

Sexual assault survivors' perspectives on enablers of and barriers to clinical follow-up at three facilities in the Eden District

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Stellenbosch University

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DECLARATION

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ABSTRACT

Background: Sexual assault affects the life of many South Africans and results in physical, emotional, psychological and spiritual health consequences. Effective follow-up care post-sexual assault is linked positively to recovery. However, follow-up rates are known to be low. The study aimed to explore enablers of and barriers to clinical follow-up of sexual assault survivors, thus informing evidenced-based recommendations for the improvement of access to and utilisation of related services within the Eden District.

Methods: Following an explorative, qualitative approach, ten participants were selected using purposive sampling. Accessing data from the Hospital Sexual Assault Register, case managers obtained consent for the researcher to contact potential participants. Digitally recorded in-depth interviews between the researcher and participants were transcribed and analysed. Using an interactive process, complemented by the use of the software programme ATLAS.ti, emerging themes were identified, findings documented and discussed. Trustworthiness was ensured with attention to credibility, transferability, dependability and confirmability. Ethical principles were applied throughout the study and in accordance with the ethical approval granted by the Health Research Ethics Committee of Stellenbosch University. The Research Division of Strategy and Health Support, Western Cape Department of Health granted access approval to the study sites.

Results: All five of the ten participants who received scheduled follow-up appointments on official stationery accessed the follow-up service, whereas those who were not given appointments did not access it. Supportive responses to the survivor by the community, police and healthcare providers enabled utilisation of follow-up services. Patient-centred care, in particular individualised care, further enabled access to and utilisation of healthcare services. Survivors' coping mechanisms and resilience influenced their ability to access healthcare services. Negative perceptions, based on hearsay or prior experience of police, judicial and healthcare systems, were barriers to care. Work and/or school commitments and finance for transport were identified as barriers. However, the participants who experienced these challenges overcame them and attended scheduled consultations. The failure of healthcare providers to integrate follow-up care for sexual assault survivors into established chronic care platforms was a missed opportunity and limitation in the implementation of a holistic patient-centred approach to care.

Conclusion: This study highlights the need for patient-centred care for survivors of sexual assault, encompassing principles of good communication. The capacity to implement simple practical strategies to improve access to and utilisation of follow-up services, such as the provision of a scheduled appointment on official documentation, is available at facility level and should be implemented as a priority intervention. Additional recommendations include: the need for accurate documentation of contact details in the Facility Sexual Assault Register to enable communication with survivors; the implementation of a standardised Sexual Assault Register or alternative data collection tool promoting accurate and meaningful collection of data used for programme evaluation; the provision of a standardised referral letter to every survivor, capacitating access to healthcare; the inclusion of the survivor in follow-up planning, encouraging a patient-centred approach, and the monitoring and implementation of patient-centred care.

Key words: sexual assault, rape, follow-up, consultation, enabler, barrier, PEP, memory recall

OPSOMMING

Agtergrond: Seksuele aanranding beïnvloed die lewens van talle Suid Afrikaners en het fisiese, emosionele, psigologiese en geestelikegesondheidsprobleme tot gevolg. Doeltreffende opvolgsorg ná seksuele aanranding hou positief verband met herstel, maar opvolgkoerse is baie laag. Die doel van die studie was om instaatstellers van en hindernisse tot kliniese opvolging ná seksuele aanranding te ondersoek en sodoende bewysgebaseerde aanbevelings te maak vir beter toegang tot en gebruik van verwante dienste in die Eden-distrik.

Metode: 'n Verkennende, kwalitatiewe benadering is gevolg en tien deelnemers is deur doelgerigte steekproefneming gekies. Data is van die hospitaalregister van seksuele aanranding verkry, en gevallebestuurders het instemming vir die navorser verkry om potensiële deelnemers te kontak. Digitale opnames van diepte-onderhoude tussen die navorser en die deelnemers is getranskribeer en ontleed. Deur 'n interaktiewe proses aangevul met die gebruik van die sagtewareprogram ATLAS.ti is ontluikende temas geïdentifiseer en bevindings is opgeteken en bespreek. Betroubaarheid is verseker met oorweging van geloofwaardigheid, oordraagbaarheid, afhanklikheid en bevestigbaarheid. Etiese beginsels is regdeur die studie toegepas in ooreenstemming met die etiese goedkeuring verleen deur die Gesondheidsnavorsingsetiekkomitee van die Universiteit Stellenbosch. Goedkeuring vir toegang tot die studieterreine is verleen deur die navorsingsafdeling van Strategie- en Gesondheidsondersteuning, Wes-Kaapse Departement van Gesondheid.

Resultate: Al vyf van die tien deelnemers wat geskeduleerde opvolgafsprake op amptelike dokumentasie ontvang het, het toegang tot die diens verkry, maar nie diegene wat nie 'n afspraak gehad het nie. Ondersteunende reaksie teenoor die oorlewende deur die gemeenskap, polisie en gesondheidsorgverskaffers het die gebruik van opvolgdienste in die hand gewerk. Pasiëntgesentreerde, geïndividualiseerde sorg het verder toegang tot en die gebruik van gesondheidsorgdienste in die hand gewerk. Oorlewendes se hanteringsmeganismes en veerkragtigheid het hul vermoë om toegang tot gesondheidsorgdienste te verkry, beïnvloed. Negatiewe persepsies, gegrond op hoorsê of vorige ondervinding van polisie-, regterlike en gesondheidsorgstelsels was hindernisse tot sorg. Werks- en/of skoolverpligtinge en finansies vir vervoer is as hindernisse geïdentifiseer. Die deelnemers wat hierdie uitdagings ondervind het, het dit egter oorkom en die geskeduleerde konsultasies bygewoon. Die versuim van gesondheidsorgverskaffers om

opvolgsorg vir oorlewendes van seksuele aanranding met bestaande kroniesesorg-platforms te integreer, is 'n verbeurde geleentheid en beperking tot die implementering van 'n holistiese pasiëntgesentreerde benadering tot sorg.

Gevolgtrekking: Die studie beklemtoon die behoefte aan pasiëntgesentreerde sorg vir oorlewendes van seksuele aanranding wat beginsels vir goeie kommunikasie insluit. Die kapasiteit om eenvoudige praktiese strategieë te implementeer om toegang tot en gebruik van opvolgdienste te verbeter, soos die voorsiening van 'n geskeduleerde afspraak op amptelike dokumentasie, is beskikbaar op fasiliteitsvlak en moet as prioriteitintervensie geïmplementeer word. Bykomende aanbevelings sluit in: akkurate optekening van oorlewendes se kontakbesonderhede in die fasiliteitsregister van seksuele aanranding om kommunikasie met oorlewendes moontlik te maak; die implementering van 'n gestandaardiseerde register van seksuele aanranding om akkurate en betekenisvolle insameling van data vir progamevaluering te bevorder; die voorsiening van 'n gestandaardiseerde verwysingsbrief aan elke oorlewende om toegang tot gesondheidsorg te verkry; die insluiting van die oorlewende by opvolgbeplanning, waardeur 'n pasiëntgesentreerde benadering aangemoedig word; en die monitering en implementering van pasiëntgesentreerde sorg.

Sleutelwoorde: seksuele aanranding, verkragting, opvolg, konsultasie, instaatsteller, hindernis, nablootstellingsprofilakse, geheueherroeping

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ABBREVIATIONS

FAMSA	Families South Africa
HIV	Human immunodeficiency virus
PEP	Post-exposure prophylaxis
PTSD	Post-traumatic stress disorder
WHO	World Health Organization

CHAPTER ONE

FOUNDATION OF THE STUDY

1.1 INTRODUCTION

Sexual assault is a reality in the lives of many South Africans. An estimated one in four women living in Gauteng has experienced some form of sexual violence in her lifetime (Gender Links and the Medical Research Council, 2010:1). The extent of sexual assault directly impacts the physical and psychological health of survivors (Dunleavy & Kubo Slowik, 2012:340; Garcia-Moreno & Watts, 2011:2). Care has been shown to mitigate the negative impact of sexual assault on survivors (Tiihonen Möller, Bäckström, Söndergaard & Helström, 2014). Guidelines followed in the Eden District recommend that sexual assault survivors be followed up with three clinical consultations at one week, six weeks and three months following the initial consultation (Western Cape Department of Health, 2006a; Western Cape Department of Health, 2006b). The Eden District guidelines outline the provision of a comprehensive care plan designed to minimise the long-term health challenges following sexual assault.

Historically the rate of attendance at any scheduled follow-up session is low: in the region of 35.5% (Ackerman, Sugar, Fine & Eckert, 2006:1653). This finding is corroborated by data collected at the George Regional Hospital Sexual Assault Healthcare Centre, which suggests an attendance of approximately 45% at the first visit. This figure decreases markedly for subsequent visits, with a rate of 27% at six weeks and as low as 7% attendance at the six-month follow-up consultation (Eden District Office, 2016).

This study explored the personal experiences of sexual assault survivors from three sites in the Eden District to better understand the enablers of and barriers to accessing follow-up consultations. Barriers and enablers influence the rate of attendance at follow-up consultations, therefore the findings may provide useful information and evidence to inform future care strategies and change management aimed at improving follow-up care.

1.2 SIGNIFICANCE OF THE PROBLEM

Violent crime, including sexual assault, pervades our lives as South Africans. However, the true extent of sexual assault is unknown due to under-reporting. The Institute for Security Studies Fact Sheet: Assault and sexual offences (2015:4) reports the proportion of rape victims who reported their victimisation to the police decreased by 21% between 2011 and 2014. A study conducted in Gauteng suggests that as few as one in 25 cases of sexual

assault is reported to the police (Gender Links and the Medical Research Council, 2010). This finding is supported by Jewkes, Nduna, Shai & Dunkle (2012:4), who note that one in five young South African men enrolled in their study based in the Eastern Cape, had raped or attempted to rape someone over a two-year follow-up period. Röhrs (2011:23) suggests that sexual assault survivors may not report the violation to the police, citing poor outcome resolution as a deterrent. This indicates that the need for healthcare by sexual assault survivors encompasses many more individuals than just those attending sexual assault care facilities.

Research has shown a link between sexual assault and post-traumatic stress disorder (PTSD) and the need for constructive follow-up of survivors to limit negative consequences of the violation (Tiihonen Möller *et al.*, 2014). PTSD is only one element in a barrage of social and psychological consequences that may occur post-sexual assault (WHO, 2012:1). During the initial contact with the survivor, containment counselling is provided according to the needs of the individual and the capabilities of the counsellor (Pretoria Trauma Counselling, 2011). In-depth supportive counselling is available during follow-up consultations as part of a comprehensive care package. However, the low uptake of attendance at these sessions reveals that many survivors do not benefit from the comprehensive care package designed to minimise the long-term health challenges following sexual assault.

In addition to social and psychological harm, survivors of sexual assault face a number of physical health risks including life-threatening HIV infection. Current health policy requires the availability and access of post-exposure prophylaxis (PEP) to survivors of sexual assault to reduce the risk of transmission of HIV (Republic of South Africa, 2007; Western Cape Department of Health, 2014a; Western Cape Department of Health, 2014b). PEP consists of a 28-day course of a combination of effective antiretroviral drugs. In some instances within the Eden District, the survivor is issued with the first seven-day supply of antiretroviral medication at the initial consultation. The balance of the 28-day course is issued at the first follow-up consultation. This means that if the survivor is unable to attend this first follow-up session, they will not have access to the complete 28-day course of PEP, thus increasing their risk of acquiring HIV from the assault.

According to the Western Cape Antenatal Survey Report (Western Cape Department of Health, 2014c), the HIV prevalence amongst pregnant women attending public health facilities in the Western Cape is 18.6%. Eden District showed a prevalence rate of 17.5%, with pockets of higher prevalence noted in Bitou (28.9%), Knysna (23.2%) and Mossel Bay (27.6%). It follows that risk exists in that perpetrators of sexual assault may expose survivors

to the virus. The inability to complete the prescribed PEP post-sexual assault poses a challenge to the provision of quality healthcare.

1.3 RATIONALE

One of four pillars of service delivery identified as a priority for quality healthcare in the Western Cape is a person-centred approach (Western Cape Government Health, 2014). The principles support the promotion of integrated, holistic and continuous care. Furthermore, the department subscribes to the core values of care, competency, accountability, integrity, responsiveness and respect (C²AIR² Club). (Western Cape Government Health, 2015).

In keeping with a person-centred approach as well as the principles and values outlined above, healthcare providers should continually monitor and evaluate their service delivery and strive to improve patient experiences and outcomes. Research has shown that staff courtesy and a collaborative empathetic approach have a major influence on client satisfaction and ultimately affect service delivery and loyalty (van de Ven, 2014:131). The initial consultation following sexual assault occurs at a time when the client is extremely vulnerable, and first impressions created during this initial encounter may be an important influence on attendance for follow-up treatment.

The low rate of attendance by sexual assault survivors at follow-up consultations (Ackerman *et al.*, 2006:1653) implies that most sexual assault survivors accessing healthcare do not receive the intended benefit of the comprehensive care plan included in the follow-up sessions. This is contrary to the provision of, and access to, quality healthcare described in the Healthcare 2030 document (Western Cape Government Health, 2014).

Najdowski and Ullman (2011:221) inform us that 45% of female sexual assault survivors reported subsequent re-victimisation within a year of the initial violation. Re-victimisation (subsequent exposure to sexual assault) was linked to worse outcomes, as the survivors implemented ineffective coping techniques to comfort themselves, such as sex, alcohol and drugs, either alone or in combination. As the Eden District Health Services strive towards the vision of holistic, quality, patient-centred care (Western Cape Government Health, 2014), issues impeding clients from receiving the maximum benefit from available services should be identified and addressed to minimise negative health outcomes following sexual assault.

Insight into barriers that influence a survivor's ability to access follow-up care may inform interpretation of treatment guidelines at a local level to suit the particular needs of the local community. This may inform the development of a more individualised person-centred

approach, ultimately improving the provision of holistic healthcare within this vulnerable population.

Improving access to follow-up consultations may not only limit the effects of PTSD, but also improve the possibility of completion of PEP (Abrahams & Jewkes, 2010: 481). Therefore, defining barriers and enablers to follow-up, as experienced by sexual assault survivors, will play a crucial role in developing improved strategies to strengthen service delivery to this vulnerable group.

1.4 RESEARCH PROBLEM

A research problem may be identified as a result of questions asked in response to an identified challenge within a particular situation (Brink, Van der Walt & Van Rensburg, 2012:61). As the coordinator of the Women's Health programme for the Eden District, the researcher observed a knowledge gap regarding the factors influencing sexual assault survivors' ability to attend follow-up consultations. Literature suggests that follow-up care is beneficial. However, there is limited current, local research regarding the actual barriers experienced by the survivors, which deter them from attending follow-up (Smith, Bryant-Davis, Tillman & Marks, 2010:269). Without an in-depth understanding of clients' experiences, improvements to the service may be misguided, ineffectual and potentially wasteful in a resource-constrained environment.

1.5 RESEARCH QUESTION

What are the enablers of and barriers to clinical follow-up from the perspective of survivors of sexual assault in three health facilities within the Eden District?

1.6 RESEARCH AIM

To explore enablers of and barriers to clinical follow-up of sexual assault survivors in order to inform evidenced-based recommendations for the improvement of access to and utilisation of related services within the Eden District.

1.7 RESEARCH OBJECTIVE

To explore enablers of and barriers to clinical follow-up post-sexual assault within the Eden District by analysing data obtained from in-depth semi-structured interviews with survivors of sexual assault.

1.8 RESEARCH METHODOLOGY

1.8.1 Research design

The study followed an explorative qualitative approach to the topic. Researchers have noted that certain questions cannot be answered effectively using quantitative research (Brink *et al.*, 2012:120). In some instances, satisfactory answers can only be obtained through in-depth dialogue with the affected population. This study explored real-life experiences of sexual assault survivors, using in-depth interviews. This identified enablers and barriers experienced by survivors that influenced their access to and use of follow-up care, thus providing a comprehensive understanding of these factors.

1.8.2 Study setting



Figure 1.1 Map showing seven sub-districts of Eden (Local Government Handbook, 2016)

The study took place in Eden District, Western Cape. Eden District comprises seven sub-districts over a large and diverse geographical area. Three hospitals providing treatment and care for sexual assault survivors were identified as participating centres, namely: Knysna District Hospital, Mossel Bay District Hospital and George Regional Hospital. The study setting is discussed in detail in Chapter Three.

1.8.3 Population and sampling

The study population consisted of sexual assault survivors with cell phone contact details entered into the sexual assault registers of the three designated Hospitals. Purposive sampling was implemented to select participants resulting in an information-rich study population (Reid & Mash, 3). Data saturation was achieved with a sample size of ten participants.

1.8.4 Interview guideline (Appendix 4)

Since the study followed a semi-structured interview format, open-ended questions were formulated for each of the key topics in the interview guide (Reid & Mash, 2014:2). These were used to explore relevant topics if they were not spontaneously mentioned. This format encouraged the participants to explore concepts deeply, thereby generating answers to the research question. The interview guideline is discussed in detail in 3.6.

1.8.5 Pilot interviews

Two pilot interviews were conducted with participants selected according to the inclusion criteria and sampling technique. The pilot interviews did not identify any challenges; therefore, no changes were made to the interview guideline. The pilot interview is discussed in detail in 3.7.

1.8.6 Trustworthiness

Lincoln and Guba's model (1985:290) refers to trustworthiness as the "truth value". It ensures the value of the findings by using strategies that promote an accurate and honest reflection of the participants' experience. Criteria used to promote trustworthiness include credibility, transferability, dependability and confirmability and were established through the use of the techniques discussed in depth in Chapter Three.

1.8.7 Data collection

In qualitative studies, the researcher is engaged in perceiving, reacting, interacting, attaching meaning and recording nuances throughout the data collection process (Burns & Grove, 2005:537). The researcher completed data collection for this study with the assistance of an interpreter. Ten in-depth interviews were digitally recorded for transcription and analysis. The interviews took place at neutral venues and followed the study interview guide (Appendix 4). A participant number replaced the participant's names during transcription to maintain confidentiality and anonymity.

1.8.8 Data analysis

Data analysis followed a series of steps, commencing with the management and organisation of collected information. This allowed the researcher to become immersed in the data and is known as familiarisation (Brink *et al.*, 2012:193). The development of a thematic index followed, based on the familiarisation process. Indexing and charting allowed

the researcher to interpret the data and confirm the findings. The qualitative analysis software package, ATLAS.ti, was used to manage the data.

1.9 ETHICAL CONSIDERATIONS

Approval for the study was obtained from The Health Research Ethics Committee 1 of Stellenbosch University (Ref: S15/10/225) in accordance with the ethical principles of research and guided by the World Medical Association Declaration of Helsinki (2008). Access approval to the three Western Cape government facilities was obtained via the online application process of the Strategy and Health Support component of the Government Health Research Department (Ref: WC-2016-RP56-169).

Participation in the study was voluntary. The right to withdraw from the study at any point was explained prior to the participants providing written informed consent. Throughout the study process, principles of autonomy, beneficence, non-maleficence and justice were maintained as detailed in Chapter Three. Data was stored in a secure location and access limited to people directly involved with the study.

1.10 OPERATIONAL DEFINITIONS

Barriers: Factors that hinder the sexual assault survivor's ability to attend clinical follow-up consultations.

Clinical follow-up: A healthcare consultation between sexual assault survivor and medical staff at specified intervals following the initial consultation/forensic evidence collection intervention.

Enablers: Factors that assist, facilitate or enhance the sexual assault survivor's ability to attend clinical follow-up consultations.

Sexual assault: An intentional and unlawful act of sexual penetration with another person under coercive circumstances (Western Cape Department of Health, 2006b).

Sexual assault survivor: In this study, the term refers to any person who has reported for healthcare following sexual assault and has been entered into the Facility Sexual Assault Register.

1.11 DURATION OF THE STUDY

Table 1.1 Dates and duration of the study

Action	Organisation and reference	Dates/Duration
Ethical approval	Health Research Ethics Committee 1 Stellenbosch University S15/10/225	27/01/2016
Western Cape Government access approval	George Hospital WC 2016RP56-169	02/03/2016
	Knysna Hospital WC 2016RP56-169	12/04/2016
	Mossel Bay Hospital WC 2016RP56-169	07/06/2016
Fieldwork	Researcher: Gail Holton Interpreter: Boniwe Skoti	12/04/2016– 15/06/2016
Pilot interviews	Two participants	12/04/2016
Participant interviews	Nine participants	12/04/2016– 11/06/2016
Transcriptions	Ten transcriptions	24/04/2016– 13/07/2016
Data analysis and collation of findings	Concurrent with data collection	12/04/2016– 15/07/2016
Submission	Stellenbosch University	01/09/2016

1.12 CHAPTER OUTLINE

Chapter One: Foundation of the study

This chapter provides the background to, rationale for and framework of the study.

Chapter Two: Literature review

Chapter Two presents a review of literature identified by the researcher. The content provides information on related prior research and indicates a knowledge gap supporting the scientific value of the study.

Chapter Three: Research methodology

This chapter provides an in-depth account of the research methodology followed during the implementation of the study.

Chapter Four: Findings

This chapter provides a detailed account, in narrative form, of the findings of the study.

Chapter Five: Discussion, conclusions and recommendations

Findings detailed in Chapter Four are discussed and relevant recommendations made as a contribution towards improved healthcare for future sexual assault survivors.

1.13 CONCLUSION

Health professionals cannot afford to base their practice on unquestioned principles. Instead, they should actively engage in critical thinking and progressive research to ascertain the most appropriate treatment options (Brink *et al.*, 2012:12). Given the low rate of attendance at follow-up consultations post-sexual assault, the researcher was keen to explore the possible enablers of and barriers to follow-up as experienced by this vulnerable group. Recommendations arising from the study may have significant impact on internal policy and protocols regarding the future treatment guidelines for sexual assault survivors, by encouraging improved patient-centred outcomes. The credibility of data collected via the formal channels of registered research is supported by a comprehensive literature review detailed in the following chapter.

CHAPTER TWO

LITERATURE REVIEW

2.1 INTRODUCTION

Sexual assault in South Africa has far-reaching effects for many individuals. According to the *Victims of Crime Survey 2014/15*, 67% knew the perpetrator in reported sexual assault cases (Statistics South Africa, 2015). This disturbing finding gives an indication of the complexity of issues faced by survivors of sexual assault when accessing follow-up services.

A preliminary literature review provided background and scientific value to the intended study in the findings of related published research. This information influenced the researcher's decision regarding the study design, methodology and interview guideline. The preliminary review commenced with the concept of governance, defining the legal and clinical frameworks which bind the services available to sexual assault survivors. Subsequent reviews focused on exploring how healthcare systems, issues relating to clients and providers, and models of improving care contributed to the sexual assault survivor's ability or decision to access follow-up care.

Research has shown the link between sexual assault, post-traumatic stress disorder (PTSD) and the need for constructive follow-up of the survivor to limit negative consequences of the violation (Tiihonen Möller *et al.*, 2014). Follow-up systems have been motivated further by legislation advocating the issuing of post-exposure prophylaxis (PEP) to survivors of sexual assault. However, the uptake of the scheduled follow-up at clinical consultations is low (Ackerman *et al.*, 2006:1653).

