USAID South Africa Program in Support Of PEPFAR: Thuthuzela Care Centres FY06

Final Report on the Compliance Assessment of the Thuthuzela Care Centres with National Department of Health Guidelines for Managing HIV in the Context of Sexual Assault

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The author’s views expressed in this publication do not necessarily reflect the views of the United States Agency for International Development or the United States Government.

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ACRONYMS

ART:	Anti-retroviral treatment
ARV:	Anti-retrovirals
COC:	Combined Oral Contraceptive
DOH:	Department of Health
DoSD:	Department of Social Development
EC:	Emergency Contraception
ECI:	ECI*Africa* Consulting
EMS:	Emergency Medical Services
FCS:	Family Violence, Child Protection and Sexual Offences Unit (SAPS)
HAST	HIV, AIDS, STI and TB (Gauteng DOH programme)
HCP:	Health Care Provider(s)
IDMT:	Inter-Departmental Management Team
J88:	Report by Authorized Medical Practitioner on the Completion of a Medico-legal Examination
KZN:	KwaZulu-Natal
NGO:	Non-government Organisation
NPA:	National Prosecuting Authority
OPD:	Out-patient Department
PEP:	Post-exposure Prophylaxis (for HIV)
PEPFAR	President's Emergency Plan for AIDS Relief
POP:	Progestogen Only Pills
POPD:	Paediatric Out-patient Department
RTI:	RTI International
SAECK:	Sexual Assault Evidence Collection Kit
SAPS:	South African Police Services
SOCA:	Sexual Offences and Community Affairs (NPA)
STAT:	refers to a dose of medication given immediately (onsite)
STI:	Sexually Transmitted Infection
TCC:	Thuthuzela Care Centre
TOP:	Termination of Pregnancy
USAID	United States Agency for International Development
VCT:	Voluntary Testing and Counselling (for HIV)
WHO:	World Health Organization

EXECUTIVE SUMMARY

Introduction

The Thuthuzela Care Centres (TCC's) are one-stop facilities for managing sexual assault cases and were introduced as part of South Africa's national anti-rape strategy. Located in public hospitals, the ten TCCs aim to provide survivors with a broad range of essential services – from emergency medical care to counsel to court preparation – in a holistic, integrated and victim-friendly manner.

Objectives and Methodology

The purpose of the study was to assess the extent to which the health care services provided by the Thuthuzela Care Centres comply with the National Guidelines for Sexual Assault Care, with an emphasis on HIV-related issues. The National Guidelines were grouped into two categories namely general health standards as well as specific HIV/AIDS including reproductive health.

A qualitative study was conducted and this was underpinned by interviews with role-players and observations on the facilities. In all cases, data collection tools were used.

Findings of the study

There are basically two models of the TCCs, the medico-legal and the hospital based models. These models are characterized by different management structures and resource allocations. The medico-legal sites tend be stand alone centers that provide services beyond sexual assault care.

Below are summary scores for the overall assessment:

- 2 sites were compliant with more than 75% of the guidelines
- 5 sites were compliant with between 50% and 75% of the guidelines
- 2 sites were compliant with between 25% and 50% of the guidelines
- 1 site was compliant with less than 25% of the guidelines

Major gaps observed

- There are few laws relating specifically to HIV/AIDS or sexual assault care. The Sexual Offences Bill is the only legislation that mandates the provision of post-exposure prophylaxis (PEP) at designated health care centres.
- Health care providers appear to be far more familiar with local protocols than the National Guidelines.
- All the sites provide Voluntary Counselling and Testing (VCT) for HIV; however, the quality of counselling varies from site to site.
- The PEP starter pack is not offered to all patients including those who postpone testing for HIV with the exception of one site.
- Patients are not given the full 28 day pack of PEP after the starter pack which is not consistent with national and international guidelines.
- It is common for patients not to return for follow-up and testing. Most centres do not provide support and incentives for patients to return for further counseling and repeat testing for HIV.

- Most centers do not have skilled personnel in dealing with children and patients with special needs. Most centres record large proportion of children as their clients.
- Many doctors are not adequately trained in dealing sexual assault cases. In many cases, doctors are not trained in filling J28 or 308 forms and often they cannot calculate the PEP formula for children.
- Session and on-call doctors are not supervised with the exception of one site and there are perceptions that services after hours are of poorer standards than during the day.
- The forensic nurses appear to be adequately trained and skilled in providing comprehensive services; however, many sites have vacancies in this category, thus compromising service delivery.
- Vacancies exist in many centres, thus compromising capacity for delivery of quality services.
- The design of some sites is not conducive for protecting patients from secondary victimization.
- Institutional arrangements between role-players and personality traits influence the performance of the sites.

Conclusion and Recommendations

Gaps in compliance are most often attributable to inadequate staffing/resources, lack of training, and lack of awareness of the National Guidelines.

There are several areas where the clinical practices at the TCCs (and in casualty/hospital, generally) are not operating strictly in accordance with the National Guidelines. Differences were noted particularly in the area of HIV testing (availability of VCT 24 hours/option to delay testing) and PEP administration (use of 3d drug/schedule for supplying PEP to patients), as well as prophylactic treatment of STIs and other infections. Getting patients to return to the site for testing and PEP, or to finish the course of PEP, poses a major challenge for most sites.

The TCC model is a good one, but implementation is uneven across the current ten sites. There is a need to review and strengthen implementation of the model before rolling out additional TCCs.

The following recommendations are made:

a. Strengthen partnerships between role-players and clarify roles and responsibilities.
b. Fill vacant posts and recruit enough staff in order to operate services 24 hours. Appoint volunteers for suitable positions.
c. Provide training regularly to staff and other role-players who are responsible for service delivery.
d. Purchase equipment and upgrade facilities.
e. Establish and strengthen relationships with referral organizations.
f. Review local protocol and ensure conformity with National Guidelines.

PART I: INTRODUCTION AND BACKGROUND

1. INTRODUCTION

The Thuthuzela Care Centres (TCC's) are one-stop facilities for sexual assault survivors, introduced as part of South Africa's national anti-rape strategy.[2] Located in public hospitals, the TCCs aim to provide survivors with a broad range of essential services – from emergency medical care to counselling to court preparation – in a holistic, integrated and victim-friendly manner. The goal of the TCC model is to effectively address the medical and social needs of sexual assault survivors, reduce secondary victimization, improve conviction rates and reduce the lead time for finalization of cases.

The Thuthuzela project is an interdepartmental collaboration between the departments of Justice, Health, Safety and Security, Social Development, Education, Local Government, Correctional Services, Treasury and designated civil society organizations (at the project site). The project is led by the Sexual Offences and Community Affairs (SOCA) Unit of the National Prosecuting Authority (NPA) and managed by a high-level Interdepartmental Management Team (IDMT) consisting of representatives of all member departments at national level.

Services offered by the TCCs include: reception and comforting of client; information counselling on services and procedures; history taking and medical-legal examination; prophylaxis and treatment for pregnancy, sexual transmitted infection (STI), and HIV; bath or shower, refreshments and change of clothing; transportation home or to safe shelter; referrals; and follow-up support. At some TCC sites, clients are able to open a case on-site, give their statement to the police, and/or receive longer-term psycho-social counselling and other support services. Case management and support relating to the client's criminal case are provided by a case manager and/or victim assistant. Effective delivery of services requires ongoing coordination and cooperation of all relevant stakeholders, including police, health care professionals, prosecutors, social workers and affiliated NGOs.

There are currently ten (10) TCCs in South Africa, located in six of the nine provinces. These include:

<u>Eastern Cape</u>
- St. Barnabas Hospital (Libode)
- Cecilia Makiwane Hospital (Mdantsane)

<u>Gauteng</u>
- Chris Hani Baragwanath Hospital (Soweto)

[2] Sexual assault services are provided nationally by a wide range of health service providers, including but not limited to the TCCs. These include independent NGO-run centres, and crisis centre units within public hospitals and community health centres. Sexual assault management is also part of the overall health service package coordinated through district health services, and may also be provided by private doctors, clinics and hospitals. Most service providers are not able to offer a full-range of services, however, and links between health and the justice system are generally not well established outside the TCCs.

- Natalspruit Hospital (Katlehong)
- Mamelodi Hospital (Pretoria)

Kwa Zulu Natal

- Prince Mshiyeni Hospital (Umlazi)
- Mahatma Gandhi Memorial Hospital (Phoenix)

Northern Cape

- Galeshewe Day Hospital (Kimberly)

North West

- Mafikeng Hospital (Mafikeng)

Western Cape

- G.F. Jooste Hospital (Mannenburg)

The first TCC was launched at G.F. Jooste in 2000; the newest centre opened in Mafikeng in November 2006. A further roll-out of the TCC model is planned in 2007-2008.

The South African government took a decision to begin providing post-exposure prophylaxis (PEP) to victims of sexual assault in 2002. The provision of PEP, in a country with a high prevalence of HIV, is reportedly one of the services most valued by victims of sexual assault, along with access to justice. By most reports, the Thuthuzela model has been effective in improving overall care to victims of sexual assault and increasing the chance of successful prosecution in court. Despite these successes, however, gaps have been noted in the implementation of systems to prevent HIV transmission. In a recent study by the South African Medical Research Council, for example, only 15% of patients from the Mannenburg TCC were found to have completed the 28-day course of PEP.[3]

In 2004, the South African National Department of Health (DOH) produced comprehensive National Management Guidelines for Sexual Assault Care ("National Guidelines") in public health facilities. The National Guidelines provide an implementation framework to improve the quality of health care provided to sexual assault patients across South Africa, and to reduce the secondary trauma commonly associated with the process of seeking sexual assault care. Included in the National Guidelines are both general health standards for sexual assault management as well as specific standards relating to medical-legal examination and documentation, psychological support, reproductive health, and HIV. With respect to HIV, these include voluntary testing and counselling, provision of PEP, follow up HIV testing, and referral of HIV positive patients for further HIV management.

1.1 Objectives/Mandate of Study

In February 2007, RTI International, commissioned ECIAfrica Consulting (ECI) to conduct a "Gap Analysis" of the Thuthuzela Care Centres on behalf of the SOCA Unit, USAID and the IDMT. Funded by PEPFAR, the overall purpose of the project was to review HIV/AIDS services offered by the TCCs in relation to the National Guidelines

[3] Christofides, N. et al, "Including Post-exposure Prophylaxis to Prevent HIV/AIDS Into Post-Sexual Assault Health Services in South Africa: Costs and Cost Effectiveness of User Preferred Approached to Provision," Medical Research Council, 2006. Although some TCCs report higher rates of compliance, data collection and monitoring is not adequate at most sites to provide reliable compliance figures.

and to develop a system for more effective monitoring and evaluation of HIV-related care.

Specific objectives included:

- to determine what practices and procedures relating to HIV are currently followed at each TCC site;
- to assess the extent to which the HIV/AIDS related services provided by the TCCs comply with the National Guidelines;
- to identify gaps in compliance with the National Guidelines;
- to develop recommendations to address gaps and weaknesses in compliance;
- to assess how HIV/AIDS services are monitored and make recommendations on how the current system can be enhanced; and
- to identify operational challenges impacting on the TCCs' ability to provide quality HIV/AIDS related services.

Because HIV-related services are offered at the TCCs within the larger context of sexual assault management and health care service delivery, the gap analysis also considered the overall context in which HIV services are provided at the TCCs and the general challenges faced by the TCCs in delivering quality sexual assault care. This is reflected in the study's analysis of TCC compliance with the general principles and standards of the National Guidelines. Researchers also looked generally at services provided; number of service providers and their roles; network of support and/or referral services provided; intersectoral cooperation; monitoring/ data collection systems; and some service quality elements.

Given the limits of its mandate, however, ECI did not attempt in this research to assess all services provided by the TCCs per the TCC "Blueprint," or to assess TCC compliance with all standards for sexual assault management covered by the National Guidelines. In particular, the study did not specifically assess TCC compliance with respect to the medico-legal examination (history taking, medical examination and collection of forensic evidence) or related issues such as documentation, protection of evidence and testimony in court. As a result, these issues are only addressed in the report to the extent that persons interviewed at the TCCs raised them as specific challenges or areas of concern. The study also did not aim to evaluate the individual performance of any health care providers or assess the impact of TCC services. Focus was rather on identifying the general practices and procedures followed by TCC health providers and noting gaps and challenges.

1.2 Methodology

The research study was conducted from March - June 2007 in five phases. Phase one consisted of a review of background documents and relevant secondary research, including a detailed analysis of the National Guidelines and World Health Organization standards for sexual assault management. Phase two included an audit of relevant South African legislation and other policy documents. The research design was completed in phase three, and data collection/field research in phase four. Phase five consisted of data analysis and drafting of the research report. A one-day stakeholder workshop was held on June 27, 2007 to present and validate the preliminary findings

of the research and to develop recommendations to address major gaps in compliance.

Researchers employed qualitative methodologies based largely on site observations and interviews. Interviews were based on semi-structured questionnaires and directed primarily at health care practitioners, TCC site coordinators, and other TCC service providers. To avoid causing secondary trauma to sexual assault survivors, no TCC patients or care-givers were included in the interview sample.

Key components of the field research included:

- 1-2 day site visits to each of the ten TCCs.
- Tour of the facility (infrastructure, layout, equipment, supplies).
- Interviews with key health care providers (doctors/nurses/counsellors) and non-health care staff (site coordinators/victim assistance officers).
- Interviews with hospital management and affiliated NGOs, clinics, and/or hospital service providers providing referral services for TCC patients.
- Identification/collection of written protocols, guidelines, consent forms and/or informational materials.
- Identification of data collection/monitoring/reporting tools and instruments used at each site.

1.2.1 Interview Schedules

In order to ensure consistency in the research across sites, ECI developed standardized interview schedules based in part on assessment tools developed by the South African Medical Research Council,[4] as well as the standards and policy framework provided by the National Guidelines[5]. Separate questionnaires were developed for Health Care Providers (HCPs), the TCC Site Coordinator, and Affiliated Health Care Providers /Referral Organizations, in addition to a facility checklist. Interview schedules were approved in advance by the project steering committee and pilot tested at two TCC sites.

Interviews of health care providers focused on the health services provided, protocols or clinical guidelines followed, level of skills and training received, staffing of the facility/division of responsibility, problems and challenges, and staff recommendations for improving quality of care. Detailed questions on practices and procedures with respect to testing and prophylaxis (pregnancy, STIs and HIV) were asked of each health care provider interviewed to assess the site's compliance with National Guidelines for HIV and HIV-related care. Interviews with other TCC staff members, hospital managers, affiliated HCPs and referral organizations focused on staffing and delivery of services, integration of HIV-related issues in information, counselling and follow-up, patient compliance with PEP, concerns relating to patient care, monitoring and evaluation systems, and obstacles to more effective service delivery.

[4] See Christofides N, et al, Gender and Health Research Unit, Medical Research Council, South Africa (August 2006).

[5]

1.2.2 Interview Sample

At each site, the TCC site coordinator was asked to identify the various health care providers responsible for sexual assault management at their site. This generally consisted of a small team of key services providers – i.e. a dedicated doctor or forensic nurse, staff nurses (ranging from professional nurses to nursing assistants), and lay counsellors at some sites – as well as various on-call doctors and general staff nurses responsible for after-hours care. Although attempts were made to select a representative sample of day and night staff for interviews, this proved unrealistic due to hospital staffing patterns and the unavailability of most on-call and casualty doctors/nurses to conduct interviews during the site visits. As a result, interviews were conducted primarily with day staff assigned full-time to the TCC, as well as others from the hospital who were on duty and available to be interviewed on the day of the site visit. In most cases, interviews were conducted privately (one on one) with health care providers. In a few instances, however, it was only possible to talk to doctors *en masse* during morning staff meetings, usually for a very limited amount of time.

Through the site coordinators, ECI also identified other key individuals and/or organizations providing services to TCC patients to interview at each site. These varied at each hospital, but generally included affiliated NGOs or service providers (either on or off-site), hospital social workers, psychologists, and/or pharmacists. To the extent possible, ECI also included at least one interview with hospital management (superintendent or CEO) at each site, as well as the managing doctor/matron responsible for the overall management and oversight of the TCC.

1.2.3 Analysis of Compliance

Data collected from the site visits was compiled and synthesized in individual site summaries and compliance matrices. These matrices are attached as Annexures B - K. A comparative summary matrix was also compiled to identify strengths and weaknesses across the ten sites.

The compliance matrices were developed as a tool to assist in the assessment of the TCCs. In designing the matrix, ECI took the various standards discussed in the National Guidelines and consolidated them into 30 categories.[6] The first 12 categories reflect the general guiding principles articulated in the National Guidelines for sexual assault care.[7] Categories 13 and 14 pertain to information provided to patients and the availability of psychological support and counselling services. The last 15 categories (15-30) relate specifically to HIV and reproductive health services, including

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[6] It should be noted that the standards included in the National Guidelines are not enumerated and that the number of categories (30) used to summarize the standards is somewhat arbitrary. Many of the categories could be easily disaggregated or further consolidated – both of which would lead to a different overall “score” or compliance percentage. In addition, some of the standards articulated in the National Standards (i.e. those relating to medico-legal examination) are not included in this summary. As a result, while potentially useful for identifying gaps in services and potential patterns across the sites, care should be taken before drawing conclusions about a site’s overall compliance with National Standards based on this particular instrument.

[7] See National Guidelines, Section 4, pp. 6-7.

testing, treatment, follow-up, referrals, and HIV-related skills. For each category, sites were rated as compliant (a), partially compliant (b), or non-compliant (c). "A" ratings were given where the researchers felt the TCC at least met the minimum standard provided by the National Guidelines for that category of service. Within that rating, sites could range from extremely good to minimally compliant. "B" ratings were given where either 1) the site met some but not all of the standards for that category; or 2) where there appeared to be inconsistencies in skills or delivery of services, depending on who was providing the service or when the patient presented at the site (usually regular hours versus after-hours) Finally, sites received a "C" rating where a standard or procedure included in the Guidelines was not being implemented at all or was being implemented consistently below the standard of service required.

Because of differences in how the TCCs were staffed and/or structured, it was difficult to select a rating methodology that would accurately or fairly reflect the overall compliance at each site. For example, some TCCs are open 24 hours, whereas others only operate during business hours. After hours, on-call doctors may provide services in the TCC, or patients may be referred to casualty or to another hospital. After weighing the pros and cons of various approaches, ECI decided to rate the TCCs based on the services provided to sexual assault patients *in the TCC,* and to exclude from the ratings services provided by the hospital when the TCC is closed. Since more gaps and challenges occur after hours and on weekends, the result of this approach is that TCCs that operate 24-hours may end up with a lower overall score or compliance rating than TCCs that close at 16h00.

1.3 Limitations and Constraints

While every attempt was made to conduct a fair and comprehensive assessment at each site, the following important limitations should be noted:

- The findings from this study are based on self-reporting by TCC service providers. Given the time constraints imposed on the study, it was not possible to obtain ethics approval to review patient medical files or interview patients about their experiences. Without an independent review of files, it was not possible to verify the information reported by health care practitioners or to assess the consistency or quality of the services delivered. This study can therefore be considered an assessment of compliance to the Guidelines, but not an independent "audit" per se.
- Interviews were largely conducted on the basis of availability of health care personnel rather than a scientifically selected sample. It is noted in particular that the reports and opinions reflected in this study are primarily those of regular TCC staff (designated doctors, nurses and NPA staff) servicing the centre during the day, as well as some on-call/casualty doctors and/or nurses on rotation at the TCC. Although efforts were made to interview at least some casualty or "on-call" doctors and "night" nurses at each site, this was not always possible. Moreover, ECI was not able to interview any private session doctors working solely on an on-call basis. Thus, although representative of regular staff, the sample may not reflect a representative sample of all health care practitioners providing services to

- Collection of data was limited to some degree by the demands of patient care. For various reasons, hospitals were not able to make staff available for interviews outside their regular shift. As a result, all health care providers were interviewed while on duty. In some cases, this severely limited the amount of time HCPs had available to be interviewed and the interview schedule could not be completed. In other cases – particularly those who had responsibilities outside the TCC – certain HCPs with whom ECI had scheduled interviews could not make themselves available at all.
- Access to statistical records (re patient care, HIV testing, follow-up, and PEP compliance) was very limited at most sites. In some cases, health staff was unwilling to share data without permission from the Department of Health; in other cases, the data was not available or could not be easily compiled without reference to patient files.
- The final 2004 version of the National Guidelines was only made available to the consulting team after the data collection instruments were developed and five site visits conducted.[8] As a result, some issues discussed in the 2004 Guidelines were not integrated into the initial instruments and therefore were not covered in the interviews at those sites.
- Finally, the timeframe for the background and research design phase of the study was compressed to less than two weeks due to factors beyond ECI's control. This necessarily limited the time available to test and fine-tune the data collection instruments as well as to set up an effective system for data management.

2. BACKGROUND:

2.1 The Thuthuzela "Blueprint"

The Thuthuzela model is based on the concept of comprehensive, integrated, inter-sectoral provision of services to victims of sexual assault. Effective implementation of the model requires all role-players to provide services in a sensitive, thorough, and efficient manner, from the victim's first contact with police to the final dispensation of the criminal case. In this model, health care providers play a critical role in attending to the medical, emotional and psychological needs of sexual assault patients, collecting and documenting evidence, interacting and networking with other professionals involved in the care and management of sexual assault victims, and referral of patients for longer-term care. All role players – including those from the criminal justice system – also play a role in ensuring that patients do not experience secondary trauma through the process of seeking justice and/or medical treatment.

