UNTREATED VIOLENCE:

The Need for Patient-Centred Care for Survivors of Sexual Violence in the Platinum Mining Belt

MEDECINS SANS FRONTIERES
DOCTORS WITHOUT BORDERS

Untreated Violence: The Need for Patient-Centred Care for Survivors of Sexual Violence in the Platinum Mining Belt

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DEFINITIONS USED IN THE REPORT [i]

During a 2015 survey conducted by Doctors Without Borders/Médecins Sans Frontières (MSF) in Rustenburg Local Municipality, South Africa, women aged 18-49 were asked about their experiences of the following forms of behaviour:

SEXUAL VIOLENCE (SV)

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

- **Rape:** forced sexual intercourse or sexual act performance perpetrated against a person and without that person's consent, **by a non-partner and/or any current or prior sexual partner.**

INTIMATE PARTNER VIOLENCE (IPV)

Refers to any **behaviour within an intimate relationship** that causes physical, psychological or sexual harm to those in the relationship. Types of intimate partner violence include:

- **Physical Intimate Partner Violence (P-IPV):** intentional use of physical force with the potential for causing death, disability, injury, or harm.
- **Sexual Intimate Partner Violence (S-IPV):** forced sexual intercourse or performance of unwanted sexual act(s), sexual intercourse or sexual acts out of fear, and/or being forced to perform a sexual act that was degrading or humiliating.
- **Emotional Intimate Partner Violence (E-IPV):** use of verbal and non-verbal communication with the intent to harm another person mentally or emotionally.
- **Controlling behaviours (CB):** isolating a person from family and friends; monitoring their movements; and restricting access to financial resources, employment, education or medical care.

Kgomotso Care Centre

EXECUTIVE SUMMARY

This brief provides a snapshot of the findings of a survey conducted by Doctors Without Borders/ Médecins Sans Frontières (MSF) in November-December 2015, among women in Rustenburg Local Municipality, in the heart of the platinum mining belt in North West Province. The survey found that one in four women living in Rustenburg has been raped in her lifetime, and approximately half have been subject to some form of sexual violence or intimate partner violence—shocking but not uncommon statistics in South Africa.

In line with the South African Constitution, MSF works to ensure that all survivors of sexual violence have access to emergency medical care and psychosocial support. Services for survivors should be of high-quality, and accessible at the primary health care level.

Yet, survey findings suggest that survivors do not report incidents of sexual violence to health facilities. Women's responses also suggest low levels of treatment literacy about how a basic package of care can prevent HIV and mitigate other potential health consequences of rape.

Survivors of sexual violence face numerous other barriers to seeking care--stigma within communities is high, and options are few for accessing well-resourced, dedicated sexual violence health services.

There is urgent need to improve access to medical services for sexual violence survivors, and provide a more patient-centred response to sexual violence—both in Rustenburg, and across South Africa.

Shifting from widespread stigma and untreated violence to the practice of seeking and providing care will prevent unnecessary infections of HIV and other sexually transmitted diseases, and limit unwanted pregnancies. At the same time, improved access to services will provide psychosocial support and facilitate the process of seeking legal recourse for those who choose to do so.

As South Africa finalizes a new five-year National Strategic Plan for HIV, TB and STIs, government departments must ensure they adequately support survivors to receive prevention and treatment services, and manage other detrimental impacts of sexual violence on individual and national health and wellbeing.

"For many women, sexual violence has become part of their daily lives. Violence is routine."

Rosina Palai, Community Health Worker

MSF ACTIVITIES IN BOJANALA PLATINUM DISTRICT

Since July 2015, and in cooperation with the North West Province Department of Health (DOH), MSF has worked in the Rustenburg Local Municipality of Bojanala Platinum District, providing patient-centred medical and psychosocial care to survivors of sexual violence. This project started in response to perceived high rates of sexual violence and difficulties faced by survivors in accessing care in the platinum mining belt.

