Sexual violence: using research for policy development & implementation
Historical Problems with South African rape services

- **District surgeon system:** riddled with racial prejudice; untrained staff; unsympathetic & judgemental; quality of care poor

- **1999** – policy change: care provided by ‘any doctor’ – policy of rape care as part of PHC with clinics as first line level of service provision. Some forensic nurse training (with variable deployment)

- New initiative to deal with rape from Dept. Of Justice – Thuthuzela Centres – one-stop centres based in district hospitals aiming to improve legal case management – not medical
South African Gender-based Violence & Health Initiative (SAGBVHI)

- SAGBVHI was formed in 2000 with funding from a Rockefeller Millenium Health Award (to R Jewkes of Medical Research Council)
- Partnership of 15 individuals & organisations working at gender-based violence & health interface
- Included: researchers; clinicians (forensic medicine & nursing); advocates; trainers;
- Aim: to contribute to building an effective the health service response to gender-based violence through research, advocacy & training
SAGBVHI & the DoH

• Initiated meetings from the inception of SAGBVHI with key DoH staff

• Organised a workshop with national & provincial stakeholders to learn what was being done in Provinces with DoH

• A key theme from the workshop was that no one really seemed to know what was the quality of rape health services and the DoH expressed the need for a situation analysis and asked SAGBVHI to do it…
Situation analysis of rape services: key findings

- Facilities: lacked privacy, facilities & proper equipment
- Workload variable: 21% staff >100 victim/survivors per year; 30% <20 cases
- Training: 70% of staff had none; 43% had seen a protocol
- Attitudes: 33% rape not ‘a serious medical problem’
- Clinical competence: 88% ‘treated’ STIs but only 35% named correct drugs for this
- Factors associated with higher quality of care: provider attitudes; having a management protocol; & higher caseload
- Implications: training, policy & service provision at a level high enough to secure caseload and good facilities were needed
Using research to develop the new model

• Started discussions on shared vision of quality services and discussions around a new model of care
• Workshops with DoH & SAGBVHI & a huge range of stakeholders
• Areas of agreement and areas of uncertainty in new model
• Uncertainty: access – would poor women travel for better care?
• Was providing HIV testing and PEP a potential barrier to care seeking? Would women want PEP without HIV testing? Could we contemplate giving it?
Second project: women’s preferences for services after rape using discrete choice analysis
(Collaboration with Women’s Health Project & Centre for Health Policy at Wits)

• Results of the random effects probit models (what determined choice of service):
  – PEP and HIV test was most important
  – PEP without HIV test was preferred to no PEP
  – Attitudes of the provider (and skills) was next most important
  – A longer examination with M/L evidence collected was preferred
  – More return visits to the facility welcomed (for counselling)
  – Overall decisions were NOT made on travel time (up to 3 hours)

• We also did a cost effectiveness model for PEP and showed it to be affordable
Writing the policy & products from the process

• DoH identified the need for a new policy on Sexual Assault Care and clinical management guidelines
• SAGBVHI members were invited to join (and Chair) the drafting committee for these
• Drafted in consultative process over ~ 2 years
• Policy & CMG released by the Minister in March 2005
• Researchers also wrote peer reviewed journal publications (papers in World Health Bulletin & British Medical Journal) & other publications
• Situation analysis tools published through SVRI & shared with other countries via a WHO multi-country project
Research: Tracking Justice
(collaboration with Tshwaranang and CSVR)

• Review of police dockets, court records & medico-legal forms from rape cases reported to the police in 2003

• Objective of the research:
  – To describe the attrition of cases from reporting to sentencing
  – To determine the role of medico-legal evidence in case progression and legal outcomes
Methods

• A random sample of 70 police stations from Gauteng province
• Probability proportional to size of the police station
• 30 rape dockets were selected using systematic sampling of all closed rape dockets that are available in the station
• Data collected from 2064 dockets
## Attrition in the criminal justice system

### Attrition in the criminal justice system

(\(n=1552\) cases of completed rape of adults 18+ yrs and children<18 years)

<table>
<thead>
<tr>
<th></th>
<th>Adults</th>
<th>%</th>
<th>Child</th>
<th>%</th>
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<tbody>
<tr>
<td>Opening case</td>
<td>951</td>
<td>596</td>
<td></td>
<td></td>
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<tr>
<td>Suspect arrested or asked to appear in court</td>
<td>430</td>
<td>45.2</td>
<td>341</td>
<td>57.2</td>
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<tr>
<td>Charged in court</td>
<td>365</td>
<td>38.4</td>
<td>284</td>
<td>47.7</td>
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<tr>
<td>Trial commenced</td>
<td>101</td>
<td>10.6</td>
<td>108</td>
<td>18.1</td>
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<tr>
<td>Found guilty of sexual offence</td>
<td>31</td>
<td>3.3</td>
<td>44</td>
<td>7.4</td>
</tr>
<tr>
<td>Sentenced to imprisonment</td>
<td>30</td>
<td>3.2</td>
<td>24</td>
<td>4.0</td>
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## Attrition in handling and processing forensic evidence

