

# WOMEN AND SEXUAL VIOLENCE

# 4

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*This chapter provides an overview of the magnitude of sexual and gender-based violence (SGBV) in South Africa. The definition of SGBV is broad and encompasses a range of issues including intimate partner violence, human trafficking, early marriage and female genital mutilation, amongst others.*

*This chapter focuses more narrowly on issues regarding the prevention and management of sexual assault, although the authors acknowledge that many forms of SGBV often co-exist. It begins by highlighting the magnitude of SGBV in South Africa as a development issue, the complexity of addressing prevention and comprehensive management of SGBV and the importance of a multi-sectoral response within the current policy and legal context. The latter sections of the chapter explore SGBV as a public health issue, highlighting the health sector response, comprehensive clinical care and links to the justice system. Many examples and data have been drawn from the important contributions that civil society and non-governmental players have made to the research and response to SGBV in South Africa.*

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## Introduction

Violence is a major obstacle to development and violence against women hinders progress in achieving development targets. The Millennium Declaration explicitly recognises that the equal rights and opportunities of women and men must be assured. While Millennium Development Goal (MDG) 3 specifically addresses the promotion of gender equality and women's empowerment, gender equality is recognised as a key factor in achieving all MDGs. Violence against women intersects with and is relevant to all the MDGs, providing powerful arguments and a number of entry points for approaches to eradicating violence against women.<sup>1</sup>

## Magnitude of sexual violence in South Africa

Sexual violence experienced by women, and girls in particular, remains a huge and daunting problem in South Africa, which is perceived to have one of the worst sexual and gender-based violence (SGBV) rates in the world. The term sexual violence describes a broad range of behaviours that include physical violence, sexual violence, emotional violence and intimate partner violence (also called domestic violence). Sexual violence is gender-based and embedded in pre-existing social, cultural and economic inequalities between men and women.

The true magnitude of the problem in South Africa remains unknown and there are great disparities with respect to reported cases of sexual violence. For example, Statistics South Africa (StatsSA) found that one in two rape survivors reported to the police, while a Medical Research Council (MRC) study found that only one in nine women reported their experience of rape.<sup>2,3</sup> Both studies point to gross under-reporting of cases. Added to this is the poor use of health services by sexual violence victims with only an estimated one in six women who have experienced rape seeking health services.<sup>3</sup> Intimate partner violence is often also sexual and emotional, usually occurring in a broader context of relationships marked by controlling behaviours by men and a pervasive sense of fear among women, limiting freedom of choice and access to services. In research interviews over 40% of men reported having been physically violent to a partner.<sup>4,6</sup> In a study on understanding men's health and use of violence conducted by Jewkes et al., one in 30 men reported having been victims.<sup>5</sup>

Since December 2007 the definition of rape has broadened from the exclusive concept of vaginal rape to include oral and anal rape, thus encompassing other forms of rape experienced by women, together with male rape that was previously grouped under indecent assault. As a result, comparing

historical data on sexual offences is difficult. Police statistics are often viewed with scepticism, with a number of groups holding the opinion that the problem of sexual violence is much larger than is reflected by official sources.

Some of the factors that affect reporting include ambivalence to rape as a crime and victim ambivalence regarding the value of reporting. The definition and characterisation of different forms of sexual violence (e.g. sexual coercion, rape, intimate partner sexual violence) also contribute to the difficulty in determining the magnitude of the problem and trends and, consequently, in effectively shaping public health policies and programmes.

Data on sexual violence is fragmented and largely limited to cases reported to the police, collected by researchers or during interventions implemented by organisations working to address the needs of victims or seeking to influence policy. Thus, comprehensive and cumulative data on sexual violence is lacking and government and civil society responses are based on sporadic and sometimes outdated statistics. Population studies in South Africa indicate that one in four women have experienced intimate partner abuse.<sup>7,8</sup> Young women are often most affected. Between 1996 and 1998, girls 17 years and younger constituted 40% of rape and attempted rape cases in the country.<sup>9</sup> Data from a study among adolescents shows that women experience violence at an early age, with 32% of pregnant teenagers and 18% of non-pregnant teenagers having experienced forced sex or rape as their first sexual encounter.<sup>10</sup> Although women and children are most commonly affected by gender-based violence (GBV), men also experience it. In the Eastern Cape province 10% of men reported being indecently assaulted by a man.<sup>5</sup>

