TSHWARANANG
LEGAL ADVOCACY CENTRE
TO END VIOLENCE AGAINST WOMEN

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From Paper to Practice:
Lessons in the Implementation of Health and Victim Empowerment Policy Applicable to Rape Survivors

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The treatment of rape *survivors by the health care and criminal justice systems has been found wanting in many respects. Research studies have highlighted the following as denying women access to health care and justice:

- lengthy waits for medico-legal examinations;[6,7]
- delays in the provision of medical treatment;[6,8]
- lack of privacy and confidentiality during examination and reporting processes;[6,9,10]
- inadequate training and prejudicial attitudes towards rape survivors;[6,9,11,12]
- the absence of referral systems, as well as counselling services;[6,12]
- inadequate record-keeping and documentation;[13,14] and
- the filtering of rape complaints out of the criminal justice system.[13]

* *The terms 'victim', 'survivor' and 'patient' have been used interchangeably in this report to reflect the shifting and multiple circumstances of those who have experienced rape.*

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1. Introduction

The devastating consequences of rape have galvanised policy-makers to provide services intended to ameliorate rape's after-effects, as well as promote women's access to justice. Yet the implementation of these various interventions has more often been the subject of critical scrutiny than acclaim. But while it is one thing to identify defects in policy, it is entirely another to test what makes policy effective in practice. In this brief we describe the Refentse ("resilience in the face of adversity") project, an intervention drawing on the Department of Health's *National Sexual Assault Policy*[1] and *National Management Guidelines for Sexual Assault Care*,[2] as well as aspects of the Victim's Charter[3,4] and the draft Integrated Victim Empowerment Policy.[5]

The state has introduced a range of policy interventions addressing rape, the more significant of these being:

- the Cabinet decision in 2002 to provide anti-retroviral drugs to rape survivors to prevent HIV infection;
- the enactment of the Criminal Law (Sexual Offences and Related Matters) Amendment Act number 32 of 2007;
- the SAPS National Instruction 3/2008 *Sexual Offences*;
- the Department of Health's 2005 *National Management Guidelines for Sexual Assault Care* and the *National Sexual Assault Policy*; and
- the 2004 *Service Charter for Victims of Crime in South Africa* (the Victim's Charter) introduced by the Department of Justice and Constitutional Development, coupled with the *Integrated Victim Empowerment Policy* developed by the Department of Social Development (although still in draft form by July 2007, nine years after the victim empowerment programme (VEP) was mooted).

The Tintswalo Hospital is 1.5 km away from the Tshwaranang office, Police Station and Court in Acornhoek, Mpumalanga

Background to the Refentse project

The Refentse project is based at Tintswalo Hospital and the Acornhoek SAPS in the Bushbuckridge municipality of Mpumalanga. First instituted in March 2003 by the Rural AIDS and Development Action Research Programme (RADAR) of the University of the Witwatersrand's School of Public Health in collaboration with the Population Council, it is intended to ensure rape survivors' access to justice and health care. Both phases of the project have been funded by USAID and PEPFAR, with the second phase receiving additional support from SIDA and the Norwegian Ministry of Foreign Affairs.

Phase 1

Refentse initially set out to determine the feasibility, effectiveness and cost of implementing a nurse-driven, integrated post-rape care programme (including HIV post-exposure prophylaxis (PEP), within the rural, public sector health services. **The objectives of the first phase were to:**

- document the existing state of post-rape care services as a basis for designing the intervention and for evaluating change within the study site;
- define and strengthen the components of an integrated rape care programme, including PEP;
- assess the impact of this programme on existing service delivery for rape survivors; and
- determine the feasibility, effectiveness, and cost of the programme.

Phase 1 was carried out by a research coordinator, a research specialist and a full-time professional nurse, all employed by RADAR. The professional nurse received three weeks of training and mentorship under the guidance of experts at the Maternal Child and Women's Health (MCWH) Department in the Western Cape, followed by ongoing supervision by doctors at the study hospital. During the first phase of Refentse, she conducted many of the forensic examinations while also working closely with Tintswalo staff to transfer skills and knowledge.

