

**ADULT FEMALE RAPE VICTIMS' VIEWS ABOUT THE  
THUTHUZELA CARE CENTRES: A SOUTH AFRICAN  
MULTI-DISCIPLINARY SERVICE DELIVERY MODEL<sup>1</sup>****Nigel Bradely Bougard<sup>2</sup> and Karen Booyens<sup>3</sup>****ABSTRACT**

*The article explores adult female rape victims' views about the Thuthuzela Care Centre (TCC) service delivery model as a multidisciplinary one-stop centre for victims of sexual offences and domestic violence. The research primarily followed a descriptive purpose, although some of the components were exploratory in nature. Adult female rape survivors were asked to complete a self-administered questionnaire with the assistance of staff located at a specific TCC. Hence, the data were collected at four TCCs in the Gauteng province, South Africa, during 2012-2014. The research results indicated that service delivery was experienced as satisfactory and that a positive relationship existed between the victim and TCC staff. Forty-five research respondents participated in the study.*

**Keywords:** *victim/survivor; rape; service delivery; Thuthuzela Care Centre (TCC) service delivery model.*

**INTRODUCTION**

South Africa is considered to be the rape capital of the world, with a high rate of sexual offences reported to the South African Police Service (SAPS) annually. The statistics for rape indicated that 62 649 cases were reported during the period of 2013/2014 (South African Police Service, 2015). The aforesaid statistics furthermore substantiate claims that 1 300 women can be expected to be raped in South Africa per day, deducing that a woman is raped every 17 seconds. In addition, it is also postulated by researchers that of the total number of sexual offences, it is projected that around 55 000 rapes are reported to the police, annually. An accurate prediction of the number of rapes is thus articulated to be approximately nine times higher than the actual reported figure (Jewkes, Sikweyiya, Morrell & Dunkle, 2010: 23; Pistorius, 2005: 240; Rape Statistics South Africa & Worldwide, 2012: 1; Seedat, Van Niekerk, Jewkes, Suffla & Ratele, 2009: 1011-1013; Van der Watt & Van Graan, 2013: 106). South African rape statistics are nearly four times the rate of sexual offences reported in the United States of America (USA) annually. Nonetheless, despite the high occurrence of rape, the South African National Institute for Crime Prevention and the Reintegration of Offenders (NICRO) estimates that only one in every 20 rapes is reported. This under reporting can be attributed to a number of influences; such as the fear of stigmatisation that rape victims may suffer, feelings of self-blame, restrictions that exist in the community pertaining to sexual violence against women, fear that the police may discriminate against them and secondary victimisation by role players within the criminal justice system (CJS) (Jewkes, Sikweyiya, Morrell & Dunkle, 2009: 1; Sigsworth, 2009: 8).

“It is also imperative to take note that a strong relationship exists between sexual offences and the frequency of the Human Immunodeficiency Virus (HIV)”. Statistics indicate that the prevalence rate of women living with HIV internationally has stabilised at 50 percent,

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although more women are affected with HIV in sub-Saharan Africa (59% of the entire population is living with HIV) (UNAIDS, 2011: 6-7). In addition, the total number of persons infected with HIV has increased from 4 million in 2002 to 5.6 million by 2013 in South Africa, inferring that more than ten percent of the total population is HIV-positive. African women in particular aged 18-34 years have the highest HIV prevalence rate (31.6%) in South Africa, which demonstrates a higher risk of being exposed to HIV. Collectively, 17.4 percent of South African women aged 15-49 years were HIV-positive by 2013 (Statistics South Africa, 2012: 4; Shisana, Rehle, Simbayi, Zuma, Jooste, Zunga, Labadarios, 2014: 28).

Research conducted by Jewkes et al. (2009: 1-12), found that the significant HIV infection rate in SA may be that physically violent men are also likely to rape and engage in high risk unprotected sexual acts (inclusive of unprotected anal sex), which makes victims of rape more susceptible to contracting HIV. Furthermore, this particular group of men are between the ages of 25-45 years of age, and most likely to have been arrested for a sexual offence.

The HIV/AIDS prevalence rate and the number of rapes reported to the SAPS, as described above, are just some of the matters that led to the enactment of the Criminal Law (Sexual Offences and Related Matters) Amendment Act (32 of 2007). Chapter 5 of this Act deals with the services for rape survivors, including the statutory provisions for the compulsory HIV testing of alleged sex offenders.

Despite this high incidence of rape, services for the victims only emerged during the 1980s, which was furthermore considered to have been insufficient with the implementation thereof. Henceforth, during the 1980s the South African government addressed the occurrence of rape through initiatives, such as a rape crisis centre at Tygerberg Hospital in Cape Town, as well as the establishment of Helpline for victims of crime in Pretoria, Benoni, Randburg, Pietermaritzburg and Port Elizabeth (renamed to Nelson Mandela Bay). The founding of People Opposing Woman Abuse (POWA), as a means of activism with a vision of empowering women as victims of crime, also came to light. However, these mechanisms to assist rape survivors did not share a common objective, since the services during this period were to address the unresponsive methods employed by the SAPS when in contact with victims of sexual offences (Labuschagne, 1987: 5).

During the 1980s, victims of sexual assault or rape were medically examined by District Surgeons (DSs) (occasionally in a room located at the police station). This perceived unsatisfactory mode of service delivery of not being sensitive towards the needs of victims of rape, prompted DSs over the last decade to nurture a new approach in working with survivors of sexual violence. These concerns pertaining to the treatment of rape survivors also led to the development of the Family Violence, Child Protection and Sexual Offences Unit (FCS) located at police stations. Furthermore, the emergence of the FCS also made way for several rape crisis centres to develop, which involved the participation of national activists and members of the community. Although the FCS places an emphasis on the prevention of child sexual abuse, most of the cases they deal with comprise of domestic violence and sexual offences (see the *Uniform Protocol For the Management of Victims, Survivors and Witnesses of Domestic Violence and Sexual Offences* document of the National Prosecuting Authority (NPA), 2008: 2).