Male sexual violence directed at intimate partners is well documented. A study in Cape Town showed that 15% of men participating in a survey reported having perpetrated sexual violence against an intimate partner in the last 10 years.<sup>11</sup> Such violence was seen to be associated with factors such as alcohol abuse, conflict outside the home, having more than one current partner and conflict which resulted in the men feeling that their authority had been undermined. A recent MRC study that focused on men's perpetration of sexual violence in the Eastern Cape and KwaZulu-Natal provinces revealed a number of startling results. Of those interviewed (1 738 men, 70% under 30 years), 28% reported having raped a woman or girl and 3% reported raping a man or boy. About half of the men who reported rape said they had done so more than once and three-quarters of them said they had engaged in this behaviour for the first time before they were 20 years old. Men who had perpetrated more than one episode of physical intimate partner violence were more

likely to have HIV and to engage in high risk behaviours such as having sex with a sex worker, consuming high levels of alcohol, using condoms inconsistently, having more than 20 lifetime partners and being sexually violent. In total, 42% of the men reported having been physically violent toward an intimate partner.<sup>5</sup>

In the South African context other vulnerable groups such as migrants, incarcerated populations, refugees, men-who-have-sex-with-men, lesbians and sex workers are at increased risk of being targeted for GBV. Examples include 'correctional rape' targeted at gays and lesbians; rape within prisons; and rape and sexual harassment by uniformed staff at border posts. Vulnerable groups also experience limited access to information, prevention and support services.

There is limited information and knowledge on the extent of sex and sexual violence in prisons. The Department of Correctional Services annual report for 2002/03 indicates that little is known about male prisoner sexual abuse and confirmed the absence of statistics or reports on incidents of prison rape. In 2001 Goyer estimated that in the Westville Medium B Prison, more than 50% of inmates engaged in anal sex either in consensual relationships or as a result of threats or coercion.<sup>12</sup> Sexual violence contributes not only to the cycle of sexual abuse and to other forms of violence within prisons, but also spills into communities when prisoners return home.<sup>13</sup>

The HIV infection rate in prisons is estimated to be more than double that of the general population.<sup>14</sup> A study by the Institute for Security Studies estimated in 2004 that 40% of prison inmates were HIV infected the year before.<sup>15</sup>

## Policy and legal context in South Africa

Contemporary international and various national laws and policies uphold gender equality, people-centred development and health and human rights. Current responses to SGBV in South Africa, however, focus primarily on the criminal justice system and health services. Recognising the importance of addressing widespread sexual violence and noting the complexity of addressing prevention and comprehensive sexual assault care, the National Department of Health (NDoH) developed the National Sexual Assault Policy and accompanying Guidelines that were launched in 2005.

The vision of the National Sexual Assault Policy is a high-quality, well co-ordinated and holistic sexual assault service that meets the needs of the rape survivor, the needs of the criminal justice system for well-presented medico-legal evidence and the needs of the community in contrib-

uting to community protection and justice.<sup>16</sup> The aim of the Management Guidelines is to equip health-care providers with tools to facilitate examination, treatment and management of sexual assault patients and to provide standards for the provision of health care and the collection of forensic evidence for sexual assault survivors.<sup>17</sup>

Research which analysed the 2 608 rape cases reported in Gauteng in 2003, showed that only 17% of reported cases made it to trial and almost one-quarter of these were withdrawn. In only 6.2% of all reported rape cases was the perpetrator convicted.<sup>18</sup>

In 2009, following recent changes to the laws and associated advances in research, the NDoH decided at a stakeholders meeting to revise both the policy and guidelines.<sup>19,20</sup> This process is currently underway and it is hoped that the new documents will be launched in 2010.<sup>a</sup> Issues that are being addressed include:

- alignment to the current legislation, especially changes to the definitions of rape, sexual offences and sexual violation;
- inclusion of additional information on paediatric care;
- including recent data on the epidemiology of sexual violence in South Africa;
- an increased focus on mental health care;
- updated regimens for the treatment of sexually-transmitted infections and for HIV post-exposure prophylaxis (PEP);
- expanding the provision of follow-up care and adherence support; and
- providing guidelines on the compulsory HIV testing of alleged sexual offenders.

