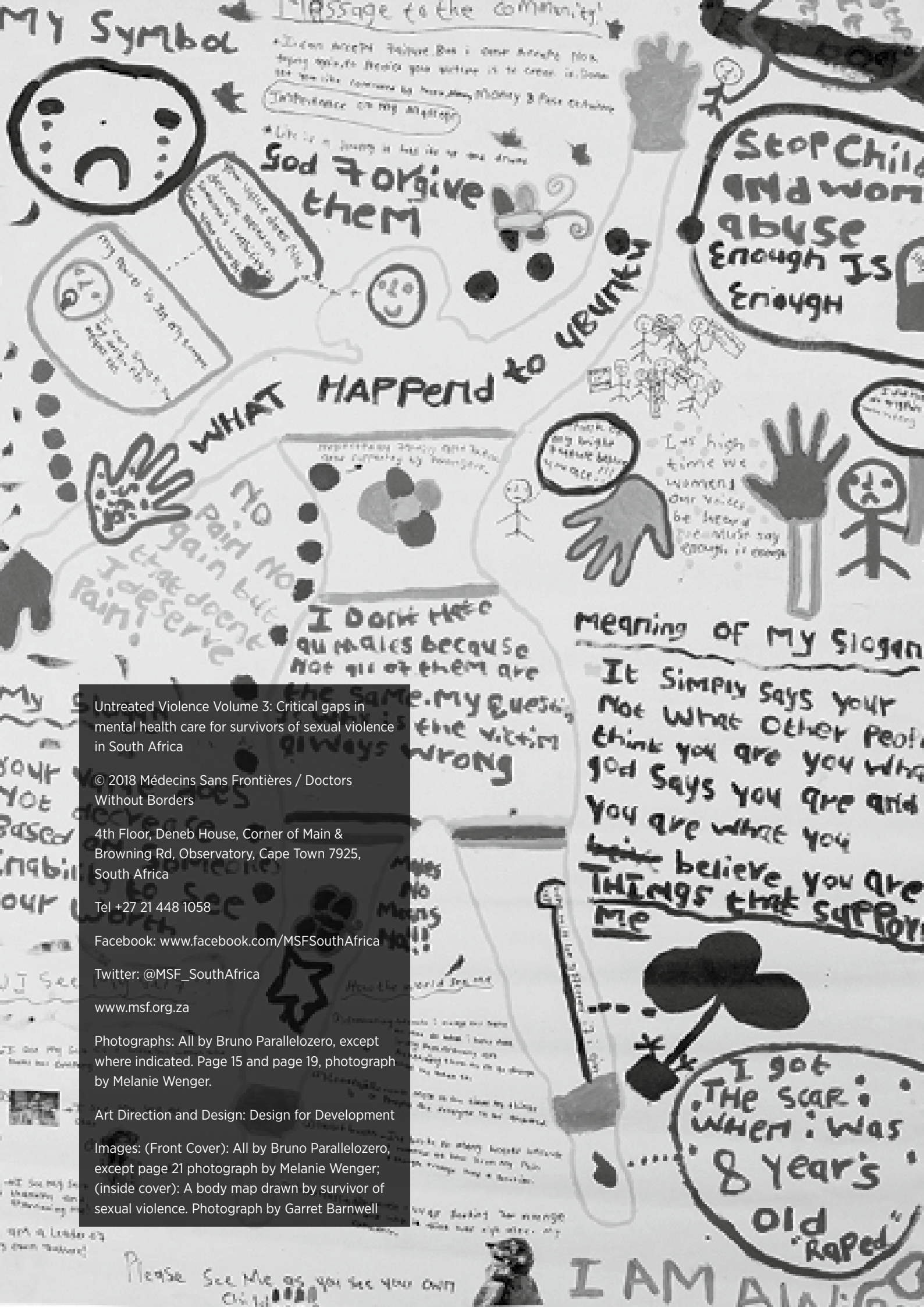
UNTREATED VIOLENCE:

Critical gaps in mental health care for survivors of sexual violence in South Africa

MEDECINS SANS FRONTIERES
DOCTORS WITHOUT BORDERS

VOLUME 3



Untreated Violence Volume 3: Critical gaps in mental health care for survivors of sexual violence in South Africa

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Photographs: All by Bruno Parallelozero, except where indicated. Page 15 and page 19, photograph by Melanie Wenger.

Art Direction and Design: Design for Development

Images: (Front Cover): All by Bruno Parallelozero, except page 21 photograph by Melanie Wenger; (inside cover): A body map drawn by survivor of sexual violence. Photograph by Garret Barnwell

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DEFINITIONS USED IN THE REPORT

DESIGNATED HEALTH FACILITY:

A public health facility in South Africa designated by government gazette to apply clinical investigative processes in the determination of cause and manner of injuries to living victims of sexual assault. Designated health facilities should provide survivors of sexual violence with care that addresses all possible health consequences, including mental health. These facilities are required by law to provide clinical forensic medicine services, and to offer post-exposure prophylaxis for HIV to eligible patients.

SEXUAL AND GENDER BASED VIOLENCE (SGBV):

Refers to any act that is perpetrated against a person's will and is based on gender norms and unequal power relationships. It encompasses threats of violence and coercion. It can be physical, emotional, psychological, or sexual in nature, and can take the form of a denial of resources or access to services.

KGOMOTSO CARE CENTRE (KCC):

A primary healthcare facility in North West Province that provides comprehensive medical, psychological and social care for survivors of sexual violence. KCCs are an initiative of the North West Department of Health (DoH).

POST-EXPOSURE PROPHYLAXIS (PEP):

A short-term antiretroviral treatment to reduce the likelihood of HIV infection after potential exposure, such as after unprotected sexual intercourse or rape.

RAPE:

When a perpetrator(s) invade the body of a person by conduct resulting in penetration, however slight, of any part of the body of the victim or of the perpetrator with a sexual organ, or of the anal or genital opening of the victim with any object or any other part of the body. The invasion is committed by force, or by threat of force or coercion against such person or another person, or by taking advantage of a coercive environment, or the invasion is committed against a person incapable of giving genuine consent.

SEXUAL VIOLENCE:

Any sexual act, attempt to obtain a sexual act, unwanted sexual comment or advances, or acts to traffic or otherwise, directed against a person's sexuality using coercion, by any person regardless of their relationship to the victim, in any setting, including but not limited to home and work. Sexual violence includes, but is not limited to rape.

INTIMATE PARTNER VIOLENCE (IPV):

Refers to any behaviour within an intimate relationship that causes physical, psychological or sexual harm to those in the relationship.

EXECUTIVE SUMMARY

This is the third report in the **Untreated Violence** series by Doctors Without Borders/ Médecins Sans Frontières (MSF), guided by MSF experience of responding to Sexual and gender based violence (SGBV) in Rustenburg, South Africa, since 2015. This edition of the series highlights the immense individual psychological distress and long term consequences caused by sexual violence. It additionally presents findings of a survey undertaken to quantify the mental health services available to survivors of sexual violence in health facilities across South Africa. The report draws conclusions from the survey and offers recommendations from the experience of MSF in supporting the Department of Health (DoH) to provide mental health care to survivors of sexual violence.