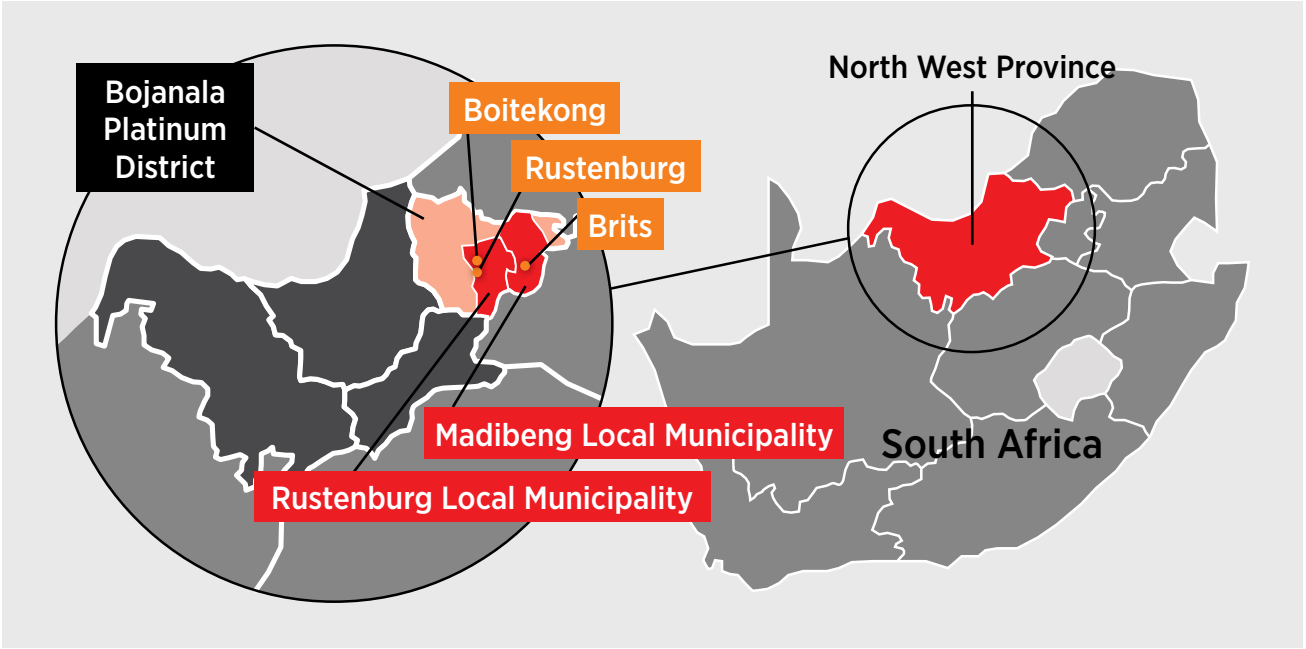
MSF supports the DOH in running the Kgomotso Care Centre (KCC) in Boitekong, which provides patient-centred care for survivors of sexual violence (SV), including for rape, intimate partner violence (IPV) and other forms of domestic violence. The model of care offered at KCC emphasizes the importance of addressing the survivor's medical and psychosocial needs first. Survivors are offered a forensic examination at the time of presentation, so they may pursue the judicial process at a later stage if they wish to do so. KCC staff includes a dedicated forensic nurse, counsellor and social worker to ensure that survivors have timely access to comprehensive care.

MSF will extend its support to Bapong and Letlhabile community health centres in Madibeng Local Municipality from August 2016, to increase the capacity of these facilities to provide comprehensive patient-centred care for survivors of sexual and intimate partner violence. As part of this strategy to improve will increase access to quality care, clinical mentorship will be provided to professional nurses working in these facilities.

MSF has observed a gap in the number of health care professionals who are trained in providing services - including forensic examination - for survivors of rape and other forms of sexual violence. This gap is due in part to a lack of rapid training options for health care staff to learn about the components of high-quality care for sexual violence. MSF has therefore with the DOH and other partners in the district embarked on piloting a clinical mentorship programme for professional nurses in the care and management of survivors of sexual and domestic violence.

Professional nurses in the programme are provided with two weeks' training in a course endorsed by the National DOH called: *Caring for Survivors of Sexual Assault and Rape: a Training Programme for Health Care Providers in South Africa*.[ii] Once professional nurses have completed the course, a six-month clinical mentorship follows. The system offers practical training and consultation to foster professional development of mentees to deliver high-quality care for survivors. Furthermore, the programme identifies mentored staff that can be trained as trainers, to promote sustainability and support further scale-up of the model by DOH in the future.

MSF and the DOH depend on close partnerships with the Thuthuzela Care Centre (TCC); Family Violence, Child Protection and Sexual Offences Unit (FCS); South African Police Service (SAPS); Department of Social Development (DSD); National Prosecuting Authority (NPA); and the Victim Empowerment Forum (VEP). Together with active health promotion activities in the district and regular engagement with the community, these partnerships are intended to ensure as many survivors as possible receive medical attention following incidents of sexual violence, and are appropriately referred to other social or legal services.



Living and Working in the Platinum Mining Belt

The local economy around Rustenburg is fuelled by the extraction of platinum-group metals from the world's largest repository, the Bushveld Igneous Complex. Accounting for 68% of Rustenburg's economy, around 50% of people living in the area rely on the mines for their direct employment. The potential of finding work in and around the mines has contributed to exponential growth of the population of Rustenburg, which increased by 78% between 1996 and 2011, from 308 903 to 549 575 people.[iii] Health care coverage in Rustenburg is low compared to the high concentration of people who live and work in the area.[iv]

Unlike in the rest of South Africa, the bulk (55%) of people living in Rustenburg are men.[v] This is due in part to men making up the overwhelming majority (~89 %) of mineworkers, many of whom come from rural areas of South Africa and surrounding countries.[vi, vii] However, Rustenburg also attracts many women from across South Africa and abroad who hope to benefit from the local mining economy in the platinum belt. Unemployment is particularly high for migrant women, creating conditions that promote dependency on men who are more readily employed by mines in the area.[viii]

The presence of mines creates economic growth for some, but - at the same time - many who migrate to the mining areas in hopes of finding work are unsuccessful, or receive low levels of remuneration. Consequently, a large number of informal settlements have developed around the mines in recent years, many of which are characterised by "grim poverty, the absence of government services, limited basic infrastructure, no running water and poor sanitation".[viii] As a result, the communities that live alongside one of South Africa's biggest industries are particularly vulnerable to violence, financial dependence on others and disease.

