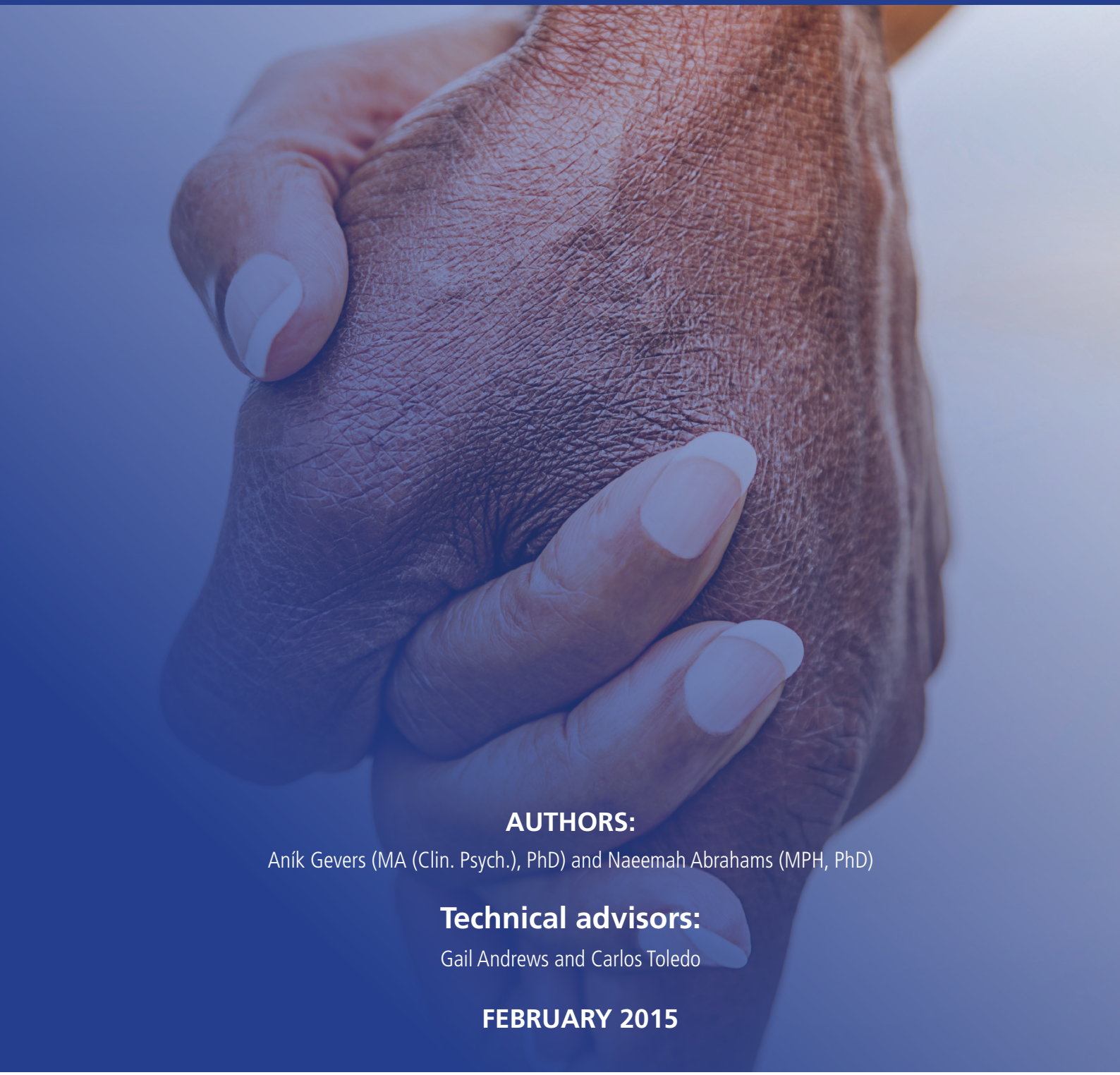
CAPACITY ASSESSMENT OF MENTAL HEALTH SERVICES FOR RAPE VICTIMS IN ACUTE HEALTH-CARE SETTINGS:

A rapid appraisal of services in the Western Cape Province



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INTRODUCTION

Sexual violence and HIV are two serious public health problems in South Africa. Population-based prevalence studies with men found 28.37% disclose rape perpetration and 12.25% of women report victimisation (Machisa, Jewkes et al. 2011). In 2012, UNAIDS reported substantial decreases in new HIV infections, but HIV remains a critical health problem in South Africa, with 5.6 million people living with HIV in South Africa (UNAIDS, 2012; Shisana, 2005). In populations with high HIV prevalence such as South Africa, HIV transmission through rape is a serious issue. The South African government adopted a policy in 2002 to provide antiretroviral medication to prevent HIV transmission as part of a comprehensive service for people who have been sexually assaulted (Department of Health 2005). Studies have shown that post-exposure prophylaxis (PEP) to prevent HIV is highly effective if commenced as soon as possible, ideally within 72 hours of exposure and if taken for 28 successive days (Roland, Neilands et al. 2005). Other than the direct risk of HIV transmission during rape, there are also other indirect possible pathways for HIV risk post rape in the medium and long term. Evidence for these pathways stems from research on intimate partner violence (IPV) and HIV (Jewkes, Sikweyiya et al. 2011), and mental health has been hypothesised as one of the main mediators in the indirect pathways to HIV post rape. Unfortunately, managing and recognising these risks have not been adequately addressed in the treatment and care of rape survivors.

The focus of post-rape care has been on the prevention of HIV from direct transmission, but unfortunately completion of the drug regimen remains a huge challenge in the provision of post-rape care and therefore ultimately impacts the prevention of HIV. Although comparisons between adherence studies are complicated by the use of different definitions, samples and methods used, low levels of adherence have been described as common internationally (Wiebe, Comay et al. 2000, Linden, Oldeg et al. 2005, Siika, Nyandiko et al. 2009). A recent systematic review showed an overall adherence of 40% (Chacko, Ford et al. 2012). In South Africa, studies have reported rates as low as 15% (Mugabo, Sahabodien et al., Christofides, Muirhead et al. 2006). Three South African studies reported levels above 50% and these included two studies at dedicated rape services: the Thoyoyandhou Victim Empowerment Project in Limpopo (Vetten and Haffejee 2004) and Northdale Lifeline Rape Crisis Centre in KwaZulu-Natal (Carries, Muller, Muller, Morroni & Wilson, 2007). A third study reported an increase in adherence from 20% to 57% after the introduction of a comprehensive intervention of a nurse-driven service (Kim, Askew et al. 2009). Not many studies document the reason for poor adherence but poor follow-up and lack of psychological support has been reported by many (Linden, Oldeg et al. 2005; Loutfy, Raboud et al. 2007; Wiebe, Comay et al. 2000, Olshen, Hsu et al. 2006, Martin, Young et al. 2007).

Systematic reviews for quantifying the health impact of violence against women for the Global Burden of Disease Study have shown the wide range of psychological morbidity associated with sexual violence (World Health Organization, 2013). These psychological effects are much more prevalent than physical morbidity, although most services emphasise developing responses to the latter, while mental health gets inadequate, often cursory, attention during the acute post-rape period. Soon after rape, survivors often develop a cluster of symptoms of post-traumatic stress disorder (PTSD), and may develop depression, obsessive-compulsive disorders, panic attacks, substance abuse and suicidal ideation (World Health Organization 2013; Resnick, Acierno et al. 1997; Ullman, Filipas et al. 2007). Researchers suggest that the life-time prevalence of symptoms after sexual assault ranges from 30% to 94% (Kilpatrick, Edmunds et al. 1992; Resnick, Kilpatrick et al. 1993) and suicide attempts are much more common among rape survivors than other population groups. Few studies have been conducted in South Africa. A national study has shown the association between rape and PTSD (Kaminer, 2008) while work done by Abrahams and colleagues (2013) found symptoms of depression to be high, one month after the rape, with 62.8% of women showing signs of depression and suicide. Recent research with children in Cape Town found that two-thirds had significant PTSD symptoms persisting three months after the rape (Mathews, Abrahams et al. 2013), but there have been no long-term studies on the mental health impact of rape among survivors in South Africa.

