CHALLENGES IN ACCESSING HEALTH CARE SUPPORT SERVICES ENCOUNTERED BY RAPE VICTIMS IN KHOMAS REGION, NAMIBIA

by

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Declaration of originality

Full names of student: Prisca Tambo

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Challenges in accessing health care support services encountered by rape victims in Khomas region, Namibia.

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5. I have not submitted this work to any other university for any other degree.

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ABSTRACT

Candidate: Prisca Tambo

Title: Challenges in accessing health care support services encountered by rape victims in Khomas region, Namibia.

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Domestic violence is an endemic problem in Namibia and may be the most underreported form of violence against women and men, girls and boys residing in the country [Ministry of Health and Social Services (MoHSS), 2014:295]. Domestic violence, takes many forms, including physical aggression (hitting, kicking, biting, shoving, restraining, slapping, or throwing objects) as well as threats, rape, other forms of sexual and emotional abuse, controlling or domineering behaviours, intimidation, stalking, and passive or covert abuse (e.g., neglect or economic deprivation). Victims of rape and gender-based violence (GBV), however appear to face significant challenges in accessing healthcare support services.

It is against this background that this study was conducted. The main goal of this study is to explore and describe the challenges faced by survivors of rape in the Khomas region of Namibia in accessing health and support services. The study utilised a qualitative research approach, which was applied research, as it focused on problems faced in the practice of identifying and seeking to address the challenges faced by rape survivors in the process of trying to heal from the trauma of rape. The phenomenological design was deemed appropriate for this study since it dealt with some sensitive issues regarding personal experiences of violence and reaction to it. The study was therefore exploratory and descriptive in nature an unstructured one-on-one interviews were used to collect data.

Findings from the study showed that rape survivors in the Khomas region of Namibia face many challenges in accessing healthcare support services which relate to the problems that they face as a result of the rape, as well as to the nature of support that

they get from healthcare centres, the police, the community as well as their socio-economic circumstances. Close collaboration is required between relevant stakeholders such as healthcare workers, police, communities, the legal justice system and policy makers. This will assist in the development of more effective policies and the building systems and institutions that are more effective in offering support to survivors of rape. It is therefore recommended that service delivery to support survivors of rape be improved in such a way that it becomes more accessible and survivor friendly.

KEY WORDS

Challenges

Access

Health care

Support services

Social work

Rape victims

Khomas region

Namibia

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CHAPTER ONE

GENERAL INTRODUCTION AND ORIENTATION TO STUDY

1.1 Introduction

The World Health Organisation (WHO) defines Sexual Violence as: “any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic, or otherwise directed against a person’s sexuality using coercion, by any person regardless of their relationship to the victim, in any setting including but not limited to home and work.” (World Health Organisation, 2010:11). Violence against women was declared to be a violation of human rights by the United Nations (UN) General Assembly in 1993, in its Declaration on the Elimination of Violence Against Women (Bloom, 2008:12). In 2008, the United Nations Secretary General stated that “There is one universal truth, applicable to all countries, cultures and communities: violence against women is never acceptable, never excusable, and never tolerable.” (WHO, 2013:2).

Sexual violence is a global problem, not only in the geographical sense, but also in terms of age and sex (Fernandez, 2011:596; Osinde, Kaye & Kakaire, 2011:2). The WHO multi-country study on women's health and domestic violence against women carried out in 2005 was a groundbreaking effort to document the prevalence of intimate partner violence and other forms of violence against women using population-based sampling. It was initially carried out in 15 sites in 10 countries (WHO, 2010:12). The study found that across the study sites, between 15% and 71% of women reported physical or sexual violence, or both, by an intimate partner at some point in their lives. Most sites reported prevalence rates in the range 30–60%. Between 4% and 54% of women reported physical or sexual violence, or both, by a partner within the 12 months prior to the study, with most estimates falling between 15% and 30% (WHO, 2010:13).

There is no doubt that the potential reproductive, mental and sexual health consequences resulting from violence against women are numerous: – unwanted pregnancy, Sexually Transmitted Infections (STIs), Human Immunodeficiency

Virus/Acquired Immunodeficiency Syndrome (HIV/AIDS) and increased risk for adoption of risky sexual behaviours (Campbell, Baty, Ghandour, Stockman, Francisco & Wagman, 2008:9; UNAIDS, 2013:2). There is therefore a clear need to scale up efforts across a range of sectors, both to prevent violence from happening in the first place and to provide necessary services for women experiencing violence. The health sector must play a greater role in responding to intimate partner violence and sexual violence against women. Strategies to prevent and respond to VAW/G have been launched by agencies around the world based in a range of sectors, including governmental and non-governmental organizations. The multi-sectorial nature of prevention and response efforts is critical to the ultimate success of programmes (Bloom, 2008:13).

1.2 Key concepts

The key concepts are subsequently defined:

Challenges: For the purpose of this research the term refers to the difficulties/obstacles faced by victims of rape in accessing support services that enable to deal with, and recover from, the trauma of abuse. (Bosmans, 2007:9,10,11; World Health Organisation [WHO], 2012:3).

Gender based violence: Any harm or suffering that is perpetrated against a woman or girl, man or boy and that has a negative impact on the physical, sexual or psychological health, development or identity of the person. The cause of the violence is founded in gender-based power inequalities and gender-based discrimination (SIDA, 2015:6). In this study gender-based violence refers to all forms of violence that happen to women, girls, men and boys because of the unequal power relations between them.

Healthcare support: A range of services available to help survivors of rape and their families cope with the aftermath of sexual violence (Networking HIV/AIDS Community of South Africa [NACOSA], 2015:2; Rege, Bhate-Deosthali, Reddy & Contractor, 2014:96). In this study healthcare support services can be based at police stations,

courts, health facilities and non-profit organisations' premises and address survivors' health, social and justice needs.

Khomas Region: Khomas is one of the fourteen regions of Namibia. The region is centred around the capital city, Windhoek

Rape Victim: Any person who has been subjected to an event that occurs without their consent and which involves the use or threat of force to penetrate the victim's vagina or anus by penis, tongue, fingers, or object, or the victim's mouth by penis (WHO, 2010:11; Holm-Hansen & Kelly, 2007:3; Wellington Community Law Centre, 2011:7). For purposes of this research the term refers to an individual who has suffered rape in any form. The terms rape victim and rape survivor are used interchangeably in this study.

Social work: A practice-based profession and an academic discipline that promotes social change and development, social cohesion, and the empowerment and liberation of people. Principles of social justice, human rights, collective responsibility and respect for diversities are central to social work. [International Federation of Social Workers (IFSW), 2014]. The same definition is applied in this study.

1.3 The Ecological Approach

There is no single model for addressing violence against women and girls within the health sector, which is related to the lack of an evidence-base for comprehensive health sector programming. However, there are several overlapping and inter-related models that have been used globally and that are important for those working in the health sector to know and understand. The **ecological approach**, the **multi-sectoral approach**, and an **integrated (systems) approach** for services are all strategies to adopt when trying to respond to GBV. The multi-sectoral approach references the agency and sector level, while the ecological and integration models reference the health service-delivery level (UN, 2011:18; USAID, Colombini, Mayhew & Watts, 2008:636).

Rape, being a form of sexual violence, can therefore be best explained using the ecological approach. The ecological approach underpins this study and presents rape as a multi-faceted problem, grounded in personal, family, and socio-cultural factors (WHO, 2010:19; WHO, 2012:4). The ecological approach supports a comprehensive public health strategy that not only addresses an individual's risk of becoming a victim or perpetrator of violence, but also the norms, beliefs and social and economic systems that create the conditions for sexual violence to occur (UN, 2011:18). At the core of the approach is a strong emphasis on the multiple and dynamic interactions among risk factors within and between its different levels (WHO, 2010:18-19). Using the ecological model will therefore help to identify and promote the development of cross-sectoral prevention policies and programmes by highlighting the links and interactions between different levels and factors. As a result, when designing comprehensive approaches to prevent rape and sexual violence, the embedding of effective strategies into mainstream programmes addressing such issues will increase both their relevance and sustainability (UN, 2011:19).

The ecological approach comprises of four levels, as presented in figure 1.1 below.

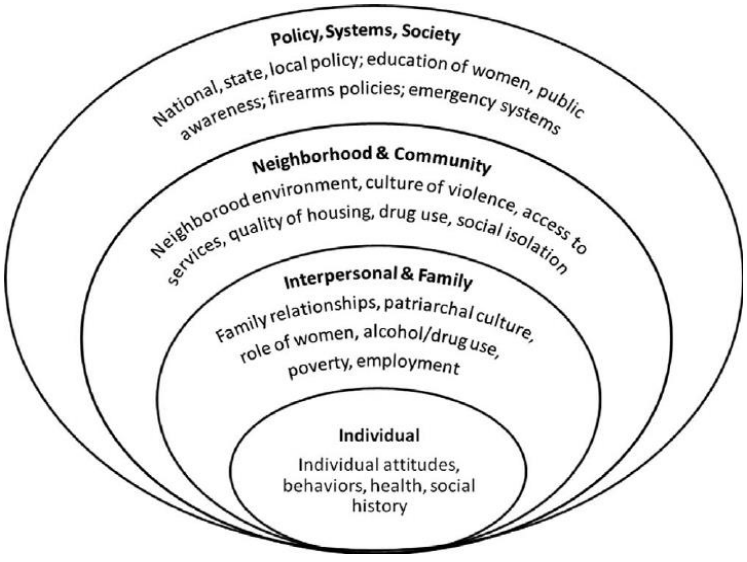

Figure 1. 1: Factors related to violence against women at different levels of the social ecology (Adapted from the WHO, 2012:4).

The four-level social-ecological model can be used to better understand rape and the effect of potential prevention strategies. Challenges faced by rape victims in trying to access support services can be identified at each level. The utility of the ecological approach is that it can suggest multiple strategies, at multiple levels of analysis, for

alleviating the psychological harm caused by sexual assault (UN, 2011:19; Campbell Dworkin, & Cabral, 2009:227). This approach considers the complex interplay between individual, relationship, community, and societal factors. It allows us to understand the range of factors that put people at risk of rape, or protect them from experiencing, or perpetrating rape. The overlapping rings in the approach illustrate how factors at one level influence factors at another level. Besides helping to clarify these factors, the approach also suggests that in order to prevent rape, it is necessary to act across multiple levels at the same time. Such an approach is therefore more likely to sustain prevention efforts over time than any single intervention initiatives (WHO, 2010:18).

Individual: The first level identifies biological and personal history factors that increase the likelihood of becoming a victim or perpetrator of rape. Some of these factors are age, education, income, substance use, or history of abuse. Prevention strategies at this level are often designed to promote attitudes, beliefs, and behaviours that ultimately prevent rape. Specific approaches may include education and life skills training (WHO, 2010:19; Campbell et al., 2009:228).

Relationship: The second level examines close relationships that may increase the risk of experiencing rape as a victim or perpetrator. A person's closest social circle-peers, partners and family members-influence their behaviour and contribute to their range of experience. Prevention strategies at this level may include parenting or family-focused prevention programmes, and mentoring and peer programmes designed to reduce conflict, foster problem solving skills, and promote healthy relationships (WHO, 2012:4; Campbell et al., 2009:228).

Community: The third level explores the settings, such as schools, workplaces, and neighbourhoods, in which social relationships occur and seeks to identify the characteristics of these settings that are associated with becoming victims or perpetrators of violence. Prevention strategies at this level are typically designed to impact the social and physical environment – for example, by reducing social isolation, improving economic and housing opportunities in neighbourhoods, as well as the climate, processes, and policies within school and workplace settings (Campbell et al., 2009:228; WHO, 2012:4).

Societal: The fourth level looks at the broad societal factors that help create a climate in which rape is encouraged or inhibited. These factors include social and cultural norms that support rape as an acceptable way to resolve conflicts. Other large societal factors include the health, economic, educational and social policies that help to maintain economic or social inequalities between groups in society.
(WHO, 2012:4; WHO, 2010:19; Campbell., Dworkin, & Cabral, 2009:228).

The ecological approach combines factors operating at the individual, relationship, community, and society levels, making it an appropriate framework for examining the combination of risk factors that increase the likelihood of gender-based violence in a particular setting (Morrison, Ellsberg & Bott, 2007:26), thus it was found to be appropriate for this study. For any intervention to be effective, it will generally need to address factors at these different levels.

1.4 Contextualisation of the study

In order to understand the importance and feasibility of this thesis, as well as to familiarise the reader with the background against which this study was conceptualised, it is necessary to first provide a brief account of the context in which it is undertaken. (The literature review provided in chapter 2 provides an in-depth review of the points of discussion).

Namibia has the second-lowest population density of any sovereign country, after Mongolia (United Nations 2009:3-4). Namibia has a population of 2.6 million people and a stable multi-party parliamentary democracy. Agriculture, herding, tourism and the mining industry – including mining for gem diamonds, uranium, gold, silver, and base metals – form the basis of its economy. Namibia recorded its slowest growth in recent years,registering an estimated growth of 1.1 percent in 2016 due to weak performance by the secondary, tertiary and primary industries (National Planning Commission, 2018:7). The observed contractions in the economy over the past years have driven by significant declines in sectors such as construction, manufacturing, wholesale and retail, trade, utility, fishing, hotels and restaurant sectors among others, which have predominantly been key growth drivers.

Namibia's labour market looks more vulnerable with unemployment increasing over the years and employment decreasing. Latest data for 2016 show that the number of people in employment declined over the past year, with the employment level now stands at 676,885 from 708,895 in 2014 (National Planning Commission 2018:16). While average monthly wages have slightly increased over the past years, there is however a significant difference between sex, professions and industries. Females are generally lowly paid as compared to male counterparts in the same industry. Namibia has been ranked the second most unequal country in the world after South Africa (National Planning Commission, 2018:17).

1.5 Rationale and problem statement

The rational for this study is based on the premise that rape survivors face many social, physical, psychological and emotional challenges in healing from the trauma of abuse. The rape victims also face many challenges in accessing services that are critical for their healing and recovery from the trauma of abuse (UNAIDS, 2013:2). For many survivors of rape, a visit to a health professional is the first point of contact, enabling them to access support and care. Therefore, strengthening the capacity of health professionals to identify and support survivors of rape is crucial to the prevention of and response to rape (WHO, 2013:35). Although policies and guidelines have been developed to improve services for ameliorating the after effects of rape and improve access to justice, many women still do not receive adequate support (CSVR, 2011:62). A study by Tshwaranang Legal Advocacy Centre confirmed that women experience systemic access problems when seeking support services at health-care facilities (CSVR, 2011:62).