SEXUAL VIOLENCE SURVEY OF RUSTENBURG WOMEN

Between November and December 2015, MSF conducted a household survey in Rustenburg Municipality. Women, aged 18 – 49 were randomly selected for participation and the survey was designed so that the findings would represent all women living in the area.

The survey aimed to:

- **Quantify the prevalence of rape**
- **Describe the knowledge and perceptions of rape and intimate partner violence**
- **Describe the awareness of and access to services and perceived barriers to accessing care**

MSF received responses from more than 80% of eligible women, with over 800 women participating. Of women surveyed, only 30% had lived in Rustenburg since birth. South African citizens comprised more than 90% of women, with others primarily hailing from neighboring countries in the region.

ROUTINE SEXUAL VIOLENCE

The survey gathered information about rape and physical intimate partner violence (P-IPV) with past partners, as well as non-partner rape. It also asked for detailed information about intimate partner violence (IPV)— sexual, physical and/or emotional— experienced with the participants' current or most recent partners. Given the operational focus of MSF in providing emergency medical and psychosocial care to survivors of sexual violence, this section of the report only focuses on sexual and physical violence perpetrated against women.

49% of women reported experiences of at least one of the following:

- **Physical or sexual IPV**
- **Rape by a non-partner**

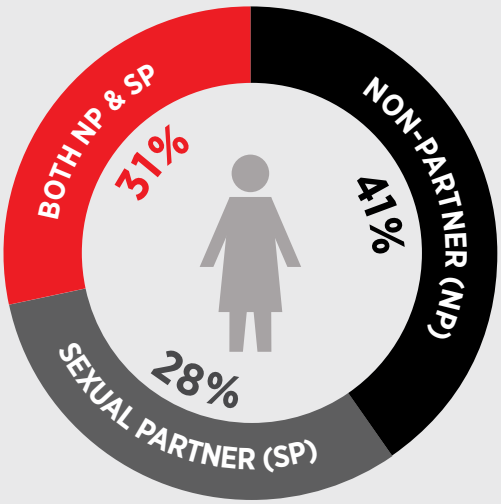
This may under-estimate actual lifetime experiences of sex and gender-based violence because it does not include emotional or non-rape sexual violence experienced with all sexual partners.

Rape

Survey findings suggest that rape is highly prevalent in Rustenburg. **One in four women surveyed had been raped in their lifetime.** Extrapolating this statistic to the population level, **approximately 50 000 women and girls in Rustenburg Local Municipality have experienced rape in their lifetime.**

Of those who had reported being raped, 40.5% of women stated they had been raped by a non-partner only, 28.2% by a sexual partner only and 31.2% had experienced rape by both a non-partner and sexual partner over the course of their lifetime.

Percentage of women who experienced rape by perpetrator type, among women who had ever been raped



A higher proportion of women reported rape by a non-partner than by a partner, and the majority (61%) of women raped by one or more non-partners were raped once or twice by these perpetrators.

Women who experience rape by partners tend to experience rape more frequently – among currently partnered women, two-thirds had been raped more than once by their primary partner, with 15% having been raped "many times". Eighty-two percent of these women had been raped by their primary partner in the previous 12 months.

Based on survey data, we are able to estimate the number of women raped each year based on:

- Rape by partners in the previous 12 months, and;
- An estimate of the number of rapes experienced by non-partners over the number of years women and girls were at risk of being raped.

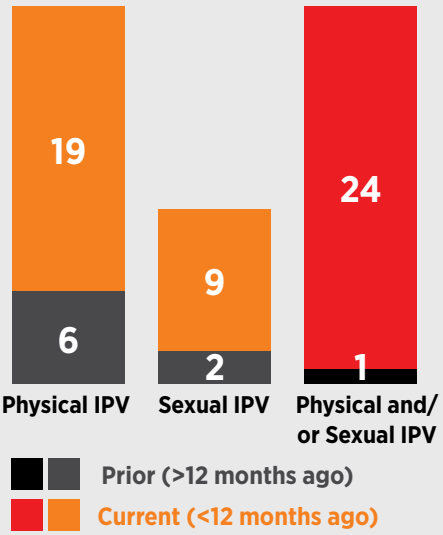
If we extrapolate the survey findings to the general population, we estimate that there are **more than 11 000 women and girls experiencing rape each year in Rustenburg Local Municipality.**

Sexual and physical IPV

Eighty-one percent of women were currently partnered, and the majority of these (56%) had been in the relationship for at least five years. An additional 25% of these had been in their relationship for between two and five years. Responses received of women's experiences of different forms of intimate partner violence—in what for many are long-term partnerships—suggest that many women experience routine physical or sexual violence perpetrated against them by their partners.