Despite the well-known impact of rape on mental health and the widespread problem of rape in South Africa, mental health services for rape victims are scant. In general, South Africa does not have well-integrated mental health services within acute health-care or in rape services (Lund, Stein et al. 2008). In general, we have very little information on what mental health support is provided, by

whom and how it operates. The development of mental-health support for rape victims during the period of taking PEP at acute level care requires a detailed understanding of what mental health services are available at the acute level care, what possibilities there are for referrals, and the nature of mental health needs after rape and in the period of taking PEP to prevent HIV.

The aim of this PEPFAR-funded project was to conduct a rapid appraisal of mental-health services for rape victims in the period of taking PEP at three sexual assault services in the Western Cape. Data from interviews with various service providers and rape survivors will help us to understand current mental-health services for rape victims at acute level services, at non-governmental organisations (NGOs) as well as long-term care at secondary level services. The outcomes of this study will be used to make recommendations for an intervention that aims to train and develop the skills of staff employed in the public health-care sector to provide psychological support to rape victims in the critical period of taking PEP medication for HIV prevention.

METHOD

Qualitative data were collected during observations and from in-depth interviews (IDIs) with service providers in the sexual assault response service sector and rape survivors recruited from centres in urban (Cape Town Metropole District) and rural (Overberg District) areas in the Western Cape province (see Table 1). Study sites included primary response services that offered immediate, acute, primarily medical, care for rape survivors and secondary response services that offer longer-term mental health support for these survivors (mainly counselling services). Primary response service sites included three specialist rape care centres located in the Cape Town Metropole district, a community health clinic located in the Overberg district, and five SAPS stations located in the two abovementioned districts. The secondary response service sites were all in the urban district and included nine non-governmental organisations (NGOs), one secondary level hospital, and two private practices. Service providers were recruited from each study site and included health-care professionals, site managers, victim assistance officers, police officers, and lay counsellors or volunteers. In total, 37 interviews were conducted with 43 service providers (36 females). Rape survivors who were eligible for the 28-day PEP regimen to prevent HIV were recruited from the three rape care centres and one rural police station. Thirteen interviews were conducted with 14 female survivors (two sisters, both rape survivors, requested to be interviewed together). Observations were conducted at the three rape care centres.

Table 1 Description of study sites and participants

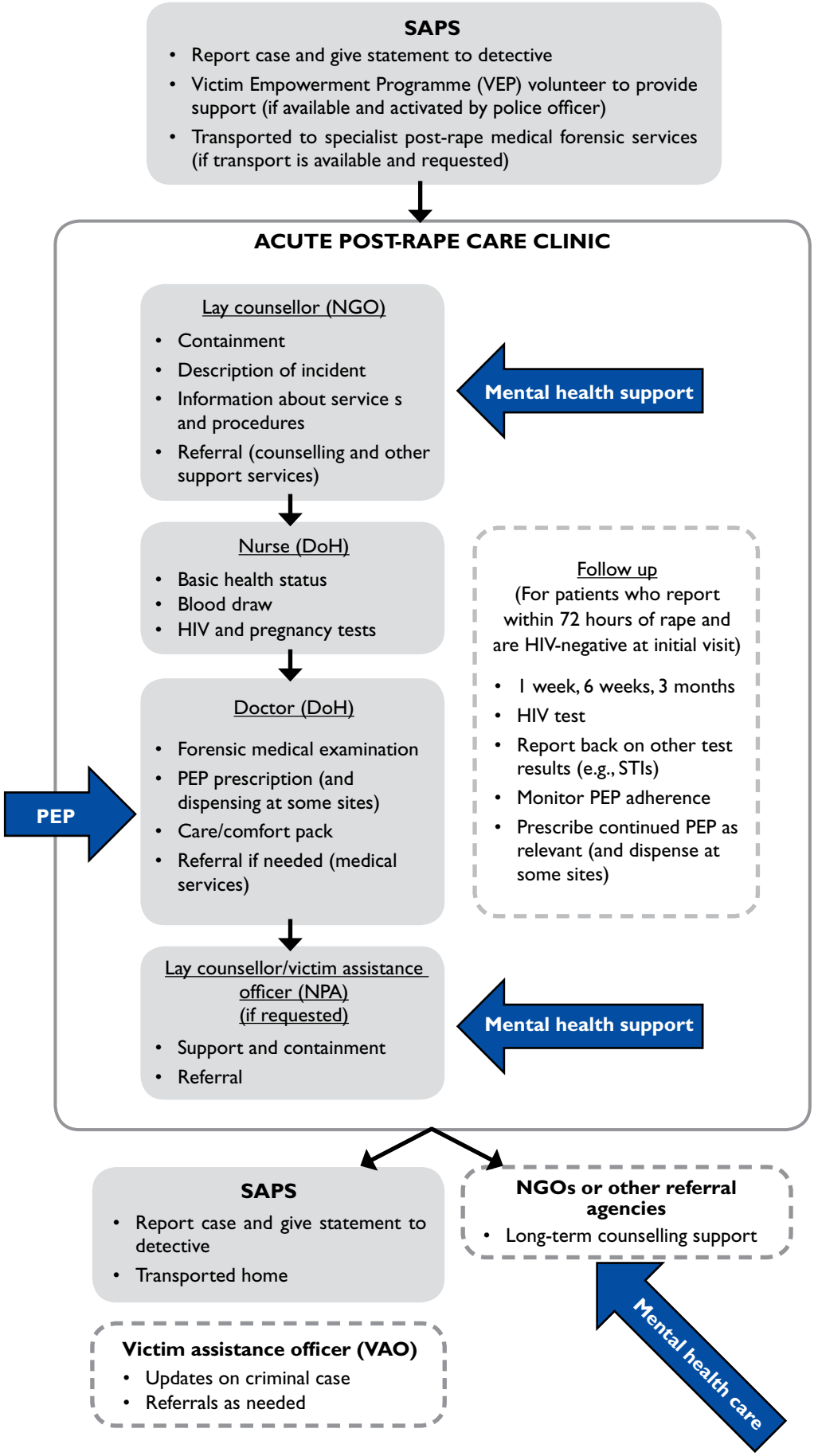
SITE CATEGORY	SITE DESCRIPTION	PARTICIPANTS
Acute level response (acute, short-term)	3 Rape care centres (urban)	12 survivors (female)
		3 medical doctors
		1 nurse
		3 victim assistance officers/site managers
		6 lay counsellors
	1 CHC (rural)	2 survivors (female)
		2 nurses
		1 lay counsellor
	5 SAPS stations (4 urban, 1 rural)	6 police officers
		1 police social worker
		2 VEP volunteers
Secondary level response (long-term)	9 NGOs (9 urban)	15 service providers (also filled roles of coordinators and managers)
	1 Secondary level hospital	1 clinical psychologist
	2 Private practice (urban)	2 clinical psychologists

All observations and all IDIs with service providers were conducted by a researcher who is a clinical psychologist with specific expertise in trauma-related mental health. Ten interviews with 11 survivors were also conducted by this researcher. An isiXhosa-speaking research assistant conducted three interviews with rape survivors who requested this option; this staff member is trained and experienced in conducting gender-based violence research and received additional training to use the interview protocol developed for this study.

Interviews with service providers explored their role in post-rape care, training to provide this service, perspectives on PEP adherence and retention in care within the service, perspectives of survivors' mental health needs and mental health support within the service package, and personal experiences of working in post-rape care. Interviews with survivors explored the post-rape services they received and how they accessed these services; their experiences of these services (long-term support services if applicable), various service providers and taking PEP medications to prevent HIV; and their coping strategies and support needs throughout the post-rape/PEP period.

All interviews were audio recorded with the permission of participants. All interviews were transcribed and the three isiXhosa interviews were translated into English. Interviews were coded thematically and analysed by group (acute health response services, SAPS services, survivors and secondary support services).

This study was granted ethical approval by the review committees at the Centres for Disease Control and the South African Medical Research Council. In addition, permission was granted to conduct this study in the primary response service sites by the Western Cape Department of Health, the National Prosecuting Authority and the provincial commissioner for the South African Police Service. No adverse events occurred during this study. Participation in the interviews was voluntary and written, and informed consent was obtained from all participants. Study sites gave permission for service providers to be interviewed during work hours and were scheduled so as not to interrupt service delivery. These interviews took place in private rooms at the study sites. Rape survivors were offered monetary compensation (R50) for their time and transport costs, and researchers met survivors at a time and location convenient for the participant. All identifying information was removed from the data in order to protect the identity of participants.