Through a nationwide telephonic survey, MSF assessed the level of mental health care provided at over 130 of the 265 facilities designated to provide services for survivors of sexual violence across the country.

Although the survey was not exhaustive, the observations indicate an urgent need to address gaps in providing psychological care for victims of sexual and gender based violence (SGBV).

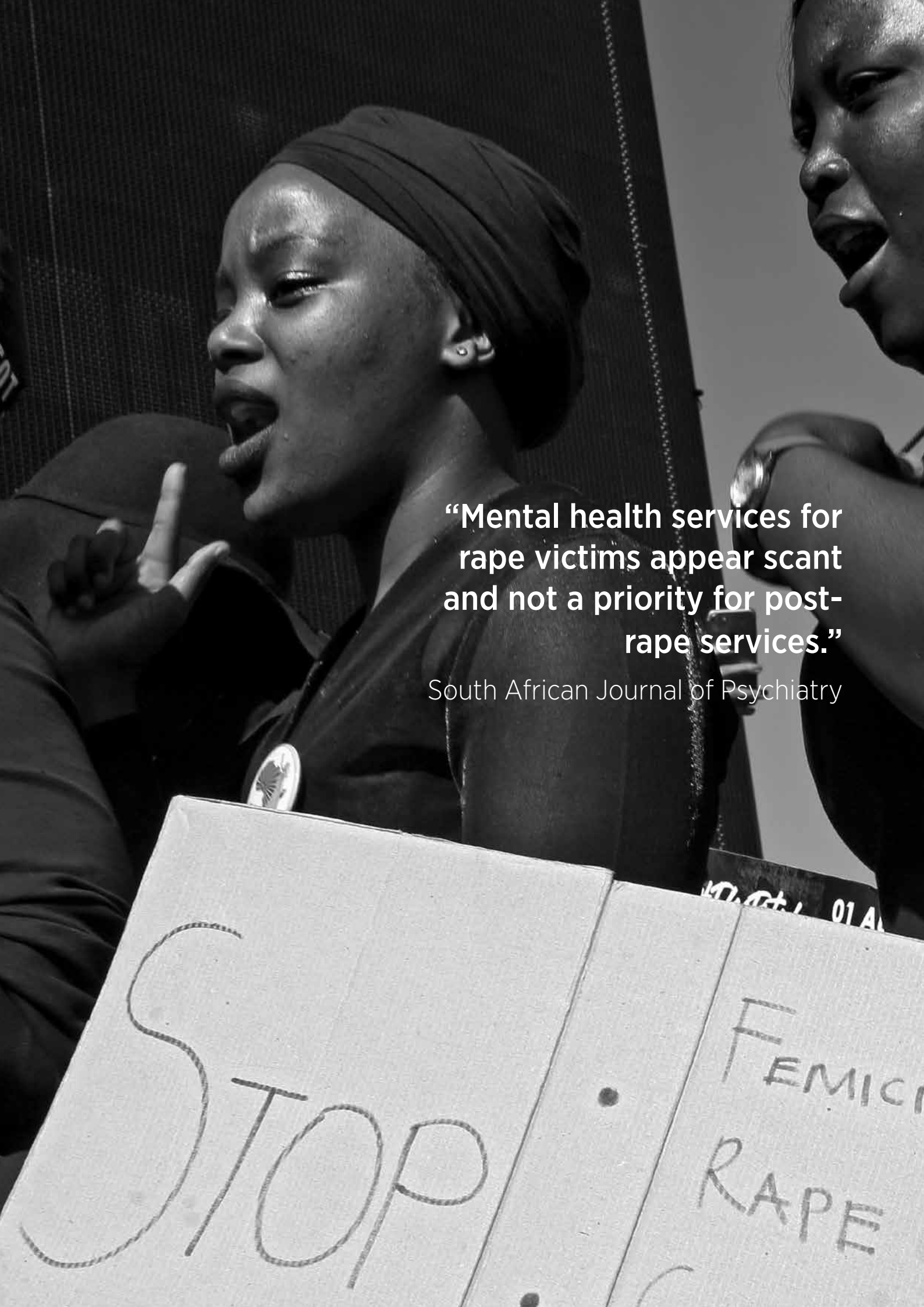
Out of 265 designated facilities, 51% (n=135) participated in an interview. Main findings include:

- 20% (n=24) do not provide trauma counselling for victims of acute violence, while 4% provided no mental health services at all.
- One in ten facilities (n=12) said they would refer survivors, because they do not have the capacity to provide mental health services to survivors of sexual violence.
- More than a third of facilities (39%, n= 46) did not provide a risk assessment for suicidality at their facility.
- 45% (n=53) of designated facilities did not provide counselling for children.
- One in five (21%, n=25) of facilities stated that there was no health care provider available at the facility to conduct mental health counselling.
- More than half (57%, n=47) of facilities indicated that there are no mental health services for victims of intimate partner violence.

Some immediate remedies are within reach. All 265 designated facilities should be capacitated to provide counselling services 24 hours per day, seven days per week. To address additional gaps, an interdepartmental review of mental health care is needed to assess where services are offered, how, and by whom. Resource and budget implications towards improving the availability and quality of care should be addressed and secured.

“Only experiences of political torture match or exceed the severity of rape’s psychological effects – yet little local research has been undertaken to explore rape’s psychological impact.”

Lisa Vetten, Mellon doctoral Fellow, University of the Witwatersrand



"Mental health services for rape victims appear scant and not a priority for post-rape services."

South African Journal of Psychiatry

INTRODUCTION

South Africa has one of the highest rates of violence against women in the world[1]. However, measuring the prevalence of rape in the country is difficult. Studies have shown anywhere between 1 in 10 and 1 in 25 rapes are actually reported to the police[2]. According to the latest South African Police Services (SAPS) data, there are 71 rapes per 100,000 of the population (roughly 50,000 rapes a year)[3]. The prevalence of sexual abuse among children in South Africa is also alarming, with a recent study in *The Lancet* finding that 35.4% of the young people interviewed in schools had been sexually abused at some point in their lives[4]. The study found that at least as many boys (36.8%) as girls (33.9%) reported some form of sexual abuse[4]. Extrapolating these figures, the study estimated that between 314,000 to 785,000 young people aged 15 - 17 in South Africa have been sexually abused from September 2013 to October 2015[4].

Since July 2015, the Médecins Sans Frontières (MSF) has worked in Bojanala Platinum District in partnership with the North West Province Department of Health (NWDoH), supporting four "Kgomotso Care Centres" (KCCs) – community health center-based (CHC-based) services that provide an essential package of medical and psychological care.

In addition to providing care, MSF seeks to document its experience and to interrogate how best the health needs of SGBV survivors can be met. Through our series of "Untreated Violence" reports we aim to quantify the gaps in service provision to victims of sexual and gender based violence (SGBV), in order to find ways, together our partners in civil society and government, to address them.

This is the third in the **Untreated Violence** series. The first report established the extent of sexual and direct violence in the Platinum Mining Belt. The second report focused on the general gap in public health services and forensic nursing for survivors of sexual violence across the country. This report aims to document the current level of mental health care available to victims of SGBV in South Africa.