Phase 2

The first phase concluded in August 2006 having noted a number of improvements as a result of the intervention. However, interviews conducted with 109 rape patients over the course of the study found they had little confidence in the criminal justice system. Ninety-one per cent of these patients had laid criminal charges and many had spent in excess of four hours at the hospital undergoing the forensic examination. However, only 22% believed that their case would actually go to trial. **To address this, Tshwaranang Legal Advocacy Centre ("Tshwaranang") managed phase 2 of the project which set out to:**

- continue monitoring uptake of post-rape care at the hospital (including voluntary counselling and testing (VCT) and PEP);
- introduce a strengthened referral system between the health sector and the criminal justice sector;
- introduce direct legal services and psycho-social counselling for survivors of rape and domestic violence; and
- document the use of these additional services to inform further development of the intervention and evaluate change within the study site.

Phase 2 was inaugurated by Tshwaranang in March 2007 with the establishment of an office on the grounds of the Acornhoek SAPS. These premises had previously functioned as the police's victim support centre (VSC) and were opened in 2006, along with an overnight shelter with sleeping and bathroom facilities. The VSC was initially run by volunteers and managed by a VEP executive. Because the VEP executive had been experiencing problems in sustaining the VSC, they found the option of handing it over to Tshwaranang attractive. The organisation employed one of the VSC volunteers as a lay counselor and also introduced a para-legal officer into the service while the research coordinator and forensic nurse remained at Tintswalo to monitor the hospital service.

2. Developing a comprehensive health care response for rape patients

Phase 1 comprised a pre/post-intervention study that utilised both quantitative and qualitative methods of research including chart reviews and interviews with rape survivors, a range of health care workers (HCW), police and other service providers.

From diagnosis to intervention

The baseline findings uncovered systemic problems in the delivery of post-rape care. Few HCWs had received any training on post-rape management, including PEP. The service was fragmented and not patient-centered, forcing patients to interact with up to 10 different service providers during their first visit. Multiple obstacles interfered with the timely provision of emergency contraception (EC), VCT and PEP. Indeed, PEP was often the last step in the treatment chain. Further, while the majority of patients presenting for care were eligible for PEP, many arrived during hospital after-hours when the service was least prepared to meet their needs. For instance, the pharmacist was reluctant to stock PEP in the out-patients' department (OPD), stating that he was always on call for such requests. In practice, problems with transport, lack of cell phone coverage (ensuring that he could not always be reached) and the belief that some women lied about rape undermined the provision of PEP. A further key finding was that only 14% of patients prescribed a starter pack of PEP were able to return for any subsequent doses.

A five-part intervention was implemented at the study site in March 2004 to address these challenges:

- establishing a sexual violence Project Advisory Committee (PAC) comprising RADAR, OPD nursing management, the police, social workers, HIV services, doctors and the pharmacist and psychiatric nurse;
- instituting a hospital rape management policy;
- running training workshops for HCWS and other providers;
- centralising and coordinating post-rape care through a designated OPD room; and
- running community awareness campaigns through community radio and morning health talks to patients waiting in the OPD queue, as well as at the surrounding primary health care clinics.

Following the implementation of this intervention between March 2004 and August 2006, a number of improvements were noted.

Uptake and efficiency of services: Utilisation of services increased in the post-intervention phase, with the mean number of rape cases presenting to hospital increasing from 7.8 to 12.9 cases per month. In addition, interviews with patients suggested that the service had become more private and streamlined, necessitating fewer interactions with service providers. Those who reported having to see six or more service providers on their first visit decreased from 85.7% to 54.0%.

Clinical post-rape management: Both the chart review and patient interviews suggested substantial improvements across all domains measured, including the quality of history and forensic examination and the provision of pregnancy testing, EC, STI treatment, VCT and PEP, as well as follow-up counselling and referrals. Those in the post-intervention group were three times more likely to have been given a pregnancy test, while the prescription of EC increased from 65.1% to 72.5%. Syndromic treatment of STIs also increased from 87.5% to 91.5% and those in the post-intervention group were four times more likely to have received any VCT following the assault, and three times more likely to have received it during their initial visit.