Smith *et al.* (2010:269) comment on the dearth of literature relating to the barriers to help-seeking, and strategies to promote health-seeking behaviour in children in general. There is limited current research dealing with the barriers to follow-up care as experienced specifically by sexual assault survivors, both adults and children. A study of these factors offers valuable insight into how to address the poor uptake of follow-up consultations among sexual assault survivors.

2.2 ELECTING AND REVIEWING THE LITERATURE

A variety of resources was accessed during the literature review process. Current literature from the last five years was prioritised. However, relevant and fundamental resources beyond this timeframe were included if they provided valuable insight into the research topic. Electronic databases including PubMed, ProQuest, CINAHL and Google Scholar were

accessed. Other resources used include textbooks, journals, dissertations, government policy documents and public reports. Articles were critically reviewed and categorised under the identified themes for inclusion in this chapter.

Key words used during electronic database searches included: sexual assault, rape, follow-up, consultation, enabler, barrier, PEP, memory recall.

2.3 GOVERNANCE

The promulgation of the Criminal Law (Sexual Offences and Related Matters) Amendment Act No. 32 of 2007 (Republic of South Africa, 2007) has expanded the statutory offence of rape to be non-discriminatory against gender. The inclusion of data pertaining to crimes against males, previously excluded by definition, is in keeping with the concept of justice. All members of society should be able to access and receive the same quality of care irrespective of gender.

It follows that the inclusion of data relating to crimes against males may have resulted in an increase in incidence. In contrast, Röhrs (2011) argues that the pressure on the South African Police force to show a reduction in the number of cases reported, as part of crime reduction initiatives, may negatively affect the reporting profile. This concept is further explored in the Institute for Security Studies Fact Sheet (2015). The authors suggest that the target-driven need to reduce violent crime by 4–7% per annum results in a disincentive for police to encourage reporting of sexual assault.

However, the net result is marked under-reporting, as demonstrated by a study conducted in Gauteng indicating that as few as one in 25 cases of sexual assault is reported to the police (Gender Links and the Medical Research Council, 2010). This indicates that the level of sexual violence in the community may be far greater than we are aware of, even with the expanded definition of rape in a criminal context.

The Act repealed the common law offence of indecent assault, replacing it with a new statutory offence of sexual assault. This broadens the scope of sexual assault to include all forms of sexual violation without consent. Sexual exploitation or grooming, exposure to or display of pornography and the creation of child pornography are examples of specific inclusions within the amended Act (Republic of South Africa, 2007). This may impact on the ability to prosecute reported cases.

The provision of post-exposure prophylaxis (PEP) in terms of human immunodeficiency virus (HIV) transmission is specifically identified as a management option that should be made

available as a basic right to care. The provision of PEP is considered a strategy to reduce secondary trauma. The survivor, or an interested person on behalf of the survivor, has the right to request that the alleged offender be tested for HIV. The process followed to implement HIV testing of alleged offenders is detailed in Chapter Five of the Criminal Law (Sexual Offences and Related Matters) Amendment Act No. 32 of 2007 (Republic of South Africa, 2007).

It is noteworthy that this Act refers to the person violated by a sexual offence as “victim”, a term associated with disempowerment and not conducive to proactive psychological care of the post-assault survivor.

Whilst the Act provides ample opportunity and legislative directive for the reporting and preparation for prosecution, it fails to adequately address the provision of follow-up care post-assault. The provision of PEP and the associated medical need for follow-up care guide the post-assault care programmes with little reference to the complex issues associated with the survivor’s ability to access follow-up care.

The Act does, however, provide a framework for the formulation of treatment guidelines. Government circulars regulate detailed treatment policies for implementation. The core documents pertaining to the treatment of survivors of sexual assault, both adult and children, predate the promulgation of the Criminal Law (Sexual Offences and Related Matters) Amendment Act No. 32 of 2007 (Republic of South Africa, 2007). The Western Cape Department of Health has subsequently revised the provincial treatment guidelines pertaining to PEP for survivors of rape and sexual assault in both adults and children.

It is encouraging to see that Circular H-68 of 2006, *The Management of Survivors of Rape and Sexual Assault (Adults): Policy and Standard Management Guidelines* (Western Cape Department of Health, 2006b) refers to the violated client as “survivor”, not “victim”, which is more progressive than the subsequent Act 32 of 2007. This sets the tone for a document which should address the more technical details of a holistic approach to all related care.

Provincial Policy Circular H-68 of 2006 (Western Cape Department of Health, 2006) makes reference to the Regional/District Rape Forum being obligated to identify deficiencies and obstacles in the care of rape survivors and to develop strategies to address these. To some extent, this has been addressed by the introduction of the Thuthuzela Care Centre approach, which aims at providing the survivor with access to comprehensive care, and medical, legal and social assistance at a single site. However, the implementation of this

multisectoral collaboration is neither uniform nor available to all facilities in Eden as there is only one Thuthuzela Care Centre in the District.

The guidelines referring to the immediate treatment and processing of forensic evidence are clear and detailed. This facilitates evidence collection and documentation that complies with legal requirements. However, the section in the standardised guidelines dealing with post-assault follow-up care is vague, using language such as “should be given the option of” referral to follow-up counselling care (Western Cape Department of Health, 2006b) The follow-up care is mentioned in Addendum A of the same document, suggesting that it is not the highest priority. This fails to place significant emphasis or value on the follow-up process.

The Integrated Case Management Guidelines: Child Abuse Circular H-2 of 2006 (Western Cape Department of Health, 2006a) deals explicitly with the technical details of the physical examination of the traumatised child. However, unlike in the adult document, this circular clearly outlines the procedure to be followed when integrating follow-up care with other allied professionals and care services. Referral to the social worker and the nurse’s role as patient advocate feature strongly.

These circulars are complemented by the provisions set out in Circulars H-123, of 2014, *Guidelines for Paediatric Post Exposure Prophylaxis* (Western Cape Department of Health, 2014a) and H-77 of 2014, *Post-Exposure Guidelines for Adults* (Western Cape Department of Health, 2014b). These documents are current and detail appropriate pharmaceutical regimes and medical tests for survivors requiring PEP. The documents make no reference to the psychosocial care of the client, despite the devastating impact of the traumatic event preceding the need for PEP. A cross-sectional study showed a positive association between lifetime traumatic experiences, including sexual assault, and subsequent chronic physical conditions (Scott, Koenen, Aguilar-Gaxiola, Alonso, Angermeyer, Benjet, Bruffaerts, Caldas-de-Almeida, de Girolamo, Florescu, Iwata, Levinson, Lim, Murphy, Ormel, Posada-Villa & Kessler, 2013). The study included data from respondents in 14 countries across the Americas, Asia and South Pacific, Europe and the Middle East. This indicates that the effects of traumatic stress should concern all healthcare providers, in addition to mental health specialists.

Independent human rights organisations such as Rape Crisis, which was founded in 1976 by Anne Mayne, a political activist at the time, act as sexual assault survivor advocates. Their multipronged approach to reducing the incidence and effect of sexual assault is a collaborative partnership with stakeholders, supporting programmes focused on justice, recovery and making a change. The organisation provides legal support, training, education

and public awareness, and collates a research database. It also provides valuable online, personal and printed information to the public (Rape Crisis Cape Town Trust, 2016).

In summary, the legislation, in the form of the Criminal Law (Sexual Offences and Related Matters) Amendment Act No. 32 of 2007 (Republic of South Africa, 2007) and related provincial policies and guidelines, clearly defines the process and management of a client reporting to a healthcare provider for physical care. The documents assist in the provision of quality management to all citizens accessing the service for the initial consultation. However, scant attention is given to standardising holistic follow-up care, of which psychological care is a critical component.

2.3.1 Data collection in facility

Data collection in the Eden District is governed by the Provincial Indicator Data Set, which is defined by the National Indicator Data Set. Collected data is submitted to the National Health Information System. The National Indicator Data Set is reviewed every three years and defines the data collection indicators at facility level that are then used to monitor and evaluate the health service (Western Cape Government Health, 2016). In 2013, the indicators for sexual assault were reviewed and elements directly pertaining to clinical follow-up visits were excluded. As a result, after 2013 there is no reliable data at any level on the follow-up attendance rate post-sexual assault. Some facilities have maintained data collection reflecting follow-up attendance for their own service evaluation. However, as there is no requirement to submit this information beyond the facility, the collection of follow-up attendance rates is not standardised throughout the facilities.

2.4 RATIONALISATION OF NEED FOR CARE

2.4.1 Post-traumatic stress disorder

Research conducted in Sweden has shown the link between sexual assault and post-traumatic stress disorder (PTSD), and the need for constructive follow-up of the survivor to limit negative consequences of the violation (Tiihonen Möller *et al.*, 2014).

Psychology Today (2014) defines PTSD as an anxiety disorder that may develop after exposure to a terrifying event or ordeal in which severe physical harm occurred or was threatened. According to Tiihonen Möller *et al.* (2014), rape is considered a common trauma associated with PTSD, and leaves approximately one-third of rape survivors with a clinical diagnosis of PTSD at some time following the assault. The care the survivor receives after the traumatic event may influence the outcome or progression of PTSD (Meredith,

Eisenman, Han, Green, Kaltman, Wong, Sorbero, Vaughan, Cassells, Zatzick, Diaz, Hickey, Kurz & Tobin, 2016:509). As PTSD is an anxiety disorder, the presence of symptoms impacts clients' ability to access follow-up care as well as their vulnerability to re-victimisation.

Ullman and Peter-Hagene (2016) found a high incidence of re-victimisation in their study of 1013 volunteer women from the Chicago metropolitan area. The study was conducted in three waves at yearly intervals. At wave 2, 37% of respondents indicated experiencing re-victimisation within the past year. At wave 3, 58% of participants re-victimised during wave 2 had experienced further re-victimisation. Correlation between PTSD symptoms and social reactions was noted at all three waves. Negative social reactions had a stronger relationship to PTSD symptoms than positive social reactions. Comprehensive follow-up care post-assault aims to maximise the health of the client and reduce the chances of re-victimisation. The relationship between symptoms of PTSD and social reactions to sexual assault disclosure was observed. The study suggests a correlation between negative reaction/lack of social support and a higher incidence of PTSD symptoms. It also indicates that PTSD symptoms lessened with time. The inclusion of three waves of data and the vigorous analysis of the input add credibility to the findings.

Tiihonen Möller *et al.* (2014) conducted an empirical study using structured clinical interviews and self-rating questionnaires to determine the presence of PTSD according to the DSM-IV classification. Of 1047 eligible participants, 317 women over 18 years of age completed the study. The attrition rate of subjects was fairly high at about one-third, with a notable comment that non-completers were more depressed and had more avoidance symptoms at baseline. Although the Swedish infrastructure provides more protection against the burden of poverty than the South African system, the attributes of PTSD as a recognised medical condition are universal. The study does not deal specifically with barriers to clinical follow-up but provides valuable insight into the psychological dynamics that may influence the survivor's ability to access post-assault care.

In St Louis, Missouri, Galovski, Blain, Chappuis & Fletcher (2013:247) compared the treatment response between males and females to modified cognitive processing therapy following interpersonal assault. The results suggested that men and women demonstrated similar rates of change in PTSD and depressive symptoms following therapy. The differences were noted on the secondary outcomes, such as global guilt, guilt cognitions, anger/irritability and dissociation, where women tended to show more rapid improvement than men, suggesting the benefits of individualised care.

In Chicago, Relyea and Ullman (2015) assessed how two types of negative social reactions to sexual assault related to post-assault outcomes in a sample of 1863 women. The social reactions experienced by the survivors were categorised into two groups: unsupportive acknowledgement and “turned against”. Unsupportive acknowledgement comprised a combination of positive and negative responses indicating some form of acknowledgment of the trauma, but not necessarily providing the support needed by the survivor. “Turned against” was purely a negative social reaction as experienced by the survivor.

Relyea and Ullman (2015) found that 94% of participants received unsupportive acknowledgement, while 78% experienced some type of ‘turned against’ reaction. The participants who reported ‘turned against’ reactions reported greater levels of potentially harmful behaviour. This was in line with expectations. This finding is particularly relevant to exploring potential barriers to follow-up care post-sexual assault, as unfortunately the survivor frequently experiences the initial crisis consultation and examination as secondary victimisation.

2.4.2 Post-exposure prophylaxis and HIV

The need to understand and limit the HIV pandemic has resulted in dynamic and focused research funding and resource allocation being applied to the field of HIV medicine and related social dynamics. This is reflected in the number of research articles related to possible barriers to completion of PEP following sexual assault.

A South African-based study by Abrahams & Jewkes (2010:473) explored the patient-reported barriers to completion of PEP using semi-structured, individual, in-depth interviews. The participants experienced one or more barriers that could have influenced completing the PEP regime. Side effects to the PEP drugs were identified as the most dominant experience reported by the participants, followed by fear of being blamed for the rape, poor understanding of the treatment and poor social support. The ability of the individuals to cope and process these situations had a direct result on their ability to complete the PEP regime.

Of the study group of 29, only 33% completed their PEP regime. A mere 7% (n=2) completed the regime without missing a dose. There is reference to PTSD symptoms being associated with the inability to complete the regime, as the tablets created a strong reminder of the traumatic experience. It was also noted that health services did not follow-up the clients actively and offered “no psychological support beyond containment in the immediate post rape visit” (Abrahams and Jewkes, 2010:481).

Arend, Maw, de Swart, Denny & Roland (2013) completed a qualitative sub-study of a quantitative, observational PEP study, exploring the individualised nursing care approach to PEP at a sexual assault clinic outside of Cape Town. An intensive follow-up and case management system was implemented for a period of six months. A multi-disciplinary team was available for referral purposes. The consultations were managed primarily by appointed study nurses. Part of the care plan included telephonic appointment reminders, one week and one day prior to each visit. Open-ended, semi-structured interviews were conducted until saturation was achieved with ten clients.

Common barriers to completion of PEP correlating with previous study findings of Abrahams and Jewkes (2010) included medication side effects, association with blame and inadequate social support. However, the positive response to the increased and individualised follow-up care plan was noticeable (Arend *et al.*, 2013). This spotlights the importance of psychosocial support in the provision of effective care post-rape and sexual assault.

In 2007, the World Health Organization stated that “All countries should have a policy on the services provided for people who have been sexually assaulted. These policies should include post-exposure prophylaxis whenever sufficient resources are available.” (World Health Organization, 2007:54). South Africa made provision for this in 2002 with follow-up legislation in terms of the Criminal Law (Sexual Offences and Related Matters) Amendment Act No. 32 of 2007 (Republic of South Africa, 2007) which regulates the provision of PEP, free of charge, in designated facilities. However, as related in the following articles, clearly defined policy does not necessarily translate into service.

Du Mont, Macdonald, Myhr and Loutfy (2011) conducted a prospective research study focused on capturing the different healthcare providers’ views regarding the universal offering of HIV PEP in Ontario, Canada. The study identified the challenges related to inadequate funding as a major factor hindering provision of the service. Note that this is not applicable within the South African context, as pharmaceuticals and primary health services are provided free of charge to all citizens. By contrast, other factors influencing the ability of staff to provide the service, including “overworked and unacknowledged staff” and “insufficient external support”, resonated clearly with the South African scenario.

Although this study has limited relevance for South Africa, it stimulates thought regarding the quality of the service provided in the healthcare centres. Draughon, Anderson, Hansen & Sheridan (2014) explore similar concepts among sexual assault nurse examiner/forensic nurse examiner practices in providing HIV testing and PEP. Voluntary participants (n=174) were emailed and asked to complete an online questionnaire in which they prioritised the

barriers to offering HIV testing and PEP. The most highly prioritised barrier concerned the provision of pre- and post-test counselling and follow-up.

These findings suggest the need to examine barriers to follow-up, not only from clients' perspectives but also to encompass providers' perceptions of the service, which may influence follow-up outcomes.

2.5 ADMINISTRATIVE SYSTEMS

The most comprehensive document detailing barriers to accessing post-rape healthcare in South Africa is a research report by Röhrs (2011). The extensive document focuses primarily on the structural barriers to accessing PEP and healthcare. An observation not found in the other documents reviewed was the inaccessibility of telephonic information. Survivors expressed difficulty in accessing information telephonically regarding treatment and access to service points. This could be extended to other forms of media such as social media and the internet, which have become readily accessible to many communities in recent years. The report noted that the challenges in accessing appropriate information contributed to barriers to quality healthcare.

Quality care was questionable in some facilities and negative attitudes, specifically among the police service, were identified as barriers to PEP and follow-up care. Extensive and specialised training was recommended as a strategy to reduce most of the identified barriers, in conjunction with increased collaboration between all sectors, governmental and non-governmental, to strengthen psychosocial support (Röhrs, 2011).

2.5.1 Healthcare systems

Healthcare systems in general function within defined boundaries guided by legislation, policy and ethical principles inherent to the healthcare profession. An Iranian study highlighted the concern that sexual assault survivors' expectations were not necessarily met by the health system (Shahali, Mohammadi, Lamyian, Kashanian, Eslami & Montazeri, 2016). The study suggests that the neglect of healthcare systems to adequately address clients' needs and expectations may lead to them accessing alternative, not necessarily safe, options. Shahali *et al.* (2016) suggest that survivors of sexual assault who were physically injured during the assault, and where the perpetrator is unknown, were more likely to access legal and medical assistance. This finding is of concern in South Africa, where the perpetrator is known by the sexual assault survivor in 67.6% of the cases (Statistics South Africa, 2015).

The Western Cape Government Circular H 68-2006 (2006b) recommends that a one-week supply of PEP is given to clients on discharge from the first consultation, with the balance of the 28-day regime to be collected when the survivor attends the one-week follow-up visit. However, allowance is made for clients who, due to logistical or economic reasons, cannot return for the one-week follow-up. In this instance, survivors may be issued with the complete 28-day regime at initial consultation. No reference is made to the limitation of a seven-day supply of PEP in the current *Post-Exposure Guidelines for Adults Circular H77-2014* (Western Cape Department of Health, 2014b).

A Boston study investigating the attrition between the emergency department and the clinic for participants who were issued PEP, found women were less likely than men to complete a 28-day PEP regime (Bogoch, Scully, Zachary, Yawetz, Mayer, Bell & Andrews, 2014). The study suggests that commonly-used models of care, providing a PEP starter pack with subsequent follow-up in the clinic, may not provide adequate protection for vulnerable populations. Of the 180 participants issued with PEP, only 54.4% attended the first follow-up consultation, ensuring their ability to complete the 28-day regime by collecting the balance of the medication. This suggests the need to review and improve current models of care by tailoring treatment programmes to suit the individual.

Healthcare providers employed at government facilities are bound by the *batho pele* principles of placing people first (Republic of South Africa, 1997). The White Paper aimed at transforming public service delivery defines eight fundamental principles addressing quality of care, in support of the Patients' Rights Charter included in the Constitution (South African Government, 1996). The Patients' Rights Charter outlines the standards in healthcare to be provided to all citizens of South Africa. Notably, in the context of sexual assault survivors, these rights include the right to have access to healthcare, to be included in decision-making and to continuity of care. These rights speak to the unconditional provision of healthcare to all sexual assault survivors, regardless of their choice to report the assault to the police or not.

Personnel are encouraged to internalise the core values of the Department of Health through initiatives such as the C²AIR² Club (Western Cape Government Health, 2015). Facilities identified to participate in the initiative are rewarded for innovative implementation of the core principles: Care, Competence, Accountability, Integrity, Respect and Responsiveness. Patients have various confidential platforms on which to address their dissatisfaction, including written, telephonic and verbal systems. Monitoring of quality assurance indicators ensures a patient's right to complain about health services, to have their complaints heard and acted upon.

2.5.2 Police systems

The *Victims of Crime Survey 2014–15* indicates that public satisfaction with the police in the Western Cape has decreased by 11.5% since 2011 (Statistics South Africa, 2015:39). This is higher than the national trend of 7.7% decrease in satisfaction. Some of the reasons cited for this dissatisfaction were: “Harsh towards victims” – 26.5%; “Release criminals early” – 34.4%; and “Corrupt” – 42.6%. Conversely, 70.2% of household survey participants felt the police were trustworthy in the way they dealt with crime (Statistics South Africa, 2015:40).

However, the Institute for Security Studies Fact Sheet (2015) suggests the target-driven need to reduce violent crime by 4–7% per year creates a disincentive for police to encourage formal reporting of these cases. This idea is echoed in the report by Röhrs (2011) and in the decreased number of sexual offences reported to the police by persons 16 years and older (Statistics South Africa, 2015). According to the *Victims of Crime Survey 2014–15*, the percentage of incidents of sexual assault reported to the police fell from 93.9% in 2011 to 63% in 2014/15 (Statistics South Africa, 2015:66).

A specialised unit, the Family Violence, Child Protection and Sexual Offences (FCS) Unit, exists within the South African Police Service. It was re-launched in 2010 and employs forensic social workers who provide expert testimony in court, in addition to professional assessment of abused children and the compilation of court reports (South African Police Service: 2015a). The Civilian Secretariat for Police found that between October 2013 and March 2014, only two out of 145 police stations in South Africa were fully compliant with the Domestic Violence Act (Institute for Security Studies Fact Sheet, 2015:2). However, in the South African Police Service Strategic Plan 2014–2019, the resourcing of FCS Units, including equipment for forensic social workers, was listed as a critical intervention for the medium term (South African Police Service: 2015b). Currently the Family Violence, Child Protection and Sexual Offences team in George consists of 14 investigating officers, two section heads, one commander and one forensic social worker (Marx, 2016).

2.5.3 Judicial system

The National Prosecuting Authority (NPA) is the lead department in the multisectoral collaboration of the Thuthuzela Care Centre concept (National Prosecuting Authority, 2009). These one-stop facilities aim to reduce secondary victimisation, improve conviction rates and reduce the cycle time for finalisation of cases. This has seen the implementation of target-driven monitoring and evaluation of the programme, with NPA advocates expected to achieve a 66% conviction rate (Marx, 2016). The Thuthuzela Care Centre in George attained

a conviction rate of 77% for 2015. However, only 54% of the 609 cases that were reported jointly to the Thuthuzela Care Centre and the police were referred to court.

Despite interventions such as the Thuthuzela Care Centre, the Victims of Crime Household Survey in the Western Cape found a 12.8% decrease in satisfaction with the way courts generally deal with perpetrators of crime from 2013/14 to 2014/15 (Statistics South Africa, 2015:44). The primary reason for dissatisfaction, given by 53.1% of respondents, was that they felt the courts were too lenient on criminals. The Western Cape's perception of this element was the most negative across all nine provinces. This finding may represent that respondents in the Western Cape had a higher expectation of the criminal justice system than those in other provinces. Alternatively, the negative perception may point to widespread weakness in the judicial system in the Western Cape.