Eleven percent of women surveyed reported sexual IPV (S-IPV) which includes, but is not limited to rape with their current or most recent partner. Twenty-five percent of women experienced physical intimate partner violence (P-IPV). Taken together, **25% of women experienced S- and/ or P-IPV with their current or most recent partner.**

Percent of women who experienced IPV with their current or most recent primary partner



Health consequences of rape, and the medical and psychosocial response

Rape can have severe detrimental effects on the survivor's physical and mental health, and wellbeing. Women who have been raped are exposed to mental and physical trauma, unwanted pregnancy, loss of pre-existing pregnancy, or acquisition of sexually transmitted infections (STIs), including HIV. Psychological suffering from rape is widespread and can be severe; for example, depression as well as alcohol use disorders are five times more common in survivors. Rape can also be fatal - perpetrators may kill their victim and survivors are more than four times more likely to take their own life.[ix]

High levels of sexual violence and HIV are inextricably linked in South Africa.[x] Due to the physical trauma which occurs during rape, HIV and other sexually transmitted infections spread more easily during rape than during consensual sex. Forced oral sex can cause lesions, increasing the risk of HIV acquisition. Pre-existing STIs also increase the chances of acquiring HIV during forced sex.

However, a basic package of health care services can mitigate or prevent the adverse health consequences of rape and sexual violence, if provided timeously. Antiretrovirals (ARVs) given as post-exposure prophylaxis (PEP) can prevent HIV if initiated within 72 hours of unprotected sex. Antibiotics and vaccination can prevent or treat other sexually transmitted infections. Women can avoid potential unwanted pregnancy if given emergency contraception within 120 hours of unprotected sex. With supportive counselling, the psychological impact of rape can be reduced.

Provision of forensic examination--at the facility providing the first consultation, or through referral to a dedicated sexual violence care facility--can support the legal process for those who choose to pursue it.

Essential package of care

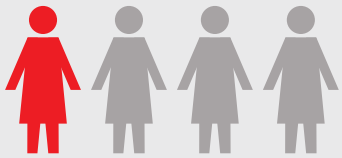
- **Comprehensive medical assessment, including forensic examination**
- **First aid to treat injuries**
- **Medicine and post-exposure prophylaxis (PEP) to prevent HIV infection and treat other sexually transmitted infections (STIs)**
- **Emergency contraception to prevent unwanted pregnancies**
- **Vaccinations to prevent hepatitis B and tetanus**
- **Psychosocial care (psychological support and social work intervention)**

LIMITED POST-RAPE UPTAKE OF HEALTH SERVICES

Despite the medical and psychosocial benefits of accessing healthcare, many survivors of rape do not receive these services. **95% of women surveyed never told a health facility about their rape incident.** Only 4% of women told a counsellor and only 3% told a social worker that they had been raped.

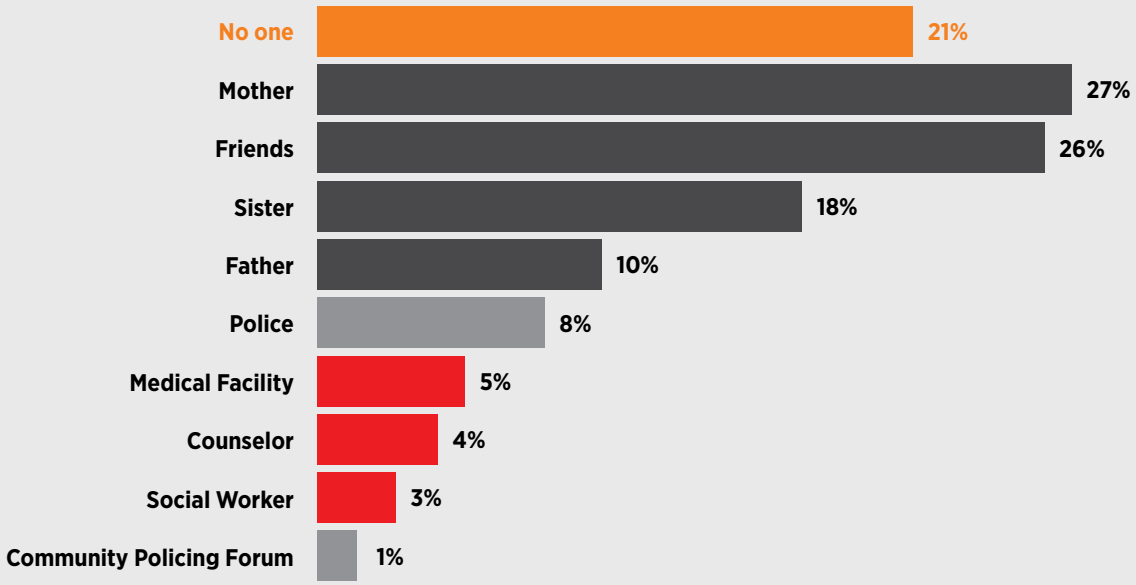
Opportunities to refer people to care are limited — according to the survey, one in five people do not tell anyone about their experience of rape. Women who have been raped very seldom tell the police (8%) or the community policing forum (1%). Those who do confide in someone will most often tell a family member or friend.