As with the previous policy and guidelines, dissemination and subsequent implementation will be critical for improvement in service delivery. This will require strengthened co-ordination and engagement and close collaboration with civil society. Resources will be required to strengthen capacity in both government and non-government sectors.

The HIV and AIDS and STI Strategic Plan (NSP) for South Africa 2007-2011 represents the NDoH's response to the challenge of HIV infection and the wide-ranging impact of AIDS.<sup>21</sup> The NSP is informed by the nature, dynamics and character of the epidemic – as well as by developments in medical and scientific knowledge. The NSP addresses gender-based violence under key priority four: human and legal rights – focusing on the human rights of women and girls, including those with disabilities, while mobilising society to stop gender-based violence and advance equality in sexual relationships. A

a Personal Communication: R. Jina, September 17, 2010.

further clause of the NSP seeks to ensure implementation of existing laws and policies that protect women and girls from gender-based violence.

The 365 Day National Action Plan to End Gender Violence is a comprehensive and concerted initiative with measurable targets and indicators to which South Africans from all walks of life, in all spheres of government and at all levels of society, can contribute.<sup>22</sup> The Plan adopted the tenets of the 2006 Kopanong Declaration. This Declaration envisaged that each year the Sixteen Day campaign on gender violence would become a platform to both heighten awareness and take stock of gaps and achievements and to ensure sustained, measurable efforts to end gender violence. The Plan addresses key issues such as multi-sectoral approaches to SGBV, adequate budget allocation, provision of comprehensive treatment and care for all SGBV survivors, including the provision of PEP and reducing cases of rape in line with the South African Police Services target.

Most violence is directed at women by their partners, often in the home. Intimate partner violence was never criminalised in the past until 1993 when the Prevention of Family Violence Act (Act 133 of 1993) was enacted. This law also criminalises rape in marriage. The National Crime Prevention Strategy of 1996 also addressed violent crimes against women and children as a priority. Furthermore, in 1998 the government passed the Domestic Violence Act (Act 118 of 1998) and in 2003, the Policy Framework and Strategy for Shelters for Victims of Domestic Violence in South Africa.<sup>23</sup>

Insufficient attention is paid to the needs of children exposed to violence.<sup>24</sup> Research shows that the prevalence of sexually abused children in South Africa is high. Of the 55 000 cases of rape reported to the police in 2005-2006, 40% were children under the age of 18 and, of those, 14% were less than 12 years old.<sup>18</sup>

Section 72 of the New Sexual Offences Act provides for the implementation of Chapters 1 to 4 and 7, which mainly deal with the creation of statutory sexual offences, special protection measures for children and persons who are mentally challenged, certain transitional arrangements and evidence-related matters. The Act will help intensify South Africa's efforts to combat sexual crimes against all people, but especially those committed against vulnerable groups, including women, children and people who are mentally challenged. Other critical areas included in the Act are offences relating to sexual exploitation or grooming, exposure to or display of child pornography or pornography to children and the creation of child pornography.

Despite the plethora of progressive and comprehensive policies in place, implementation remains a challenge. Implementation

of the 365 Day Plan, which can be viewed as the overarching GBV strategy, has not been monitored adequately and progress has been slow. The Anti-Rape Strategy has been launched, but without further action. Factors contributing to poor implementation include a lack of collaboration and co-ordination, limited consultation with NGOs, lack of resources, lack of political commitment and providers lacking in implementation skills. There are also many challenges in terms of capacity, poor understanding of the medical needs of survivors, misconceptions regarding the necessity for a police report prior to accessing medical attention, and delays.