2.6 HEALTHCARE PROVIDER FACTORS

It has been noted that survivors expressed a need for care by competent and empathetic staff (Röhrs, 2011). Training forms an integral component of competency, and in 2007 a training programme on caring for survivors of rape was developed for the South African Department of Health (Jina, Jewkes, Christofides & Loots, 2014). The implementation of this training and the effects on the knowledge and confidence of the trained healthcare professional was evaluated using self-administered questionnaires.

Generally, both knowledge and confidence levels improved significantly on completion of the training. The participants who scored low on the initial test improved the most. This indicates good training, but may not necessarily translate to improved levels of care. To evaluate this would require long-term follow-up and assessment of both trained staff and survivors (Jina *et al.*, 2014).

The essence of *Healthcare 2030: The Road to Wellness* is "access to person-centred quality care" (Western Cape Government Health, 2014). This document provides the blueprint for the standard of healthcare in the Western Cape. The document details three dimensions in the vision for quality care: improved patient-centred experience, improved technical quality and caring for the carers. The National Health Amendment Act No. 12 of 2013 (Republic of South Africa, 2013) regulated the establishment of the National Core Standards forming the foundation for improvement of technical quality. All hospital facilities in the Eden District audit the quality of their care according to the National Core Standards for Health Establishments in South Africa (National Department of Health, 2011).

A systematic review of results from 34 studies addressing the associations between patient experiences and indicators of healthcare quality found that a positive patient care experience was associated with higher levels of adherence to recommended prevention and treatment processes (Anhang Price, Elliott, Zaslavsky, Hays, Lehrman, Rybowski, Edgman-Levitan & Cleary, 2014). This study states that patient-centred care is a critical aspect of care quality.

Quality of care has many facets: professional competency, access, appropriate community sensitivity and a good patient-centred experience all play a role in defining the outcomes of services rendered.

2.7 CLIENT FACTORS

A limited number of studies addressing barriers to follow-up post sexual assault were identified in this review. Smith *et al.* (2010) published a literature review with specific reference to childhood sexual assault survivors. This review highlighted the complexity of family dynamics, prevalent in South African families. Smith *et al.* (2010) suggest that “parents may see themselves as disciplinarians rather than their children’s confidants”. This tends to contribute as a barrier to follow-up care for survivors.

Multifaceted barriers identified range from sociocultural to economic challenges. Poverty may render children vulnerable to sexual coercion and put them at risk during activities of daily living. Lack of education may hinder social development from influencing individual empowerment. Psychological barriers speak to “fear of not being believed”, the right to prevent or refuse sex, and fear of stigmatisation. Structural barriers include access to a single health facility that would take care of all their needs. Transport-related barriers did not feature prominently (Smith *et al.*, 2010).

In the Democratic Republic of Congo (DRC), survivors’ concerns that family would find out about the sexual assault and general stigma surrounding sexual violence hindered participants’ access to care (Bartels, Scott, Leaning, Kelly, Joyce, Mukwege & Van Rooyen, 2012). Lack of means to access medical care was identified as another barrier causing delays.

“You Blame Me, Therefore I Blame Me”: The Importance of First Disclosure Partner Responses on Trauma-Related Cognitions and Distress discusses the impact on the survivors (Bonnan-White, Hetzel-Riggin, Diamond-Welch & Tollin, 2015). This study found that the response of the first person that the participants disclosed to was more beneficial than that of the rest of the participants’ sociocultural environment. This highlights the need

for a positive patient-centred experience at primary care level, especially when police and healthcare providers complete the forensic examination.

A retrospective analysis found that survivors in King County, Washington, assaulted in their own or another home were more likely to access follow-up than those assaulted in public (Ackerman *et al.*, 2006). Participants reporting assault by a partner had the lowest follow-up rate (23%) versus those assaulted by a stranger (35%) This is both significant and problematic, given the high incidence of assault by an individual known to the survivor (Statistics South Africa, 2015). Violent coercion was negatively associated with follow-up. Interestingly, survivors who had reported drinking alcohol prior to the assault (50%) had higher follow-up rates than those that did not report drinking alcohol.

Not surprisingly, survivors with physical trauma, specifically genital, were more likely to attend follow-up, as were those who had been issued with medication. Women aged 15 to 19 years, compared with women above 20 years, were more likely to access follow-up care. This emphasises the need to explore enablers to service access within this age group and to apply the principles broadly. Improvement strategies should focus on women over 20 years of age without marginalising the youth.

Mason & Lodrick (2013:27) discuss the psychological consequences of sexual assault, stating that perceived threat impairs brain function, probably disrupting the vital role of the higher brain structures in mediating explicit memory. The function of the hippocampi, critically involved in the storage of explicit memory and the organisation of spatial and temporal information, may be disrupted under threatening conditions. This can severely impair the sexual assault survivor's ability to recall details of the traumatic incident. The forensic examination and history taking are an integral part of the survivor's traumatic experience. Mason & Lodrick (2013:33) indicate that to avoid the distress of recalling the traumatic events, survivors may dissociate themselves from the incident by avoiding recall during court preparation and interviews. The article states that extremes of retention, forgetting and even amnesia may result from the traumatic experience. This suggests that the survivor's ability to process information provided during the forensic examination may be compromised.

2.8 METHODS FOR IMPROVING FOLLOW-UP CARE

The quality of follow-up care post-sexual assault influences the long-term health of the client; psychological support post-assault is highly valued by survivors (Arend *et al.*, 2013). In an article entitled "Care of the Adult patient after Sexual Assault" (Linden, 2011); Linden only devotes two paragraphs to emotional needs and follow-up. Follow-up care is only referred to

in the last sentence of the conclusions and recommendations to be included in the discharge plan.

Various methods of improving follow-up care have been explored. The concept of specialised “one-stop” treatment centres has been adopted by some South African facilities: these are the aforementioned Thuthuzela Care Centres (Unicef South Africa). These projects are a collaboration between various stakeholders, with the National Prosecuting Authority as lead. The Thuthuzela concept is considered a best practice in the provision of comprehensive care to survivors of sexual assault while improving conviction rates. No improvement in follow-up care of survivors at Thuthuzela Care Centres was noted in this article.

An Ireland-based article by Eogan, McHugh & Holohan (2013) outlines the role of the sexual assault centre. Although the healthcare systems in Ireland and South Africa differ significantly, certain parallels exist; notably the identified need to improve access to appropriate care. The article provides guidelines on what a sexual assault centre should offer and gives particular reference to the need for holistic follow-up care.

In the conflict-ridden DRC, Kohli, Makambo, Ramazani, Zahiga, Mbika, Safari, Bachunguye, Mirindi & Glass (2012) conducted a study exploring the impact of a community-based health programme on survivors of sexual violence. The programme was implemented in response to survivors’ reports on their perceived barriers to accessing health services. Mobile clinics, staffed by trained personnel, rotated healthcare services within the community setting regularly. The service was supported by the community healthcare worker network and integrated the role of the partner in the treatment care plan. This intervention resulted in a 72% attendance at the first scheduled follow-up visit – a significantly higher uptake than noted in previous studies (Ackerman *et al.*, 2006).

Although the DRC represents a particular conflict situation with specific impacts on the client’s ability to access care, fundamental barriers to care expressed by the clients resonate with a cross section of studies within different countries (Arend *et al.*, 2013).

It is certainly worth noting how taking the service to the community increased the uptake in follow-up care, especially as we have many rural areas in South Africa where access is a challenge.

A retrospective study based in Indianapolis found that by simultaneously reducing potential barriers to follow-up, the attendance rate at specialist clinics post-discharge from the Emergency Department (ED) increased to 80% (Messina, McDaniel, Trammel, Ervin, Kozak

& Weaver, 2013:1495). The study implemented four key methods aimed at reducing barriers to follow-up:

- Patients scheduled their own specialty care follow-up appointment date and time before leaving the ED.
- The ED provider determined the need for an urgent follow-up and confirmed follow-up urgency in conjunction with the specialist.
- The specialty service provides point-of-care input (collaboration between referral physician and specialty service).
- Payment was not required at the time of the follow-up visit

Integrating a patient-centred approach with administrative detail (such as scheduling follow-up appointments) and practical logistical assistance (giving the patient a formal date, time and location for the appointment) may have significant impact on follow-up attendance rates.

2.10 CONCLUSION

The theme at the Western Cape Department of Health Research Day held in October 2014 was: “Translating Research into Policy”. It is crucial to translate this research into policy if we aim to address the quality of care provided to vulnerable members of our community, particularly survivors of sexual assault. Providing a holistic patient-centred experience for these survivors will involve improving the uptake of post-assault follow-up care. To make sense of what is needed, one should hone in on survivors’ expectations, individual needs and what they consider to be barriers to follow-up care, not just provide healthcare in silos. (Jewkes *et al.*, 2012). Research findings should be translated into practical strategies that can be implemented with an integrated effect.

CHAPTER THREE

RESEARCH METHODOLOGY

3.1 INTRODUCTION

This chapter explains the methodology followed while exploring the perspectives of sexual assault survivors in Eden District regarding enablers of and barriers to clinical follow-up.

3.2 AIM AND OBJECTIVE

Aim

To explore enablers of and barriers to clinical follow-up of sexual assault survivors in order to inform evidenced-based recommendations for the improvement of access to and utilisation of related services within the Eden District.

Objective

To explore enablers of and barriers to clinical follow-up post-sexual assault within the Eden District by analysing data obtained from in-depth semi-structured interviews with survivors of sexual assault.

3.3 STUDY SETTING

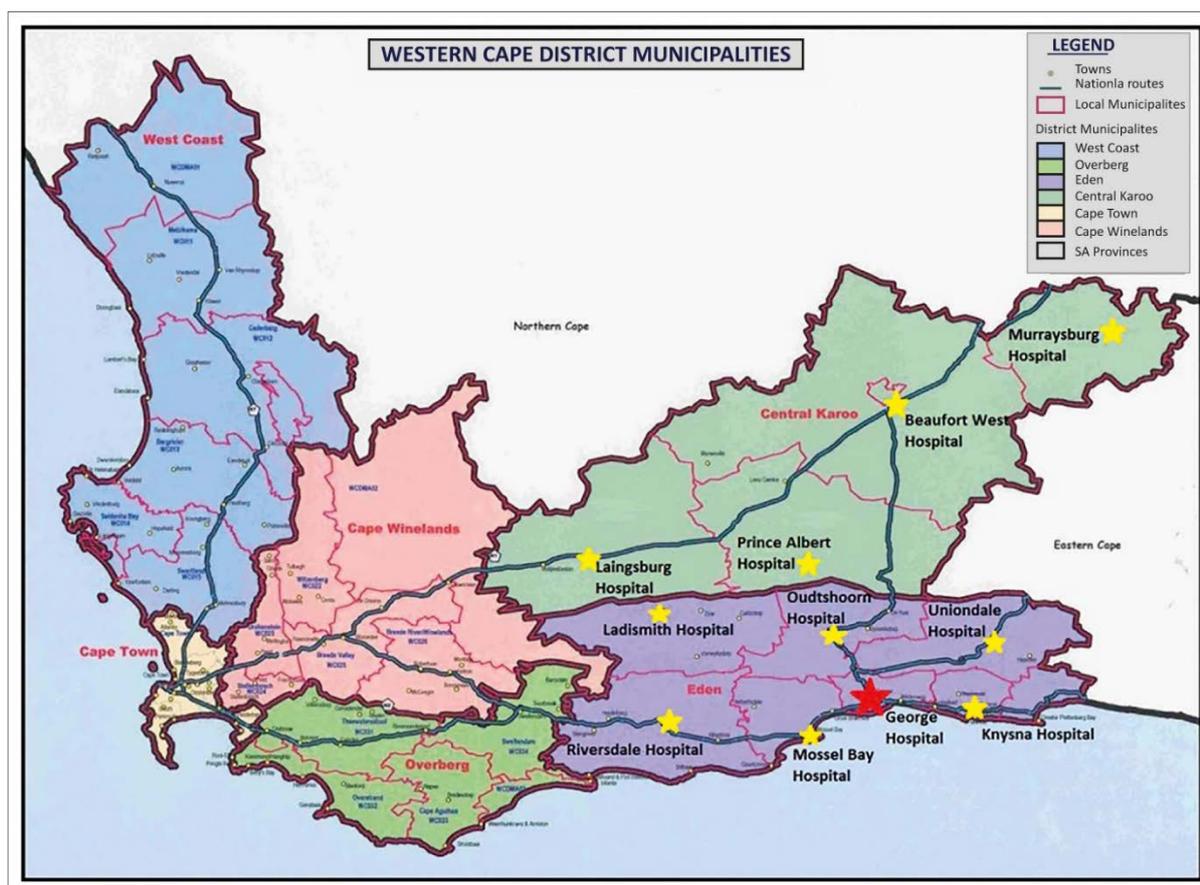


Figure 3.1 Eden District in the Western Cape, indicated in purple (*African Journal of Primary Health Care & Family Medicine* 7(1), 2015)

The Western Cape incorporates five rural districts and one metropole. Eden District forms one of five rural districts covering an area of 22 720 km² on the south eastern coastal boarder of the province (Western Cape Eden District profile, 2012). Within Eden there are seven sub-districts, bound by Hessequa in the south, Mossel Bay in the east, Knysna in the north and Kannaland in the west. The distances between urbanised settlements within this rural district are vast. According to the Western Cape Eden District profile (2012), 76% of the Eden population speak Afrikaans as a home language, 18% speak Xhosa and 6% speak English.

The study participants had no health insurance and were reliant on healthcare services provided by their local government primary healthcare facilities and hospitals. Their communities consist of housing provided by the Reconstruction and Development Programme, with basic amenities, sanitation, water and electricity. The houses are interspersed with informal shack dwellings forming a dense network of households without much privacy. The use of alcohol and recreational drugs is prevalent, as is the unemployment rate, which is estimated at 22.5%, and 29.3% among the youth (Western

Cape Government Provincial Treasury, 2014:10). Entertainment is frequently sought in the local taverns, which remain open for trade seven days a week.

The three study sites, George, Knysna and Mossel Bay Hospitals, managed 85% of the sexual assault cases within the district (Eden District Office, 2015–2016). This provided the best opportunity for participation while still reflecting the diversity of the communities and hospital services. The variance in models of care at the three facilities informed comparisons during the analysis of narratives from survivors.

The three hospitals function independently within the parameters of the Western Cape Department of Health. George Hospital is classified as a regional level two hospital, and as such receives referrals from the district health services in Eden and Central Karoo districts. It also provides level one district hospital-type care for the community of George. As such, it is the busiest of the three identified facilities, with an average of 20 sexual assault survivors seen per month, of which the majority (89%) were female in 2015–16 (Eden District Office, 2015–2016). The only Thuthuzela Care Centre for the district is situated within the George Hospital complex in a designated unit directly opposite the emergency centre. The Thuthuzela staff comprises one site coordinator, one victim support officer and one case manager (Marx, 2016). During 2015, the Thuthuzela Care Centre processed 697 cases, of which 609 were reported to the police (87.4%), and 326 were represented in court (Marx, 2016). This data includes cases reported in Knysna, as the Thuthuzela Care Centre case manages the Knysna area from the George office.

In 2015, George Hospital doctors working in the emergency centre attended to sexual assault cases during normal working hours. After hours, a medical doctor independently contracted for “rape call) covered services. A multisectoral team including Thuthuzela staff, hospital professional nurses, lay counsellors, non-governmental organisation counsellors and social workers from the Department of Social Development provided psychosocial support. The George Hospital occupational health practitioner provided follow-up consultation services to all survivors on a weekly basis within the Thuthuzela Care Centre.

Knysna Hospital, a small district hospital, serves the communities of Craggs, Bitou, Knysna, Sedgefield and Karatara – a diverse combination of urban and rural populations. Knysna Hospital is unique as it is the only centre in Eden where forensically-trained professional nurses provide the bulk of services for survivors of sexual assault. The service is provided by a designated team that includes medical doctors and forensically-trained professional nurses on a roster system. In the event that the designated team’s healthcare provider cannot

attend to the survivor, the medical doctor allocated to the Hospital's emergency centre manages the initial consultation.

Survivors attended to at Knysna Hospital receive case management support from the George Thuthuzela team. Support is provided by the National Prosecuting Authority (NPA) advocate assisting the Family Violence, Child Protection and Sexual Offences unit (FCS) of the South African Police Service in the criminal processing of the case, court preparation for the survivor and review of the consultation process from a legal standpoint. The Thuthuzela Centre manager arranges supportive counselling with one of the recognised partners in Knysna if the need for this service is communicated to the Centre via the National Prosecuting Authority (NPA) advocate.

The hospital is equipped with a recently renovated unit designated specifically to manage sexual assault cases. The facility is adjacent to the hospital emergency centre. The forensic nurses provide all routine follow-up care for sexual assault survivors either at the hospital or at primary health care facilities within the drainage area.

Sexual assault survivors in Mossel Bay are attended to in a secluded partitioned area within the hospital social worker's office. During office hours, all sexual assault survivors are counselled by the hospital's social worker. The forensic examination is performed by the hospital doctor on call. After hours, psychosocial support is provided by a group of non-profit organisations, counsellors and social workers. The majority of the follow-up consultations are managed via out-patient appointments facilitated by the hospital social worker. In some instances, follow-up consultations are managed at the primary healthcare clinics.

Mossel Bay Hospital does not receive support from the George Thuthuzela team. The National Prosecuting Authority advocate does however support the Family Violence, Child Protection and Sexual Offences unit with the investigation process and survivor court preparation.

The three identified facilities follow the treatment guidelines for survivors of sexual assault as set out in the relevant Western Cape Department of Health circulars discussed under heading **2.3 Governance** in Chapter Two. A summary of these documents, compiled by the researcher, is attached as **Appendix 9**.

The researcher is employed as the Maternal and Women's Health coordinator for Eden, based at the district office in George. The implementation, monitoring and evaluation of the sexual assault programmes in Eden is a key performance area in the Women's Health Programme. As coordinator, the researcher is not involved in clinical duties, but is required

to assist with quality improvement plans according to identified challenges. Regular facility audits, networking with relevant stakeholders and facilitation of training workshops are key responsibilities for the researcher. As such, she is well positioned to ensure the integration of these study findings and recommendations into quality improvement plans.

3.4 RESEARCH DESIGN

This study followed an explorative, qualitative approach. The purpose of an explorative study is to increase the knowledge of a particular field of study (Burns & Grove, 2005:356). Brink *et al.* (2012:128) indicate that the choice of research design should be most appropriate to the research problem and purpose. Information gained is not restricted to preconceived categories and questions, alternatively providing rich and detailed data that leads to focused descriptions of a given subject. (*Research Methodology*, 2012).

As described by Brink *et al.* (2012:114), there was no manipulation of variables, just a search for accurate information about the characteristics of the selected participants.

Qualitative research focuses on people's experiences and perceptions. As such, the approach was appropriate when exploring sexual assault survivors' perspectives on enablers of and barriers to clinical follow-up (*Research Methodology*, 2012). The use of semi-structured interviews allowed latitude for expression of experiences by the participants, providing rich, personalised data.

3.5 POPULATION AND SAMPLING

The study population comprised sexual assault survivors who had accessed healthcare in relation to the assault. They had been entered into the facility's sexual assault register at one of the three designated hospitals, three to six months prior to the study interview, irrespective of their attendance at follow-up consultations. Current and valid cell phone contact details were required for inclusion in the study population.

Purposive sampling allows for the selection of participants who are especially knowledgeable about the research subject (Brink *et al.*, 2012:141). For this reason, clients who had accessed the services available to sexual assault survivors, and had first-hand experience of the system, provided in-depth interviews. Participants had the opportunity to attend a minimum of three post-assault follow-up consultations. To limit challenges with memory recall, participants who were assaulted more than six months prior to the interview were excluded.

Case managers linked to the identified hospital reviewed the sexual assault case registers, identifying registered survivors with telephonic contact details for inclusion in the study. The case managers attempted to contact these survivors, starting with those whose details were entered into the register three months prior to the intended interview. When this failed to yield potential participants, the case managers reviewed the details registered four months prior to the intended interview, continuing to a maximum of six months, post-sexual assault. Once permission had been granted by the survivor, the case managers notified the researcher of the potential participant's contact details using the form supplied by the researcher (Appendix 7). This process proved challenging, as a large number of the registered contact details were incorrect or invalid. Many cell phone numbers dialled indicated that the dialled number was not in use, was on continual voicemail or the person answering was not the sexual assault survivor. In some instances, the person who answered the phone was not even related or known to the registered survivor. To ensure confidentiality, if the survivor did not answer the call in person, reasons for the call were not divulged and the call was politely terminated.

The Thuthuzela case manager who was responsible for both areas recruited the George and Knysna participants. The Mossel Bay participants were contacted for initial consent by the hospital social worker, who is the case manager for the sub-district. Once the respective case managers obtained consent for the researcher to contact survivors, the researcher in turn contacted the survivors to provide further details of the study and schedule an interview. The researcher was unable to secure interviews with all prospective participants. In some instances, despite the case manager having gained verbal consent for the researcher to contact the survivor, contact details proved defunct and some participants failed to attend scheduled interview sessions.

To ensure a range of voices and perspectives of survivors utilising the services, the researcher proposed selecting potential participants according to the patient profile, reflected on the facility database. However, adult male survivors eligible for selection were incarcerated, thus preventing access for the purpose of this study. As a result, the perspective of adult male survivors was not documented. This is discussed further under limitations, in Chapter Five.

Initially, a sample size of four participants per facility was envisaged. However, this was not possible in Mossel Bay, where the sample population was smaller than in George and Knysna. The researcher was only able to make contact with two eligible participants in Mossel Bay. Four participants were interviewed in George and Knysna, while two participants were interviewed in Mossel Bay. The participants interviewed comprised: seven

adult women; one fifteen-year-old minor, together with her mother; a father directly responsible for the care of his nine-year-old daughter; and a grandmother responsible for the care of her ten-year-old granddaughter.

Data saturation was achieved with ten interviews when emerging themes became repetitive, as reflected in the researcher's field notes. This was confirmed during the familiarisation process and development of the thematic index (Brink *et al.*, 2012:173).

3.5.1 Inclusion criteria

Applicable inclusion criteria are noted under details of the study population in 3.5.

For the purpose of this study, children accessing the service were categorised into two groups: children dependent on an adult to access follow-up and those who were independent. Children dependent on an adult were not interviewed independently. The responsible parent or legal guardian of these children responded as the primary interviewee with the option of inclusion of the child. The inclusion of the child depended on their ability to give assent, the approval of the parent or legal guardian and the weight of contribution versus secondary trauma. Children who had no means of accessing follow-up services independently were not interviewed. In these cases, the parent or legal guardian was interviewed independently, as the child had minimal input in the ability to access follow-up care without the adult. The decision to exclude these children from the interview was made to limit possible secondary trauma to the child.

Children between the ages of 16 and 18 years and functioning independently were given the option of being interviewed independently, provided the parent or legal guardian signed informed consent and the child signed assent. However, the one child who fell into this category chose to have her mother included throughout the interview process. As these children function independently, the researcher anticipated that they would be of sufficient maturity to provide pertinent valuable information. The Children's Act No. 38 of 2005 (Republic of South Africa, 2005) deems children over the age of 12 years with sufficient maturity capable of consenting independently to medical procedures.