Survey data is consistent with what MSF sees on the ground in and around Rustenburg. As of the end of July 2016, 172 survivors had accessed the KCC in the previous 13 months. Based on data from KCC, among those survivors who do access care, many do so after the time window in which they are eligible for services. Only five out of every 10 people who have been raped and are accessing care at the KCC do so within the 72-hour window during which they are eligible for PEP, when emergency contraception is most effective, and when forensic examination can most easily occur. Six out of ten people who have been raped do so within the 120-hour window during which emergency contraception can still be provided.



ONE IN FOUR WOMEN LIVING IN RUSTENBURG HAS BEEN RAPED IN HER LIFETIME

Who women told about their experience of rape*



*If women told someone about their experience, options were not mutually exclusive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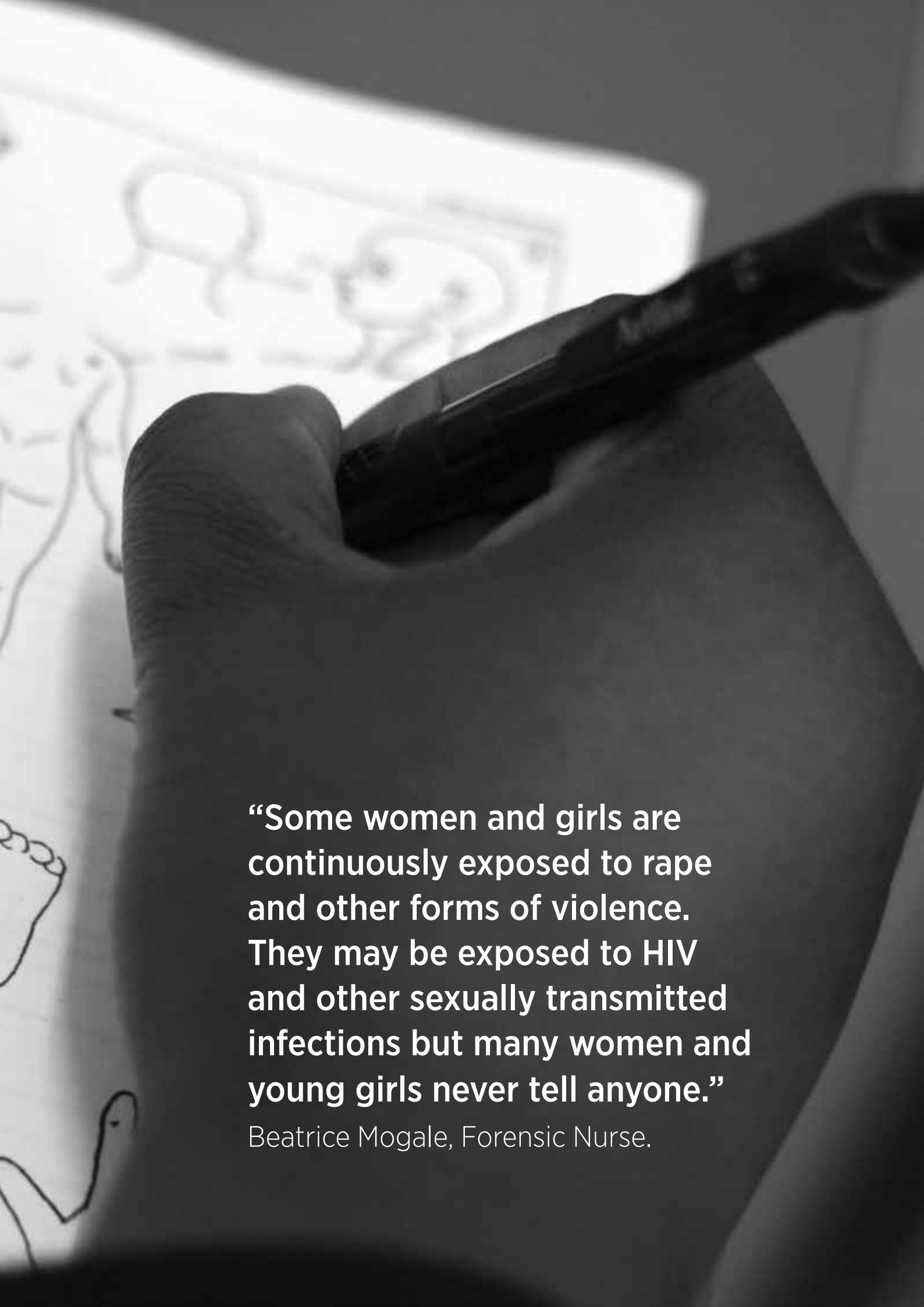

“Some women and girls are continuously exposed to rape and other forms of violence. They may be exposed to HIV and other sexually transmitted infections but many women and young girls never tell anyone.”

Beatrice Mogale, Forensic Nurse.

BARRIERS TO ACCESSING CARE FOR SEXUAL VIOLENCE

After an incident of sexual violence, survivors face barriers to accessing medical and psychosocial care at a number of levels.

At a community level, these include individual circumstances that affect service-seeking behaviour, and relationships between the survivor and their partner or people close to them. At a health service delivery level, the availability and quality of care, and the attitudes and accessibility of staff (real or perceived) have an impact on a survivor's ability and willingness to seek medical attention. From a broader societal perspective, attitudes, approaches and policies toward sexual violence can facilitate or detract from survivors receiving treatment.