Over the years there has been increasing recognition of the prevalence of violence against women, but it however appears that there has been minimal attention paid to the examination of effective approaches to address the needs of survivors of sexual violence (WHO, 2007:7). Vetten & Jacobs (2008:3) noted that while knowledgeable about emergency medical services, casualty staff have however rarely received comprehensive specialist training around dealing with sexual assaults. As indicated earlier, evidence has also shown that a large number of women who experience rape

rarely seek help from the police or other support agencies. Most of the victims only do so when their condition is near fatal (Vetten and Jacobs, 2008:3). Early reporting and access to services would however present an opportunity for early identification of cases of rape, thus limiting the health consequences resulting from this form of violence and preventing further escalation of the problem in the form of suicide attempts and fatalities (Colombini, Mayhew, Ali, Shuib & Charlotte Watts, 2012:7). With the substantial increase in the need for healthcare utilization by women, the opportunity for healthcare professionals to assist women experiencing rape is now greater than ever.

Inadequate service provision constitutes another significant hurdle to redressing GBV in Namibia (MGECW, 2011:20). While the government and civil society partners should be commended for their efforts to provide GBV focused services, it is clear that more concrete action is required to improve the delivery of comprehensive, survivor-centred services (UNAIDS, 2013:51). The pervasiveness of rape among women in Namibia, and its adverse impact on women's health, underscores the importance of developing and testing structural interventions to assist women who experience rape to have access to essential services that can assist them to recover from trauma. Findings from this research will also help to generate hypotheses as to what types of policies and programmes might be needed at health facilities to mitigate the challenges faced by women seeking support services.

The research problem to be researched within the ambit of this study is as follows:

"Survivors of rape in Namibia face numerous challenges in accessing health and support services that are necessary to help them to deal and heal from the trauma of rape"

Within the context of this research study, the following research question is focussed on in support of the research problem:

What challenges do survivors of rape in the Khomas Region of Namibia encounter in accessing health and support services that are necessary to help them heal from the trauma of rape?

1.6 Goal and objectives

1.6.1 Goal

The main goal of this study is to explore and describe the challenges faced by survivors of rape in the Khomas region of Namibia in accessing health and support services.

1.6.2 Objectives

The objectives of this study are as follows:

- To describe rape as a form of gender based violence and explore the socio-economic, emotional and psychological challenges experienced by rape survivors in the Khomas region of Namibia.
- To identify the healthcare support services that are available in Namibia for survivors of rape.
- To assess the challenges that the survivors of rape face in accessing health and support services.
- To make recommendations for intervention.

1.7 Overview of research design and methodology

In this section a brief overview of the research design and methodology employed is this study is presented. Chapter three of the study however presents a more detailed outline of the research design and methodology. In order to ensure that the opinions, subjective thoughts, feelings and experiences of the research participants are reflected as closely as possible (Lietz, Langer & Furman, 2006:444), the researcher felt that a qualitative research approach would be more appropriate for this research. This was premised on the notion that that the empirical and theoretical resources needed to comprehend a particular idea, or to predict its future trajectory, are themselves interwoven with, and throughout, the context (Tracey, 2013:3). The

research was phenomenological in design and this helped the researcher to identify the essence of the lived experiences from the participants' point of view (Creswell, 2009:13. The study can also be regarded as applied research as it had immediate relevance and application to the Namibian context (Leedy & Ormrod, 2010:44)

The study population comprised of victims of rape who reported their cases to the Gender Violence Protection Unit which is a department of the Ministry of Gender, Equality and Child Welfare. Participants for the research were purposively sampled, focusing on those participants who had the characteristics that the researcher wanted (Strydom & Delport, 2011:350). In this study the sample included women survivors of rape between the ages of 20-50 years of age in Namibia, as this is the age group that is mostly affected by rape. Unstructured interviews were used to collect data in this research (Alshenqeeti, 2014:40). Data analysis was accomplished following the qualitative data analysis protocol described by Creswell, 2009:185). Chapter 3, section 3.8 describes the ethical considerations relevant to this study.

1.8 Outline of the mini dissertation

This mini-dissertation is made up of four chapters. The first chapter provides a general introduction and orientation to the study, briefly highlighting the theoretical framework as well as the methodological approach and design of the study.

The Literature review is provided in chapter two. The chapter discusses salient issues relating to the rape, as a form of GBV, the impact of rape as well as various other aspects of rape including the role of healthcare in rape. The nature of services provided for rape survivors is also discussed.

Chapter three discusses the research methodology in detail and also reports on the empirical findings. The chapter then goes on to interpret the findings based on findings from literature.

In the concluding chapter (chapter 4), key aspects pertaining to the research are revisited. Research findings are brought into the context of the overall aims and objectives of the research, key findings are presented and conclusions and recommendations are made.

The next chapter focuses on the literature review.

CHAPTER TWO

RAPE AND HEALTHCARE SUPPORT: A BIOPSYCHOSOCIAL PERSPECTIVE

2.1 Introduction

Sexual and gender-based violence (SGBV) [UNHCR, 2011:6] is a particularly disturbing phenomenon which exists in all regions of the world. The term refers to any harmful act that is perpetrated against one person's will and that is based on socially ascribed (gender) differences between males and females. It includes acts that inflict physical, mental, or sexual harm or suffering, threats of such acts, coercion and other deprivations of liberty, whether occurring in public or in private life (UNHCR, 2011:6) Sexual and Gender Based Violence embodies a widespread human rights violations. It is also usually associated with unequal gender relations within communities as well as power. It can take the form of sexual violence or persecution by the authorities, or can be the result of discrimination embedded in legislation or prevailing societal norms and practices.

Sexual violence against women is a public health problem of epidemic proportions and puts women's health at risk, limits their participation in society, and causes great human suffering (Brown & Walklate, 2010:241). Sexual violence takes place within a variety of settings, including the home, the workplace, schools and the community. Dada (2014:65), states that despite many years of feminist advocacy and awareness contributions, targeted at breaking the silence surrounding sexual victimization, the rape of girls and women persists is a world-wide public health challenge and unfortunately, the public response to sexual violence often seems too low in comparison to its prevalence. Overall, 35% of women worldwide have experienced either physical and/or sexual intimate partner violence or non-partner sexual violence. While there are many other forms of violence that women may be exposed to, this already represents a large proportion of the world's women (WHO, 2013:2).

This literature review examined some critical issues that surround rape as a crime in our society, especially, rape of girls and women. In the worst case scenario rape culminates in murder. Vetten (2014:2) notes that a national study of cases drawn from 25 medico-legal laboratories in South Africa estimated that about one in six (16,3%) of the female homicides that occurred in 1999 involved rape. According to this study, rape had a homicide rate of 3.65 per 100 000 women over the age of 13. This is a prevalence rate higher than that of all female homicides in the United States of America (Vetten, 2014:2).

Among other things, the literature review will explore the causes of rape as well as the myths surrounding rape. Furthermore the review looks at the effects of rape as well as the response of healthcare systems in incidences of rape.

2.2 Contextualisation of rape

Definitions of rape vary from one nation of the world to another, depending on the beliefs, laws and criminal Justice system of those nations. Rape is a serious offense punishable by law, but there exists no consensus regarding the precise definition of this crime (Buba, 2015:4). The World Health Organisation defines sexual violence as any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic, or otherwise directed against a person's sexuality using coercion, by any person regardless of their relationship to the victim, in any setting including but not limited to home and work (WHO, 2010:11). This definition includes rape, defined as the physically forced or otherwise coerced penetration of the vulva or anus with a penis, other body part or object. However, these terms may have very different meanings (and implications) in varying situations and locations. Legal definitions of specific types of sexual violence such as rape may however differ from medical and social definitions, and furthermore, can vary between countries and even within countries. It is important, therefore, that healthcare professionals are aware of the legal definitions of rape and sexual violence within their own jurisdiction, particularly as it applies to the age of consent and marriage (WHO, 2010:11, United Nations [UN], 2010:27).

The Namibian Combating of Rape Act, No. 8 of 2000:3, notes that "Any person who intentionally under coercive circumstances:
(a) commits or continues to commit a sexual act with another person; or
(b) causes another person to commit a sexual act with the perpetrator or with a third person, shall be guilty of the offence of rape."

The Ministry of Gender Equality and Child Welfare (MGECW) notes that Namibia's Combating of Rape Act 8 of 2000 has been hailed as one of the most progressive laws on rape in the world (MGECW, 2012:9). This law contains a broad, gender-neutral definition of rape which covers a range of sexual acts committed in "coercive

circumstances", thus moving away from requiring proof of "absence of consent" which has historically made the rape survivor feel as if she were the one on trial. The law sets stiff minimum sentences for rape, acknowledges the fact that rape can occur within marriage, and gives increased protection to children – both girls and boys (MGECW, 2012:9). It also has a range of provisions aimed at meeting some of the needs of the rape survivor – such as increased protection for the survivor's privacy and new procedures to ensure that the rape survivor has an opportunity to place information before the court at the bail hearing (MGECW, 2012:9).

The South African Criminal Law (Sexual Offences and Related Matters) Amendment Act (Act, No. 6 of 2012:20) states that "Any person ("A") who unlawfully and intentionally commits an act of sexual penetration with a complainant ("B"), without the consent of B, is guilty of the offence of rape." The amendment reformed and codified the law relating to sex offences, setting it on a gender-neutral basis. It also expanded the range of offences, expanded services for victims and helped to create a national register of sex offenders.

The cited definitions indicate that rape is a persistent and universal problem occurring in every culture and social group.

2.2.1 International and regional instruments relevant to GBV

Namibia is party to the following international instruments which are particularly relevant to GBV (Ministry of Gender Equality and Child Welfare, 2016:7):

- UN Convention on the Elimination of all Forms of Discrimination Against Women
- UN Convention on the Rights of the Child
- UN Convention on the Rights of Persons with Disabilities
- Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa
- African Charter on the Rights and Welfare of the Child
- Protocol to the Convention Against Transnational Organised Crime to Prevent, Suppress and Punish Trafficking in Persons, Especially Women and Children

- SADC Protocol on Gender and Development
- Optional Protocol to the Convention on the Rights of the Child on the Sale of Children, Child Prostitution and Child Pornography

2.2.2 Namibian policies and laws relevant to GBV

The Constitution of the Republic of Namibia guarantees both equality on the basis of sex and freedom from discrimination. Namibia has ratified international instruments that forbid gender-based violence. Some of these are indicated below:

- Vision 2030 (2004)
- National Policy on Orphans and Vulnerable Children (2004)
- Third National Development Plan (2008)
- Education Sector Policy for the Prevention and Management of Learner Pregnancy (2009)
- National Gender Policy (2010-2020) and accompanying Plan of Action (2011)
- Namibia's National Agenda for Children (2012-2016)
- Children's Act 33 of 1960 (child protection)
- Marriage Act 25 of 1961
- Combating of Rape Act 8 of 2000
- Combating of Domestic Violence Act 4 of 2003
- Criminal Procedure Amendment Act 24 of 2003 (vulnerable witnesses)
- Labour Act 11 of 2007 (sexual harassment)

(Ministry of Gender Equality and Child Welfare, 2016:7)

2.2.3 Health services and programmes in Namibia

The government of Namibia recognizes that health is a fundamental human right, and it is committed to achieving health for all Namibians (Unicef, 2013:3). The mandate of the Ministry of Health and Social Services (MoHSS) is derived from Article 95 of the Namibian Constitution, whereby the government is required to support the health and well-being of all people by putting in place legislation that helps provide healthcare for all and social assistance to the country's most vulnerable groups (MoHSS, 2012).

Upon gaining independence in 1990, Namibia inherited a health service delivery structure that was segregated along racial lines and based entirely on curative health services (MoHSS,2014:3) Since then, the MoHSS has adopted a primary healthcare (PHC) approach for the delivery of health services to the Namibian population. The core functions of the PHC directorate within the MoHSS are organized around four pillars: health promotion, disease prevention, curative services, and rehabilitation services.

Intersectoral collaboration has been recognised as an important aspect of health and social care delivery in Namibia, with a number of partners and stakeholders playing a role. Although the government is the main health care and service provider, private and faith-based facilities make an important contribution. The private sector is mainly urban, providing healthcare through medium-sized hospitals as well as through private pharmacies, doctors' surgery offices, and nursing homes. Faith-based services are entirely subsidised by the government. (MoHSS, 2014:3).

2.2.4 Domestic and Sexual Violence

Domestic violence is an endemic problem in Namibia and may be the most underreported form of violence against both women and men, and girls and boys residing in the country (MoHSS, 2014:295). Domestic violence, takes on many forms, including physical aggression (hitting, kicking, biting, shoving, restraining, slapping, or throwing objects) as well as threats, sexual and emotional abuse, controlling or domineering behaviours, intimidation, stalking, and passive or covert abuse (e.g., neglect or economic deprivation).

As a result of the escalating numbers of domestic violence cases in the country, the government of Namibia has enacted several laws to protect survivors and punish perpetrators of domestic violence (MoHSS, 2015:295). These laws include, among others, the Married Persons Equality Act (No. 1 of 1996), the Combating of Rape Act (No. 8 of 2000), the Combating of Domestic Violence Act (No. 4 of 2003), the Maintenance Act (No. 9 of 2003), and the Children Status Act (No. 6 of 2006) (Ministry of Gender Equality and Child Welfare [MGECW], 2012).

2.2.5 Demographics of experience of sexual violence

The MoHSS (2014:297) notes that 7 percent of women age 15-49 have experienced sexual violence since age 15. Experience of sexual violence varies substantially by background characteristics. Women aged 20-24 (5 percent) are the least likely to have ever experienced sexual violence and those age 30-39 are the most likely (9 percent). Experience of sexual violence is lowest among women who practice ELCIN religion (5 percent) and highest among those with no religion (12 percent). Urban women (8 percent) are slightly more likely to have ever experienced sexual violence than rural women (7 percent). At regional level, Omaheke has the highest percentage of women who have ever experienced sexual violence (13 percent), followed by Hardap and Kavango (12 percent each). The prevalence of sexual violence is also relatively high in Karas, Otjozondjupa, and Khomas (8-9 percent) but is lower in Oshana, Omusati, and Ohangwena (4 percent each). Nineteen percent of women who are divorced, separated, or widowed and 11 percent of women who are currently married or living together with a partner have experienced sexual violence since age 15. Research on marital rape indicates that this form of violence is not confined to women of any specific age, race, ethnicity, social class, or geographic location (Bergen, 2006:3).

