based facilities rape survivors wait for examinations, HIV testing and voluntary counseling and testing (VCT) for longer or shorter periods of time. These waits are generally longest at night and over week-ends when services are most dependent upon casualty staff or district surgeons. VCT counselors are not available at night either so this additional task also falls to casualty nurses (Vetten and Haffejee, 2005). Waits are also the result of staff shortages, as well as the distance from the health facility of doctors on call (Christofides et al, 2003). Many women do not have access to transport and particularly depend upon the police to help them access healthcare. They thus wait not only for health care workers but also for the police.

Long waits impact particularly negatively upon women's right to emergency medical treatment in the form of PEP. PEP should ideally be taken as soon as possible after the rape and no more than 72 hours later; anyone presenting after this 72-hour period is no longer eligible. However, Human Rights Watch's 2004 report into access to PEP in South Africa records instances of the police sometimes refusing to open cases of rape, or delaying transporting victims to health facilities – to the extent that the 72-hour period had lapsed. Such delays effectively deny survivors access to PEP and place them at risk of HIV infection.

The problems with a lack of transport are particularly pronounced in rural areas, as well as historically-disadvantaged urban areas – suggesting that black women's healthcare needs are particularly likely to suffer.

QUALITY OF HEALTH SERVICE FOR RAPE SURVIVORS

The uneven implementation of policy has weakened services for rape survivors in South Africa.

Privacy and confidentiality

Rape victims are a highly stigmatised group of people in South Africa and the stigma attached to being raped acting as a significant barrier to it being reported. As the National Sexual Assault Policy notes: "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" (2005: 6). The attack itself is also humiliating and many victims experience shame in having to recount the rape to others. Yet the necessity for both confidentiality and privacy in healthcare services is not always respected. Out of 31 health facilities surveyed nationally, less than half (47.4%) had a private room available for the examination of rape survivors (Christofides et al, 2006). Some of these private examination rooms were also kept locked after hours (Christofides et al, 2003).

Privacy may be violated in other ways during rape examinations. Although only medical personnel should be present during the examination, both Suffla et al (2001) and Vetten and Haffejee (2005) record instances of police officers and other unauthorised, non-medical persons sometimes being present in the examination room.

Availability of equipment, amenities and drugs

Being able to wash after the rape is of paramount importance to rape survivors. However, the national survey of healthcare facilities found no access to a bath or shower in health facilities in the provinces of Gauteng, Limpopo, North West or Free State. Western Cape facilities were most likely to have access to such amenities, with 56.8% of facilities having access.

A shortage of Sexual Assault Evidence Crime Kits (SAECK) - vital to the forensic examination - has also been noted consistently (Human Rights Watch 1997; Suffla et al 2001; Christofides et al 2003). When these are not available at health facilities, delays in the examination will result while the police return to the station to fetch kits.

Other gaps in treatment and care were also identified:

- 79.6% of healthcare facilities had pregnancy tests available;
- 66.7% had emergency contraception;
- 52.4% had an angle lamp (an essential basic for the forensic examination); 7.8% had spare clothing for emergencies; and
- 15.2% a lockable cupboard for storing crime kits and other evidence (Christofides et al, 2006).

Extent of prior training and knowledge around rape survivors' health care needs

The national survey found that just under a third (30.3%) of healthcare practitioners surveyed had received training on caring for rape survivors (Christofides et al, 2006). The Gauteng PEP adherence study found that less than half of health workers interviewed had received training around rape and PEP (Vetten and Haffejee, 2005). Other healthcare practitioners not only did not know about PEP, but were also unfamiliar with the treatment for other STIs; only 36.9% of practitioners in the national survey provided the correct treatment for such infections (Christofides et al, 2006).

The forensic examination

In as early as 1997 Human Rights Watch commented on the inadequacies of the medico-legal examination, as well as the J88 form used to record the examining doctor's findings. Four years later, in 2001, Suffla et al found little had improved. The J88 remained of limited utility and doctors still did not fill out the form accurately or completely. Additionally, the majority of centres audited did not keep copies of all completed forms and nor did they have copies of the blank forms either.

In relation to the SAECKs, doctors interviewed for the national survey said that sometimes no SAECKs were available at all and that the kits brought by police to them for completion had sometimes already been used or were incomplete. Only 15.2% of facilities had lockable cupboards for storing evidence. Where these did not exist, SAECKs might be left on a nurse's desk or in an open cupboard – in clear breach of requirements to maintain the chain of evidence and pre-empt defence attorneys' claims that the medico-legal evidence had been tampered with.