Based on the survey and MSF experience in service provision in Bojanala Platinum District, the following themes emerged as some of the most critical barriers to accessing care:

INDIVIDUAL CIRCUMSTANCES

Routine sexual violence

Sexual violence is widespread in Rustenburg, affecting people of all ages and genders. Twenty-five percent of survey participants personally knew a woman who has been raped. Six percent personally knew a man who has been raped, and 21% of women knew a child who has been raped. Very few survivors seek health care services following an incident.

As evident from the survey, the lifetime prevalence and incidence of sexual violence is extremely high among adult women in Rustenburg. Sexual violence in the area, however, is not exclusively directed toward adult females. Of KCC clients from end July 2016, 11 survivors (6.4%) have been males. Household studies in South Africa have found that almost one in 10 men (9.6%) are victims of sexual violence in their lifetime[xi]—the low number of males reporting to KCC suggest this group may face particular challenges in seeking or accessing care.

Furthermore, among women surveyed, 8% had experienced rape by non-partners as a child before the age of 15—nearly a third of all women who had experienced rape in their lifetime. Project data also suggests that sexual violence is widespread among children and youth. As of the end of July 2016, one in four clients at the KCC has been under the age of 12, and a further 26% of clients between the ages of 13-18. These statistics suggest that sexual abuse among children may be more likely to be reported than sexual abuse of adults.

Treatment literacy gap

The survey found that women are aware of the negative mental and physical health consequences of rape. However, there is a relatively low level of understanding that these consequences can be mitigated or prevented by receiving medical and/or psychosocial care. **Low treatment literacy may be one potential reason for the low number of women reporting to medical care after rape.**

A striking example of this is that **only 50% of women surveyed were aware that HIV is preventable after rape.** Furthermore, 55% were unaware that there is a treatment that is available to prevent HIV infection. It is highly likely that a similar lack of awareness regarding PEP and other post-rape services exists among the general population, male and female alike.

Consequences

Of women surveyed about rape's consequences:

99%
knew it can lead to: a) HIV; b) STI infections; c) pregnancy; d) injury.

93%
knew it can lead to death.

Treatment

But when surveyed about post-rape care, only:

73%
knew pregnancy could be prevented.

50%
knew HIV could be prevented.

45%
knew there was treatment to prevent HIV infection.

Lack of financial independence

Of women surveyed, despite relatively high levels of education (44% had completed at least secondary school), 59% were unemployed or looking for work. More than four out of five women surveyed were in some type of sexual partnership, though only 27% of women surveyed were married. Among women with partners who knew their partner's employment status (85% of partnered women), only 13% of partners were unemployed, and 44% of partners worked in the mining sector. The gender imbalance in employment status suggests that many females in Rustenburg may be financially dependent on men, creating a power differential between partners.

Dependency on partners may make women less able to seek care if they do not have the resources to travel to services, or less likely to report violence by a partner they depend on, if they fear it risks compromising their financial or environmental security.

INTERPERSONAL RELATIONSHIPS

Controlling behaviour by sexual partners

Given high levels of financial dependence on partners, and high levels of intimate partner violence by current or most recent partners (detailed above), women may feel unsafe or unable to disclose physical or sexual abuse, or access care if they fear a potentially negative or violent reaction by a partner. The survey assessed women's experience of emotional IPV (E-IPV) or controlling behaviours by partners, as women in such partnerships may be more likely to become victims of sexual violence.[xii]

Of women with sexual partners who were surveyed, 26% reported E-IPV by partners in the previous 12 months, with a further 3% reporting E-IPV prior to 12 months. Seventy-seven percent reported that their partners exhibit controlling behaviours.

Controlling behaviours included exhibiting jealousy if the woman spoke to another man (57%); insistence on knowing where the woman was at all times (53%); accusations of being unfaithful (42%); and limiting contact with family (13%) or female friends (24%).

The survey also found that women who have experienced controlling behaviours are more likely to have ever visited a clinic, and have visited a clinic more recently than those who have not experienced controlling behaviours. This implies that improved screening at health facilities could result in more women disclosing incidents of violence, and receiving medical and psychosocial care.

HEALTH SERVICE AVAILABILITY AND QUALITY

Availability of first consultation/emergency services

Bojanala Health District serves approximately 1.3 million people. According to the North West DOH, only 11 designated public health facilities - including the Boitekong KCC - provide PEP and support forensic examination for survivors of rape, out of 783 total health facilities in the district.[1] Most of the dedicated facilities for rape survivors are at district hospital or community health centre (CHC) level.

The district has only one Thuthuzela Care Centre (TCC) providing dedicated support to sexual violence survivors, housed in the Job Shimankana Tabane Provincial Hospital. TCCs are a national initiative led by the NPA Sexual Offences and Community Affairs Unit, in partnership with sexual violence stakeholders. Thuthuzela Care Centres tend to be hospital-based, and are intended to be one-stop facilities that offer medical, social and legal services for sexual violence survivors.