3.5.2 Exclusion criteria

Exclusion criteria detail the characteristics that would cause a person to be excluded from the target population (Burns & Grove, 2005:343). The process of exclusion further refines the identified participant sample group to provide exclusive appropriate data. Exclusion criteria for the proposed study were profoundly and severely intellectually disabled and/or

psychotic patients who were unable to give a coherent interview, as well as those assaulted more than six months prior to the interview.

3.6 INTERVIEW GUIDELINE (APPENDIX 4)

The interview guideline was formulated to elicit commentary relevant to the research question (Reid & Mash, 2014:3). Questions were grouped by topic, leading with less sensitive content (Burns & Grove, 2005:396). The semi-structured interview technique allowed for a guided approach without curbing the participants' expression.

Interviews were conducted in English by the researcher, as principal investigator of the study. A designated contracted trilingual interpreter was available during the interview sessions to enable participants to express themselves in their home language, either Afrikaans or Xhosa. Participants often chose to use a mix of languages depending on the depth of content being discussed.

Prior to the formal, recorded interview, the researcher established rapport with the participant, providing refreshments and discussing general non-threatening issues. Once the participant appeared comfortable with the surroundings and process, the researcher commenced recording the session and opened with a question in the context of:

“After you were sexually assaulted, you went to the hospital for an examination and care. Please tell me how you experienced this consultation.”

(Researcher)

Leading questions were restructured according to the educational level and language requirements of the participant. The technique of probing was used to encourage the participant to communicate an experience or comment on a deeper level. For example, when probing for further information on the participant's recollection of any information provided to them during the initial forensic consultation, questions such as, “Can you remember being told to return somewhere for follow-up?” were used.

Questions directly related to the research subject, such as, “Were there certain things that helped you to return to the hospital/clinic for follow-up care? Please tell me about the kind of things that helped you.” were included in the interview guideline (Appendix 4).

Concluding the interview, the researcher thanked the participants for their valuable contribution to the study. The researcher then addressed any participant questions not necessarily related to the interview topic, such as family planning needs, off record.

3.7 PILOT INTERVIEWS

The purpose of conducting pilot interviews was to ensure that the interview guide was appropriate and the interviewer sufficiently prepared to conduct the interview. In preparation for the pilot interviews, the researcher conducted a briefing and training session with the interpreter. During this session, the study aim was clarified, ethical considerations discussed and working conditions agreed on. The consent document was reviewed together with the interview guideline and expected interview format. A confidentiality agreement was signed between the researcher and interpreter and a debriefing system put in place. The researcher provided the interpreter with a notebook to be used for personal reflection and the entries shared with the researcher.

Two potential participants residing in Knysna were contacted. Interviews were arranged at a date, time and venue suitable for all parties. One participant chose to meet at a private office within walking distance from the local taxi rank; the other requested the interview take place in her home.

The interviews were conducted as per the study proposal, in accordance with ethical principles. Informed consent was obtained, permission for the interpreter to be present for the entire interview granted and the procedure recorded for future transcription.

Following the interview guideline, the process was complete within a 60-minute session. The recorded interview was submitted via Dropbox to the supervisor, Dr Joyner, who provided feedback on improving the interviewing technique, but found the content to be suitable for the proposed study. The first interview was thus included in the final sample.

During the second interview, the researcher established that although the participant had been registered in the Thuthuzela Sexual Assault Register, healthcare staff had not managed her. As such, this interview was not included in the final sample. The participant expressed a need for dialogue and a safe forum to tell her story, so the interview was conducted in full regardless of the eligibility for the study.

The interview guideline and planned data collection process were not altered following the pilot interview.

3.8 DATA COLLECTION

Consistent adherence to the ethically-approved protocol was maintained throughout the study, commencing with pilot interviews. Following the process described in 3.7 for the pilot interviews, participants were contacted via information detailed on the form provided by the case manager (**Appendix 7**). Data collection took place between April and June 2016.

The researcher employed a fieldworker who provided translation in Afrikaans and Xhosa when the participants requested her assistance in responding in their preferred language. The fieldworker's background of fifteen years' experience as a lay counsellor, dealing specifically with HIV-related counselling, ensured she had in-depth insight into the sensitive nature of the interview and the issues of confidentiality that bound the process. The researcher and interpreter had a constructive, complementary professional relationship, having worked together as professional nurse and counsellor during this period.

Despite the fact that the case managers had made telephonic contact with eligible participants and obtained verbal consent, the researcher was not able to contact all leads provided by the case managers. Some numbers disconnected immediately when dialled, indicating the number was no longer in use. Others repeatedly diverted immediately to voice mail. With respect to confidentiality, the researcher felt it inappropriate to leave a voice message without having personally established contact with the survivor. In some instances, the survivors had moved to neighbouring provinces and not informed the case manager.

When making contact with prospective participants, the researcher introduced herself and explained the background and aim of the study in simple terms. Details regarding the optional inclusion of the interpreter were discussed and the right of the participant to withdraw at any stage was emphasised. Participants were informed about reimbursement for transport costs (R50.00) and that refreshments would be provided during the interview session. The researcher booked a time and venue for the scheduled interview.

A potential benefit of the George interview location was that it was privately positioned, not connected to any health facility. Consequently, and paradoxically, this created the disadvantage of it not being easily recognisable from the Main Road. To simplify access, the researcher arranged to meet the participants at a venue chosen by them and transported them to the designated office. The interview venue was a designated meeting room within a private healthcare practice. Interviews were conducted on a Saturday when the practice was not open for business. The choice of this location ensured privacy and confidentiality for the participant.

In Knysna, a central office within walking distance of the taxi rank was used. The premises also accommodate a construction company and accountant. A private meeting room within the complex was used for the interviews, which were scheduled for times when the usual occupants were closed for business, thus similarly addressing participants' confidentiality and privacy.

In Mossel Bay, the first participant was provided with three options: her own home, a private consultation room in the proximity of a mall close to the area where she lived, and the hospital. The participant requested to meet at the hospital. The interview was conducted in a private meeting room and the participant was not required to go through any hospital administrative procedures that may have compromised confidentiality. The second participant was interviewed in her place of residence, a night shelter. The shelter staff made the manager's office available for the interview. The participant requested this venue as her health and financial situation were not conducive to meeting outside the shelter.

In one instance, the participant was interviewed in her home. The family provided a quiet room without disturbance for the session. The interview was conducted in Sedgefield, which is 20 km outside Knysna, falling under the healthcare jurisdiction of Knysna. Inadequate public transport systems between Sedgefield and Knysna necessitated the interview to be conducted in Sedgefield.

Data collection commenced in April 2016 and concluded in June 2016. The collection period took longer than intended, as establishing contact with prospective participants was considerably more complicated, and therefore protracted, than anticipated. Additionally, both the researcher and interpreter's full-time work obligations only allowed for data collection out of official work time.

Interviews commenced with the researcher introducing herself and the interpreter to the participant. Refreshments were offered and a general non-threatening rapport was established. The role of the interpreter was discussed with each participant and the option given for her inclusion in the interview. Only one participant chose not to use the interpreter. In this instance, the interpreter waited across the road in a coffee shop on standby, should her translation services be required, which was not the case.

Participants indicated their language preference and the appropriate consent form was provided. Participants were left undisturbed to read the consent form. The interpreter and researcher were available to answer questions and clarify any uncertainty regarding the study process. Some participants needed clarity regarding non-payment for participation, but

were satisfied when it was explained the R50.00 provided was reimbursement for transport costs incurred and was not subject to study participation. Younger participants appeared to enjoy engaging with the document. Interestingly, Xhosa-speaking participants chose their home language document, which is contrary to the researcher's experience with health education material, where materials in English are often preferred by Xhosa speakers. Once the participant was satisfied, the consent form was signed and the formal digitally-recorded interview commenced.

As agreed in the preliminary session and informed consent, the interview was recorded using a dictaphone. The researcher followed the interview guideline with sensitivity to the emotional needs of the participant. When necessary, the recorder was paused allowing the participant time out to blow her nose, drink some tea and regain her composure. Participants seemed to appreciate the empathetic response to them as individuals, not merely study participants. No dialogue was omitted during the pause; as soon as participants indicated they were ready to speak, recording was restarted. Participants conversed in their chosen language. The researcher conducted the bulk of the interviews in either English or Afrikaans. If necessary, the interpreter assisted with Afrikaans terms not clearly understood by researcher or participant. Where the participant chose to speak in Xhosa, the interpreter provided detail to enable the researcher and participant to understand the question asked and the content expressed. Often when a deeper level of emotional connection to the content was required, the participants chose to switch to their home language. As a result, although all participants were able to speak English, all the interviews included a mixture of languages.

Interviews were complete within 60 minutes; however, there was no time limit and participants often lingered after termination of the interview to express their appreciation for the opportunity to talk. The researcher provided contact details of appropriate toll-free counselling services to all participants. No participants were identified as requiring urgent referral for in-depth counselling.

Practical follow-up of health needs unrelated to the sexual assault was requested by some participants. Appropriate referral was arranged by the researcher. Participant three had concerns regarding her family planning method. Referral facilitated the changing of contraceptive methods, for which the participant was extremely grateful. Participant two was provided a referral letter to the primary healthcare clinic for cervical screening and blood pressure monitoring. The researcher facilitated the transfer of files from one primary healthcare facility to another to enable participant four access to her chosen clinic.

After clarifying contact details and confirming permission, the researcher followed up all participants with a post-interview text message thanking them and offering further contact if needed. The only participant to communicate with the researcher post-interview was participant three regarding practical arrangements for contraception follow-up.

Recorded pilot interviews were sent via Dropbox link to the researcher's supervisor for initial review. Subsequent interviews were submitted via Dropbox to an independent professional transcriber who was proficient in English and Afrikaans, and based outside Eden District. All Xhosa was translated within the interview and transcribed as translated. Complete transcriptions were returned to the researcher's private email address. The researcher removed all detail of names from the transcriptions to further protect the participants' privacy.

3.9 DATA ANALYSIS

Data analysis followed the steps detailed below.

3.9.1 Familiarisation

The process of familiarisation commenced in the field, with the detailed recording by the researcher of reflective notes following the interview. A second set of notes was added to the initial post-interview reflection, as the researcher listened to the recorded interview. Emerging themes and observations were discussed with the interpreter, who also kept a reflective diary, thereby providing another layer of peer review. Further familiarisation occurred when the researcher reviewed the transcriptions. Throughout familiarisation, the researcher tried to stay consciously focused on the survivors' experiences as the data emerged, filtering out her preconceived opinions, which may have caused bias. These processes are discussed in **3.10.4 Confirmability**.

3.9.2 Development of a thematic index

Based on the researcher's interaction with the data during the familiarisation phase, a list of codes was created. With the study objective in mind, using inductive reasoning, the codes were grouped into sub-categories and further refined into six main categories. The development and finalisation of the thematic index was continually reviewed during the familiarisation and coding process.

3.9.3 Indexing

Transcriptions were imported into ATLAS.ti and the codes in the thematic index were applied to all the data (Mabuza, Govender, Ogunbanjo & Mash, 2014:640). Coding assignment was

an interactive, subjective process reliant on the researcher's judgement to decide on the correct code. Confirmability was supported through the triangulation of the coding sequence by the supervisor, co-supervisor and a colleague.

3.9.4 Charting

The computer software ATLAS.ti was used to group codes together into families, which corresponded with the categories from the thematic index. The codes and associated quotes from the raw data could then be collated for each family in an output file. ATLAS.ti uses the term family to refer to the grouping of similarly coded text.

3.9.5 Interpretation

During this phase, the researcher read and interpreted the collated material in the output files for each family/category developed in the previous step. Each participant's contributed experience was accorded equal value regardless of differences.

3.9.6 Confirmation

The fieldworker who provided translation during the interview sessions corroborated transcriptions. The accuracy of the data was confirmed and corrections were made prior to analysis. Confirmation of the analysis was obtained during the process of peer review, when a colleague familiar with coding reviewed and coded a transcript, comparing the outcome with that of the researcher. Final confirmation was achieved during the review process by the supervisor and co-supervisor.

3.10 TRUSTWORTHINESS

Procedures employed to ensure the accuracy of the findings and evaluate the scientific rigour of the study are discussed under the headings: credibility, transferability, dependability and confirmability (Brink *et al.*, 2011:131; Mabuza *et al.*, 2014).

A peer review team was formed to support the study processes and its trustworthiness. Each team member contributed a specialised skill set. The team comprised a medical doctor practising in public health, an educational psychologist who facilitated debriefing, an interpreter skilled in community counselling, a researcher with expertise in women's health as well as the supervisor, Dr Joyner and co-supervisor, Prof. Mash.

3.10.1 Credibility

The researcher attempted to contact all eligible survivors who had provided verbal permission to the case manager. Due to the challenges encountered in gaining access to eligible survivors, the anticipated data collection period was extended until data saturation was achieved. Data saturation was achieved when the content elicited during the interviews did not provide any new information. This ensured a rich in-depth understanding of the participants' experience.

Reflective field notes and the coding of transcribed data using the ATLAS.ti software programme confirmed repetition of existing codes indicating data saturation. These steps were implemented concurrently as the data became available.

Peer debriefing commenced in the field where both interpreter and researcher kept detailed reflective notes of each interview. On completion of the interview, the interpreter and researcher discussed their respective interpretations of the interview. Prior to subsequent interviews, the interpreter and researcher compared reflective notes, ensuring an accurate reflection of the experiences of the participants. As a further measure, the interpreter confirmed the researcher's findings (Chapter Four) prior to submission.

A member of the peer review team experienced in community participatory interventions, coded and categorised data from one interview. The agreement of peers regarding code allocation contributed to reliable analysis of the data.

As member checking was not possible, interview techniques such as reflection, clarification and summary were used to ensure accurate understanding of the participant's dialogue. The collection of data from three different facilities allowed for triangulation of data from different health services to give a more accurate picture of the whole district.

The credibility of the study was supported by the granting of study approval by a recognised Health Research Ethics Committee and adherence to the ethical principles of research.

3.10.2 Transferability

In-depth semi-structured interviews conducted in a private, non-threatening, neutral setting, enabled participants to discuss their experiences in detail. This allowed the researcher to include thick descriptions of the study content in the report. Purposive sampling was implemented to maximise the collection of relevant data. This enabled the researcher to provide a detailed description of the participants interviewed and the context of the study.

3.10.3 Dependability

The transcripts, field notes, thematic index of codes and outputs from ATLAS.ti used for interpreting the data, document the process of analysis and can be audited. Peer review strengthened this process.

3.10.4 Confirmability

For the purpose of this study, the researcher acknowledges operational duties that may have influenced the interpretation of data during the analysis process (Mabuza *et al.*, 2014). As the Maternal and Women's Health coordinator for Eden District, the researcher deliberately chose a field of study applicable to her portfolio. Her position does not involve clinical work at the designated facilities, therefore she was not directly involved in clinical consultation with participants. Having identified a gap in knowledge, there was an expectation that data obtained would provide practical recommendations for implementation and subsequent improvement in service. After interview one, the researcher's mood was buoyant and she immediately started thinking in the direction of cell phone-based follow-up prompts and supportive messages to survivors. However, with each interview, the researcher was reminded that there is no "one size fits all" in healthcare. The crux of quality care rests in an individualised approach. The researcher viewed the study process and findings as a means to develop improvement strategies rather than dwell on negative findings.

During reflective sessions with the interpreter, the researcher realised the merit of action research. Although she had identified attendance at follow-up consultations as a perceived problem, it was not necessarily a priority for participants. It took a concerted effort to process that some participants had no perceived need for follow-up and possibly would not benefit from the process until such time that they internalised and prioritised the need for follow-up care.

During initial interviews, the researcher noted that the participants generally struggled to identify their emotions and consequently found expression difficult. It appeared the predominant frame of reference for participants was patriarchal. This made interviewing challenging, as it was difficult to ensure that the researcher was not considered an authority figure. To minimise this perception, the researcher wore appropriate clothing devoid of any connotation with healthcare authority and engaged in informal conversation with the participant while sharing refreshments, thus establishing rapport.

It was necessary for the researcher to reflect on her personal expectations of what the survivors needed in terms of follow-up care, and be open to the actual needs expressed by

participants. The process of peer review ensured undue bias did not influence the interpretation of the survivors' experience. Overall, the process was a lesson in acceptance and listening to the voice and needs of the client, as opposed to presuming knowledge and understanding.

3.11 ETHICAL CONSIDERATIONS

Approval for the study was obtained from The Health Research Ethics Committee 1 of Stellenbosch University (Ref: S15/10/225) – **Appendix 1**. Access approval to the three Western Cape government facilities was obtained via the Strategy and Health Support component of the Government Health Research Department (Ref: WC-2016-RP56-169).

In preparation for the interview sessions, the researcher facilitated fieldworker training for the interpreter encompassing clarification of the aims and objectives of the study and adherence to ethical considerations. Specific reference to informed consent and confidentiality was covered during this training session. The interpreter signed a confidentiality agreement binding her to the ethical principles of the study.

Written informed consent, including permission to record the interview, was obtained prior to the commencement of the interview. For the participants who were minors (<18 years of age), written informed consent was obtained from the parent with assent from the child in accordance with legislation (Republic of South Africa, 2005). No children under the age of 16 years were interviewed independently.

The study was formulated taking the four ethical principles of autonomy, beneficence, non-maleficence and justice into consideration (Pera & Van Tonder, 2011:53). These principles speak to the following rights:

3.11.1 Right to self-determination

Self-determination was respected by obtaining written informed consent prior to participation in the study interview. Only participants who had given verbal consent during initial telephonic contact were invited for the interview. The participants had the right to withdraw consent and terminate the interview at any stage. Children under the age of 18 years signed assent in conjunction with informed consent signed by their parent or legal guardian to participate in the study. The assent and consent documents were available in English, Afrikaans and Xhosa. The consent process informed the participants of their right to request assistance from the interpreter during the interview, should they prefer to express

themselves in their home language. The presence of the interpreter throughout the interview was negotiated during informed consent.

The inclusion of a representative sample of sexual assault survivors who met the selection criteria ensured that the views of survivors and relative caregivers were represented without exclusion on grounds of age or gender, provided informed consent and assent had been obtained. It is acknowledged that the exclusion criteria detailed in Chapter Three meant that survivors with intellectual disabilities were excluded from this study, as they were not in a position to give informed consent/assent. The researcher was unable to secure interviews with any adult male sexual assault survivor, which is expanded on in Chapter Three. Consequently, their views have not been obtained in this study. Although the participants may not have benefited directly from the study, the intention is for the findings and subsequent recommendations to ultimately benefit the larger community of survivors of sexual assault.

3.11.2 Right to confidentiality and anonymity

Participant confidentiality was protected; original data recordings, transcripts and notes were held in a locked filing cabinet at a secure location. Only the researcher, immediate supervisors and select colleagues conducting peer review had access to these documents. Audio recordings of the interviews were deleted on completion of the study. During data analysis, a participant's personal identity was protected through the use of an interview number in place of names in the transcript and reporting documents.

3.11.3 Right to protection from discomfort and harm

The researcher and fieldworker's experience in counselling vulnerable individuals enabled them to be mindful of providing support and giving participants a voice rather than provoking secondary trauma. This speaks to the principle of beneficence where the intention is to "do good".

If the need was identified, participants were referred, with their consent, to the appropriate medical and support counselling services linked to the facility, Families South Africa (FAMSA) or the hospital social worker. All participants were offered the opportunity to access follow-up care. This relates to the principle of non-maleficence, where the intention of the study did not inflict any harm on the participant. The researcher was able to anticipate and circumvent the possibility of harm by having clear insight into the participants' needs. The researcher was particularly cognisant of the risk of secondary trauma during the interview. The interview process focused on the barriers to follow-up and not on the sexual

assault. Notably, none of the participants required immediate referral for medical or psychological support, and all participants expressed feelings of gratitude following the opportunity to detail their experiences. Each participant was provided with referral information and was followed up by the researcher telephonically at least once post-interview.

3.12 CONCLUSION

This chapter has outlined the methodology followed, and provided detailed information to facilitate study replication. The analysis of the data collected during this process informs the findings of the study which are discussed in Chapter Four.

CHAPTER FOUR

FINDINGS

4.1 INTRODUCTION

The findings identified during the analysis, outlined in the previous chapter, are presented here in a narrative format. In answer to the research question, findings on enablers of and barriers to clinical follow-up from the perspective of survivors of sexual assault are presented as themes and subthemes.

4.2 BACKGROUND INFORMATION: PARTICIPANTS

Participant one is a fifteen-year-old young woman who was accompanied by her parents to the interview. The father chose not to be part of the actual interview, but expressed that he wanted to show support. The mother took part in the interview along with the principal participant, the survivor. Afrikaans is the home language of this family. The survivor is currently in Grade 9 at a local co-education secondary school. Participant one attended the first follow-up consultation as scheduled. Thereafter she was not provided with a second follow-up appointment, only receiving verbal instruction to have the follow-up HIV test done at the local clinic. At the time of the interview, she had not accessed further healthcare.

Participant two is a thirty-two-year-old Afrikaans-speaking single woman, who had relocated to another town as a means of coping post-sexual assault. At the time of the interview, the participant was unemployed and ceded all her child grants (five) to her mother, who was taking care of her children. Participant two openly admitted to using alcohol and drugs as both recreational and coping mechanisms. The healthcare provider did not provide participant two with a scheduled follow-up appointment but gave verbal instruction that she should have a follow-up HIV test and cervical smear at the local clinic. At the time of the interview, she had not accessed follow-up healthcare.

Participant three is a nineteen-year-old Xhosa-speaking woman. She has not managed to complete matric, but intends returning to school next year. She lives with her parents and siblings and currently works full-time as a cashier at a local fast food outlet. Participant three attended all scheduled follow-up appointments and showed commitment to attending the final follow-up appointment scheduled for six months following the assault.

Participant four is a thirty-two-year-old Afrikaans-speaking woman. The survivor had moved homes prior to the assault to provide emotional support to her mother following the death of her mother's partner and sister. Participant four is single and was unemployed at the time of

the interview. Her nine-year-old daughter accompanied her to the interview, but did not take part. Participant four was not given a follow-up appointment and had not accessed follow-up care at the time of the interview. She is HIV-positive and was unable to give a clear account of her current treatment regime.

Participant five is a thirty-one-year-old Xhosa-speaking man, the father of a nine-year-old daughter who had been sexually assaulted while living with her biological mother in another province. Participant five is employed full-time as a bus driver and had access to the use of his brother's car to attend the interview. He lives in low-cost housing as a family unit with his current partner and three children. The child (principal survivor) was not interviewed. The father ensured that the survivor attended all scheduled follow-up consultations.

Participant six is a twenty-two-year-old Xhosa-speaking woman. She is the only participant who chose not to have the interpreter present throughout the interview, and conversed in English only. Participant six works full-time at a local business, with her only day off being Sunday. She lives in low-cost housing with her mother and siblings. Although she was not given a scheduled follow-up appointment, she attends the local clinic for HIV care. The healthcare providers managing her HIV care have not been informed of the sexual assault.