The Thuthuzela "Blueprint" is a four-page document that sets out the basic requirements of a Thuthuzela Care Centre and the responsibilities of the various

[8] The interview schedules were developed based on the 2003 draft version of the National Guidelines provided to the team by the Department of Health.

role-players, including SAPS, Health, Justice/NPA, the Site Coordinator, Case Manager, Emergency Medical Services, NGOs, and/or the Department of Social Development. According to the Blueprint, each TCC should be based in a separate area inside a health care facility, offer services 24 hours a day, and be linked to a Sexual Offences Court. The Blueprint does not provide detailed standards for health care delivery. However, it does require the TCC to have "specially assigned health care professionals responsible for forensic and clinical management," "health care professionals available 24 hours," "support health staff assigned to the TCC," and "provision of preventive and curative medical care." Other requirements are a full staff complement of non-health professionals (site coordinator, victim assistance officer and case manager), NGO or DoSD counsellors, identified referral services, transportation of victims to and from the TCC by EMS or SAPS, "trained charge officers," and "assigned and trained investigating officers/statement taking officers" available 24 hours to take victim statements "*at the TCC*." The Blueprint also sets out the basic facilities, equipment and supplies required at each site, including a "fully equipped sexual assault examination room," spare clothing and comfort items for patients, and adequate communications equipment (telephone, fax, and computers) for TCC staff.

In addition to the Blueprint, some TCCs also have a site-specific protocol, setting forth the responsibilities of each role-player at their particular site.[9] Under these protocols, nurses are generally responsible for providing information to the victim and assisting with intake, examination, record keeping, and protection of evidence. Doctors and/or forensic nurses are responsible for examining the victims "in accordance with established medical procedures" and documenting evidence on the J88 form. The protocols provide various models for crisis counselling, including volunteer "victim supporters" based at the TCC or available on-call. The site protocols do not generally provide detailed guidelines for health care service delivery (except with respect to protection of evidence), although some do make reference to HIV testing and PEP.

2.2 The Legislative and Policy Framework for Sexual Assault Care

2.1.1 Legislation

The legislative framework for sexual assault care in South Africa includes the Constitution and various statutory provisions. Together, these establish a strong right to access health care and to receive appropriate medical treatment.

South Africa currently has very few specific laws relating to HIV/-AIDS or the care and treatment of victims of sexual assault. On May 22, 2007, the National Assembly passed the Sexual Offences Bill, containing provisions on access to PEP. Chapter 5, section 31 creates a legal duty on the part of police, medical practitioners and qualified health practitioners to inform victims of rape or sexual assault (and/or an "interested person" or care-giver) of the importance of obtaining PEP within 72 hours and services available to provide PEP. It also creates a legal

[9] See, e.g. Protocol for the Senakekelwe Thuthuzela Care Centre (Natalspruit), June 2006; and Protocols for the Initiation of Thuthuzela Care Centre (Mannenberg), 6 July 2000.

right for victims of sexual assault to receive PEP for HIV infection at designated public health establishments at State expense, provided that they report within the 72-hour timeframe.[10]

Although not limited to cases of sexual assault, new provisions in the Children's Act[11] pertaining to children's access to medical care are also relevant. Section 129 of the Children's Act decreases the age of consent for medical treatment from age 14 to age 12.[12] It also allows consent to be given by a child under 12 (without consent by a parent or caregiver) where the child is of "sufficient maturity and has the mental capacity to understand the benefits, risks, social and other implications of the treatment." Provisions are also included in the Act to allow a medical superintendent, child protection organization or the children's court to give consent for a child 12 years and under, where circumstances require (i.e. no parent, parent is not available or parent unreasonably withholds consent). Section 130 specifically allows a child over the age of 12 to consent to an HIV test, with additional consent provisions for children 12 years and under. Section 132(1)(2) provides that a child may be tested for HIV only after proper counselling (of the child or the child's parent/care-giver) by an "appropriately trained person," and that "post-test counselling must be provided." Section 133 pertains to confidentiality of HIV test results and Section 134 extends access to contraceptives to children 12 and over without consent or notification of a parent.

Aside from these provisions, South African law only governs the general provision of health care services. This includes the constitutional right of all South Africans to access health care services (including reproductive health care services) and the right to obtain emergency medical treatment. Statutes such as the National Health Act and common law provide a general framework for health care and also regulate such issues as informed consent, confidentiality, and participation of patients in health-care decision making. The Choice on Termination of Pregnancy Act (92 of 1996) establishes the right to terminate unwanted pregnancy, and various statutes govern the qualifications and responsibilities of health care providers.[13] Notably, South African law does not define who is qualified to conduct a rape examination (beyond the standard qualifications for health care practitioners), assign responsibility for sexual assault care to a particular branch of health services, or delineate what health services – beyond PEP – that victims of sexual assault are entitled to receive. In practice, these issues are determined at a policy level, and may differ somewhat from province to province.

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[10] The Sexual Offences Bill also makes provision for compulsory HIV testing of alleged offenders. Survivors of rape or sexual assault may obtain a court order for alleged offenders to undergo compulsory testing and for results to be revealed to them.

[11] Children's Act, No. 38 of 2005.

[12] The Child Care Act of 1983 allows minors over the age of 14 to consent to medical treatment (including HIV testing and PEP) without the assistance of a parent or guardian.

[13] See, e.g., Allied Health Professions Act (1982), Health Professions Act (1974), Nursing Act (1978), and Pharmacy Act (1974).

2.2.2 National Policy on Sexual Assault and National Management Guidelines for Sexual Assault Care

In the absence of specific legislation, the most important documents governing the provision of health care to survivors of sexual assault are government policies and health protocols. Although policies are not legally binding, government employees are required to follow them. At the national level, the key policy documents are the National Policy on Sexual Assault (Dept of Health 2004) and the National Management Guidelines for Care and Treatment of Sexual Assault (Dept of Health 2004).

The National Guidelines were developed by the National Department of Health to provide specific guidelines for implementation of the National Policy, with the overall goal of improving sexual assault care within health services. The Guidelines are largely based on the World Health Organization's Guidelines for Medico-Legal Care for Victims of Sexual Violence (2003), and also embrace many of the key principles of the National Health Act (2003) and the Patients' Rights Charter (1999). Consistent with these documents, the National Guidelines stress the need for sensitivity, training, and appropriate skills on the part of health care workers, and the importance of informed consent, protection of confidentiality, and participation of the patient in health care decisions. The Guidelines also articulate the essential health services that should be made available to all victims of sexual assault, and norms and standards for provision of care. Critical elements include: history taking; medical and forensic examination and use of the SAECK kit; evidence protection and management; information counselling and psychological support; screening tests for HIV, pregnancy, hepatitis and STI; treatment of physical injuries; prophylaxis for pregnancy, Tetanus, Hepatitis, STI and HIV; documentation of findings; referrals; follow-up appointments; and presenting evidence in court.

With respect to HIV, the National Guidelines identify the key issues that should be included in pre and post-test counselling, and provide standards for HIV testing and administration of PEP. Particular emphasis is placed on the need for health care providers to be sensitive to and consider the emotional state of the patient and his or her ability to absorb detailed information with respect to HIV testing and test results. The guidelines also stress the importance of fully briefing patients on the PEP medications and implementing systems or procedures to facilitate full compliance.

TABLE 1: National Guidelines Relating to HIV-AIDS

HIV-AIDS RELATED STANDARDS
• HIV counselling/testing and PEP takes place in the context of comprehensive health services for victims of sexual assault
• Patients are informed about the risk of HIV infection from sexual assault
• Patients reporting within 72 hours are informed about the availability of PEP to reduce the risk of HIV infection in patients who are HIV-
• Patients reporting after 72 hours are informed of the reasons why PEP cannot be offered to them (no impact after 72 hours), offered HIV test and advised to return for repeat HIV test at 3 months
• Patients are informed about window periods, and the need to be tested for HIV at 6 weeks and 3 months
• Pre- and Post-test counselling is provided by appropriately trained and skilled personnel: o Adequate training and experience with VCT generally o Understanding of special needs of sexual assault patients and capacity to provide VCT in the context of sexual assault
• HIV counsellors are sensitive to the emotional state of the sexually assaulted patients, their ability to absorb information and cope with positive results
• Counsellors are able to postpone testing/test results up to three days for patients reporting within 72 hours if the patient does not wish to be tested/receive results in the acute phase.
• HIV testing is offered to all TCC patients
• HIV-related counselling/testing is available 24 hours per day
• HIV-related counselling is conducted in private
• HIV counselling is conducted in a language that the patient understands
• Children >14 years may be tested without parental consent
• Written consent for HIV testing is obtained
• Thorough pre-test counselling is provided
• Where possible, rapid tests are used and test results are provided immediately
• Thorough post-test counselling is provided:
• HIV- patients are advised on how to maintain HIV- status
• The patient's emotional reaction, fears, concerns are adequately discussed/addressed
• HIV+ patients are counseled on living positively
• Confidentiality re: HIV result is assured and maintained;
• PEP/ARV therapy is offered to all patients presenting before 72 hours (where chance of HIV infection); starter pack minimum, with rest of medication provided after patient determined to be HIV-
• No more than five day PEP prior to test results; PEP not offered or stopped where patient knows or tests HIV+
• Pregnant patients (<12 weeks) are advised re risks/benefits of PEP with respect to pregnancy/ allowed to make informed choice
• Recommended regimen prescribed: AZT- 300mg 12 hourly and 3TC –150mg 12 hourly for 28 days; for children the dose is set in accordance with age, weight and height
• Third drug lopinavir/ritonavir 400/100mg 12 hourly is prescribed in all high risk cases
• Patients are counseled re side effects of PEP and how to treat side effects; advised to return if problems
• Anti-emetics are routinely prescribed
• Importance of full compliance with PEP regimen is emphasized
• Strategies to promote compliance are utilized, (including regular follow-up)
• Patients are counseled re psychological impact and coping strategies
• If available, written materials on HIV and PEP are provided to patients to take home in order to reinforce information provided verbally
• Follow up visits at 6 weeks and 3 months are arranged
• Repeat VCT at 6 weeks and 3 months where indicated
• HIV+ patients are referred to appropriate services for long term care/management of HIV

2.2.3 Other relevant legal and policy standards

Health services to victims of sexual assault are also governed by a number of other policies and health protocols. At the National level, these include:

- National Antiretroviral Treatment Guidelines (Dept of Health 2004)
- The National Policy on Testing for HIV (Dept of Health)
- The Patients' Rights Charter (Dept of Health 1999)
- The Service Charter for Victims of Crime in South Africa ("the Victim's Charter") and Minimum Standards on Services to Victims of Crime (Dept of Justice 2004)
- National Policy Guidelines for Victims of Sexual Offences (Dept of Justice 1998) – responsibilities of all relevant stakeholders
- National Drug Policy (Dept of Health 1996) –promoting rational drug use, with an emphasis on ensuring good dispensing and prescribing, safety and efficacy, and availability and accessibility of essential drugs to all citizens.
- Standard Treatment Guidelines and Essential Drug List (Dept of Health 2006)

Additional protocols and treatment guidelines relating to management of sexual assault, HIV counselling and testing, informed consent/confidentiality and anti-retroviral treatment (ART) also exist at the provincial and/or hospital level. Provincial and/or local protocols must conform to national policies; however "guidelines" may be adapted as necessary to take local conditions into account.

A detailed analysis of relevant laws and policies is included in Annexure A of this Report.

2.2.4 International Standards for Sexual Assault Care

International standards for sexual assault care are reflected in the 2003 document developed by the World Health Organization, "Guidelines for Medico-Legal Care of Victims of Sexual Violence." Like the National Guidelines, the WHO guidelines provide standards for all essential elements of comprehensive sexual assault care, from forensic examination to psycho-social services. Many of the guiding principles and standards contained in the WHO guidelines have been incorporated into South Africa's National Guidelines.

Comparative analysis shows that South Africa's National Guidelines relating to HIV management in cases of sexual assault are generally consistent with WHO standards. Like the National Guidelines, the WHO Guidelines state that sexual assault patients should be informed of the risks of pregnancy, STI and HIV transmission from sexual assault, and receive appropriate screening and prophylactic treatment. The WHO guidelines do not provide detailed standards for HIV counselling and testing or PEP administration, however, recommending that practitioners "refer to local protocols" for guidance on these issues.

The main difference between the two guidelines with respect to HIV and reproductive health care is that WHO does not recommend routine prophylaxis for STI or HIV, preferring a case by case approach. This, however, is not inconsistent as the WHO guidelines acknowledge that routine prophylactic treatment may be indicated in certain

high-risk areas. The WHO also recommends baseline blood tests before initiating PEP, while the National Guidelines are silent on this issue.[14] A few differences were also noted with respect to emergency contraception and STI treatment regimes. For example, the WHO guidelines strongly recommend the use of a Stat dose of progestogen-only pills (1.5mg levonorgestrel) for prevention of pregnancy. This is allowed but not required by the South African National Guidelines. The WHO's recommendations regarding choice of antibiotics for STI prophylaxis also differ somewhat from South Africa's recommended regime. Overall, however, there are few inconsistencies in the two documents and both reflect a common approach to HIV and STI prevention in the context of sexual assault care. Both stress the importance of locating HIV-related services within a context of comprehensive sexual assault services, and prioritizing the health and welfare of the patient over other considerations.

PART II: ANALYSIS OF FINDINGS

The findings from the field research are organized into three sections. The first describes the general operation of the Thuthuzela Care Centres and key differences observed between the ten sites. The second analyzes the overall compliance of the sites with the general principles and standards for sexual assault care set forth in the National Guidelines. The third looks specifically at HIV/AIDS and reproductive health services provided by the TCCs and the extent to which reported practices across the ten sites comply with the National Guidelines for HIV-related care.

3. IMPLEMENTATION OF TCC MODEL

The TCC Blueprint provides a model of service provision premised on strong partnerships between the NPA, police, health services, social workers and NGO referral services. The implementation of this model varies from site to site and is dependent on leadership, resources, provincial systems and arrangements within the Department of Health, and the policies and operational systems of partner departments.

Site visits to the TCCs confirmed that significant differences exist in terms of how the TCCs are functioning on the ground. Although all sites experience some operational challenges, some TCCs are performing very well, whereas others are struggling to provide basic services. The study found that while some TCCs are well integrated with hospital services, reasonably staffed and equipped, and operating more or less in terms of the "Thuthuzela Blueprint," others are isolated within the hospital, under-staffed, lacking leadership and suffering from low morale. During the research period, one of the TCCs (Mamelodi) was barely operational, having been "closed" by hospital management.[15] Another site reported that some patients were being diverted by police

[14] According to South Africa's National Anti-Retroviral Treatment Guidelines (DOH, 2004), routine administration of baseline blood tests (full blood count and liver enzymes) is not recommended for a short course of ART treatment such as in the case of non-occupational PEP. However, blood tests should be performed where indicated by the patient's condition. P. 76

[15] At the time of the site visit, new patients were being diverted to a nearby NGO clinic for medical examination and PEP. The TCC continued to provide follow-up services to existing patients and to

to an NGO clinic rather than being brought to the TCC hospital because of long delays in obtaining services. Only six of the ten TCCs currently operate 24 hours per day.

3.1 Structural arrangements, staffing and related challenges

3.1.1 Two Models for Health Services Delivery

All of the TCCs are based in public health institutions. The host institutions include tertiary hospitals, regional hospitals and district hospitals. Of the ten sites, at least two are in a tertiary hospital, three in a regional hospital, four in a district hospital and one in a day hospital. The relations between the TCCs and the hospitals are generally good, yet the degree of integration, cooperation and support varies across sites and is influenced by financing and staffing dynamics, individual personalities, and the extent to which the hospital is responsible for the services.

In general, the TCCs seem to fall into one of two models, with some overlap and variations, as noted below:

Table 1: Different Models for Health Service Delivery

Model 1: medico-legal services	**Model 2: hospital managed**
Sites:	Sites
Chris Hani-Baragwanath Galeshewe [16] Mahatma Gandhi Prince Mshiyeni	G.F. Jooste[17] Cecilia Makiwane Mamelodi Natalspruit St Barnabas Mafikeng
General Characteristics	General Characteristics
• Centre operates independently from other hospital services • Service package includes other medico-legal services, not only sexual assault • Key medical staff (including on-call doctors) are employed by the district and/or province[18] • Receive resources for health services from	• Sexual assault services provided as part of emergency services within the hospital • Sexual assault/domestic violence patients only • All health care practitioners (including on-call doctors) are employed or contracted by hospital • All resources are from hospital budget/

accept "walk-ins." Discussions were underway between SOCA and hospital management to address concerns and develop a way forward.

[16] Galeshewe is unique in several respects, in that it operates largely as an adjunct of the forensic unit at Kimberly hospital. At Galeshewe, only sexual assault victims are seen at the TCC; other medico-legal patients are served by the forensics unit at Kimberly Hospital. After-hours services and sexual assault services for children are provided by the forensic team at Kimberly Hospital.

[17] The TCC at GF Jooste has aspects of both models. The TCC is officially part of the casualty/trauma unit of the hospital and is managed by the hospital. However, like Medico-Legal Services, it operates in a separate unit of the hospital and also receives some funding support from district/region. The TCC has its own roster of on-call doctors/forensic nurses for after-hours care (not shared with casualty), which results in a higher level of skills/experience in sexual assault and forensic examination. Oversight is provided by a senior medical officer who attends implementation meetings and supervises the after-hours team.

[18] An exception is Prince Mshiyeni, where the principal doctor is employed by the hospital. A second doctor and on-call doctors are provided by district services.

outside hospital • Greater autonomy from hospital[19]/ relationship is mainly one of referrals • Support nurses generally provided by hospital • Facility separate from casualty (sometimes located in separate unit away from main building) • Dedicated doctor responsible for the site[20] • Generally higher degree of training/skills in forensic examination • 24 hour service • DOH plays leadership role and role in service provision is clearer	• Hospital management generally more involved/ more knowledgeable about operations and challenges • Facility located in/near casualty or other hospital ward • No full time doctor allocated to the centre. Arrangements for medical supervision vary between sites; more likely to have forensic nurse • After-hours services provided by casualty unit (at TCC or in general casualty ward) • Doctors have more limited training/skills in forensic examination • NPA site coordinator tends to play a stronger management role

Under Model 1, sexual assault services are provided within the broader context of medico-legal services and are more closely linked to district or regional services. With some exceptions, these TCCs generally have better facilities and doctors with specialized training in forensic examination. The centres are also able to draw on outside resources to supplement those provided by the hospital itself. Some aspects of management fall within the jurisdiction of medico-legal services rather than the hospital/TCC. The vertical model seems to be working particularly well at Chris Hani Baragwanath, where the relationship with district/regional medico-legal services is viewed as of major benefit to the centre.

A weakness of Model 1 is that the TCCs are responsible for other medico-legal services besides sexual assault, such that sexual assault patients are sometimes exposed to drunk drivers and even rape suspects in the course of obtaining sexual assault evidence.[21] Division of responsibility for the TCC between the hospital and district services also appears to cause tensions in some cases, i.e. where the hospital lacks supervisory control over staff employed by the district, or responsibility for staffing or resources is not clear.[22]

The TCCs falling under the second model fall entirely under the jurisdiction of the hospital. Resources for health services are derived from the general hospital budget, and the hospital is responsible for management of health and medical staff. The level of support from the hospital is reflected in the quality of the facility and staff assigned to the TCC. Support is often “personality-driven.”[23] For the most part, these centres struggle to provide services due to understaffing in the hospital at large. Except where there is a dedicated health care provider for the TCC (usually a forensic nurse),

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[19] The degree of autonomy varies between sites. At CHB, Prince Mshiyeni, and Galeshewe, there are no shared files and the hospital plays little to no oversight role over the TCC.

[20] An exception is Galeshewe where there is only a forensic nurse.

[21] This is not the case at Chris Hani, which has a separate entrance and special procedures for handling suspects.

[22] For example, one site expressed concern about inadequate supervision and control over on-call doctors provided by district, as well as having on-call doctors servicing more than one hospital at a time.

[23] As one CEO explained, “whether hospitals support the [TCC] is largely individual. I feel a moral obligation to [rape] patients to provide high quality service, but the next superintendent may not.”

nurses and doctors are generally drawn from casualty or other departments within the hospital. A weakness of this model is the lack of specialized training/skills among general hospital staff to provide sexual assault care as well as lack of outside resources to support the operations of the centre. Quality of care is also compromised by the demands placed on casualty and/or on-call doctors responsible for TCC patients in addition to other patients in the hospital. Jooste represents an exception within this category, in part due to certain unique characteristics in the provincial health system. For example, unlike other centres, the hospital pays for after-hours doctors and nurses through its own budget (using a combination of overtime and agency-based session doctors), but then can claim the costs back from region. This enables Jooste to have a dedicated roster of qualified doctors servicing the TCC after hours.

3.1.2 Inter-sectoral dynamics and centre history

Partnership dynamics and differences in the historical set-up of the TCC may also have a bearing on current operations. Most of the TCCs were established at existing medico-legal units or “comfort/crisis centres” already operating within the hospital. Although most have been upgraded, only four were newly established and launched from the beginning as TCCs.