The capacity of each of these designated public health facilities varies, however, dependent upon the number of trained staff available that can conduct the examinations. In the absence of a trained health care professional at their first consultation, rape survivors may rely on the availaiblity of a doctor for a forensic examination. Empowering professional nurses to provide survivors with quality treatment inclusive of forensic examination--as is being piloted through the MSF/DOH mentoring programme--is one way to increase the number of trained staff and help address the current gap in service provision.

1. Health facilities in the district include one provincial hospital, four district hospitals, 13 community health centers, 16 clinics operating on a 24-hour basis, 88 clinics, 646 mobile points and 15 health points.

Proximity to first consultation/emergency services

Limited availability of dedicated sexual violence services close to where people live can be a barrier to accessing care as soon as possible. **Ninety percent of women surveyed stated a preference for having services provided in their community after rape.**

Traveling long distances to reach services may be unfeasible for many people around Rustenburg. Of 136 clients seen at the KCC that specified an address where aggression against them occurred, 26% came from within a five-kilometre radius of the facility. A further 52% travelled between five and nine kilometres from the site of the aggression to seek care—which would take between 50-90 minutes to walk, depending on a person's fitness and physical state. Only 7% of clients travelled more than 30 kilometres to the KCC.

Approachability and trustworthiness of health staff

Roughly a third of women surveyed indicated that the staff at their local clinics are not approachable, with a similar proportion considering staff not trustworthy. If survivors do not perceive staff as being empathetic to the trauma of experiencing rape or sexual violence, then they may be less likely to seek care or disclose their experiences. If health care staff are not considered trustworthy, survivors may fear breaches of confidentiality regarding their experiences. Any efforts to improve the capacity of facilities to provide services must include the sensitisation of staff in caring for survivors, in order to improve the actual and perceived approachability and trustworthiness of staff.

Availability of follow-up services

Following an incident of rape, survivors are recommended to receive in-person consultations for specific screening, and medical and psychological care. These follow-up consultations can help to limit the negative effects of rape on individual health and wellbeing. Medical check-ups allow health care service providers to provide adherence support to ensure survivors finish their PEP course, and allow for follow-up vaccinations, HIV and pregnancy tests, and monitoring side effects. Survivors should receive follow-up consultations on approximately a weekly basis in the six weeks following the incident which include psychological support (four to six sessions), and social work assessment, assistance and support, dependent on survivor needs. The Kgomotso Care Centre also allows for self-initiated appointments between consults, for various reasons—survivors may be concerned over potential side-effects, want to access family planning, or want to see a counsellor due to experiencing psychological distress.

A contributing factor to why survivors do not always receive these services may be the lack of social services in the community. There are 7.7 social workers per 100 000 people[xiii] who work directly in welfare activities in North West Province, making the area one of the most disadvantaged in the country—by comparison, Northern Cape and Western Cape respectively have 20.4 and 15.7 social workers per 100 000 people. According to the survey, only 58% of women said that there was a social worker available in their community and even less (51%) stated that there were counselling services available in their community. Of those women that were aware of social work and counseling services (both in the community or elsewhere), 28% and 29% respectively expressed that it was difficult to access these services.

Need for integrated care and referral networks for sexual violence survivors

Survey findings suggest that while very few women seek medical attention following incidents of rape, women do attend health facilities for any number of reasons—**60% of women surveyed had accessed their local clinic in the previous six months.** This suggests that screening for sexual violence in clinics may provide an opportunity to link more survivors of sexual violence to care.

Of the overwhelming majority of women who preferred services to be located in their community after rape, 57% wanted services on the same property as other health services, with a further 7% saying it did not matter if services were on the same property or separate. Just over one-third of women wanted services on a different property.

These findings suggest a need for: Integrating medical and psychosocial services for sexual violence survivors into existing health services. For individuals that prefer the anonymity or ease of accessing local health facilities for sexual violence services, family planning or other outpatient consultations may provide good screening opportunities for sexual violence. At the same time, it is important for survivors who turn to locations other than a health facility following an incident of sexual violence to be appropriately referred to seek medical attention.

SOCIETAL ATTITUDES AND POLICIES

Social stigma and normalization of sexual violence

Negative societal perceptions of sexual violence may dissuade survivors from reporting incidents of sexual violence, or seeking care. Almost all women surveyed (95%) indicated that sexual violence can lead to stigma. Eight out of 10 women indicated that people might call someone who has experienced sexual violence names, and seven out of 10 women indicated that people might avoid someone who has experienced sexual violence.

While almost all women surveyed knew that women and children could be raped, one-third of the participants indicated that a man could not be raped. Among those that thought that a child, man, or woman could be raped, less than 2% indicated that a child could be at fault for their rape; however, the proportion indicating that a man or woman could be at fault were similar (14% and 16%, respectively). These responses suggest some level of tacit acceptance of sexual violence toward adults, and may lead to some survivors blaming themselves or feeling ashamed about incidents of sexual violence.