Sexual and Gender Based Violence: a public health and human rights crisis

- South Africa has a rate of female murders almost six times higher than the global average[2].
- Indirect costs of SGBV are significant. An estimated 16% of all HIV infections in women could be prevented if women did not experience sexual violence from their partners[2].
- Women who have been raped are at risk of unwanted pregnancy, HIV and other sexually transmitted infections. Over a third of them develop post-traumatic stress disorder (PTSD), which if untreated persists in the long term and depression, suicidality and substance abuse are common[5].
- Economic costs of gender based violence in South Africa, through lost economic output, are estimated to be between R28.4 – R42.4 billion per year (0.9-1.3% of GDP annually)[6].

MSF activities on the Platinum Belt

A 2015 MSF survey found that 1 in 4 women living in the platinum belt city of Rustenburg had been raped in her lifetime – approximately 12,000 rapes a year – yet fewer than 5% of rapes are reported to health care, in spite of the fact that rape can result in serious illness and suffering.

Recognising the need for a better medical and psychological response to rape, the North West Department of Health (NWDoH) developed a concept of one-stop-shop health facilities for survivors of sexual violence at the primary health care level, providing essential medical, medico-legal, psychological and social services. Kgomotso is Setswana for "place of comfort", and the NWDoH envisaged that Kgomotso Care Centres (KCCs) would be designed with the comfort of survivors in mind.

Since 2015, MSF has supported the establishment of four DoH KCCs, the first being a stand-alone clinic on the site of Boitekong Primary Health Centre (PHC), with the other three integrated in Community Health Centres in Bapong, Letlhabile and Tlhabane. All KCCs provide survivors of sexual violence with an essential package of care, including comprehensive medical and forensic examination; first aid to treat injuries; post-exposure prophylaxis to prevent HIV and other sexually-transmitted infections; emergency contraception to prevent unwanted pregnancy; vaccination to prevent Hepatitis B and Tetanus; psychological care; social care; and referral to additional services as needed.

However, bringing these services closer to communities addressed only one of several barriers to accessing care that survivors face, and to overcome stigma, low levels of treatment literacy and other issues preventing survivors from reporting for care, MSF has rolled out a series of community-based initiatives, including a large-scale health promotion program, the positioning of staff in police stations and grassroots welfare organisations, and a partnership with the provincial Department of Basic Education (DBE) on a school SGBV program. Community-based staff are able to identify survivors of sexual violence through screening and link them to the services they need. KCC attendance has risen from 18 clients on average per month per clinic in 2015/2016, to 30 clients average per month per clinic in 2017/2018.

In supporting the NWDoH to develop and pilot the KCC model, MSF aims to pioneer a scalable, cost-effective response to the medical, psychological and social needs of survivors of sexual violence, and ultimately to mitigate illness and suffering resulting from rape.

MENTAL HEALTH CONSEQUENCES OF SEXUAL VIOLENCE

While the physical consequences of sexual violence are to some extent recognised, the psychological consequences, which according to the World Health Organization (WHO) can include post-traumatic stress disorder (PTSD), depression, anxiety and suicidality, often receive less attention, despite being both common and severe[5].

Little data exists on the mental health consequences of sexual violence in South Africa, although one small study of 30 children found that 67% of the children had symptoms indicative of full PTSD, while 29.3% exhibited partial symptoms. 45.2% of the children had anxiety and 35% of the children had depression[4].

In Rustenburg, a city of more than 500,000 people, analysis of a 2015 MSF survey revealed that sexual and intimate partner violence (IPV) are probably responsible for 1 in 3 cases of major depressive disorder in women, and that women who were raped in childhood are six times as likely to experience non-partner rape as an adult, compared to those who were not. The analysis also found that the odds of experiencing emotional abuse by an intimate partner are much higher for adults who experienced rape in childhood.

The severe mental health consequences of sexual violence undoubtedly requires a medical and psychological response, yet a recent report in the *South African Journal of Psychiatry* notes that, "mental health services for rape victims appear scant and not a priority for post-rape services[7]."

MSF mental health response on South Africa's platinum belt

The current gaps in mental health services provided to victims of sexual violence determines the support that MSF provides to DoH KCCs, where survivors of sexual violence can access an essential package of care, including mental health counselling and social care. In addition to placing registered counsellors and social workers in KCCs, as well as forensic medical nurses, mentorship for counsellors and forensic nurses is also provided, as well as supervision for all staff working with victims of sexual violence.

Each client who enters a KCC is seen by any of the available professionals, which include the registered counsellor, for a mental health assessment, and is requested to return for a follow up assessment one week later if needed. All staff in the KCC have been trained as first-responders to SGBV cases. The current public health response to the mental health needs of patients is heavily reliant on lay counsellors, whose main responsibilities lie in the response to HIV/TB. MSF experience with this model suggests that lay counsellors are ill-equipped to manage the emotional severity presented by survivors of sexual violence, whereas registered counsellors can be more easily up-skilled to respond to survivors at different post-rape stages, and make more appropriate determinations for referral to further psychological care for survivors.

If after counselling symptoms of post-traumatic stress disorder, depression, anxiety, psychosis or behavioural problems persist, or if the registered counsellor determines a need for urgent higher mental health care at any time during the counselling process, the survivor is referred to a psychologist or psychiatrist, either in a community health centre, or district hospital. Assessing outcomes from these referrals remains a challenge, partly because DoH psychologists are often hesitant to provide feedback about the cases.

Since 2016, 1821 survivors of SGBV have received a mental health consultation. 92 (5%) have shown symptoms of PTSD, while 15% (n=279) needed to be referred for psychological or psychiatric support, showing severe and persistent psychological effects. Since the health needs of survivors cannot be adequately addressed without also considering the social needs that survivors present with, survivors are connected to a social worker. The social worker will conduct a social needs and safety risk assessment, develop effective safety plans to manage risks, and provide follow-up social care and referral to external agencies as required.

KCC ESSENTIAL PACKAGE OF MENTAL HEALTH CARE

Psychological Care

- Provide initial containment after crisis
- Provide short-term supportive counseling and therapy
- Conduct psychological risk assessment and manage behavioural risks identified
- Provide follow-up psychological care and make referral for advanced psychological care as and when required
- Ensure continuity of mental health care
- Prevent secondary traumatisation

Social Work care

- Provide initial intake and social needs assessment
- Conduct safety risk assessment and manage risks through effective safety plans
- Provide follow-up social care and make referral to external agencies (Department of Social Development, NGOs, SAPS) as and when required
- Ensure continuity of social care
- Prevent secondary traumatisation
- Link to community-based resources including organisations, groups, and individuals for continued social support in the community.

CURRENT MENTAL HEALTH CARE FOR SURVIVORS OF SEXUAL VIOLENCE

In total, the Department of Health has designated 265 public health care facilities– mostly hospitals – across all provinces to provide medical and psychological care to survivors of sexual violence, as well as the option of clinical forensic services. Of these, 55 designated facilities are specialised, interdepartmental Thuthuzela Care Centers (TCC), based on hospital premises. These are meant to attend to survivors' medical, mental health, social care, and legal needs.