## A multi-sectoral response to SGBV

There are a number of broader social dynamics and risk factors that underpin the problem of sexual assault and GBV – including gender inequality, poverty, unemployment, income inequity, alcohol consumption and access to firearms. In a survey of 63 countries, South Africa was found to have the worst income inequality and homicide rates of any of the countries surveyed. Income inequity has been found to be a strong predictor of violence. South Africa also has the highest per capita alcohol consumption and firearm death rates in the world.<sup>25</sup> A third of women killed by partners were shot and many with legally-owned guns.<sup>26</sup>

In May 2009 a multi-sectoral symposium bringing together a diverse group of 96 role players working in South Africa was convened. The group recognised that the country faces an overwhelming SGBV problem. Not only was this recognised as a violation of human rights of women and girls, it was also acknowledged as a major cause of mortality and morbidity and a key driver of the HIV epidemic for women.<sup>27</sup>

The importance of traditional and religious leaders involvement was also stressed at the symposium.<sup>27</sup> Traditional leaders are influential in most rural communities in southern Africa and play a key role in advocating and driving social mobilisation initiatives that address HIV and AIDS and SGBV.<sup>28</sup>

In response to the intersectoral collaboration required in managing survivors of rape and sexual assault, one-stop centres have been established across the country. These centres consist of a combination of multi-disciplinary teams comprising police investigators, health-care providers, community volunteers, social workers and prosecutors.<sup>18</sup> Most developed are the Thuthuzela<sup>b</sup> Care Centres (TCCs) that were established by the National Prosecuting Authority (NPA), with the support of United Nations Children's Fund and the involvement of other related government departments, in a bid to improve the reporting, service provision and successful prosecution of rape and other sexual offences. First established in GF Jooste Hospital in Manenberg in 2000,<sup>18</sup>

b A Xhosa word meaning comfort.

there are now 17 centres across the country, although the NPA had planned to expand the number to 22 by 2009.<sup>29</sup>

The TCCs have succeeded in reducing the waiting times for survivors, but the quality of care is still questionable.<sup>18</sup> A review in 2007 found that there was poor awareness of the National Management Guidelines amongst service providers, poor adherence to good clinical practices, a lack of follow-up care, insufficient staffing and resources and a lack of training.<sup>30</sup> The special needs of children, in particular, were not being addressed.<sup>30</sup>

The NPA has reported a higher rate of convictions at TCCs – 62% in 2004 and 83% in 2006/7 as opposed to rates at other sexual offences courts – 42% in 2004 and 65% in 2006/7.<sup>31,32</sup> Several concerns regarding one-stop centres exist, including the fact that they tend to be located in urban areas and may not be accessible to all. This implies that the model cannot provide the only solution to the provision of rape services and need to co-exist with other lower-level health services that are able to provide immediate care and, where necessary, referral for forensic examination. Concerns regarding the impact on other nearby health facilities also exist as there is anecdotal evidence that clinics previously providing post-rape services now refer survivors to one-stop centres, which may result in longer delays or other challenges in accessing care. Another concern is that these centres focus primarily on the provision of justice and may not be focusing on medical care. Furthermore, only specific cases considered to be more defensible are submitted for trial, thus reducing access to justice for many.<sup>29</sup> Finally, a major concern with TCCs is the dependence on donor funding.<sup>18,29</sup> With almost no financial support from government, sustainability of the centres is thus a major concern.

## Health impact and health sector responses to SGBV

In addition to the fatal outcomes, there are a wide range of non-fatal health outcomes of SGBV including physical, sexual, reproductive, psychological and behavioural. Given the broad range of health outcomes, a comprehensive and long-term approach is required to provide an appropriate package of health-related interventions at the appropriate time. Although Table 1 describes the varied health consequences of SGBV some outcomes, such as STIs and unwanted pregnancy, are more prevalent than others and have a higher possibility of occurring. Other outcomes are more long-lasting and may have a higher relative impact on morbidity. Women experiencing GBV are less likely to be able to negotiate safe sex, use family planning or access reproductive health services. Yet, existing responses for GBV are often narrowly focused and do not address reproductive health needs comprehensively.