SAPS
• Report case and give statement to detective
• Victim Empowerment Programme (VEP) volunteer to provide support (if available and activated by police officer)
• Transported to specialist post-rape medical forensic services (if transport is available and requested)
ACUTE POST-RAPE CARE CLINIC
Lay counsellor (NGO)
• Containment
• Description of incident
• Information about service s and procedures
• Referral (counselling and other support services)
Mental health support
Nurse (DoH)
• Basic health status
• Blood draw
• HIV and pregnancy tests
Follow up
(For patients who report within 72 hours of rape and are HIV-negative at initial visit)
• 1 week, 6 weeks, 3 months
• HIV test
• Report back on other test results (e.g., STIs)
• Monitor PEP adherence
• Prescribe continued PEP as relevant (and dispense at some sites)
PEP
Doctor (DoH)
• Forensic medical examination
• PEP prescription (and dispensing at some sites)
• Care/comfort pack
• Referral if needed (medical services)
Lay counsellor/victim assistance officer (NPA) (if requested)
• Support and containment
• Referral
Mental health support
SAPS
• Report case and give statement to detective
• Transported home
NGOs or other referral agencies
• Long-term counselling support
Mental health care
Victim assistance officer (VAO)
• Updates on criminal case
• Referrals as needed

RESULTS

DESCRIPTION OF POST-RAPE SERVICES IN URBAN AND PERI-URBAN AREAS OF CAPE TOWN

Service providers from the post-rape care centres and the police described the typical services that survivors are offered within the post-rape care services that are run by the Department of Health and the National Prosecuting Authority in collaboration with the South African Police Service. This service – available in most of urban and peri-urban Cape Town – is illustrated in Figure 1. This diagram is based on the description of services from service providers interviewed in this study as well as researcher observations. The service package centres around a 'one-stop shop' specialist service centre (for example, Thuthuzela Care Centre) that provides initial medical and forensic services with strategic partnerships with the police and relevant NGOs. Usually, survivors enter post-rape services through their initial report to the police, but some enter directly at specialist service centres if they or another first responder (for example, a community or religious leader, a friend, a neighbour, or a family member) are aware of this clinic and its specific post-rape services.

The three post-rape care centres visited as part of this study and from which participants were recruited all had premises at public hospitals in Cape Town. The specialist centres had multidisciplinary staff, including a doctor and nurses (usually employed by the Department of Health), lay counsellors (usually employed by NGOs), a victim assistance officer and a centre administrative manager (usually employed by National Prosecuting Authority). The focus of this care package is a biomedical forensic service including completing a forensic examination and report, and providing key medical care including PEP to prevent HIV. At these specialist centres, survivors moved through a series of services, usually beginning with a session with the lay counsellor and then moving on to the medical-forensic service with the nurse and doctor. Survivors would only see the lay counsellor again at the end of the visit if they requested such a consultation, otherwise they would be referred to the police to open a case (if not yet done), provide additional information to the detective, or be transported home. In addition, survivors may be provided with referrals to additional sources of support during the first visit.

The stated protocol was to prescribe PEP to prevent HIV infection to all survivors who presented within 72 hours of the rape incident and tested HIV-negative at the initial visit. In addition, survivors were offered prophylaxis for STIs, and pregnancy as well as anti-emetics and pain relief medication. The PEP regimen for HIV prevention was explained to the survivors and, at some centres, the medication was dispensed directly, whereas at other centres survivors had to go to the general pharmacy within the hospital or their local community health centre. Survivors were also given follow-up appointments for one week, three weeks and three months following the initial visit; these follow-up visits were primarily for on-going clinical management and HIV-status monitoring. The centres visited for this study provided eligible survivors with a one-week supply of PEP medication, and after assessing adherence and conducting an HIV test at the one-week follow up appointment, they provided the remaining three weeks of medication as indicated (i.e., to those who tested HIV-negative and were adherent to the first week of medication) and further follow up appointments. At the three-week and three-month follow-up visits, survivors met with either the nurse or doctor on duty at the centre to complete a basic consultation, including an HIV test.

DESCRIPTION OF POST-RAPE CARE SERVICES IN RURAL SETTINGS

The primary community health clinic (CHC) and police station in a small, farming town outside Cape Town were visited to understand services available to rape survivors in rural areas (nearest town with a district hospital approximately 26 km from the smaller town). In contrast to the specialist services available in urban Cape Town (described above), observations of post-rape services in more rural areas indicated that they relied on general health and police services, with no clear organisation or person leading a coordinated post-rape response. This rural setting had an active Victim Empowerment Programme (VEP) based at the police station, and volunteer counsellors were called by police to support and remain with a survivor through the series of services, including medical treatment.

The forensic medical examination and accompanying report (J88), and police reporting is standard. However, the health-care service providers (medical personnel, including doctors and nurses) in the rural CHC do not perform this examination regularly and, according to members of the police and the VEP volunteers at the local police station, these providers are often reluctant to perform it In addition, few medical health-care providers

had received specialised training to conduct the post-rape forensic examination. Interviews with the nursing staff at the local community health centre indicated that they do not feel equipped to deal with rape cases and none of them had completed available training in forensic nursing. Further constraining post-rape services in this area are the restricted operating hours of the CHC (week days only, closed overnight). Therefore, in this rural community, rape survivors were usually transported to the nearest district hospital by the police. The NPA had no official role or presence in post-rape care in this rural community as they do in the urban setting. At the district hospital, there was no dedicated forensic doctor, therefore survivors had to wait for a doctor on call (usually the doctor on call in the casualty or emergency department) to become available either in the general hospital waiting area or at a centre set up by an NGO next door to the hospital specifically for rape survivors. Both police and rape survivors from this area complained that there were long waiting periods at the district hospital, and at times, they had to wait up to several hours for on-call NGO volunteers to unlock the NGO facility and for an emergency department doctor to come over from the hospital. Based on survivor reports, it appears that these long waiting periods added to the stress of the situation, perhaps because they were not offered comfort and support during these waiting times.

There was little follow up available for survivors in this rural site, which presents a concern regarding monitoring and supporting rape survivors' well-being, and provision of the full course of PEP medications. Indeed, there appeared to be little coordination or systematic protocol for PEP; that is, some survivors obtained the full 28-day course, whereas others only obtained the first week of medication and had to obtain the rest of the course independently from a pharmacy such as at the CHC. In this particular town, support for rape survivors was primarily provided through the volunteers at the town's police station. However, according to the VEP coordinator, awareness of this support and the implementation of proper post-rape support protocols varied widely depending on the understanding of the police officer responding to the case. Another challenge to service provision was the vast geographical area that the police and health-care services based in this small town had to cover and survivors' generally poor access to adequate transport. Such transport difficulties may also impact negatively on PEP adherence if survivors are unable to return for follow-up appointments to obtain PEP medication if they were not given the full 28-day course at the first appointment. In addition, not returning for follow-up appointments also has implications in linking survivors with on-going mental health support for their recovery.

In contrast to the services available in urban settings, it appeared much more difficult to access comprehensive post-rape care services in rural areas. Survivors must travel long distances to service centres, endure long waiting periods, and overcome several structural barriers to obtaining initial and follow-up care. In addition, service providers in rural areas are rarely post-rape care specialists and often appear to lack confidence in their skills to provide post-rape care. The quality of services depended on individual service providers or volunteers on duty at the time, as well as what partnerships are established between different sectors.

LOCATING MENTAL HEALTH SUPPORT WITHIN THE RAPE SERVICES

Mental health support or care was not found to be integrated throughout the post-rape care services. The specific areas providing mental health support or care are indicated on Figure 1. As illustrated, initial mental health support was located in the acute services, although the service is not delivered by the medical health-care staff. This support was usually provided by lay counsellors employed and trained by an NGO and seconded to the rape care centre. Usually, such mental health support is provided at the beginning of the initial visit. Although provided within the acute post-rape care service that is run by Department of Health and the National Prosecuting Authority, these mental health support services are not funded by the Department of Health; instead they rely on funding that the NGOs can generate themselves. Further, these mental health services are largely provided by paraprofessionals and very few use evidence-based approaches (also influenced by the paucity of evaluated acute post-rape mental health care interventions). The VEP volunteers (based at police stations) in rural settings attempted to provide similar initial counselling and support to survivors at the time that the rape was reported to the police, but at times also appeared to provide continued support over a longer period.