Mostly urban-based, the main aims of TCCs are to reduce secondary victimisation, increase convictions and reduce the time taken to finalise prosecution. It is widely accepted that the emphasis of post-rape care in South Africa has been to provide a medico-legal response, through increasing the number of TCCs[8]. The mental health support provided at the TCCs is largely by non-governmental organisations (NGOs) and is often inadequate, potentially being a cursory response to mental health issues. Indeed, while it is clearly stipulated what medical services designated facilities must provide, the psychological and social service offering is not clearly defined.

QUANTIFYING THE GAP IN MENTAL HEALTH CARE FOR SURVIVORS OF SEXUAL VIOLENCE

In this report, we provide a snapshot of the capacity that exists in designated facilities to deliver comprehensive mental health services for survivors of sexual violence. The mental health services that designated facilities must provide is not clearly outlined in any specific Standard Operating Procedures, and so we have evaluated facilities against the WHO-recommended guidelines on service provision for victims of sexual violence on page 13. The evaluation of designated facilities was conducted telephonically in September/October 2018, with the interviewer asking to speak to, in the following order: operational manager or counterpart; nurse in charge; or the focal contact persons on the list of designated facilities.

SURVEY STRENGTHS AND LIMITATIONS

This is the second known telephonic mapping of all designated facilities in South Africa and provides much needed information about nation-wide gaps in mental health services for survivors of sexual violence.

Although every effort was made to contact all the designated facilities, 14% (n=39) were not reachable as their telephone line did not work. A further 14% (n=39) delayed responding to the survey, asking interviewers to call back at another time. Each of these facilities was called five times, but did not respond by the time the survey was completed. A further 28% (n=52) of designated facilities declined to respond, stating that they did not have permission from the DoH to participate in the survey.

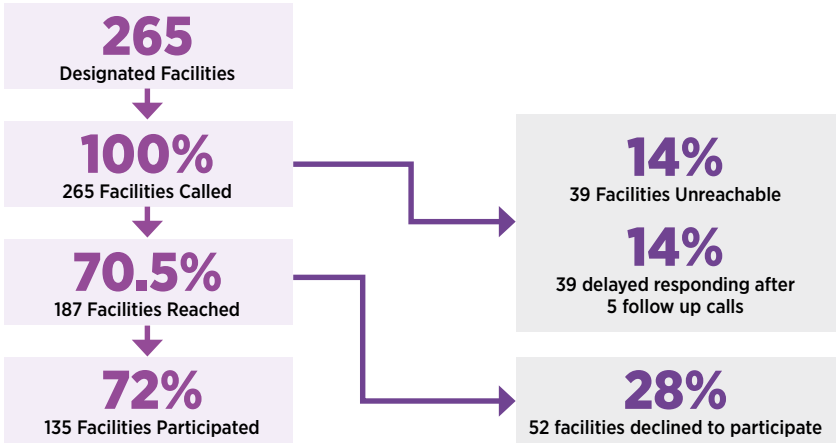
While only 51% (n=135) of all designated facilities responded to the survey, the findings do provide a view of the gaps in mental health services available for victims of sexual violence.

Self-reported results may present a more positive picture about services than exists in reality. Respondents potentially seek to respond in a way that reflects favourably on themselves or their place of work. Therefore, while the mapping indicates that there is a significant gap in services, the results may actually underestimate how common gaps in service are.

Telephonic surveys do not provide an accurate measure of the quality of service provision. For example, questions regarding the availability of a commodity provide only an understanding of a facility's capacity to offer a service, but capacity does not always translate to patients receiving the service for which they are eligible.

SURVEY RESULTS

This section presents a detailed breakdown of the essential mental health services that should be available at each designated facility and the gaps in service as quantified by the telephonic survey.



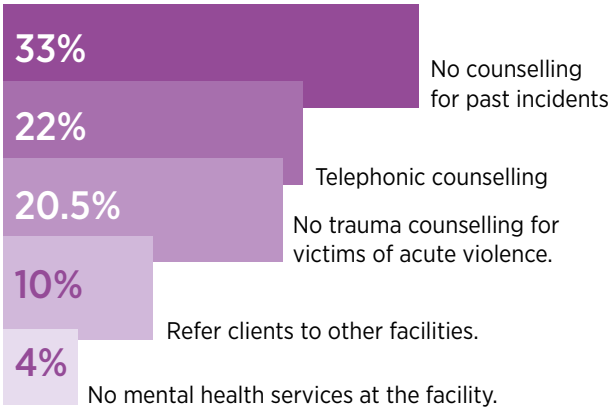
Flowchart outlining participation in national telephonic mapping exercise

ACCESS TO TRAUMA COUNSELLING FOR PATIENTS PRESENTING AT THE ACUTE STAGE OF THE TRAUMA:

20,5% (n=24) stated that they do not provide trauma counselling for victims of acute sexual violence. This is the minimum mental health service that victims of sexual violence should receive, according to South African and global guidance. 4% (n=6) stated that they provide no mental health services at the facility, while 10% (n=12) indicated that they refer clients to other facilities for mental health services

33% of facilities (n=39) stated they did not offer counselling for individuals of past incidents of sexual violence.

Only 22% (n=27) of facilities provided telephonic counselling services to victims of sexual violence.



MENTAL HEALTH SERVICES FOR VICTIMS OF INTIMATE PARTNER VIOLENCE:

Almost half (42%, n=47) of facilities indicated that there are no mental health services for victims of intimate partner violence. Given the high rates of intimate partner violence in South Africa, this is of grave concern.

42% No mental health services for victims of intimate partner violence

RISK ASSESSMENTS FOR SUICIDALITY:

39% (n=46) facilities stated that they did not provide a risk assessment for suicidality at their facility.

ACCESS TO PSYCHOTROPIC DRUGS:

53% (n=61) of the facilities indicated that they had access to psychotropic drugs to treat acute anxiety for victims of sexual violence.

“After my rape I was thinking about suicide. I felt useless. I told myself these people destroyed me in and out, maybe if I go my gran will take care of my kids. But since I’ve come here [Lethlabile KCC] for counselling everything’s changed. I go to work every day, I smile with people, although it’s hard when I think about it. It’s very traumatising.”

Bridget Monegi, survivor.

COUNSELLING FOR CHILDREN:

45% (n=53) of designated facilities indicated that they did not provide counselling for children, including established methods such as play therapy. In addition, 62% (n=69) of the facilities did not have a child-friendly space, including toys, a corner for play and/or equipment for play therapy.

45% No counselling for children

62% No child-friendly space

FOLLOW UP COUNSELLING SESSIONS:

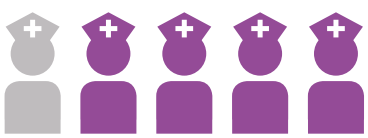
25% of facilities (n=30) reported they did not provide any follow up mental health counselling sessions for victims of sexual violence.

Only 13% (n=16) of facilities had indicated that they had social care groups for victims of sexual violence. In addition, only 20% (n=24) of facilities conducted home visits for victims or had any kind of community outreach activities.

PROVIDERS OF MENTAL HEALTH CARE:

Across the 117 sites that provide mental health service, the below cadres of health care workers are potentially available to provide the mental health services for victims of sexual violence.

