Using research to improve service nationally: developing strategies

Rachel Jewkes
Gender & Health Research Unit,
Medical Research Council, South Africa

Change in sexual assault services and policy in South Africa

- Process conducted through an informal partnership between the Department of Health and researchers and (clinician/NGO/researcher) activists
- Building blocks:
  - Partnership and collaboration in research, policy drafting and development of training
- Software:
  - All partners willing to learn, to share and primarily motivated to improve sexual assault services

Historical Problems with South African rape services

- **District surgeon system:** riddled with racial prejudice; untrained staff; unsympathetic & judgemental; evidence collection was poor and doctors didn't want to go to court; no access to care without going through the police.
- **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. Start of forensic nurse training.

South African Gender-based Violence & Health Initiative (SAGBVHI)

- SAGBVHI was formed in 2000 with funding from a Rockefeller Millenium Health Award
- 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

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SAGBVHI: close joint working with the Department of Health

- 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

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Situation analysis methods

- South Africa has 9 provinces and within each province we collected data at:
  - the tertiary hospital (only in 5 provinces)
  - one regional hospital (randomly selected):
  - two district hospitals (randomly selected):
- In each facility we interviewed 2 doctors and 2 nurses – these were those who treated most sexual assault patients (giving an anticipated bias towards perhaps better care)
- We also completed a facility check list

Situation analysis of rape services : key findings

- **Facilities:** lacked privacy, washing 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

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Findings: shared in an iterative process

- Iterative process – DoH was kept informed of general sense of findings as we got them
- Conclusions were obvious early on – services in a mess and we need to work out what to do about them

2002 – Study tour to Toronto Sexual Assault Services

- Organised by South African Women for Women included both some SAGBVHI partners & DoH
- Instigated discussions on shared vision of quality services and discussions around a new model of care & cemented ‘partnership’
- Developed a vision of services providing ‘sexual assault care’ rather than medico-legal services (or PEP services)
- Organised joint workshops with a range of stakeholders to discuss this vision

Using research to develop the new model

- 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

- Results of the analysis of 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
  - More return visits to the facility (for counselling)
  - Overall decisions were NOT made on travel time (up to 3 hours)

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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 & management guidelines released by the Minister in March 2005

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National curriculum

- 2007: Medical Research Council was given funds to so a project for the DoH to develop a national curriculum for training sexual assault care providers
- Established a collaborative process involving all the many people in the country who had developed training on sexual assault as drafters of modules or as reviewers
- Process has also enabled an information brochure for survivors to be developed & the medical examination recording form (J88) to be revised
- This year we have trained ~160 providers in 4 courses from 8 provinces

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Key elements of success

- Joint factors:
  - **trust** between DoH and researchers was built
  - openness - we shared our knowledge & ignorance / uncertainty
  - communicated
  - mutually respectful – researchers did not try to ‘own’ policy
  - kept under the radar – not a high profile area

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