Participant seven is a thirty-two-year-old Xhosa-speaking woman. At the time of the interview, she was unemployed after losing her job as a cashier, which she experienced as a direct result of not being able to concentrate following the sexual assault. Participant seven lives alone in an informal structure after moving suburbs in an attempt to appease, and distance herself from, an abusive ex-partner. She had previously lived together with her sisters in a low-cost house. At the time of the interview, she had not accessed follow-up care. No formal medical follow-up appointment was provided, though telephonic contact was made providing her with details for a counselling session, which she did not attend.

Participant eight is a fifty-one-year-old Afrikaans-speaking woman, the grandmother and guardian of her ten-year-old granddaughter, the principal survivor. Participant eight lives in a formal house with her partner, one daughter and three grandchildren. At the time of the interview, the participant was unemployed after being released from her previous employment due to poor health. The grandchild (survivor) is the participant's son's child, though she was not living with her father at the time of the sexual assault. The participant openly discussed the challenges associated with her son's addiction to drugs and alcohol. The son is not part of the family unit living with the participant. The survivor (grandchild) was not interviewed. Participant eight ensured her grandchild attended all scheduled follow-up appointments, three in total.

Participant nine is an eighteen-year-old Afrikaans-speaking woman. At the time of the interview, the participant was in Grade 10 at a secondary school in the neighbouring town. She was a weekly boarder at the school hostel, returning for weekends and holidays to stay with her sister and cousins. Participant nine was interviewed independently as an adult. Although participant nine is able to access healthcare independently, she relies on the support of her sister. This participant invited her sister to join us on conclusion of the primary interview, as she wanted her sister's input included. She has attended all three scheduled follow-up consultations.

Participant ten is a forty-two-year-old Afrikaans-speaking woman. At the time of the interview, she was living in a shelter for homeless people. She expressed that she had no alternative accommodation options as she was estranged from her family. This participant is a chronic cardiac patient complicated by additional arthritis and HIV infection. She was unemployed, receiving a disability grant, the bulk of which is used to secure accommodation and meals at the shelter. No follow-up consultations were scheduled following the assault and related medical information was not shared with the healthcare staff managing her chronic illnesses.

4.3 ENABLERS: THEMES EMERGING FROM THE INTERVIEWS

Table 4.1: Enablers of clinical follow-up

Themes	Sub-themes
Healthcare systems	Patient-centred care
Police systems	Empowering documentation
Judicial system	None identified
Provider factors	Positive experience at initial consultation Formal appointment made
Community response	Catalyst for accessing healthcare
Client factors	Passive compliance

This section explores the positive attributes, structures and dynamics that enabled sexual assault survivors in this study to attend clinical follow-up consultations.

4.3.1 Healthcare systems

Although the personal dynamics of facility staff allow for a certain amount of flexibility in management style, the overriding bureaucratic structure of a large organisation, namely government, can be seen to dominate client experiences. Care is provided according to protocols and guidelines designed to minimise risk to both patient and provider, and is measured by targets and numbers achieved. In this type of setting, an individualised caring approach that can inspire a healing environment is underrated by the very system that demands it.

4.3.1.1 Patient-centred care

Continuity of care was of prime importance to the participants who indicated a definite preference for consulting with a familiar and trusted healthcare provider at each follow-up consultation:

“It would be better to go to the same person, like the social worker, because she doesn’t want to repeat the same story to somebody else.” (Participant seven)

Similarly, some participants expressed their dissatisfaction at not being able to see the same healthcare provider due to staff leave or rotation. When attended to by a healthcare provider other than who they were expecting, the participants expressed a sense of dissatisfaction. This feeling was compounded if the alternative healthcare provider was male:

“I want to go to the sister again because the doctor didn’t explain nicely to me. I thought I was going to see that sister again, and then I saw it was a man. I was embarrassed.” (Participant one)

The importance of an individualised care plan was highlighted by participant nine who indicated her appreciation for the help she received. She felt the attending healthcare provider had made a special effort to accommodate her needs by facilitating additional specialist counselling services. This individualised approach encouraged attendance at all scheduled consultations despite financial and transport constraints:

“The psychiatric sister has told us that she will get someone to help us with counselling and stuff. That will help a lot because they are making a lot of effort to help us. So actually they are helping us a lot at the hospital.” (Participant nine)

These views emphasise patient-centred care as an enabler to follow-up care among sexual assault survivors.

4.3.2 Police systems

A notable theme emerging from conversations with study participants was the need for them to feel their case was justified. The police played an integral role in establishing this sense of purpose and assurance with the sexual assault survivors.

4.3.2.1 Empowering documentation

A particularly empowering tool was the case document issued to the survivor by the police. The case document contains written details of the case number and personal details including a contact number of the investigating officer (South African Police Service, no date). This appeared to provide encouragement and a sense of purpose that enabled survivors to overcome their vulnerability and in some instances take proactive measures to assert themselves:

“And then I showed the paper. They said, if I see this guy, even if the van is not coming to me, I must stop the van and show that paper. And then I showed them that paper. They said, ja, we’re coming for you and then we’ll go there. Then they caught the guy and they took the guy to the police station.” (Participant six)

Reinforcement that the survivor had a legitimate case appeared to validate the survivor’s belief in her right to care, generating the motivation to access follow-up healthcare.

4.3.3 Judicial system

No enablers of follow-up under the theme of judicial systems were volunteered during the interviews. However, the researcher did not specifically prompt this theme and the limitations of this are discussed in Chapter Five.

4.3.4 Provider factors

One may anticipate that the survivor’s first encounter with a healthcare provider at their most vulnerable moment would shape their attitude toward accessing future healthcare services. Bearing in mind that the Western Cape Department of Health has implemented a drive focused on strengthening the patient-centred experience in the delivery of quality healthcare, it was reassuring to note that all ten participants told of a positive initial encounter with the sexual assault healthcare service.

4.3.4.1 Positive experience at initial consultation

The views expressed by the survivors were a strong reminder that as a healthcare provider one needs to put aside personal feelings and opinions of what the client ought to need and instead elicit the actual needs of the client from her/him in person. This even more so when the client is particularly vulnerable as a survivor of sexual assault. A caring, sensitive approach makes for a positive experience, encouraging trust and promoting access to continued healthcare:

“Yes. The doctor worked very nicely with me. They tested for pregnancy and everything... AIDS, everything.” (Participant seven)

This indicates relief and appreciation for what the survivor considered a caring and thorough initial consultation.

A common theme emerged during the interviews that the survivors preferred minimal, but reassuring, conversation with the healthcare provider during the initial consultation. Therefore, the seemingly brusque manner of a healthcare provider who did not encourage the survivor to verbalise much and did not bombard them with excessive chatter, may have been more in line with what the client needed at the time:

“Hmm, he [doctor] worked alright with me, gently, and also didn’t hurt me. Every now and then he spoke a few words with me and so on. It was enough because at that time I didn’t feel like talking, not a lot anyway.” (Participant four)

Participants expressed their preference for same gender healthcare providers, a sentiment echoed in the enablers detailed previously under healthcare systems:

Researcher: *“And how was that experience to have a lady doctor?”*

Participant: *“It was fine because it was too comfortable to ask those questions.”*

Although participants indicated a preference to be attended to by female healthcare providers, this was superseded by their understanding that a professionally qualified and competent healthcare provider was essential, regardless of the healthcare provider’s gender. The female participants therefore rationalised their acceptance of a male healthcare provider.

4.3.4.2 Formal appointment made

A critical factor enabling sexual assault survivors’ attendance at follow-up consultations emerged as being the provision of a scheduled, documented appointment. In this study, all five participants who were given a formal appointment for follow-up consultation accessed

the follow-up service, whereas the five not given an appointment did not access healthcare services for this purpose.

Participants perceived the provision of a formal follow-up appointment as a necessity to accessing ongoing healthcare. Of primary importance was issue of an appointment on a recognised official document, stating the date, time and place to attend. Accessing healthcare facilities without recognised documentation prompted unwarranted scrutiny from front line staff; in some instances, this even included the security personnel at the entrance gate. Lack of referral documentation compromised confidentiality as the survivor was expected to provide reception staff, both male and female, with intimate information prior to being allocated a healthcare service:

“And you also can’t go without a letter, because he can’t just say you must go to the clinic or you must come back. He must write a date and must give you a letter to be able to go to the clinic.” (Participant four)

This enabler was further enhanced if a named healthcare provider was specified on the appointment card. This appeared to encourage trust and an expectation that their needs would be met in the follow up consultation:

“It’s better to go to a person.” (Participant three)

Participants preferred to receive written instructions or information that they could refer to at a later stage. Many of the participants expressed difficulty in retaining information provided during the initial consultation. Having a document to refer to enabled the participants to process information, consult their support networks and ultimately access services:

“She says it would have been better if they had written something down because she was not thinking straight that day.” (Participant seven)

For participants who were employed or attending school, having a set appointment enabled them to negotiate and plan time off to attend the follow-up appointment. Employers and school officials appeared understanding if they were notified in advance of the follow-up appointment and provided proof of attendance in the form of a “sick” certificate:

“Yes, it’s not a problem because I get the sick note and then I show them at work.”
(Participant five)

In only one instance did the healthcare provider note all three follow-up dates on the appointment card. The participant appreciated this as it assisted her with planning. Having the appointment dates clearly written and pinned to her wardrobe served as a visual

reminder. Notably the appointment card had been completed meticulously and the participant found the small writing difficult to read. However, the enabler of being provided with an official appointment was further strengthened by a clear and detailed explanation by the healthcare provider of the proposed healthcare plan:

“Yes, I asked my children to rewrite the dates on another paper so that I could stick it on my wardrobe so that I could see it better.” (Participant eight)

Participant three verbalised that she simply attended follow-up out of curiosity. She had no expectations of the proposed appointment and was only interested in hearing what the healthcare provider would discuss with her during the scheduled consultation. The need to satisfy her curiosity was strong enough that she returned to the clinic, despite being turned away on the day of the appointment when the designated healthcare provider was unavailable:

“She went there because she was curious; she wanted to hear what sister was going to say to her.” (Participant three)

4.3.5 Community response

By virtue of proximity, the community plays an integral role, positive and negative, in assisting sexual assault survivors on their road to recovery. Participants, without exception, spoke of interaction with members of the community during the interview sessions.

4.3.5.1 Catalyst for accessing healthcare

In many instances, the community acted as a catalyst, assisting the survivor in accessing initial healthcare. The participants told stories of community members coming to the survivor’s assistance, providing clothes, calling the police and staying with her until the police arrived. Participant ten spoke of vigilante-style community support, where men from the surrounding area, armed with sticks and traditional weapons, gathered together to search for the alleged perpetrator, saying they would beat him so he could be caught by the police when they arrived:

“Then the men and the women came out, everyone came outside, they wanted to beat the man [alleged perpetrator]. I took my container of water and went to the place where the man sat. The menfolk followed me with sticks and other things because they wanted to beat him up so that when the police arrived the man would be lying there.”
(Participant ten)

The community assisted participant five by providing contact details and anecdotal referral to the local counselling service of FAMSA after he relocated his child and distanced her from an abusive environment. The participant appreciated the community support and accessed the services offered at FAMSA.

The positive response toward the survivor appeared to enable a sense of purpose and credibility for the participants, reassuring them that accessing care was the right option.

4.3.6 Client factors

Ultimately, the responsibility for accessing follow-up care rested with the survivor. Their decision to access follow-up care may be influenced by various factors such as the enablers already discussed, however the survivor alone prioritises his or her needs.

4.3.6.1 *Passive compliance*

A common theme emerging from the interviews was an attitude of unquestioning compliance. Many of the participants who had attended follow-up consultations expressed that they did so because they were told to:

“She went there because the doctor told her to go to the clinic, so that is why she went there.” (Participant three)

Even though the intervention during the initial examination was unpleasant and at times invasive and painful, participants rationalised the need to comply with the requests of the attending doctor. Participants became passive beneficiaries of care through acceptance of the healthcare provider’s authority. Seemingly, the path of least resistance was to tolerate the necessities of the forensic examination, securing the best possible chance of both prosecution and healthcare:

“Ja, she says she didn’t feel like speaking to the doctor about what happened to her. But because it was a doctor, the doctor was helping her so she had to tell the doctor what happened.” (Participant three)

4.4 BARRIERS: THEMES EMERGING FROM THE INTERVIEWS

Table 4.2: Barriers to clinical follow-up

Themes	Sub-themes
Healthcare systems	Primary healthcare reception Lack of confidence in the health service Waiting times
Police systems	Distrust Inability to provide safety Discouraging reporting
Judicial system	Slow and unresponsive Too lenient Despondent
Provider factors	No follow-up appointment made Unmet healthcare expectations
Community response	Judgemental Vigilante concern
Client factors	Internal conflict: PTSD symptoms Relocation as a means of coping and ensuring ongoing safety Work or school obligations Financial constraints

In this section, the barriers to attending follow-up consultations post-sexual assault as identified by the interview participants are described.

4.4.1 Healthcare systems

In order to improve the quality of healthcare, it is important to evaluate the service by listening to the experiences of those utilising the service. These personal accounts form the foundation for recommendations discussed in the following chapter.

4.4.1.1 Primary healthcare reception

It was noted that many participants experienced challenges when interacting with the primary healthcare reception staff. As gatekeepers to accessing a primary healthcare facility, the reception staff plays a critical role in creating barriers between the client and service. The study participants were of the opinion that the primary healthcare reception staff were very exacting in applying the “rules” of access. Participant four told of the challenges she experienced getting her folder transferred from one clinic to the other, and the reluctance to initiate access to care at the current location without the formal transfer of data:

“And I want to go to the clinic but I have to get my folder transferred from [name withheld] clinic first.” (Participant four)

Participant three had been given an appointment at a particular facility, only to be turned away by the reception staff who said the designated healthcare provider was not on duty:

“She says that her treatment wasn’t good at reception. She was told that Sister [name withheld] was not there – but not in a nice way. Then she was told to come back the next Wednesday when Sister is there.” (Participant three)

Participants’ concerns regarding the confidentiality of the primary healthcare reception staff were identified. The system means that reception staff are privy to, or directly ask the client, why they are attending clinic. Often the reception staff are members of the same or neighbouring communities, and there is doubt that personal information shared will remain confidential:

“It was difficult with the sisters [slang for friend] at reception. If I talk with the sisters at reception they will know the reason why I am coming to the clinic. Do you understand?” (Participant two)

When probed regarding consultation privacy, one participant said:

“No I’m much better off at the hospital than at the clinic.” (Participant eight)

This statement referred to the Thuthuzela Care Centre as the Hospital. As the centre is a specialised service located within the George Regional Hospital, survivors do not need to be part of the general primary healthcare clinic system to access follow-up. As clinics are located within most urban communities, the familiarity of healthcare staff and the proximity of the primary healthcare clinic to the area where the sexual assault took place are barriers to accessing follow-up care.

Participants consequently preferred the perceived anonymity of the Thuthuzela Care Centre system:

‘And the reason why I also don’t want to go to the clinic is because it is actually in the same area as where this thing [sexual assault] happened to me.’ (Participant two)

4.4.1.2 Lack of confidence in the health service

Participants told of a positive experience with the healthcare system during the initial consultation; however, their perception of the services available at the primary healthcare facilities showed a lack of confidence in the treatment provided:

“Yes, because it looks like they don’t give you the right pills because those pills don’t help as they should.” [referring to primary healthcare services] (Participant four)

This view was extended to the follow-up services at the hospital, where the participants were not entirely satisfied with their treatment outcomes. Some expressed that not all their health needs were met, despite compliance with the prescribed healthcare plan. This may have been an unrealistic expectation as the treatment plan for this participant involved a chronic illness requiring long-term interaction with healthcare services. It does however indicate the importance of ensuring that the content of treatment programmes is discussed with clients in a meaningful way:

“He’s happy with the treatment, but he’s got a “but” because of the actions of the child. He’s not happy. He thinks that there is something wrong.” (Participant five)

4.4.1.3 Waiting times

At the time of the initial consultation, participants seemed to accept delays in being attended to. They expressed understanding that they would have to wait for: various services; the Family Violence, Child Protection and Sexual Offences unit to arrive from neighbouring towns; folders to be drawn; and healthcare providers to be available for consultation. However, in terms of follow-up consultations, waiting times proved a common barrier to accessing the service:

“And that is where a person loses motivation, because you sit and wait but people that came after you get helped first.” (Participant four)

These opinions seemed to originate from prior experiences of accessing the clinic/health service for other reasons, creating barriers as a result of a preconceived evaluation of the service.

4.4.2 Police systems

It is worth noting that the policing system operates in two distinct sections: the Family Violence, Child Protection and Sexual Offences specialist unit, and the general police officials on duty in the community and at the charge office. In general, the participants expressed their satisfaction with the services received from the Family Violence, Child

Protection and Sexual Offences unit; the barriers mostly related to the general police officials. The participant's need for affirmation that she had been violated and had just cause to open a case was paramount. If this reassurance was broken down during interaction with the police, it seemed to hinder the survivor's ability and motivation to pursue the case and attend to her health needs.

4.4.2.1 Distrust

A general feeling of distrust for the police emerged as a common thread throughout the interviews. Actual experience and anecdotal accounts of community dealings with the police fuelled this distrust:

“And people can also not trust the police these days because they also do wrong things, understand? We also lived in [name withheld] and at night you would hear how the police caught the people and how the police would beat the community that they got on the side of the road. Then they scream and are loaded in the police van. That’s how I feel.” (Participant four)

This view appeared to be directed at the community police officers, rather than at the Family Violence, Child Protection and Sexual Offences (FCS) unit officers, who did not share a common identity with the police force as they drove in unmarked cars and wore plain clothes.

4.4.2.2 Inability to provide safety

Contributing to this feeling of distrust was the opinion that the police did not have the capacity or means to ensure the safety of the survivor who had opened a case against the alleged perpetrator. Participants reported alleged perpetrators not adhering to bail conditions involving proximity, leaving the survivors with serious concern for their own safety. When the police were notified that the alleged perpetrator had transgressed bail conditions, no remedial action was taken. In some cases, the participants relocated to avoid being in close proximity to the alleged perpetrator. Even this did not ensure safety, as participant seven disclosed:

“I have decided to move out from there. I’m staying on my own now. But still, he is still following me. The other day he told me that he was looking for me.” (Participant seven)

“She says she moved out and then he started harassing her. And then he was wearing a balaclava and was carrying a machete. So he was looking for her. Luckily another lady saw him and told her.” (Interpreter for Participant seven)

4.4.2.3 Discouraging reporting

Throughout the interviews, the survivors' need for reassurance, confirmation that they had valid reason and were justified in believing they had been sexually assaulted, was apparent. Distressingly, some participants gave accounts of interactions with the police where they were led to believe there was no point in opening a case. This could be interpreted as the police discouraging reporting, but more importantly it made the survivors question the integrity of their claim. If the police did not believe their story and discouraged reporting of the case, the survivor appeared to lose impetus and not equate the assault with the need for continued healthcare. The severity of the violation was minimised:

"Because they [police] asked me, the day [name withheld] was raping me, did I call anyone? I said no. So that's why the guy [police officer] said he doesn't think they're going to take me seriously because I didn't cry." (Participant seven)

Although participant seven had endured physical injuries requiring medical attention on the night she reported the sexual assault to the local police, she decided to withdraw the case as she felt there was no point in continuing further as no one would believe her:

"For me it felt like I should go and open a case with the police. But it felt like they [police] didn't believe." (Participant two)

This participant withdrew charges after feeling it was pointless continuing if the police did not believe her.

4.4.3 Judicial system

During conversation with participant six, it became apparent that her primary focus was on the delivery of justice, namely the conviction of the alleged perpetrator. This may have been highlighted as the case was still current (three to six months prior to the interview). The researcher was left with the impression that at the time of the interview, some clients prioritised the legal process above their own health.

4.4.3.1 Slow and unresponsive judicial system

Participants who had persevered with the judicial process found it slow and unresponsive. Participant six, quoted below, stated that she had prioritised the legal aspects of ensuring the perpetrator was brought to justice above her health needs. She focused all her energy and time away from work following up on the progress of the case. The attention required to do this was exhausting and meant that as she was not experiencing any critical healthcare issues, she tended to ignore them.

“No. I was like, nothing is happening, that is why I’m always following you up because there’s nothing happening. It’s just me who is wondering what’s happening. And even my boyfriend, when he came from Eastern Cape he was like, Sisi, did this case really go into whatever, because I don’t see anything happening. You said you were raped, but I don’t see anything happening. Then Constable [name withheld] said, you know, Sisi, I’m so sorry, I’ve got many cases but they are going to be testing this in court now. They are going to call you when you have to take the stand and when you have to be in court.” (Participant six)

4.4.3.2 Too lenient

The timing of the interviews post-assault meant it was unlikely that the judicial process would be at an advanced stage. The participants however expressed their concern regarding the leniency shown in terms of bail granted to the alleged perpetrators. Some alleged offenders were only jailed for a week before being released:

“Every time when I saw him it hurt me a lot. But he was taken away for a week to jail then he came back.” (Participant seven)

This was often to the same community as the survivor, thereby leaving her in fear of her safety, as discussed previously. The quick release and seeming inability to enforce bail conditions eroded the survivor’s tenacity in pursuing the case. Note that once the survivor started doubting the validity of her claim, she did not prioritise her need for follow-up healthcare.

4.4.3.3 Despondent

The response below indicates the level of despondency with the system:

“Then they said to me, they did catch them but they put the case back for a while because I couldn’t identify the perpetrators faces. So I decide not to go back to [name withheld] again.” (Participant two)

This survivor was brutally raped by multiple perpetrators, and although she reported just after the 72-hour window, a foreign body in her vagina that was present at the time of the rape was removed for forensic processing. This foreign body should have furnished valuable evidence, yet she was told there was insufficient evidence to proceed with prosecution:

“When she saw my folder, it was written in red that she should tell me that the case has been postponed because I could not identify the men. I asked her even though I can’t identify their faces did you not find anything [evidence] on my clothes. Is there no

indication of who it could be? Then she said to me, lady, sorry there is nothing I can do about that.” (Participant two)

“The police also said there’s not enough evidence, even the court won’t take her seriously.” (Participant seven)

The participants expressed repeated accounts of challenges within the judicial system and with each event the survivor’s integrity came into question. These assaults on their self-worth resulted in participants focusing on immediate real-life challenges rather than long-term health benefits. Follow-up care unrelated to a tangible illness or injury thus moved down in the order of priority.

4.4.4 Provider factors

The healthcare provider played a pivotal role in enabling survivors of sexual assault to attend follow-up consultations. Unfortunately, the healthcare provider was also seemingly responsible for the greatest barrier to access of follow-up care. Recommendations to address these shortcomings will be detailed in the following chapter.