**Table 1: Health consequences of sexual and gender-based violence**

SGBV is a public health issue			
Fatal outcomes	Non-fatal outcomes		
	Physical	Sexual and reproductive	Psychological and behavioural
<ul style="list-style-type: none"> <li>➢ Femicide</li> <li>➢ Suicide</li> <li>➢ AIDS-related mortality</li> <li>➢ Maternal mortality</li> </ul>	<ul style="list-style-type: none"> <li>➢ Fractures</li> <li>➢ Chronic pain syndromes</li> <li>➢ Fibromyalgia</li> <li>➢ Permanent disability</li> <li>➢ Gastro-intestinal disorders</li> </ul>	<ul style="list-style-type: none"> <li>➢ Sexually-transmitted infections, including HIV</li> <li>➢ Urinary tract infections</li> <li>➢ Unwanted pregnancy</li> <li>➢ Pregnancy complications</li> <li>➢ Vaginal bleeding</li> <li>➢ Traumatic gynaecologic fistula</li> <li>➢ Unsafe abortion</li> <li>➢ Chronic pelvic pain</li> </ul>	<ul style="list-style-type: none"> <li>➢ Depression and anxiety</li> <li>➢ Eating and sleeping disorders</li> <li>➢ Drug and alcohol abuse</li> <li>➢ Poor self-esteem</li> <li>➢ Post-traumatic stress disorder</li> <li>➢ Self harm</li> </ul>

Source: Bott et al., 2005.<sup>33</sup>

As described in Table 1, sexual violence has a wide range of effects and, apart from physical and emotional harm, stigma and social ostracism, women suffer sexual and reproductive health implications such as unwanted pregnancy, sexually-transmitted infections and the risk of HIV infection.<sup>34</sup> The links between gender-based violence and HIV and AIDS are pronounced in the areas of sexual abuse of adolescent girls, sexual violence between partners, sexually-transmitted infections, domestic violence and sexual violence.

Gender-based violence and gender inequality are often cited as determining factors in women’s risk of contracting HIV and AIDS. The underlying gender power imbalance affects women’s ability to protect themselves and studies have shown that forced sex, for example, limits a woman’s ability to effectively negotiate preventative behaviours such as the use of condoms.<sup>35,36</sup> A study in South Africa reported that the experience of violence and controlling behaviour of male partners are strongly associated with the risk of HIV infection in women.<sup>6</sup>

A recent study which followed up 1 099 HIV-negative women aged 15-26 years showed that women who reported more than one episode of intimate partner violence at baseline were 50% more likely to become HIV-positive than those who reported none or one episode.<sup>37</sup>

Women’s vulnerability to HIV and AIDS is mediated by sexual violence in a number of ways, both directly and indirectly. Direct risks of sexual violence include transmission occurring during rape if the perpetrator is HIV-positive, while those who experience anal rape are at greater risk of HIV infection.



Intimate partner violence poses indirect risks for HIV infection in a number of ways: men who are abusive towards their partners are more likely to have multiple sexual partners, be HIV infected, have sex more frequently and impose unsafe sexual practices on their partners.<sup>5</sup> Violence or fear of violence may deter women from seeking HIV testing, stop them from disclosing their status and discourage them from accessing counselling and treatment.<sup>38</sup>

Young women's reproductive health vulnerability and the link with sexual violence was reported in a recent article by Speizer and others.<sup>39</sup> Programmes which address sexual transmission of HIV in South Africa often ignore the mediating factor of sexual and physical violence on women's lives. In KwaZulu-Natal, a study showed that coerced first sexual experience was significantly associated with the likelihood of ever being pregnant, having had an unwanted pregnancy and having experienced a sexually-transmitted infection.<sup>40</sup>

## Primary prevention

Interventions targeting the primary prevention of gender-based violence are critical and complex, but also the most difficult to implement and assess. This is because primary prevention seeks to change the underlying norms, attitudes and behaviours of individuals, communities and society. Primary prevention addresses issues related to the low status of women, gender roles and power imbalances.<sup>41</sup> Despite the implementation of a number of prevention programmes targeting various groups and levels in the country (e.g., Men