Provision of PEP: Significant improvements were also seen in provision of PEP, and those in the post-intervention group were five times more likely to have received any PEP – whether a starter pack or full 28 day course - following the assault. Whereas prior to the intervention only 15.1% had been given the full 28-day course on the first visit, this increased to 55.1% in the follow-up period. These changes in provider practice appear to have impacted positively on PEP adherence, as reported by patients. Following the intervention, patients were more likely to report having received PEP, to have received a full 28-day course on their first visit, and to have completed the full 28-day regimen. In addition, there was a reduction in the mean time interval (27.8 hours to 18.1 hours) between the assault and receiving the first dose of PEP.

An expanded role for nurses: This study showed that it is possible to substantially expand the role of nurses in the management of sexual assault. Prior to the intervention, most care was delivered by the doctor, with the nurse's role confined primarily to obtaining the medical chart, taking vital signs, and waiting to assist the doctor. Following the intervention, this role was expanded to include documenting the rape history, providing acute trauma debriefing, providing a stat dose of PEP, taking a pregnancy test, dispensing the treatment package (STI medications, EC and PEP), providing medication counselling, and making follow-up referrals.

However, while the RADAR nurse eventually gained the confidence and skill to conduct forensic examinations, she was unable to transfer these skills to other nurses in OPD. Indeed, a disappointing finding from the study was the lack of impact on training nurses capable and willing to perform the forensic examination. In general, nurses were reluctant to learn about this aspect of post-rape management and intimidated by the long time required to conduct the exam. Moreover, many felt there was a lack of clarity in current government policies that would allow nurses to present evidence in court, should they be called to testify. It is also possible that the intensity of training required to develop proficiency and confidence in this area was under-estimated.

Sustaining the intervention: Phase 2 of Refentse

In September 2006 Tintswalo Hospital employed a forensic nurse trained to conduct rape medico-legal examinations. With the Tintswalo forensic nurse now taking responsibility for the care and management of rape survivors, the RADAR/Tshwaranang nurse focused primarily on playing a supportive and monitoring role: ensuring the OPD room was stocked with the necessary medications and forms and that all equipment and amenities were clean and in working condition; training the new nurses allocated to OPD every month; ensuring patient records had been correctly completed and transferring data from the OPD patient records to the Tshwaranang clinical care assessment data sheets. The results of this monitoring are reported next.

Between 1 October 2006 to 31 August 2008 Tintswalo Hospital examined a total of 284 rape survivors, a mean average of 12.4 cases per month. This represents a negligible decrease in the number seen during phase 1 when uptake rose from 7.8 to 12.9 cases per month. As in phase 1, women and girls constituted the bulk of victims (95.8% vs. 4.2% male victims). Victims ranged in age from 8 months to 89 years (mean 22.14 median 18). The majority of those seen during this period were adults (56.0%) with children 17 years and younger comprising 44% of the sample. Just over half of survivors (51.8%) arrived at the hospital via a police referral while 30.3% were self-referred. Primary health clinics accounted for 4.6% of referrals.

Eight out of ten victims (80.3%) presented within 72 hours. The remaining 10.2% arrived after this time period, rendering them ineligible for PEP. A further 8.5% of victims were also found to be ineligible for PEP, having tested positive for HIV at the time of the medico-legal examination. Of the remaining 231 eligible patients, 81.3% were provided with a stat dose. We could not determine in 3.9% of cases whether patients had been given anything further after the initial stat dose.

Table 1 below compares four aspects of quality of health care during the two phases of the project. These show that the quality of care was not only maintained, but exceeded during the second phase of the project.

Table 1: Comparing quality of care across the two phases

Quality of care indicators	Phase 1		Phase 2
	Pre	Post	
Pregnancy test done	67.5%	86.0%	(216/236) 91.5%
EC given	65.1%	72.5%	(187/231) 80.9%
VCT at first visit	41.2%	60.6%	73.2%
28 days PEP given at first visit	15.1%	55.1%	67.6%

3. Introducing legal and lay counselling services for rape survivors

Tshwaranang's legal and mental health services for rape survivors were established on 1 March 2007, six months into phase 2 of the Refentse project. In comparison to the health care component, they are still in their infancy. As essential first steps in getting the service off the ground, the organisation focused on establishing a client record-keeping system, as well as implementing a functional referral system. For the purposes of this brief the client record-keeping system was analysed from its inception (1 March 2007) to the end of phase 2 (31 August 2008), with the results for the first eighteen months of operation presented below. These findings provide a baseline against which to assess services in future, as well as identify where they require adjustment.