4.4.4.1 No follow-up appointment made

Perhaps the most critical barrier to follow-up care was that not all survivors were given follow-up appointments at the initial consultation. Some were not provided with any information regarding the need for follow-up, and others were only given verbal instructions to attend the local clinic. As noted in the previous sections, the primary healthcare system does not make it easy for clients to access healthcare without an appointment or referral letter. A clinic visit without appointment or referral would necessitate the survivor disclosing intimate information to the reception staff whose respect of confidentiality has been shown to be questioned by participants:

“No, I asked him [doctor] must I come again and he said: No you must not come again, I must just take her to the clinic for an HIV test. And then I didn’t go.” (Participant one)

It was particularly evident that HIV-positive survivors were not issued follow-up appointments. This indicates a knowledge gap among healthcare providers who may not understand that a sexual assault follow-up consultation aims to address the survivor’s health holistically, not merely to follow-up on the provision and efficacy of PEP.

4.4.4.2 Unmet healthcare expectations

Participant ten, who has regular interaction with healthcare during chronic illness consultations, indicated the reluctance of her regular healthcare provider to engage with the

topic of sexual assault. Even though the clinical notes were available for reference, the doctor did not enter or initiate any discussion regarding the sexual assault during routine chronic care consultations; rather the doctor emphasised the necessity of an appointment specific to sexual assault. This indicated a lack of integrated and comprehensive care:

“They did give him the information about what happened to me, but he has still never asked me, [name withheld] how do you feel about this business, how are you coping? How can I help you get back to your life, to help build you up and try and forget about this case? He is my doctor, I don’t know, perhaps he is too busy and everything. I don’t know.” (Participant ten)

4.4.5 Community response

During the interviews, it became clear that the sexual assault survivors were an integral part of the community. As such, the reaction of the community to the participants’ disclosure of sexual assault weighed heavily on the survivors’ motivation and self-esteem. A negative response seemed to perpetuate the survivors’ need to keep the assault a secret, avoiding disclosure, with consequent loss to follow-up care.

4.4.5.1 Judgemental

Participants verbalised anticipating a negative response from the community, and so avoided disclosure to circumvent the associated blame and emotional angst that accompanied this response. This was particularly apparent if the survivor had been exposed to an abusive relationship over a period of time: a sense that intimate-partner violence had, to a point, become normalised. It appeared as though the community became desensitised to the injustice of the continual abuse and were unsympathetic to the survivor when she was able to take the step and register the abuse as sexual assault:

“She says the boyfriend also said to her that there is no evidence, and also other people saw that he didn’t do anything wrong.” (Participant seven)

The community appeared more judgemental if the sexual assault could be associated with social activities such as entertainment at local taverns. The judgemental response, casting aspersions on the survivor’s character and blaming her for putting herself at risk, was common:

“I have to be brave because it was like for the other people, like in the location when I’m staying there, they said, no, I asked for it and we agreed to do that.” (Participant six)

This type of response made the survivor feel like the perpetrator:

“And I felt like I was the one who had committed the crime. That is how I felt.”
(Participant two)

There were definite concerns regarding confidentiality among community members. Participants voiced how they felt the whole community knew what had happened to them, regardless of their choice to disclose or not. This left the survivor suspicious and cautious, reluctant to access healthcare as they thought it would label them further as the one who was raped:

There isn’t a person you can really trust because everyone is one and the same. There are people you can trust but not just everyone.” (Participant four)

4.4.5.1 Vigilante concern

Some participants told of how the community wanted to intervene in a vigilante type manner. In one instance, the sisters of the survivor physically assaulted the alleged perpetrator on more than one occasion. This mob justice was difficult for the survivor, as she in turn became anxious about the security of her sisters. Not only was there the consideration that her sisters had transgressed the law, but there was a very real physical danger posed by the man they had assaulted. Eventually she chose to relocate to a settlement far away from her sisters, to avoid the conflict. Thus, she lost her strongest support network that may have assisted and motivated her to attend follow-up sessions as part of the recovery:

“She says it’s very difficult for her. It’s like everyone is just seeing that she is going through this. And when he came out of prison he wanted to rape her again. Then she and her sisters, they decided to beat him up. She called them, and then they came and they beat him up.” (Participant seven)

4.4.6 Client factors

During interaction with the participants, it became apparent that they did not prioritise their own health needs. Circumstances seemed to direct the participants’ focus on tangible challenges and issues. Physical health was dealt with, but the more abstract concepts of emotional, psychological and spiritual health were not given much attention. This may be a reflection of the poor insight into the importance of psychological and spiritual care, as

demonstrated by those interacting with the survivor, including healthcare providers. These vital aspects of self-care did not seem to form part of the participants' frame of reference.

4.4.6.1 Internal conflict: PTSD symptoms

Participants spoke of experiencing insomnia following the sexual assault. Difficulty concentrating, flashbacks of the assault occurring at any time of the day or night, and wanting to be alone in a peaceful quiet place were commonly discussed. These are recognised symptoms of PTSD, collectively creating challenges for the survivor to function optimally. Some participants openly told of how they had turned to drugs and alcohol as a form of escape from the painful reminders of the sexual violation.

There was an overwhelming sense of self-blame as the participants described how they felt responsible for putting themselves at risk and hence being responsible for the sexual assault:

"I was blaming myself, that if I didn't go to that tavern, maybe that thing wouldn't have happened." (Participant six)

Participants experienced severe challenges with being able to retain information or concentrate. This was particularly important during the initial consultation, where healthcare providers gave verbal instruction related to taking of medication and follow-up care. The participants were unable to recall much of the information provided by the healthcare provider in the initial consultation. They explained how they had to read the directions on the medicine packets when they got home to understand how to take the medication:

"Yes. When someone is talking to you, your mind is not there. You hear she is talking, but you don't know what she's saying." (Participant seven)

It was notable that participants expressed that they did not want to talk about the incident. They felt uncomfortable discussing the actual incident repeatedly, expressing the desire to move on and not focus on what had happened. This was particularly difficult during the initial consultation where the survivor was expected to repeat her story to a number of people from various disciplines:

"I actually didn't feel like talking. It's old stuff and I really didn't want to talk about it."
(Participant nine)

Some participants expressed that they did not feel it necessary to attend follow-up sessions as they anticipated having to discuss the incident again and it was not their main priority. These participants felt they were coping and did not see the point in attending follow-up

sessions. As all participants told of varying symptoms associated with PTSD, avoiding talking about the sexual assault may have been a self-preservation measure.

This finding may indicate challenges within the therapeutic approach and counselling skills of healthcare providers. The perception that follow-up consultations would entail a repeated recount of the ordeal posed a barrier to care for some participants:

“I don’t need any follow-ups. I don’t need anything. For my personal life I need this [prosecution of perpetrator].” (Participant six)

4.4.6.2 Relocation as a means of coping and ensuring ongoing safety

Some participants coped by relocating to a different suburb or neighbouring town. This distanced themselves from daily reminders, both visual and personal, of the violation and the alleged perpetrator, and at the same time, this resulted in a barrier to follow-up care.

Participant seven, a survivor of intimate partner violence, relocated in an attempt to ensure her personal safety. She resorted to drastic measures to protect her children, sending them to a neighbouring province where her mother became the primary caregiver:

“Then if I leave there, he is going to stop harassing me if I’m not staying there. Then I did that, I moved out.” (Participant seven)

Relocation, whether permanent or temporary, hindered survivors’ access to follow-up services. Participants who relocated did not notify the case manager of their altered contact details. This denied them access to follow-up care, as they had no referral documentation to present at an alternative healthcare facility.

4.4.6.3 Work or school obligations

School-going participants seemed to have a good relationship with the education staff, principals, teacher and hostel matrons. The children had no concerns regarding missing school to attend follow-up consultations, except when writing exams. In one instance, the professional nurse arranged for the child to attend follow-up after writing her exam. The child however struggled to concentrate during the exam, as her thoughts were focused on the pending follow-up consultation and blood test results:

“I just wished that the exam could be finished because I still had to go to the hospital the same day.” (Participant one)

For the participants who were employed full-time, negotiating time off to attend follow-up consultations was a challenge. Although most of the employers were accommodating, the time off was deducted as sick leave:

“I just didn’t feel like going to the clinic because then I would have to have a talk to the sister about it and then I would also have to stay out of work.” (Participant two)

Some participants expressed that they did not want to miss work as they preferred keeping themselves occupied, avoiding concentrating on the sexual assault. Survivors implemented methods of resilience to enable continued functionality:

“And I was even like, let me drop this, because after that incident I just went to work, and worked and worked and worked.” (Participant six)

4.4.6.4 Financial constraints

Discussing financial constraints was very difficult for the male participant. He felt embarrassed to mention money as an issue when taking his child for follow-up consultations. He spoke via the interpreter, broaching the subject in a circumspect manner:

“He says it’s a difficult question, and he’s also ashamed to say money is the problem.” (Participant five)

The women were more open expressing that money for transport to access follow-up consultations was a challenge. The participants who identified money for transport as an issue were unemployed and relied on social grants for income:

“I thought...oh every time I must be there [follow-up consultation] I must use my own transport. I must take the bus and what is uncomfortable for me is the bus fare because I do not always have money.” (Participant eight)

4.5 PERTINENT OPERATIONAL FINDINGS

4.5.1 Challenges in contacting survivors telephonically

Even though cell phone contact details were entered in the sexual assault register, telephonic contact was not guaranteed. Many of the numbers provided were incorrect, went straight to voicemail, or belonged to someone other than the survivor. On one occasion, the case manager from the Thuthuzela Centre phoned eleven different contact numbers and only connected with one of the eleven survivors.

4.5.2 Challenges in contacting male survivors

Preliminary data review indicated adult male survivors of sexual assault were routinely managed at the three identified facilities. However, when the case managers were contacting potential participants, it became apparent that the majority of male adult sexual

assault survivors managed at the George and Mossel Bay hospitals were inmates at correctional service facilities. Correctional facility healthcare staff managed follow-up consultations in-house. As inmates, they had virtually no control over their attendance at post-assault follow-up consultations which were managed in-house. The feedback system regarding these follow-up consultations has been strengthened, with the correctional service provider submitting follow-up data routinely to the hospital case manager.

4.5.3 Gaps in monitoring and evaluation tools for sexual assault services

In 2013, when the Provincial Indicator Data Set was revised, the formal capturing and reporting system directly relating to clinical follow-up post-sexual assault fell away. As a result, although some hospitals in Eden District have maintained some form of data collection, the process is neither uniform nor accurate. In a system that is overloaded with accountability to key data indicators, non-specified data often does not receive the scrutiny it deserves. Although the service is delivered, the long-term quality and effectiveness of the service is not evaluated regularly.

4.6 CONCLUSION

The experiences of ten participants were explored during in-depth interviews, providing perspectives of enablers of and barriers to follow-up consultations post-sexual assault. The findings were separated into two sections: enablers of and barriers to follow-up consultations, and presented in six main themes using direct quotation to highlight participant perspectives. The themes collated findings under the following headings: healthcare systems, police systems, judicial system, provider factors, community response and client factors. The findings confirmed a plethora of enablers of and barriers to follow-up consultations. In Chapter Five, the findings are discussed and recommendations made based on the evidence collected during the study.

CHAPTER FIVE

DISCUSSION, CONCLUSIONS AND RECOMMENDATIONS

5.1 INTRODUCTION

In this chapter, study findings are discussed in detail in relation to identified literature. Conclusions relating to the study aim (namely to identify enablers of and barriers to clinical follow-up post-sexual assault) are drawn, and recommendations provided to promote improved access to and utilisation of this service. The consequent intention is to translate research into action.

5.2 DISCUSSION

In response to the study objective, the enablers of and barriers to clinical follow-up post-sexual assault are discussed according to the identified key themes.

5.2.1 Healthcare systems

Effective, patient-centred systems are the goal of the Department of Health and are in keeping with a primary healthcare approach (Western Cape Government Health, 2014). Access to healthcare is a basic right enshrined in the Constitution of South Africa and is a core dimension of primary healthcare (South African Government, 1996). However, the mere provision of a healthcare service does not imply the effective utilisation of the resource. The declaration of Alma-Ata states that primary healthcare must be “accessible to individuals and families in the community through their full participation” (World Health Organisation, 1978). In this study, access to services for sexual assault survivors can be evaluated by its ability to meet the following components, which are outlined in *Norms and Standards Regulations in terms of Section 90 (1)(b) and (c) of The National Health Act* (Republic of South Africa, 2015).

5.2.1.1 Availability

Although services for survivors of sexual assault are available at all hospital facilities within the Eden District, it should be noted that the Thuthuzela Care Centre model is only fully operational in one of the three study facilities. The absence of functional Thuthuzela Care Centres in the other two sub-districts identified in this study may influence the accessibility and interaction between survivors and the judicial system. The impact is on the comprehensive, multisectoral care provided to the survivor rather than merely the provision of critical medical care.

5.2.1.2 Geographic factors

The current follow-up service available to sexual assault survivors relies primarily on a hospital-based system. Transport to follow-up appointments is not facilitated by the healthcare system and depends on the patient's ability to both arrange and pay for transport to and from the healthcare site. Some clients reflected that they found the additional finances required to attend follow-up consultations difficult. However, those that cited transport costs as a barrier to follow-up overcame the financial pressure and attended scheduled appointments regardless. Smith *et al.* (2010:269) indicated that transport-related barriers did not feature prominently in their study. The findings demonstrate that although financial constraints presented a barrier to follow-up, the participants that were committed to attending follow-up care were able to overcome this barrier. It is worth noting the participant living the furthest from the follow-up centre risked her personal safety by hiking to avoid the prohibitive cost of a local taxi service. Survivors not as committed to attending follow-up may have greater issues with the cost of transport.

5.2.1.3 Acceptability: Patient-centred approach

It was clear that participants preferred to be managed at follow-up consultations by a trusted, competent healthcare provider. The trusting relationship between participant and healthcare provider was established through a previous positive healthcare experience. The gender sensitive nature of sexual assault fostered a preference for same-gender healthcare providers. In this study, this preference was for female healthcare providers. However, participants expressed an acceptance of male healthcare professionals if they trusted the healthcare provider. Knowing and trusting the healthcare provider encouraged the participants to attend scheduled follow-up consultations as supported by the findings of Röhrs (2011) and Anhang Price *et al.*, (2014).

A patient-centred approach was a central enabler of this study and included continuity of care, being attended to by trusted healthcare provider and an individualised treatment plan. The Patients' Rights Charter (South African Government, 1996) indicates that continuity of healthcare should be guaranteed. Healthcare 2030 (Western Cape Government Health, 2014) further articulates and advocates a patient-centred experience. This corresponds with the finding that participants preferred to be managed at follow-up consultations by a familiar and trusted healthcare provider. This was not necessarily the healthcare provider directly involved in the initial consultation and could include any member of the healthcare team that had formed a positive relationship with the participant. There was, however, an acceptance and understanding amongst participants that it was not always possible to be attended to by the same or preferred healthcare provider. These findings suggest it was important that false

expectations were not created resulting in disappointment or an unpleasant experience if the preferred provider was unavailable.

Where participants' expectations were unmet, they expressed a lack of confidence in the healthcare provided. Eliciting and acknowledging people's expectations is a key aspect of being patient-centred. Lack of confidence in the system led some participants to question the necessity of adhering to treatment when the plan included follow-up consultations. Findings highlight the need to include the survivor, and indeed all clients, in the planning of their treatment programmes. Unfortunately, the appropriate patient-centred skills that facilitate this mutual decision-making process appear to be lacking. Howe, Mash & Hugo (2013:899) suggest this may be due to inadequate training in generalist skills that capacitate healthcare providers to implement holistic care.

Failure to include the client in the decision-making process and address their needs and expectations may lead to them access alternative treatment options. This was evident in participant five's experience, where the family was in consultation with a traditional healer and the healthcare system simultaneously. Once the participant's expectations were satisfied by medical care, and her confidence restored, she continued with the Western healthcare system exclusively. Shahali *et al.* (2016:6) found similarly that failure of the legal healthcare system in Iran to address the needs and expectations of survivors resulted in them accessing illegal solutions to overcome their issues.

Continuity of care is a core dimension of effective primary health and chronic care. It can be limited to just information, but really requires a longitudinal connection to a specific provider or team of providers. The ultimate concept of relational continuity implies that the quality of this longitudinal connection is patient-centredness, trust, commitment and being known. The weakness of the current system is highlighted in this study, demonstrating the practical importance of the provision of patient-centred care.

5.2.1.4 Influence of previous experience

Many participants recounted incidents based on previous healthcare experiences, not necessarily related to sexual assault management. In particular, they recounted negative experiences during prior interactions with facility front-line staff, creating the perception that primary healthcare facilities' reception personnel posed a barrier to follow-up consultations. This is an important observation to ensure survivors experience positive patient-centred care, across the board, at every healthcare encounter (Anhang Price *et al.*, 2014). Previous experience weighs heavily on decisions to return to a particular facility for healthcare.

Long waiting times, particularly at primary healthcare facilities, proved problematic for some participants. However, the majority of sexual assault follow-up consultations in the three study facilities were managed via a specialised system that circumvented the challenges noted by participants in terms of primary healthcare reception and waiting times. This indicates the challenge of long waiting times as more of a perception than reality. A strong reminder of the powerful influence previous experience has on people's choice whether to access care or not. As primary health clinic waiting times specifically were identified as a barrier to follow-up consultations, the findings suggest the Thuthuzela one-stop system may be more conducive to a positive patient experience, encouraging attendance at follow-up consultations (National Prosecuting Authority, 2009). However, the individual circumstances should be considered, weighing up the benefit of returning to a centre specialising in sexual assault management against prohibitive transport costs, given that there is only one Thuthuzela Care Centre in the Eden District.

The findings indicated the need to address communication skills among, specifically, but not limited to, front-line staff at all facilities – not merely at the immediate crisis centre where staff may be sensitised to providing the best possible patient-centred experience to vulnerable clients. Challenges with confidentiality at primary healthcare reception areas were highlighted; again, this appeared to be primarily based on previous experience – the mere possibility of an unpleasant experience being a sufficient barrier to utilising follow-up services. This indicates that all staff, regardless of their position, should be made aware of and appreciate the impact they may have on the utilisation of other services. Adeniji & Mash's findings (2016), that most patients turned to support staff, cleaners and security officers for assistance in dealing with the triage system of a primary healthcare facility in Cape Town, support this observation.

5.2.1.5 Affordability

Although the service is ostensibly provided free, the "hidden" costs are significant for survivors with low or no income. Public transport services in the Knysna and Mossel Bay sub-districts do not exist, making survivors dependent on the sometimes unscrupulous charges and timetable of the taxi industry. As discussed previously, despite these challenges, participants who identified transport costs as a barrier managed to overcome them and attend follow-up.

5.2.1.6 Utilisation

Challenges identified in the monitoring and evaluation of the utilisation and outcomes of the sexual assault services were reflected in the absence of long-term, accurate data collection

processes. This is primarily because relevant data is not collected as an official reporting indicator. This finding informs recommendations detailed in **5.4 Recommendations**.

5.2.1.7 Equality

No restriction of access to the service in terms of age, gender, political or religious affiliation was identified during this study. However, it should be noted that incarcerated males may face challenges not identified by this study.

5.2.2 Police systems

The views expressed by participants regarding the police provided valuable insight into the influence of the initial encounter between survivor and the community police – in particular, how the approach and actions of the police sector at the time of the initial encounter may impact on the client's utilisation of healthcare services and their ability to respond to personal health needs. It is unlikely that the police are aware of the profound influence their interaction with the survivor may have on follow-up healthcare; this represents a valuable finding of the study. The need for recognition, justification and confirmation that the survivor's claim of sexual assault was valid was a dominant theme.

A notable study finding not identified during the researcher's literature review was the positive impact of the provision of a case document. The empowering element of an official document was echoed in the findings that participants responded positively if provided with a scheduled appointment on formal stationery.

As supported by findings documented in the Röhrs report (2011), study participants expressed negative attitudes towards members of the police service. Personal encounters and anecdotal secondhand accounts led some participants to harbour a deep-rooted distrust of the police. This despite some participants indicating they were satisfied with their initial encounter with the police following the sexual assault. The findings of the study indicate the importance of survivor's ability to trust the police.

Issues of trust were compounded by the participants' perception that the police did not have the capacity to ensure their safety. Some participants recalled experiences of alleged perpetrators stalking them whilst armed with dangerous weapons. Where the police did not adequately enforce restraining orders, survivors appeared to lose confidence in the system and withdrew charges in order to feel safer in the community.

Statistics South Africa (2015) shows a decrease in the number of sexual assault cases reported to the police during the year 2014/15. Röhrs (2011:110) intimates that this may be

attributed to under-reporting as a direct result of the pressure on the police service to show an annual decrease in crime. The study findings indicated a disturbing pattern of police discouraging reporting and convincing the survivor that there was insufficient evidence to proceed with the case. As discussed previously, this had a massive negative impact on uptake of follow-up care.

Despite attempts by the government and human rights activists to address and protect the rights of victims, it is apparent that communities continue to be exposed to unsupportive, obstructive attitudes of the police. This entrenched response to survivors of sexual assault is perplexing, given the efforts of organisations such as Rape Crisis that have actively campaigned for the rights of survivors since 1976 (Rape Crisis Cape Town Trust, 2016). Human rights enshrined in the Constitution of South Africa, together with strategies implemented to improve client service within government departments, appear overshadowed by inappropriate police attitude, undermining the vision of *batho pele* (Republic of South Africa, 1997).

The challenges associated with the police services are complex and beyond the scope of this study. However, the researcher's participation in the Thuthuzela forum provides opportunity to create awareness of the problem within police structures. Unfortunately, the representatives participating in this forum are from the Family Violence, Child Protection and Sexual Offences unit, which was not implicated in the negative findings. However, it will be in the interest of the unit to disseminate the findings to their community policing colleagues and consider the feasibility of including a community police representative on the forum. Recommendations are discussed in **5.4 Recommendations** and the dissemination of findings is discussed in **5.6 Dissemination**.

5.2.3 Judicial system

The National Prosecuting Authority (NPA), as the lead department of the Thuthuzela Care Centre, has a clear mandate to facilitate prosecution of sexual offences. The Thuthuzela Care Centre included in this study is situated within George Hospital. The Centre is not identified by prominent signage indicating the collaborative partnership between the National Prosecuting Authority and healthcare. As such, it is possible that participants accessing services via this centre did not identify the role of the National Prosecuting Authority, rather viewing the service as a healthcare facility. This may provide some explanation for the absence of identified enablers associated with the judicial system.

Limitation of access to the Thuthuzela Care Centre model may influence the interaction between survivors and the judicial system. Notably, only one of the four participants facilitated by the George Thuthuzela system had an active court application, therefore their interaction with the judicial system was minimal. The slow and unresponsive judicial system failed to meet participants' individual needs. Study findings reflected participants proceeding with an official case had experienced little progress within the first six months post-assault. This led to an erosion of confidence in the judicial system, with the knock-on effect of derailing self-care strategies.

Study findings are in agreement with those documented in the Victims of Crime Survey of 2014/15 (Statistics South Africa, 2015). Participants indicated that they felt the system released criminals (perpetrators) early and that conditions imposed on perpetrators were too lenient. The collective outcome of these experiences was expressed as despondency and lack of belief that the judicial system had the capacity to meet survivors' needs.