Availability and quality of legal services

While very few survivors of sexual violence report to health facilities, reporting of cases to the police is also low. In the past five years, 6 128 sexual offences cases have been reported in Rustenburg Local Municipality. These figures are not disaggregated by type of offence, and could include cases of sexual assault, rape, and domestic sexual abuse. However, an average of 1 225 cases a year constitutes less than one-tenth of the estimated incidence of rape alone, and few of these cases will proceed to a court verdict or conviction.

Survivors may choose not to engage the legal system due to an unwillingness to prosecute the perpetrator (particularly if a female survivor is financially dependent upon a male perpetrator), or a lack of faith in the courts to deliver justice. An additional reason women may not access legal services may be due to their limited availability. Only 15% of women surveyed said that legal services were available in their community and among these women, the majority who were aware of services (either in their community or outside of their community) indicated that these legal services were difficult or very difficult to access (60%). Forty-one percent of women did not know if legal services were available in their community, and an additional 16% didn't know how easy or difficult it was to access services.

Legal and policy framework on medical care for sexual violence survivors

Survivors of rape and sexual violence should always be able to access timely emergency medical care. Section 27 of the South African Constitution makes provision that everyone have access to health care services, and puts a positive obligation upon the state to take measures that help achieve the progressive realisation of this right. The constitution also makes explicit that "no one may be denied emergency medical treatment."

Several government departments—including but not limited to the DOH, DSD and NPA— bear a level of responsibility in ensuring their approach to addressing sexual violence supports access to a medical response for survivors. Yet a coordinated interdepartmental approach to achieve this vision is lacking. Current national rhetoric around service provision to survivors places a strong emphasis on the judicial system, and increasing conviction rates of the perpetrators of sexual violence. The National Strategic Plan on HIV, TB and STIs (2012-2016) lists as a core indicator: "the number of women and children reporting gender-based violence (GBV) to the police in the last year," but features no indicators on sexual violence survivors receiving medical services.[xiv] TCCs provide medical services, but have the primary aim to "reduce secondary victimisation, improve conviction rates, and reduce the cycle time of finalising cases".[xv] The only medical service to be provided to survivors that is listed in the Sexual Offences Act is PEP.[xvi]

While all survivors should be offered forensic examinations by a trained professional, the survivor should also always have the choice of whether or not to report cases to the police. Any number of factors or vulnerabilities may contribute to a survivor not wanting to pursue a legal case, including fear of reprisal attacks from the perpetrator, fear of being shamed by or isolated in their community after disclosure, or fear of a detrimental change in living situation after reporting. A survivor's decision on whether or not to engage with the legal system should never compromise the ability to access medical and psychosocial services.

"It is difficult to access sexual and reproductive health services, because I do not have money for transport. I am unemployed."

Woman surveyed in Rustenburg Municipality

“Many women are afraid of reporting rape because they fear public embarrassment, judgment by staff, and being isolated in their community.”

Caroline Walker, MSF Health Promotion Manager

RECOMMENDATIONS FOR A PATIENT-CENTRED RESPONSE TO SEXUAL VIOLENCE

As a medical organisation, we are concerned about the high levels of sexual violence in Rustenburg and the low number of women reporting to health care services after being raped. The voices of women heard through the survey, and the reality that MSF encounters on a daily basis raises serious concerns about how much is being done to address the gaps in helping survivors receive attention for their medical and mental health needs.

There is need for a more coordinated national response to sexual violence which is able to address the variety of social, economic and structural barriers to accessing care, and reduce the stigmatization that survivors may experience.

At an individual and community level, there is a clear need to provide education to people of all ages and backgrounds, in order to:

- Raise awareness around what actions constitute sexual violence
- Raise awareness of the potential medical consequences of rape (e.g. HIV), and the preventive responses that can be provided (e.g. PEP), especially when care is sought in a timely manner.
- Attempt to de-normalise and reduce acceptability of violent behaviour and social stigma

At a service delivery level, there is urgent need for comprehensive, high-quality medical and psychosocial services, including:

- Preventative and treatment services for survivors available at all primary healthcare facilities, with staff trained to screen for sexual violence among people visiting for other health reasons
- Staff, including professional nurses, trained in forensic examination, present in all community health clinics and other dedicated centres
- Increased numbers of social workers and counsellors dedicated to providing survivors facility- and community-based care and follow-up services
- Routine sensitization of health care workers and other stakeholders (e.g. FCS, SAPS) to recognise, support and refer to care survivors of sexual violence

At a national policy level, a patient-centred approach toward responding to sexual violence must include:

- An inter-departmental plan that assigns accountability to government entities for offering services that progressively realise the right to have access to healthcare services, and ensures survivors of sexual violence receive emergency and other medical care
- Service delivery indicators featuring a medical component, used to measure progress toward implementing national laws and policies that feature a sexual violence response component, including in the next National Strategic Plan for HIV, TB and STIs (2017-2021)

MSF, the DOH and other partners are working to implement community-level and clinical recommendations in Rustenburg, in hopes that mistakes can be avoided and successes replicated in other parts of the country. MSF will also continue to advocate for policy reform, so that societal barriers to survivors of sexual violence accessing medical and psychosocial services, can become a relic of the past.

While such efforts might not mitigate all barriers to access, they are crucial in improving access to medical care for survivors, whom today are largely surviving in silence.

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