Mental health support at first visit

Providing mental health support for rape victims was the primary function of the lay counsellor, who was usually the first person the survivor encountered at the initial visit at the service. The first session with the lay counsellor lasted between 10 and 45 minutes, and providers described that the session focuses on containment – "here we contain their feelings" (Provider 14) – and providing information about the post-rape service package offered at the centre. A significant focus of this session was preparing the survivor for the medical examination and care they would receive during the initial visit at the centre. A lay counsellor described: "we prepare them ... maybe they are too traumatised ... sometimes they are not ready for the examination, so we actually prepare them and if we

see they are not ready we tell the doctor or the doctor will send her back here and say that she is not ready for examination" (Provider 11). It is clear that 'prepared' in this context refers to a survivor being emotionally ready and accepting the medical examination, which can be very difficult for survivors because of its invasive nature. It is therefore not surprising that all counsellors reported that a key aspect of the first session counselling was to provide survivors with information on what will happen during the session, although it was unclear in discussions and observations as to how they would help to prepare them emotionally or give them coping skills to get through the examination. One counsellor said:

"I contain the feelings, I do trauma counseling to contain feelings and to give them information … and explain everything that is going to happen, what is going to happen inside the doctor's room … they have to do an examination on you but it is up to you if you want the doctor to do so because he cannot force you... he has to collect the evidence from the vagina or on the mouth or anal or whatever but he has to collect the evidence, you see and he has to draw blood and do the blood test. Ja and then about the medication that they are going to get. You are going to get a certain medication and that medication is going to make you nauseous but please drink that because it's for your own safety" (Provider 15).

A survivor explained what happened during the first session: "they tell me a lot of things that when you have a rape you are going to have a HIV or I'm pregnant. Then I started to tell her what's going on and they always told me about the pills I'm going to take it" (Survivor 11).

There were different views among providers about survivors re-telling their rape experience to multiple providers at this first visit. A counsellor said: "Everybody wants the story from the horse's mouth, because I can't just read the statement from the police and accept, I must ask my questions also, I need the story so that I know what's happening on my own, and also the doctor, it's the procedure" (Provider 31). Another said relating the rape event was not always part of the first sessions with the counsellor although some counsellors noted that they may be asked by the police to assist with taking a statement. Another said they do not ask the survivor about the event and will allow her to talk about it if she wants. Survivors confirmed the counsellor asked about the event and one said 'They took a statement first. The other ladies took a statement of what happened, how did I get there and all that stuff. Ja, every story, so she wrote the whole story down. Then I had to see a doctor" (Survivor 10). This practice was also confirmed during sessions that appeared to primarily focus on the survivor relating an account of the rape incident, the counsellor expressing his/her sympathy and then a cursory description of the services. A survivor explained what happened during her session with the counsellor: "… they give me support that you are, you are lucky because that guy is not raping you and after raping you killing you, you see?" (Survivor 11). In a rural setting, a survivor may encounter more than three people (police and volunteer lay counsellors) to whom the event must be related: "Now that police officer [at the pick-up site where he/she is called to a complaint] ... will talk to the victim and ask a lot of questions... after he's convinced that okay the rape did occur he will bring her to the police station. Now [at the station] ... an officer is going to talk to the victim again, then they contact the counsellor ... the counsellor will talk to the victim and then they will contact the FCS unit ..." (Provider 16).

The lay counsellors interviewed and observed as part of this study all had different ideas of what to do during these sessions. Several counsellors expressed their concern that providers asking survivors to recount the story of the rape was an issue because it might be distressing to survivors. When asked why counsellors asked for a description of the rape event, no-one had a definitive answer except for two counsellors who suggested it was good for survivors to talk about their experience. Despite the stated objective to provide survivors with information during the initial counselling session, few counsellors provided detailed information about the procedures and purpose of the medical and forensic services that would follow the counselling session, or psycho-education about typical reactions to rape. Several counsellors noted that the latter was provided during long-term counselling. One very experienced counsellor described that she would discuss survivors' feelings of guilt and different manifestations of victim blame in the community or family that she may face, noting that "rape is only about power" (Provider 14). However, these discussions were not observed. Counsellors described that containment was about allowing clients to express their feelings through crying or screaming, or allowing them to continue talking. In general, counsellors provided very cursory information about the procedures for the medical forensic examination and other services that survivors would go through at the centre, with the exception of their strong focus on the HIV test and the potential PEP medication to prevent HIV. Counsellors also strongly encouraged those survivors who had not yet reported the rape to the police to open a case and, as relevant, would also inform survivors about the possibility of obtaining a protection order and describe other rights. At some centres, lay counsellors would act as interpreters between the survivor and doctor during the forensic medical examination, and at others they conducted outreach and community awareness activities.

Few survivors saw the counsellors again after the first visit, unless they requested such a meeting. However, because of rotating staff schedules within the 24-hour service, it was unlikely that survivors would speak to the same counsellor or other service provider on subsequent

visits, thus disrupting continuity of care, which is important for mental health services. The quality of this mental health support differed across clinics and appeared to be influenced by the on-going training, supervision, and support the lay counsellors received, and how well they were accepted, respected, and integrated into the health-care team at the clinic (see discussion below on service providers).

Mental health support in follow-up visits

According to service provider and survivor reports, mental health care and support by the lay counsellor was not automatically part of the follow-up visits. The primary purpose of the follow-up visits at the rape centre was HIV prevention together with monitoring adherence to the PEP regimen and testing for HIV at six weeks and three months. Survivors rarely met with counsellors during the follow-up visits unless they specifically requested such a consultation, suggesting that mental health support is not considered an essential part of the post-rape care package. Sometimes doctors or nurses would ask the lay counsellor to meet with a survivor to discuss adherence issues.

One centre in the study arranged for survivors to complete their follow-up visits at the Community Health Centres (CHCs) closer to where the survivors lived, and again this follow-up visit focused on continuing PEP medication and mental health support was not a part of this referral. Indeed, at the CHCs, rape survivors would have been grouped with the general patients and thus not received any trauma-related follow-up that may be more likely within the specialist post-rape care centres. The referrals for continuation of the PEP to prevent HIV management were seldom followed up by the post-rape care centre to assess whether survivors attended these CHCs to obtain the continued course of PEP. A provider explained: "we'll fax the referral to them [CHC] first so that they know how many people are coming to that centre for the follow-up and then we also give her [survivor] a letter to take to the centre" (Provider 10). Most service providers lamented the poor follow-up rate of survivors; their main concern being the collection of PEP medication and testing of HIV. However, mental health treatment was rarely mentioned as part of their concern for the on-going care and needs of rape survivors. Of concern was that there were no specific protocols identified or implemented by service providers interviewed in this study to improve adherence and retention in care to address the HIV-related concerns within the very medically focused service. It is possible that protocols or policies exist, but that providers are unaware of them, or they may have integrated existing protocols into their daily operations to such an extent that they may not have identified them as independent or specific protocols during the inquiry.

REFERRAL PROCESSES

The protocol at the specialist centres was to provide referrals (usually a letter with the name, address and contact information of relevant organisations, and verbal encouragement to attend) at the initial visit to all survivors for long-term counselling services available in different areas of the city as well as additional social service referrals if needed (for example, shelters, social grant applications or special needs organisations). Some service providers reported that they would not always provide referrals at the initial session, but preferred to do it at a follow-up appointment because they felt the survivor was already getting too much information during the first visit. Doctors would provide referrals for specialist medical services (for example, gynaecology referral, trauma surgery referral or psychiatry) as needed. However, such referrals – especially those for mental health – were observed and reported to be infrequent. Service providers, specifically victim assistance officers (VAOs) and some counsellors, described that they gave mental health referrals – NGO-run services – to all survivors based on their home location and not on any specific mental health need, assessment or screening. These referral letters or lists were usually passed through the counsellor with little or no direct contact between the survivor and VAO unless they were providing telephonic updates on the case progress.