In 2002 an anti-rape strategy focussing on the reaction, prevention and support for victims of rape and sexual assault was instigated by the South African government at the time, through the assistance of the Department of Justice and Constitutional Development (DOJCD). Other stakeholders who also formed part of this multidisciplinary team were, amongst others, the Government Communications and Information Systems (GCIS), the Department of Safety and Security (DSS), the Department of Correctional Services (DCS), the Department of Education (DoE) and the Department of Treasury (DoT), which became known as an Inter-Departmental Management Team (IDMT). The IDMT functioned under

the directives of the Sexual Offences and Community Affairs Unit (SOCA) of the National Prosecuting Authority (NPA) (Sexual Offences and Community Affairs Unit (SOCA), National Prosecuting Authority (NPA), 2008: 10).

During April 2008, IDMT hosted an INDABA (a discussion conference), which focused on the collaboration and support, as well as the establishment of support mechanisms at provincial levels that would be responsible for the implementation of the so-called TCCs nationally. The Southern Hemisphere Agency (SHA), who specialised on service delivery, was approached to explore the role players to be enshrined within the TCC Model, the type of governance structure within the aforesaid edifice and the manner in which the services for rape survivors should be implemented. After an extensive consultative process with all role players from IDMT, the TCC Model was adopted and deals with the management of the services for rape survivors, elaborating upon the need for the victim of rape to be placed at the forefront of service delivery. A victim-centred approach thus seeks to instil some means of victim empowerment and guidance throughout the CJS and gave rise to the TCC Model in its current format (NPA, 2008: 5; SOCA/NPA, , 2008: 10-11).

The aim of the article is to provide an overview of the TCC Multidisciplinary Service Delivery Model that provides medico-legal services to victims of rape. More specifically, the article explicates a brief overview of the development of the TCC Multidisciplinary Care Model approach as a service provider for victims of rape. The roles and responsibilities of the various stakeholders and professionals within the TCC Model will also be contextualised, with an emphasis placed upon the quality of services rape survivors received at the respective TCC centres. Furthermore, the importance of Post-Exposure Prophylaxis (PEP) to rape survivors within 72 hours (3 days) will also be explored (World Health Organisation (WHO)/International Labour Organisation (ILO), 2008: 33; Abrahams & Jewkes, 2010: 472).

### **OVERVIEW OF THE DEVELOPMENT OF THE TCC CARE MODEL**

Thuthuzela is an isiXhosa word meaning 'comfort', which became the adopted TCC Model as a multidisciplinary approach led by the SOCA unit of the NPA. TCCs are situated in all the nine provinces of SA in terms of criteria set forth in a Blue Print Document (Protocol) and are located at health facilities; have a victim-centred approach; are directed by courts; and are guided by a prosecutor during the investigation of the alleged sexual offence. Furthermore, the TCC Model ensures co-ordination, co-operation and the involvement of all the relevant stakeholders in the provision of several services offered at the TCCs (NPA, 2008: 5).

The objectives of the TCCs are as follows, to:

- Expand the services provided to victims of rape, sexual assault and domestic violence, complemented with a reduction of secondary victimisation;
- Safeguard a speedy, efficient investigation and prosecution of sexual offences, with a decline of cycle times in which the victim is in the CJS; and
- Increase the conviction rates for sexual offences (NPA, 2008: 5).

Moreover, the TCC protocol seeks to address the following, namely to:

- Warrant uniformity and the regulation of services at TCCs within all provinces;
- Afford a standardised set of principles to ensure predictability, contribution, collaboration and accountability among all service providers, yet not neglecting joint decision making processes;
- Guarantee that victims of rape and sexual assault receive the most proficient and effective co-ordinated services, in an effort to reduce secondary trauma;

- Set forth clear explanations and definitions of all the role players, including responsibilities;
- Inspire confidence of victims and survivors in the CJS and service providers as such;
- Offer a continuous working document for service providers in a multidisciplinary environment;
- Facilitate capacity building and knowledge acquirement through the training of personnel in a multidisciplinary team, in adhering to fore set protocol;
- Provide directives on the implementation of a competent, effectual and confidential data management system;
- Ensure that referrals within all nine provinces in relation to TCCs are streamlined;
- Regulate stakeholder alliance at TCCs and Regional Courts devoted to sexual offences (NPA, 2008: 6).

### **PROTOCOL FOR SERVICE PROVIDERS INVOLVED IN THE TCC MODEL**

The key responsibilities and duties of the role players within the TCC Model are discussed briefly, in which the focus will be upon the NPA, SAPS, DoH and Department of Social Development (DSD). The role players consist of practitioners within the NPA that render support and prosecute the case; medical healthcare professionals from the DoH, who conduct the medico-legal examination; the Investigating Officer (IO) from the SAPS, who has both an administrative and investigative task; and the DSD that primarily offer support services for victims of rape and sexual assault.

#### **National Prosecuting Authority**

The NPA was established in 1996 under Section 179(1) of the Constitution of the RSA, (108 of 1996), to act as a single prosecuting authority in South Africa, with the authority to carry out the following functions, namely to:

- Initiate, regulate and monitor criminal proceedings on behalf of the state;
- Execute such proceedings; and
- Dismiss criminal proceedings (Burger, 2010: 370; Booyens, 2011: 72).