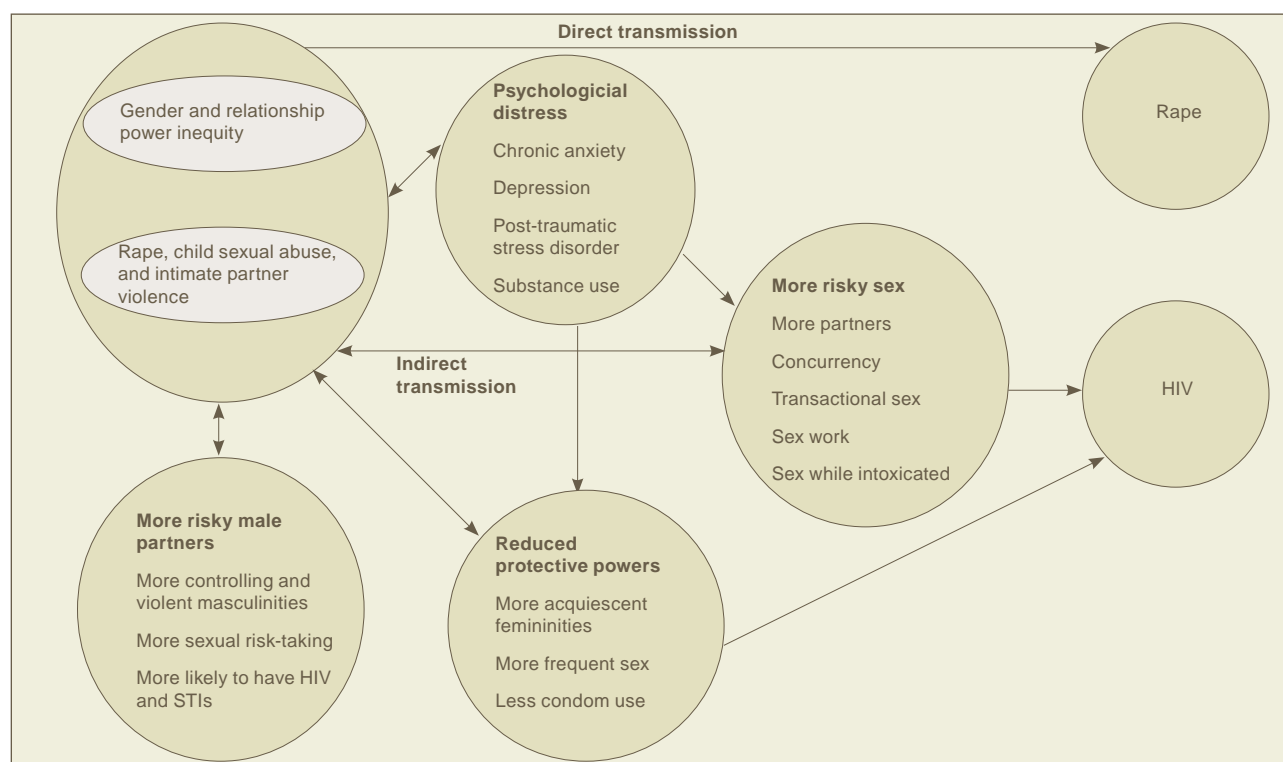
as Partners, One Man Can Campaign), there are two prevention interventions that have been shown to be particularly effective in reducing SGBV, namely the Stepping Stones and IMAGE interventions.

The Stepping Stones study evaluated a gender-transformative programme aiming to improve sexual health through building stronger and more gender-equitable relationships.<sup>42</sup> The intervention was implemented in 64 rural villages and six townships in the Eastern Cape. A total of 2 800 young men and women were interviewed, tested for HIV and herpes at the inception of the intervention and followed up after two years. Men who had been in the programme for two years had a 33% reduction in new infections of herpes and were 38% less likely to have perpetrated physical and sexual intimate partner violence. They also had fewer partners, less transactional sex and were less likely to abuse alcohol.