Women who are not employed are more likely than other women to have experienced sexual violence since age 15.Experience of sexual violence since age 15 generally shows a decrease with increasing education, from 11 percent among women with no education to 8 percent among women with more than a secondary education. There is however no clear pattern in the relationship between wealth and experience of sexual violence (MoHSS, 2014:297).

2.2.6 Support for Rape Survivors

Namibia's Combating of Rape Act 8 of 2000 has been hailed as one of the most progressive laws on rape in the world. This law contains a broad, gender-neutral definition of rape which covers a range of sexual acts committed in "coercive circumstances", thus moving away from requiring proof of "absence of consent"

which has historically made the rape survivor feel as if she were the one on trial.

The Government of the Republic of Namibia has committed itself to combating and working towards the eradication of all forms of GBV. In addition, the Government has enacted statutes aimed at addressing specific forms of GBV. The Government has also adopted the National Gender Policy 2010-2020 to promote gender equality and the advancement of women (MGECW, 2012:1). In 1993, the Government established the first Woman and Child Protection Unit (WCPU) in Khomas Region, and to date another 14 WCPUs have been established countrywide. The WCPUs take a multi-sectoral approach to assisting victims of rape, domestic violence and other forms of GBV.

2.2.7 Seeking of support services by abused women in Namibia

Overall, only 21 percent of women in Namibia who have ever experienced any form of physical violence have sought help from any source. Fifteen percent of women who have experienced any type of physical violence have never sought help and never told anyone about the violence and 9 percent have never sought help but have told someone that they were victims of violence. (MoHSS, 2014:315).

The most common source of help for physical or sexual violence is the woman's own family. Forty-eight percent of abused women who sought help did so from their own family, 15 percent did so from the police, 8 percent did so from their friends and 7 percent from a doctor or medical personnel. Social work organisations are a source of help for only 5 percent of abused women. One in five women sought help from other unspecified sources. Notably few women seek help from neighbours, religious leaders, or their husband/partner (MoHSS, 2014:315). Campbell, Dworkin & Cabral, (2009:233) state that what happens in one instance of seeking support, has implications for further help seeking and distress, thus many women do not seek support services (Campbell, 2006:2; Campbell, 2008:712).

2.3 Prevalence and incidence of rape

Demographics of sexual violence are usually obtained from crime records, hospital data, non-governmental organizations and a survey carried out for research. Some researchers believe that these data underestimate the actual magnitude of the problem of sexual violence. Researchers in western world estimate that only 16 –33% of rapes are reported (Suprakash, Ajay, Murthy & Biswajit, 2017:1).

Rape is a reality for millions of people worldwide and for women in particular. Eileraas, (2011:1) suggested that on average, over 250,000 cases of rape or attempted rape are reported each year worldwide. Research indicates that the vast majority of victims of sexual violence are female, most perpetrators are male, and that most victims know their attacker (WHO, 2010:11). This does not, however, negate the fact that sexual violence against men and boys is also widespread (WHO, 2012:5).

Violence against women and children is a serious human rights problem in Namibia, although the extent of the problem is not known due to underreporting by survivors of violence and the non-correlation of existing statistics (UNAIDS, 2013:1). Reporting has increased since independence in 1990, but many women, especially those subject to violence in the home, do not feel free to report the crimes. Domestic violence figures are obscured in criminal reports as common assault. Domestic violence is not recognised as a specific crime, although legislation is underway to promulgate changes to reporting of such crimes (MGECW, 2012:18).

In Namibia, gender-based violence is rampant (UNAIDS, 2013:7). A report by the Namibian Police observed that rape was the most prevalent crime between January and April 2013 with 122 reported cases (Namibian Police [NAMPOL]), 2013:14). On average, there have been approximately 1075 reported cases of rape nationwide for each of the past four years (2009-2013) (MGECW, 2012:9). It is however likely that the number of actual rape and other incidents of sexual and physical violence are much higher as survivors often do not report the violence due to fear of reprisal from the perpetrator, family pressure, self-blame and/or societal stigma and discrimination. Women and girls are overwhelmingly targeted by rape accounting for 92% to 94% of complainants in reported rape cases. One third of rape victims are below the age of 18 (UNAIDS, 2013:7). The number of reported rapes has not abated in more recent

years. In 2008, the police recorded 939 cases of rape and 222 of attempted rape (MGECW, 2012:9)

The incidence of rape in Namibia is worrying especially given the fact that the country has a relatively small population of 2.1 million (Namibia Statistics Agency, 2011:25). Rape and other sexual assaults or violence are some of the most common and perverse crimes in Namibia (Namibia Crime Statistic, 2013:35). As indicated above, records show that the phenomenon is a widespread one, affecting a significant proportion of the population in various sectors of the society. This therefore calls for an urgent need not only to provide support for the victims, but also to curb its continuous spreading.

Much rape occurs in families, where children and young people are the victims (Stern, 2012:29). Most rapes are carried out by someone the victim knows. As a rape victim told us, 'with so much of rape within marriage, you don't say anything… It is not seen as rape, and that is a really hard area to tackle: to understand that it is rape and you can do something about it.' Vulnerable and powerless people are often the victims of men who identity them as easy targets and take advantage of their need for attention and affection (Stern, 2012:29).

2.4 Factors contributing to rape

The prevalence estimates suggest that rape is a widespread incidence affecting a significant proportion of the female population. Bryden and Grier, (2011:173) suggest that, among other things, the factors that contribute to rape include: bad parenting, castration anxiety (effort to cloak and negate the castration feelings by overriding them), prostitute complex, patriarchal tendency and a desire to terrify women. Rape serves the purpose of a conscious process of intimidation by which the offender keeps the victim in a state of fear. Other factors also include unstable, acrimonious relationships with consensual sexual partners, sexual curiosity and revenge against racial discrimination (Bryden and Grier, 2011:175).

In addition to the above reasons, Dada, (2014:68) asserts that rape may be a war tactic which is far more than just an assault to an intimate and vulnerable aspect of an individual's dignity, but a violent attempt to rip apart the social fabric of communities. Political or military leaders sometimes initiate mass rapes against a hated enemy, for example rapes of Jews by Nazis and Chinese by Japanese (Bryden and Grier, 2011:193). It may also be a means of revenge against the enemy in war time. For instance in Second World War, Soviet troops engaged in such widespread rape in retaliation for sexual violence by German troops (Wood, 2006:389).

The ecological model, which proposes that violence is a result of factors operating at four levels: individual, relationship, community and societal, is helpful in understanding the interaction between factors and across levels (WHO, 2012:4). The United Nations (2010) treats violence against women, including rape, as a form of 'gender-based discrimination' as well as 'a violation of women's human rights'. The WHO (2002:12) uses an 'ecological model' that distinguishes nested levels of societal, community, relationship and individual. Brown and Walklate (2012) find that rape is a consequence of both gender inequalities in power and also of an absence of effective state power to sanction offenders.

The aim of the criminal justice system is to prevent people from committing crime by deterrence, punishment and rehabilitation. However in most cases rapists are not convicted (Stern, 2010:32). In order for the criminal justice system to be effective in deterring rape there is need to ensure that rapists are convicted more frequently in the courts. For this to happen there is need to ensure that reforms are made to the criminal justice system (Dada, 2014:71). The prevention of rape also requires the changing of the minds and attitudes of communities, so that people understand that rape is something that should never be done (McMahon, 2011:8).

Dada, (2014:67) asserts that patriarchal tendency could be another contributing factor to rape. According to this assertion, rape is a kind of pervasive patriarchal violence against women. When a man grows up in a culture of patriarchy, he is taught to be assertive, inculcates traditional sex roles, and objectifies women. Rape may therefore be the way of expressing these.

In the case of domestic rape, where sexual abuse may be part of a pattern of coercive control by an intimate partner, economic inequalities are complexly entwined with vulnerabilities to rape and other violence (WHO, 2009:4; Omari, Ondicho and Kungu, 2014:66). The gender imbalance in decision-making means that women's experiences and interests are under-represented when crucial decisions are made in professional bodies, parliaments and communities (European Parliament, 2013:115).

Poor women and those with low levels of education are also more likely to live in insecure rented accommodation or to be marginally housed or homeless, all of which have been found to increase women's vulnerability to rape (Marium, 2014:41; African Population and Health Research Centre, 2010:1-2). The odds of women in vulnerable housing experiencing rape/attempted rape by a known man were found to be significantly higher than those of women living in non-vulnerable housing.

Among other factors that have been reported to contribute to rape are harmful or illicit use of alcohol or drugs, antisocial personality, exposure to intra-parental violence as a child, history of physical or sexual abuse as a child, limited education, and gender-inequitable views (WHO, 2012:5; Krebs, Lindquist, Warner, Fisher & Martin, 2007:35)

One of the most common manifestations of rape is that which occurs by an intimate partner, suggesting that being married or cohabiting with a partner is a risk factor for rape (Fernandez, 2011:598). Women may also be at greater risk of sexual assault as they become more educated and thus empowered. Fernandez (2011:598) observed that the likely explanation for this is that greater empowerment brings with it more resistance from women to patriarchal norms, so that men may resort to violence in an attempt to regain control. Similarly, low socioeconomic status is noted to be a risk factor. This may also force people into vocations which carry a high risk of sexual violence (e.g. sex work); in addition to creating pressure to acquire or maintain jobs and study, which may place people at risk for rape from individuals who can promise each (Fernandez, 2011:598).

Some researchers suggest that the risk factors are organized according to the individual, relationship, community and societal levels in relation to the ecological model (Perry, 2012:2; WHO, 2012:3). Individual factors include such things as young

age, low levels of education, intra-parental violence, harmful use of alcohol and drugs, and previous exposure to sexual violence and maltreatment (WHO, 2010:21). At the relationship level, men who report having multiple sexual partners are also more likely to perpetrate intimate partner violence or sexual violence (Chan, 2009:8). The WHO (2010:25-26), observed that at the community level, risk factors include weak community sanctions against intimate partner and sexual violence and poverty. Societal-level factors mainly relate to traditional gender norms and social norms supportive of violence. Societal norms related to gender are believed to contribute to violence against women and gender inequality and other inequities by creating power hierarchies where men are viewed by society as economically and religiously superior, and of higher social status compared to women (WHO, 2010:24).

2.4.1 Myths and stereotypes about rape

Rape myths are a specific set of attitudes and beliefs that may contribute to ongoing sexual violence by shifting blame for sexual assault from perpetrators to victims. Edwards Turchik, Dardis, Reynolds & Gidycz (2011:763) have presented a compelling argument that rape myths are deeply rooted in history, law, religion, and media stereotypes. These myths help to foster a climate in which rape is perpetrated and rape victims blamed for their victimization. Ryan (2011:4) notes that the concept of myth has (at least) two connotations. One is myth as a story that is imbedded in history, religion, and culture and that guides human behavior and gives it meaning. The second myth is a mistaken belief—a lie. It is this connotation of rape myth that is evoked by Edwards and her colleagues in describing rape myth research.

Rape myths usually create negative ideas which affect the victims, the reporting, the trial of rape cases and the society at large. Rape myths are causally related to rape proclivity; negative attitudes towards rape victims; and reporting of sexual assaults incidents to the police (Dada, 2014:69; Moor, 2007:23). Myths and stereotypes about rape and rape victims considerably worsen the plight of victims of sexual offences as they tend to trivialise the harm of sexual victimisation and blame victims for its occurrence (Vetten, 2014:5). Vetten further asserts that these myths may result in unsympathetic, disbelief and inappropriate responses to the victims by society in general., as well as at each stage of the criminal justice process (Vetten, 2014:5).

Several authors have described a number of commonly held myths about rape on women and what the reality really is (Centre for Research & Education on Violence against Women and Children, 2015:3; WHO, 2012:5; McMahon & Farmer, 2011:71; Chapleau & Oswald, 2010: 66; Edwards et al., 2011:763).

The vast majority of scholarly research on rape and rape myths pertains to the female rape victim. However more recently, there has been a focus on the existence of rape myths related to male rape victims (Turchick & Edwards, 2012:211). Anderson (2007:236) found that in an analysis of hypothetical rape scenarios written by college students of what they perceived to be typical rape incidents for male and female victims, male rape scenarios contained more mythical elements than female rape scenarios.

Rape myths, assumptions, and stereotypes are harmful and hinder the society from effectively dealing with and eradicating sexual violence. Listed below are some of the common 'myths' about rape and sexual violence with information on the facts of this very serious subject.

- *Some people 'ask for it' by dressing provocatively, walking alone at night or drinking too much* (Edwards, Turchik, Dardis, Reynolds & Gidycz, 2011:766; McMahon, 2011:7*)*. It is however a fact that one 'asks' for rape or sexual assault or deserves to be raped or sexually assaulted. The way a person dresses, how much they drink, or use drugs does not mean that the person gives up the right to determine what happens to their body (Stern, 2010:33; Suprakash et al., 2017:2)
- *Sexual assault is committed by men upon female victims*. It is however a fact that sexual assault can be committed by any gender identity upon any other gender identity. Sexual assault can happen to any person regardless of gender identity or sexual orientation/identity (Stern, 2010:31).
- *It wasn't rape if the victim didn't physically fight back or was not physically harmed (TeBockhorst, O'Halloran & Nyline, 2014:173).* Someone who is being assaulted has to do what they feel is best in order to survive the assault. And sometimes, people freeze with fear. Other times, even just the threat (implied or directly stated) of physical violence, will make someone comply with an attacker's demands. Every person responds differently. Just because someone

does not physically fight back, does not mean that they consented to what happened (Suprakash et al., 2017:2).