Sites where the TCC model was superimposed on an existing centre are often better integrated with and supported by the hospital,[24] but also tend to experience some power struggles between Health and NPA personnel over management and approach. This is particularly the case where the site coordinator’s responsibilities seem to overlap with that of the health care staff or health facility manager. At many of these sites, the Thuthuzela “brand” is not well-known, and sites still refer to the centre by its original name.

With the exception of GF Jooste, TCCs that were established initially as TCCs do not seem as well integrated into or “owned” by the hospital hosting the site. This is reflected in poorer infrastructure, lack of signage, problems getting supplies, and feelings of isolation among TCC staff. In some cases, ECI found that hospital staff outside the TCCs was not aware of the services TCC’s provided or viewed the TCC as an “NPA project”, rather than as part of the hospital’s regular clinical care. This was not the case at Jooste where hospital management was very engaged and supportive of the centre and where a senior doctor is assigned to provide medical oversight.

Pre-existing Centres	Thuthuzela only
• Natalspruit • Mahatma Gandhi • Cecilia Makiwane • Chris Hani-Baragwanath • Prince Mshiyeni • Galeshewe	• St. Barnabas • Mamelodi • Mafikeng • GF Jooste

[24] This is reflected in such aspects as signage, awareness of TCC among hospital staff outside the TCC, referrals within the hospital, participation of hospital management in TCC implementation meetings, facilities, and access to various hospital resources, such as meals and/or petty cash.

3.1.3 Staffing and stakeholder presence

Under the TCC model, comprehensive sexual assault care is provided by a range of professionals and service providers, on and off-site, working together as an inter-sectoral team.

At the TCC's, health care is generally provided by a combination of doctors and nurses (nurse assistants to professional nurses/sisters) or by a forensic nurse. Eight of the ten sites have a dedicated staff doctor or forensic nurse during regular hours. After hours (nights and weekends) or when the regular doctor/forensic nurse is not available, patients at these sites are examined by various on-call doctors (both hospital and private session doctors) in the TCC or examined in the casualty/Out Patients Department (OPD). Two sites (Mamelodi and Cecilia Makiwane) do not have a doctor or forensic nurse assigned to the TCC at present, and rely instead on doctors from casualty or other departments in the hospital during regular hours as well as at night and on weekends.[25] Four of the ten sites have an on-call roster specifically for the TCC/medico-legal services TCC, but most rely on doctors from casualty for after hours care.[26]

Nursing staff is generally assigned to the TCC on a rotational/shift basis, although a few sites (such as GF Jooste, Prince Mshiyeni and Cecilia Makiwane) have dedicated, permanent staff nurses during regular hours. TCC nurses range from professional nurses (sisters) to nurse assistants. After hours, most sites that remain open are staffed by only one assistant or auxiliary nurse.

Very few sites have trained trauma counsellors on staff. Four sites utilize the services of NGO lay counsellors for HIV and/or crisis counselling, but most rely on the nurses to provide this function. A few sites also have psychologists or NGO/DOH/DoSD social workers on-site during regular hours for longer term counselling and psycho-social services, who can assist the nurses with crisis containment. However, their primary role is to provide follow-up care on an appointment basis. Only two sites –Chris Hani-Baragwanath and Galeshewe —have a dedicated social worker specifically for the TCC. The provision of crisis counselling drops off at most sites after hours and on weekends, as sites are understaffed and the nurses on rotation are not trained in crisis counselling skills.

Of the ten TCC sites, at least four do not have a sufficient staff complement of health care providers to provide services in a timely fashion – long waits are reported even during the day. Timeliness and quality of service is also compromised to varying degrees after hours, when patients must wait for on-call or casualty doctors to examine them, and sites do not have adequate nursing/counselling support to provide a full range of services.

Aside from Health, the key government stakeholders are the NPA, SAPS and DoSD. At present, most of the sites do not have a full complement of NPA staff. Three of the

[25] At Cecilia Makiwane, patients under 13 are examined by doctors from the Pediatric Out Patient Department (POPD); all others are examined in Casualty. This site used to have a forensic nurse, but the post is now vacant. Two new forensic nurses are being trained but are not yet qualified to conduct the examinations.

[26] At some sites, the TCC doctors and/or forensic nurses also form part of the "on-call" roster.

ten sites do not have a site coordinator, five do not have a case manager, and seven do not have a victim assistance officer on-site. NPA staff is present in the centre during the day only, although the site coordinator may be reached by phone after hours (i.e. to arrange shelter, etc.)

Links with the police are generally good at all sites. However, with one notable exception (Cecilia Makiwane), the capacity of the TCCs to provide specialized, integrated services with the police has suffered as a result of reorganization within the SAPS and the disbanding of the Family Violence, Child Protection, and Sexual Offences (FCS) unit. A few sites (Mafikeng, Prince Mshiyeni, and Cecilia Makiwane) have made special arrangements to have SAPS officers available at their centres – at least during regular hours -- to open cases, and in some cases to take patient statements. For the most part, however, specialized police officers are no longer available to take statements from patients on-site at the TCC, and patients must give their statement at the police station before or after receiving health care services.

The Department of Social Development (DoSD) presence in the TCCs is very limited. Only one of the ten TCCs has a dedicated social worker from DoSD.[27] Other sites rely on hospital social workers for referrals and/or counselling services. At GF Jooste, part-time NGO counsellors are paid through a contract with DoSD. At most sites, however, NGO counsellors/social workers are either independent or contracted to provide services by the Department of Health.

Significant variations exist among the TCCs in terms of the linkages developed between the sites and NGOs or other community-based services. Of the ten sites, only three (Chris Hani Baragwanath, Prince Mshiyeni, and Natalspruit) have reliable and consistent psycho-social counselling services provided through an NGO on-site. In Gauteng, VCT counsellors are provided through a service agreement partnership between the DOH and various HIV counselling NGOs, along with local clinics and ART clinics, are also used for referrals by some sites. In North West, Northern Cape, and Eastern Cape, however, NGO/community links are very weak or absent.

[27] The full time social worker at Nthabiseng/Chris Hani-Baragwanath is employed by the Department of Health.

Table 2: TCC STAFF COMPLEMENT

√ = have = not assigned or post vacant a/h = after hours	Dedicated doctor or forensic nurse	Other Nursing Staff	NPA Site Coord.	Victim Assist. Officer	Case Manager	Trauma counsellor/ dedicated SW on site	VCT counsellor	Police officer on site
Natalspruit	1 forensic nurse (day only); casualty dr.s on call a/h	1 designated staff nurse + 3 asst. nurses on rotation	√	--	--	NGO SWs/counsellor (day only); primarily follow up/support groups, not crisis counselling	2 per DOH/NGO contract (HAST) (day only)	--
Chris Hani-Bara	2 forensic nurses and 1 dr. (day); 1 dr. a/h	6 staff nurses on rotation; 1 nurse a/h	√	--	√	√ (SW-day) + volunteer 24 hours; NGO SWs on site (day) for follow-up	2 per DOH/NGO contract (HAST) (day only)	√ (day only)
Mamelodi	--(designated dr. on call during day; casualty on call after hours)	-- (use casualty nurse if needed)	√	--	--	-- (VCT counsellors do)	4 per DOH/NGO contract (HAST) 24 hours	--
St. Barnabas	1 forensic nurse (day only); casualty a/h	--	--	-- (court prep officer off site)	√ (offsite)	--	--	--
Cecilia Makiwane	-- (use casualty/POPD drs on call)	3 designated prof. nurses + 1 nurse assistant (day only); none at night	√	√	√	--	--	√ avail onsite or on-call 24 hours
Jooste	1 forensic nurse (day); forensic nurse or dr. on call a/h	1 prof. nurse + nurses/assistant nurses on shifts (day); 1 nurse or nurse assistant a/h	√	√	--	√ NGO counsellors,2x per week	1 per DOH/NGO contract, 3x per week (day only)	--
Prince Mshiyeni	2 drs. (day); dr. on call a/h	3 designated prof. nurses + 8 staff nurses and 2 enrolled nurses on rotation; Full team during day; 1 nurse at night; 2 nurses weekend days	√	--	--	NGO SWs/counsellor (day only); primarily follow up/ support groups	--	√ (only to open case)
Mahatma Gandhi	1 dr.(day); dr. on call a/h	Various nurses on rotation; 1-2 a/h	√	--	--	Hospital psychologist 3x per week (day only); primarily follow up counselling	--	--
Galeshewe	1 forensic nurse (day); patients referred to other hospital after hours	--	--√ [confirm]	√	√ (off-site)]	√ SW and aux. SW (DSD) (day)	borrowed from Kimberly Hospital per demand	--
Mafikeng	1 forensic nurse and casualty dr on call (day); casualty a/h	--	-- √ [confirm]	--	√ (off-site) [confirm]	--	--	√

3.1.4 TCC Clients

The number and type of patients served by the TCCs also varies substantially from site to site.[28] Some sites serve on average from 100-150 patients per month (Mahatma Gandhi, Prince Mshiyeni, Jooste), while others serve as few as 30 (St. Barnabas, Galeshewe). At Prince Mshiyeni, St. Barnabas, and Cecilia Makiwane, 70-80% of TCC patients (on average) are under 18 years old. Of these, between 30-60% are under the age of 12, with many 8 years old and under. At Jooste, approximately 40-50% of patients are under 18. Only one site (Galeshewe) does not provide TCC services to children. The majority of TCC clients are female.

Most TCC patients (as many as 80%) are reportedly brought to the centres by police, although TCCs also accept self-referrals and referrals from the hospital. Most “walk-ins” reportedly consist of “older” cases of suspected child abuse or cases where patients do not wish to report to police. The breakdown of day versus night cases could not be determined, as statistics were not available at most sites

3.2 Awareness and Use of the National Guidelines

The study found that not all health care providers serving TCC patients are familiar with the National Guidelines. While most of the dedicated health care providers are aware of the National Guidelines (referred to as the “yellow book”), many do not have copies readily available and none have been formally trained on the contents. Awareness of the National Guidelines appears very low among casualty doctors and other doctors serving the TCCs on an on-call basis, as well as among hospital management.

It is also clear that general awareness of the National Guidelines does not necessarily translate into detailed knowledge of the standards or the implementation of new standards and/or practices advocated by the Guidelines. Although many of the practices followed by the sites are consistent with the National Guidelines, health care providers can not always say what protocol they follow or where the standards originate. In most cases, it appears that health care practitioners are following provincial or local protocols for sexual assault care, rather than using the “yellow book.”[29] Other sites appear to be following older or different national health protocols (i.e. with respect to PEP administration) rather than the 2004 National Guidelines.[30]

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[28] Patient statistics were not obtained at most sites. Reports are based on HCP and/or site coordinator estimates, as well as a sample of monthly statistics from four of the ten sites.

[29] For example, examining doctors in Mannenberg follow a local protocol (Report on Sexual Assault Examination for Males and Females >14 years) developed by the Western Cape Department of Health. This protocol is mostly consistent with the National Guidelines; however, some practices included in the National Guidelines (3d drug for HIV, Hepatitis screening/vaccines) are not included in the local protocol. In the Eastern Cape, casualty and pediatric doctors referred to provincial protocols, handbooks, and flow-chart diagrams, including, for example, the “Adult PEP Protocol,” “Paediatric PEP Protocol,” and the “Eastern Cape Handbook of Child & Maternal Health” (2006). Again, these appeared to be largely consistent with the National Guidelines, although some important differences and/or omissions were noted (timeframe for ECP, dosage calculations for children, STI regimens, Hepatitis prophylaxis, testing requirements for PEP).

[30] For example, while the National Guidelines allow patients to postpone testing for PEP older protocols as well as general health guidelines (i.e. Standard Treatment Guidelines and Essential Drugs List,

Only a few sites indicated that they had specifically changed certain practices to conform with the new National Guidelines for sexual assault care. Others were trying to make changes but had encountered resistance from the hospital or at the provincial level.[31]

Finally, although most health care providers are aware that National Guidelines exist, the Guidelines do not appear to have been widely disseminated to all relevant health care providers in the field. Obtaining a hard copy from the Department of Health is very difficult, as ECI's researchers experienced first hand. The Guidelines also do not appear to be available on the DOH website.

4. COMPLIANCE WITH GENERAL STANDARDS FOR SEXUAL ASSUALT CARE SERVICES

The following section of the report analyzes TCC compliance with the general standards for sexual assault services as set forth in the guiding principles of the National Guidelines. Summaries of compliance by each site are contained in Annexures B - K of the Report.

4.1 Emphasis on Patient's Health and Welfare

A basic guiding principle of the National Guidelines is that the health and welfare of the patient should be prioritized over the gathering of medico-legal evidence. This principle represents a departure from prior practice, where the collection of evidence was viewed as the primary purpose of the post-assault examination and only district surgeons (forensic specialists) were permitted to conduct the examinations. Under the new National Guidelines – and consistent with TCC principles – the emphasis has shifted to holistic and comprehensive care, such that treatment of injuries, prevention of pregnancy and sexually transmitted infection (including HIV), and attention to the patient's psychological and emotional needs are considered of equal, if not greater, importance than the collection of evidence. The National Guidelines also emphasize that the medico-legal exam must be done in a way that respects and protects the dignity and autonomy of the patient, and does not result in secondary victimization.

Based on our interviews with health care providers and other TCC staff members, it appears that substantial efforts are being made to address the overall health and welfare of patients in the context of sexual assault management. Specifically:

- Post-exposure prophylaxis for pregnancy, STI, and HIV are included as part of the standard protocol/procedure for sexual assault management in all of the TCCs (as well as most of the casualty wards for after-hours care). While not all sites are fully compliant in terms of how prophylaxis is administered, none of the sites conduct examinations without also providing prophylactic treatment where indicated. Where gaps in delivery occur, it appears to be

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2006) state that the patient's HIV status must be determined before starting PEP. Older guidelines also do not include prescription of a third drug in high risk cases.

[31] One doctor reported, for example, that the Province would not approve Hepatitis vaccinations.

due primarily to unavailability of certain tests or medications after hours rather than health care practitioners failing to follow the protocol.[32]

- All of the TCCs are aware of the need to address patients' emotional needs by providing some form of containment counselling/comfort to patients. In practice, however, not all TCCs are able to deliver adequate support. The availability and quality of crisis counselling services varies considerably between sites, and also depends largely on when the patient presents at the centre. Many sites are not able to provide any counselling after hours or on weekends, or struggle to provide more than a minimal level of counselling/crisis management due to understaffing. Moreover, not all health care providers tasked with seeing sexual assault patients have the skills, time, and/or disposition to provide effective emotional/psychological support. While some TCCs reported challenges even during regular hours, the research found that patients' emotional needs were least likely to be addressed after hours and on weekends when the TCC was closed or minimally staffed, especially when responsibility for patient care rested with overstretched doctors/nurses from casualty/OPD or with inexperienced auxiliary nurses.

- Receipt of health care services is not dependent on collection of medico-legal evidence or reporting the case to police. In almost all cases, sexual assault patients who present too late for forensic examination (after 72 hours), who refuse the medico-legal exam, or who do not wish to report to police, are still offered health care services (comfort, physical examination, HIV counselling, medical treatment, and referrals). Problems sometimes occur when police do not immediately refer patients to the TCC because they have reported "too late," or when patients are turned away after hours and told they must come back during regular hours because their cases are no longer viewed as urgent. Many TCCs/hospitals are also unable/unwilling to perform a medico-legal exam on patients who have not reported to police (because they do not have SAECK kits, J88 or 308 forms, or because they require a case number). Such practice is arguably inconsistent with the National Guidelines, which encourage HCPs to collect evidence and document injuries (within 5 days and with the patient's consent) even in cases where the patient is not ready to or is uncertain about whether to report the case to police.[33]

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[32] At least two sites identified problems with medication not being available in casualty after hours when the pharmacy was closed. At Mamelodi, the site coordinator and HIV counsellors reported that sometimes the casualty unit runs out of PEP and other medications, and patients must return the next day for the starter pack. In some cases, the TCC only finds out later during follow up appointments that the patient did not get certain medications (including PEP and ECP) during the initial examination. At St. Barnabas, casualty doctors reported that the casualty is not stocked with Ovral, so sexual assault patients presenting after hours cannot be given ECP. They are told to come back during regular hours for the medication. At CMH, medications were well-stocked after hours, but doctors did not have access to rapid urine pregnancy tests. Doctors take urine samples and send them to the lab, but results are not immediately available. Finally, two sites reported that they can only provide children with a Stat dose of PEP after hours, because of inadequate supplies of syrups in the TCC/casualty. Care-givers in these cases must wait or return to the site for additional PEP when the pharmacy is open.

[33] National Guidelines, section 7, p.10.

- All TCCs stress the need to treat patients with dignity and to minimize secondary victimization. This includes obtaining informed consent, protecting privacy, minimizing waiting times, and dealing with patients in a sensitive manner. While most TCCs are able to achieve this standard during regular hours –at least in terms of health care delivery -- compliance is sometimes weaker after hours, as described in more detail below. Appropriate levels of sensitivity are also reportedly lacking among some nurses and on-call doctors who rotate in and out of the TCCs without sufficient training or orientation to the special needs of sexual assault patients. In a few cases, patient privacy is also compromised by limitations in the facility itself.

4.2 Training and Skills of Health Care Providers

The National Guidelines state that all health care providers providing care to victims of sexual assault should be "appropriately trained and skilled in managing sexual assault patients."[34] According to the Guidelines, health care workers at all levels of the health care system should be able to:

- Recognize physical and sexual assault
- Document pertinent history
- Perform a thorough head to toe physical examination
- Document all injuries
- Collect forensic evidence as prescribed in the SAECK/SAEK
- Conduct pre and post test counselling for HIV
- Screen for STI and HIV
- Treat physical injuries
- Prevent unwanted pregnancy
- Prevent and treat STIs
- Provide PEP for HIV
- Provide psychological support
- Refer to appropriate resources
- Complete the J88 form in police cases
- Present evidence in court

The term "health care provider" is defined in the Guidelines as a medical officer, specialist, or nurse who has "received the **appropriate (necessary)** training" in sexual assault care.[35]

The level of training and skills among health care providers serving TCC patients varies considerably between sites and, to some extent, even within sites.

In general, trained forensic nurses and doctors dedicated/specifically assigned to the TCC appear to be well-qualified and experienced in sexual assault management. They

[34] Ibid, section 4, p.6.
[35] Ibid, section 19.15, p.37. The Guidelines do not specify what constitutes appropriate or necessary training other than to list the skills that HCPs should have.

also tend to convey sensitivity and a greater understanding of the needs of sexual assault patients.

  - Most of the dedicated examiners have specialized forensic training and at least three years of experience working with rape victims.
  - Most reported a high level of confidence in their knowledge and skills
  - In two cases, newly assigned practitioners reported that they did not feel entirely confident in their skills before coming to the TCC. One doctor reported that he had not received sufficient training in medico-legal examination (especially with regard to children), using the SAECK/J88, or testifying in court. Another had received her forensic training a long time ago without receiving a "refresher" course before coming to the site. She also reported that she had never been trained in HIV counselling although she was responsible at times for providing this service.
- Several doctors and forensic nurses said they learned their skills on the job before receiving formal forensic training
- Although answers varied between sites and practitioners, skills gaps were reported in the following areas: use of colposcope; recent changes to the SAECK kit; specific clinic aspects relating to PEP administration (such as administering PEP in repeat cases, or procedures for continuing PEP in cases of minor default); orientation to new standards in the National Guidelines; trauma containment (especially for children); and testifying in court.

Training and skill levels among doctors not full-time at the TCC are much more variable. Several of the TCC sites rely on private session doctors to examine patients on an "on-call" basis, after hours, on weekends, and/or when the dedicated doctor/forensic nurse is not available. At some sites, session doctors are also used after-hours in casualty. Although it was not possible to interview any private doctors for purposes of this study, at some sites, such as G.F. Jooste, Mahatma Gandhi Memorial and Chris Hani Baragwanath, the managing doctors reported that all of doctors and/or forensic nurses responsible for examining patients after hours are experienced practitioners with sufficient skills in medico-legal services.[36] At other sites, however, day staff expressed concern about the quality of care provided after-hours. Concerns included mistakes on the J88 form, sloppy or incomplete documentation of injuries, inadequate information counselling, and prescribing errors for medication.[37] Some also raised concerns that the session doctors "rushed" the examinations, did not complete patient records, and/or did not provide sufficient empathy for patients/ care-givers.

In most cases, session doctors are not directly supervised/monitored by the TCC. Except at Chris Hani Baragwanath and Jooste, the TCC appears to have little control over who provides on-call services, and can only raise concerns with the hospital's managing doctor or district services if they are not satisfied with the quality of care. Training session doctors also presents practical problems, as the doctors have their

[36] At Jooste, the CEO said he personally "hand-picked" the session doctors on the TCC roster based on their skills and experience. At MGMH, the doctors were selected by district medico-legal services, but all had training in forensic examination.
[37] TCC staff at several sites (including Mamelodi, Natalspruit, and Prince Mshiyeni) expressed concern about session doctors.

own private practices during the day and are generally not available or willing to attend training workshops.[38]

Lack of training and appropriate skills was also reported by HCPs at TCC sites that rely on casualty/OPD or other departments for sexual assault care. With few exceptions, the study found that "on-call" and casualty doctors providing sexual assault care have received little or no formal training on sexual assault management in medical school or through in-service training programs. Many are junior doctors – either interns or community service doctors – serving on short rotations. Others have more experience but no specialized training (or interest) in sexual assault care.