The synergistic effect of a lack of recognition, failure to deliver and inertia across different services is a key point. While we see these services as separate, the patients' motivation to attend the health services may be eroded by their experience of the police and courts. The interdependence of these services to meet their goals is clear, and therefore they need to address the needs of people in an intersectoral way.

5.2.4 Provider factors

Reassuringly for healthcare providers and managers, all the participants indicated their satisfaction with the healthcare service provided during the initial hospital consultation at all three hospitals. Not all participants elected to open a police case and some were cold cases where evidence collection was no longer viable. Yet all participants felt they were provided with quality healthcare during the initial consultation. This positive initial experience provided a platform for continued utilisation of healthcare services. These findings support work published in the systematic review of Anhang Price *et.al.*, (2014) indicating that positive patient care experiences are associated with higher levels of adherence to treatment processes.

Participants who were provided a formal follow-up appointment using official documents, adhered to scheduled appointments. This enabler to follow-up consultations is strikingly obvious; however, it is perhaps the most critical finding of the study. It stands to reason that if a survivor is not given a follow-up appointment, they will be less likely to access the service. This barrier signified an operational gap in the healthcare service that does not

require high-level intervention. Apart from the authoritative expectations linked to a scheduled appointment, the document also expressed a tangible commitment to continuity of care. Simple implementation of providing all survivors with a formal follow-up appointment should have far-reaching influence, whilst a referral letter that is kept by the survivor can enable follow-up in a different town or with a different health authority.

This was particularly evident in the Knysna model, where all three participants given a scheduled appointment attended the follow-up consultation. The fourth participant in Knysna who did not attend follow-up was not given a return appointment date. It was anticipated that she would receive follow-up care as an integral part of her routine HIV care. However, this was not the case as the participant chose not to disclose details regarding the sexual assault to her chronic healthcare provider.

The findings suggest that survivors who were HIV-positive at the time of the assault were not prioritised for follow-up care. This prompts the question of a correlation between “overworked and unacknowledged staff”, as described in a study by Du Mont *et al.*, (2011), and the healthcare providers’ apparent prioritisation of those perceived as most in need. Faced with stressful workloads, healthcare providers may have rationalised not providing HIV-positive survivors a follow-up appointment as they assumed the survivor was already included in a chronic care system that should encompass holistic health support. Alternatively, it could be considered that healthcare staff only focused on the physical needs of the survivor and did not perceive the importance of comprehensive healthcare encompassing, physical, psychological, emotional and spiritual health.

The failure of healthcare providers to implement a holistic caring approach to patient care reflects poorly on the implementation of initiatives such as the C²AIR² values and *batho pele* principles applicable to all government employees (Western Cape Government Health, 2015. Republic of South Africa, 1997). Standard practice within a caring profession should encompass qualities of respect, competency and approachability. This was evident when participant ten, who had an established doctor–patient relationship managing her chronic illness, spoke of her unmet needs. Participant ten indicated she had a good relationship with her chronic care manager, yet he failed to provide comprehensive care by making no reference to the emotional impact of the sexual violation. The missed opportunity to combine patient needs with routine healthcare indicates a challenge in the understanding of comprehensive integrated care.

The reluctance on behalf of healthcare providers to enter into the realm of basic mental healthcare may represent a lack of confidence and a notion that mental healthcare requires

specialised intervention. Measures to address the integration of mental health into general primary healthcare are underway, with the introduction of mental health screening as a routine data indicator collected at facility level (Western Cape Government Health, 2016). Mental health has been incorporated into the *Practical Approach to Care Kit (PACK): Primary Care Guideline for Adults 2016–2017*, (Western Cape Government & Knowledge and Translation Unit UCT, 2015) a basic tool for standard care within the Western Cape. The integration of mental health in primary healthcare should encourage healthcare providers to implement a holistic approach to care, no longer viewing emotional aspects of care as strictly the function of specialists.

Howe *et al.* (2013:899) define medical generalism as “an approach to the delivery of healthcare that routinely applies a broad and holistic perspective to the patient’s problem”. Current healthcare training does not appear to be addressing the qualities of generalism or producing competency in the field. To truly implement the vision of holistic care, training, re-orientation and “up-skilling” of existing health care providers will be needed on a grand scale.

5.2.5 Community factors

Relyea and Ullman (2015:46) discussed the importance of the community’s response to sexual assault survivors, suggesting the benefits of training community members to respond to survivors in a kind and supportive manner. Participants experienced a positive community response, as community members often provided the catalyst for the survivor to access healthcare post-sexual assault. Confirmation by the community that the survivor was justified in her accusation of sexual assault provided much needed psychological support for survivors. Having the crime validated by external people legitimised the survivors’ need for care. This not only applied to validation by the community; formal police and healthcare documents provided authority that the violation was real and required further follow-up intervention.

Participants commonly experienced a negative community response to disclosure of a sexual assault. Ullman and Peter-Hagene (2016) observed that negative social reactions to sexual assault disclosure were associated with symptoms of PTSD among participating sexual assault survivors. Some clients reflected that they feared disclosure, anticipating prejudiced and judgemental reactions from the community, and thus preferred to keep silent and cope on their own. This is corroborated by the study estimating that only one out of 25 cases of sexual assault is reported to the police (Gender Links and the Medical Research Council, 2010). This indicates that the magnitude of this barrier to care is far greater than the findings of this study. Judgemental, disbelieving views expressed by the community

reinforce and thus promote stigma and blame, entrenching the connotation that the survivor is somehow responsible for the sexual violation. Altering community attitudes and interactions is, however, complex. Maximum benefit requires an all-inclusive call to action by enough members of society, backed up by legislation that is enforceable and healthcare that serves the needs of the client.

The flip side of a negative community response is overzealous action, possibly motivated by ineffectual judicial and policing systems, resulting in vigilante-style support. Some participants indicated that this was problematic, as the community action meant they not only feared for their own safety, but for those apparently responding on their behalf. To downplay or defuse the situation, they withdrew charges and in some instances relocated. Ironically, instead of assisting the survivor, this community action and apparent solidarity with survivors compromised their ability to access and utilise healthcare services.

5.2.6 Client factors

Participants appeared to respect the healthcare provider as an authority figure and accepted their judgement. This was supported by their passive compliance toward the authority figure's instruction and at times was suggestive of patriarchal relationships. Despite expressing limited knowledge or understanding of the follow-up process or possible benefits thereof, participants simply did as they were told. This attitude may reflect patriarchal relationships in a society that has been shaped by decades of apartheid rule, where unquestioning compliance with authority was expected. If the trusted healthcare provider scheduled a follow-up appointment and the participant accepted the necessity or perceived need to comply with the appointment, they attended the session.

Participants did not connect their emotional response to the sexual assault as a contributing factor when discussing barriers to follow-up. The participants were so focused on dealing with survival issues at the base of Maslow's hierarchy of needs, there was no time or energy to deal with higher issues connected to emotion. However, it was clear that participants experienced various symptoms suggestive of PTSD. In particular, the participants' inability to retain information impaired their ability to recall instructions regarding follow-up appointments and treatment management. This dissociation is supported by Mason and Lodrick (2013), suggesting extremes of retention, forgetting and even amnesia may result from the traumatic experience. This highlights the need to provide survivors with documentation detailing follow-up appointments and treatment information that they can reference as needed.

Some participants expressed how they did not feel like talking about the assault during potential follow-up consultations. However, they gave the impression that although they had not sought psychological support previously, they appreciated the opportunity to tell their story within a safe environment. The study interview did not prompt participants to share their experience of the sexual assault, focusing primarily on the enablers of and barriers to clinical follow-up. As a result, participants were in control of the content they chose to share. The reluctance on the part of the participants to explore and address emotional challenges within the six months post-assault may suggest the current system is failing to meet the mental health needs of survivors; the focus on physical health may result in the failure to equip survivors with coping techniques and emotional resilience required for complete recovery.

Some participants relocated to avoid confrontation with the alleged perpetrator or with the reminders of the traumatic event. During the sampling phase, case managers encountered survivors who had relocated to neighbouring provinces. These survivors had not notified the healthcare team, meaning they were effectively lost to follow-up services, as they had no formal transfer or referral documentation. This barrier to follow-up may be minimised by the issue of a standard referral letter to all survivors facilitating their access to healthcare facilities other than the initial referral centre. This finding informs recommendations discussed later in this chapter.

Participants expressed the need to avoid thinking about the sexual assault, employing various coping techniques to deal with their situation. This included an excessive commitment to work, maintaining functionality as a means of coping. Some clients reflected that work obligations were barriers to access and utilisation of follow-up consultations. Although employers were generally accommodating, the time spent attending follow-up consultations was deducted from participants' annual sick leave allocation. This gave rise to the dilemma of using sick leave when not feeling physically sick, as opposed to having the leave in reserve for necessities. Participants working shifts were able to request time off to coincide with scheduled appointments. This was not possible for those working normal office hours, highlighting the need to ensure follow-up consultations are patient-centred. This involves a process where healthcare providers include survivors in the decision-making process and supplement mutual decisions with the authority associated with formal documentation.

5.3 LIMITATIONS OF THE STUDY

Only survivors with registered cell phone details were included in the study, as challenges regarding confidentiality were of concern. It would have been inappropriate to trace survivors in the community without prior consent. However, the poor response and accuracy of cell phone details registered in the sexual assault register limited the sample population. Although data saturation appeared to be achieved, a range of survivors' voices was not included.

Triangulation of the study data may have been enhanced by including findings emerging from a focus group dialogue with eligible sexual assault survivors. However, this would have required specific consent and a multitude of ethical considerations primarily related to confidentiality. Future studies should consider innovative methods of increasing the sample population without compromising confidentiality.

Eligible adult male survivors were not available for participation in the study as they were incarcerated in correctional facilities. Forensic evidence collection and immediate medical care was managed by the relevant regional or district hospital. The healthcare team at the correctional facility managed follow-up care internally. As such, the inmates had minimal input into their access to and utilisation of follow-up care. For this reason, the experiences of male adult survivors are not included in the findings of this study. Although adult males form the minority of survivors in Eden, their voice is none the less valuable. Extension of the time frame post-assault may have allowed for the inclusion of adult male survivors. In terms of inmates, this finding exposes a topic worthy of further investigation.

The researcher's function as the Women's Health coordinator for Eden District allowed for intervention unrelated to the study. In response, the feedback system regarding follow-up consultations for sexual assault survivors in the relevant correctional facilities has been strengthened. Details of follow-up consultations managed by correctional service healthcare providers are submitted routinely to the hospital case manager.

No enablers related to the judicial system were identified during the interviews. Specific prompting for enablers connected to the judicial system was not pursued. The researcher found the participants had a story to tell and were happy to have a safe forum for discussion and dialogue. The challenge was to find the balance between directing the conversation according to the study objectives and being sensitive to the needs of the participant.

5.4 RECOMMENDATIONS

Based on study findings, recommendations incorporate practical suggestions for enhanced service implementation at facility level.

5.4.1 Accuracy of contact details: Sexual assault register

Current methods of tracing clients who have missed scheduled clinic appointments rely on community health workers visiting clients within their homes. This is not conducive to maintaining confidentiality, especially given the sensitivity of sexual assault. Telephonic contact provides easy, prompt and personal opportunity for dialogue between healthcare provider, case manager and survivor. Accurate contact details are imperative to this process. The standard process is for reception staff to confirm client details on admission to a facility. This step is often by-passed in the management of sexual assault; hence it becomes critical that the task is designated to the survivor's management team. Victim support counsellors, Thuthuzela Care Centre staff and medical personnel should prioritise detailing accurate contact details for survivors in the sexual assault register or database. Documented confirmation of the survivor or caregiver's permission for communication with the healthcare team would provide attention to confidentiality.

5.4.2 Provision of scheduled appointments on an official document

All survivors, regardless of HIV status, should be provided with follow-up appointments on official documentation. Healthcare providers need to embrace the principle of continuity of care by providing equal access to follow-up services for all survivors of sexual assault. This is in line with the vision of the Department of Health outlined in Healthcare 2030 and supported by the principles of *batho pele* and patients' rights (Western Cape Government health, 2014, Republic of South Africa, 1996, Republic of South Africa, 1997:15).

Appointment details recorded on the appropriate official document should consist of a specific date, time and facility. It is advisable to provide a referral to a specified healthcare practitioner; however, caution against unrealistic promises. This easily attainable recommendation should be implemented as a priority.

5.4.3 Provision and implementation of a standardised referral note

All clients should receive a written referral note that is kept by the survivor. This will facilitate access to healthcare in the event of relocation or referral to a primary health care facility. The implementation of a standardised referral note is recommended. The uniformity streamlines the documentation process for attending healthcare providers and provides

professional information enabling access to appropriate care not limited to the referral facility.

5.4.4 Inclusion of client in follow-up planning

Healthcare providers should take cognisance of the individual needs of survivors and their caregivers when deciding on follow-up plans. The date, time, facility and, where possible, preferred healthcare provider, should be decided in consultation with the client responsible, to enable access to follow-up care.

5.4.5 Standardised sexual assault data collection system

Implementation of a standardised sexual assault register or alternative data collection system in the absence of dedicated reporting indicators is recommended. This will ensure that data critical to monitoring and evaluation of the sexual assault programme is available for analysis. Information drawn from the analysis of collected data should be reviewed by the facility quality improvement forum and disseminated to all staff providing services to survivors of sexual assault.

5.4.6 Monitoring and implementation of patient-centred care

By focusing on a topic that demands the best of primary care, this study exposes some of our current deficiencies. It also emphasises the need for the whole primary healthcare system to move towards being holistic, patient-centred and comprehensive, while supporting core dimensions such as accessibility, continuity and coordination of care.

Monitoring, evaluation and implementation of this will require training and change management to ensure that every person involved with patient care implements the principles of holistic, patient-centred care. Training should not be limited to healthcare providers to increase the capacity to provide a positive patient experience at every point in the healthcare system. Communication skills and principles of confidentiality among reception staff within the primary healthcare setting should be prioritised. As the numbers involved with sexual assault follow-ups are relatively low, this may provide a useful platform where improvements can be implemented and explored in a controlled setting. Best practice identified in the primary healthcare setting should be shared with allied stakeholders, for example, police, the National Prosecuting Authority (NPA), non-governmental organisations and community leaders.

5.4.7 Future research

The following areas for future research are proposed:

Explore the knowledge and insight of comprehensive, holistic, patient-centred follow-up care post-sexual assault among healthcare providers, to inform future training of non-specialist healthcare providers.

Development of strategies and training programmes designed to address identified limitations in providing care that encompasses mental health within the primary health consultation.

Action research exploring what sexual assault survivors actually want, need and benefit from, while simultaneously changing personal practices during a process of reflection.

5.5 DISSEMINATION

As the Women's Health coordinator for Eden District, the researcher has a moral obligation to ensure the findings and recommendations of this study are presented to and discussed with the District Management Team. Principle support of the recommendations would ensure the effective implementation of suggested improvement strategies. The researcher has scheduled presentation and discussion of the research findings and recommendations at the following forums:

- Department of Health, Eden District management, inclusive of allied components; supply chain; finance; people management and professional support
- Sub-district sexual assault management teams in George, Knysna and Bitou
- George Thuthuzela team, including all stakeholders; Family Violence, Child Protection and Sexual Offences unit; Department of Education; Department of Social Development; non-governmental organisations involved in counselling and victim support

The findings will be prepared for publication and conference presentation.

5.6 CONCLUSION

This study aimed to explore survivors' perceptions on enablers of and barriers to clinical follow-up post-sexual assault, thus informing evidence-based recommendations for the improvement of access to and utilisation of related services within the Eden District. This was achieved through the analysis of personal accounts of sexual assault survivors' experiences. The findings indicate that the enablers identified by participants spoke to

practical and achievable systems, that if implemented, should have a positive impact on the ability of sexual assault survivors to access and utilise follow-up services. The primary focus centres on an interactive, participative, integrated patient-centred approach to follow-up care, in keeping with the principles of caring that are advocated by the Healthcare 2030 vision (Western Cape Government Health, 2014). Identified barriers included complex behavioural attitudes of both community and professional services, such as the police and healthcare facility personnel. Although these barriers are more difficult to remedy, they are as valuable in the process of improving care to survivors of sexual assault. Insights gained provide input to recommended strategies that may reduce some of the identified barriers and strengthen enablers, thereby improving future access for sexual assault survivors to the comprehensive healthcare package, which includes follow-up consultations.

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APPENDICES

Appendix 1: Ethical approval from Stellenbosch University



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Approval Notice

Response to Modifications- (New Application)

27-Jan-2016
Holton, Gail G

Ethics Reference #: S15/10/225

Title: Sexual assault survivors' perspectives on enablers and barriers to clinical follow-up at three facilities in the Eden district.

Dear Mrs Gail Holton,

The Response to Modifications - (*New Application*) received on 07-Dec-2015, was reviewed by members of Health Research Ethics Committee 1 via Expedited review procedures on 27-Jan-2016 and was approved.

Please note the following information about your approved research protocol:

Protocol Approval Period: 27-Jan-2016 -26-Jan-2017

Please remember to use your **protocol number** (S15/10/225) on any documents or correspondence with the HREC concerning your research protocol.

Please note that the HREC has the prerogative and authority to ask further questions, seek additional information, require further modifications, or monitor the conduct of your research and the consent process.

After Ethical Review:

Please note a template of the progress report is obtainable on www.sun.ac.za/rds and should be submitted to the Committee before the year has expired. The Committee will then consider the continuation of the project for a further year (if necessary). Annually a number of projects may be selected randomly for an external audit.

Translation of the consent document to the language applicable to the study participants should be submitted.

Federal Wide Assurance Number: 00001372

Institutional Review Board (IRB) Number: IRB0005239

The Health Research Ethics Committee complies with the SA National Health Act No.61 2003 as it pertains to health research and the United States Code of Federal Regulations Title 45 Part 46. This committee abides by the ethical norms and principles for research, established by the Declaration of Helsinki, the South African Medical Research Council Guidelines as well as the Guidelines for Ethical Research: Principles Structures and Processes 2004 (Department of Health).

Provincial and City of Cape Town Approval

Please note that for research at a primary or secondary healthcare facility permission must still be obtained from the relevant authorities (Western Cape Department of Health and/or City Health) to conduct the research as stated in the protocol. Contact persons are Ms Claudette Abrahams at Western Cape Department of Health (healthres@pgwc.gov.za Tel: +27 21 483 9907) and Dr Helene Visser at City Health (Helene.Visser@capetown.gov.za Tel:

+27 21 400 3981). Research that will be conducted at any tertiary academic institution requires approval from the relevant hospital manager. Ethics approval is required BEFORE approval can be obtained from these health authorities.

We wish you the best as you conduct your research.

For standard HREC forms and documents please visit: www.sun.ac.za/rds

If you have any questions or need further assistance, please contact the HREC office at 0219389657.

Included Documents:

Declaration R Mash
20151208 MOD Protocol
Declaration G Holton
Consent form
20151208 MOD Application form
Checklist
Conflict of interest statement G Holton
Application form
Protocol
20151208 MOD Protocol Synopsis
Request to Director Health Eden District
Child assent form
20151208 MOD Application form signature page
Declaration K Joyner
20151208 MOD Cover letter
Application form_Signature page
CV R Mash
CV K Joyner
Protocol Synopsis
CV G Holton

Sincerely,

Franklin Weber
HREC Coordinator
Health Research Ethics Committee 1

Investigator Responsibilities

Protection of Human Research Participants

Some of the responsibilities investigators have when conducting research involving human participants are listed below.

1. Conducting the Research. You are responsible for making sure that the research is conducted according to the HREC approved research protocol. You are also responsible for the actions of all your co-investigators and research staff involved with this research.

2. Participant Enrolment. You may not recruit or enrol participants prior to the HREC approval date or after the expiration date of HREC approval. All recruitment materials for any form of media must be approved by the HREC prior to their use. If you need to recruit more participants than was noted in your HREC approval letter, you must submit an amendment requesting an increase in the number of participants.

3. Informed Consent. You are responsible for obtaining and documenting effective informed consent using **only** the HREC-approved consent documents, and for ensuring that no human participants are involved in research prior to obtaining their informed consent. Please give all participants copies of the signed informed consent documents. Keep the originals in your secured research files for at least fifteen (15) years.

4. Continue Review. The HREC must review and approve all HREC-approved research protocols at intervals appropriate to the degree of risk but not less than once per year. There is no grace period. Prior to the date on which the HREC approval of the research expires, it is your responsibility to submit the continuing review report in a timely fashion to ensure a lapse in HREC approval does not occur. If HREC approval of your research lapses, you must stop new participant enrolment, and contact the HREC office immediately.

5. Amendments and Changes. If you wish to amend or change any aspect of your research (such as research design, interventions or procedures, number of participants, participant population, informed consent document, instruments, surveys or recruiting material), you must submit the amendment to the HREC for review using the current Amendment Form. You may not initiate any amendments or changes to your research without first obtaining written HREC review and approval. The only exception is when it is necessary to eliminate apparent immediate hazards to participants and the HREC should be immediately informed of this necessity.

6. Adverse or Unanticipated Events. Any serious adverse events, participant complaints, and all unanticipated problems that involve risks to participants or others, as well as any research-related injuries, occurring at this institution or at other performance sites must be reported to the HREC within five (5) days of discovery of the incident. You must also report any instances of serious or continuing problems, or non-compliance with the HRECs requirements for protecting human research participants. The only exception to this policy is that the death of a research participant must be reported in accordance with the Stellenbosch University Health Research Ethics Committee Standard Operating Procedures www.sun025.sun.ac.za/portal/page/portal/Health_Sciences/English/Centres%20and%20Institutions/Research_Development_Support/Ethics/Application_package. All reportable events should be submitted to the HREC using the Serious Adverse Event Report Form.

7. Research Record Keeping. You must keep the following research-related records, at a minimum, in a secure location for a minimum of fifteen years: the HREC approved research protocol and all amendments; all informed consent documents; recruiting materials; continuing review reports; adverse or unanticipated events; and all correspondence from the HREC.

8. Reports to the MCC and Sponsor. When you submit the required annual report to the MCC or you submit required reports to your sponsor, you must provide a copy of that report to the HREC. You may submit the report at the time of continuing HREC review.

9. Provision of Emergency Medical Care. When a physician provides emergency medical care to a participant without prior HREC review and approval, to the extent permitted by law, such activities will not be recognised as research nor will the data obtained by any such activities should it be used in support of research.

10. Final reports. When you have completed (no further participant enrolment, interactions, interventions or data analysis) or stopped work on your research, you must submit a Final Report to the HREC.

11. On-Site Evaluations, MCC Inspections, or Audits. If you are notified that your research will be reviewed or audited by the MCC, the sponsor, any other external agency or any internal group, you must inform the HREC immediately of the impending audit/evaluation.