One of the units of the NPA is the SOCA unit, which was erected in 1999, with the vision of eradicating all forms of gender-based violence against women and children. SOCA was also accountable for the establishment of the TCCs. The mandate of SOCA includes:

- Developing policy with regard to the prosecution of sexual offences and gender-based violence (GBV);
- Regulating research regarding sexual offences;
- Employing community awareness about sexual offences; and
- Improving training, plans and mechanisms for the prosecution of sexual offences and gender-based violence (Booyens, 2011: 73).

These initiatives had been developed to alleviate the suffering of victims of sexual offences, as well as to increase the reporting of these offences. The various role players of the NPA will be outlined briefly.

**Site co-ordinator**

The Site Co-ordinator (SC) is responsible for the organisation of services at the TCC. Once a call has been received from a referral institution the SC must inform all the service providers, such as the SAPS and health clinics. If the SC receives details that an emergency vehicle needs to be dispatched to transport the victim, the SC with the assistance of the nurse, should make the necessary arrangements. Once the victim arrives at the TCC, the SC must make sure that the victim is not offered anything to eat or drink, nor relieve herself without the knowledge of the SC. The latter is an effort to preserve evidence until the medical examination is completed. It is also expected of the SC to explain all the procedures that will follow to the victim of rape or sexual assault. The SC should then open a TCC file for the victim and the victim's details are recorded accordingly (NPA, 2008: 24).

The SC is also expected to provide initial short-term emotional support and debriefing, and if the need arises, to make the necessary arrangements with a psychologist or counsellor for long term counselling. After the initial support and debriefing, the victim is examined by the Forensic Nurse (FN) or Forensic District Surgeon (FDS). Upon the completion of the physical forensic examination, the victim may be afforded with an opportunity to take a bath or shower at the centre. The SC should provide comfort packs, such as toiletries and clothing, if necessary and if available at the TCC. The SC should then ensure that the victim is handed over to the police for statement taking and thereafter arranges transport back to the residence/shelter for the victim. New cases that are reported at the TCC should be communicated to the case manager (CM) by the SC twice a day, at 09:00 and again at 15:00, Monday to Friday. The SC is also responsible for co-ordinating and chairing implementation meetings, public education interventions and awareness initiatives (NPA, 2008: 24-25).

**Victim assistant officer**

The victim assistant officer (VAO) is tasked with the duty of completing an intake form with the victim's information and contact details. The VAO is also responsible for determining the victim's psychological, physical, social and safety concerns. Furthermore, it also remains the responsibility of the VAO to ensure the placement of the victim in a place of safety or shelter, in instances whereby it is necessary to do so, in partnership with a social worker and/or the investigating officer (IO) (NPA, 2008: 24-25).

It is also expected of the VAO to partner with the FN in making arrangements for long-term counselling and to inform the SC of all the relevant issues pertaining to the victim. The VAO should request a progress report from the relevant service providers, in relation to any issues affecting the victim. The VAO should ensure that court preparation programmes are offered to victims of rape or sexual assault. Other duties of the VAO include continuously informing the victims about their cases, such as the bail application of the offenders and the conditions thereof, court dates and outcomes of legal proceedings. The VAO may also be requested to engage in activities aimed at prevention, protection, promotion, rehabilitation and outreach within the context of victim empowerment (NPA, 2008: 25-26).

**Case manager**

The case manager (CM) (prosecutor), is responsible for guaranteeing that cases are reported to him/her by the SC and are properly investigated. The CM must screen dockets and provide further directives to the IO(s), who must ensure that suspects are arrested and taken to court within 48 hours. The CM also acts as a link between the courts that delegate referrals and the allocation of cases from the lower courts to the High Court. The CM also communicates directly with the Office of the Directorate of Public Prosecutions (DPP) for decision on the merits of reported sexual offences and provides the control prosecutor with a daily statistics form. In addition, the CM conducts consultations with witnesses in order to make a decision

pertaining to the merits of the case and reports on the progress of TCC cases. The CM also has the duty of forwarding the information regarding the outcomes of proceedings to the VAO daily. According to the TCC protocol, it is stipulated that the prosecutor should be available to assist the IO and FCS officials on a 24 hour basis, ensure that a case is thoroughly investigated and inform the victim of the outcome thereof. Senior Public Prosecutors (SPP), have the designated task of allocating a specific sexual offences prosecutor to a specific docket (NPA, 2008: 27).

### **South African Police Service**

The IO is expected to inform the victim of rape of the compulsory HIV testing of an alleged sex offender and PEP as outlined in paragraph 11 of the Criminal Law (Sexual Offences and Related Matters) Amendment Act (32 of 2007). The reasons for completing the SAPS 308 and J88 forms and the purposes of obtaining samples should also be explained to the rape survivor. After the victim has been informed about the services available to him/her, the contents of the affidavit should be studied by the IO, in order to establish whether the victim might have been exposed to the risk of contracting HIV during the execution of the crime. The victim would have been susceptible to contracting HIV if she had been exposed to the bodily fluids of the alleged sex offender, such as blood, semen and/or vaginal fluid. Notwithstanding, if the victim had been exposed to the risk of contracting HIV, the victim should complete a copy of the Form SAPS 580 (a) (Notices of services to victim), which is available in English and Afrikaans (Department of Safety and Security, 2008: 9-10; McQuoid Mason, 2009: 31-36; Faull & Mphuthing, 2009: 132).