According to lay counsellors and VAOs, referrals to mental health services were usually provided to all survivors based on geographical location and not based on specific mental health needs. However, survivor reports indicated that one survivor interviewed in this study did not receive a referral letter and two others only received one after their second visit when they reported to the doctor that they were experiencing flashbacks. These referrals were made very briefly with a simple statement noting their importance, but very little or no psycho-education about typical mental health consequences or needs following rape, nor any information about the counselling services themselves. Service providers also did not appear to help survivors develop an action plan for accessing these support services. A survivor noted how she had no idea what would happen at the NGO to which she was referred "I don't know what is going to happen there. I don't know what they are doing. … I still have the letter, I never opened it" (Survivor 11). It is well known that survivors receive huge amounts of information while still coping and dealing with the stressful event at the initial session, and it might not be surprising if they do not retain information. However, no efforts are made to overcome this challenge of ensuring priority information is understood and retained during this stressful period or to support it with follow-up plans to retain survivors in care or involve family members or other social support within the survivors' social networks. The poor linkage to

long-term mental health counselling, the weak referral and retention strategies, and the issues with communicating essential information in the midst of high stress are likely to contribute to few survivors taking up the counselling referrals. Several NGOs in the referral network required survivors to make appointments for themselves to make sure that they were ready and willing to engage with the service. However, this approach may also introduce an unintended barrier to taking up the service. There were no procedures in place to track whether survivors accessed any of the referral services suggested by the acute post-rape service providers.

Various service providers noted that they did not make referrals to psychologists or psychiatrists, either because they did not have easy access to them or because they believed such referrals were only necessary in the case of a survivor with severe mental illness. Only one doctor described that she would make referrals to a mental health professional – namely, the community service psychologist at the adjacent hospital. However, she noted that she would very rarely make such referrals because she knew that the psychologist was not often available, as she served all referrals at the hospital and was only posted there for a few days in the week. These referrals would take the form of a letter from the doctor to the psychologist with the survivor's information and the survivor would then wait for a call from the psychologist. This doctor did not have a formal protocol to make decisions about which survivors to refer to the psychologist and which survivors would receive the standard referral to a branch of a Cape Town-based NGO specialising in post-rape counselling. More than one service provider said they had little faith in the referral services because of the long waiting lists or because of concern about the treatment. One said that service providers from other organisations or sectors "come with their own idea which is not what the book says, which is not what they are supposed to do ... we refer to other services hoping they that they will do what they are supposed to do, but we don't know, really know, exactly what happens behind those closed doors" (Provider 08). Their knowledge of the limited mental health services influenced their decisions to probe for mental health problems and to make referrals, as one doctor said: "Sometimes you hold back the screening ... because you can't guarantee services ... sometimes you're even afraid to suggest it in-case you're opening up a can of worms, you know? So you have to be a bit careful around that, it's a bit constrained because of the system" (Provider 12).

What happened at the referral services

Only five out of the 14 survivors interviewed for this study had accessed to on-going counselling at a local, specialist NGO. The five survivors emphasised that this counselling was very helpful and all had positive experiences, which was important to their ability to cope. Some persevered despite difficulties accessing transport to attend the counselling sessions, even if they had additional good social support among their family and friends. These survivors demonstrated the best understanding among the survivors interviewed of post-rape mental health issues and most mentioned receiving a helpful informational booklet from the NGO about typical psychological reactions to rape and recovery from such trauma. Further, several survivors noted many barriers to accessing counselling including transport difficulties, the inability to get time off work and perceived stigma of attending counselling at an NGO specialising in post-rape support.

Although the NGO sector is the only service that was identified for providing post-rape mental health care, and specific NGOs were regarded as having more expertise and being more accessible than formal mental health professionals, many did not offer an evidence-based treatment protocol. Further, financial pressures and fundraising problems contributed to instability within this sector and potential disruptions in continuity of care.

SURVIVORS' MENTAL HEALTH NEEDS

The survivors – all adult women who were taking or had taken PEP to prevent HIV infection – interviewed in this study at various stages after their initial visit to a post-rape care clinic demonstrated different levels of coping and well-being or distress. For example, some survivors spoke easily and confidently about their experiences in post-rape services and articulated their thoughts and feelings about the rape incident or perpetrator. These survivors were still experiencing emotional difficulties and described some stigmatisation, anxiety and anger, but appeared to be coping. Generally, these survivors had a good support structure, including caring and supportive family members or close friends. However, other survivors exhibited symptoms of hypervigilance, emotional disregulation, flat affect, and described thoughts of self-blame and stigma during the interviews. These survivors generally did not have supportive people in their lives or had not disclosed the rape to anyone other than the police and clinic staff. Further, these survivors were generally not coping well and reported disruptions in their daily functioning such as insomnia, having to miss work, flashbacks, not trusting people or not wanting to leave home. Two survivors disclosed having suicidal thoughts with one reporting that she experienced them in the few days after the rape but not again because she had good family support. The other survivor reported current suicidal thoughts even several weeks after the rape. However, an assessment of this ideation revealed that she had not made any plans

for suicide, indicating a low risk if she accessed supportive services (which she planned to do after the researcher helped her develop an action plan to access such help; she sent a text message confirming that she had implemented the plan).

Twelve of the thirteen survivors were given PEP to prevent HIV (one survivor from the rural centre tested HIV positive at the initial visit); three of them were still taking the medications at the time of the interview; one described that she was not given the full course (although she did not understand that this was due to her intermittent adherence during the first week); and the remaining eight survivors reported that they were mostly or entirely adherent to the full course of PEP. Some noted that it is "not easy because sometimes it reminds me about why I'm taking it" (Survivor 6). Those who reported adherence and were able to articulate their strategies for ensuring adherence all noted a close family member or friend helping to remind and support them during this 28-day medication course. One survivor described that she was taking the medication for her young daughter's sake. Another survivor described using an alarm reminder set on her cellphone to help remember to take the medications.

Generally survivors were grateful for the services they received at the post-rape care clinic and described the service they received as primarily the forensic examination with few discussing the mental health support or care without being prompted to do so. A survivor stated: "I think it was helpful because of the medication and the bit of counselling that they gave" (Survivor 6). Any small gestures of caring or support were appreciated by the survivors and some even marvelled at the attention they received and how long the doctor spent with them. One survivor remarked: "I really appreciate the way she [the doctor] handled me. … she was just very respectful. I really appreciated the doctor. Like she even made some informal conversation" (Survivor 8). One doctor expressed that survivors generally had very low expectations, possibly because of their previous experiences in primary health care settings: "[they are] so used to bad service so much that when someone is doing their job properly … it's such a shock. Like I had a patient on Monday … it took a long time to get through the history and … she said 'but you are so much time with me, is it ok …? You know, I said 'No, it's fine.' … she could not understand" (Provider 8).

However, survivors also noted several frustrations with the post-rape care services. Almost all survivors noted their frustration and anger with the police and the judicial system more broadly. That is, survivors found it difficult to make a report at police stations, experienced unsupportive responses from police, received little or incorrect information about the procedures, and rarely received follow up. Three survivors – two sisters and one individual – described a positive experience with the police who were first responders at the rape scene (called to the scene at the sisters' home and happened to drive past the scene with the individual). The police took them to the post-rape care clinic. In addition, some clinic staff described how sometimes police would help to bring survivors back to the clinic for follow-up visits, but that such help was not routine or universal. Despite the police members describing the availability of VEP services, including a comfortable, private room for victims to wait and volunteers to help support them, no survivors discussed receiving such service.

Survivors also described frustrations with the post-rape care clinics, with one survivor describing her experience as chaotic, similar to "a very unrehearsed play" (Survivor 8). This survivor, like several others, described how their trauma-related anxiety or shock were exacerbated at the clinic when they were confused about or did not know what the procedure would be. Indeed, sessions with the counsellor were observed to focus primarily on asking the survivor to recount the incident while the counsellor took notes and then gave some brief, cursory information about the next steps of seeing the nurse or doctor. Most of the survivors said they had to wait a long time at the police station and again at the clinic, which was frustrating, tiring and stressful given their traumatic state at the time. Also of concern were that several survivors appeared to have a poor understanding of PEP medication to prevent HIV infection, including misunderstandings about the importance of adherence or effectiveness, even though they all reported that they were told that it was important to take the PEP. This confusion suggests a gap in how and what information is provided during the initial visit by clinic staff. This process needs to be sensitive to the emotional and informational needs of the survivor.