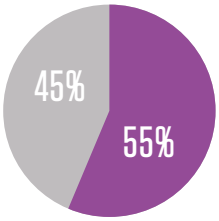
Cadre of health care worker	Total number across 117 sites
Lay counsellors	57
Registered counsellor	29
Social worker	92
Social auxiliary worker	30
Psychologist	41
Psychiatrist	21
Nurse	69
Paediatrician or Paediatric nurse	22



One in five (21%, n=25) facilities stated that there was no health care provider available at the facility to conduct mental health counselling. 17% (n=20) of the facilities indicated that that there was health care provider on call 24 hours per day, seven days per week available to provide mental health counselling, while only one in four (24%, n=29) of the facilities had a health provider that could provide mental health counselling on duty at the facility at all times.

LOCATION OF SERVICES:

Only 55% (n=65) of facilities reported that they had a separate unit or victim-friendly room for survivors. Other facilities provide counselling for survivors in sites such as the general outpatient department.



55% had a separate unit or victim-friendly room for survivors

GEOGRAPHICAL COVERAGE AND REFERRAL NETWORKS OF DESIGNATED FACILITIES:

One in ten facilities (9.9%) reported that they prefer to refer survivors to another facility, as they did not have the capacity to provide basic mental health care.

9.9% Refer survivors to another facility.

Of the facilities who did refer clients to other facilities for mental health services, only 57%, n=23 referred to facilities less than 5km from the original health facility.

OUT OF THE 265 DESIGNATED FACILITIES, 86% PROVIDE SERVICES FOR VICTIMS OF SEXUAL VIOLENCE AT HOSPITALS.

ANALYSIS

There are considerable gaps in both the availability and nature of services that exist for survivors of sexual and gender-based violence in designated facilities, the very facilities specifically designed to meet their needs. As a consequence, many opportunities to reduce the harm associated with sexual violence are not realised. Even survivors who make it to care in many cases fail to receive the help they need.

ABSENCE OF SERVICES

Some of the gaps in current service provision highlighted in our survey give cause for particular concern. More than a third of facilities (39%, n= 46) indicated that they did not provide a risk assessment for suicidality at their facility. This is an extremely serious limitation of current services, particularly given the relatively high frequency of serious mental health consequences of sexual violence. This finding also highlights the need for a review of how triage is conducted in designated facilities. The assessment of suicidality would typically be included within triage or screening questionnaires. The finding that most facilities do not assess suicidality seriously calls into question both the adequacy of assessment that is conducted as well as the likelihood that survivors receive care that is appropriate to their needs more broadly.

MORE THAN A THIRD OF FACILITIES (39%, N=46) INDICATED THAT THEY DID NOT PROVIDE A RISK ASSESSMENT FOR SUICIDALITY AT THEIR FACILITY.

In 4% of responding facilities, it was stated that they provided no mental health services of any kind to survivors. Indeed, a larger number - one in ten facilities (n=12) - said they would refer survivors because they do not have the capacity to provide mental health services to survivors of sexual violence. Referral is generally best limited, as it has the disadvantage of potentially increasing secondary traumatisation associated with having to seek out care at multiple locations. In some cases, individuals may not be referred, or once referred may not successfully reach a care provider. In either case, this is a critical and concerning gap, and urgent work should be undertaken to ensure that this situation is addressed. Furthermore, it should be noted that there is evidence to demonstrate that victims of sexual violence are unlikely to return to facilities if they do not receive counseling when they visit a facility.

Close to half (45%, n=53) of designated facilities told us they did not provide counselling for children. This is concerning, as child survivors of sexual violence require a certain sensitivity in approach, and care should be delivered in such a way as to reduce the risk of further traumatisation of the child during interview, examination and the provision of medical and other services.

CLOSE TO HALF OF DESIGNATED FACILITIES TOLD US THEY DID NOT PROVIDE COUNSELLING FOR CHILDREN.

INSUFFICIENT SERVICES

One in five (21%, n=25) facilities stated that there was no health care provider available at the facility to conduct mental health counseling. This lack of specific resources indicates that in such facilities, if any counseling were to be provided, it would be provided by a staff member lacking specific training and skills in counseling. The quality of any such counselling offered would therefore be of concern.

One of the most alarming findings of this survey is that even in facilities that report that they provide counselling services, provision is often dependent upon the time of the day as well as who happens to be working at that site. 17% (n=20) of the facilities indicated that that there was a health care provider on call 24 hours per day, seven days per week to provide mental health counselling. While we cannot establish how often survivors would receive care in those designated facilities that report they offer some counselling services, only in 1 in 4 cases could a survivor be confident that there always be someone available to meet their needs for counselling.

A third (33%, n=39) of facilities stated they did not offer counselling for individuals of past incidents of sexual violence. This is concerning because the majority of survivors do not present to care at the time of the incident, and yet many of the psychological and psychiatric consequences of sexual violence only appear after some time and can become more difficult to address in the longer term. The result of this will be that many opportunities to support individuals in need of care will be missed, and potentially severe consequences are not prevented in time.

Only half (53%, n=61) of the facilities indicated that they had access to psychotropic drugs to treat acute anxiety

for survivors of sexual violence. Although South African policies do not explicitly require that psychotropic drugs are available to victims of sexual violence in acute anxiety, this medication assists in stabilising a victim who has experienced trauma.

More than half (57%, n=47) of facilities indicated that there are no mental health services for victims of IPV. This implies that counseling would be dependent upon the perceived nature of the event that led the individual to present to care. Sexual violence in an intimate partner relationship, especially in transactional ("blesser-blessee") relationships are missed and patients are not given support and care. In addition, many survivors of sexual violence do not immediately disclose the incident. It is also of concern that someone experiencing intimate partner violence in the absence of sexual violence does not receive counseling, particularly someone having presented to health services. Moreover, providing services based on the perceived nature of the event on a patient's presentation to care is by definition not a patient centred approach.

SEXUAL VIOLENCE IN AN INTIMATE PARTNER RELATIONSHIP, ESPECIALLY IN TRANSACTIONAL ("BLESSER-BLESSEE") RELATIONSHIPS ARE MISSED AND PATIENTS ARE NOT GIVEN SUPPORT AND CARE.

STAFFING

In 49% of facilities (57/117) it was stated that counselling was provided by lay counsellors, and only 25% of facilities (29/117) reported a registered counsellor to be available to provide counselling. Sexual violence often leads to serious psychiatric problems, such as PTSD or major depression, and it is unlikely that a lay counsellor can adequately address such issues in their entirety. While lay counsellors alone are not sufficient to meet the needs of survivors, they may have a role in areas such as triage and supporting psychological first aid provision. The feasible and desirable scope of work for lay counsellors in the response to sexual violence does warrant careful consideration, in conjunction with issues of the available financial resources to support counselling in this context, something beyond the scope of this report. Nevertheless, the heavy reliance on lay counsellors for the provision of care is of particular concern given that for the most part their role is in the provision of HIV-TB care, and structured training programmes to support lay counsellors in addressing the psychological needs of survivors are not widely implemented.

OVERALL IMPRESSIONS

These results illustrate that critical counselling care is often partially or completely absent in designated facilities. Where counselling services do exist, there are serious concerns about how those services are organised, provided, and resourced. Consequently, opportunities to address psychological and psychiatric harm are missed. In many cases, secondary trauma may occur through the provision of care by untrained individuals.