The IMAGE study was a cluster randomised trial that combined micro-finance with gender and HIV training. Loans were provided to the poorest women in villages in a rural area of Limpopo and one-hour gender and HIV sessions were conducted during loan repayment visits. Results of the study showed that, after two years, the risk of physical and sexual violence in the preceding year was reduced by 55%.<sup>43</sup>

Overall, there has been a mixed response to preventative efforts – not all have been completely successful and sustaining the change is still problematic. Similarly, success has only been reported in limited settings and wider expansion of programmes has not yet occurred.<sup>41</sup>

**Figure 1: Hypothesized direct and indirect pathways for HIV acquisition**



Source: Jewkes et al., 2010.<sup>37</sup>

## Secondary prevention

Project Ndabezitha is an example of secondary violence prevention that trains traditional leaders and prosecutors to deal with domestic violence, while NERINA-Stepping Stones in Port Elizabeth focuses on tertiary prevention for child perpetrators.<sup>44</sup> The Vezimfihlo package has been used to train primary health care nurses and HIV counsellors to screen for intimate partner violence, but long-term maintenance of the programme has been challenging.<sup>45,46</sup> Similar training on the Domestic Violence Act has been provided to primary health care nurses by the Gender Advocacy Project.<sup>47</sup>

For the health sector, however, the core focus remains providing medico-legal services that, although pertaining to secondary and tertiary prevention, can indirectly lead to change at the primary preventative level.

Medico-legal services provide for both the medical and legal needs for survivors of rape and sexual assault. Medical needs include the care and management of injuries, immediate and long-term psychological care, prevention and management of unwanted pregnancies and infections, including HIV. Legal needs include the documentation and collection of evidence, including the recording of injuries.

Medico-legal health services in South Africa have undergone drastic changes since 1994. Delivered as a vertical programme, services were provided by district surgeons employed by the Department of Health. This resulted in fragmentation of service delivery, limited access especially in rural areas, varying provision of services and often poor quality of care.<sup>48</sup> In 2002 the district surgeon services were removed and medico-legal services were integrated with primary health care responsibilities, which improved the accessibility of services.<sup>49</sup> These changes were, however, made without adequate planning, resulting in untrained and inexperienced doctors being required to provide these services.<sup>49,50</sup> These doctors were ill-prepared and lacked confidence to conduct examinations and collect evidence and the services were characterised by long waits, structural inadequacies, lack of intersectoral collaboration and poor practices by health-care providers.<sup>50,51</sup> A study that investigated women's preferences found that having a sensitive health-care provider and PEP were more important to women than the distance they would need to travel to access these services.<sup>52</sup>

## Comprehensive post-rape clinical care

While the need for a multi-sectoral response to SGBV is clear, how to ensure co-operation and collaboration between sectors for policy and service delivery is not. The SGBV response is not co-ordinated, nor is a multi-sectoral approach promoted. Opportunities are missed for integrating SGBV prevention, screening and services, while successful models are not replicated. Furthermore, while a large proportion of survivors of rape and SGBV are children, the services are geared towards adults.

Despite numerous opportunities existing for the health sector to provide care for SGBV survivors, it has lagged far behind other public sectors (e.g. criminal justice) in tackling the issue. Clients attending health facilities for various health needs come into contact with health-care workers as a point of first contact. While some victims or survivors presenting at health facilities will disclose that they have been violated, others may not despite having symptoms. Early identification could help with treatment, limit the consequences and decrease further violence. However, many health-care workers know little about national legislation on domestic violence, or how to manage SGBV clients.

Yet there are many ways in which the health sector could be strengthened to deal with the issue. These include:

- identifying appropriate medical and counselling services;
- making health services available at the first point of contact;
- facilitating referrals to other services;
- integrating medical services;
- developing health-care workers' capacity to screen routinely for SGBV;
- enhancing the capacity of health-care workers to diagnose accurately – especially for children;
- clarifying the legal requirements for reporting an assault – or suspicion of an assault; and
- strengthening the role of forensic evidence in prosecution.