- *A 'real' rape victim reports to the police what happened right away. Someone who waits to report or just reports it to the school is probably lying or just wants to get revenge on someone (Stern, 2010:33)*. Delayed reports in sexual assaults are very common and do not signify that someone is lying. Sometimes victims need time to process what has occurred to them and it may take time for them to feel safe to come forward. When the people involved in a sexual misconduct situation know each other well, have a prior relationship, or have mutual social circles it is not at all uncommon for a victim to feel fear of reporting. Just because someone needs time to process and weigh their options, does not mean that they are making a false report. It is not easy to talk about being sexually assaulted – it may cause the person to relive what happened to them. Often there is a fear that others will not believe them or blame them for their own attack.
- *If a parent teaches a child to stay away from strangers they won't get raped.* The fact however is that a large number of rape and sexual abuse cases are perpetrated by someone the person knows from outside the family or within the family.
- *If someone does not say 'no' then they must have wanted or enjoyed to have sex* (Edwards et al., 2011:765). It is never a good idea to assume that absence a 'no' means 'yes.' Yes means Yes (Block, 2006:39). Consent should be clear, knowing, and voluntary – it is never assumed from silence. When a person displays hesitation or reluctance, the person initiating sexual contact has an obligation to get effective consent before proceeding further!
- *Women lie about being raped* (Edwards et al., 2011:767). Although there is great debate about the prevalence of unfounded accusations of rape (Marshall and Alison 2006:21-24), most researchers suggest that false rape allegations are highly infrequent. In fact, an international report that reviewed studies and law enforcement estimates reported that approximately 2–8% of reported sexual assaults are believed to be false (Lonsway, Archambault & Lisak, 2007:4).

Dada (2014:69) points out that rape myths create an imbalance between reporting and conviction rates. When reporting a sexual assault, victims often face formidable tasks of establishing their own credibility and dealing with reactions of others (relatives and acquaintances). Because of myths, the general public may not be wholly sympathetic to the victim's plight.

2.4.2 Social Stigma

Josse (2010:180) posits that sexual violence can tear a family apart. A woman who has been raped may be barred by her family from returning home. If she is allowed to come home, she may be deliberately ignored by her parents or subjected to humiliation and taunts (insults may escalate into arguments or outright conflicts). Furthermore (Josse, 2010:180) points out that rape victims often speak of the shame that they experience. They talk of being mocked, ridiculed, denigrated, insulted, humiliated, and disparaged. When they go out in public, they risk being made fun of by villagers who parody songs in a demeaning way, using the victim's name, interrupt their conversation, or change subjects when the victim walks by, and whisper, giggle, or exchange knowing looks in her presence. Villagers may also point at the victim or stare at her with obvious disdain. A rape victim may also find that her behaviour, however ordinary, is seen as morally reprehensible and is unfairly associated with the rape. Often, the victim is prevented from expressing her opinion. In addition, old friends may stop talking to her or refuse even to see her.

Ahrens (2006:270) argues that for most survivors, no matter what they did or how they behave, they are likely to be blamed for the assault. For some survivors, this blame may be so traumatizing that they are effectively silenced by the negative reactions they receive. Sadly, when rape survivors are silenced by negative reactions, their experiences and perspectives are concealed and our ability to identify the causes and consequences of rape are obscured. Such silences thereby obstruct our ability to engage in social change.

In a qualitative study in Congo, Claude, Fance & Danielle (2013:2) showed that stigmas for victims of sexual violence are associated with the perception of rape and

rigid social norms to the detriment of women. Additionally, these stigmas were rooted in fears of the spread of sexually transmitted infections, as well as the shame and guilt felt because of the families and communities.

2.4.3 Cultural beliefs

Sexual violence committed by men is to a large extent rooted in ideologies of male sexual entitlement. These belief systems grant women extremely few legitimate options to refuse sexual advances (WHO, 2010:29). Many men thus simply exclude the possibility that their sexual advances towards a woman might be rejected or that a woman has the right to make an autonomous decision about participating in sex. In many cultures women, as well as men, regard marriage as entailing the obligation on women to be sexually available virtually without limit (WHO, 2010:29).

In societies such as Namibia, where the ideology of male superiority is strong – emphasizing dominance, physical strength and male honour – rape is more common (WHO, 2010:30). This is further supported by the theory that rape and sexual violence tends to be promoted by the maintenance of patriarchy or male dominance within a society (WHO, 2010:25; Taft, Weatherill and Deke, 2009:50). Patriarchal and male dominance norms reflect gender inequality and inequities at a societal level, and legitimize sexual violence and rape perpetrated by men (Russo & Pirlott, 2006:187).

Much of what people are is shaped by the culture that they are born in and live through, acquiring cultural values, attitudes, and behaviours. Culture determines definitions and descriptions of normality and psychopathology. Culture plays an important role in how certain populations and societies view, perceive, and process sexual acts, as well as sexual violence (Kalra, & Bhugra, 2013:5). In Namibia, for example, some cultures consider sexual relationships between cousins as normal. The victim in such a situation hence finds it difficult to report to anyone or make a case. Gender inequality exists at many levels in Namibian society: at the social level, at the extended family level, at the household level and even at the intimate level within a sexual relationship (Tibinyane, 2002:8).

Rape has been described as the psychological extension of a dominant-submissive sex-role stereotyped culture. Socio-culturally transmitted attitudes toward women, rape, and rapists can predict sexual violence. (Kalra, & Bhugra, 2013:6). Such stereotypes are often internalized from the male dominated sociocultural milieu. The California Coalition Against Sexual Assault (2008:14) notes that the phenomenon of rape is a result of larger forces within our culture, such as sexism, racism, homophobia, classism, to name a few. Together this set of cultural values and dynamics, creates an environment that allows rape to thrive and allows perpetrators to avoid accountability. To eliminate sexual violence altogether, we must end all of these forms of oppression. Simultaneously, we must ensure the provision of culturally and linguistically appropriate services to survivors (California Coalition Against Sexual Assault, 2008:33).

2.5 Consequences of rape

Rape as a form of sexual violence has a significant impact upon individuals, families, communities and wider society (Josse, 2010:177; UNAIDS, 2013:1; WHO, 2014:17). At an individual level, violence occurring during the younger years – particularly child sexual abuse – may affect that individual and their family for the rest of their lives. This can lead to negative consequences in many spheres of life, including educational and economic under-performance, unsafe sexual practices, reduced ability to bond as part of parenthood, increased uptake of health-risk behaviours (such as the harmful use of alcohol and illicit drugs) and the perpetration of intimate partner and sexual violence (WHO, 2014:13; WHO, 2010:15). The health consequences of sexual violence are numerous and varied (Campbell et al., 2009:225; Centre for Research on Violence Against Women, 2011:4; UNAIDS, 2013:3) and include physical and psychological effects, both in the short-term and in the long-term. Most significantly perhaps, rape can have devastating long-term psychological effects, influencing and radically altering a person's entire life course. The availability of post-rape treatment and services, as well as the attitudes and approaches by health providers can affect the long-term physical and psychological health and safety of survivors. Initiatives to respond to sexual violence within the health sector, have however been extremely limited relative to those within other sectors, and very few initiatives have been

rigorously evaluated (Harris and Freccero, 2011:21). Some of the key consequences of rape are elaborated below.

2.5.1 Physical consequences

Individuals who have experienced sexual assault may suffer a range of physical injuries, genital and non-genital, or in extreme cases, death (Campbell, Snow, Dienemann, Kub, Schollenberger, O'Campo, Gielen, & Wynne, 2002:1159). Mortality can result either from the act of violence itself, or from acts of retribution or from suicide (WHO, 2014:12). In addition, rape victims are at an increased risk from Sexually Transmitted Infections (STIs), including HIV/AIDS, sexual dysfunction, infertility, pelvic pain and pelvic inflammatory disease and urinary tract infections (WHO, 2012:2; WHO, 2014:15). Rape victims also often suffer from genital injuries, which include tears, abrasions and swelling, as well as non-genital injuries. Rape is also associated with a higher risk of contracting a Sexually Transmitted Infection (STI) including HIV/AIDS, and Hepatitis B and C (Harris & Freccero, 2011:2).

Pregnancy may result from rape, though the rate varies between settings and depends particularly on the extent to which non-barrier contraceptives are being used. Most medical experts and published studies report that a woman's chances of becoming pregnant are roughly the same after rape, as they are after consensual intercourse (Coleman, 2015:3). While emotional, medical or nutritional stress impacts a woman's capacity to get pregnant, a study of adolescents in Ethiopia found that among those who reported being raped, 17% became pregnant after the rape. This figure is similar to the 15–18% reported by rape crisis centres in Mexico (WHO, 2012:162). While emotional, medical or stress impacts a woman's capacity to get pregnant, there are an estimated 32,101 pregnancies in the United States each year as a result of rape (Coleman, 2015:3).

A study in the United States which sampled women sexual assault survivors presenting for care to ten SANE Programs in four states found that the majority of sexual assault survivors experience moderate or severe pain during the early aftermath of rape (McLean, Soward, Ballina, Rossi, Wheeler, Rotolo, Foley, Batts,

Casto, Collette, Holbrook, Goodman, Rauch, & Liberzon (2012:740). The research by Mclean et al., (2012:740) also noted that less than one third of women with severe pain received any pain medication, a finding which is also consistent with findings from this current research.

Regardless of cause, acute pain is important to identify and treat when present, not only to reduce immediate suffering, but also because preliminary evidence suggests that the treatment of acute pain may also improve psychological outcomes (Holbrook, Galarneau, Dye, Quinn & Dougherty, 2010:112). It is therefore suggested that the training of nurses and others who provide care to sexual assault survivors in the early aftermath of assault should emphasize that moderate or severe pain is common after sexual assault, should provide specific recommendations for pain evaluation and treatment (Mclean et al, 2012:740).

Research has consistently shown that injury plays a significant role at multiple decision-making points during criminal justice proceedings such as the decision to report, file, prosecute, and convict (Sommers, 2007:275). The importance of the documentation of injury cannot be overlooked, especially given that an important reason for not reporting to the police is the lack of proof that an incident happened (Sommers, 2007:275). Forensic evidence documenting the existence of injury following sexual assault can be used as part of a larger constellation of factors of evidence to enhance the government's case in allegations of sexual assault and allows the jury or judge to make an informed decision to convict or not.

2.5.2 Rape and HIV/AIDS

The inter-connections between violence against women and HIV, as both a root cause and consequence of HIV, are now widely acknowledged both by the scientific community and development practitioners (United Nations Educational, Scientific and Cultural Organization, 2013:48). Violence against women, especially rape, may increase the risk of transmission of HIV both directly and indirectly.

The linkages between sexual violence and HIV, especially among young women in high prevalence countries, are well-documented (Devries, Bacchus, Mak, Child, Falder, Pallitto, Garcia-Moreno & Watts, 2013:6; Silverman, 2008:707). In the most obvious way we can understand the link between HIV and GBV in instances of sexual violence, in particular rape, where women are not able to demand condom use, thus increasing the likelihood of HIV transmission. Studies from several countries have found that HIV-positive women, report higher rates of intimate partner violence (Osinde, Kaye & Kakaire, 2011:5) and there is increasing evidence that HIV risk is linked to exposure to sexual violence (Campbell et al., 2008:9).

2.5.3 Emotional and psychological consequences

In the same way that there is no typical victim, there is also no typical reaction to the experience of sexual violence; psychological effects vary considerably from person to person. The response of survivors to the trauma of rape are complex and unique (Suprakash et al., 2017:2). While some rape survivors suffer from severe symptoms or long-term distress, others do not. The difference in outcomes is explained by survivor attributes, environmental conditions, type of violence perpetrated and resulting injuries, availability of social support and resources. Generally speaking, however, sexual abuse should be suspected in individuals who present, particularly repeatedly, with the following health problems (Patton, McNally & Fremouw, 2015:1-2; Josse, 2010:183; Campbell et al., 2009:232; UNESCO 2013:48):

- rape trauma syndrome (RTS)
- post-traumatic stress disorder (PTSD)
- depression and anxiety;
- social phobias (especially in marital or date rape victims);
- increased substance use or abuse;
- suicidal behaviour.
- sexual difficulties and dysfunction
- inter-personal difficulties, including sexual problems.

The aftermath of rape involves a cluster of acute and chronic physical and psychological effects. It is important that victims receive comprehensive care that

addresses both the short and long-term effects of rape as they become apparent. Victims of rape, or those who were assaulted repeatedly or at a very young age, may need treatment for the rest of their lives (Campbell et al., 2008:708; Moor, 2007:21).

2.5.4 Medium-to-long-term psychological effects

Rape is a significant trauma that leads to short term and long term stress reactions and victims are at significantly increased risk of developing PTSD (Suprakash et al, 2017:4). Nearly one third to 50% of all rape victims develop Rape-related PTSD (RR PTSD) sometime during their lifetime (Feeny, Foa, Treadwell and March, 2004:468). The four major symptoms of rape related PTSD are re-experiencing the trauma or intrusive thoughts, social withdrawal, avoidance behaviours and actions and increased physiological arousal characteristics. Rape survivors exhibit depression, fear and anxiety, problems with social and work adjustment, and problems with sexual functioning subsequent to their assault (Suprakash et al., 2017:5; WHO, 2003:13).

Research suggests victim/survivors may experience a range of medium-to-long-term impacts, like feelings of low self-esteem, self-blame and guilt can endure for months and years after the assault (Suprakash et al., 2017:4; Edmond, 2006). Commonly survivors forget or deny aspects of their experience which can be a defense against overwhelming feelings of confusion, shock and bewilderment. This may be especially powerful in partner rape (Suprakash et al., 2017:4). Sexual abuse was associated with multiple psychiatric disorders, including lifetime anxiety disorders, depression, eating disorders, PTSD, sleep disorders, and attempted suicide (Chen, Hassan, Murad, Paras, Colbenson, Sattler, Goranson, Elamin, Seime, Shinozaki, Prokop & Zirakzadeh, 2010:620; Russel and Davis, 2007:28). It is suggested that more research is needed to improve our understanding of the pathogenesis of rape to improve their treatment in survivors of sexual assault.

Although most rape victims do not develop clinical depression, almost all feel, at some point, sad and hopeless. Symptoms of depression include sadness, loss of interest in life, suicidal impulses, and feelings of powerlessness (e.g. feeling unable – especially

as a woman – to defend oneself, improve one's lot in life, etc.), discouragement, pessimism, hopelessness, and the feeling that the future holds nothing good. These symptoms may be accompanied by crying spells, constant weeping, feelings of rejection, suicidal thoughts, suicide attempts, or suicide itself (Josse, 2010:186)Victims may feel anger against the perpetrators, against all men or against their husbands and communities for having rejected them (WHO; 2003:14).