Appendix 2: Permission obtained from institutions/Department of Health



STRATEGY & HEALTH SUPPORT
Health.Research@westerncape.gov.za
tel: +27 21 483 6857; fax: +27 21 483 989
5th Floor, Norton Rose House, 8 Riebeeck Street, Cape Town, 800
www.capegateway.gov.za

REFERENCE: WC_2016RP56_169
ENQUIRIES: Ms Charlene Roderick

University of Stellenbosch
Private Bag X1
Malland
7602

For attention: Dr Kate Joyner, Prof Robert Mash and Mrs Gail Holton

Re: **SEXUAL ASSAULT SURVIVORS' PERSPECTIVES ON ENABLERS AND BARRIERS TO CLINICAL FOLLOW-UP AT THREE FACILITIES IN THE EDEN DISTRICT.**

Thank you for submitting your proposal to undertake the above-mentioned study. We are pleased to inform you that the department has granted you approval for your research. Please contact the following people to assist you with any further enquiries in accessing the following sites:

George Hospital Michael Vonk Contact No: 044 802 4534

Kindly ensure that the following are adhered to:

1. Arrangements can be made with managers, providing that normal activities at requested facilities are not interrupted.
2. Researchers, in accessing provincial health facilities, are expressing consent to provide the department with an electronic copy of the final feedback (**annexure 9**) within six months of completion of research. This can be submitted to the provincial Research Co-ordinator (Health.Research@westerncape.gov.za).
3. In the event where the research project goes beyond the estimated completion date which was submitted, researchers are expected to complete and submit a progress report (**Annexure 8**) to the provincial Research Co-ordinator (Health.Research@westerncape.gov.za).
4. The reference number above should be quoted in all future correspondence.

Yours sincerely

DR A HAWKRIDGE
DIRECTOR: HEALTH IMPACT ASSESSMENT
DATE: 2/3/2016.
CC: H SCHUMANN

DIRECTOR: EDEN & CENTRAL KAROO



Western Cape
Government

Health

STRATEGY & HEALTH SUPPORT

Health.Research@westerncape.gov.za
tel: +27 21 483 6857; fax: +27 21 483 9895
5th Floor, Norton Rose House, 8 Riebeeck Street, Cape Town, 8001
www.capegateway.gov.za

REFERENCE: WC_2016RP56_169
ENQUIRIES: Ms Charlene Roderick

University of Stellenbosch
Private Bag X1
Maitland
7602

For attention: **Dr Kate Joyner, Prof Robert Mash and Mrs Gail Holton**

Re: **SEXUAL ASSAULT SURVIVORS' PERSPECTIVES ON ENABLERS AND BARRIERS TO CLINICAL FOLLOW-UP AT THREE FACILITIES IN THE EDEN DISTRICT.**

Thank you for submitting your proposal to undertake the above-mentioned study. We are pleased to inform you that the department has granted you approval for your research. Please contact the following people to assist you with any further enquiries in accessing the following sites:

Knysna Hospital **E J du Plooy** **Contact No: 044 302 8405**

Kindly ensure that the following are adhered to:

1. Arrangements can be made with managers, providing that normal activities at requested facilities are not interrupted.
2. Researchers, in accessing provincial health facilities, are expressing consent to provide the department with an electronic copy of the final feedback (**annexure 9**) within six months of completion of research. This can be submitted to the provincial Research Co-ordinator (Health.Research@westerncape.gov.za).
3. In the event where the research project goes beyond the *estimated completion date* which was submitted, researchers are expected to complete and submit a progress report (**Annexure 8**) to the provincial Research Co-ordinator (Health.Research@westerncape.gov.za).
4. The reference number above should be quoted in all future correspondence.

Yours sincerely


DR A HAWKRIDGE
DIRECTOR: HEALTH IMPACT ASSESSMENT
DATE: 12/4/2016.
CC: H SOHUMANN

DIRECTOR: EDEN & CENTRAL KAROO



STRATEGY & HEALTH SUPPORT
Health.Research@westerncape.gov.za
tel: +27 21 483 6857; fax: +27 21 483 9895
5th Floor, Norton Rose House, 8 Riebeeck Street, Cape Town, 8001
www.westerncape.gov.za

REFERENCE: WC_2016RP56_169
ENQUIRIES: Ms Charlene Roderick

Stellenbosch University
Private Bag x1
Matieland
7602

For attention: Dr Kate Joyner, Prof Robert Mash, Mrs Gail Holtan

Re: **Sexual assault survivors' perspectives on enablers and barriers to clinical follow-up at three facilities in the Eden district.**

Thank you for submitting your proposal to undertake the above-mentioned study. We are pleased to inform you that the department has granted you approval for your research.

Please contact the following people to assist you with any further enquiries in accessing the following sites:

Mosselbay Hospital Jaco Bolma 044 691 2011

Kindly ensure that the following are adhered to:

1. Arrangements can be made with managers, providing that normal activities at requested facilities are not interrupted.
2. Researchers, in accessing provincial health facilities, are expressing consent to provide the department with an electronic copy of the final feedback (**annexure 9**) within six months of

completion of research. This can be submitted to the provincial Research Co-ordinator (Health.Research@westerncape.gov.za).

3. In the event where the research project goes beyond the *estimated* completion date which was submitted, researchers are expected to complete and submit a progress report (**Annexure 8**) to the provincial Research Co-ordinator (Health.Research@westerncape.gov.za).
4. The reference number above should be quoted in all future correspondence.

Yours sincerely

DR A HAWKRIDGE
DIRECTOR: HEALTH IMPACT ASSESSMENT

DATE: 7/6/2016.

**Appendix 3: Participant information leaflet and declaration of consent by
participant and investigator**



PARTICIPANT INFORMATION LEAFLET AND ASSENT FORM



TITLE OF THE RESEARCH PROJECT:

**Sexual assault survivors' perspectives on enablers of and barriers to clinical
follow-up at three facilities in the Eden District**

RESEARCHERS NAME: Gail Holton

**ADDRESS: Nursing Division
P.O Box 19063
Tygerberg 7505**

CONTACT NUMBER: 0823783816

WHAT IS RESEARCH?

Research is something we do to find new knowledge about the way things (and people) work. We use research projects or studies to help us find out more about people's experiences and find better ways of helping, or treating them.

WHAT IS THIS RESEARCH PROJECT ALL ABOUT?

This research study involves conversations with people who have experienced sexual assault. The aim is to hear what type of things help or hinder their ability to go to follow up consultations at the hospital or clinic. This is important information for the healthcare staff to use when trying to improve the services available for future survivors of sexual assault.

WHY HAVE I BEEN INVITED TO TAKE PART IN THIS RESEARCH PROJECT?

YOU HAVE BEEN INVITED TO TAKE PART IN THIS STUDY BECAUSE YOU HAVE EXPERIENCED WHAT IT IS LIKE TO BE A SURVIVOR WHO HAS BEEN ASKED TO RETURN TO THE HOSPITAL OR CLINIC FOR FOLLOW-UP. YOU WILL BE ABLE TO TELL US WHAT THINGS HELPED OR HINDERED YOUR ABILITY TO GET TO THE FOLLOW UP VISITS.

WHO IS DOING THE RESEARCH?

My name is Gail Holton, I will be doing the interviews and writing the report for the study. I work for the Department of Health as the sister looking after the Women's Health programmes for Eden District. This study is part of what I have to do to pass a course at university. The study will help me to be able to make suggestions on how to improve the service for survivors in the Eden District. If you would like to speak to me in Afrikaans or Xhosa there will someone available who can translate.

WHAT WILL HAPPEN TO ME IN THIS STUDY?

If you choose to participate in the study we will have a conversation where I will ask you to tell me about some of the things you experienced in connection with follow up visits at the hospital or clinic after the assault. The interview will be recorded so that later I can write up exactly what you have told me, making sure it is a true reflection of your experience. Once the conversation has been written down the recording will be deleted and your real name will not be used to make sure your information stays private.

CAN ANYTHING BAD HAPPEN TO ME?

I do not expect anything bad to happen to you but it may make you sad as you remember things about the sexual assault during our conversation. If you feel you cannot cope with these feelings, you may choose to stop the conversation at any stage. I can also refer you to a counsellor who is specially trained to help you cope with these feelings if you would like.

CAN ANYTHING GOOD HAPPEN TO ME?

The main aim of the study is to help future survivors of sexual assault but you may find it makes you feel good to have a safe place to talk about your experience.

WILL ANYONE KNOW I AM IN THE STUDY?

Because you are under 18 years old your parent has to give permission for you to take part in the study so they will know. If you choose to use the translator she will also know. Any information you tell us will be kept private and we will not use your real name so no one will be able to identify you from the report.



WHO CAN I TALK TO ABOUT THE STUDY?

Researcher: Gail Holton 0823783816

Health Research Committee 021 9389207

WHAT IF I DO NOT WANT TO DO THIS?

You do not have to take part in this study if you do not want to. You can also choose to stop taking part at any stage, even if we have started with the interview.

Do you understand this research study and are you willing to take part in it?

YES

NO

Has the researcher answered all your questions?

YES

NO

Do you understand that you can pull out of the study at any time?

YES

NO

Signature of Child

Date

PARTICIPANT INFORMATION LEAFLET AND CONSENT FORM

TITLE OF THE RESEARCH PROJECT:

Sexual assault survivors' perspectives on enablers of and barriers to clinical follow-up at three facilities in the Eden District

REFERENCE NUMBER: HREC: S15/10/225
PGWC: WC-2016-RP56-169

PRINCIPAL INVESTIGATOR: Gail Holton

ADDRESS: Division of Nursing
P.O Box 19063
Tygerberg 7505

CONTACT NUMBER: 0823783816

You are being invited to take part in a research project. Please take some time to read the information presented here, which will explain the details of this project. Please ask the study staff any questions about any part of this project that you do not fully understand. It is very important that you are fully satisfied that you clearly understand what this research entails and how you could be involved. Also, your participation is **entirely voluntary** and you are free to decline to participate. If you say no, this will not affect you negatively in any way whatsoever. You are also free to withdraw from the study at any point, even if you do agree to take part.

This study has been approved by the Health Research Ethics Committee at Stellenbosch University and will be conducted according to the ethical guidelines and principles of the international Declaration of Helsinki, South African Guidelines for Good Clinical Practice and the Medical Research Council (MRC) Ethical Guidelines for Research.

WHAT IS THIS RESEARCH STUDY ALL ABOUT?

This study aims to listen to what sexual assault survivors feel helps or hinders their ability to attend follow-up consultations as requested by the healthcare provider.

The information provided by the study participants will be used for obtaining a further qualification and may be used to improve the service for future sexual assault survivors in Eden District.

Study participants will have registered a sexual assault at Knysna, Mossel Bay or George provincial hospitals. The hospital case manager will have asked your permission for the researcher of this study to contact you. It is anticipated that a minimum of four participants from each hospital will take part in the study.

If you agree to take part in the study Gail Holton (principal researcher) will interview you in person. The interview will be recorded to make sure we are able to recall your words accurately. Once we have written down what was said in the interview the tapes will be deleted and your name will not be used in the report. This is to make sure you cannot be identified.

The interview will be in English but if you would like to express yourself in Afrikaans or Xhosa a translator will be available. You can choose whether she is part of the interview or not. It is expected that the interview may last up to one hour. The interviewer and the translator are trained to keep information private.

If you agree to take part in the interview you may stop the session and withdraw from the study at any time in the process. If the interview process causes undue distress the interviewer may end the session and facilitate referral to the appropriate healthcare service. Should the interviewer feel you would benefit from or if you request, additional counselling can be arranged with an experienced counsellor.

The study has received some funding from the National Research Foundation. The principal investigator is employed as the nursing sister managing women's health programmes in Eden District. This means she is interested in exploring ways of improving the service offered within the programme and is in a good position to make sure the findings of the study are used effectively.

WHY HAVE YOU BEEN INVITED TO PARTICIPATE?

You have been invited to participate in this study because you have personally experienced sexual assault and received care from the health services. Because of this experience you will be able to provide the researcher with valuable information that may help improve the healthcare service for future survivors.

WHAT WILL YOUR RESPONSIBILITIES BE?

If you agree to participate you will have a responsibility to describe your perspectives of what helps and what hinders attendance at clinical follow-up accurately and honestly.

Will you benefit from taking part in this research?

Although the benefit of this study is aimed at future survivors of sexual assault you may find the experience of being listened to or referred to an experienced counsellor helps you deal with difficult feelings.

ARE THERE RISKS INVOLVED IN YOUR TAKING PART IN THIS RESEARCH?

You may find the interview process brings back memories of the assault that you find difficult. If this is too difficult you can choose to withdraw from the interview or you may prefer to be referred to an experienced counsellor to continue sessions afterwards. Participating or withdrawing from the study will not affect the treatment or counselling available to you at your health facility.

IF YOU DO NOT AGREE TO TAKE PART, WHAT ALTERNATIVES DO YOU HAVE?

Should you choose not to take part in the study you can still access medical treatment and counselling as normal without any repercussion.

WHO WILL HAVE ACCESS TO YOUR INTERVIEW RECORDS?

The information provided during the interview will be kept private and held in a safe place. The information will be used to write a report as part of a Master Degree. It may also be used in a publication. Your name will not be used in any report. This is to protect your identity. Only the researcher, immediate supervisor and professional colleagues who check that the report is accurate will have access to the interview information.

WHAT WILL HAPPEN IN THE UNLIKELY EVENT OF SOME FORM OF INJURY OCCURRING AS A DIRECT RESULT OF YOUR TAKING PART IN THIS RESEARCH STUDY?

IT IS NOT ANTICIPATED THAT ANY FORM OF INJURY MAY RESULT BECAUSE OF YOUR PARTICIPATION IN THE STUDY. IN THE UNLIKELY EVENT THAT AN INJURY DOES OCCUR THE PRINCIPLE RESEARCHER WILL ARRANGE FOR TREATMENT VIA THE HOSPITAL FACILITY WHERE YOU ARE REGISTERED AS A PATIENT.

WILL YOU BE PAID TO TAKE PART IN THIS STUDY AND ARE THERE ANY COSTS INVOLVED?

No, you will not receive any payment to take part in the study. You will receive R 50 to cover your transport costs to and from the interview session. You will receive liquid refreshments (tea or coffee) during the interview.

IS THERE ANYTHING ELSE THAT YOU SHOULD KNOW OR DO?

- You can contact **Gail Holton** at tel **0823783816** if you have any further queries or encounter any problems.
- You can contact the Health Research Ethics Committee at 021-938 9207 if you have any concerns or complaints that have not been adequately addressed by your study investigator.
- You will receive a copy of this information and consent form for your own records.

Declaration by participant

By signing below, I agree to take part in a research study entitled **Sexual assault survivors' perspectives on enablers of and barriers to clinical follow-up at three facilities in the Eden District.**

I declare that:

- I have read or had read to me this information and consent form and it is written in a language with which I am fluent and comfortable.
- I have had a chance to ask questions and all my questions have been adequately answered.
- I understand that taking part in this study is **voluntary** and I have not been pressurised to take part.
- I may choose to leave the study at any time and will not be penalised or prejudiced in any way.
- I may be asked to leave the study before it has finished, if the study doctor or researcher feels it is in my best interests, or if I do not follow the study plan, as agreed to.

Signed at (*place*) on (*date*) 2016.

.....
Signature of participant

.....
Signature of witness

Declaration by investigator

I (*name*) declare that:

- I explained the information in this document to
- I encouraged him/her to ask questions and took adequate time to answer them.
- I am satisfied that he/she adequately understands all aspects of the research, as discussed above
- I did/did not use an interpreter. (*If an interpreter is used then the interpreter must sign the declaration below.*)

Signed at (*place*) on (*date*) 2005.

.....
Signature of investigator

.....
Signature of witness

Declaration by interpreter

I (*name*) declare that:

- I assisted the investigator (*name*) to explain the information in this document to (*name of participant*) using the language medium of Afrikaans/Xhosa.
- We encouraged him/her to ask questions and took adequate time to answer them.
- I conveyed a factually correct version of what was related to me.
- I am satisfied that the participant fully understands the content of this informed consent document and has had all his/her question satisfactorily answered.

Signed at (*place*) on (*date*)

.....
Signature of interpreter

.....
Signature of witness

Appendix 4: Interview guideline

Open the interview with an introduction of the role-players involved in the interview including the availability of the interpreter should they request her input.

Thank the survivor for participating in the study.

Explain the purpose of the study, reason and process of obtaining informed consent.

Explain that the interview will be recorded and later transcribed. Ensure the participant understands and is comfortable with the measures in place to protect confidentiality.

Engage in non-threatening dialogue to set the tone for the main body of the interview.

Once participant is comfortable introduce questions related to the research topic.

- “After you were sexually assaulted, you went to the hospital for an examination and care. Please tell me how you experienced this consultation.”
- Probe: What were your feelings at this time?
- “What information can you remember being told by the healthcare staff?”
- Probe: Can you remember being told to return somewhere for follow-up? (This will only be used as a last resort to probe for important data if she/he has not remembered.)
- “Were there certain things that helped you to return to the hospital/clinic for follow-up care? Please tell me about the kind of things that helped you.”
- “Please help me to understand some of the things that made it difficult for you to return for your follow-up consultations.”
- “From what you told me at the beginning of the interview, I understand you had a positive/negative experience of the care you received at that first consultation. Please tell me how this experience influenced your decision to attend follow-up consultations.”
- “If you could list one thing that you felt would really help you to get to the follow-up sessions, what would that be?”

Close the interview by thanking the participant. Acknowledge that the interview process may have brought memories and feelings to the surface but that you hope the participant experienced the interview positively, allowing self-expression within a safe environment. Offer to arrange for follow-up consultations with support from a counsellor or further medical management.

Provide all participants with relevant contact details for support services within the area.

Appendix 5: Confidentiality agreement with translator

CONFIDENTIAL INFORMATION AND NON DISCLOSURE AGREEMENT

Entered into between

GAIL ALLISON HOLTON
(as Researcher)

and

Boarwe G. Skofa
(Identity Number *6717240910087*)
of *Kayana*
(as Research Assistant)

1. THE PARTIES

This agreement is made and entered into by and between the above parties, both professional persons, engaged in the conduct of academic research.

The Research Assistant will, in her capacity as such, be privy to confidential information, from differing sources, including that of independent third parties.

2. CONFIDENTIALTY AND NON DISCLOSURE

- 2.1. The parties agree to abide the professional ethics applicable to their respective professions throughout their involvement with this project and thereafter and to treat such information as confidential, at all times; and
- 2.2. The Research Assistant specifically undertakes not to disclose to any person, unless strictly required for the purposes hereof and then only with the prior consent of the Researcher, any information made available to her by any person interviewed by them or otherwise.

Dated at *Kayana* on this *2* day of *2 April* 2016

Gail Allison Holton
.....
Researcher

Boarwe G. Skofa
.....
Research Assistant

Appendix 6: Extract of transcribed interview: Participant three

GH: And what helped her to get to sister [name withheld]? Was there something that helped her, like because she had a letter or because she had a date? Or her aunt helped her to get there and reminded her?

R: She went there because she was curious; she wanted to hear what sister [name withheld] was going to say to her.

GH: So she went because she wanted to hear what the person was going to say.

R: Yes.

GH: Or she went because she wanted to hear the results of the blood test.

R: She says she went there just to hear what sister [name withheld] was going to say, because the doctor didn't tell her what sister was going to say. And also, no, she didn't go there because of the blood results.

GH: So she was just interested to hear what sister was going to say.

R: Yes.

GH: Was there something she was expecting sister [name withheld] to tell her?

R: No.

GH: She was just curious to hear.

R: She was just curious to hear.

GH: Was there something that made it difficult for her to go to that appointment?

R: There were no difficulties.

GH: No difficulties with work?

R: She had to go to work as well that day, but she told herself that she was going to go to sister [name withheld] first and then work.

GH: So she could organise her things.

R: Yes, she organised her things.

GH: And it was an easy place for her to go to? No problems?

R: Yes, it was easy for her to get there.

GH: Was it better for her to be able to go there or back to the hospital?

R: She went there because the doctor told her to go to the clinic, so that is why she went there.

Appendix 7: Case manager consent for researcher to contact participants**STUDY TITLE**

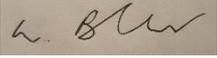
Sexual assault survivors' perspectives on enablers of and barriers to clinical follow-up at three facilities in the Eden District

**George Hospital/Knysna Hospital/Mossel Bay Hospital
Details of telephonic consent providing permission for contact regarding participation in study:**

Date	Time	Date of assault	Client name	Contact number	Permission granted	Case manager signature

Appendix 8: Declaration by language and technical editors

I, Natalie Bell, professional editor, hereby declare that I provided copyediting and proofreading services for this thesis, focusing on grammar, usage, spelling, punctuation and other mechanics of style. I have not added my own content or adjusted the author's intended meaning in any way.

Signed:  Date: 26 August 2016 At: Cape Town

Natalie Bell

Editor

Appendix 9: Summary: Western Cape Department of Health Circulars

H2-2006: Management of survivors of rape, sexual assault and child abuse

H68-2006: Management of survivors of rape and sexual assault (adults)

These circulars provide guidelines for the management and technical aspects of forensic evidence collection. The principles of management include:

- The right for all cases to be treated respectfully and afforded a thorough examination.
- Clients may not be turned away; everyone has the right to medical treatment regardless of their decision to open a police case.
- All cases require informed consent prior to the forensic examination (SAPS S308 form).
- Detailed account of J88 legal document which provides a detailed record of the clinical findings of the medical / forensic examination.
- The provision of consent for a third party to testify using the original J88 report should the original healthcare provider be unavailable (Affidavit 212(4) form).
- The guideline directs the implementation and access to PEP at all facilities managing sexual assault.
- The guideline recommends the provision of a seven-day supply of PEP with the balance to be collected at one-week check-up. However, at the discretion of the service provider the full twenty-eight-day regime may be supplied if there are considered to be logistical barriers hindering the client's ability to attend follow-up at one week.
- The provision of three follow-up sessions at intervals of, one week, six weeks and three months post sexual assault.
- Follow-up forms provide guidelines to the minimum requirements at each session. One-week follow-up recommends PEP adherence and side effect check and review completion of sexually transmitted infection medication if issued. Six-week follow-up recommends, review completion of PEP, HIV rapid test, pregnancy test if necessary. Three-month follow-up recommendation includes final HIV rapid test and pregnancy test if necessary.

H77-2014: New guidelines on post-exposure prophylaxis for adults

PEP regimes to be used for eligible clients i.e. those presenting within 72 hours of the sexual assault are detailed in this circular. PEP regimes are divided into high and low risk categories. High risk exposure constitutes exposure to any one of the following; multiple perpetrators, anal penetration, obvious trauma to the genitalia and/or a known HIV positivity of one of the perpetrators. Survivors falling into the high risk exposure category are prescribed a three drug antiretroviral regime for 28 days. Survivors considered having low risk exposure to HIV are prescribed a two drug antiretroviral combination. One perpetrator, vaginal penetration only and no visible genital trauma are categorised as low risk exposure to HIV during sexual assault. The guideline makes no mention of providing PEP starter packs (seven days) as in H 68-2006.

H123-2014: New guidelines for paediatric post-exposure prophylaxis (PEP) for HIV and Hepatitis

This circular outlines a three-drug antiretroviral regime for twenty-eight days prescribed to all children exposed via sexual assault presenting within 72 hours of the exposure. The circular includes dose according to weight tables for use when prescribing antiretroviral drugs for children.