Given the complexity of the service needs and delivery systems, the provision of PEP cannot be implemented in isolation, but must be considered as part of a systematic approach to the prevention of GBV and to caring for sexual assault survivors. After sexual assault, meeting the immediate sexual and reproductive health needs (including STI care, pregnancy prevention, treatment of injuries and counselling) is a priority. Even in the absence of HIV-PEP, there is still a need for timely emergency contraception, prophylaxis for Hepatitis B, prophylaxis for sexually transmitted infections, while sometimes, in cases of rape, legal termination of pregnancy needs

to be provided. This highlights the importance of early and integrated services by a multi-disciplinary team of service providers. In addition, medical evidence is of critical importance in the investigation and prosecution of sexual assault perpetrators. The need for mental health care following post-rape care is extremely important, but the proportion of survivors receiving psychosocial follow-up is unknown.

Adherence to PEP regimens remains poor even with the provision of psychosocial support and can be influenced by a number of factors such as being blamed and not receiving social support.<sup>53</sup> Further research is needed to support the development of interventions that acknowledge the complex barriers to PEP adherence after rape.<sup>54</sup>

In 2007 the NDoH recognised the need for improved training and a programme with a standardised curriculum was launched in 2008, after being piloted with doctors and nurses across eight provinces.<sup>53,55</sup> Further rollout has been problematic as the programme requires 10 days of residential training. The Criminal Law Amendment Act (Act 32 of 2007) requires that the Minister of Health table a national training curriculum in Parliament, but this has not yet been done.<sup>20</sup>

Due to the poor rollout of the national training curriculum, most health-care providers are still not equipped with the skills to make decisions around when to test for HIV before providing PEP; under what circumstances to provide the three-day starter pack, rather than a full 28-day course; which drug combinations to provide – the PEP regimen and treatment of STIs, or PEP for children younger than 14 years. STI treatment is based on body weight or body surface area which makes it complex and challenging for some health-care workers.

Attempts have been made to train nurses to do sexual assault examinations. This began with small groups of nurses being trained in the Eastern Cape by international and local experts in 1997 and has slowly evolved so that, currently, Forensic Nursing Diplomas are offered by a number of nursing colleges across the country. However, these qualifications are not yet recognised by the South African Nursing Council. As a result, some provinces have fully trained forensic nurses who are recognised as experts in court, yet forensic nurses are not utilised at all in other provinces.

Although the South African antiretroviral (ARV) guidelines recommend a 28-day regimen of a combination of ARV drugs, the Population Council recently conducted a review of site-level data conducted in two provinces which identified gaps at different levels of service provision.<sup>56</sup> Mechanisms to monitor and follow up clients for side effects were not in place and administration of ARV drugs, HIV testing, emergency contraception and referral were weak. In many cases doctors did not specify the medication and simply wrote “PEP” on the prescription, leaving pharmacists to use their own discretion

as to what medication to dispense. Survivors often had to relive the traumatic memory when repeating the history of their assault to the pharmacist as well. Misconceptions about the need to open a police case before accessing PEP still exist among some health-care workers, leading to delays in survivors accessing treatment. Providers also lack understanding of the need to treat HIV-PEP service delivery as an emergency. This review also showed that referrals beyond the initial contact for mental health or other services, including HIV services for those testing HIV-positive at the initial visit, were rare and in the majority of cases this information on referral was missing.

## Services for children

Despite the above-mentioned developments, there has been minimal attention paid to services for children. As a result, care of children is generally restricted to specialised centres and providers outside of these centres often have no knowledge relating to the immediate needs of children. Long-term care, the provision of psychological support, and services for the protection of children are poor.<sup>57,58</sup> This is, however, one area on which the revision of the national policy and guidelines and the national training curriculum focuses.

## Recommendations

- Improve the collection and analysis of information related to the incidence, prevalence and trends concerning potential and actual victims of SGBV that will support evidence-based policy-making.
- Develop and evaluate operational models to support implementation of the post-rape management policy framework, with particular attention to the under-resourced rural areas.
- Develop a coherent approach, including co-ordination, collaboration and funding, for informing women, female youth and other community groups about South Africa’s revised SGBV policies and guidelines.
- Strengthen intersectoral linkages and train police and community members on post-rape care so that more survivors seek care within the 72-hour window period.

Develop appropriate policies and strategies for:

- HIV-PEP following non-coercive, potential exposures;
- the role of nurses in SGBV service provision;
- improving PEP adherence and long-term care of survivors; and
- addressing the mental health needs of survivors.



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