Many of the young doctors interviewed expressed concern about lack of training to conduct the medico-legal examination, use the equipment (particularly the colposcope), complete the J88 form correctly, or testify in court. Some paediatric interns and community service doctors also expressed lack of confidence in identifying abnormalities in children and difficulties determining the appropriate dosage for paediatric PEP.

All of the casualty and paediatric doctors interviewed said that aside from a short briefing/orientation, they learned their skills "on the job." Some of the newer doctors described their experience as "trial by fire," noting that they had never witnessed a forensic examination or seen a crime kit until they were called to examine their first sexual assault patient. This was reported as very stressful for them and not beneficial to the patient. Older doctors expressed more confidence in their skill levels, although not all were comfortable with changes in the SAECK kits or prescribing for children. None of the casualty or on-call doctors interviewed were familiar with the National Guidelines, reporting that they relied on personal experience, provincial or hospital protocols (including posted flow diagrams/testing algorithms), and the instructions included in the SAECK kit/ J88 form. None had received training in VCT or basic counselling skills, and few were aware of referral services available for sexual assault patients.

Although inadequate training did emerge as an issue in most sites, lack of skills is not always due to lack of training. Some on-call and casualty doctors – particularly private and some of the more senior doctors -- reportedly resent having to do sexual assault examinations and do not see it as part of their job. Others have a reputation for being unwilling to testify in court.[39] Some doctors (particularly males) said they find it emotionally difficult to work with sexual assault patients and feel ill-equipped to deal with the patients' emotional needs. Finally, several casualty doctors noted that despite their best efforts it is not always possible for them to conduct a full history and examination, take all the forensic samples and attend to the patient's physical and emotional needs. They are simply under too much time pressure and do not have enough support from nurses or other staff to do all that is required. Others noted language barriers, particularly at night when nurses are not available to assist with interpretation.

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[38] Interview with Medical Officer, Mamelodi Hospital.

[39] Aside from the time required to complete a sexual assault examination, fear of testifying in court (and/or resentment regarding the time and opportunity costs involved) was sited as one of the factors behind poor quality examinations and/or documentation by casualty and/or private doctors.

Capacity and skills among nursing staff at the TCCs also varies considerably. At some sites – particularly Jooste and Cecilia Makiwane Hospital – assigned TCC nurses display a high level of skill, sensitivity, and experience. The nurses are well regarded by the forensic nurses/doctors in the hospital as well as the non-health staff of the TCC. While nurses who were assigned on a "permanent" basis to the TCC appear appropriately skilled and dedicated, however, a number of problems were reported at various sites with respect to general nursing staff. At Natalspruit and Mahatma Gandhi, for example, existing staffing patterns are such that nursing staff rotate through the TCC every 3 to 6 months. The nurses arrive with little or no experience working with sexual assault patients and leave the centre soon after they have developed adequate skills. Moreover, at many sites, the more experienced nurses work the day shift. During evenings and weekends, responsibility for all nursing functions at the TCC (crisis containment, counselling, VCT, taking of medical history, dispensing of medication, and assisting with examination) often falls to one auxiliary or assistant nurse with limited skills and training, or even to a volunteer.[40]

It was also noted that many nurses serving the TCC lack training and skills in trauma containment and counselling. In the absence of specialized training, many reportedly rely on religious comforting to calm their clients, and few have the capacity to counsel severely traumatized patients or traumatized children.

The most common skills and knowledge gaps reported among nurses included:

- Special needs of victims of sexual assault
- HIV pre- and post-test counselling (particularly in the context of sexual assault management)
- Trauma containment/ counselling
- Familiarity with National Guidelines

As with doctors, it appears also that not all nurses assigned or on rotation to the TCCs have an interest in or ability to work effectively with sexual assault patients. Some sites expressed concern about insensitivity or "bad attitudes" among some nurses, and nurses who "don't want to be there." Another doctor explained:

> "It takes a certain kind of person to be able to work with rape victims – calm, collected. Not all of our nurses are suitable [for this kind of working environment]. The hospital needs to understand this and take it seriously. We need to have a system to assess the nurses [before they are assigned to the centre] to determine whether they are capable of doing the job."[41]

4.3 Information and Consent

The National Guidelines identify a wide range of information that must be conveyed to sexual assault patients by health care providers during initial and follow up visits. These include, for example: information about the examination process and health related tests and procedures; health risks after sexual assault (pregnancy, STIs, HIV, Hepatitis B, and long and short term psychological effects); taking of prescribed

[40] At Mamelodi, volunteer VCT counsellors fulfill all support functions after hours, including crisis containment, VCT, collecting medications from the pharmacy and explaining the medications to the patient.

[41] Interview at Prince Mshiyeni Hospital.

medication, risks/interactions and side effects; contraception and condom use following treatment and during PEP; HIV pre- and post test counselling (window periods, repeat testing, living with HIV, etc.); procedure for reporting the case to police; complaint mechanisms; and local support services available. Information should be provided in a language the patient can understand and in a manner that takes into account the age and emotional state of the patient at the time the information is conveyed. Take-home, written information should be provided whenever available.

With respect to consent, the National Guidelines require HCPs to obtain the patient's informed consent for the medico-legal examination, release of information to the police/court and any referral organizations, pregnancy testing/EC, HIV testing and PEP. According to the Guidelines, informed consent should not be "once off," but should be obtained at various stages throughout the counselling and examination process. Moreover, the Guidelines state that written consent should be obtained for pregnancy testing, emergency contraception, HIV testing and PEP, in addition to the 308 or facility's general consent form.

The study found the following with respect to information counselling:

- Various people at the TCCs play a role in providing information to patients. The Site Coordinator generally is responsible for receiving the client and explaining the various steps and procedures involved. The Site Coordinator also explains the criminal justice process to those who wish to open a case. At some sites, the Site Coordinator plays an important role in reinforcing health-related information, such as the importance of complying with the PEP regimen and returning for follow up testing. Often it is the site coordinator (and/or victim assistant officer, if available) who arranges safe shelter for the patient if necessary and provides information about community support services (such as rape crisis helpline) where such services are available.

- Primary responsibility for health-related information rests with the various health care providers at the TCC and/or casualty unit. At some sites, the forensic nurse and/or examining doctor provide most of the information counselling. At other sites, the nurses play the major role (in terms of explaining medications, making referrals, etc.). At some hospitals, the hospital pharmacists are responsible for counselling patients on medications, compliance, interactions and side effects.

- Although we found that all HCPs – to varying degrees – discuss the examination and medications with patients, some of the issues identified in the Guidelines are not routinely or thoroughly discussed with patients at every site. Some of the more common gaps identified include: psychological impact of rape, Rape Trauma Syndrome/Post Traumatic Stress Disorder symptoms and coping strategies; contraception/condom use during and after treatment; local support services for victims of sexual assault; and complaint mechanisms.

- Written information or brochures on relevant health topics and referral organizations/support services are not available or available only sporadically at most sites.[42] Much of the information is available in English only. None of the sites distribute written information on medications or coping strategies for psychological/emotional issues. Only two have brochures available on taking PEP for prevention of HIV.

- In general, the quality and type of verbal information provided to patients seems to depend largely on who is providing the information, the time of day the patients present at the hospital/TCC, and the information protocols used at the various sites. Dedicated, daytime staff (particularly the forensic nurses) appears to be very thorough in terms of the information routinely discussed with patients and sensitive to how the information can best be communicated. This appears to be a function of both knowledge/experience and the amount of time spent with patients.

- After hours, in casualty, and in sites where there are no dedicated nurses, provision of information is generally far weaker. Again, the HCP's level of training, experience and familiarity with sexual assault management guidelines seems to play the major role, as well as language and the amount of time available to spend with each patient. In one hospital, for example, on-call doctors described as "significant challenges" their inability to communicate with patients in their own language, lack of trained nursing staff to provide information or counselling after hours, and pressure to complete the examination in the shortest possible time. Concerns were also raised about the quality and consistency of information counselling provided after hours by inexperienced nurses, particularly where the nurses are alone at the site and have to juggle many duties and patients at once. Several sites have developed information checklists for nurses and/or lay counsellors to use during counselling sessions to ensure that all critical information was covered with the patient. While helpful, this may not be adequate where the HCP/counsellor lacks knowledge and/or basic counselling skills.

- Another challenge relating to information is the ability of the patient to absorb and understand information provided while the patient is in a traumatized state.[43] At Natalspruit and Jooste, for example, affiliated NGOs reported that TCC patients/caregivers often do not understand or remember the information provided to them during the initial visit. For this reason, it is therefore critical that the TCC repeat and reinforce information during follow up visits and through written IEC materials, as well as check on patients within the first several days to ensure that they are taking their medications appropriately.[44] . (At most sites, follow up is only provided at the patient's one-week appointment, and none of the sites provide standard written information packages. A few sites do not follow-up with patients before their appointment at six weeks.)

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[42] GF Jooste, Chris Hani-Baragwanath and St. Barnabas were among the better sites in this regard, with reasonable numbers of brochures available in the waiting and/or examination rooms on various topics for patients to take home.
[43] See National Guidelines, section 8.2.1 at p.14.
[44] At most sites, follow up is only provided at the patient's one-week appointment, and none of the sites provide standard written information packages. A few sites do not follow-up with patients before their appointment at six weeks.

- Some interviewees also reported that the timing of information counselling is critical, and that detailed information (and particularly VCT) should not be provided until after the patient has been examined and had a chance to bath, change clothes, and have something to eat and drink. Some Site Coordinators and NGO social workers felt that HIV counselling should not be provided at all at the initial visit, except insofar as necessary to explain the risks of HIV infection and the benefits of starting PEP. [45]In practice, though, most counselling is done before the examination while the patient is waiting for the doctor/forensic nurse, in part to minimize the overall time the patient has to stay at the centre.

- Disabilities hampering communication, asking questions and imparting information to children, and communicating in the patient's language[46] are some of the challenges experienced by many practitioners.

In the area of consent:

- All of the hospitals visited have standard policies and procedures relating to informed consent and special cases involving children, unconscious, and/or mentally impaired patients.

- All TCCs provide services (including HIV testing) to children age 14 and above without requiring consent from a parent or guardian.[47] A few HCPs interviewed reported problems with parents refusing consent for young children to be examined or tested for HIV.

- For medico-legal examination, most of the sites rely exclusively on the SAPS 308 form. A few TCCs also have a general consent form that is routinely used in addition to the 308, or that can be used as an alternative where the patient does not come to the site with police, or where a forensic examination is not performed.

- Most of the TCCs (8 of 10) require patients to sign a separate written consent form for HIV testing, although Natalspruit and Prince Mshiyeni routinely obtains written consent for PEP. At St. Barnabas, HIV consent forms are available in Xhosa and English.

- Written consent for pregnancy testing and/or ECP is not obtained in most cases, although consent is reportedly obtained verbally.

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[45]Interviewees at both Prince Mshiyeni and Jooste expressed concern about the impact and/or effectiveness of VCT on traumatized patients and caregivers, and suggested that most HIV related counselling as well as testing be delayed a few days. According to one Site Coordinator, "Some patients come in in such a state that they don't even know what is happening. They need trauma counselling. Sometimes they need to sleep or eat. Sometimes I talk to [patients] the next day and they don't remember anything – they haven't understood the information we've given them…" The challenge, they noted was that if testing is delayed, some patients "won't come back," and will lose the opportunity to get PEP.

[46] Although this challenge can be easily overcome in many cases where a nurse or other person is available to translate, it can be particularly problematic in the area of counselling and/or psychological services.

[47] Current consent policies for children are based on age 14 as the age of consent for medical treatment. Although consistent with the National Guidelines, these will require adjustment to reflect recent changes in the law. See discussion on legislation, above.

Written Consent forms used at the TCCs				
	308 (medico-legal exam and release of info/ evidence)	General Consent Form	HIV test	PEP
Chris Hani-Baragwanath	√		√	
Mamelodi	√		√	
Natalspruit	√	√	√	
Cecilia. Makiwane	√		√ (day only)	
St. Barnabas	√	√	√ (day only)	
Mafikeng	√			
Galeshewe	√			
M. Gandhi	√		√	
Prince Mshiyeni	√		√	√
GF CF Jooste	√	√	√	

The following concerns were also noted with respect to informed consent:

- First, it appears that a written HIV consent form is not always used after hours or in casualty where blood is drawn for HIV along with the DNA sample, without the patient receiving pre-test counselling. Presumably verbal consent is obtained from the patient/caregiver, but this could not be verified.
- Second, several sites reported that they will not do a medico-legal exam without a 308. If the police fail to bring the form with them or the patient is a "walk-in," the site will contact the police and the patient will have to wait for the police to bring the form before starting the examination. Few sites keep extra copies of the 308 or a hospital general consent form on hand for such occasions. This omission results in unnecessary delays and may also force patients who are not ready to report to police to open a case in order to be examined.[48]
- Third, some HCPs reported that they do not independently discuss consent with the patient if the patient presents with a signed 308 form. Most of these assume that the patient has already been counselled by police on the nature and implications of the examination and that the patient has already given informed consent. Of potential concern is that patients may not always understand that the examination is voluntary and that they have a right to refuse the exam and still get medical care. While several TCC site coordinators reported that they specifically discuss consent with patients, a gap may occur after hours when site coordinators are not on duty. At GF Jooste, the examination form included in each file contains a general consent form for medico-legal examination that patients must sign before the examination is conducted. This ensures that the process is explained to the patient at the TCC and that consent is voluntarily obtained.

[48] According to the Guidelines, HCPs should encourage patients who are not ready to report to police to do a medical-legal exam in order to preserve evidence should they decide to report later.

4.4 Emotional support/Counselling

An important theme running through the National Guidelines is the need to provide immediate emotional or psychological support to patients who have experienced sexual assault,[49] as well as to the care-taker/parents of an abused child.[50] At the initial visit, this primarily takes the form of "containment" or crisis counselling. According to the Guidelines, providing empathy, comfort, reassurance, and support in the "acute" phase, is essential to enable the patient/caregiver to cope with the examination, absorb information, and make decisions about his or her care. It may also help minimize the extent and duration of Rape Trauma Syndrome symptoms. In addition, ongoing psychological support and counselling should be offered as part of the patient's longer-term care.

It appears from the research that immediate, short and long-term psychological support and counselling is inadequate at many TCC sites.

- Trauma containment/ crisis counselling is not strategically approached at the TCC sites. Most sites do not have designated trauma counsellors, and rely instead on various staff members or volunteers to play this role. Most staff, including HCPs are not trained in trauma counselling. The trauma containment that exists is based largely on the individual skills of the service provider.

- Comfort and support services are generally better during the day, when permanent/full-time staff are available in the centre. After hours, some sites do not have the human resources to adequately fill this role.

- Only two of the ten sites (Mamelodi and Chris Hani Baragwanath) have volunteer lay counsellors available 24 hours a day to provide containment counselling on-site. At Mamelodi, the counsellors have recently received some training in containment, but are primarily trained in VCT. At Chris Hani Baragwanath, volunteers provide emotional support to patients along with other members of the TCC staff. Jooste has struggled to provide on-site counsellors at the centre and identified this as a major challenge. After nine months with no counsellors, it has recently worked out an arrangement with an NGO (Rape Crisis) to provide services at certain times, but there are still gaps when no counsellors are available.

- At most sites, containment is a team effort, with the site coordinator, nurses, and/or examining doctors/forensic nurse all providing emotional support/crisis counselling in addition to their other duties. This arrangement works reasonably well at some sites, such as Cecilia Makiwane and Prince Mshiyeni where there is a sufficient number of staff during regular hours with experience in containment/crisis management. Challenges occur after hours, however, when the centre is closed or only staffed by one assistant nurse.

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[49] See, e.g. National Guidelines, section 8, p. 10; 8.2, p. 13-15.
[50] Ibid, section 4, p. 6 ("In the instances of child sexual assault, provision of care and support should be extended to the parent/caretaker of the child who may be as, and sometimes more, traumatized as the child patient.")

- At smaller sites, such as Galeshewe, Mahatma Gandhi and Mafikeng, none of the HCPs have received training in trauma containment or counselling, and services are ad hoc. Essentially whoever receives the client is responsible for "containment" and emotional support. At St. Barnabas, the Forensic Nurse provides comfort and counselling to patients in conjunction with the medical examination. Problems arise, however, when there is more than one patient as the Forensic Nurse is alone at the site without even a site coordinator to provide back-up support.

- Of major concern is the unavailability of any containment counselling or psychological support to patients who are seen in casualty or by on-call doctors when the TCC is closed. At Cecilia Makiwane Hospital and St. Barnabas, there are no lay counsellors or TCC staff on duty after hours, and the nurses serving casualty are generally too busy to counsel patients or to provide more than minimal emotional support.

- A few sites also raised concerns about the lack of specialized skills to contain traumatized children and/or mentally impaired patients. At some sites, the TCC can call on the hospital social worker/psychologist or a specialized NGO with an office onsite to assist in emergency cases, but these services are not available at many sites and only available during regular hours.[51]

Availability and quality of short to long-term psychological support also varies between sites.

- Only two sites have a full-time social worker on staff at the TCC. Three sites have NGO social workers and/or lay counsellors working on site at least two days per week. Other sites must refer patients to hospital psychologists or social workers to provide follow-up counselling, or refer the patients to community-based NGOs.

- Psychological support services seem to work best when provided on-site at the TCC.
    - At Chris Hani Baragwanath, the social worker provides up to six counselling sessions for all TCC patients, covering trauma containment, trauma impact, normalization and review of rape trauma syndrome. Appointments are linked with PEP collection/follow up sessions, and PEP is also discussed during the sessions. Patients can also be referred to the Teddy Bear Clinic (patients under 18) and POWA, both of which operate onsite at the hospital.
    - At Natalspruit, the TCC works with Ekupholeni Mental Health Services to provide ongoing counselling and support. Ekupholeni operates a centre on hospital grounds (the TCC #2) exclusively for TCC patients. Services include private counselling sessions and age-appropriate support groups "for as long as the client needs."[52] Like Chris Hani Baragwanath, appointments are scheduled to coincide with PEP pick-up and follow-up appointments at the TCC. This provides both an incentive for patients to return to the site, as well as an opportunity for counsellors to reinforce information and support patients to complete the full course of PEP.

[51] See, e.g., Prince Mshiyeni, St. Barnabas, Mahatma Gandhi, and Mamelodi.
[52] Interview with Ekupholeni Director.

- At Prince Mshiyeni, Childline and Lifeline have offices at the TCC. Three trained social workers from Childline and one Lifeline counsellor are available onsite to see patients for individual therapy sessions two to three days per week. Four days a week, Childline also has a counsellor on site to run support groups and court preparation programs, as well as to provide comfort and support to patients generally. Individual therapy sessions are limited to six, but patients and care-givers can continue to come for support groups as long as they like.[53]
- Patients at Galeshewe receive follow-up counselling from a full-time DoSD social worker. The site also has an auxiliary social worker for domestic violence patients.

- At other sites, opportunities for psycho-social support are much more limited.
  - At C.F. Jooste, the TCC has relationships with two NGOs offering services off-site. Safeline (in Athlone) works with abused children and their care-givers; Crisis Line (in Mitchell's Plain) works with victims of gender-based violence. TCC patients are routinely referred to these organizations for follow-up counselling. Although both organizations provide valuable services, the services are not accessible to many TCC patients because of their location and most patients attend only a few sessions. [54]
  - St. Barnabas and Mamelodi do not have any NGO partners and refer patients solely to the hospital social worker. At St. Barnabas, TCC patients presenting during the day are referred to the hospital social worker for trauma debriefing. If she is available, she will see them the same day (about 30-45 minutes); otherwise they must make an appointment to come back. The social worker reported that she tries to see the patients at least two times, as soon as possible after the incident and again in two weeks. Only "5-10%" return to the centres for further appointments.[55] The social worker also arranges places of safety for children where necessary and occasionally conducts home visits to provide "family support." The social worker serves the entire hospital and was not aware of any counselling services available in the area outside the hospital.
  - At Cecilia Makiwane Hospital, TCC patients are generally referred to the hospital psychologist for longer-term counselling and support. Due to under-staffing, however, it is often difficult for patients to get an appointment. According to one interviewee, the wait to see the psychologist is currently six weeks, and there are no NGOs or other organizations linked with the TCC to provide alternative services.
  - At Mahatma Gandhi, only "severe cases" can be referred to the hospital psychologist, who serves the entire hospital and splits her time with another site. In general, the psychologist reported that she sees less than 20% of TCC patients. Of those who do receive therapy, most are limited to a maximum of four sessions. Recently, a Childline social worker has started coming to the site

[53] One of the doctors at Prince Myshieni expressed concern about the DOH policy that limited individual sessions by Childline to six per patient. In her view, this number was inadequate for some patients, especially children, "who can take two or three sessions before they'll even say a word." She also noted that some situations require family counselling or other longer-term interventions.
[54] In addition, Crisis Line reported that some problems are beyond their capacity to manage – patients need assistance from professional psychologists and/or social services – both of which are lacking at the Jooste TCC.
[55] Lack of money for transport was identified as one of the major factors why patients do not return for additional follow-up.

one day per week to provide specialized care for children. Because of backlog, however, new patients must wait several months to get an appointment.

- At Mafikeng, no longer-term counselling is available, as the hospital psychologist post is currently vacant and no NGO linkages have yet been established.