Who used Tshwaranang's services?

Tshwaranang saw a total of 77 rape survivors during 1 March 2007 to 31 August 2008. They ranged in age from 5 to 61 years and included three male victims. Where age could be determined, adult victims constituted the majority of the organisation's clients (53.4% vs 46.5% of those 17 years and younger). The average mean age was 20.30 years and the median 18 years.

The circumstances of rape

A few clients (6 or 7.8%) were attacked by two or more perpetrators. These rapes accounted for an additional nine perpetrators. The relationship between perpetrators and victims is set out below and shows that the greatest proportion of victims was raped by strangers, followed by acquaintances.

Table 2: Relationship between perpetrator and victim	N=86
Stranger	33 (42.9%)
Acquaintance/known by sight	27 (35.1%)
Father/other male relative	8 (10.4)
Ex-husband/boyfriend	3 (3.9%)
Other/unknown	6 (7.6%)

Robbery accompanied 14.3% of the rapes while 5.2% of victims were raped more than once by the same perpetrator. In one in three rapes (35.1%) the victim was abducted and taken to another spot where the rape took place. The greatest proportion of rape victims was attacked at home, with many of these cases involving break-ins while the victim was asleep.

Table 3: Circumstances preceding the rapes	N=66
Victim going about daily *routine	17 (25.8%)
Victim walking somewhere	17 (25.8%)
Victim at home	24 (36.4%)
Victim socialising with friends	8 (12.1%)
Other	1 (1.5%)

Weapons featured in 28 (42.4%) rapes and were most likely to be knives or other sharp objects. One in four Tshwaranang clients (20 or 26.0%) stated that they had been physically assaulted during the course of the rape, while eight (10.4%) were threatened with death.

Table 4: Weapons involved in the rapes	N=77
Knife/sharp object	16 (20.8%)
Gun	6 (7.8%)
Blunt object	4 (5.2%)
Other	2 (2.6%)

Who referred rape survivors to Tshwaranang?

Introducing a strengthened referral system between the health sector, the criminal justice sector and Tshwaranang was a key objective for phase 2. This is in keeping with the minimum standards for service delivery in victim empowerment: "[i]t should be ensured that victims have received effective developmental assessment, referral and support services, enabling the victim/witness to effectively participate in court proceedings."[4] Such referrals to social support services are the responsibility of health workers, police officers and social workers.[3]

Table 5 shows where Tintswalo Hospital staff referred rape patients to. Of the 228 rape survivors presenting to the hospital, approximately 112 (49.1%) were referred to Tshwaranang. (For the purposes of this analysis we have focused only on the 228 patients presenting to Tintswalo from 1 March 2007 onwards when Tshwaranang began offering its service.)

Table 5: Referral of rape patients by Tintswalo Hospital	N=228
Social worker	69 (30.3%)
Psychiatric nurse	42 (18.4%)
TLAC	40 (17.5%)
Social worker and TLAC	60 (26.3%)
Psychiatric nurse and TLAC	12 (5.3%)
Other	5 (2.2%)

Tintswalo staff were therefore somewhat more likely to refer rape cases to other hospital staff (either alone or in combination with referrals to Tshwaranang) than they were to refer to Tshwaranang (again, either alone or in combination with hospital staff). This pattern is explained to some extent by the youthfulness of many rape victims presenting at Tintswalo. Children 16 years and younger comprised 73.9% of referrals to the social worker and only 20.0% of referrals to Tshwaranang and 9.5% of referrals to the psychiatric nurse. Given that a different set of skills and knowledge is required for working with younger children as opposed to adolescents and adults, the organisation had decided against attempting to also provide services to younger children.