CONCLUSIONS AND RECOMMENDATIONS

Current mental health services for survivors of sexual violence in South Africa are not sufficiently accessible, nor are they comprehensive. Urgent interventions are required to ensure that access to services improves, so that victims can receive care to prevent, reduce or treat the serious mental health consequences of sexual violence.

- All 265 designated facilities should take steps to **ensure that counseling services are available 24 hours, 7 days a week, and that service providers** have **adequate qualifications (registered counselor level) and experience**.
- There is an urgent need to **institute a consistent approach for screening for conditions such as suicidality, major depression and post-traumatic stress disorder**
- While we did not directly assess the quality of care here, these findings highlight the **need for an interdepartmental review and action plan concerning where, how, and by whom mental health support to survivors of sexual violence are provided**
- In order to provide comprehensive mental health care for survivors of sexual violence, **a costing exercise should be undertaken, leading to the allocation of sufficient dedicated funding** by all stakeholders providing counseling services to survivors.

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WORLD HEALTH ORGANIZATION RECOMMENDATIONS

The World Health Organization[i] recommends the following approach for victims of sexual violence:

1. **Health-care providers should, as a minimum, must offer first-line support, including:**

- being non-judgemental and supportive and validating what the individual is saying
- providing practical care and support that responds to their concerns, but does not intrude by asking about their history of violence, listening carefully, but not pressuring them to talk (care should be taken when discussing sensitive topics when interpreters are involved)
- helping them access information about resources, including legal and other services that are helpful.
- assisting them to increase safety for herself and their children, where needed
- providing or mobilizing social support.

Providers should ensure:

- that the consultation is conducted in private
- confidentiality, while informing of the limits of confidentiality (e.g. when there is mandatory reporting)

If health-care providers are unable to provide first-line support, they should ensure that someone else (within the same facility or another that is easily accessible) is immediately available to do so.

2. Unless the person is depressed, has alcohol or drug use problems, psychotic symptoms, is suicidal or self-harming, or has difficulties functioning in day-to-day tasks, apply **"watchful waiting"** for 1–3 months after the event. Watchful waiting involves explaining to the victim that they are likely to improve over time, and offering the option to come back for further support by making regular follow-up appointments.

3. If the person is incapacitated by the post-rape symptoms (i.e. they cannot function in day-to-day tasks), arrange for cognitive behaviour therapy **(CBT)** or eye movement desensitisation and reprocessing **(EMDR)**, by a health-care provider with a good understanding of sexual violence.

4. Cognitive behavioural therapy (CBT) or eye movement desensitization and reprocessing (EMDR) interventions, delivered by **health-care professionals with a good understanding of sexual violence** are recommended for individuals who are no longer experiencing violence but are suffering from post-traumatic stress disorder (PTSD).

[i] World Health Organization (2013) Responding to intimate partner violence and sexual violence against women: WHO clinical and policy guidelines.

SOUTH AFRICAN GUIDANCE

South Africa follows the WHO guidance and recommends the following mental health support for adult victims of sexual violence, as outlined in the South African Department of Health Sexual Assault Guidelines of 2011:

- An immediate response and urgent attention to the patient accessing the services. Prompt care should be offered.
- Ensuring that privacy and confidentiality are maintained, for adults and children.
- Provide information on psychological reactions to rape and mention that experiencing these is normal.
- A clinical follow-up visit should be scheduled for after one week, six weeks and three months to provide assessments of the general state of health and emotional and psychological well-being of the victim
- Provide referral for psychiatric and psycho-social care when required, such as cases of self-harming behaviour, trauma symptoms are still present after one to two weeks (such as, flashbacks, emotional distress when reminded of the event and disturbing dreams), high level of mental distress or mental health symptoms (such as, anxiety, prolonged sadness, helplessness, insomnia and agitation) and/or suicidal ideation.
- Every facility should maintain a comprehensive and up-to-date referral list that includes contact details for local shelters and medium to long-term counselling services. In addition, the list should contain information about specialised services for people with disabilities, LGBTI survivors, refugees and migrants and any other grouping which needs specialist assistance.

For children under the age of 18:

- Parents should be informed of the symptoms of psychological distress that may develop, told that many of these will improve over time without treatment, but if they do not, then specialised psychotherapy is needed.
- Parents should be informed that children may show developmental regression after sexual abuse. This usually resolves spontaneously but if it does not, specialised referral is needed.
- Early intervention involves identifying anxiety symptoms and problems that may have arisen with social functioning, and developing a plan for how to manage these and their social consequences with the care-giver.
- Care-givers should be asked about symptoms of psychological distress. These include flashbacks, sleep disturbances, altered appetite, features of separation anxiety and general behavioural changes.
- When symptoms are very severe and persistent, refer for psychosocial or therapeutic management of the child and caregiver. If symptoms are very severe consider a short course (10-14 days) of medication, such as Diazepam to reduce anxiety whilst waiting for psychotherapy to start.

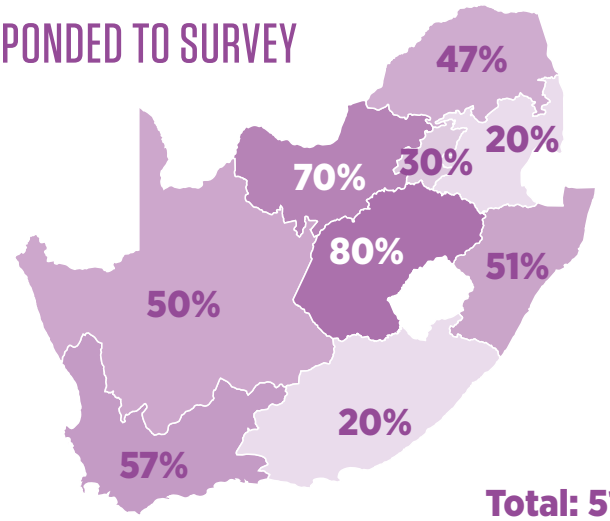
APPENDIX 1: MAPPING DATA

Where are the services of all designated sites located?										
	Eastern Cape	Free State	Gauteng	KwaZulu-Natal	Limpopo	Mapumalanga	Northern Cape	North West	Western Cape	TOTAL
Hospital-based	1	21	12	42	33	9	23	18	30	189
Primary care facilities	4	4	18	5	5	11	5	12	12	76
TOTAL	5	25	30	47	38	20	28	30	42	265

Sites that responded to survey										
	Eastern Cape	Free State	Gauteng	KwaZulu-Natal	Limpopo	Mapumalanga	Northern Cape	North West	Western Cape	TOTAL
Hospital based	1	16	3	22	14	3	5	13	18	95
Primary care facilities	0	3	3	2	4	1	8	4	3	28
Refer to another site	0	1	3	0	0	0	1	4	3	12
Total sites that responded to survey	1	20	9	24	18	4	14	21	24	135
Total number of designated sites	5	25	30	47	38	20	28	30	42	265
% of sites that responded to survey	20,00	80,00	30,00	51,06	47,37	20,00	50,00	70,00	57,14	50,94