4.5 24-hour Services

According to the National Guidelines, sexual assault services, including PEP, should be available 24 hours a day, and sexual assault patients should be prioritized irrespective of the nature of physical injuries. Our research found the following:

- All of the TCC hospitals (with the current exception of Mamelodi) provide at least basic health services to sexual assault patients 24 hours a day, seven days a week. At minimum, this includes a medico-legal examination, treatment of physical injuries and prophylaxis for patients reporting within 72 hours, either within the TCC or in another unit of the hospital.

- Only six of the TCCs offer 24 hour-service. Three of the sites (St. Barnabas, Mafikeng and Galeshewe) are only open during regular business hours; after hours, patients are referred to casualty and Kimberly Hospital, respectively. At Cecilia Makiwane, children under 13 may use the TCC waiting room and are examined in the TCC by doctors on-call; Police may also use the TCC to take patient statements. The TCC is not staffed, however, and all patients over 13 must be seen in casualty. At these four sites, VCT and crisis/information counselling are not available after hours; patients can get a STAT dose or starter pack of PEP, but then must wait or return to the site during regular hours for VCT and additional medication. Support services such as showers, changes of clothing, food and referrals are also not available after hours.

- Of the six TCCs open 24 hours, most operate after hours with minimal staff. After hours and on weekends, the sites have examining HCPs on call (usually either session doctors or on-call doctors from casualty) and either a nurse or lay counsellor to receive and comfort the patient, call the examining doctor, and provide VCT and other services. Of the six, only four of the TCCs operate fully independently after hours. Two of the sites (Mamelodi and Natalspruit) depend on collaboration with other hospital services to provide services after hours.

- Sexual assault cases are prioritized at most TCCs, even where the site also provides other medico-legal services. Concerns in this area were reported primarily at sites where TCC patients must be seen by doctors from casualty (whether during regular hours or after hours), because of the demands placed on casualty staff and the amount of time required to conduct a sexual assault examination. At some sites (Natalspruit, Mamelodi, and St. Barnabas) doctors reported that they generally clear their OPD/casualty load before seeing sexual assault patients. At Cecilia Makiwane, doctors claimed to prioritize sexual assault patients over patients with less serious

4.6 Victim-Friendly Environment

Consistent with the TCC model, the National Guidelines recognize the importance of providing sexual assault care in a victim-friendly environment. Specific standards include[56]:

- a quiet environment and private room for the management of sexual assault patients to ensure privacy and reduce anxiety
- protection from secondary victimization
- ensuring that patients are able to maintain their dignity after the assault and do not feel humiliated or degraded
- for female patients, the opportunity to be seen by a female health worker or to have a woman present in the room during examination by a male HCP
- the choice to have a friend or family member in the examination room
- gender sensitivity and sensitivity to the special needs of children, the elderly, and patients with disability
- extending care and support to parents/caregivers of child sexual assault patients
- respectful and non-judgmental attitudes
- involvement of the patient in decision making
- an opportunity for patients to provide feedback[57]
- where possible, the opportunity to shower and change clothes[58]

Implementation of many of the above standards was difficult to assess without speaking to patients about their experience at the sites. However, some specific aspects regarding the physical environment, services, and treatment were noted:

4.6.1 Physical environment:

- All of the TCCs are separated in some way from the rest of the hospital so that sexual assault patients can wait and be examined in a calmer and more private environment.
- The quality of the facility and availability of amenities differs substantially from site to site. Some – such as Jooste, Cecilia Makiwane, Galeshewe and Mafikeng – have large, pleasant spaces with private entrances; their own bathing and kitchen facilities; quiet, comfortable waiting areas; and in some cases, toys for children and/or TVs to distract patients while they wait. A few, particularly Mahatma Gandhi and Mamelodi, are quite small and minimally furnished, with no amenities to speak of.

[56] See National Guidelines, section 4, p.6-7
[57] National Guidelines, section 13, p. 30.
[58] Ibid.

- The physical layout of some sites can pose challenges for maintaining privacy and/or monitoring patients while they wait to be examined.
- Privacy is compromised to some extent in TCCs that provide a full range of medico-legal services in addition to sexual assault care. In these sites, sexual assault patients must wait along with drunk drivers and others requiring medico-legal services, although examinations and counselling are done in private. Where patients are brought in through or to casualty with police carrying rape kits, the patient's privacy and dignity may not be adequately protected.
- Most of the casualty/OPD wards at TCC hospitals have private examination rooms for sexual assault patients, but waiting areas are not quiet, comfortable or private. Indeed, most are very public and stressful environments that are not conducive to sexual assault management.

4.6.2 Gender-sensitivity/special needs of children and people with disabilities

Most HCPs appear sensitive to gender concerns and the special needs of children and people with disabilities; however not all HCPs or TCCs sites are adequately equipped to meet these needs.

- Most of the HCPs and TCC staff interviewed appear to be sensitive to gender concerns. Gender-sensitivity is most often expressed by asking female patients if they are comfortable to be examined by a male doctor. Such questioning is often symbolic, however, as some sites do not have female HCPs available to examine patients, particularly after hours.[59]
- Lack of female doctors and/or forensic nurses was cited as a concern at some sites. Although many of the staff doctors/forensic nurses are female, most of the on-call doctors are male.
- In most settings, a female nurse is present in the examination room when a male doctor examines a sexually assaulted patient. This is not always possible after hours, however, when the TCCs and/or casualty are busy and understaffed.
- Although HCPs appeared to deal sensitively with male children, most TCCs had few or no reported cases involving adult or adolescent male patients. Gender-sensitivity could not be assessed, therefore, with respect to older males.[60]
- All TCCs reported that they allowed patients (particularly children) to have a family member or other support person in the room during examination. It was not established whether this policy was also in force in casualty (particularly with respect to adults). Some TCCs also noted that young patients had the choice to be counselled/examined without a parent present if they felt more comfortable.

[59] Likewise, not all sites have male doctors or forensic nurses available to examine male patients, although this was only rarely sited as a problem.
[60] The study did not research potential barriers to adult and/or adolescent males seeking sexual assault care and PEP from the TCCs. However, this would be an interesting question for future research.

- Dedicated personnel generally expressed an understanding of/ respect for the rights and concerns of children and patients with special needs, including the right to information and right to participate in decision-making.
- Although some HCPs appear naturally skilled in this area, most HCPs and lay counsellors have not received specific skills training on communicating with very young or traumatized children, patients with mental incapacity, or patients with disabilities impacting communication (i.e. sight or hearing impaired). Although a few sites said they could call on a hospital social worker or HCP from a specialist department if necessary, most HCPs draw on their general skills and rely on the patient's caregiver to communicate with the patient.
- Lack of skills/services for special-needs patients was reported by interviewees as a weakness at several sites, including Mafikeng, Mamelodi and Chris Hani-Baragwanath.
- Appropriate management of young children also poses challenges for most sites. Challenges occur at all points of service, including containment, information giving, testing, counselling, examination, and support services (such as psycho-social support and court preparation). Most sites are not able to meet these needs to their satisfaction.
- Because of space limitations, most sites do not have a separate waiting area or examination room for children. Four sites have created a "child-friendly" area, but these are not well equipped or ideally located.
- Some TCCs do not have any toys or books for children, including for therapy purposes. Others are well equipped, primarily due to private donations.
- At least five sites are unable to provide specialized counselling services for children and caregivers. Where services are available (Chris Hani Baragwanath, Prince Mshiyeni, Natalspruit, and to a lesser degree, Jooste and Mahatma Gandhi), services are provided primarily through on- or off-site NGO service providers, and may be limited in terms of access or duration.
- Problems were also reported at some sites with respect to examination of young children under anesthesia. In Natalspruit, for example, the TCC reported extremely long delays in getting a doctor from the hospital to prioritize and examine a severely traumatized child in theatre.

4.6.3 Patient support and "comfort" services

- In keeping with the TCC model, all of the sites provide patients with an opportunity to shower and change clothes following the examination. Most sites were well stocked by SOCA with underwear and tracksuits for adults and at least some emergency clothing for children. All sites provided patients with soap and towels, and a few – particularly Cecilia Makiwane – distributed (privately donated) "comfort kits," containing personal toiletries (including toothbrush and paste, mouthwash, shampoo, lotion, sanitary pads, etc.).

- Most of the TCCs were able to offer patients tea, biscuits, and/or instant soup following the examination. Only one site (St. Barnabas) reported problems with not having adequate supplies of basic refreshments.
- Some HCPs (particularly at Prince Mshiyeni and St. Barnabas) felt that TCCs needed to provide more substantial food to patients than was currently available. They noted that many of their patients presented without having eaten in many hours and needed to have food in their stomachs before taking medications.[61]
- A few TCCs -- those with strong relationships and support from the hospital – were also able to order meals for patients/care-givers from the hospital kitchen (Cecilia Makiwane, Jooste, and to a lesser degree, Mahatma Gandhi). This was reported as extremely beneficial, especially for children. It also contributed to the overall experience of a caring and victim-friendly environment.
- Showering facilities, spare clothing, food/drink, and other amenities were not available after hours or on weekends at the three sites where examinations were conducted outside the TCCin casualty.[62]

4.6.4 Protection of dignity/ reducing secondary victimization

- All of the TCCs are making substantial efforts to minimize secondary victimization and protect the dignity of sexual assault patients. Permanent staff does its best to cultivate a culture of sensitivity and respect among all role-players, and to provide a full range of services within the TCC so as to minimize the patients' interaction with other parts of the hospital.
- On the health care side, a few sites reported problems with insensitivity on the part of HCPs serving sexual assault patients – primarily on-call doctors and/or general nursing staff who either do not want to work with sexual assault patients or who had not received adequate training in sexual assault management.
- Most TCC sites try to limit the wait for examination to a maximum of two to three hours. In reality, however, much longer waits were reported at most sites, particularly after hours and at sites that rely on doctors from casualty. Waits as long as six to eight hours were reported at some casualty-based sites. Waits tend to be shorter where there are dedicated examining HCPs on-site or a dedicated roster after hours. However even these can be long when the centre is busy (as most TCCs only have one staff doctor or forensic nurse on duty at any given time), or where the on-call doctors are shared with another hospital.
- Some TCCs – those responsible for all medico-legal services -- reported problems with rape suspects being brought into the centre at the same time when victims were waiting for services. Such incidences reportedly caused considerable stress to the patient as well as to TCC staff. At present, only Chris Hani Baragwanath has a separate entrance for suspects to avoid contact with sexual assault patients.

[61] The National Guidelines note that certain medications, such as STI prophylaxis, ECP and the 3d drug Lopinavir/ritonavir, are best taken after meals.
[62] Cecilia Makiwane reported that casualty patients could shower in another part of the hospital, but most chose not to.

- Not all sites stock medications in the TCC – some have to be collected from the general pharmacy or from casualty/OPD. Most sites have addressed this problem by having TCC staff collect medication for patients or by having special arrangements with the pharmacy to avoid patients having to wait in long queues.
- All but one TCC (St. Barnabas) conducts VCT onsite in the TCC, so patients do not have to leave the centre to receive services unless they have a physical injury requiring emergency or specialized care.[63]
- Some sites reported problems with the quality/consistency of sexual assault examination, documentation of the J88, and protection of the chain of evidence, particularly after hours. Although not assessed for purposes of this study, such reports raise concern about the potential for loss of evidence and negative impact on the patient's case.
- Several TCCs expressed concern about secondary victimization arising out of patient interaction with police. Among their chief concerns:
    - Police not available to take statements on site. Patients have to give statements before coming to TCC (resulting in long waits and further delays of medical treatment) or return to the station after leaving the TCC;[64]
    - Long waits at the police stations for transportation to the TCC, or at the TCC after health care is completed, for transportation home;
    - Lack of space in the TCC for patients to speak privately with police officers;
    - Unavailability of specially trained FCS officers to take patient/care-giver statements; lack of gender-sensitivity and/or specialized skills to take statements from children; and
    - Gross insensitivity toward patients on the part of some police officers/ judgmental attitudes/ failure to take victim complaints seriously.

- Part of the TCC model is to integrate criminal justice services with health services at the health care delivery site. At some TCCs, vacancies in non-health positions (site coordinator, victim assistance officers, case managers) have made it difficult to effectively monitor the status of investigations/court cases or to communicate with TCC clients about their cases in a timely manner. Lack of communication about suspects being let out on bail and failure to provide court preparation before patients are called to testify were sited as the most serious concerns leading to secondary victimization. However, site coordinators noted that other problems/gaps in this area could also cause patients to become frustrated with the process and "lose faith in the TCC."[65]

[63] At St. Barnabas, sexual assault patients receive VCT at the hospital ART unit during regular hours. (No VCT is available after hours). Although a reasonable response to understaffing at the TCC, the ART unit director felt that "it would be better for the patients if everything were done at the [Thuthuzela] centre."

[64] Only one TCC (Cecilia Makiwane Hospital) still had a specialized officer onsite at the TCC to take patient statements in keeping with the TCC model. This officer was removed for a period of time due to restructuring within SAPS, but the TCC lobbied successfully for his return. A female officer is also due to be added to the TCC staff complement soon.

[65] Interview with site coordinators at Mamelodi, Mahatma Gandhi, and Prince Mshiyeni.

4.7 Confidentiality

A general principle of the National Guidelines is that patient confidentiality should be assured and maintained. This includes, but is not limited to, protecting the confidentiality of the patient's HIV test results. Specific standards include: maintaining files separately from other patient files, controlling access to files,[66] not disclosing information about patients to other people (including family member and referral organizations) without the patient's consent, and never writing the HIV result on the J88 form.

The study found that not all sites maintain the medical files of sexual assault patients separately from the hospital.[67] "Model one" sites – those under medico-legal services – are more likely to have an independent filing system than TCCs managed by the hospital. Among the "Model two" sites, Natalspruit has one of the better systems. There, patient files are kept in the TCC for six months, then moved to a separate, access-controlled cabinet in central administration. At Cecilia Makiwane, doctors noted that once a patient is treated for rape, his or her history as a rape patient, and his or her HIV test result is always evident from the information kept in the hospital medical file. Some (though not all) doctors felt this compromised patient privacy, since patients keep the same file for all future treatment at the hospital.

Aside from sharing files with the hospital, the study found that most of the sites have good systems in place to maintain patient confidentiality. Measures include: confidentiality policies (particularly with respect to HIV status), areas to register clients in privacy, locking away patient files, not allowing discussion of patient information or test results over the telephone, allocating responsibility for files to one person, and sensitizing staff to the importance of confidentiality. A few sites, such as Prince Mshiyeni, have taken additional steps to protect patient information, including removing sensitive documents (J88 form, HIV results) from the medical file when patients are referred to other services in the hospital.

Three of the ten sites were rated as only partially compliant with National Guidelines with respect to patient confidentiality. At these sites, key challenges include limited space in the TCC (leading to sharing of offices and file cabinets), and/or lack of lockable cabinets, making it harder for the health worker in charge to ensure the security and confidentiality of information stored.

4.8 Referrals and follow up

The National Guidelines provide general standards for referral and follow up care (as well as specific guidelines for HIV follow up, discussed in section 5).

4.8.1 Referral

Under Referral (Section 14), the Guidelines advise HCPs to provide information to patients about appropriate local support services, including written referrals on

[66] These standards also relate to file security.

[67] All TCCs maintain their own patient registers and "TCC" files (primarily for information relating to the criminal investigation/court case). TCC files are normally locked in the site coordinator's office.

request. These services may include: NGOs supporting women/children, rape crisis centres, shelters or safe houses, Legal AID, support groups, social services, and reproductive health services/TOP.[68] (Clinical referrals, i.e. for physical injuries, psychological services, or HIV management are discussed in other sections of the Guidelines). According to the Guidelines, HCPs should obtain the patient's consent to release patient information to other referral agencies,[69] and explain the reasons for the referral and nature of services provided.

With respect to referrals, the study found that:

- All TCCs have systems in place to refer patients to temporary places of safety. This is usually the responsibility of the site coordinator or victim assistance officer (where available), in conjunction with NGOs and/or social services.

- Most TCCs appear to give referral information to patients, to the extent that relevant services have been identified and/or linkages established. Availability of support services is uneven, however, as specialized NGOs tend to be concentrated in certain geographical areas, such as Gauteng and Western Cape. In addition, not all TCCs are aware of support services in the communities they serve, and rely solely on services available within the TCC and/or hospital itself. In these sites, additional support may be required to help sites identify potential partners (such as local churches, schools, clinics, etc.) and cultivate linkages with these organizations.

- Most casualty staff and some on-call doctors are not familiar with local services available to sexual assault victims and do not refer patients for further support. Only one of the casualty or on-call doctors interviewed had ever referred patients for psycho-social counselling, and none had ever referred an HIV+ sexual assault patient for HIV-related care. None of the casualty units visited had brochures or IEC materials on hand relating to rape support services. At Cecilia Makiwane and Galeshewe, casualty/forensic doctors reportedly make a point of advising after-hour patients to return to the TCC during regular hours for counselling, information and VCT, as they are unable to provide these services. At St. Barnabas, however, several most of the casualty doctors interviewed were not even aware that the hospital had a TCC or what services the TCC offered. It appears unlikely, therefore, that patients who are seen first in casualty received any information on available local services or return to the TCC for follow up support.

4.8.2 Follow-up

Under follow-up, the Guidelines recommend clinical follow up at 3 days, 6 weeks and 3 months.[70] The purpose of the 3 day follow-up appointment is to assess the patient's general emotional and physical state, provide VCT for those that did not test or receive results at the initial visit, provide remaining PEP (ARV), assess completion of medications, look for traumatic stress disorder, and provide contraception counselling

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[68] National Guidelines, section 14, p. 30.

[69] National Guidelines, p. 8.

[70] National Guidelines, section 15, p.31. Note, however, that reference is also made to a "one-week assessment (p.27), adding some ambiguity to the recommendation. National ART Guidelines state that patients should ideally be seen one week post-rape with the next visit at 6 weeks. p. 76.

if appropriate. Subsequent follow-ups at 6 weeks and 3 months are recommended for ongoing counselling/support, physical and emotional assessment, and repeat testing for HIV (particularly for those that did not receive or complete PEP).

According to the National Guidelines, health care providers have a responsibility upon discharging the patient to "ensure that proper follow-up arrangements are in place."[71] It is unclear whether merely scheduling a follow-up appointment is sufficient to comply with this standard, or whether more proactive measures are required.

In the area of general follow-up, the study found the following:

- All of the TCCs advise patients to return for follow-up appointments after the initial visit, and most write the date of the appointment on an appointment card for the patient to take home. Only one site (Chris Hani Baragwanath) routinely makes follow-up calls before the appointment date to remind patients to return to the site. Most sites report that they do not have sufficient staff to provide this service.

- Most sites do not schedule a follow-up examination at 3 days. Only Jooste and St. Barnabas consistently schedule a 3-day appointment. Other sites see patients after one to three days only if they received a starter pack after hours or return to the site with concerns.

- The timing of the second visit depends largely on how PEP is administered at the initial visit (STAT dose, starter pack, one week supply, full supply, etc.). At seven of the ten sites, patients have to come back to the site at least once during the first month to receive additional PEP medication. Some have to return after a few days; some must return every week, whereas others have appointments only after one to two weeks and then again at 6 weeks. At two sites (Mafikeng and Galeshewe), no follow-up appointments are routinely scheduled before 6 weeks.[72]

- Doctors are not usually involved in routine follow up. Patients are most often seen by a forensic nurse/staff nurse or lay counsellor unless they report a specific problem requiring a doctor's attention. The content of follow-up appointments seems to vary depending on the practitioner and the needs of individual patients. At some sites, the focus of the appointment is on repeat HIV testing and may not include all recommended elements.

- Most sites reported loss of patients across the different follow-up points, particularly at three months and six months. Some TCCs reported high rates of return for follow up (including repeat testing at 6 weeks and 3 months), whereas others said very few patients come back. Higher rates of return appear to be correlated to some degree with the victim-friendliness of the site, and availability of ongoing, on-site support services, particularly counselling and/or

[71] National Guidelines, section 15, p. 31.

[72] Given that most TCCs offer a rapid test and PEP on the first visit, the need for a follow up at 3 days arguably falls away unless the client was not ready for the test/test results or the patient presented after hours at a site where rapid testing was not offered. Except in these cases, clinical follow up at one to two weeks may more practical.

support groups. It was not possible to establish the reasons why patients do not return for follow-up, although many sites identified lack of transport as a significant barrier.

- Concern was also expressed regarding loss of "after-hours" patients even before the 3-day visit, indicating that some patients do not return to the site to establish their HIV status or to collect further treatment.[73] Other patients return to the site more than 3 days after their initial visit -- too late to continue ARV treatment. Drop-offs were particularly noted by researchers where the patients first presented in casualty. While it is not clear how many casualty patients are "lost" after the first visit, differences in the number of rape patients recorded in casualty and monthly TCC registers suggest that some casualty patients are not linking up with the TCC afterwards for PEP and/or follow up support.[74]

5. COMPLIANCE WITH NATIONAL STANDARDS FOR HIV/AIDS AND RELATED REPRODUCTIVE HEALTH CARE

HIV transmission is one of the most serious long-term risks of penetrative sexual assault. Given the high prevalence rate of HIV in South Africa, comprehensive prophylactic treatment is essential to reduce the risk of HIV transmission as well as other serious medical and/or social consequences for sexual assault patients.