<table>
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<th>Child</th>
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<tbody>
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<td></td>
<td>n</td>
<td>%</td>
<td>n</td>
<td>%</td>
<td></td>
</tr>
<tr>
<td>J88 completed &amp; available</td>
<td>951</td>
<td></td>
<td>596</td>
<td></td>
<td></td>
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<tr>
<td>Forensic kit completed</td>
<td>868</td>
<td>91.3</td>
<td>377</td>
<td>63.3</td>
<td></td>
</tr>
<tr>
<td>Forensic specs sent to lab</td>
<td>659</td>
<td>69.3</td>
<td>273</td>
<td>45.8</td>
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<tr>
<td>Suspect's blood obtained</td>
<td>84</td>
<td>8.9</td>
<td>54</td>
<td>9.3</td>
<td></td>
</tr>
<tr>
<td>Report from forensic lab on DNA</td>
<td>10</td>
<td>1.1</td>
<td>12</td>
<td>2.0</td>
<td></td>
</tr>
</tbody>
</table>
Impact of tracking justice study

• Supt. Anton Lucassen, Forensic Analyst, DNA Database– Forensic Science Laboratory (FSL)
  – studying the results in detail in order to find the weak points within the FSL.
  – it provided them with “immense insight” into the system and they are making a deliberate effort to correct problems identified including working closely with police stations and that they are planning a ‘roadshow’ to try and improve their services.

• Advocate Brandon Lawrence of the National Prosecuting Authority, SOCA Unit
  – Very similar sentiments
Key results

- Medical documentation of injury & expert testimony in court does influence case progression and outcomes
  - Documentation of non-genital and genital injuries influenced whether children’s cases went to trial (OR 5.83; 1.87-18.13, P=0.003)
  - Documentation of:
    - non-genital injuries (aOR 6.25 95%CI 1.14-34.30, p=0.036)
    - ano-genital injuries (aOR 7.00 95%CI 1.44-33.9, p=0.017), and
    - both types (aOR 12.34 95%CI 2.87-53.0, p=0.001)
  - in adults were associated with a conviction

DNA was not associated with case progression and outcomes, perhaps because it was almost never available, only 2% of cases had a report from the lab
Conclusions

• Good basic medical practices in assist courts in rape cases
• Forensic labs and police are not working optimally
• Health care providers need to be trained to provide high quality health care responses after rape …
Evidence-based in-service training on post-rape care
Developing & piloting in-service training post-rape care

1st Stakeholder meeting

Review of local & international curricula

Identification & recruitment of local expert authors

MRC review

Review of evidence

Nat’l & Int’l Reviewers

2nd Stakeholder meeting

Pilot 1

Draft 1

Revision

Pilot 2
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- Teddy Bear Clinic
Training methodology

• Draws on adult education principles
  – Freire – critical reflection
  – Small group work
  – Case studies
  – Role plays
  – Videos

• 10 days and a practical component
Structure & content of training

Module 1: Social context of rape in SA
- Circumstances, context & magnitude
- Sexual Rights
- Rape & the Law

Module 2: Initial approach to rape survivor
- Communication skills
- Taking history & obtaining consent

Module 3: Managing Health problems
- Mental Health
- Prevention & management of pregnancy, infectious diseases & HIV
Module 4: Examination & Documentation

- Medico-legal examination
- Non-genital injuries
- Examining children
- Forensic evidence
- Documentation

Module 5: After the initial consultation

- Follow up visits
- Giving expert testimony in court
- Vicarious trauma
- Monitoring & evaluation of service
Developing skills in giving evidence in court
4 Pilot trainings – 8 provinces
Feb. – May 2008

Evaluation

3rd Stakeholder meeting - 23-24 October
Evaluation

• Evaluation – pre- & post assessments & qualitative component
  – Attitude survey self-administered at baseline, 1\textsuperscript{st} post assessment immediately after training, 2\textsuperscript{nd} at 3 months
  – Knowledge assessment pre- and post-training
  – Qualitative interviews & observation in services where health care providers were trained

Impact of training

• Change in mean knowledge score pre & post training:
  – Pre-test: 27 (Range: 13 – 49)
  – Post-test: 35 (Range: 17 – 54) p<0.01

• Change in attitudes towards rape (p=0.0001)
Increased level of confidence in all aspects of post-rape care

* All statistically significant differences at 99% CI
Next steps …

SVRI initiative
Ford Project: 
Strengthening Responses to Rape –
A Global Project

- The project builds on four components: partnership, training, policy, and research.
- The first phase is to promote the development of working partnerships among policy makers, service providers and trainers, and women's advocates within countries.
- Through Sexual Violence Research Initiative networks and partnerships, seven multi-disciplinary teams have been established in Rwanda, Zimbabwe, Zambia, Uganda, Malawi, Kenya, and Nigeria.
- Team members represent the health, justice and policing sectors from their countries.
- Training course held in Feb 2009 with 45 people from 7 countries in Pretoria
- Training course in July 2009 with ~45 people held in Harare, Zimbabwe
- Since then we have been working to support policy and service development