Steps Tshwaranang took to actively increase referrals from the hospital to the organisation included developing a referral letter for hospital staff to complete with rape survivors and including discussion of referrals within routine ongoing training for OPD nurses. Our efforts paid off in that while just 19 referrals were made to the organisation in 2007, this number increased to 96 in 2008.

However, most of those referred to Tshwaranang by Tintswalo did not make follow-up contact with the organisation. As table 6 shows, just over one in three (41 or 36.6%) of the 112 rape survivors referred by Tintswalo ultimately contacted Tshwaranang for further legal or counseling support. Nonetheless, according to our review of client records, the hospital constituted the main source of referrals.

Table 6: Source of referral to Tshwaranang	N=77
Tintswalo Hospital	41 (53.2%)
SAPS	17 (22.1%)
Other	6 (7.8%)
Not recorded	13 (16.9%)

That the majority of rape survivors referred by Tintswalo did not contact Tshwaranang could imply that at least some women saw no need for the service. On the other hand, because Acornhoek is an impoverished rural area, a low turn-up rate could also indicate that transport costs were acting as

Referring to tasks such as shopping or washing clothing at the river.

a barrier to accessing the service. With the majority of clients having no source of income (being either unemployed (54.4%) or scholars (35.3%) and 44.1% dependent on government grants (n = 68), it was decided to reimburse the transport costs of those women who required such assistance. This was set at a flat rate of R30.00 which women were informed of during the telephonic follow-ups instituted in April 2008. However, some women did not have telephones and therefore could not be contacted at all. It is too soon to know what impact these latter two interventions may make.

The comparison of our records with those collected from the hospital also provides further insight into how women use referrals, with some women contacting us almost immediately, others waiting a few weeks and still others waiting a few months. The question of when women choose to utilise referrals deserves further exploration.

Help sought from Tshwaranang

Almost all those who used Tshwaranang's services (94.9%) had reported to the police. Not unsurprisingly then, the bulk of our assistance consisted in providing advice about criminal justice system procedures, monitoring the progress of individual women's cases and engaging in supportive counseling. This included routinely contacting investigating officers and prosecutors to enquire about the status of individual matters and accompanying clients to court. With 43 of Tshwaranang's 77 cases still being pursued by the organisation, it is too soon to say what impact these interventions may have upon criminal justice system processes. However, that we so regularly needed to provide information to women on the progression of their cases is evidence of the extent to which "the right to receive information" (as set out in the Victim's Charter) was not being effectively implemented by the local police and court.

Table 7 sets out the status of our clients' cases at the time of writing. Of those cases for which we had information, only 12 had been concluded through either withdrawals; the matter having been struck off the roll; or the accused having been acquitted or having died. In other words, at the time of writing this brief, only one case had made it to trial during the eighteen months of Tshwaranang being in operation – an indication of the great persistence required to pursue a prosecution.

Table 7: Case outcomes	**77 (%)**
Police investigations still in progress	37 (29.1%)
Case withdrawn/struck from roll	10 (13.0%)
Matter currently on court roll	21 (27.2%)
No further follow-up recorded by TLAC	9 (11.7%)
Other	2 (2.6%)

4. From policy to practice: Key lessons for the study

Arguably, it is that which is implemented that constitutes 'the policy', rather than that written on paper. Findings from phase 1 and phase 2 of the research study discussed in this brief suggest that in Acornhoek, the gap between the policy on paper and the policy in practice was large. Encouragingly, the Refentse project also demonstrates that it is possible to close the gap through specific and targeted interventions. These were the steps we followed in doing so.

Describing what is (not) being implemented

The various research activities conducted over the course of the Refentse project identified situations where the national health policy and guidelines applicable to rape, as well as the victim empowerment policy, were not being effectively implemented and moreover, how institutions may inadvertently undermine their policies. At Tintswalo for example, most obstacles to providing PEP were institutional rather than patient-driven. Most of the diagnostic tests and treatments required by rape patients were generally available within the hospital, but scattered across different departments and service providers, leading to obstacles and delays in providing care.