The National Guidelines recognize the risk presented by HIV and stress that HIV counselling, testing and prophylaxis should be routinely provided by appropriately trained health care providers as part of comprehensive sexual assault management. Screening and emergency prophylaxis should also be provided to prevent pregnancy, treat and/or prevent Hepatitis B and treat and/or prevent sexually transmitted infections (STI), which can compound the risks and consequences of HIV infection.

The following section summarizes the findings on HIV-related compliance across the ten TCC sites. Site-specific compliance summaries are contained in the Annex of the Report.

5.1 HIV Counselling and Testing

Voluntary HIV counselling and testing (VCT) is addressed in sections 8 and 10 of the National Guidelines. The Guidelines state that patients should be informed of the risk of HIV infection from sexual assault during the "acute phase" (or first) consultation and offered VCT. VCT may be conducted on the first visit, with results provided immediately for those who are ready and willing to have the test performed. The Guidelines stress, however, that VCT *may be delayed for up to three days* if the

[73] TCCs do not have any system in place that would allow it to determine what percentage of these patients collect treatment elsewhere (i.e. a private doctor or local clinic).
[74] Based on statistical information provided at Cecilia Makiwane, it appears, for example, that of 31 rape patients seen by casualty in December 2006, only 25 opened case files at the TCC. The site could not say how many of those presenting after hours reported to the TCC within 3 days in time to continue the course of PEP.

patient initially refuses the test or the emotional status of the patient indicates that she/he cannot take a positive test result.[75] Patients may also choose to test immediately but delay the test result.

The Guidelines indicate that VCT should be provided by a skilled health care provider. Under the Guideline's definitions, this can be any medical officer, specialist or nurse who has received appropriate training. The Guidelines do not specifically state whether VCT may be provided by trained lay counsellors rather than health care personnel. (New provisions in the Children's Act state only that pre-and post-test counselling must be conducted by an "appropriately trained person." (Section 130 (1)).

The Guidelines do not state when VCT should be provided in relation to other health services (i.e. before, during or after the medico-legal examination).[76] They do state, however, that health care providers should try to strike a balance between providing information and the sensitivity to the emotions of the patient. They state further that health care providers should consider the patient's current level of trauma, ability to absorb information, and self-esteem/assertiveness at the time VCT is provided and should seek to ensure that HIV testing is genuinely voluntary and does not unduly exacerbate the client's level of trauma.

The Guidelines provide general guidance on the content of pre- and post-test counselling and the type of information that should be discussed in each session. Section 10.9 states that HIV testing should be done using the rapid testing protocol in all patients who agree to have the test done. If rapid test is not available, then blood should be drawn and sent to the laboratory for results. Children under 15 months with penetrative sexual abuse should have PCR performed to determine their HIV status.

Finally, the Guidelines emphasize the need for follow up HIV tests to further assess the patient's HIV status and ascertain or rule out sero conversion. Follow up tests are recommended at six weeks, three months, and six months, for those who test negative at the first visit.[77] This applies to all patients exposed to HIV, whether or not they presented in time to receive PEP. HIV counselling is recommended at each follow up visit, particularly for those not tested for HIV initially.[78]

5.1.1 HIV testing

The study found the following with respect to HIV Testing:

- All of the TCCs offer HIV testing in conjunction with other sexual assault services. Testing is offered to all patients reporting within 72 hours as well as those who report later.[79]

[75] National Guidelines, section 8, p. 11.
[76] This is in contrast to some Thuthuzela site protocols which provide for VCT after the forensic examination, bathing, etc. in the recommended process flow.
[77] National Guidelines, section 10.9, p.23.
[78] National Guidelines, section 15, p.31.
[79] Note, however, that some casualty/OPD units only provide HIV testing to patients reporting within 72 hours.

- At three sites (Galeshewe, Mafikeng, and St. Barnabus), HIV testing is not available after hours or on weekends when the TCC is closed. In these cases, patients reporting within 72 hours are generally provided with a PEP starter pack and advised to return during regular hours for VCT and additional PEP (where indicated).

- Cecilia Makiwane does not conduct rapid testing after hours because HIV counselling is not available. Where patients are seen after hours, blood is drawn and sent to the lab for HIV testing, with results available the next business day. Patients are advised to return to the TCC during regular hours for pre- and post-test counselling and test results.

- Almost all 8 of 10 TCCs use rapid tests as the basis for administration of PEP. At some sites, a blood test (Elisa) is used for patients under age 14. Elisa is also used in some cases for patients presenting after 72 hours, or for follow up HIV tests.[80]

- Confirmatory tests are performed in all TCCs. Most sites use a second rapid test for confirmation, plus a blood test (Elisa) in the case of inconclusive or positive results.

- KZN sites reported problems getting confirmatory blood test results in time, since blood has to be sent to a central (regional) lab for processing.

- Nurses and/or nurse assistants are responsible for HIV testing at all sites. Assistant nurses tend to do only the rapid test. After hours, doctors draw blood for the confirmatory test. At two sites, (Mamelodi and Chris Hani Baragwanath) lay counsellors are responsible for performing the test (after a nurse has done the prick) and interpreting results. At St. Barnabas, VCT is conducted (during regular hours) by nurses in the ART Unit of the hospital.

- Eight of the ten sites do not obtain require separate written consent for the HIV test.

- Most sites test prior to the medical examination. This practice allows the doctor/forensic nurse to prescribe all medication at once but may also mean that clients are confronted with an HIV test before receiving adequate trauma containment.[81] At one site (Prince Mshiyeni), patients presenting within 72 hours receive VCT before the medical exam, while patients presenting after 72 hours are counseled afterwards. At some sites the forensic nurse performs the test herself as part of the medical exam (a factor sometimes influenced by the absence of competent support staff).

[80] Using Elisa rather than rapid tests for repeat testing during follow up was reported particularly at Jooste. This practice seems unnecessarily burdensome for patients who then have to return again to the site for test result.
[81] Another reason sited for testing early in the process is that patients are worried about HIV transmission and prioritize getting PEP over other services. It appears, however, that patients could immediately be assured that HIV and PEP will be addressed, without necessarily requiring testing as the first step in the process.

- Eight of the ten TCCs do not give patients the option to delay VCT or VCT results. Rather, immediate rapid testing and a negative result are prerequisites for receiving PEP, including a PEP starter pack. Only Cecilia Makiwane and St. Barnabas (both Eastern Cape) reported that they allow patients to delay testing for up to three days if they are not ready to test or to receive test results at the first visit. Jooste and Galeshewe reported that they allow patients to delay results but not testing. If patients refuse to test then they are not given PEP.[82]

- In general, health care workers at the TCCs are reluctant to give starter packs without HIV testing, out of concern that patients do not return for the test/test results and they do not have systems in place to track clients. Some medical doctors also expressed concern that even giving PEP starter packs to HIV positive patients would fuel resistance to PEP.

Option to Delay HIV Test/Test Results per National Guidelines	Compliant	Partially Compliant	Not Compliant
	Option to delay test/ test results up to 3 days (with starter pack)	Must test but option to delay results (with starter pack)	Must test and get results to get PEP
Chris Hani-Baragwanath			X
Mamelodi			X
Natalspruit			X
C. Makiwane	√		
St. Barnabas	√		
Mafikeng			X
Galeshewe		~	
M. Gandhi			X
Prince Mshiyeni			X
G.F. Jooste		~	
Total number	2	2	6

5.1.2 HIV Counselling

The compliance assessment with respect to HIV counselling focused primarily on access to pre- and post-test counselling and whether staff responsible for providing the service had been trained in VCT. Although an in-depth evaluation of counselling services was not possible, some aspects of service quality were observed and noted.

The research found with respect to HIV counselling that:

[82] Note that some inconsistencies were reported on this issue, as one nurse at Jooste reported that patients could delay testing but other nurses said they could not. At Prince Mshiyeni, patients are allowed to delay testing up to 72 hours from the assault, but are not given starter packs in the meantime. Patients seen after hours by casualty at Kimberly and Mafikeng hospitals can receive a starter pack without testing, as HIV tests are not performed in casualty.

- All TCCs provide some level of pre- and post-test counselling in conjunction with the HIV test. HIV counselling is not provided in casualty when the TCC is closed.

- Post-test counselling is offered mainly to clients testing positive.

- Pre- and post-test counselling is normally performed by lay counselors contracted through the provincial DOH HIV/AIDS programme (HAST), or by the nursing staff.

- For some time, many of the TCCs have not been able to offer a consistent service with respect to HIV counselling. Counselling services at Chris Hani Baragwanath, Cecilia Makiwane, Prince Mshiyeni and Natalspruit are somewhat better coordinated. St. Barnabas depends on the ART clinic to provide HIV counselling services.

- The quality of HIV counselling appears weak at many sites. Principle reasons include:
  - Shortage of nurses skilled in HIV counselling at the site (Jooste, Mafikeng, Mahatma Gandhi);
  - Key personnel not trained in HIV counselling (Galeshewe), and
  - Inadequate mentoring of volunteers (Mamelodi, Natalspruit).

- At a few sites, nurses assigned permanently to the TCC have undergone a two week training in VCT, resulting in a higher skill level than in the general nursing population.[83] However, many of the nurses responsible for providing HIV counselling to TCC patients have not been adequately trained.

- In all sites, the quality of HIV counselling is better during regular working hours when a range of service providers are at work.

- While the counselling appears to address the informational needs of patients very well at most sites, very little is invested in managing the emotional needs of the client. Pre-test counseling is often overshadowed by the need to give or access PEP.

- Most nurses and volunteers who have been trained to conduct HIV counselling have not been specifically trained to provide VCT in the context of sexual assault. As a result some may not be adequately trained to deal with the special needs of sexual assault patients or to effectively counsel already traumatized patients. Several counselors reported lack of confidence in counselling sexual assault patients who test positive for HIV.

- Follow-up HIV counselling is not always available at the TCC, and is not included as a standard part of psycho-social counselling at most sites. Sites such as Chris Hani Baragwanath and Natalspruit are among the better sites

[83] Although some hospitals have trained “VCT nurses” on staff, these are not generally assigned to the Thuthuzela Centres or to casualty after hours.

for integrating ongoing HIV issues into longer-term counselling and support services.

- Follow-up counselling for HIV-positive patients is generally better at HIV/AIDS referral sites such as ART clinics (hospital or NGO) where nurses and/or counsellors are better trained and more experienced in HIV counselling. However, staff at these sites also reported challenges and/or concerns about lack of training/experience on how to address the special needs of sexual assault patients.

5.1.3 Follow up testing and counselling

The National Guidelines state that sexual assault patients should be advised and given appointments to return for a repeat HIV test at six weeks and again at 3 months. (A 6 month repeat test is also recommended, although several HCPs interviewed questioned the added value of this practice). Standards for repeat testing apply to all patients exposed to HIV, whether or not they present in time to receive PEP.

The study found that:

- All TCC sites advise patients to return for repeat testing and most provide appointment dates (and appointment cards) at the initial or first follow-up visit.

- The challenge for most sites is ensuring that patients actually return for follow-up testing. Some sites reported that most of their patients return for follow-up (Prince Mshiyeni, Chris Hani-Baragwanath, Natalspruit), whereas others said they lose most patients after the first month.[84] At Mahatma Gandhi and St. Barnabas, staff reported that very few of their patients – less than 10% -- returned for the 3 month appointment.

5.2 Post-exposure Prophylaxis (PEP)

The National Guidelines provide the following standards for administration of PEP in adult and child victims of sexual assault: According to Section 11.6, PEP (or “ART”) should be offered to all sexual assault patients presenting within 72 hours of exposure to HIV.[85] (Those that present after 72 hours should be counseled about the ineffectiveness of PEP started more than 72 hours after the exposure and advised to return for an HIV test at 6 weeks and 3 months.) Treatment should be stopped for those found to be HIV positive or who seroconvert during the course of treatment. The National Guidelines (as well as national ART guidelines) do not require health care providers to conduct baseline blood tests (FBC or liver function) as a routine matter on patients before prescribing PEP.[86]

[84] Note that the TCCs reporting high rates of return all offer on-going counseling and/or support groups on-site.
[85] National Guidelines, p.27.
[86] The National Guidelines are silent on this point, whereas the national ART guidelines state specifically that routine baseline tests are “not recommended for such a short duration of therapy.”

The recommended PEP regimen for adults consists of AZT (300mg 12 hourly for 28 days) and 3TC (150mg 12 hourly for 28 days). A third drug, lopinavir/ritonavir (400/100mg 12 hourly) should be added to the above in patients with a high risk of infection. “High risk” is understood to mean cases involving multiple perpetrators, anal penetration, obvious trauma to the genital area, and/or a perpetrator known to be HIV positive. The Guidelines state that PEP should be offered to pregnant patients, but those in their first trimester should be informed of risks and allowed to make a choice of whether to take PEP or not.

The standard treatment for children who have been exposed to penetrative sexual abuse also consists of AZT and 3TC, calculated according to the child’s age and weight. The Guidelines do not state whether lopinavir/ritonavir should be prescribed for children under age 14.

The protocol for administration of PEP is somewhat ambiguous in the National Guidelines. The Guidelines state that patients who prefer not to test or receive results immediately, should be given a 3 day starter back, with “the rest of the treatment … given when the HIV status of the patient is established as negative.”[87] The Guidelines also state that “patients who cannot return for their one-week assessment due to logistical or economic reasons” should be given “a month’s treatment supply with a [follow-up] appointment date.” Together, these provisions (along with the provisions of the National ART Guidelines)[88] suggest that patients who test HIV negative at the initial visit should receive either a one week supply of PEP, followed by a three week supply, or a full course of PEP treatment (all 28 days), if they are unlikely to be able to return for a one-week follow up. Patients who do not test or receive results (for whatever reason) at the initial visit should be given a starter pack, with the balance of medication given at 3 days to those obtaining a negative result.[89]

What is clear from the Guidelines is that patients should continue on PEP for 28-days (absent sero-conversion) and that proactive steps should be taken to ensure strict adherence. . Minimum standards for achieving adherence include: informing patients about the advantages of PEP for reducing the risk of HIV infection; counselling patients on the medication, common side effects, and the importance of 100% compliance (as well as providing simple written instructions on taking PEP)[90]; routinely

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(DOH, 2004 p. 76). This is one area where South African standards are inconsistent with WHO guidelines, which recommend baseline tests on all patients before starting any course of ART.

[87] National Guidelines, section 11.6, p. 27 and section 15, p. 31.

[88] Note that the National ART Guidelines (DOH, 2004) are much clearer on this point. According to these guidelines, patients testing HIV negative at the initial visit should be given a one week supply of PEP, with the “remainder” of the drugs (a three -week supply) given at the one week follow up visit, after the patient’s test results are confirmed. Patients who delay testing or test results should be given a starter pack, with the balance at 3 days. A full month supply should be given at the initial visit to patients who cannot return at one-week due to logistical or economic reasons. See pp. 75-76.

[89] Other interpretations are possible, however, given certain ambiguities/inconsistencies in the text. Note, for example, that this interpretation is somewhat in conflict with the follow up provisions of the Guidelines which call for follow-up at 3 days rather than one-week. See above discussion in Report under referral and follow-up.

[90] The National Guidelines state that all patients should be given simple clearly written instructions about taking PEP medication. National Guidelines, p. 29. As the document explains:

> “Medication regimes may be routine and sound simple for health care providers, however to patients who are traumatized and stressed, enormous difficulty may be experienced in relation to remembering what must be taken, when and why, etc.”

prescribing a one-week supply of anti-emetics; and advising patients to return to the site for follow up in the event of side effects. In addition, the Guidelines recommend that sites employ various strategies to facilitate PEP compliance, including home visits, follow up phone calls, referrals to NGOs and/or support groups.[91]

The research found the following with respect to PEP information and administration:

5.2.1 Information counselling and materials

- PEP medication is most often dispensed (at least initially) by a nurse at the site (and later by the regular pharmacy). In some cases, medications are dispensed and explained by the doctor or forensic nurse following the medico-legal examination. At other sites, however, this responsibility falls to whichever nurse or nurse assistant is on duty at the time (including some with limited information on the treatment). At two sites, volunteers collect the medication from the pharmacy and give it to patients.

- Thorough information counselling on PEP is not consistently provided at many sites, particularly after hours and in casualty. In some cases, HCPs (particularly those with limited experience and training in PEP and/or sexual assault) may not be able to explain PEP to traumatized patients in a way that patients can understand, or HCPs may be inhibited by language/cultural barriers and/or time constraints. Whether due to trauma or inadequate counselling, several NGO reported that patients often leave the TCCs not understanding why PEP is important or why they must keep taking the pills for the full 28 days.

- Except for Chris Hani-Baragwanath, none of the TCCs routinely provide patients with take-home literature with instructions for taking PEP. Most sites do not consistently stock brochures or other written information on PEP. Where materials on PEP are available, they tend to refer only generally to PEP without providing detailed information on the proper daily regimen, why full compliance is critical, or how to deal with side effects.

- Most sites counsel pregnant women in the first trimester about the risks and side effects of PEP treatment. However, not all pregnant patients are counselled according to the National Guidelines. Dedicated health care practitioners reported that they discussed the risks of PEP with pregnant patients or referred patients for consultation with OB/GYN specialists in the hospital. However other practitioners interviewed seem to discourage pregnant patients from taking PEP (or not prescribe it at all) while HCPs (at St. Barnabas) prescribe PEP without knowing the pregnancy status of the patient.

- Only a few sites reported routinely discussing the importance of condom use with patients on PEP.

[91] National Guidelines, section 11.6, p. 28.

5.2.2 Administration of PEP Treatment

- At all TCC sites, PEP is offered to patients presenting within 72 hours and testing HIV negative. Where VCT is not available (i.e. in casualty after hours), patients are prescribed a starter pack and advised to return for HIV tests during regular hours.

- All TCCs prescribe AZT/3TC to adults, consistent with national guidelines.

- Five of the ten sites do not prescribe lopinavir/ritonavir in high risk cases. In some sites, HCPs are not aware of this requirement in the national protocol;[92] in others the medication is not available. At one site, lopinavir/ritonavir is prescribed, but health care providers tend to interpret "high risk" more narrowly than the National Guidelines. At some sites, lopinavir/ritonavir is not available after hours when the pharmacy is closed, and/or not available in syrup form for children. Pre-packaged starter packs do not include the third drug.

Prescription of Third PEP Drug in Cases of High-Risk Exposure		
	Compliant	Non-compliant
Chris Hani-Baragwanath		X
Mamelodi	√	X
Natalspruit	√	X
C. Makiwane	√ (Prescribed, but "high risk" somewhat narrowly defined)	
St. Barnabas	√ (not available after hours when TCC closed)	
Mafikeng	√	
Galeshewe		X
M. Gandhi	√	
Prince Mshiyeni		X
G.F. Jooste	√	

- AZT/3TC is prescribed for children and is available in suspension form at all sites

- Calculating the right dosage of PEP for children is a challenge at most sites, as dosages for each medication vary depending on the age and weight of the child. At several sites, health care providers and pharmacists reported recurring problems with prescribing by on-call doctors, in particular. Fewer problems were reported at sites such as Prince Mshiyeni and Mahatma

[92] Interestingly, even practitioners experienced in HIV management who supported the use of the 3rd drug were not aware that this standard is provided for in the National Guidelines.

Gandhi that prominently display children's dosage charts in the examination rooms.[93]

- Administration practices with respect to supply of PEP vary considerably between TCC sites. Although some administer PEP based on the National Guidelines, others follow provincial or hospital policies/ protocols. Where practices depart from the National standards, it appears that HCPs are not aware of what the National Guidelines provide and/or disagree with the recommended approach. For the most part, TCC practices with respect to supplying PEP reflect varying views on how best to monitor and ensure patient compliance.

  - At Chris Hani Baragwanath, Natalspruit, Mahatma Gandhi[94], and Mamelodi, PEP is provided in one week supplies, compelling patients to return at least three more times to the hospital before completing treatment. Starter packs are rarely given as all patients are tested at the initial visit.

  - At Jooste, most patients receive two, two-week supplies. Starter packs may be given where patients consent to HIV test but do not want results immediately. No starter packs are provided to patients refusing to test.

  - At Cecilia Makiwane, patients are given either a starter pack (after hours or if delaying test/test results) or one-week supply (regular hours and HIV-), with the remaining three weeks normally provided at the one-week follow up. This site used to provide PEP in weekly increments, but changed recently to reduce the travel burden on patients and improve compliance. Casualty doctors are also encouraged to prescribe a 5 day starter pack in certain cases (including over holidays and long weekends) to allow patients time to return during regular hours for VCT.

  - At Prince Mshiyeni, HIV negative patients presenting during the day receive a full month supply of PEP, divided into daily packets. Patients presenting at night or on weekends receive a 1-3 day starter pack, with the remaining supply provided the next business day. Starter packs are not given to patients without determining HIV status.

  - The TCC at St. Barnabas provides all patients (presenting within 72 hours) with a 3 day starter pack, with the balance of PEP provided at the 3 day follow up appointment. Patients wishing to delay testing/test results may do so, with starter pack, up to 3 days. Patients presenting after hours at casualty are given starter pack and advised to return for VCT during regular hours. Patients seen in casualty during regular hours (i.e. when forensic nurse is on leave) are tested and, if negative, receive the full 28 day supply of PEP at once.

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[93] These charts were reportedly reproduced from the KZN provincial protocol on management of sexual assault.