Suprakash et al., (2017:4) report that suicidal ideation (the thought of committing suicide) is more common among survivors of sexual assault, than the general population. Younger survivors are at particular risk of attempting suicide following rape. While rape will always be a traumatic experience, the effects of this trauma for an individual may differ in different contexts. Some trauma measures reflect dominant views about the world that many people do not share (Suprakash et al., 2017:4). Certain symptoms of trauma, rather than being viewed as problems to be treated, need to be viewed in a more positive light—that is, as "coping mechanisms" an individual has adopted for protection and other purposes (Morrison, Ellsberg & Bott, 2007:32). Symptoms of PTSD (which can persist for 3 years or more) include: intrusive thoughts and distressing recollections of the violence; nightmares and other sleep disturbances and depression. Women survivors of sexual violence may constitute the single largest group of people affected by PTSD (Astbury 2006).

Post-traumatic stress disorder (PTSD) is an anxiety disorder that can result from a traumatic event (American Psychological Association [APA]), 2017:7). Survivors of rape might experience uncharacteristic feelings of stress, fear, anxiety, and nervousness (Minnesota Coalition Against Sexual Assault, 2013:2). With PTSD, these feelings are extreme, can cause one to feel constantly in danger, and make it difficult to function in everyday life. While all survivors react differently, the following are some of the main symptoms of PTSD (APA, 2017:8; Boyle, 2017:78):

- Re-experiencing: feeling like one is reliving the event through flashbacks, dreams, or intrusive thoughts.
- Avoidance: intentionally or subconsciously changing one's behaviour to avoid scenarios associated with the event or losing interest in activities that one used to enjoy.

- Hyper-arousal: feeling “on edge” all of the time, having difficulty sleeping, being easily startled, or prone to sudden outbursts.

Often the psychological needs of victims of sexual violence are overlooked, even in settings that offer medical services (Astbury and Jewkes, 2011:411). With that in mind, healthcare providers should be aware of the factors that influence the psychological impact on victims of sexual violence. The main approaches used to treat adult victims of sexual violence are traditional cognitive behavioural interventions; group therapies including stress inoculation; assertion training; supportive psychotherapy; and one-on-one counselling (Van der Kolk, 2005:404). Treatment for psychological disorders relating to sexual violence varies significantly in both approach and cost. Some treatments have proven effective for treating multiple types of psychological disorders, while others address symptoms related to very specific syndromes. Regardless of the disorder, patients should be provided with a safe place and an “outlet,” such as a trained psychologist or a family member or a group of friends, where they can share their feelings about the traumatic experience. (Harris and Freccero, 2011:10).

2.5.5 Impact of rape on personal integrity and self-esteem

Research suggests victim/survivors may experience a range of medium-to-long-term impacts, like feelings of low self-esteem, self-blame and guilt can endure for months and years after the assault (Suprakash et al., 2017:4). Using the ecological model, self-blame has been studied as from both individual-level and extra-individual perspective, and therefore self-blame can be seen as a meta-construct that develops from and is shaped by multiple levels in the ecological system (Campbell et al., 2009:17). Two types of self-blame are identified at the individual level (Campbell et al., 2009:17), namely, characterological self-blame, which is considered to be maladaptive because it involves blaming one’s own character for the negative event; and behavioural self-blame, which involves blaming one’s actions for the event. This latter type of self-blame may actually be adaptive because it enhances perceived control and the belief that future rapes can be avoided.

Survivors' self-blame comes both from internal and external forces, as multiple ecological factors directly contribute to victims' negative attributions. For example, certain assault characteristics (e.g., greater severity of the assault, using alcohol/drugs) contribute to an increase in self-blame and thereby more post-assault distress (Koss et al., 2002:936).

Jacques-Tiura, Tkatch, Abbey and Wegner (2010:175) reported that survivors with higher behavioural self-blame were less likely to reach out to both informal and formal support providers, perhaps out of concern that they would receive more criticism of their behaviour or choices. Such apprehension may be warranted, as negative social reactions from informal supports have consistently been found to be associated with increased self-blame (Ahrens, 2006:263).

Survivors are also likely to receive negative reactions from formal support providers (Ahrens, 2006:264). Negative reactions from professional sources may be particularly harmful for survivors. When "experts" doubt survivors, hold them responsible for the assault, or refuse to provide assistance, survivors may question both the effectiveness of such services and the use-fullness of reaching out for help to anyone at all. Harned (2005) argued that these beliefs signify the impact of rape myths on female victims and teach them to blame themselves for the assault, while taking away the responsibility from the perpetrator's actions.

If victims are able to receive the services they need and are treated in an empathic, supportive manner, then social systems can help facilitate recovery. Conversely, if victims do not receive needed services and are treated insensitively, then these systems can magnify victims' feelings of powerlessness, shame, and guilt (Campbell et al., 2009:238).

2.5.6 Fear resulting from rape

Josse (2010:184) notes that after experiencing sexual violence, the majority of victims suffer fears that they did not have before. Among the most common are fear of repeated assault, fear of situations reminiscent of the assault, and fear of the social and medical consequences of the assault. Fear of repeated assault may include fear

of being raped, kidnapped, beaten, or tortured again. Victims often fear that the traumatic event that they experienced may recur (Sable, Danis, Mauzy & Gallagher, 2006:158). Such fears are characteristic of PTSD.

Survivors of rape may experience fear generated by the possibility of pregnancy or STD's or live in fear of running onto the offender again or facing them in court. All of these fears are very real concerns (South Eastern Centre Against Sexual Assault [SECASA], 2011:2; Sable et al., 2006:158). Fear of situations reminiscent of the assault is characteristic of posttraumatic syndromes. Depending on the circumstances of the assault, the survivor might develop a fear of strangers and men in general (Lebowitz and Wigren, 2005:7). Fear of social consequences includes fear that others will find out about the assault, fear of their reactions, fear of being rejected by one's spouse or being denied the opportunity to marry, fear of being ostracized by the community, and fear of being thrown out of school (Sable et al., 2006:158; Naidoo, 2013:210).

2.6 Reasons for not reporting rape and other forms of sexual assault

Rape victims are often hesitant to report sexual assault because of humiliation, feelings of guilt, fear of retribution, lack of knowledge about their legal rights, and disillusionment with the criminal justice system (Coleman, 2015:1, UN, 2011:5). The Centre for the Study of Violence and Reconciliation [CSVR], (2011:62), notes that the rate at which rape accused are charged and convicted, along with the length of the sentences they receive, represents a failure of justice for many rape victims and survivors. Moreover, the report states that the attitudes and prejudices of law enforcement agencies and other government personnel and the inaccessibility of services, particularly in rural areas, are also part of the problem (CSVR, 2011:64). Much of the South African public regard the police as symbols of the oppressors during the apartheid; thus, poor faith in the police is still instituted in the post-apartheid country (Vetten, 2014:3).

Acquaintances, friends, co-workers or colleagues are more likely to use tricks, verbal pressure, threats, negative consequences, or victim-blaming rhetoric when they have

committed acts of sexual violence. Survivors also often worry that once they tell their story, everyone in the community, workplace or school will know. On the other hand, many fear that their disclosures will not result in helpful outcomes (Pietsch, 2015:4).

Many rape survivors often report that law enforcement personnel actively discouraged them from reporting their cases (Campbell, 2008:703, Koenig et al., 2006; Campbell & Raja, 2005:104). Survivors of rape indicate that they are usually questioned about elements of the crime (e.g., penetrations, use of force, or other control tactics) over and over again to check for consistency in their accounts, which can be emotionally unsettling and, given that trauma can impede concentration and memory (Halligan, Michael, Clark, & Ehlers, 2003), and can be cognitively challenging as well. Research has also noted that many victims report that this questioning strays into issues such as what they were wearing, their prior sexual history, and whether they responded sexually to the assault (Campbell, 2008:703, Koenig et al., 2006:132; Campbell & Raja, 2005:104). Victims however rate these questions as particularly traumatic (Campbell & Raja, 2005:105), and their legal relevance is minimal at best.

The police investigation is designed to weed out cases, and to that end, it is very effective (Campbell, Baty, Ghandour, Stockman, Francisco & Wagman, 2008:704). Crandall & Helitzer (2003) assert that most reported rapes never progress past this stage and approximately 56% to 82% of all reported rape cases are dropped (i.e., not referred to prosecutors) by law enforcement. If a case progresses past the investigation stage, prosecutors often conduct their own interviews with the victims prior to deciding whether to file criminal charges and what happens in this process is unfortunately largely unknown, but ethnographic research revealed that prosecutors require victims to go through the details of the rape again multiple times (Campbell et al., 2008:704). Victims often go through a traumatic process of reliving the assaults and defending their characters (Koss and Achilles, 2008:3). On average, approximately 44% of the cases referred by law enforcement to prosecutors for further consideration are dismissed by the prosecutors, and about half on average (56%) move forward (Spohn, Beichner, & Davis-Frenzel, 2001:207).

Monroe et al., (2005:768) and Campbell et al., (2001:1250); noted that across multiple samples, 43% to 52% of victims who had contact with the legal system rated their experience as unhelpful and/or hurtful. In qualitative focus group research (Logan et

al., 2005:593), survivors described their contact with the legal system as a dehumanizing experience of being interrogated, intimidated, and blamed. The experiences of secondary victimization noted above take a toll on victims' mental health. In self-report characterizations of their psychological health, rape survivors indicated that as a result of their contact with legal system personnel, they felt bad about themselves, depressed, violated, distrustful of others and/or reluctant to seek further help. (Campbell & Raja, 2005:103). Koss and Achilles (2006:4) has stated in her research that survivors feel their legal needs are the most poorly met and that legal services and health outcomes served only as forms of attrition and re-traumatization.

Nyblade, Stangl, Weiss & Ashburn (2009:2) posit that stigma by healthcare providers hinders the provision of quality care and adherence of patients to treatment. Stigma and discrimination in the healthcare setting and elsewhere contribute to keeping people, including health providers, from adopting preventive behaviours and accessing needed care and treatment. Fear of being identified as someone who has been raped increases the likelihood that people will avoid disclosing their predicament to healthcare providers and family members, or seeking treatment and care, thus compromising their health and wellbeing (Nyblade et al., 2009:2).

Stigma and stereotyping of victims by healthcare providers has potentially devastating consequences on care-seeking behaviour. Stigma represents a major "cost" for both individuals and public health. Both experienced and perceived stigma and discrimination are associated with reduced utilization of services (Nguyen, Oosterhoff, Pham, Hardon & Wright, 2009:9;Nyblade et al, 2009:2), provision of counselling services (Obermeyer and Obsorn, 2007:1768; Kalichman, Simbayi, Wolfe, Weiser, Bangsberg, Thior, Makhema, Dickinson, Mompati & Marlink, 2006:9) as well as the assessment of care and treatment (Kinsler, Wong, Sayles, Davis & Cunningham, 2007:589).

2.7 The role of healthcare in dealing with rape

The health sector is a critical entry point for identifying rape, providing medical care to survivors and referring them to other essential services, such as shelters, counselling centres, or specialized medical care (UN, 2011:5). For many survivors of rape, a visit

to a health professional is the first point of contact, enabling them to access support and care (UN, 2011:5, Harris and Frecerro, 2011:21).

When caring for victims of sexual violence, the overriding priority must always be the health and welfare of the patient. The provision of medico-legal services thus assumes secondary importance to that of general healthcare services (UN, 2011:36) (i.e. the treatment of injuries, assessment and management of pregnancy and STIs). Concern for the welfare of the patient extends to ensuring that patients are able to maintain their dignity after an assault that will have caused them to feel humiliated and degraded. Given these serious consequences of rape and sexual assault, it is clear that a comprehensive response, delivered by trained, sensitive and knowledgeable personnel, is essential to meeting the many healthcare needs of rape survivors (Vetten and Jacobs, 2008:2). At a minimum this includes the prevention, termination or management of pregnancy; pre- and post-test counselling for HIV, accompanied by Post-Exposure Prophylaxis (PEP) to prevent the possible transmission of HIV or any other STIs; treatment for any injuries to the body; and attention to the psychological needs of rape survivors, including PTSD. When rape survivors choose to report to the police medico-legal and forensic services are also required (Vetten and Jacobs, 2008:2). Mental health and psychosocial supports are essential components of the comprehensive package of care and aim to protect or promote psychosocial well-being and/or prevent or treat mental disorders among survivors of sexual violence (WHO, 2011:2).

Many healthcare organizations have attempted to address rape by conducting a single training event for selected medical staff or making a narrow policy change, such as requiring providers to ask women about violence. Evidence however suggests that these strategies have limited success and that the best way to respond to the violence is through a “systems approach” that promotes broad reforms through a health organization (Bott, Guedes, Claramunt & Guezmes, 2010:45). A systems approach touches on every aspect of health services, from private consultation rooms to staff support, supervision, training, and referral networks. In fact, changing the professional culture of an organization is often necessary to convince health personnel and their managers that responding to violence against women is a health concern and part of their jobs (Harris & Freccero, 2011:14-15). Support for rape survivors should be

multilevel. In other words, they should target both persons and communities (or segments thereof). The approach emphasizes training all levels of staff, including management, direct service providers, and administrators, to ensure the delivery of essential services (medical and forensic) in a caring and sensitive environment that aims to reduce further trauma to the survivor (Harris and Freccero, 2011:21). Community focused psychosocial interventions generally seek to enhance survivor well-being by improving the overall recovery environment. Person-focused interventions concentrate on the individual survivor and the survivor's immediate family and social network (WHO, 2011:3).

2.8 Improving support services for rape survivors.

Support services for survivors of sexual violence are inadequate in most developing economies. Specialized services for survivors are run mainly by nongovernmental organizations (National Aids Convention of South Africa [NACOSA], 2015:7), though many survivors turn to government institutions as well, depending on the setting (Morrison et al., 2007:40). Typically, social service interventions aim to expand, improve, and integrate services such as telephone hotlines, emergency shelters, legal assistance, counselling services, psychological care, support groups, income generation programmes, and child welfare services.