Adapting and strengthening existing policy

Working within the ambit of the *National Sexual Assault Policy* and *National Management Guidelines for Sexual Assault Care*, Tintswalo developed a rape management policy and treatment protocol that addressed the specific challenges faced by the hospital. **The institutional framework subsequently adopted enabled the following changes:**

- Coordinating care by setting out the responsibilities of a range of actors beyond HCWs (e.g. clerks, pharmacy, laboratory, VCT counsellors, social workers), as many of these providers impact directly on patient care. Such policies may also reduce the potential for individual providers to allow personal judgments and attitudes to shape their treatment of patients (e.g. withholding PEP in the belief that women lie about rape).
- Specifying a designated room for treating cases of sexual assault in order to centralise services within the hospital and increase privacy. Medications and diagnostic tests are stored and dispensed directly from this room, minimising delays and the need for additional providers.
- Putting in place treatment protocols to assist in systematising care and to make it easier for providers to follow the Department of Health's *National Management Guidelines for Sexual Assault Care*. Such protocols are particularly important given the lack of training received by many HCWs, and their high turnover within health facilities.
- Expanding nurse-driven services as there are few doctors in rural areas, with obvious implications for the quality and availability of care, as well as the length of time rape survivors wait before being attended to. Nurses can play a much greater role in the provision of post-rape care and thus enhance the implementation of policy.
- Ensuring sustained efforts to maintain and build functioning referral networks, as the practice of referring does not come automatically. This may include routinely documenting the source of referrals, meeting regularly with such sources and providing a standard letter of referral for service providers.

Institutionalising change in action

From a policy point of view, it is not desirable to have non-governmental organisations providing state services within state facilities where they have not been contracted to do so. It was critical therefore that the Refentse project did not seek to substitute for a state service, but rather entrenched the service within existing state structures instead. This institutionalisation appears to have been facilitated by including the hospital CEO and relevant senior management within discussions around the design and implementation of the Refentse project's intervention. The hospital's employment of a forensic nurse, in addition to permitting us to continue monitoring the service, also signals clear willingness to assume responsibility for the provision of quality services to rape survivors.

Gaps in current policy and knowledge

1. Further research and experience in training nurses to perform forensic exams is needed to guide policy and practice. Both the training requirements and the development of norms and standards for forensic nurses are still evolving in South Africa, and it is clear that further experience and research would be useful.
2. The examination of Tshwaranang's client records highlights a gap in services to that group of rape victims who choose not to report the violation done to them – which, research suggests, may well constitute the majority of rape victims in South Africa.[15] Further research is required to understand what services this group may require, as well as how they may be reached. Much policy (with the exception of the VEP policy) is also silent about this group, with the Victim's Charter clearly intended to apply only to those who report the crimes done to them.
3. The under-utilisation of Tshwaranang's services by rape survivors is not unusual and has been found elsewhere.[16,17] It is possible that at least some women may not experience a need for such services. Services may also need to prove their usefulness to a community before being used by its members. Barriers such as travel costs, or having no access to telecommunication services, may also hinder women from approaching follow-up services. Thus it is not only necessary to entrench referring as a practice, but also explore what hinders or enhances the uptake of referrals.

The role of non-governmental organisations (NGOs)

Finally, many NGOs (including Tshwaranang) have been involved in the formulation of some of the policies referred to in this brief. This places at least some obligation upon NGOs to monitor the implementation of government policy and critically reflect thereon to distinguish between what is 'bad' policy and what represents a failure of implementation. The access Tshwaranang has enjoyed to Tintswalo's records and the hospital's buy-in to the project may be unusual and is perhaps not readily duplicated. However, the relationship between Tshwaranang and Tintswalo is illustrative of the kind of constructive partnership that can be forged between government services and NGOs.

The review of Tshwaranang records also illustrates that NGOs, in the rendering of their service, are by no means immune from some of the challenges experienced by government departments. Staff too need ongoing training to build and widen their skills and knowledge around advocating for their clients as they navigate their way through health and criminal justice systems. Routine, consistent and complete record-keeping is key to monitoring the outcomes and impact of services, as well as identifying where they need to be refined or adapted. Indeed, if there is one thing the Refentse project demonstrates, it is how integral monitoring and evaluation is to the creation and sustainability of quality services to rape survivors.

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