- At Galeshewe and Mafikeng, a full 28 day supply is provided to all patients testing negative. (No option to delay testing reported). After hours and on weekends, patients reporting to Kimberly Hospital or casualty receive a starter pack and are referred back to the TCC during regular hours for VCT.

COMPARISON OF PEP ADMINISTRATION PRACTICES					
Site	3 day starter pack, then remaining 25 at once	1 week, then remaining 3 weeks	2 weeks + 2 weeks	Weekly (7 days x 4)	Full 28 at once (no starter pack)
Chris Hani-Baragwanath				X	
Mamelodi				X	
Natalspruit				X	
C. Makiwane	X, 1-5 day starter pack if after hours or delayed test/results	X			
St. Barnabas	X				
Mafikeng					X
Galeshewe					X
M. Gandhi				X	
Prince Mshiyeni	X, 1-3 day starter pack if after hours				X
C.F.Jooste			X May get starter pack if delay test results		

- At present, only one TCC – GF Jooste -- prescribes “Combivir” (a combination of AZT and 3TC in one pill). This practice limits the number of pills the patient must take to two per day (14 per week). All other sites prescribe AZT and 3TC. These come packaged in various ways – At Chris Hani-Baragwanath, the TCC dispenses AZT in 300mg capsules, resulting in a regimen of 4 pills per day (2 AZT and 2 3TC) or 28 per week. Most other sites provide AZT in 150mg tablets, resulting in a total regimen of 6 pills per day (42 per week). At Mamelodi, however, treatment consists of AZT in 100mg tablets (plus 150mg 3TC) resulting in a daily regimen of 8 pills total (56 per week). Although this could not be verified, sites supplying larger numbers of pills reported more problems with patients skipping pills (particularly AZT) than those providing simpler regimens.

- Only one site (Mamelodi) reported supply problems with PEP medication interfering with provision of PEP at the initial visit.[95] Although most sites reported no problems accessing adult medication (including starter packs after hours), three sites (Cecilia Makiwane, Prince Mshiyeni and Jooste) reported that only very limited supplies of children's syrups can be provided after hours (i.e. a Stat dose), and that care-givers sometimes have to stay over or return to the pharmacy the next day during regular hours to obtain additional medication. At Jooste, night nurses said they did not provide children's syrups after hours and preferred caregivers to return to the site during regular hours to obtain the PEP syrups from the pharmacy. (In this case, it appears that children's syrups can only be collected from pharmacy, a limitation on access after hours and over weekends).

- Some sites routinely perform baseline blood tests on all patients who receive PEP according to local and/or provincial protocols. However it is not clear that repeat tests are performed following completion of PEP.

- None of the sites are able to stop PEP in the event of sero-conversion, as patients are only tested for HIV at 6 weeks (after the 28 day regimen is completed).

5.2.3 Measures to Facilitate PEP Compliance

Recent research conducted by the Medical Research Council in South Africa shows that sexual assault patients are very concerned about contracting HIV from rape and that most will complete the full 28 day course of PEP if given sufficient information and support.[96] However, it also found that the completion rate among TCC patients was substantially lower than that of patients receiving care from a sexual assault NGO. This they attributed to the fact that HIV negative patients presenting at the NGO site were able to get the full 28 day regimen at once and that the NGO provided home follow-up care (emotional support, information about medication and side effects, and food supplements) after the initial visit to the care centre.

In the area of PEP compliance, the study found the following:

- Systems for monitoring and evaluation of PEP compliance are weak in most TCCs. Although all TCCs keep monthly statistics on the number of patients given PEP,[97] none of the sites visited were able to provide ECI researchers with statistics on the percentage of patients eligible for PEP that received

[95] Mamelodi gets its supply of PEP from casualty after hours. In some cases, casualty has reportedly run out of PEP and patients have had to delay PEP until the pharmacy opened.

[96] See, e.g., Christophides N et al, Medical Research Council (2006), op cit. (comparing completion rates at the GF Jooste TCC and those from a rural NGO, Thohoyandou Victim Empowerment Programme. This study found that the NGO achieved a completion rate of 87% compared to 15% at the TCC.

[97] Although not all sites were willing to share their PEP statistics, it appears that nurses are generally tasked with keeping records for both internal purposes and reporting to their respective provincial department of health.

PEP, or the percentage of those starting PEP treatment that completed the full 28 day course. As a result, it was not possible to determine the actual rate of PEP compliance or assess the effectiveness of various measures used by sites to facilitate PEP compliance.

- Several sites reported high rates of adherence and were generally positive about PEP results. Perceptions of high compliance were usually based on low sero-conversion rates among patients returning for repeat tests, rather than adherence data.

- At other sites, TCC staff expressed concerns about very low compliance (sometimes based on prior studies,[98] but generally due to low rates of return for medication and/or follow-up).

Reasons for non-compliance have not been adequately studied by the TCC sites, although other research offers some insight into this problem.[99] As has been found elsewhere, TCC service providers felt that limitations in terms of administration of PEP were due to a number of factors including:

- Side effects (fatigue, nausea, vomiting)
- Inability to return to the site for more medication, or late return to the site (usually related to lack of transport and/or transport costs)
- Not understanding the need to finish the course
- Depression, trauma, lack of emotional support.

The TCCs use a range of measures to improve compliance with PEP. At all sites, this includes counselling patients on the need for complete adherence and advising patients to return to the site for medication if they experience severe side effects. Other measures include:

- Giving limited supplies of medication to compel clients to make return visits (for monitoring and provision of additional information and counselling)[100]
- Giving larger supplies of medication to reduce the number of times patients must return to the site[101]
- Scheduling counselling appointments and/or support groups to coincide with return visits (Prince Mshiyeni, Natalspruit, Chris Hani Baragwanath)

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[98] In 2004, the University of Natal studied PEP compliance among child sexual assault patients at Mahatma Gandhi, and found that less than 30% completed the 28 day course.

[99] See, e.g., Vetter, L. & Haffejee, S., "Factors Affecting Adherence to Post-Exposure Prophylaxis in the Aftermath of Sexual Assault: Key Findings from seven sites in Gauteng," Gender Programme, Centre for the Study of Violence and Reconciliation (2005); Christofides, N et al, Medical Research Council (2006), op. cit.

[100] Several HCPs (at Mamelodi, Natalspruit, Chris Hani-Baragwanath and GF Jooste) argued that requiring patients to return to the site on a regular basis is the only effective way they have to monitor patient adherence to the PEP regimen and reinforce the need for full compliance.

[101] Some sites, including Prince Mshiyeni and Cecilia Makiwane said they used to require weekly visits, but changed their practices as patients found it difficult to return to the site for additional medication. Both sites reported that compliance had improved as a result of requiring fewer visits.

- Reinforcing PEP information in counselling/support group sessions (Natalspruit, Chris Hani Baragwanath, Jooste)
- Arranging transport (when possible and on a case-by-case basis) for patients to return for follow-up appointments (St. Barnabas, Cecilia Makiwane, Mafikeng)[102]
- Providing small amounts of transport money (petty cash) to help patients return home after a visit to the site (Mahatma Gandhi, GF Jooste, Prince Mshiyeni).

Although all TCCs take some steps to support compliance, most do not meet the minimum standards provided by the National Guidelines.

- Only three of the TCC sites routinely prescribe anti-emetics as required by the National Guidelines. At Mahatma Gandhi, the medical officer reported that he had recently begun prescribing anti-emetics for all PEP patients, and found this to substantially reduce non-compliance due to side effects. At most sites, however, health care providers only prescribe anti-emetics if the patient experiences severe symptoms of nausea/vomiting and returns to the site for follow-up. At some sites, medical officers questioned the efficacy of anti-emetics (sometimes based on their own experience with occupational PEP) and rarely prescribed them for sexual assault patients, even where emergency contraception and STI prophylaxis were also prescribed.[103] Casualty doctors at Cecilia Makiwane and St. Barnabas did not prescribe anti-emetics with PEP starter packs on the argument that patients rarely experience side effects in the first few days.

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[102] St. Barnabas is currently the only TCC with its own vehicle. The Case Manager at the site reported, however, that the TCC can not generally provide patients with transport (or conduct home visits) due to understaffing at the site. However, at three sites, TCC staff reported that police were sometimes requested (in “emergencies”) to transport patients to and/or from the site for follow-up appointments.

[103] According to the National Guidelines, anti-emetics should always be prescribed to sexual assault patients on PEP, particularly if they are also given ECP and STI prophylaxis, as these medications can compound the side effects of AZT and 3TC. The Guidelines recommend that patients be given at least a one-week supply at the initial appointment to take in the event that they experience side effects. National Guidelines, section 11.6, p. 28.

Routine Prescription of Anti-emetics per National Guidelines	Compliant	Not compliant
	Anti-emetics routinely prescribed with PEP	Anti-emetics not routinely prescribed
Chris Hani-Baragwanath		X
Mamelodi		X
Natalspruit		X
C. Makiwane		X
St. Barnabas		X
Mafikeng	√	
Galeshewe		X
M. Gandhi	√*	
Prince Mshiyeni		X
C.F. Jooste	√	
Total number	3	7

*Practice after hours not confirmed

- Most TCCs do not initiate follow up calls to check on adherence and offer informational/emotional support. About half the sites (Chris Hani Baragwanath, Cecilia Makiwane, Natalspruit, Mafikeng, St. Barnabas, Jooste) attempt to reach patients by phone if they fail to return for a scheduled follow-up appointment. Only one (Chris Hani Baragwanath) routinely calls patients during the 28 day period to remind patients of appointments to collect PEP medication, check on compliance and offer information/emotional support. In a few cases, site coordinators or victim assistant officers stated that they ask about the patient's overall health and PEP compliance when they call patients about investigation or court-related issues; however calls are not normally initiated if there are no criminal justice issues to discuss. Reported obstacles to making follow up calls included: patients not being reachable by telephone (especially in rural areas); after hours staff/casualty not recording patient contact details; inadequate staff at the TCC to conduct follow-up calls; lack of clarity on who (nurses or NPA staff) should be responsible for follow-up on health-related issues; follow-up calls not normally done at hospitals/not included in nurses' job description.

- None of the sites currently have capacity to conduct home visits. Even the one TCC with access to a vehicle (St. Barnabas) can not go out to communities to check on patients because of staffing shortages. In emergencies (i.e. when patients do not return for medication and can not be reached by phone) staff at St. Barnabas, Cecilia Makiwane, and Mafikeng reported that they would sometimes ask the police to drive out to the patient's home and offer to transport him or her back to the site. While this was reported as helpful in some cases, it also raised concerns about confidentiality and protection of the patient's privacy. None of the TCCs have developed

- Take-home information on PEP is not routinely provided. As discussed earlier, an important and easily remedied gap at the TCCs is the lack of written information provided to patients and caregivers about PEP – how it can prevent HIV infection, how to take it, how to cope with side effects and why it is essential to finish the course. Providing clear and simple instructions in the patients' own language helps to reinforce the information provided at the initial visit to the site. This particularly critical at sites where the patient is given a supply of PEP without follow up in the first three days, and in casualty, where patients may not have received adequate information and counselling.

5.2.4 Community Awareness regarding PEP

Although not discussed in the National Guidelines, several HCPs and TCC site coordinators raised as an area of concern the general lack of knowledge in their communities about PEP and its role in preventing HIV infection. According to those interviewed, many (in some sites as many as 50%) of their patients report to the TCC (and/or to the police) more than 72 hours after the assault. Although many reasons may account for these delays, concern was repeatedly expressed that many patients and caregivers are not aware that PEP must be started within the 72-hour timeframe to make any difference. Some site coordinators also felt that many patients also were not sufficiently aware of the existence of TCCs and the fact that they could come to the TCC and get PEP without having to first report to police. To address these concerns, many HCPs recommended that community awareness and information campaigns be initiated, especially at the schools, with a focus on accessing PEP. According to at least five HCPs interviewed – rape survivors and their families need to be aware of PEP *before* they become victims so that they know to take immediate action (and what they must do) to prevent HIV.

At least one TCC (Cecilia Makiwane) has initiated an awareness campaign to address this challenge.

5.3 Care and Referral of HIV Positive Patients

The National Guidelines do not provide detailed guidance on services to HIV positive sexual assault patients. Section 8.1 on HIV counselling includes standards on the issues that should be addressed in post-test counselling where the patient tests negative upon presentation at the centre (p. 12). These include: fears and concerns, emotional state and plans, information about living positively, confidentiality, and referral for further HIV management.

As discussed above, many TCC sites do not have the capacity to provide consistently high quality post-test counselling, especially for HIV positive patients. However, all of the TCCs routinely refer HIV positive patients (whether testing positive at the site or already aware of their positive status) for further HIV management and, where appropriate, ARV treatment.

- Nine of the ten sites have ART units in the hospital where the TCC is located. Of these, eight refer patients to these units for follow-up care (CD4 testing, counselling/support groups, etc.).
- One site, Prince Mshiyeni, reported that it does not refer patients to the hospital ART unit because of concerns about huge backlogs. Instead, Prince Mshiyeni refers TCC patients to an NGO clinic (iTembalebanto) elsewhere in the community. Here patients requiring ART can be immediately accepted into the program. HIV positive patients not requiring ART can still participate in support groups and receive nutrition and healthy living advice.
- At Galeshewe, HIV positive patients are referred to local clinics for appropriate follow up.

ART units/clinics generally provide a wide range of services, including CD4 testing, ART (for patients with CD4 counts under 200), adherence counselling, support groups, nutritional counselling/support, and healthy living programs.

A few concerns were raised with respect to follow-up care for HIV positive patients:

- At most sites, HIV positive patients are referred immediately for follow-up care at specialized HIV/ART sites. Although these sites are generally better equipped to address HIV related issues, they are not usually prepared to address the patient's emotional trauma relating to the sexual assault. Since HIV positive patients do not receive PEP or require repeat HIV testing, most do not return to the TCC for follow up appointments after the initial visit – except where psycho-social counselling/ support group sessions are offered on-site. At sites where this service is not available, HIV positive patients are less likely to receive whatever ongoing counselling or support is offered by the TCC for other sexual assault patients.[104]
- It also appears that HIV positive patients are less likely to be referred for HIV management if they present first in casualty rather than the TCC. None of the casualty doctors interviewed said they discussed HIV with patients other than in the context of providing PEP. Moreover, none had ever referred a sexual assault patient for further HIV management.
- None of the sites have systems in place to track whether the HIV positive patients referred for further HIV management actually receive follow up care from the referral agency/ART site.[105]

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[104] Although one site (Natalspruit) reported that HIV positive patients are *only* referred to the ART Unit and not to Ekupholeni for psycho-social counselling and support, this practice has reportedly been reviewed and changed since the researchers' site visit.

[105] One site – Prince Mshiyeni – includes its HIV referral organization (an NGO) in TCC implementation meetings, allowing it to receive general feedback. However, it does not collect statistics from the partner organization on TCC patients referred to the site.

5.4 Tetanus and Hepatitis B

Due to the high prevalence of Hepatitis B in South Africa, the National Guidelines recommend that health care providers screen sexual assault patients for Hepatitis B antibodies and offer vaccines to all patients not previously inoculated for the disease.[106] The vaccine is normally offered in three doses, at intervals of approximately one month apart. Tetanus prophylaxis is also indicated where there is a break in the skin or mucosa contaminated by external debris.

With respect to Tetanus and Hepatitis B, the study found that:

- Most TCCs do not routinely screen for Hepatitis B during the initial examination. (Only Mamelodi and Prince Mshiyeni reported routine Hep B screening).
- None of the ten TCCs offer the Hepatitis B vaccine.
- Although most HCPs appreciate the rationale, many were not aware that screening and prophylaxis is indicated by the National Guidelines, and only a few had motivated to procure the vaccine.
- Others noted potential obstacles to compliance, including the expense of vaccine, and the inability/unlikelihood of patients returning to the site for a full course of vaccinations.
- None of the TCCs currently offer Tetanus prophylaxis. Although the vaccine is available in casualty, it is not routinely offered in rape cases, and practitioners had no recollection of incidents where the vaccine was given to a sexual assault patient.

5.5 Pregnancy

The National Guidelines include detailed guidelines relating to pregnancy in the context of sexual assault. Pregnancy can occur as a result of rape and pregnancy status may affect the type of treatment the patient is provided. The Guidelines also note that in determining a course of treatment, patients will want to know if a pregnancy preceded the rape.

Under the Guidelines, all female children and women of child bearing age who are otherwise sexually active and not adequately covered by contraception should be counseled regarding the risk of pregnancy and tested for pregnancy during the initial consultation. The Guidelines recommend a urine pregnancy test with results immediately available. The Guidelines also state that written consent should be obtained before conducting the pregnancy test.[107]

To prevent unwanted pregnancy, the Guidelines state that pregnancy prophylaxis (emergency contraception) should be offered to non-pregnant female patients

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[106] National Guidelines, section 10.10 and 11.5.
[107] National Guidelines section 6, p.8.

[108]presenting within five (5) days of the rape. This timeframe expands the time available for patients to receive emergency contraception (EC), consistent with WHO guidelines. The Guidelines allow HCPs the option of prescribing either a combined oral contraceptive (COC) or progestogen-only pills (POP). The recommended regimen is two doses,12 hours apart. The Guidelines also allow for a STAT double dose of levonorgestrel (1.5mg), obviating the risk of the patient forgetting or delaying the second dose. Where the patient is on any liver enzyme inducing drugs, a double dose of COC should be prescribed.

To address the problem of side effects, the Guidelines state that HCPs should provide an anti-emetic with each dose, and administer a repeat dose of EC if vomiting occurs within 2 hours. Patients should also be counselled on when to expect her next menses and the need to use contraception until menses occurs.

Finally, the Guidelines state that patients who present too late for EC or who fall pregnant despite EC, should receive counselling and referral (if requested) for termination of pregnancy (TOP).

With respect to pregnancy prevention and management, the study found that:

- Pregnancy-related services are available at all TCCs. Services included routine pregnancy testing, emergency contraception, and referral to TOP when needed

- Urine testing is done at all TCC sites. Most sites use a rapid test. However, a few HCPs reported that they do not have access to “rapid” pregnancy tests (Cecilia Makiwane casualty and POPD after hours, St. Barnabas casualty and TCC forensic nurse). Although urine samples at these sites are sent to the lab for testing, the results are not available in time to be taken into consideration in PEP counselling, prescribing of STI prophylaxis, or EC.[109]

- There is little consistency among health care providers in terms of who is tested for pregnancy and who is given emergency contraception. In some sites, menarche is the key indicator, with contraception use taken into consideration. At others, EC is offered to a much broader range of clients – (i.e. any female age 12 to 50). At Prince Mshiyeni, the TCC doctor reported problems with after-hours doctors not providing EC to young girls because they wrongly assumed the girl was not old enough to fall pregnant. As a result, she now requires EC to be given to girls from age 10.

- Standard EC is prescribed at all sites consistent with the National Guidelines. Sites use one of two methods: Most sites prescribe Ovral 28 (2 pills, 12 hours apart) (4 total). Only two sites (GF Jooste and Mahatma Gandhi) have started using a STAT dose of Norlevo (levorgestrel .750mg).

[108] For girls, the Guidelines state that EC should be given to all girls with signs of breast development who have a negative pregnancy test. Section 11.7(d), p. 29.

[109] According to the WHO guidelines, EC will not harm a pre-existing pregnancy, so patients should be given EC even where pregnancy status cannot be determined.

- Several doctors commented that they would prefer to use the STAT dose if the medication were available at their site. Some had specifically motivated for Norlevo, but noted that it was more expensive than Ovral.

- One site reported that EC was not given after hours as they did not have access to Ovral in the casualty (St. Barnabas). Patients had to wait or return during regular hours to access EC, possibly compromising the efficacy of the medication.

- Although most sites appear to take the timing of the first dose into consideration when dispensing ECP, some HCPs (including pharmacists) noted problems with doctors/nurses administering the first dose of Ovral immediately without consideration for when the second dose would need to be taken. This can reportedly cause problems with patients missing or delaying the second dose. Consideration of timing was particularly weak in casualty.

- None of the sites routinely offer EC beyond 72 hours. One doctor interviewed said he might provide EC if the patient came within three to five days, but most sites were strict about the 72 hour cut-off.

- Anti-emetics are not routinely prescribed with EC. At a few sites, HCPs prescribed anti-emetics to patients on PEP, but presumably those receiving EC without PEP would not receive anti-emetics.

- None of the sites provide extra EC pills for patients to take home in case of vomiting.

- Not all HCPs are aware of the need to prescribe a double dose of ECP in patients on certain medications. Only one doctor (from CMH casualty) reported that he doubled the EC dose for patients on anti-TB treatment.

- Several forensic nurses said they encouraged patients to return for repeat pregnancy testing within a week or two of the initial visit, as very early pregnancies might not be picked up at the first presentation. Some also encouraged patients to be retested at their 6 week appointment if menses had not started by then.

- All TCCs reported that they counseled and referred patients with an unwanted pregnancy for TOP. A few HCPs expressed uncertainty about their role in this regard and requested clarification on the appropriate procedure.