Another survivor described sitting alone in the clinic waiting room and seeing clinic staff sitting together "chatting…and laughing and stuff" (Survivor 10), which made her feel more isolated as if the staff "don't care" about their work or survivors in the clinic. This survivor, amongst others, mentioned that they would like clinic staff to spend time with them and talk about things other than the rape to help make the survivor feel comfortable and not to ruminate on the rape incident. Indeed, as described earlier, one survivor appreciated that the doctor was able to have a conversation about things other than the rape to help her feel more comfortable. While some survivors said they felt the service was rushed, especially the session with the counsellor, others felt that although they were frustrated with waiting for up to a few hours at the clinic, they appreciated how they were seen faster within this service and spent more time with the doctor compared to a primary health or community health clinic.

CAPACITY OF STAFF TO PROVIDE MENTAL HEALTH SUPPORT

Most staff working in the post-rape care clinics did not have specific mental health training and generally, data from interviews suggested that there were generally very low levels of mental health literacy among the staff. For example, most service providers assumed questions about mental health referred to people who were 'mentally challenged' or 'mentally ill'. Of the multidisciplinary staff, the lay counsellors generally had a fair understanding of typical mental health consequences of rape. For example, one counsellor described that providing mental health support meant "support[ing] clients to accept and move on with their lives in a healthy way" (Provider 2). Most counsellors described typical post-rape mental health issues as "rape trauma syndrome" and not post-traumatic stress disorder, and additionally noted that "some [survivors] are suicidal, some are depressed, traumatised" (Provider 2).

Most staff at the post-rape care clinics who were interviewed were concerned about survivors' mental health issues. However, few believed they had any impact on or role in survivors' mental health. Indeed, there were somewhat contradictory attitudes about survivor mental health with some providers believing it more relevant later in the recovery process and outside the scope of the services at the specialist centre, where physical health needs (for example, HIV, pregnancy, STIs and injuries) and forensic tasks were the primary focus. In addition, few service providers considered that there may be links between survivors' mental health, and their adherence to PEP or uptake of immediate and long-term services. Some service providers acknowledged that some patients were very distressed at the initial visit and that this state may interfere with their ability to retain information. However, none offered solutions to this issue. In general, it appeared that despite efforts to bring in a lay counsellor to offer mental health support to survivors at post-rape care clinics, there was little integration of such support throughout the service. This poor mental health literacy and resulting poor integration of mental health care may also have contributed to compromising the mental health support services within the acute service clinics. For example, at one site, the initial appointment with the counsellor is sometimes skipped or delayed to allow the doctor to conduct the examination at a time convenient for the doctor. At this same centre, the doctor asked counsellors not to "prolong" their sessions with survivors because they would become "tedious" and this provider proudly stated that after his intervention, "they shortened their interview time with the victim" (Provider 9).

With the exception of the lay counsellors, very few of the multi-disciplinary service providers working within the specialist post-rape care clinics had any formal training in general mental health or specific, trauma-related mental health issues and care. Indeed, some providers identified this training gap as an issue that needed to be addressed, and one doctor noted the need for all staff working in the clinic to be trained in trauma-related mental health care. Without formal skills and knowledge of this area, service providers relied on the knowledge and skills that they picked up through their experiences of working with sexual assault survivors. This lack of training likely contributes to the poor mental health literacy demonstrated among many of the service providers. Many service providers immediately assumed that mental health was a reference to "mentally ill" or "mentally challenged" survivors, but they did not have a standard screening or diagnostic tool to clinically identify survivors with a mental illness or intellectual or psychosocial disability. They described these survivors as having a "malfunctioning mind [or] a missing link [or] long pauses in speech, tone of voice, can't be calmed" (Provider 3), and all these service providers noted that they did not have adequate skills or resources to address the needs of such survivors saying "we're not sure what to do with them" (Provider 3). However, some service providers, primarily lay counsellors, described common mental health issues among survivors: "some are suicidal, some are depressed, traumatised, they've just come to a dead end in their lives feeling that they can never get back on track from where they are, and some clients are in denial and continuously ask why" (Provider 2). No service providers used a formal, validated clinical screening tool to assess survivors' mental health at any stage during the acute post-rape services. However, one doctor said: "I think actually every patient should have at least one psychological, or two psychological screenings ... I think it should just be part of a protocol, but it's not" (Provider 12).

No service providers identified a potential link between survivors' mental health and their PEP adherence or take up of continued care such as returning for follow-up appointments at the clinic. Further, several service providers from various professional backgrounds asserted that they did not believe the post-rape services at the clinic had any impact on survivors' mental health. Two doctors confided the possibility of service providers "doing damage" (Provider 8) through secondary victimisation of the survivors by engaging in victim blame, asking survivors to repeatedly recount the rape, or not offering a compassionate service. Further, as discussed earlier, several service providers noted their frustration with referring survivors to long-term services that had long waiting lists or whose service was unpredictable.

The poor integration of mental health care in acute post-rape care services may also be a product of poor mental health literacy and a prioritisation of medical care and forensic examination. One provider described

this prioritisation noting that "we can just concentrate on the mental health aspect much later" (Provider 12). The prioritisation of medical and forensic services that exclude mental health are also reflected in funding, that is, neither the Department of Health nor the National Prosecuting Authority fund the lay counsellor positions at the clinics, and long-term mental health services for sexual assault survivors are almost entirely provided by NGOs and not the Department of Health. Further, even some of the lay counsellors said that basic psycho-education of common trauma-related mental health issues were left up to these NGOs: "rape trauma syndrome is covered by [the NGO]. I can only touch on that, cannot go in depth" (Provider 3). Additional barriers to full integration of mental health include the observed hierarchical nature of staff in the clinics that reinforce staff working in silos and lay counsellors having little power to educate or influence other service providers. A doctor also noted that "we sometimes very afraid to explore the mental health issue simply because we don't have the time, or the manpower to be able to do it" (Provider 12). Another doctor justified cutting down the counselling session time by asserting that "not everybody wants to be counselled, some people just actually want to go home" (Provider 9). The low levels of mental health literacy and poor value of mental health within the post-rape service system contributes to the lack of evidence-based mental health-care interventions.

SERVICES FOR CHILD AND ADOLESCENT RAPE SURVIVORS

In general, the service package was the same for children, adolescents and adults. However, some of the service centres in both urban and rural settings had child-friendly waiting areas available. In the urban centres, children and adolescents were given comfort packs donated by NGOs. These packs included a small toy, basic toiletries and a change of underwear. No service providers interviewed in this study had specialised child/adolescent training, and most found working with these young survivors "not as easy as working with adults." One lay counsellor at an urban clinic described that it was only through her experience that she learnt that she had to "chat" to children while playing with them in the play area in order to engage them. With adolescents she found it helpful to offer to meet with the teen separate from the parents and to begin talking about other things so that "they see that you are interested in them, then they start relaxing and they open up" (Provider 4) and then she offers them the opportunity to ask questions. This is in contrast to dealing with adults, with whom most providers are more direct and formal in their discussions.

SERVICE PROVIDER MENTAL HEALTH AND WORK STRESS

Many of the service providers, especially the lay counsellors, described that they found their work of helping survivors to be fulfilling and one provider described it as a "privilege" (Provider 4). However, all service providers also noted that it can be "very difficult" and, as one provider described, "there is a lot of stress, there is a lot of work" (Provider 4). As one provider noted "it's very draining … you can become very depressed sometimes because sometimes you feel – not another one" (Provider 7) and another described that "you just get so angry" (Provider 8). Specifically, hearing details of survivors' rape traumas, dealing with child or elderly survivors, seeing physical injuries, feeling helpless or not knowing how to help survivors, and dealing with victim blame attitudes in the community were particular stressors identified by various service providers. As some providers explained, the work with survivors "touches you; we are people too" (Provider 1), it can "take out so much of yourself" (Provider 2), and "sometimes it's so heart sore" (Provider 7).

Several survivors described how this stress and vicarious trauma affected them.

"You start to reach burnout very quickly. Where you reach your top. You get stressed easily. You pop up easily. Your nerves, you know, they are not stable. You've given and you've given and you've given until you can't give anymore" (Provider 2).