Rape is a traumatising experience. In too many cases this initial trauma is further exacerbated by the disbelief and blame of others, as well as harmful or ill-informed treatment. This secondary victimisation, in combination with the stigma attached to rape, makes it much harder for survivors to come to terms with what has happened to them (NACOSA, 2015:3). To prevent secondary victimisation, post-rape services must be designed and implemented to uphold the rights of the victim, including those to equality, dignity, freedom and security, and the right to healthcare services. Where children are concerned, the law also makes it clear that their best interests should be prioritised (NACOSA, 2015:3).

Counselling is a valuable service for victims of crime and helps them to address the widely recognised consequences of crime, including fear, loss of control, anxiety and depression (Victims Support Agency, 2011:58). Rape is a crime that impacts survivors on multiple levels. As the survivor manages these multiple levels of impact, her usual coping system may not be sufficient to support her as it would without such an intense and violent event. At those times, the survivor therefore needs effective counselling support which can help with coping (California Coalition Against Sexual Assault, 2008:25).

Research notes that counselling is most effective when the counsellor has a basic understanding of the sociological and psychological implications of sexual assault and applies this awareness to each individual counselling relationship. It is further noted that during counselling, counsellors need to remember, and to share with survivors, some key assumptions such as posed by Fernandez, (2011:600); Astbury, (2007:11):

- The perpetrator, not the survivor, is always responsible for the assault.
- Survivors have made the best choices and decisions possible – given the constraints, fears, feelings, and circumstances at the time. (This includes decisions made before, during, and after the rape.)
- No one “deserves” to be raped. Sexual assault is not about something that was “wrong” with the survivor – or anything that she or he did, said, wore, or thought.
- Issues of culture, race, and socioeconomic background may be involved in the healing process. Counsellors should know about cultures that are different from their own, without making broad assumptions about a survivor based on those differences.
- Survivors have strength and healing capacity. Although it may take time and be difficult, every survivor can move through an individual process and recover from sexual assault.

The literature has widely recognised the importance of attending to two important areas when counselling rape survivors: 1) acute post-sexual assault needs, and; 2) the enduring effects of sexual assault (Astbury, 2011:11; Poirier, 2002:53). Regarding acute post-sexual assault care, counsellors may be of great value when assisting with decision-making, and the provision of social support and limited legal information. For

survivors presenting within 72 hours of experiencing rape, it is noted that decision-making assistance may be offered in assisting the client to report the crime to the police; highlighting the low rate of convictions, but the importance of this period for detecting perishable evidence (e.g. spermatozoa and genital injury) which may contribute to a successful prosecution (Fernandez, 2011:599). Counsellors may also act as advocates for survivors undergoing medicolegal examinations for sexual assault, in the absence of an appointed advocate, family member or partner/friend.

First responders and other frontline staff, need to be familiar with the social and psychological consequences of rape, to ensure they create and maintain services that reduce the harm of rape, as well as take steps to prevent others causing further distress to rape survivors (Vetten, 2015:3). Rape survivors interact with a wide range of people on their journey through the health and justice systems, so first responders must also network and collaborate closely with all the other service providers, to ensure rape survivors and their families receive quality care. The trauma of rape extends far beyond the actual assault, and intervention strategies must address the difficulties rape survivors encounter when seeking community help (Campbell et al, 2001:1240)

2.8.1 Integrated delivery approaches for comprehensive post-rape care

Harris and Freccero,(2011:27) observe that innovative programme approaches that incorporate medical, forensic, psychosocial support services and referrals to community-based providers into the delivery of post-rape care services within hospitals, health centres, or clinics, can increase access to comprehensive care and facilitate timely access to justice. Such integrated programmes are regarded as best practices in addressing sexual violence, as they enable survivors to access a range of services in one location, reduce trauma and provide specialized care, and serve as the bridge or medico-legal linkage between sectors by documenting, collecting, and delivering evidence to the criminal justice system.

- **Sexual Assault Response Teams (SARTs)**

A Sexual Assault Response Team [SART], (Harris and Freccero 2011:22), is an interdisciplinary team of individuals working collaboratively to provide comprehensive

and specialized care to victims of sexual violence. While SART teams vary, they generally comprise a nurse examiner (or SANE) trained in forensic evidence collection; a counsellor, case manager or advocate; a law enforcement officer; and a prosecutor. The goals of SARTs are to provide coordinated, trauma-informed care to survivors of sexual violence, as well as to increase reporting to law enforcement and the conviction of offenders (National Sexual Violence Resource Center, 2010).

- **One-Stop-Shop: Thuthuzela Care Centers**

Survivors of sexual violence experience complex needs and many countries have developed one-stop facilities that enable survivors to access medical, legal and social support services (Kilonzo, Theobald, Nyamato, Ajema, Muchela, Kibaru, Rogena & M Taegtmeyer., 2009:555). “One-Stop-Shops” are specialized facilities designed to provide a wide range of services for survivors of sexual violence in a single location. The one-stop-shop model of service provision, generally located within or connected to a hospital, offers medical and forensic services, psychosocial counseling, legal aid, case management and referrals, and police services on site. The Thuthuzela Care Centers (TCCs), named after the Xhosa word for “comfort,” in South Africa, are a good example for managing cases of sexual violence and delivering post-rape care (Harris and Freccero, 2011:22). The TCCs assist survivors at each step, from emergency care to preparation for court, in order to minimize secondary trauma, reduce the overall length of time in finalizing cases, and improve conviction rates.

TCCs are based in communities with relatively high incidences of rape and sexual assault. Upon arrival at the centre, survivors receive trauma counselling from an on-site coordinator or nurse, an explanation of the procedures, and a medical examination, including collection of forensic evidence (NACOSA, 2018:10). Following these procedures, the victim is provided with the option of taking a shower at the centre and changing into clean clothing. The victim provides a statement to an on-site investigator. Before leaving the facility, staff will provide the victim with post-exposure prophylaxis for HIV and emergency contraception, and an appointment for a follow-up visit. The survivor can also meet with a social worker to develop a safety plan, and if needed, referrals to community-based psychosocial services or shelter. If the victim decides to file a police report and bring the case to court, she can also meet with a prosecutor at the centre for consultation (UNICEF, 2010).

2.9 Implementing National plans and policies against gender-based violence

Many countries have established national plans for addressing gender-based violence (Morrison et al., 2007:39). Some countries have established national commissions to improve inter-sectoral coordination and monitor progress in implementing the plans. The Namibia National Plan of Action on Gender-Based Violence highlights the fact that the Plan is conceived within the framework of Vision 2030 and the NDP3 goal of Gender Equality. The Plan is organised under four major outcomes with respect to GBV: prevention; response; research; and coordination and monitoring (MGECW, 2012:21). Outcomes of the National Plan of Action on Gender-Based Violence include:

- Reduced gender-based violence as a result of prevention initiatives.
- Improved services for survivors of gender-based violence.
- Increased understanding of gender-based violence in Namibia.
- More efficient interventions as a result of improved coordination and monitoring. (MGECW, 2012:22).

Many countries have developed sectoral policies to address the needs of survivors of violence. For example, health services provide a unique opportunity to address the needs of abused women, since most women come into contact with the health system at some point in their lives (Morrison et al., 2007:39). Research has however shown that unless specifically asked, women are unlikely to disclose violence to health providers (Ellsberg 2006:3). For example, a Demographic and Health Survey in Nicaragua found that only 13 percent of women had ever received medical attention for injuries associated with family violence and that even in these cases most women did not disclose the cause of their injuries.

Many countries have specific legislation and policies spelling out the obligations of the health sector to address violence against women. Adopting such policies, even though they often lack specificity, is a critical step in sensitizing health providers and programme managers to violence as an important health issue (Morrison et al., 2007:39). In some cases, national legislation has resulted in unforeseen problems for

the health sector. For example, several countries, including Guatemala and Panama, require health providers to report suspected cases of family violence to legal authorities. This puts providers in the position of betraying the privacy and confidentiality of their clients and could reduce women's willingness to disclose violence (Morrison et al., 2007:39). Providers may also be more reluctant to ask clients about violence, for fear of becoming involved in legal cases.

2.10 Summary

Chapter two has offered a literature review of rape both globally and at a National level. It has been noted that rape is a reality of millions of people all over the world especially women. Violence against women, particularly in the form of rape, has been viewed as a serious human rights problem in Namibia, although the extent of understanding about the problem is limited due to underreporting by survivors of violence and the lack of sufficient research on the issue. In this chapter an attempt has been made to explore both the causes and consequences of rape. It was highlighted that rape is a product of a number of factors such as myths about rape as well as social cultural beliefs. The physical and psychological consequences of rape were noted to have long term effects on women.

The chapter also provided some insights into the role of healthcare in providing support services for victims of rape. Support for victims of rape has been identified as being quite limited in developing economies such as Namibia. There is need for health support services to be improved if rape survivors are to obtain more effective and timeous. Integrate models of support for rape survivors have been suggested as they are regarded as best practices in addressing sexual violence, since they enable survivors to access a range of services in one location.

The following chapter focuses of the research methodology.

CHAPTER THREE

RESEARCH METHODOLOGY AND EMPIRICAL FINDINGS

3.1 Introduction

Women in Namibia face many challenges in trying to access healthcare support services. Consequently the research question for this study was: What challenges do survivors of rape in the Khomas Region of Namibia encounter in accessing health and support services that are necessary to help them heal from the trauma of rape?

The main goal of the research was: To explore and describe the challenges faced by survivors of rape in the Khomas region of Namibia in accessing health and support services.

Chapter three provides an insight into the research methodology that was used in this study. The chapter outlines the research approach, research type and the design of the the research that was used. The chapter also sets out the ethical aspects that guided the researcher as well as how trustworthiness of the study was ensured. Furthermore the chapter also outlines the limitations of the study and presents the empirical findings. Biographical data of the research participants is presented in chart and graphical form. In line with the qualitative research approach ,the empirical findings are presented in the form of a thematic analysis.

3.2 Research approach

This study used the qualitative approach to reflect as closely as possible, the subjective thoughts, feelings and experiences of research participants (Creswell 2009:145). The focus was on how participants think about and interpret what they are doing. Knowing the answer to ‘what meaning’ can explain why people think the way do and what they do.

The main reason for using this research approach for the study was to capture the “lived experiences” from the perspectives of those who lived and created meaning from it. The study allowed the researcher to capture the participant’s point of view,

rather than to rely on hearing from third party reality (Fouché & Delport, 2011:65-66). This approach enabled the researcher to understand the experiences and perspectives of the survivors of rape, the trauma that they faced and how they dealt or are dealing with the trauma, as well as the challenges that they faced in trying to access services. The researcher sought to get a deeper insight into the survivors' stories and interventions that the survivors received, to help them deal with trauma of rape abuse and to get a deeper understanding of their experiences through in-depth interviewing (Vaismoradi, Jones, Turunen & Snelgrove, 2016:100). This enabled the researcher to assess whether the interventions received were adequate or successful, or if they were not. In cases where interventions were not adequate and/or effective, reasons for this were deduced and recommendations were made. The qualitative approach allowed a holistic and thick description of what was said and by whom. The research took place in a naturalistic setting which allowed the researcher to get information of things as they are, without any outside manipulation or influence (Creswell, 2009:4).

3.3 Type of research

The research was applied as it focused on problems faced in the practice of identifying and seeking to address the challenges faced by rape survivors in the process of trying to heal from the trauma of rape. Findings from the study may serve to inform those tasked with providing services to rape survivors about the gaps and limitations that exist in assisting the rape survivors. Necessary recommendations will be made to the service providers. Practical and implementable measures will be looked into, hence the applied type of research (Leedy & Ormrod, 2010:44).

3.4 Research design

The term research design refers to 'all the decisions made in planning and conducting research, including decisions about measurement, sampling, how to collect data and logical arrangements designed to permit certain kinds of inferences (Rubin & Babbie, 2011:245). The research design focuses on the end product and all the steps in the process to achieve the outcome anticipated (Fouché, Delport & De Vos, 2011:143). It

is an outline of how the researcher will carry out the research, more of a plan. A phenomenological research design was specifically employed in this study (Lin, 2013:470). The phenomenological design was deemed appropriate, since the study dealt with some sensitive issues regarding personal experiences of violence and reaction to it. Intimate relationships were explored in an attempt to understand and find meaning of the subjects' lived experiences. This approach aims to describe the actual content of real life experiences, or more specifically, those concepts and structures of experience that give form and meaning to it (De Vos et al., 2011:316). With regard to this study, the researcher describes the phenomenon that is the lived experiences, as accurately as possible and identifies the challenges faced by survivors of rape.

3.5 Research methods

3.5.1 Study population and sampling

The entire set of objects or people which is the focus of the research and about which the researcher wants to determine some characteristics, is called the population (Bless, Higson-Smith, & Kagee, 2008:98). The study's population consisted of women who have survived rape in the Khomas region of Namibia. The population was obtained from the Gender-based Violence Protection Unit (GBVPU), at the Ministry of Gender, Equality and Child Welfare, where most cases of Gender based Violence in Namibia are reported and dealt with.

The researcher examined a relatively small number of cases in keeping with a qualitative study that promises to '…yield the most information about the topic under investigation' (Leedy & Ormrod, 2010:147). Sampling entails taking any portion of a population or universe as representative of that population. In this study the researcher used non-probability sampling, since the population that met the selection criteria was unknown. Non-probability purposive sampling was used (Palys, 2008:697), and helped to identify rape survivors who had reported their cases to the GBVPU in the Khomas region in Namibia. Purposive sampling asserts that the researcher purposely chooses people for sampling, because they have characteristics and conditions that the researcher is considering and the sample is entirely based on the judgement of

the researcher (Strydom & Delport, 2011:350). In this study the sample included women survivors of rape between the ages of 20-50 years of age in Namibia, as this is the age group that is mostly affected by rape. Choosing the sample from this age range therefore helped to ensure that those cases that maximised a range of perspectives and differences were taken into consideration (Abrams, 2010:538). The selection criteria included women who:

- were victims of rape,
- were raped in the last two years,
- were mentally stable to be interviewed,
- were aged between 20-50 years,
- reported and opened a case with the Gender Based Violence Protection Unit and the Namibian Police,
- were living in Windhoek for availability reasons and
- were conversant in English, as researcher cannot speak any of the Namibian languages.