The Criminal Law (Sexual Offences and Related Matters) Amendment Act (32 of 2007), also makes provision for the chosen IO to execute the practical compulsory HIV testing of an alleged sex offender. The IO must place the application in an envelope marked 'Confidential' and include the following on the cover of the envelope:

- (a) the application brought forth by the victim or interested person (a person of interest who has a material interest in the well-being of a victim, including a spouse, medical practitioner, partner, family member, parent, guardian, care giver, curator, counsellor, health service provider, teacher or social worker) for HIV testing of an alleged sex offender; and
- (b) the case number, rank and persal number of the IO should also be included. The application must be submitted to the clerk of the court not later than two working days after the application had been lodged. A copy of the document must also be filed as "B" and included in the case docket (Department of Safety and Security, 2008: 3,13).

If the magistrate needs any further information, such as oral evidence, then the clerk of the court should inform the IO accordingly. If the magistrate requests further evidence by means of an affidavit, the IO must obtain the affidavit(s) as soon as possible or within the period determined by the magistrate. The evidence requested must be placed in a sealed envelope with the following details:

- (a) marked 'Confidential'; and
- (b) reflecting the case number and name, rank and persal number of the IO.

The envelope should then be submitted to the clerk of the court (Department of Safety and Security, 2008:13).

The IO is also tasked with informing the victim or interested parties of the following, in circumstances whereby the magistrate requires additional information.

- (a) Inform the victim, interested person or other witness in writing on an official police letterhead (SAPS 21) to appear before the magistrate on the given date and time as instructed by the clerk of the court, along with the signature of the victim on a copy of the written notice as proof of being informed;
- (b) If the alleged offender is required to testify, and he or she:
  - (i) is in the custody of the police, to escort him or her on the arranged date and time to appear before the magistrate; or
  - (ii) is not in the custody of the police, provide the alleged offender with a written notice on an official police letterhead (SAPS 21) informing him or her of the arranged date and time to appear before the magistrate and obtain his or her signature on the copy of the written notice as proof of the fact that he or she was informed as aforesaid.
- (c) Attend the hearing on the arranged date and time and, if the victim, interested person, other witness or the alleged offender is absent, provide the magistrate with the copy of the written notice handed to the victim, interested person, other witness or the alleged offender and on which he or she has acknowledged receipt by means of his or her signature.
- (d) Once a magistrate has decided on the outcome of the application, the clerk of the court should deliver the sealed decision to the IO, who must acknowledge receipt thereof in the register kept by the clerk of the court.
- (e) The IO should also, as soon as is reasonably possible or within the period determined by the magistrate, hand a Form SAPS 580(d) (Notice to alleged offender in respect of order for HIV testing), informing him or her of the order issued by the magistrate.
- (f) Any steps taken in accordance with this paragraph must be recorded in the investigation diary of the docket (Department of Safety and Security, 2008: 13-14).

After arresting the alleged sex offender, the IO should make sure that the identity of the alleged sex offender is confirmed and take the alleged sex offender to a Public Health Facility to have blood samples taken without delay after the arrest. Additionally, the alleged sex offender must be released as soon as the samples have been taken (Department of Safety and Security, 2008: 16).

Upon receipt of the HIV result of the alleged sex offender, the IO acknowledges the receipt thereof, and then he or she must:

- (a) if the application was made by the victim or interested person, hand a sealed record of the HIV test result of the alleged sex offender, together with a copy of Form SAPS 580(e) (Notice containing information on confidentiality of and how to deal with HIV test results) to the victim or interested person, including the alleged sex offender; or

- (b) if the application was made by the IO, hand a sealed record of the result together with a Form SAPS 580(e) (Notice containing information on confidentiality of and how to deal with HIV test results) to the alleged sex offender, and keep the other record of the HIV test results (as provided for in paragraph 15(3) of the Criminal Law (Sexual Offences and Related Matters) Amendment Act (32 of 2007). The IO should also make the HIV test results of the alleged sex offender available to the prosecutor handling the case, for the purposes of the prosecution or any other court proceedings taken (Department of Safety and Security, 2008: 16).

### **Department of Health**

Sexual violence has a prominent impact on the physical, psychological and social well-being of a victim of rape or sexual assault. The provision of PEP following rape was legislated by means of the SOCA unit of the NPA, with the purpose of providing services for free to rape survivors. This aforementioned initiative curtailed from the development of the Sexual Assault Policy and Clinical Management Guidelines of the Department of Health in 2005 (WHO/ILO, 2008: 33; Abrahams & Jewkes, 2010: 472).

Upon arrival at the respective TCC, the SC and the forensic nurse (FN) should meet the victim. In instances whereby the FN receives a call, he/she must inform the SC that the victim is on the way to the TCC. The FN then has to explain to the victim that she will be examined, which is inclusive of the details and the purpose of the forensic examination (NPA, 2008: 29).

Subsequently, after the detective has taken a statement from the victim, the FN should take the victims' information and open a hospital file to be transferred into a register with a TCC file number to the case. The details of admission are forwarded to the SC/Victim Counsellor (VC). The FN should also inform the SC/VC of admissions that took place after hours or over weekends. The FN/Lay Counsellor (LC) is also responsible for the pre- and post-HIV counselling, including debriefing. The FN should also ensure that testing for pregnancy; HIV and; other sexually transmitted infections (STIs) are conducted as required by national or provincial guidelines. Furthermore, the FN should inform the District Forensic Surgeon (DFS) or the Centre Forensic Examiner (CFE) on call, who must be a medical doctor within the TCC Model, to inform him/her that a victim has arrived. The FN or LC must prepare the docket (if available) and provide the CFE/DFS with the SAP308, Crime Kits and the evidence collection kit. It is envisioned according to the TCC Protocol that no victim should wait for longer than two hours for a medical examination to be conducted. The CFE/DFS should also explain the process of the medical examination to the victim in a sensitive and informative manner, and obtain informed consent from the victim to conduct the medical examination (NPA, 2008: 29).