"When you feel like, eh, you've worked and worked and worked and worked … you feel like all your breath has been removed from you, you cannot breathe anywhere anymore because of the things that you've heard" (Provider 3).

"…this thing is working in your mind all the time and you will develop a headache and you will feel miserable and I don't think that you will be able to help your next customer" (Provider 4).

"My body is telling me now that I am tired now, I don't want to do anything really, I am really tired, that is how I feel it, I will take a leave otherwise I will be messing everything up" (Provider 14).

Some of the manifestations of this stress that service providers described included feeling afraid while at home, in the community, or when commuting home and becoming over-protective of their children and not allowing them to go out. One lay counsellor worried that she would "burnout and that will come crashing on my kids" (Provider 4). Some providers described that they experienced flashbacks, specifically of physical injuries

they witness in the clinic; feeling negative or pessimistic, especially about other people; hyper-vigilance, including an exaggerated startle response; and trouble focusing on sessions with survivors. These symptoms are typical of post-traumatic stress. These struggles with stress and vicarious trauma were compounded by facing struggles outside of work including financial stress, parenting stress, family conflict and managing a household.

Further, during observations, some service providers demonstrated behaviour that may be explained by reactions to vicarious trauma, including apparent compassion fatigue. That is, many service providers maintained a detached, business-like demeanour throughout their consultation with a survivor that significantly limited compassion or a connectedness between provider and survivor. For example, service providers wanted a brief, facts-only report of the rape and not an emotional narrative; most providers did not engage in any 'small talk' to help build rapport with the survivor and put them at ease; and some doctors did not talk the survivor through the forensic examination procedure before or during this lengthy and relatively invasive process. Several service providers were unable to cope with survivors' distress and would respond by asking the survivor not to cry. Some providers became short-tempered and irritable with other team members and some would stop taking calls or survivor appointments for periods of time when they felt overwhelmed with stress or vicarious trauma.

Despite these struggles, not all providers had access to support resources for themselves. According to service provider reports, only the lay counsellors appeared to have regular debriefing sessions. Debriefing, as a "space to offload" or "vent" as several providers said, supervision sessions, and on-going training were the most common suggestions from participants to help them deal with work-related stress and vicarious trauma. Other suggestions included on-site massages, on-site exercise equipment, being able to engage in a variety of activities instead of only sexual assault cases, and adequate supplies such as pens. Of concern, the Department of Health did not, according to participants in this study, provide any vicarious trauma prevention or support services to their staff, and although the National Prosecuting Authority organised some debriefing and support activities for clinic staff, these were irregular. Only the NGO who funded and supported the lay counsellors at the clinics had regular debriefing, supervision and on-going training sessions for their staff, which may not be surprising given that this group's focus is on trauma-related mental health care.

SUMMARY

The qualitative data from individual, in-depth interviews and observations indicate that the model of acute care for sexual assault is focused on forensic examination, biomedical intervention and legal advocacy. Mental health care is not prioritised in this acute service phase. Instead, the principal mental health care is consigned to the long-term services provided by NGOs that have to be accessed independently, outside the acute services. The low status of mental health in acute post-rape services, the inadequate capacity of service providers within the system to provide mental health care, the lack of continuity of care, the poor linkages to on-going mental health care, the mental health challenges faced by the service provider, and service inequities, all contribute to the poor integration of mental health care into the post-rape service package.

There are several service inequities that further compromise the post-rape care services. Not only are mental health services not prioritised or well integrated into the service package, but this package is geared towards adult women, meaning that children, adolescents and men are less easily accommodated, even though these groups do report to clinics for post-rape care. Further, there are striking differences between services available in urban areas compared to rural areas. Currently, the specialist post-rape care centres have a strong presence in urban and peri-urban areas. Post-rape services in rural areas have to rely on non-specialist staff at local CHCs to provide the necessary care. However, many of these staff were found to be reluctant to provide this service. However, there are individuals – usually volunteers – within rural communities who champion the cause and mobilise services within existing sectors (such as within the VEP at the rural site police station in this study) to respond to rape survivors' needs and support them through the medico-legal processes.

The findings indicated that mental health was not prioritised or reliably funded in post-rape services, with NGOs bearing the financial and practical responsibility for this service. There is generally poor mental health literacy among service providers who have little formal training in mental health. Many service providers did not see their position as having any impact on survivors' mental health or on the link between PEP adherence, retention in care and mental health. There are no screening tools, guidelines or policies related to mental health for service providers to integrate such support in their regular service provision. Further, the unaddressed mental health needs and challenges of the staff affect how service providers approach and work with survivors and one another within the post-rape care clinics. Staff turnover and rotating staff schedules within the 24-hour post-rape care services contribute to poor continuity of care for survivors who often are experiencing acute traumatic stress reactions. The poor linkages to on-going mental health care, in particular, are exacerbated by the fact that service providers generally do not instrumentally facilitate, monitor or follow up on survivors accessing these services. Given that the survivors who did access long-term counselling at local NGOs found it beneficial, it seems important to help facilitate survivors accessing such services.

Mental health support within the current service package is more of an information gathering and containment session rather than a counselling session focused on psycho-education, emotional support, and preparing survivors for the forensic examination and potential PEP regimen. Observations at the clinics indicated several missed opportunities to provide mental health care, psycho-education, and stronger linkages to on-going care for the survivors. Perhaps the greatest missed opportunity is that mental health support is not routinely provided at the follow-up sessions. Further, a survivor's emotional state may also interfere with their ability to fully engage with and absorb the large amount of complex and critical information they are given during the initial session, and this interference may negatively impact on PEP adherence and service uptake. In addition, the post-rape care service providers do not yet have an effective strategy to improve the information transfer, PEP adherence and retention in care, or referral uptake.

This study intended to focus specifically on survivors' mental health and wellbeing. However, a strong emerging theme from this research is also the importance of service providers' mental health and wellbeing. Observations of and interviews with service providers in the field revealed that post-rape services were very stressful to conduct, because of a combination of high workload, the traumatic nature of the work, and little or no support for service providers' mental health and wellbeing. Several providers appeared to be, and discussed, struggling with vicarious trauma reactions and compassion fatigue that negatively affected their work and personal lives. If service providers better understood their own mental health and vicarious trauma, and were better supported in self-care and regular support or debriefing activities that promotes their mental health and effectively treats mental health problems, then they are likely to organically pass

on some of this knowledge and attitudes to survivors. Further, their capacity for relating to and engaging with clients in an on-going compassionate and empathic way is likely to be enhanced, because they will not resort to the self-protective strategies of detachment and distress intolerance that were witnessed in several post-rape service settings.

The high workload, staff mental health challenges and vicarious trauma, general mental health illiteracy, and reliance on – without support of – the NGO sector, all contribute to poor integration of mental health into the post-rape service package and poor linkages to mental health care outside of acute services. This significant gap in post-rape care may have a cascading detrimental effect on survivors' long-term health, because mental health factors are hypothesised to be critical mediating factors in HIV acquisition and onset of chronic conditions such as hypertension, diabetes, asthma, heart disease, cancer and arthritis post-rape (Jewkes, Dunkle et al 2010). For HIV acquisition specifically, there are several hypothesised indirect pathways that have strong links to trauma-related mental health issues and rape stigma. Rape and other intimate partner violence often decreases women's agency and self-efficacy, making it less likely that they assert themselves and their needs in sexual contexts such as insisting on condom use and fidelity (Wood et al 1998; Pettifor et al 2005; Jewkes et al 2006). In addition, some women may sustain relationships with men who present high HIV risk such as violent men and men who engage in risky sexual practices (Jewkes et al 2011; Decker et al 2009; Dunkle et al 2006; Jewkes et al 2006). Some women engage in high-risk sexual behaviours and other co-occurring risk-taking (for example, substance abuse) in the aftermath of rape (Dunkle et al 2004; Jewkes et al 2006; Pettifor et al 2005; Jewkes et al 2012; Zablotska et al 2000; Gilbert et al 2009). Providing mental health support throughout post-rape services will not only help survivors cope with the psychological trauma of rape, but will also likely improve PEP adherence and retention in care, and combat the indirect pathways to post-rape HIV acquisition and chronic illnesses. Rape survivors' mental health needs should be addressed during the immediate post-rape services and on an on-going basis, particularly if the survivor has to endure court processes that are often very stressful and thus may exacerbate existing mental health struggles or trigger a relapse of psychological trauma. Providing mental health care and support during the initial services is essential to begin the process of promoting recovery and building adaptive coping and resilience methods among survivors. Such a foundation will be invaluable for increasing the likelihood that survivors will access and engage in on-going mental health services.