The researcher provided an information letter of the research to the GBVPU, so that it was shared with women who were their clients and who met the selection criteria. Those who were interested in taking part provided their contact details and permission to be contacted by the researcher. Researcher collected their contact details at the GBVPU and contacted them telephonically. The first ten (10) women, who met the selection criteria, were contacted and appointments were made. The letter of informed consent was read through with them. Once they gave their permission to participate by signing the letter, a suitable time and venue was then arranged for the interview and the interview was conducted.

3.5.2 Methods of data Collection

The interview is a data collection tool for research falling within the ambit of the qualitative research paradigm (Creswell, 2012:79). Interviews are guided question–answer conversations, or an “inter-change of views between two persons conversing about a theme of mutual interest” (Kvale & Brinkmann, 2009:2). Qualitative interviews provided opportunities for mutual discovery, understanding, reflection, and

explanation, via a path that is organic and adaptive. Interviews elucidated subjectively the lived experiences and viewpoints from the respondents' perspective (Tracey, 2013:132). All interviews were one-to-one and were voice recorded for each participant with their permission.

Unstructured interviews were used to collect data in this research. Alshenqeeti (2014:40) described unstructured interviews as a kind of interviewing which is characterised by an open situation in which a greater flexibility and freedom is offered to both the interviewer and the interviewee. He argued that the unstructured interview relies entirely on the spontaneous generation of questions in the natural flow of an interaction. While definitions of unstructured interviews may vary (Zhang and Wildemuth, 2009:223) there is however a general agreement about the basic characteristics of these interviews. The researcher comes to the interview with no pre-defined theoretical framework, and thus no hypotheses and questions about the social realities under investigation. Rather, the researcher has conversations with interviewees and generates questions in response to the interviewees' narration (Dörnyei, 2007:136). As a consequence, each unstructured interview tended to generate data with different structures and patterns.

The primary question used in the interview was: ***Tell me about the rape and the challenges you faced in accessing support services. Secondary questions followed to clarify more specific issues.***

The intention of unstructured interviews was however to expose the researcher to unanticipated themes and to help the researcher develop a better understanding of the interviewees' social reality from the interviewees' perspectives. Though time consuming (Greeff, 2011:348) interviews however gave ample time to obtain deep information from the interviewees. Researchers use unstructured interviews in order to gain a detailed picture of a participant's beliefs about, or perceptions or accounts of, a particular topic (Greeff, 2011:351). The method gave the researcher and participant much more flexibility.

The researcher had a primary question, as well as follow up questions in order to get more information and have in-depth interviews. The interviews were scheduled in

advance and took place in an environment that was conducive to the interviewee. They were private and no costs were incurred by the participants. The researcher obtained the permission of the participant in advance and informed them that the interview would be audio-taped in order for the researcher to fully capture all the responses.

3.5.3 Methods of data analysis

De Vos (2011:397) states 'qualitative data analysis transforms data into findings. This involves reducing the volume of raw information, sifting significance from trivia, identifying significant patterns and constructing a framework for communicating the essence of what the data reveal'. It is the process of bringing order, structure and meaning to the mass of collected data (Schurink, Fouché & De Vos, 2011:397). It is widely demonstrated in literature (Schurink et al., 2011:405) that qualitative data collection and analysis are so enmeshed, that during the data collection period, ideas about directions for analysis occur, patterns take shape and possible themes that inform subsequent data collection spring to mind.

The steps that the researcher took in analysing the data collected were those identified by Creswell (2009:185). The qualitative data analysis process provided a systematic means of analysis of data through which the researcher was able to analyse data yielded by the one on one interviews. The model consisted of eight steps which were followed in organizing and preparing the data into thoughts, codes and categories.

- **Organising and preparing data for analysis**

Firstly the researcher had to organize and prepare the data for analysis since the interviews were voice recorded. The researcher organised and prepared the data through analysis by means of transcribing the audio taped interviews, typing field notes and sorting the data (Creswell, 2014:197). The transcribing process involved listening to the audio taped interviews several times and producing manually typed verbatim transcripts of the data.

- **Reading through all the data**

The researcher then read through all the data so as to make sense of the information. General ideas that emerged from the data were jotted down. Reading through the data enabled the researcher to obtain, 'a general sense of the information and an opportunity to reflect on its overall meaning' (Creswell, 2014:197).

- **Coding the data**

This involved segmenting sentences and paragraphs into various categories and using highlighters to colour code each category (Creswell, 2014:198; Leedy & Ormrod, 2010:152). Similar ideas/topics were clustered together and were highlighted in the same colour as codes, for instance anything to do with emotions was coded in a certain colour until all the main aspects are coded.

- **Generating themes**

Themes were then be generated from the coding and these were the ones that appeared as major findings in the study. As 'sophisticated qualitative studies go beyond description and theme identification and form complex theme connections' (Creswell, 2014:199), the researcher looked for associations among the themes. These included social, emotional, psychological and health aspects, for instance.

- **Interpreting the meaning of themes/ descriptions**

The researcher then used a narrative passage to convey the findings of the analysis, comparing the findings with what came out in the literature review. Meanings were conveyed in terms of themes and their related subdivisions as subthemes (Vaismoradi, Jones, Turunen & Snelgrove, 2016:1011). The findings were thoroughly scrutinised to determine whether they confirmed or diverged from information generated by previous researchers. Based on the findings, the researcher drew conclusions on the challenges faced by GBV survivors in Namibia and made applicable recommendations.

3.5.4 Data quality

Qualitative researchers emphasise data quality through trustworthiness as a parallel idea to objective standards in quantitative research (Billups, 2014:1). Trustworthiness helps to guard against bias and ensures honest and truthful research. 'Trustworthiness is established when findings as closely as possible reflect the meanings as described by the participants' (Elo, Kääriäinen, Kanste, Pölkki, Utriainen & Kyngäs, 2014:2).

Patnaik (2014:5746) maintains that trustworthiness involves establishing:

- ***Credibility:*** having confidence in the 'truth' of the findings. Techniques that were used to ensure credibility included, eliciting feedback; member checks and flexibility (Tracy, 2013:3). Feedback was elicited from the research supervisors so as to determine whether appropriate interpretations had been made and valid conclusions had been drawn from the analysed data (Leedy & Ormrod, 2010:101). With member checking, research participants were given an opportunity to read through their own interview transcripts and check if they agreed with how the researcher had quoted them. Harper and Cole (2012:2) emphasize this as a powerful technique for establishing credibility. It gives research participants the opportunity to react to the data and to correct errors in the collection and interpretation of data. The trustworthiness was also increased through eliciting feedback from others, using her research supervisor and through eliciting feedback from a colleague through peer debriefing (Leedy & Ormrod, 2010:101). Reflexivity was achieved through acknowledging the potential for bias (Leedy & Ormrod, 2010:101) and how this could have affected how the data were collected and interpreted.

- ***Transferability*** (validity): showing that the findings have applicability in other contexts. Thick description as described by Tracy (2013:3) was used as a way of achieving external validity. By providing verbatim quotes from interviews to support themes, phenomenon were described in sufficient detail, so that researcher could evaluate the extent to which the conclusions drawn were transferable to other times, settings, situations, and people (Moon, Brewer, Januchowski-Hartley, Adams & Blackman, 2016:10).

- **Dependability** (reliability): showing that the findings are consistent and can be repeated in the same context using the same methods. Lincoln & Guba (1985) emphasize "inquiry audit" as one measure which may enhance the dependability of qualitative research. This involves having a researcher who was not involved in the research process to examine both the process and product of the research study (Moon et al. 2016:8). A peer reviewer was used in this study to examine the transcribed interviews and themes generated.

- ***Conformability:*** this can be seen as a degree of neutrality or the extent to which the findings of a study are shaped by the respondents and not the researcher's motivation, or interests. In order to ensure conformability in the research, the researcher used the technique of performing an audit trail by keeping files of all processes followed and of the collected data recordings, transcriptions and field notes, as well as of the signed letters of informed consent. This involved making a transparent description of the research steps taken from the start of the research project to the development and reporting of findings (Leedy & Ormrod, 2010:101).

3.6 Pilot study

A pilot study was conducted prior to the main investigation. The pilot study served as a dress rehearsal of the actual research (Hazzi & Maldaon, 2015:53). This presented the researcher with an opportunity to determine the feasibility of the study and to pre-test the interview schedule to find out the extent to which the participants would respond to the questions and identify any challenges and flaws that were there (Gorman and Clayton, 2005:98) The electronic voice recorder was also be tested for its operations and to test the clarity of responses captured in the recording. The pilot study was conducted with two (2) of the clients who provide their contact details to the Gender-Based Violence Protection Unit (GBVPU) and who also met the criteria mentioned earlier on. The sampling of the participants for the pilot study was the same as for the main study, where the data collection instruments were pre-tested using the primary question, as well as the secondary questions. No adaptations were made to the interview questions. The data of the participants of the pilot study were included for the main investigation due to the richness, which is common in phenomenological studies.

3.7 Ethical considerations

According to Polit and Beck (2010:553), as supported by Brink et al., (2012:59) together with Hinkle and Cheevers (2014:24), ethics is defined as a system of moral

values that is concerned with the degree to which research procedures adhere to professional, legal and social obligations to study participants. Research should be based on mutual trust, understanding, acceptance, cooperation, promises and well accepted conventions and expectations between all parties involved in a research project (Strydom, 2011:113). Ethics implies preferences that influence behaviour in human relations, conforming to a code of principles, the rules of conduct, the responsibility of the researcher and the standards of conduct of a given profession (Strydom, 2011:114). The researcher was granted permission to conduct interviews by the Gender Based Violence Protection Unit in the Ministry of Gender, Equality and Child Welfare in Namibia, Ministry of Safety and Security and from the Ministry of Health Welfare and Social Services. Ethics approval was granted by the Research Ethics Committee in the Faculty of Humanities, University of Pretoria.

There are several ethical aspects that researchers should take into considerations as they conduct research. For this study the researcher took into consideration the following ethical considerations:

3.7.1 Voluntary participation and Informed Consent

Voluntary participation and informed consent are to some extent intertwined. Participation should be voluntary and no participant should be forced or coerced into taking part in the research. The principle of informed consent stresses the researcher's responsibility to completely inform participants of different aspects of the research in comprehensible language and that their participation is entirely voluntary (Sanjari, Bahramnezhad, Fomani, Shoghi and Cheraghi, 2014:3). Participants should be legally and psychologically competent to give consent and they can withdraw any time they feel they no longer want to participate. For this study, the researcher requested respondent's permission to take part in the study through the signing of a letter of informed consent, which explained thoroughly and truthfully the purpose of the study. The participants were informed of the goal and purpose of the study, expected duration, risks and benefits. The participants were also informed about the electronic voice recorder that was used during the interview, mainly the fact that the recording was aimed at capturing all the information clearly, thoroughly, accurately and systematically. The participants then signed the informed consent letter. The informed

consent also informed the participants that the recorded data will be stored in a safe place for 15 years and will only be used for research purposes.

3.7.2 Privacy and confidentiality

Privacy and confidentiality can be seen as complimentary ethical principles. Crow and Wiles (2008:2) posit that anonymity and confidentiality of participants are central to ethical research practice in social research. Strydom (2011:120) emphasises that, 'information given anonymously ensures the privacy of subjects.' In this study anonymity was not applicable, as face-to-face interviews were conducted.

The principle of confidentiality means that information obtained about the respondents should not be leaked to other people. As maintained by Atkinson and Delamont (2010:7), confidentiality is also related to issues of access to research data and how the data is used. Where possible, researchers aim to assure participants that every effort will be made to ensure that the data they provide cannot be traced back to them in reports, presentations and other forms of dissemination. In accordance with these ethical principles the researcher made reasonable efforts to ensure that interviews were conducted in line with the recommended ethical standards and confidentiality was maintained. The researcher made sure that no other persons had access to information that the participants communicated to the researcher, except for the supervisor and peer debriefer. She also ensured that the identity of participants was protected, by not using their names, instead pseudonyms were assigned.

3.7.3 Protection from harm

People can be harmed in many different ways and bearing this in mind, the researcher made sure that the study would not cause harm to the participants in any way. The researcher handled the participants appropriately without causing emotional harm to them. This was done by ensuring that the nature of the study was clearly explained to all participants. The researcher had an ethical obligation to protect research

participants from '…unnecessary physical or psychological harm' (Leedy & Omrod, 2010:101). It is well documented (Strydom, 2011:115), that participants should be thoroughly informed beforehand about the potential impact of the investigation. The researcher avoided 'low-priority probing of sensitive issues' (Stake, 2005:459) that were irrelevant to the goal main goal of the study. Researcher explained in detail to the participants that the sharing of their experiences may open up some healed wounds. It was explained that in situations where this happened, referrals for counselling would be done. Arrangements were made beforehand with a social worker at GBVPU for participants who might need counselling. None of the research participants however needed or requested to be referred to a Lifeline/Childline GBV Centre for counselling.

3.7.4 Debriefing

After conducting the interviews the researcher debriefed participants in order to elicit their experiences and feelings. Strydom (2011:122) maintains that 'debriefing sessions after the study, during which subjects get the opportunity to work through their experience and its aftermath, are one way in which researchers can assist subjects in minimising possible harm, which may have been done in spite of all their precautions against it'. The researcher worked through the interview experiences of the participants and their feelings were addressed. The data gathered in the interview were clarified, to ensure researcher understood it correctly.

3.7.5 Competence of the researcher

The researcher had also an ethical obligation to ensure that she is competent and adequately skilled to undertake research (Strydom, 2011:124) on the challenges of Gender Based Violence survivors. The researcher has extensive experience working with cases involving various forms of GBV, including rape, in the past. Since the researcher is also a masters' degree postgraduate student in social work specialising in healthcare, she deems herself competent to undertake and adequately skilled to undertake the study of this nature. The researcher observed all the ethical considerations involved in undertaking this study. She was supervised by an experienced academic.

3.7.6 Dissemination of information and honesty with professional colleagues

The researcher after conducting the study has an ethical obligation to ultimately report her findings because research is meant to contribute to the wider body of knowledge. The research findings were presented in the form of this mini-dissertation submitted to the University of Pretoria, as well as a journal article for possible publication and presentation of a paper at a conference. The findings were reported in an honest manner without any data manipulation or misrepresentation. Hence none of the findings were fabricated to support a particular conclusion or to mislead readers (Leedy & 2010:103).