The physical medical examination of the victim of sexual violence serves two objectives, namely: to collect evidence and start therapy as an initiative to address the emotional and physical consequences of the sexual assault or rape. Determining a link between the victim and offender is vital in placing the offender at the crime scene. Henceforward, a sex crimes kit, the examination of the crime scene, and the physical examination of the victim are interchangeably crucial in supporting the corroborating evidence of the victim. In addition, this link (between the victim and the alleged offender) is usually based upon Deoxyribonucleic Acid (DNA); although physical evidence is considered to have a probative and investigative purpose in confirming the facts during the enquiry process. Efficacious prosecution is highly dependent upon a careful examination of the rape survivor (Aggrawal, 2009: 214; Osterburg & Ward, 2010: 437).

### Department of Social Development

Structures within the Department of Social Development (DSD), such as the Victim Councillor (VCs), provide a pivotal service to victims of sexual offences. The VC provides psychological support to the victim(s) and should also inform the SC of any relevant information relating to the well-being of the victim on a weekly basis. The VC is also responsible for ensuring that court support programmes are offered to the victim by a suitable service provider (if not offered by the TCC where the victim sought assistance). Henceforth, the VC is also responsible for facilitating any means of referral for statutory interventions and follow-up visits. The VC should thus ensure short- medium- and long-term psycho-social services for victims of rape and sexual assault. The role of the VC is to assist the VAO with the psychological well-being of the rape survivor (NPA, 2008: 29-31).

### RESEARCH FINDINGS

The methodology is inclusive of the biographic and demographic information of the respondents and are the same as indicated in the previous article. Below follows the empirical findings of the views of the rape survivors relating to the TCCs that rendered them assistance.

#### Perspectives of adult female rape survivors about the TCC that offered assistance after the alleged rape

The following table provides an overview of the research respondents relating to the quality of services that they received at the respective TCC.

**Table 1: Views about the centre that offered assistance after the rape**

Variable	Views about the centre that offered assistance								Total	
	Yes		No		Not sure		Missing data			
	n	%	n	%	n	%	n	%	n	%
1. Victim was <b>welcomed</b> at the TCC centre.	44	97.8	0	0	1	2.2	0	0	45	100
2. Victim received <b>immediate attention</b> upon arrival at the centre.	39	86.7	1	2.2	4	8.9	1	2.2	45	100
3. Victim <b>received</b> counselling.	41	91.1	2	4.4	0	0	2	4.4	45	100
4. Victim was <b>informed</b> of an opportunity to have the alleged rapist tested for HIV within 90 days.	21	46.7	18	40.0	5	11.1	1	2.2	45	100
5. Victim received <b>treatment</b> for STIs.	40	88.9	3	6.7	0	0	2	4.4	45	100
6. Victim was informed of the <b>window period</b> of HIV.	40	88.9	1	2.2	3	6.7	1	2.2	45	100
7. Victim was informed to <b>return</b> for <b>follow-up</b> tests at the TCC centre.	42	93.3	0	0	2	4.4	1	2.2	45	100
8. Victim was examined by a doctor or nurse at the TCC centre <b>immediately</b> after the rape.	36	80.0	4	8.9	4	8.9	1	2.2	45	100
9. Victim was provided with an opportunity to <b>wash</b> at the centre.	20	44.4	23	51.1	0	0	2	4.4	45	100
10. Victim received <b>regular updates</b> from <b>personnel</b> at the centre about their case.	23	51.1	9	20.0	12	26.7	1	2.2	45	100

The 10 (ten) variables pertaining to the subjective views of adult female rape survivors will be discussed briefly:

***Variable 1: Victim was welcomed at the TCC centre***

The majority of the rape survivors (n=44) 97.8 percent were welcomed at the TCC centre, while only one (n=1) 2.2 percent of the respondents was unsure.

***Variable 2: Victim received immediate attention upon arrival at the centre***

Almost all of the respondents (n=39) 86.7 percent reported that they had received immediate attention upon arrival at the centre, only one respondent (n=1) 2.2 percent indicated that she did not receive immediate attention, whilst four (n=4) 8.9 percent of the respondents were unsure.

***Variable 3: Victim received counselling***

A large number of the respondents (n=41) 91.1 percent received counselling, and only a small fraction of the total respondents (n=2) 4.4 percent did not receive counselling.

***Variable 4: Victim was informed of an opportunity to have the alleged rapist tested for HIV within 90 days***

Almost half of the respondents (n=21) 46.7 percent were informed of the opportunity to have their alleged rapist tested for HIV within 90 days, while 18 respondents (40.0%) were not informed. Only a few respondents (n=5) 11.1 percent, were unsure if they had been informed.

***Variable 5: Victim received treatment for STIs***

A relatively large proportion of the respondents (n=40) 88.9 percent received treatment for STIs, whilst three respondents (n=3) 6.7 percent indicated that they did not receive treatment for STIs.

***Variable 6: Victim was informed of the window period of HIV***

Most of the respondents (n=40) 88.9 percent were informed of the window period. One of the respondents (n=1) 2.2%, however, indicated that she had not been informed and three (n=3) 6.7 percent were unsure if they had been informed.