	Eastern Cape	Free State	Gauteng	KwaZulu-Natal	Limpopo	Mapumalanga	Northern Cape	North West	Western Cape	TOTAL
Total sites that responded to survey	1	20	9	24	18	4	14	21	24	135
Total number of designated sites	5	25	30	47	38	20	28	30	42	265

% OF SITES THAT RESPONDED TO SURVEY



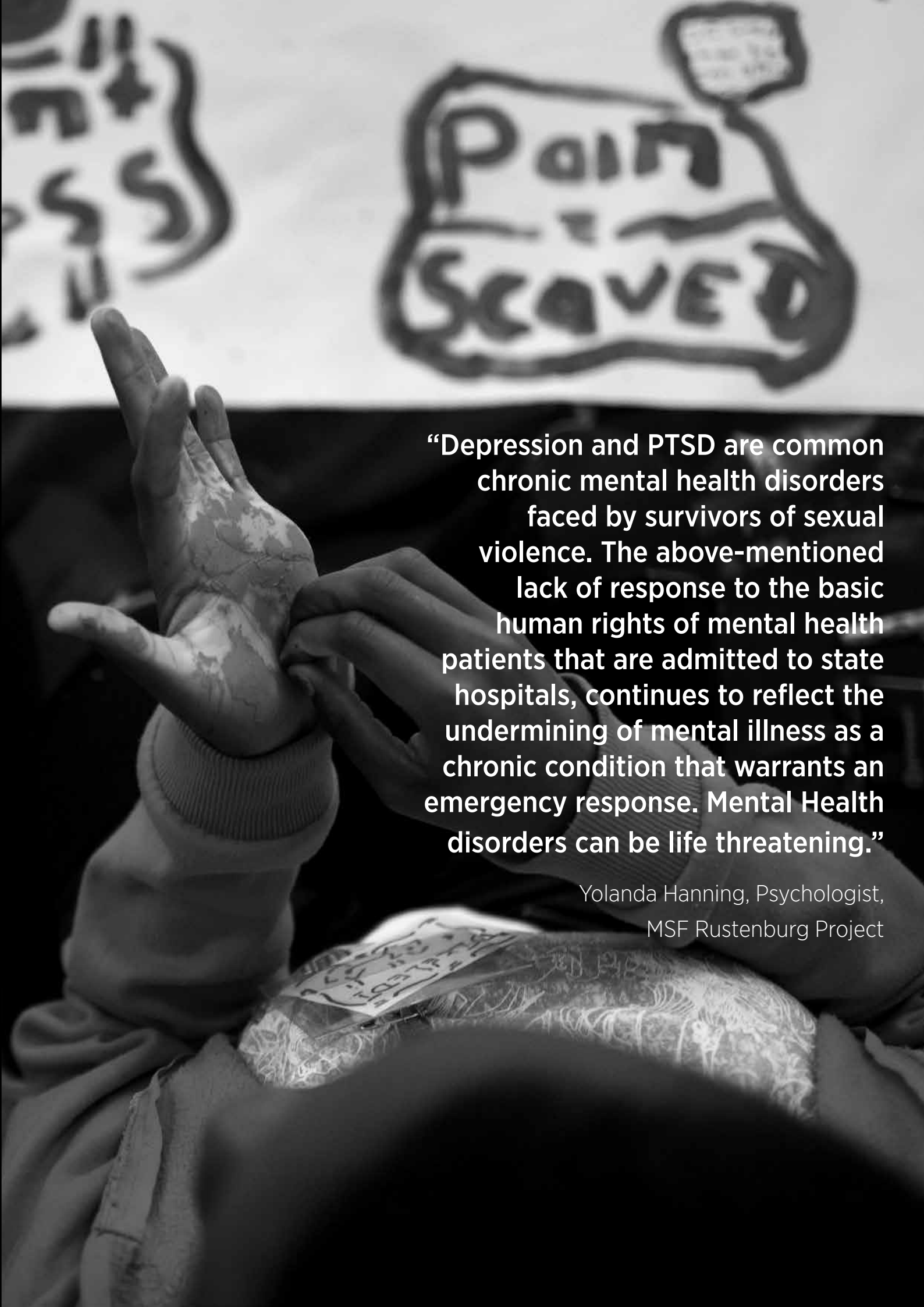
Total: 51%

Which services are currently offered in your health facility to survivors of sexual violence?											
		EC	FS	GP	KZN	L	Mp	NC	NW	WC	Total
Trauma counseling (acute cases of violence	Yes	1	8	6	27	17	4	4	13	13	93
	No	0	7	1	1	1	0	6	2	6	24
	Refer to another site	0	1	3	0	0	0	1	4	3	12
	Do not provide any services	0	0	0	1	0	0	3	0	2	6
	total response	1	16	10	29	18	4	14	19	24	135
	% yes	100	50	60	93	94	100	29	68	54	79
	% no	0	50	40	7	6	0	71	32	46	21
Ongoing counselling (more than one session)	Yes	1	8	6	26	17	4	3	13	9	87
	No	0	7	1	2	1	0	7	2	10	30
	Refer to another site	0	1	3	0	0	0	1	4	3	12
	Do not provide any services	0	0	0	1	0	0	3	0	2	6
	total response	1	15	7	28	18	4	10	15	19	135
	% yes	100	53	86	93	94	100	30	87	47	74
	% no	0	47	14	7	6	0	70	13	53	26
Counselling for children, including play therapy	Yes	1	6	2	18	15	4	2	7	9	64
	No	0	9	5	10	3	0	8	8	10	53
	Refer to another site	0	1	3	0	0	0	1	4	3	12
	Do not provide any services	0	0	0	1	0	0	3	0	2	6
	total response	1	15	7	28	18	4	10	15	19	135
	% yes	100	40	29	64	83	100	20	47	47	54
	% no	0	60	71	36	17	0	80	53	53	46

Which services are currently offered in your health facility to survivors of sexual violence?											
		EC	FS	GP	KZN	L	Mp	NC	NW	WC	Total
Counselling for clients who were victims of violence in the past	Yes	1	8	5	24	17	4	3	9	7	78
	No	0	7	2	4	1	0	7	6	12	39
	Refer to another site	0	1	3	0	0	0	1	4	3	12
	Do not provide any services	0	0	0	1	0	0	3	0	2	6
	total response	1	15	7	28	18	4	10	15	19	135
	% yes	100	53	71	86	94	100	30	60	37	67
	% no	0	47	29	14	6	0	70	40	63	33
Termination of pregnancy referral	Yes	1	8	6	25	16	2	1	13	13	85
	No	0	7	1	3	2	2	9	2	6	32
	Refer to another site	0	1	3	0	0	0	1	4	3	12
	Do not provide any services	0	0	0	1	0	0	3	0	2	6
	total response	1	15	7	28	18	4	10	15	19	135
	% yes	100	53	86	89	89	50	10	87	68	73
	% no	0	47	14	11	11	50	90	13	32	27
Psychotropic drugs	Yes	1	1	1	18	10	2	4	10	14	61
	No	0	10	6	10	8	2	6	5	5	52
	Refer to another site	0	1	3	0	0	0	1	4	3	12
	Do not provide any services	0	0	0	1	0	0	3	0	2	6
	total response	1	11	7	28	18	4	10	15	19	131
	% yes	100	9	14	64	56	50	40	67	74	54
	% no	0	91	86	36	44	50	60	33	26	46
Risk assessment for suicidality	Yes	1	7	5	23	9	3	4	9	10	71
	No	0	8	2	5	9	1	6	6	9	46
	Refer to another site	0	1	3	0	0	0	1	4	3	12
	Do not provide any services	0	0	0	1	0	0	3	0	2	6
	total response	1	15	7	28	18	4	10	15	19	135
	% yes	100	47	71	82	50	75	40	60	53	61
	% no	0	53	29	18	50	25	60	40	47	39
Social support groups	Yes	1	0	2	5	1	2	0	4	1	16
	No	0	15	5	23	17	2	9	11	18	100
	Refer to another site	0	1	3	0	0	0	1	4	3	12
	Do not provide any services	0	0	0	1	0	0	3	0	2	6
	total response	1	15	7	28	18	4	9	15	19	134
	% yes	100	0	29	18	6	50	0	27	5	14
	% no	0	100	71	82	94	50	100	73	95	86