5.6 STI Screening and Prophylaxis

Sexually transmitted infections can result from rape and can also increase the risk of HIV infection. As with pregnancy and HIV, the National Guidelines state that patients should be informed of the risk of acquiring a sexually transmitted infection from rape and offered STI prophylaxis. According to the National Guidelines, HCPs should skip STI screening tests in adults and provide "syndromic management."[110] In children, a full range of diagnostic tests should be performed including cultures (vaginal swab) and blood for syphilis, Hepatitis B and HIV.[111]

The standard for treatment of STI in adults and children 14 years and over is described in section 11.4. For non-pregnant women, the National Guidelines prescribe a regimen of doxycycline (100 mg bd for 7 days); ciprofloxacin (500mg po stat); and metronidazole (2g po stat). For pregnant women, they prescribe ceftriaxone (125mg imi stat); erythromycin (500mg q.i.d. for 7 days) and metronidazole (2g po stat). For children under 14 years, the Guidelines prescribe a course of ceftriaxone (Stat injection), metronidazole and erythromycin, according to the child's age and weight.[112] The Guidelines state that STI treatment should be "provided to all patients, including asymptomatic patients." (p. 26).

With respect to STI screening and treatment, the study found that:

- All TCC sites routinely provide STI prophylaxis as part of emergency sexual assault care, and STI treatment for those presenting with symptoms. STI prophylaxis is not limited to patients reporting within 72 hours

- In all sites, a syndromic approach is taken for treatment of STI in children and adults. Children suspected of being abused are also examined for symptoms.

- In Western Cape and KZN, blood screening (WR or RPR) is routinely done on all patients, in addition to the standard syndromic treatment. The rationale is that it is meant to inform the management of HIV.

- Screening of children is generally limited to examination and blood test for syphilis. Most sites do not conduct a full screening with vaginal swabs/cultures in the absence of STI symptoms.

- HCPs at two sites reported that they only prescribe STI prophylaxis to female patients (St. Barnabas and Cecilia Makiwane casualty). The practice at other sites was not confirmed.

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[110] National Guidelines, section 11.4, p. 25.
[111] National Guidelines, section 10.13, p. 23.
[112] National guidelines, section 11.7(b), p. 28-29.

While Syndromic Management STI is administered at all sites, STI medication is not always prescribed strictly in accordance with the National Guidelines. Prescribing practices for STI antibiotics seems to vary between provinces, sites and individual practitioners. The general practice in the TCCs is to prescribe a combination of ciprofloxacin ("Ciprobay"), metronidazole (", Flagyl") and doxycycline in adults and substitute erythromycin in pregnant women. (Most sites do not prescribe ceftriaxone/ "Rocephin" instead of ciprofloxin in pregnant women, as recommended in the Guidelines). Additional departuresHowever, variations from the Guidelines were also often noted: For example, some HCPs prescribe ammoxycyllin or other antibiotics in lieu of doxycycline,; some vary the regimen (i.e. prescribe antibiotics for 5 days rather than 7, or 8 hourly rather than 12 hourly doses); some prescribe only two of the three medications (Stat doses only); some prescribe medication without knowing the pregnancy status of the patient, and others prescribe the "pregnant patient" regime to all patients, regardless of pregnancy status. Differences were particularly noted in practices on-call/casualty doctors, as well as some TCC staff.

Prescribing practices for children also vary.

- The general practice in the TCCs is to prescribecmetronidazole (prescribe flagyl), either ceftriaxone (Rosephin) or ciprofloxacin (ciprobay), and either ammoxycyllin or erythromycin in children. In KwaZulu-Natal, ciprobay is replaced with a stat injection of Rocephin. Again, however, variations exist between practitioners, especially between casualty doctors and the forensic nurse/TCC team. In all cases, however, a minimum stat does is given with the trust that clients will return if symptoms manifest.

PART III: CONCLUSION AND RECOMMENDATIONS

6. CONCLUSION

There are wide differences between the various TCCs in terms of institutional arrangements, staffing, resources, and implementation of the comprehensive, intersectoral model. While most are operating reasonably to very well, several of the sites are struggling to provide basic service. Interventions to strengthen the weaker sites are needed on an urgent basis. At all sites, efforts should be made to achieve greater buy-in and support from the Department of Health and other stakeholders, particularly at the provincial level.

The approach to sexual assault management followed at the TCC Care Centres is generally consistent with the principles set forth in the National Guidelines, including the overall approach to HIV/AIDS and related reproductive health care. This includes, in particular,

- HIV testing and counselling
- Post-exposure prophylaxis for pregnancy, STI and HIV
- Attention to the emotional needs of patients
- Treating patients with dignity and minimizing secondary victimization

Gaps in compliance are most often attributable to inadequate staffing/resources, lack of training, and lack of awareness of the National Guidelines.

There are several areas where the clinical practices at the TCCs (and in casualty/hospital, generally) are not operating strictly in accordance with the National Guidelines. Differences were noted particularly in the area of HIV testing (availability of VCT 24 hours/option to delay testing) and PEP administration (use of 3d drug/schedule for supplying PEP to patients), as well as prophylactic treatment of STIs and other infections.

In some cases, sites are not aware of the national standards in these areas and have not incorporated them into their standard practice. However, in other cases, sites seem to have consciously adopted different approaches, based on provincial or local protocols or HCPs views on how best to manage PEP and ensure compliance. On these issues, in particular, it is important to open a dialogue with the sites on the relative merits of various approaches and to develop strategies to address concerns. Getting patients to return to the site for testing and PEP or to finish the course of PEP pose major challenges for most sites. Changes in testing and administration procedures must therefore be accompanied by strategies and resources to ensure adequate follow-up and support to patients.

Patients' needs for counseling and psychological support (both immediate and longer-term) are not being adequately addressed at many sites. Only a few sites are able to offer consistently good care in this area for all patients, including children. This is an area where greater resources and support to the sites are needed, as most gaps are related to understaffing.

Finally, awareness of/ and implementation of specific National Guidelines are not as high as they should be. There is a need to ensure that the National Guidelines are

disseminated and that practitioners are trained on their contents. Most practitioners would also benefit from "refresher" courses to address individual skills gaps, and to bring them up to date on new developments in HIV/AIDs and PEP, and changes in the SAECK kit/forensic-examination procedures.

The TCC model is a good one, but implementation is uneven across the current ten sites. There is a need to review and strengthen implementation of the model before rolling out additional TCCs.

Monitoring is an important element of management as provides an account of performance against plans and standards as well as a base for decision making. This element is weak within the management system.

7. RECOMMENDATIONS

Strengthening Inter-Departmental Partnerships

1. Engagement with the Department of Health

Although all TCC stakeholders play a role in service delivery, assuring compliance with National Department of Health standards is necessarily a function and responsibility of the Department of Health. It is predominantly DoH has the authority and capacity to address gaps in health-related staffing and/or services at the TCCs, and to ensure that health care providers are appropriately trained and supported.

Although Health is represented on the IDMT at national level, there is a need for the TCC management structures to engage more closely with the Department of Health, *particularly at the provincial and hospital level*, to open lines of communication, clarify roles and responsibilities, discuss concerns, , and strategize a way forward for each site. Discussion should include identification of potential resources within DoH at the provincial/district level, as well as other sources of funding (such as donor support to SOCA/IDMT), that could be used to support *health* services at the TCCs and address gaps or weaknesses in the provision of sexual assault care. Closer engagement with Health at the provincial, district, and hospital level is also essential to ensure the success of future TCC roll-outs.

Close consultation with stakeholders at the hospital level is also essential. Although some common challenges were identified across the ten sites, all of the TCCs have different strengths and weaknesses. Moreover, given the structural and institutional differences between sites, there is no "one-size-fits-all" solution to address the gaps identified. Some issues can and should be addressed locally, while others may require outside intervention/support. While SOCA/IDMT has an important role to play in strengthening the TCC sites and supporting compliance, it is important that site interventions are not perceived as coming from outside/top-down. *As a first step, a facilitated meeting should be held at each site with key health role-players (including practitioners and hospital/medical managers) to review the findings of the compliance assessment and develop an action plan. This will ensure greater ownership, realism and sustainability of planned interventions.*

2. Formalization of cooperation frameworks

The TCC Model is premised on the concept of intersectoral cooperation in the provision of sexual assault care. Although all sites have coordination mechanisms at the local/operational level, there is a need to strengthen and formalize communication/coordination structures at higher levels, clarify roles and responsibilities, and ensure institutional accountability. Specifically:

- Institutional arrangements between the stakeholders (NPA, DoH, DoSD, SAPS, etc) should be formalized through signed service level agreements at the provincial and hospital level.
- Management level meetings involving all stakeholder agencies and local TCC/hospital management should be held on a regular basis to address strategic issues.
- Stakeholders such as DoSD should be encouraged to provide more support to the TCCs at the local/district level.
- TCCs should engage closely with SAPS at appropriate levels to address operational and strategic challenges – particularly sensitization of police officers and delays in transport to/from site.

Staffing and Capacity Building

a. Recruitment of staff and provision of services 24 hours

Most of the sites do not have the full staffing complement as defined in the TCC blueprint. Priority must be given to the filling of vacant positions/assigning additional personnel in order to provide services 24 hours per day. Ideally, each of the centres should have at least three dedicated health care professionals and support staff (including counsellors) serve the TCC day and night. Sites should not rely on overloaded casualty departments to provide sexual assault care, except in emergency situations. Recruitment and training of forensic nurses should be strongly encouraged.

To the extent that sites continue to rely on "on-call" doctors after hours, they should also maintain a dedicated roster of doctors/forensic nurses specifically for session doctors who must be trained in providing sexual assault care. There must be assurance that the doctors on the roster are willing and able to conduct sexual assault examinations per the National Guidelines/relevant site protocols, and are be prepared to make presentations in court when required.

Hospital management/DOH should ensure that female forensic nurses or doctors are available whenever possible to conduct the medico-legal examinations of sexual assault patients. If necessary, efforts to recruit and train female examiners should be made a priority, and female examiners included on the on-call rosters for forensic services.

Sites should review staffing/rotation policies for support nurses (including the after hours shift). To the extent possible, nurses/nurse assistants with an interest in sexual assault care should be recruited and trained to work in the TCC, with longer rotations to improve continuity and experience.

Where possible, a dedicated psychologist or social worker should be assigned to the site to ensure that all sexual assault patients receive trauma debriefing and longer-term psycho-social support.

Where not already in place, sites should strongly consider appointing a senior medical officer to provide general oversight over health services at the TCC and to monitor on-call (after hours) HCPs. In hospital-managed sites, managing doctors/matrons for the hospital should be included in TCC implementation meetings, as part of the core team.

The NPA should fill vacant NPA positions (particularly site coordinator posts) as a matter of urgency.

b. Training of existing personnel.

Current staff members have cited need for training and this should be arranged for both doctors and nurses, as appropriate. The topics covered should include:

- Orientation on the National Guidelines standards. Hospital/medical managers, pharmacists, site coordinators and other interested personnel should be oriented on the National Guidelines.
- In-service training in the following areas: HIV pre-J88 and post-test counselling (including in the specific context of sexual assault); use of308 forms, using SAECK kit/J88 forms; use of colposcope; basic counselling/crisis containment skills; issues relating to administration of PEP; working with special-needs patients;and providing adequate treatment/ and care of for children; testifying in court.
- Mentoring of volunteers and less experienced HCPs by more experienced staff.

Basic training on HIV and HIV counselling should be provided to all HCPs serving the TCC, whether or not they are assigned responsibility for VCT at the site.

Training programs on sexual assault management should be organized in such a way that doctors can get continuing education credit for attending the training. Efforts should be made to coordinate the TCC training strategy with broader training efforts (such as being developed by the Medical Research Council).

Sites should also establish a mechanism to provide periodic debriefing and emotional/psychological support to HCPs and other TCC staff working with sexual assault patients.

Every site should have an information sheet or brochure on the services available at the TCC. This should be widely distributed within the hospital to increase awareness of the TCC among hospital staff and also be available for patients to take home (especially if they present first in casualty/OPD). Where necessary, TCCs should conduct a hospital wide briefing (i.e. at staff meetings) to raise awareness of the TCC and the services it provides and encourage HCPs to refer patients to the TCC.

c. Recruitment and training of volunteers to augment the staffing complement.

All of the TCCs experience staffing shortages at various times, particularly at night and on the weekends. Volunteer "victim supporters" can play an important role, freeing up nursing staff for VCT and other health services. Volunteers can also be used to follow-up with patients, including conducting home visits where appropriate.

At Chris Hani Baragwanath, volunteers play a critical role in terms manning the reception area, counseling patients, providing pre and post test counseling, and providing ongoing support to patients by calling them and reminding them to return to the centre for further management. In addition the volunteers keep track of community campaigns and maintain relationships between the centres and other agencies.

For this model to work, it critical that the volunteers are appropriately trained, mentored, and supervised (by the TCC staff, social services or an affiliated NGO) and that they should receive a stipend.

d. Establish and strengthen relationships with referral organizationsreferrals

Recognising the value added by NGOs at key sites, strength of the Chris Hani Baragwanath site, it is recommended that all sites establish and strengthen referral networks with other organizations and/or agencies in order to provide comprehensive services. Mapping exercises should be conducted to help sites identify potential partners in the communities they serve and to cultivate linkages with these organizations. In due course, projects can be implemented to develop, mentor, and support local organizations to provide support to the TCCs where established NGOs or other specialized services are not available. Mapping exercises can be conducted by the sites to determine services that are provided by other organizations so that appropriate referrals are made. In due course, forums can emerge where reviews of demand and service provision are conducted.

Wherever possible, TCCs should arrange to have affiliated organizations operate on-site, as at Chris Hani Baragwanath, Prince Mshiyeni and Natalspruit. Such arrangements seem to increase the accessibility of psycho-social support and other services (such as court preparation), and also provide an incentive for patients to return to the TCC for follow-up.

e. Strengthen Sexual Assault Management Practices

i. Local Policies

All sites should review their existing policies/practices in light of the National Guidelines and make adjustments as necessary to achieve compliance. Particular attention should be paid to the following key areas where gaps were noted across multiple sites:

- HIV testing: Allowing patients option to delay HIV testing/test results (with starter pack)
- PEP counseling: pregnant patients (risks and side effects)

- PEP administration: Prescription of 3d drug (lopinavir/ritonavir) in high risk cases
- Proper calculation of PEP for children (provide dosage chart)
- PEP administration: Starter pack or one week supply, followed by remaining supply all at once (once HIV negative status established.)
- Routine provision of anti-emetics with PEP and ECP
- Providing written handouts to patients on medications, particularly PEP
- ECP: Expanding time frame for ECP from 72 hours to 5 days from assault
- Written consent for HIV test, PEP, pregnancy test and ECP
- Medications prescribed for STI treatment/prophylaxis
- Hepatitis B screening and prophylaxis
- Tetanus prophylaxis
- Clinical follow up at 3 days (or one week)
- Providing patients with information on psychological effects/coping strategies; advising condom use during PEP; providing contraception counselling or referral in conjunction with ECP.

Each site should develop a Site Protocol, checklist or similar tool for clinical management of sexual assault patients. This should be prominently displayed in the examination room and/or included in each medical file to ensure that correct procedures are followed by all practitioners and that no steps are omitted.

ii. Supply of tests/medications/SAECK

Hospital management (and/or district services where applicable) should take appropriate steps to ensure that TCCs (and casualty/OPD departments, where applicable) are supplied with necessary tests and medications, *including after hours.* These include (without limitation):

- Rapid urine pregnancy tests
- ECP
- Children's PEP (syrups)
- Correct antibiotics for STI treatment, *per National Guidelines*
- Lopinavir/Ritonavir

Use of levornogestrel (Norlevo), in lieu of Ovral, is highly recommended to simplify the ECP regimen and improve adherence.

Efforts should also be made to supply AZT in a fewer number of pills – i.e. 300mg tablets instead of 100mg tablets, or ideally, Combivir. Where possible, sites should pre-package AZT/3TC in daily packets (as per Prince Mshiyeni) to simplify the process for patients.

All sites should have extra SAECK kits (including for children) and 308 forms on hand, including after hours or in casualty.

Hospitals should make food available to sexual assault patients after the examination before medication is administered.

iii. Measures to Facilitate PEP Compliance

All sites should consider ways to improve follow-up and support of clients on PEP. At minimum, sites should establish a system to easily track whether patients (including those presenting after hours and in casualty) are returning to the site for testing/PEP, and to make follow-up calls to patients at key points to check compliance and offer support. Roles/responsibilities for patient follow-up should be clearly delineated.

Since transport is a major barrier, sites should investigate the availability and cost-effectiveness of various methods and develop a strategy to assist patients with transport to/from the site for follow-up appointments (and off-site support services to the extent possible). These could include aTCC vehicle, petty cash, taxi "vouchers," etc. SOCA and/or Health should make resources available to the site coordinators for this purpose.

iv. Coordination with Casualty after hours

Sites closing after hours should develop a coordinated system with casualty to register rape patients and ensure they are referred to the TCC for follow up.

All sites should ensure that patients have access to the TCC facility and "comfort services" (private waiting room, bathing facilities, change of clothes, food, etc.) after hours, and are examined in the TCC whenever possible. Effective implementation of this model requires that the site have a person (such as a nurse or lay counselor/volunteer) available to monitor/wait with the patient and liaise with the casualty unit to ensure the patient is seen in a timely fashion.

v. Consent Policies/Procedures for Children

TCCs/Hospitals will have to adjust their consent policies and procedures to conform with the new provisions of the Children's Act. All personnel should be informed of the changes and trained on how to implement the new procedures. Guidelines should be established to help practitioners determine whether a child under 12 is of sufficient maturity to give consent.

f. Development of IEC materials

Taking into account the trauma encountered by clients/care-givers and acknowledging the fact that they may not be able to fully grasp and internalize issues that are discussed with them during the examination or counselling session, simple Information, Education and Communication (IEC) materials for rape survivors should be developed and handed out to patients to read at home. These need not be fancy brochures – one-page, photocopied information sheets on various topics can be equally effective.

- To avoid duplication of effort, effort should be made to identify (and obtain permission to use) existing materials (i.e. from specialized NGOs, DOH, etc.) or to develop one set of materials.

g. Information Sheets

A number of information sheets should be developed for all TCC sites (that can be customized as required). Materials should be translated and available in several local languages. The TCC phone number and information on available support services (such as hotlines and local referral organizations) should be included on the information sheets wherever possible.

Sites relying on casualty after hours should ensure that written information is available in casualty and provided to all sexual assault patients/care-givers before they leave.

h. Equipment/supplies

A number of TCC sites do not have necessary equipment or often the equipment is outdated and malfunctioning. The equipment is used for examination and communication. TCCs should be provided with the following:

i. Physical examination tools - colopscope, digital camera;
ii. Communication/M&E tools - fax machines, telephones, photocopy machines, PCs, printers and access to email;
iii. Storage: lockable cabinets for patient files, and TCC supplies
iv. Education tools – TVs, posters, leaflets;
v. Therapy aids – specializedMonitoring tools – Computers and printers
vi. Environmental enhancement - toys for children's therapy (where services are available)
vii. Environmental enhancement – toys, games and soft "comfort" toys for children; fans and heaters
viii. Integration/ Awareness – updated signage for TCC at various points in the hospital (including entry areas); posters/information pamphlets in casualty and other hospital wards

At present, SOCA is responsible for providing and maintaining most of the non-health equipment to the sites, including basic supplies and communications equipment. The current system is overly centralized and results in unreasonable maintenance delays. SOCA should revisit current policies/procedures and work with the hospitals to establish a more workable system for maintenance of equipment and supply of goods to the sites.

i. Refurbishment of the sites

A number of sites require physical refurbishments. Many sites do not an ideal layout which provides an atmosphere of calm and comfort. Only two sites have reception areas designed for children with toys and colorful walls. Some sites are too small and lack ventilation; others are large but do not make optimal use of available space.

It is important that all “medico-legal” sites have a dedicated space where the privacy of sexual assault the patients can be observed, and where patients will not come into contact with suspects.

It is also necessary to have an adequate number of private counselling rooms, including a space where police can meet with the client on-site. Sites should also have adequate space (either in or near the TCC) to accommodate on-site psycho-social services including support groups.

All sites should have a lockable storage unit in a commonwaiting area, so that clothes, food, comfort kits, etc. are accessible available after hours. Sites should also have basic kitchen facilities (microwave, refrigerator) wherever possible.

j. Further analysis and follow up

The following areas are recommended as a follow-up to the HIV/AIDS Gap Analysis:

- Assessment of TCC compliance with national health standards with respect to medico-legal examination and documentation of evidence/ identification of gaps/training needs with respect to medico-legal/criminal justice aspects
- Comprehensive review of TCCs/ assessment against Thuthuzela Blueprint (Justice, SAPS, civil society, etc.)/ identification of gaps/challenges
- Targeted public information campaigns to raise awareness in local communities about TCC services and accessing PEP
- Sharing of best practices among TCC health care managers/practitioners; national/regional workshops; study visits to other sites.
- Study to assess impact of different PEP administration regimens and follow up/support measures on PEP adherence rates

8. LIST OF ANNEXURES

Annexure A: Legislative/Policy Analysis Report

Annexure B: Compliance summary for Cecilia Makiwane

Annexure C: Compliance summary for Chris Hani Baragwanth

Annexure D: Compliance summary for Galeshewe

Annexure E: Compliance summary for Mafikeng

Annexure F: Compliance summary for Mamelodi

Annexure G: Compliance summary for Mannenberg

Annexure H: Compliance summary for Natalspruit

Annexure I: Compliance summary for Phoenix

Annexure J: Compliance summary for Prince Mshiyeni

Annexure K: Compliance summary for St Barnabas