***Variable 7: Victim was informed to return for follow-up tests at the TCC centre***

A distinctive number of respondents (n=42) 93.3 percent were informed to return for follow-up tests at the respective TCC centre, with only two (n=2) 4.4 percent respondents not being sure if they had been informed.

***Variable 8: Victim was examined by doctor or nurse at the TCC centre immediately after the rape***

A large proportion of the respondents (n=36) 80.0 percent were examined by a doctor or nurse at the TCC centre. An equal distribution of the respondents (n=4) 8.9 percent specified that they had not been examined or were unsure.

***Variable 9: Victim was provided with the opportunity to wash at centre***

Almost half of the respondents (n=20) 44.4 percent were afforded with an opportunity to wash at the centre, whereas (n=23) 51.1 percent of the respondents indicated that they were not provided with an opportunity to wash at the relevant centre.

***Variable 10: Victim received regular updates from personnel at the TCC about their case***

A partial response of (n=23) 51.1 percent received regular updates from the TCC regarding their case, while nine (n=9) 20.0 percent of the respondents were not informed. A few respondents (n=12) 26.7 percent were unsure if they had received regular updates from personnel at the TCC.

The *Cronbach alpha* ( $\alpha=0.683$ ) for the subjective views of adult female rape survivors about service delivery, was close to the acceptable ( $\alpha=0.7$ ). The internal consistency for this specific scale was thus found to be satisfactory.

## DISCUSSION

The vast majority of the research respondents were welcomed by the TCCs and received counselling upon arrival. Pre-and-post HIV counselling was also offered to the rape survivors by the FN, along with preventative treatment for pregnancy and STIs. The TCC protocol makes provision that upon arrival at the centre, the FN is expected to explain to the victim of rape or sexual assault that she will be examined, which is inclusive of the purpose thereof (NPA, 2008). The physical medical examination of a victim of rape serves two purposes; namely: to collect evidence and start PEP. Establishing a linkage between the victim and offender is vital in placing the offender at the crime scene, and therefore the use of a sex crimes kit to collect evidence. The medical examination thus entails the establishment of corroborating evidence to establish whether or not the alleged rape took place from a medico-legal forensic perspective. Successful prosecution is highly dependent upon a careful examination of the rape survivor (Aggrawal, 2009: 214; Osterburg & Ward, 2010: 437).

After the medical examination had been completed, the FN should then discuss follow-up psychological and medical appointments with the victim. Dates for follow-up appointments must be documented by the FN/VC on an 'Information Card', which is located at the centre. Moreover, it remains the responsibility of the FN/VC to keep the victim informed of medical appointments and referrals for further counselling and support. The TCC centre also makes provision for a victim of rape to wash or shower at the centre after the medical examination (NPA, 2008: 29).

It is also of importance that the victims receive the appropriate treatment for STIs. The most common forms of STIs are syphilis, chlamydia and gonorrhoea (bacterial infections); genital herpes, genital warts, HIV, hepatitis (viral infections); and trichomoniasis (parasitic infection). Of these, gonorrhoea, trichomoniasis (bacterial infection of the genitalia) and bacterial vaginosis (an abnormal vaginal discharge due to an excess of normal bacteria in the vagina) increase the risk of HIV infection even further (Fong, 2001: 243; Lukhozi, 2013).

It is crucial that a rape survivor is informed of the window period of HIV. Jewkes (2011/05/08), articulates that the HIV test result may be of doubtful value, as an alleged sex offender in the window period could test HIV-negative, which may be immeasurably risky to a rape victim. Although it might serve as a relief to the victim to know that her perpetrator was HIV-negative during the time that the rape occurred, the offender in the window period could test HIV-negative, even though further tests might disclose different results. The victims were also informed about the compulsory HIV testing of an alleged sex offender (21; 46.7%), to return for a follow-up at the centre (42; 93.3%) and also received regular updates from the personnel at the TCC (20; 44.4%). Only 20 (44.4%) specified that they were provided with an opportunity to wash at the centre, although it is unclear if some rape survivors declined this opportunity and preferred to wash at home. It is also of noteworthy importance to see that 36 (80%) of the respondents received immediate attention upon arrival at the TCC.

The study found evidence to suggest that the victim had been examined by a FN or DFS, in accordance with set protocols and the required documentation in preparation for legal proceedings, yet not neglecting the provision of PEP and counselling for the adult female rape survivors. The role of the police is also visible from the empirical analysis of the data, although only about half of the respondents indicated that they were informed of an opportunity to have their alleged assailant tested for HIV by the police. The study therefore concludes that the service delivery for victims of rape was satisfactory.

**RECOMMENDATIONS REGARDING SERVICE DELIVERY FOR RAPE VICTIMS**

Altering the ‘sequence’ of the medical management system could facilitate the administration of PEP and prevention of STIs before explaining and performing the forensic physical examination of the rape survivor. “Another possibility to be considered is to provide the victim of rape with an opportunity to come back for HIV counselling and start PEP (within 72 hours of the incident) as stipulated in section 3(b) and 4(b) of the Health Directives”. The aforesaid makes provision for a victim of rape who is too traumatised to be tested for HIV immediately after the rape, to be tested at a later stage. The latter may be beneficial for the victim in not having to deal with the trauma of the incident, as well as a potential HIV-positive test result at the same time. It is also imperative to take note that the “Directives of the DoH do not make provision for refusing HIV counselling on behalf of the victim of rape before receiving PEP” (Roehrs, 2011: 42).

**CONCLUSION**

Given the sensitive nature of the research, it could have been expected that a low number of respondents would participate in the study. Nonetheless, the research results suggest that the role players within the TCC Multidisciplinary Model are keen to assist victims of rape. Although the attitude of the respondents towards the TCCs was constructive and optimistic, a gap still exists in informing victims of rape about an opportunity to have their alleged assailant tested for HIV. Due to the small sample size, generalisation with regard to the broader population can thus not be made.