Which services are currently offered in your health facility to survivors of sexual violence?											
		EC	FS	GP	KZN	L	Mp	NC	NW	WC	Total
Telephonic counselling	Yes	1	2	3	6	4	2	0	6	3	27
	No	0	13	4	22	17	2	10	9	16	93
	Refer to another site	0	1	3	0	0	0	1	4	3	12
	Do not provide any services	0	0	0	1	0	0	3	0	2	6
	total response	1	15	7	28	21	4	10	15	19	138
	% yes	100	13	43	21	19	50	0	40	16	23
	% no	0	87	57	79	81	50	100	60	78	78
Home-visits or community outreach	Yes	1	3	3	6	2	2	0	4	3	24
	No	0	12	4	22	16	2	10	11	16	93
	Refer to another site	0	1	3	0	0	0	1	4	3	12
	Do not provide any services	0	0	0	1	0	0	3	0	2	6
	total response	1	15	7	28	18	4	10	15	19	135
	% yes	100	20	43	21	11	50	0	27	16	21
	% no	0	80	57	79	89	50	100	73	84	79
Does your facility offer a private room (with door, walls and private bathroom) for victims of sexual violence?	Yes	1	5	7	14	7	4	3	10	13	64
	No	0	9	0	15	11	0	7	5	6	53
	Don' know	0	1	0	0	0	0	3	0	0	4
	Refer to another site	0	1	3	0	0	0	1	4	3	12
	Do not provide any services	0	0	0	1	0	0	3	0	2	6
	total response	1	16	10	30	18	4	17	15	24	135
	% yes	100	31	70	47	39	100	18	67	12	55
	% no	0	56	0	50	61	0	41	33	25	45
Does your facility have a child-friendly space, including toys, a corner for play and/or equipment for play therapy?	Yes	1	8	7	13	6	2	4	7	10	58
	No	0	7	3	16	12	1	6	7	9	61
	Don't know	0	1		1	0	1	3	1	3	10
	Do not provide any services	0	0	0	1	0	0	3	0	2	6
	total response	1	16	10	31	18	4	16	15	24	135
	% Yes	100	50	70	42	33	50	25	47	42	49
	% No	0	44	30	52	67	25	38	47	38	51

Which services are currently offered in your health facility to survivors of sexual violence?											
		EC	FS	GP	KZN	L	Mp	NC	NW	WC	Total
Where do you refer and how far is that location	Under 5km	1	0	6	5	0	0	0	4	7	23
	5km - 10km	0	2	0	1	0	0	1	1	1	6
	Over 10km	0	12	0	12	12	0	7	12	5	60
	No Referral	0	1	1	8	7	4	2	0	6	29
	Total:	1	15	7	26	19	4	10	17	19	118
	% Total under 5km	100	0	86	19	0	0	0	24	37	19
	% Total 5km - 10km	0	13	0	4	0	0	10	6	5	5
	% Total over 10km	0	80	0	46	63	0	70	71	26	51
	% Total no referral	0	7	14	31	37	100	20	0	32	25
Are the providers who usually conduct mental health counselling at this facility available	Not available	0	8	0	1	1	0	5	2	8	25
	On call - Mo – Fri	0	0	1	1	3	0	1	2	0	8
	On call 24/7	0	4	1	5	2	1	0	1	6	20
	On duty - Mon – Fri	0	2	3	11	10	2	3	3	0	34
	On duty 24/7	1	1	2	8	4	0	2	7	4	29
	On duty Sat – Sun	0	0	0	0	0	1	0	0	0	1
	Declined Question	0	0	0	0	0	0	0	0	1	1
	Total	1	15	7	26	20	4	11	15	19	118
	% Not available	0	53	0	4	5	0	45	13	42	21
	% On call - Mo – Fri	0	0	14	4	15	0	9	13	0	7
	% On call 24/7	0	27	14	19	10	25	0	7	32	17
	% On duty - Mon – Fri	0	13	43	42	50	50	27	20	0	29
	% On duty 24/7	100	7	29	31	20	0	18	47	21	25
	% On duty Sat – Sun	0	0	0	0	0	25	0	0	0	1
	% Declined Question	0	0	0	0	0	0	0	0	5	1
Does your facility provide mental health services to victims of Intimate Partner Violence or Domestic Violence?	Yes	1	7	3	20	11	4	3	8	7	64
	No	0	8	3	8	7	0	7	3	11	47
	Refer to another site	0	1	3	0	0	0	3	4	3	14
	Do not provide any services	0	0	0	1	0	0	2	0	2	5
	Don't know	0	0	0	0	0	0	0	0	0	0
	Declined question	0	0	1	1	0	0	3	0	1	6
	total response	1	16	10	30	18	4	18	15	24	136
	% yes	100	44	30	67	61	100	17	53	29	47
	% no	0	50	30	27	39	0	39	20	46	35



“Depression and PTSD are common chronic mental health disorders faced by survivors of sexual violence. The above-mentioned lack of response to the basic human rights of mental health patients that are admitted to state hospitals, continues to reflect the undermining of mental illness as a chronic condition that warrants an emergency response. Mental Health disorders can be life threatening.”

Yolanda Hanning, Psychologist,
MSF Rustenburg Project

Doctors Without Borders/Médecins Sans Frontières (MSF) is an international, independent, medical humanitarian organization that delivers emergency aid to people affected by armed conflict, epidemics, natural disasters and exclusion from healthcare. MSF observes strict principles of neutrality, impartiality and independence. 95% of MSF's funding comes from 6.1 million individual donors. MSF does not accept funding from the extractive industry and has a policy against forming partnerships with mining companies.

MSF has pioneered approaches to treat HIV in South Africa since 1999. MSF was one of the country's first providers of antiretroviral treatment in the public sector and has since led efforts to decentralise treatment strategies for HIV and tuberculosis, including drug-resistant tuberculosis. Since June 2015, MSF has partnered with the Department of Health to provide medical and psychosocial care to survivors of sexual violence in Bojanala Health District, North West Province.

www.msf.org.za

MEDECINS SANS FRONTIERES