Attitudes to rape survivors

Almost one in three (32.6%) health practitioners interviewed for the national survey said they did not consider rape to be a serious medical condition (Christofides et al, 2006). Suffla et al's evaluation of 26 medico-legal services in Gauteng also refers to the "unsympathetic, judgemental and impatient attitude" demonstrated by health workers towards the women. Further illustrations of insensitivity emerge from the PEP

adherence study. One adolescent rape survivor reported being screamed at by the nurse when she went for the first visit:

While she was busy doing the blood test she kept asking me questions like what happened…and she was like shouting. So I had to tell her what happened. That's when she told me that "As a 17 year-old girl what you were thinking? You deserve things like that." So I just kept quiet because T. had already warned me that the sisters will shout at me and told me to just ignore them." (RS 16)

Victims who do not report the rape to the police are also frequently denied health care. This is contrary to the Policy which states "No patient should be turned away if they have not reported assault (sic) to police or choose not to report sexual assault" (2004: 15). Nonetheless, researchers in the Gauteng PEP adherence study observed patients being refused treatment until they reported the rape to the police (Vetten and Haffejee, 2005).

Finally, the Guidelines currently do not provide adequate guidance to healthcare workers for assessing and dealing with the range of functionality displayed by cognitively-impaired people. It is also unclear what training healthcare workers receive around the effective management, care and treatment of this group of victims.

Provision of Psychosocial Support, Counselling and Therapy[2]

Given the very serious and potentially long-term emotional consequences of rape, it is essential that attention be paid to the mental health of victims. However, less than half (48.4%) of healthcare providers interviewed for the national survey reported referring patients for counselling after rape (Christofides et al, 2006). The Gauteng medico-legal survey noted a similar absence of referrals to psychosocial services but also highlighted additional problems in the form of an inadequate number of counselling services to meet the demand, as well as poorly-trained, unqualified counselling personnel (Suffla et al, 2001).

The PEP adherence study points to other problems with the provision of counselling services to rape survivors. At the sites studied it appeared as though health workers' primary focus was on providing PEP, with less attention being to the emotional needs of the survivor. Furthermore, interviews with health care workers suggested that counselling was primarily centred on VCT. In addition to the lack of counselling, it was observed that health workers were not always equipped with the necessary skills and attitude to counsel rape survivors, or run support groups.

Emotional support however, was not only necessary for patients, but also for PEP facility staff, some of whom were demotivated and discouraged. The PEP facilities appeared to be functioning in isolation, with relations between health, the police and NGOs relatively undeveloped (Vetten and Haffejee, 2005).

WHAT HEALTH SERVICES DO RAPE SURVIVORS WANT?

It is worth highlighting the value that rape survivors place on counselling services. Christofides et al's (2005) face-to-face interviews with 319 women found that respondents most valued the availability of PEP (with an HIV test) and having a sensitive health care provider who could provide counselling. They did not make choices based on travel time. The findings suggest that patients are willing to trade off access to services (time travelled) for attributes such as HIV PEP, counselling and examination rigor. This study has important implications for the provision of patient-centred services for rape survivors. It suggests that women who have been raped would most value services run by health care providers who have received special training in managing patients after rape and understand what the impact of being raped upon patients, in settings that are appropriately resourced, rather than seeking to provide the most geographically accessible service.

[2] This includes emotional and psychological support through various forms of counselling or psychotherapy and at times even psychiatry

IMPLICATIONS FOR POLICY AND SERVICE PROVISION

The WHO defines good health as "a state of complete physical, mental and spiritual well-being." This broad definition is particularly apposite in the context of sexual violence. It suggests that if women are ever to attain a state of well-being after a sexual assault, then the state must develop a comprehensive package of services to address these serious consequences and uphold women's rights.

Section 27 of the South African Constitution states that "Everyone has the right to have access to health care services, including reproductive health care" and that "[N]o one may be refused emergency medical treatment." Section 27(1)(b) provides for the State to "take reasonable legislative and other measures, within its available resources to achieve the progressive realisation of the right." In addition to the right to access health care, the Constitution also protects the rights to dignity, privacy and freedom and security of the person. In light of these Constitutional obligations we recommend that the Department of Health explicitly identify the health needs of rape victims as a priority area of concern and that it continue to develop services that meet its constitutional obligation to provide access to health care in a manner that protects the rights of victims to dignity, privacy and freedom and security of the person:

- The Department needs to develop a comprehensive plan outlining implementation of their Policy and Guidelines, including the training required to enable heath workers to discharge their duties effectively. Such a plan should outline performance targets in this area over the next three years, as well as the budget available for the implementation of their policies.
- Organisations dealing with violence against women have traditionally focused most of their efforts on the criminal justice system and rarely the health system. It is important that organizations also build referral networks with health facilities and seek to strengthen the healthcare component of their work.

"Everyone has the right to have access to health care services, including reproductive health care"

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