The article explicated the TCC Multidisciplinary Service Delivery Model as a mode of medico-legal services to victims of rape. The roles and responsibilities of the various stakeholders and professionals within the TCC model was explored, which focused on the quality of services that rape survivors received at the respective TCC centres. Henceforth, the research findings validated that the service delivery for adult female rape survivors was deemed as being adequate.

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**ACKNOWLEDGEMENTS**

The National Prosecuting Authority of South Africa (NPA) and Gauteng Department of Health (GoDH) for granting permission to conduct the research.

Prof Mkobung Nkomo, University of Pretoria (UP), for proofreading the manuscript.

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**REFERENCES**

- Abrahams, N. & Jewkes, R. 2010. Barrier to post exposure prophylaxis (PEP) completion after sexual assault: A South African qualitative study. *Journal of Culture, Health and Sexuality*, 12(5): 471-484.
- Agarwal, N.K. 2011. *Verfying survey items for construct validity: A two-stage sorting procedure for questionnaire design in information behaviour research*. Paper presented to the 74<sup>th</sup> Annual Meeting of the Association for Information Science and Technology. *Bridging the Gulf: Communication and Information in Society, Technology, and Work*. New Orleans, Louisiana, USA. 9-13 October 2011. Available at: [http://www.asis.org/asist2011/proceedings/submissions/166\\_final\\_submission.pdf](http://www.asis.org/asist2011/proceedings/submissions/166_final_submission.pdf) (accessed on: 20/03/2015).

- Agarwal, N.K., Xu, Y.C. & Poo, D.C.C. 2011. A context-based investigation into source use by information seekers. *Journal of American Society for Information Science and Technology*, 62(6):1084-1104.
- Aggrawal, A. 2009. *Forensic and medico-legal aspects of sexual crimes and usual practices*. London: CRC, Taylor & Francis.
- Booyens, K. 2008. *The sexual assault and rape of male offenders and awaiting-trial detainees*. Unpublished thesis. DPhil. Pretoria: University of Pretoria.
- Booyens, K. 2011. The South African Criminal Justice System. In C. Bezuidenhout (Ed.). *A Southern African perspective on fundamental criminology*. Cape Town: Pearson.
- Burger, D. (Ed.). 2010. *South African Yearbook 2009/2010*. (15<sup>th</sup> edition). Pretoria: Government Communication (GCIS) on behalf of the Presidency.
- Department of Justice and Constitutional Development, South Africa. 2007. *Service Charter for victims of crime in South Africa: The consolidation of the present legal framework relating to the rights of and services provided to victims of crime*. Available at: <http://www.justice.gov.za/VC/docs/vc/vc-eng.pdf> (accessed on: 21/12/2012).
- Department of Justice and Constitutional Development, South Africa. 2008. Criminal Law (Sexual Offences and Related Matters) Amendment Act 32 of 2007. *Government Gazette*, (31076), 22 May. Pretoria: Government Printer.
- Department of Safety and Security, South Africa. 2008. National Instruction on Sexual Offences. *Government Gazette*, (31330). Pretoria: Government Printer.
- Department of Social Development, South Africa. [Sa]. Integrated Service Delivery Model. Available at: <http://www.socdev.gov.za> (accessed on: 23/07/2015).
- Durrheim, K. 2006. Research design. (Pp. 33-59). In M. Terre Blanche, K. Durrheim & D. Painter (Eds). *Research in practice: Applied methods for the social sciences*. (2<sup>nd</sup> edition). Cape Town: University of Cape Town Press.
- Faull, A. & Mphuthing, P. 2009. Victim support. (Pp. 124-147). In C. Gould (Ed.). *Criminal (in)justice in South Africa: A civil society perspective*. Pretoria: Institute for Security Studies.
- Fong, C. 2001. Post exposure prophylaxis for HIV infection after sexual assault: When is it indicated? *Emergency Medicine Journal*, 18(4): 242-245.
- Fouché, C.B., Delpont, C.S.L. & De Vos, A.S. 2011. Quantitative research designs. In A.S. de Vos, H. Strydom, C.B. Fouché & C.S.L. Delpont (Eds). *Research at grass roots: For the social sciences and human service professions*. (2<sup>nd</sup> edition). Pretoria: Van Schaik.
- Goodey, J. 2005. *Victims and victimology: Research, policy and practice*. Harlow, England: Pearson.
- Jewkes, R. 2011. *Compulsory HIV testing of adult male sex offenders*. E-mail correspondence to N.B. Bougard, 08/05/2011.
- Jewkes, R., Sikweyiya, Y., Morrell, R. & Dunkle, K. 2009. Understanding men's health and use of violence. *Medical Research Council Policy Brief*, June: 1-2.
- Jewkes, R., Sikweyiya, Y., Morrell, R. & Dunkle, K. 2010. Why, when and how men rape: Understanding rape perpetration in South Africa. *SA Crime Quarterly*, 34: 23-31.
- Koss, M.P., Abbey, A., Campbell, R., Cook, S., Norris, J., Testa, M., Ullman, S., West, C. & White, J. 2007. Revising the SES: A collaborative process to improve assessment of sexual aggression and victimization. *Psychology of Women Quarterly*, 31: 357-370.
- Labuschagne, I.L. 1987. *The role of voluntary rape crisis service: A victimological investigation*. Unpublished dissertation. MA (Criminology). Pretoria: University of Pretoria.
- Lukhozi, M. 2013. Interview with Forensic District Surgeon, Mamelodi Thuthuzela Care Centre. [Transcript]. 22 August. Pretoria.
- McQuoid-Mason, D. 2009. Compulsory HIV testing of alleged sex offenders. *South African Journal of Medicine*, 1: 26-28.

