
From paper to practice: Lessons in policy implementation.

Lisa Vetten,
J.Kim, E. Ntlemo
and L. Mokwena



TSHWARANANG
LEGAL ADVOCACY CENTRE
TO END VIOLENCE AGAINST WOMEN

The policy context

- Department of Health's 2005 *National Sexual Assault Policy and National Management Guidelines for Sexual Assault Care*,
 - Department of Justice and Constitutional Development's *Victim's Charter*
 - Department of Justice and Constitutional Development's *Minimum Standards on Services for Victims of Crime for Implementing the Service Charter for Victims of Crime in South Africa*.
 - Department of Social Development's 2004 *Minimum Standards for Service Delivery in Victim Empowerment (Victims of Crime and Violence)*
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Services in small and rural areas

- Public spaces and community relations far more localised and intimate in rural areas - anonymity and confidentiality more difficult.
 - Low population density = lower numbers of incidents being reported = too few to warrant full-time or specialist services.
 - Chronic shortage of doctors in rural areas
 - Rural service providers may be at greater risk of isolation and burnout due to greater likelihood of working alone and in geographical isolation.
 - Rural infrastructure often inadequate so may cost more to provide services. Higher cost of providing services exacerbated by expectations that rural service provision should be equivalent to urban service provision but without additional funding from government always being provided.
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Refentse project description

- Phase 1: Rural AIDS and Development Action Research Programme (RADAR), Wits School of Public Health in collaboration with the Population Council
 - research coordinator, a research specialist and a full-time professional nurse based at Tintswalo
 - Phase 2: Tshwaranang, supported by the Population Council
 - lay counselor and para-legal officer based at police station and research coordinator and forensic nurse at Tintswalo to monitor the hospital service.
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Interventions

- Baseline study
 - Sexual violence Project Advisory Committee (PAC) comprising RADAR, OPD nursing management, the police, social workers, HIV services, doctors and the pharmacist and psychiatric nurse;
 - hospital rape management policy;
 - training workshops for HCWS and other providers;
 - centralising and coordinating post-rape care through a designated OPD room; and
 - community awareness campaigns run through community radio and morning health talks to patients waiting in the OPD queue, as well as at the surrounding primary health care clinics.
 - Establishment of service providing lay counselling and para-legal assistance
 - Establishment of referral pathway
 - Baseline study of women's use of lay counselling and para-legal services
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Lessons learned

- It is possible to improve healthcare services.
 - Most obstacles to provision of healthcare institutional rather than patient-driven. Therefore change processes require institutional buy-in and must be constantly monitored in rapidly-changing environments.
 - Politics of NGO and government partnerships a fine balancing act
 - Easier to bring about change within one system than across systems eg referrals
 - May be easier to change healthcare services than policing and prosecution services because only 1 secondary cog in complex CJS machinery
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Challenges going forward

- 228 patients presenting to Tintswalo from 1 March 2007 – August 2008. 112 (49.1%) referred to TLAC
 - Just over one in three (41 or 36.6%) of the 112 rape survivors referred by Tintswalo ultimately contacted Tshwaranang.
 - The CJS response: out of 77 cases dealt with by Tshwaranang during first 18 months, 1 made it to court. (NOTE: Mpumalanga has lowest conviction rate in SA, no prosecutor for six months at only regional court in area (on leave.)
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