This study did not engage with policy makers or review post-rape care policies. Therefore, no comment can be made on the extent to which policy makers and policies acknowledge and address mental health within acute post-rape services and if they do, what specifically the attitudes and recommendations are about mental health within this specialised service.

RECOMMENDATIONS

TRAINING AND SUPPORTING SERVICE PROVIDERS

In order to reduce mental health illiteracy, vicarious trauma and compassion fatigue among post-rape care service providers, all staff working within this service system should be given foundational pre-service and on-going in-service training in trauma-related mental health issues. Further, staff need routine self-care and debriefing in order to promote and support their own mental health and wellbeing within this particularly traumatic and stressful field. If feasible, staff may also benefit from routine relief either by rotating tasks or providing short-term locum service providers who are adequately trained and supported.

Service providers' own mental health and well-being appears to have an impact on their work and ultimately on the services that the survivors receive. It is likely that improving the service providers' understanding of mental health issues and supporting their mental health will result in subtle, but significant changes in the way they approach each survivor (for example, 'bedside manner'), the way they provide information and referrals, and the mental health information they integrate into their discussions with survivors. This approach does not need extensive resources and would not require the training and integration of a new intervention package, but just important adjustments within the current service package. Further, supporting service providers' mental health is likely to improve staff retention and resilience within this crucial and stressful service area.

STRENGTHEN SERVICES FOR SURVIVORS

The referral process should be improved to better facilitate the transition between and access to longer-term support services for rape survivors, which will address the current problems with linkages between acute services and long-term services. In addition, all providers need to consider that their interaction has an impact on survivors' mental health and thus they need training to consistently provide mental health support across service providers. This may be as simple as how providers approach and engage with survivors in a compassionate and supportive, yet professional and efficient way.

It is essential to consider evidence-based service models for providing acute and long-term mental health services to rape survivors. For example, psychological first aid (Garcia-Moreno and van Ommeren, 2012) or implementing a buddy system similar to the one used in the HIV-ART services may be helpful and feasible to integrate into the busy acute post-rape care services. Given that survivors with good social support from family or close friends appeared to fare the best in terms of PEP adherence and mental wellbeing, it is important to try to involve and support the family through the service offered to the rape survivors and to have a consistent case management approach that will provide survivors with continuity of care and support through the post-rape care services. Further, mental health support should be integrated throughout the initial and follow-up visits. Indeed, the follow-up visits may be opportunities for service providers to conduct standard mental health screenings using validated tools for depression, anxiety and PTSD. These screening tools can prompt specific and detailed referrals for specialist mental health services for survivors.

In addition, long-term services should consider cognitive behavioural therapeutic approaches that address the often co-occurring issues of PTSD, depression and substance abuse, which have been found to be promising in other low-resource contexts (Garcia-Moreno and van Ommeren, 2012; Bass, 2013; Woollett, 2013). Interventions will need to be brief in order to fit into an already highly burdened service system and also to accommodate many survivors' struggles to access transport and secure time off from work.

INTEGRATE MONITORING AND EVALUATION STRATEGIES TO ENSURE ON-GOING EFFECTIVENESS

Monitoring, evaluation and learning strategies help service providers and managers to understand how well a particular service system or specific interventions are working. In addition, such strategies need to evaluate fidelity to the service model including the manualised mental health support suggested earlier. Integrating these processes into the service system will also help to establish new, innovative practices as effective, evidence-based interventions, which are essential and currently lacking in the field. For example, the field is struggling to find the most effective mode of information transfer within a traumatic situation. Monitoring and evaluation strategies should include tracking survivors throughout acute and long-term care, and potentially integrating support services into on-going justice procedures.

SPECIFIC POLICY CLARIFICATION

Monitoring and evaluation strategies would be most effective with standardised policies and protocols developed and communicated to all service providers within the post-rape care service system. That is, PEP to prevent HIV administration, adherence promotion and mental health support procedures need to be clear to all service provider stakeholders, whether they are within the clinics or those who link survivors with the health services. Better understanding of clear, simple policies and procedures is likely to promote consistent and coordinated care across service institutions and providers.

There should be consideration of PEP provision policies that promote adherence and linkage to on-going care. That is, it is unclear whether providing the full 28-day course or stages of medication is more effective. It is also unclear whether obtaining on-going PEP medication from the same centre or from a more conveniently located general clinic is more effective, and what implications these practices will have on PEP adherence and linkage to on-going care needs, particularly for common mental health difficulties. Further exploration is needed on mono-therapy/fixed-dose combination options, and whether the medication options affect adherence.

A comprehensive post-rape care policy should also take into account services in urban and rural areas, and specifically the additional roles that, for example, VEP plays in post-rape services in rural areas that do not have one-stop care centres. Further, policies should take into account the multiple roles played by paraprofessionals, such as lay counsellors, in the post-rape service model. Adequate training, support, and recognition must be given to these positions as they play a key role in a linking different aspects of post-rape care.

SUSTAINABILITY OF POST-RAPE SERVICES

We posit that providing mental health support and training for service providers, integrating mental health care for survivors into the service system, implementing appropriate monitoring and evaluation strategies, and clarifying policies and procedures for comprehensive post-rape care will contribute to sustainable and effective post-rape services that address the health-care, justice and support needs of survivors. One key aspect to ensure sustainability is providing adequate funding for post-rape services, with mental health as a core pillar of these services, and which is currently dependent on inconsistent sources of funding, which has implications for provision and quality of care.

RESEARCH PRIORITIES

Effective mental health interventions for service providers and survivors need to be developed and evaluated particularly to find those that can be feasibly implemented in low-resource settings with staff with diverse skill sets ranging from volunteers and paraprofessionals to medical forensic specialists. Therefore, such research should seek to identify the minimum skills, training, supervision, and resources needed to implement such interventions in culturally appropriate ways. These research priorities have also been identified in a recent WHO report (Garcia-Moreno and van Ommeren, 2012).

Although there have been great strides in providing acute post-rape care within a single-site, comprehensive or 'one-stop' specialist service, such a service cannot be considered truly comprehensive without providing essential mental health support and care for both survivors and service providers. Improving the general approach and manner of engaging survivors, and strengthening the linkages to on-going mental health care, are essential in order to better integrate mental health services into the post-rape care service package.

CONCLUSION

Although there have been great strides in providing acute post-rape care within a single-site, comprehensive or 'one-stop' specialist service, such a service cannot be considered truly comprehensive without providing essential mental health support and care for both survivors and service providers. Improving the general approach and manner of engaging survivors, and strengthening the linkages to on-going mental health care, are essential in order to better integrate mental health services into the post-rape care service package.

CASE EXAMPLE: Convincing service providers to assist with accessing counselling

A woman who was well informed of her rights spoke of her difficulty in accessing counselling services in her rural area. She explained attending court and said: 'Yes, I was very emotional on that day. After the session I asked if there was an organisation that they can refer, or counselling or whatever. For me, in fact, what I was looking for, an organisation that deals with the victims of my situation. And then she said, okay, we'll arrange that for you via Mr B. , the detective. So I came back. After a week there was no phone call from Mr B. I asked the prosecutor about this, and she said she was going to talk to them. Okay, yes, she did, and after two days I had a certain call from the station, asking me do I know A-Centre, it's a centre and they do counselling. I said, yes, I know because it's in our community. And they said, okay, yes, that's where you can go. Then I went to A-Centre during June month. However, they were closed because they are working like a school, so during school breaks they are also closed. And then they were going to open on the 18th of July. Ja, then I went there, maybe not the 18th ... I can't remember the date ... to make an appointment, and I got the appointment. So I went for my first session to a lady who speaks Xhosa for my session. I told the counsellor what happened and the reason I was there, and the session took place. Also, I was also emotional. The next session was scheduled for last week Thursday. However, on Tuesday they phoned me and said she was off sick up to Thursday, so she can be available on Friday. And on Friday my detective told me I had to be at court on the 12th. Then I said, okay, let's postpone it. (rural woman, Survivor 7)

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