- McFarquhar, H. 2011. *Key concepts in criminology and criminal justice*. Basingstoke, UK: Palgrave Macmillan.
- Monette, D.R., Sullivan, T.J. & DeJong, C.R. 2002. *Applied social research: Tool for human services*. (5<sup>th</sup> edition). Orlando: Harcourt College.
- Monette, D.R., Sullivan, T.J., DeJong, C.R. & Hilton, T.P. 2011. *Applied social research: A tool for the human services*. (9<sup>th</sup> edition). Belmont, CA: Brooks/Cole/Cengage Learning.
- National Prosecuting Authority (NPA), South Africa. 2008. *Uniform Protocol For the Management of Victims, Survivors and Witnesses of Domestic Violence and Sexual Offences, Thuthuzela Care Centres*. Pretoria: National Prosecuting Authority.
- Osterburg, J.W. & Ward, R.H. 2010. *Criminal Investigation: A method for reconstructing the past*. New Providence, NJ: Routledge, Matthew Bender & Company.
- Pistorius, M. 2005. *Profiling serial killers and other crimes in South Africa*. Johannesburg: Penguin Books.
- Rape Statistics South Africa and Worldwide. 2012. Available at: <http://www.rape.co.za> (accessed on: 13/07/2013).
- Roehrs, S. 2011. 'I feel for rape survivors, but I don't have the time, I'm always running': *Barriers to accessing post-rape health care in South Africa*. Research Report, Gender Health and Justice Research Unit. Cape Town: University of Cape Town.
- Seedat, M., Van Niekerk, A., Jewkes, R., Suffla, S. & Ratele, K. 2009. Violence and injuries in South Africa. Prioritising an agenda for prevention. *The Lancet*, 374: 1011-1022.
- Sexual Offences and Community Affairs Unit (SOCA), National Prosecuting Authority (NPA), South Africa. 2008. *Report on the feasibility and location of Thuthuzela Care Centres Phase 2 Report*. Pretoria: National Prosecuting Authority.
- Sexual Violence Research Initiative. 2007. Available at: <http://www.svri.org/> (accessed on: 12/06/2012).
- Shisana, O., Rehle, T., Simbayi, L.C., Zuma, K., Jooste, S., Zunga, N., Labadarios, D. 2014. *South African National Survey HIV Prevalence, Incidence and Behaviour Survey, 2012*. Cape Town: HSRC Press.
- Sigsworth, R. 2009. *Anyone can be a rapist: An overview of sexual violence in South Africa*. Johannesburg: Centre for the Study of Violence and Reconciliation.
- South African Law Commission. 2002. *Project 107 – Sexual offences: Process and procedure*. Pretoria. Available at: <http://www.justice.gov.za/salrc/dpapers/dp102-execsum.pdf> (accessed on: 09/10/2013).
- South African Police Service (SAPS). Available at: <http://www.saps.co.za> (accessed on: 11/07/2015).
- Statistics South Africa. 2012. *Victims of Crime Survey: 2012*. Available at: <http://www.statssa.gov.za/publications/p0341/p03412012.pdf> (accessed on: 21/12/2012).
- Strydom, H. & Venter, L. 2002. Sampling and sampling methods. In A.S. de Vos, H. Strydom, C.B. Fouché & C.S.L. Delpont (Eds). *Research at grass roots: For the social sciences and human service professions*. Pretoria: Van Schaik.
- Strydom, H. 2011. Sampling in the quantitative paradigm. In A.S. de Vos, H. Strydom, C.B. Fouché & C.S.L. Delpont (Eds). *Research at grass roots: For the social sciences and human service professions*. (2<sup>nd</sup> edition). Pretoria: Van Schaik.
- Sun, S., Pan, W. & Wang, L.L. 2010. A comprehensive review of effect size reporting and interpreting practices in academic journals in education and psychology. *Journal of Educational Psychology*, 20(1): 1-14.

- UNAIDS. 2011. *World AIDS Day Report*. Available at: [http://www.unaids.org/sites/default/files/en/media/unaids/contentassets/documents/unaidspublication/2011/JC2216\\_WorldAIDSday\\_report\\_2011\\_en.pdf](http://www.unaids.org/sites/default/files/en/media/unaids/contentassets/documents/unaidspublication/2011/JC2216_WorldAIDSday_report_2011_en.pdf) (accessed on: 10/10/2012).
- Van der Watt, M. & Van Graan, J. 2013. Towards the demystification of gang rape: An investigative analysis of a sample of closed and unsolved gang rape cases in Port Elizabeth. *Acta Criminologica: Southern African Journal of Criminology*, 26(1): 106-121.
- Williams, K.S. 2012. *Textbook on Criminology*. (7<sup>th</sup> edition). Oxford: Oxford University Press.
- World Health Organisation (WHO)/International Labour Organisation (ILO). 2008. *Post-exposure prophylaxis to prevent HIV infection: Joint WHO/ILO guidelines on post-exposure prophylaxis (PEP) to prevent HIV infection*. Geneva: World Health Organisation. Available at: [http://apps.who.int/iris/bitstream/10665/43838/1/9789241596374\\_eng.pdf](http://apps.who.int/iris/bitstream/10665/43838/1/9789241596374_eng.pdf) (accessed on: 23/07/2013).