3.8 Empirical Findings

In this section the demographic data of the participants is presented. This is followed by a thematic analysis of the dominant themes and sub-themes that emerged from the interviews that were carried out with the participants. The findings are presented using narratives from the participant interviews which were then compared and contrasted with evidence obtained from literature sources. As a way of maintaining confidentiality, participants' names were not revealed, but pseudonyms were assigned in the form of numbers.

3.8.1 Demographic information of the participants

All twelve participants who took part in the study were female victims of rape aged between 20 and 50 years old. All the participants were informed of the purpose of the research and gave their consent to participate in the study. Demographic data that will be highlighted in this section include age range, current occupation, highest educational qualifications, marital status and place of residence of the participants.

3.8.1.1 Age range of the participants

The age range of rape survivors who took part in this study is shown in the figure 3.1 below.

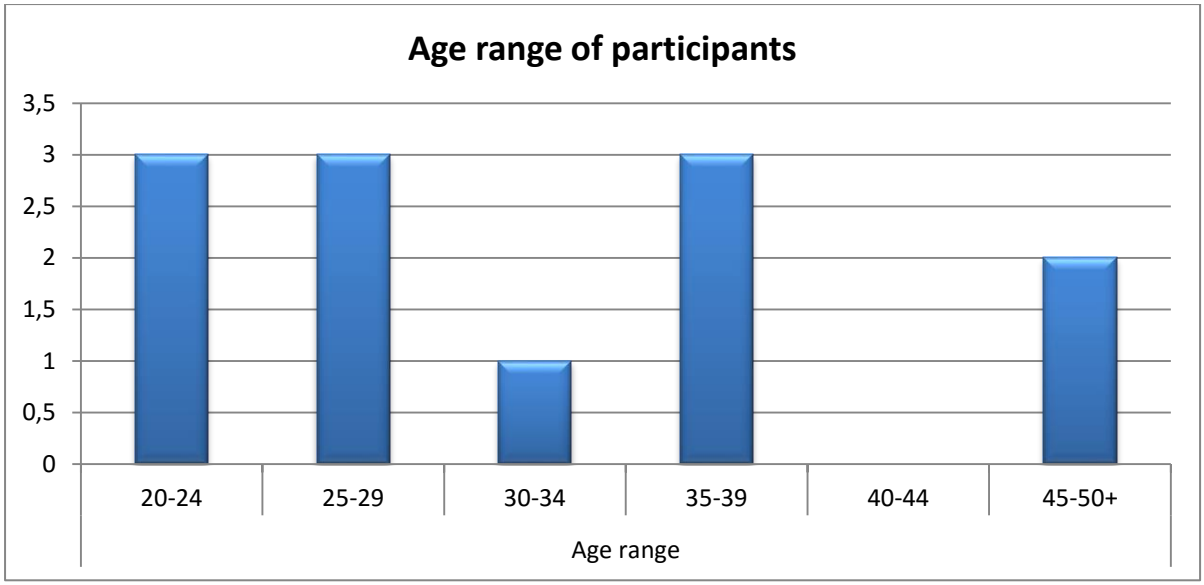

Figure 3. 1: Age range of participants (n=12)

Participants were largely young adults between the ages of 20-50. The youngest participant was aged 21 while the oldest was 50. The WHO (2012:3) confirm that most victims of rape in Namibia fall within this age range. A similar age range was also noted in a survey of a representative sample of women aged 18–49 years in three provinces of South Africa (WHO, 2012:151).

3.8.1.2 Level of education attained by the participants

Figure 3.2 below indicates the level of education of the participants.

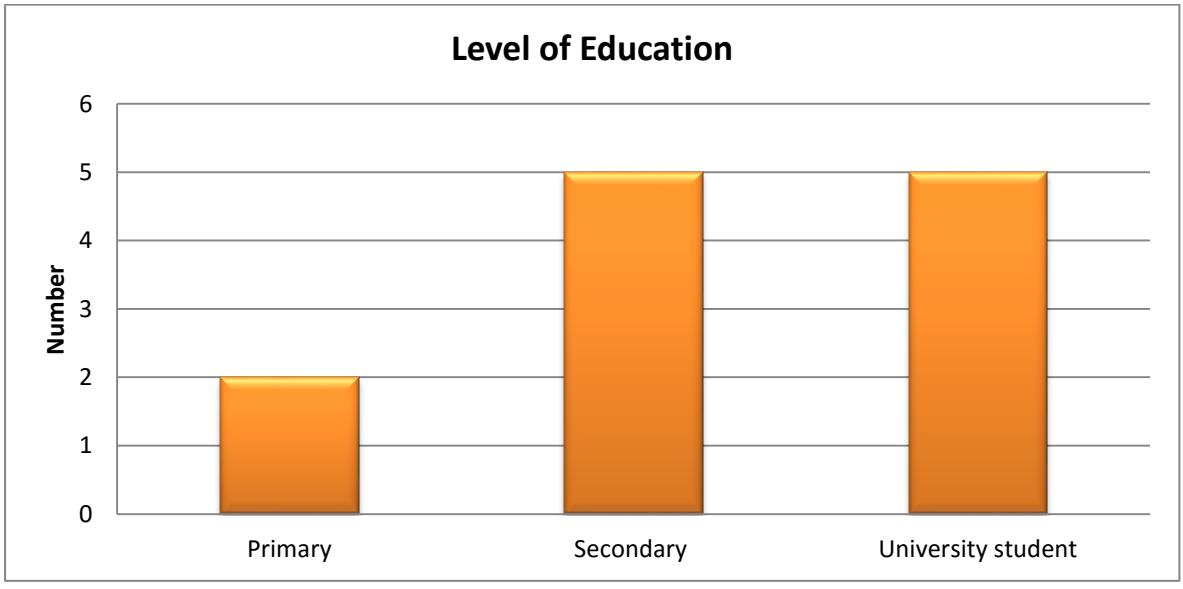

Figure 3. 2: Participants level of education (n=12)

It is clear from the above figure that five of the participants were still students at University, 5 had acquired secondary school education, while two only attained primary level of education. It is generally assumed that a low literacy rate of women contributes as an important factor of rape, as uneducated women are economically less productive, and typically have a less bargaining power (Marium, 2014:41). While this is noted, this study however was in accordance with other studies showed that many young women are sexually coerced and harassed at school (WHO, 2002:155), namely five (5) out of the twelve participants.

3.8.1.3 Current occupation of participants

The current occupation of participants is depicted in figure 3.3 below.

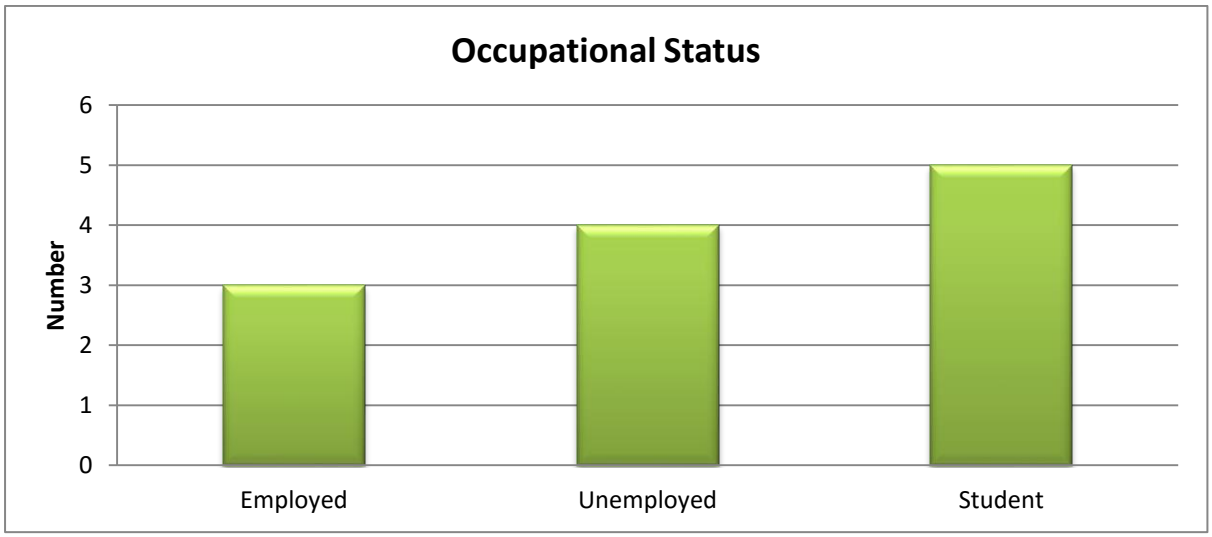

Figure 3. 3: Occupational status of participants (n=12)

Figure 5 shows how five (5) of the participants were students, still enrolled at college or university. While three of the participants were employed, it is important to note that they were all engaged in none professional work such as cleaner, domestic worker and informal trader. Four of the participants were unemployed and were basically staying at home. WHO (2002:158) states that poverty forces many women and girls into occupations that carry a relatively high risk of sexual violence. It also creates

enormous pressures for them to find or maintain jobs, or to pursue trading activities. College women, Krebs, et al., (2007) and Krebs, et al., (2009), found, were disproportionately raped by men, compared to their non-college peers and the general population, often by someone they know. It is also noted in this study that most of the student victims who experienced rape knew the offender.

3.8.1.4 Marital status of participants

Figure 3.4 below shows the marital status of the participant.

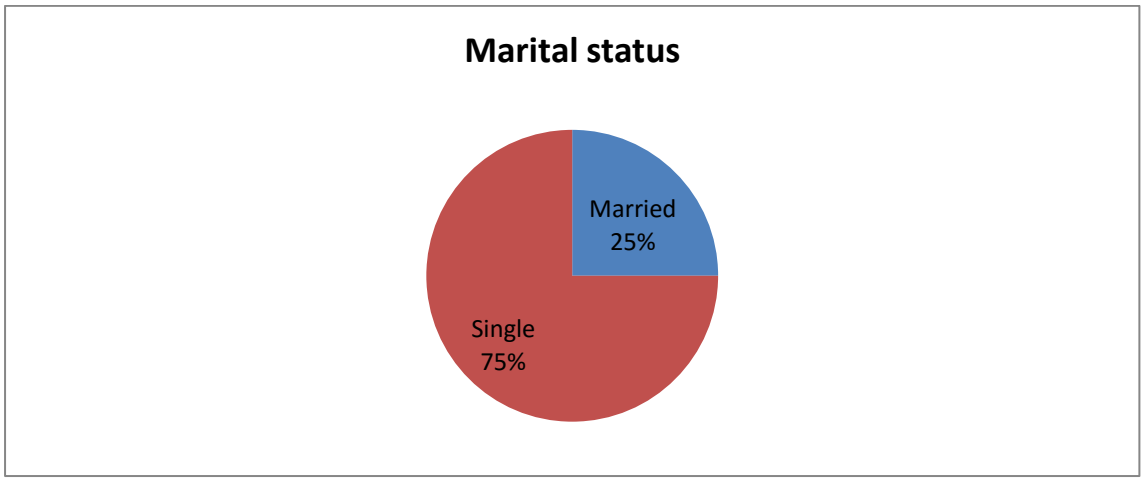

Figure 3. 4: Marital status of participants (n=12)

From the above figure it is clear that nine (75%) of the rape survivor participants were single, with only three (25%) married. Recent statistics suggest that 10% to 14% of married women are raped by their husbands in the United States (Bergen, 2006). The 2008-09 Kenya Demographic and Health Survey - Preliminary Report shows that 13 per cent of married women, that is more than one out of every ten women, reported being raped by their male partners (African Population and Health Research Center, 2010:1).

3.8.1.5 Participants' place/area of residence

Figure 3.5 illustrates the place or area of residence of participants.

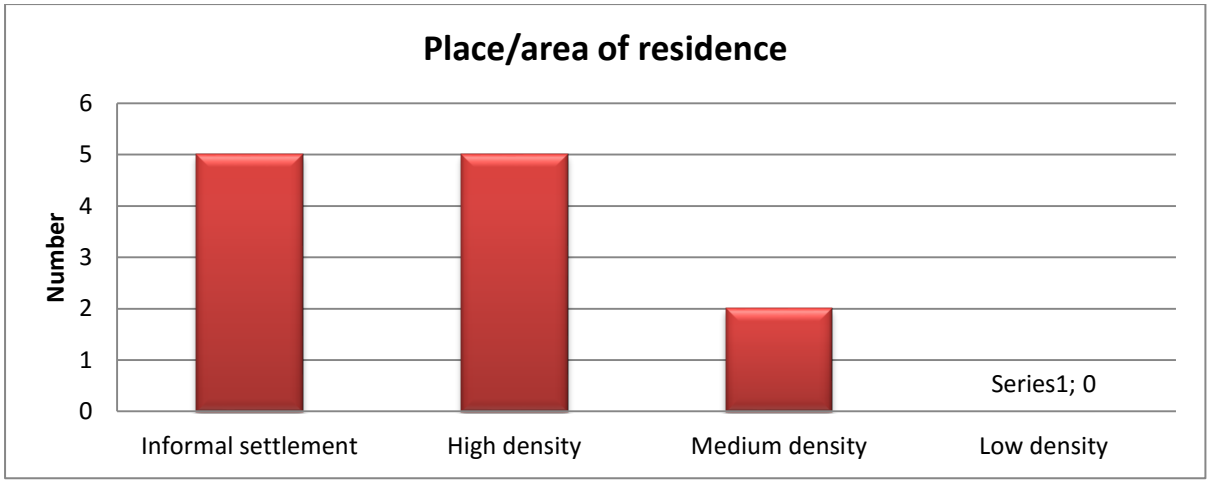

Figure 3. 5: Participants' place/area of residence (n=12)

Five participants resided in an informal settlement, five in the high density living areas and only two resided in medium density residential areas. Suffice to point out that none of the participants resided in low density nor more affluent areas. This basically indicates that the participants came from poor economic backgrounds.

Studies have shown that there is an undeniable link between poverty and sexual violence (Omari, Ondicho and Kungu, 2014:67). The research found that living without one's basic needs being met can increase a person's risk for sexual victimization and that perpetrators of sexual violence target individuals who seem vulnerable as a result of being economically challenged. They exploit individuals caught in Catch-22 situations created by poverty. Studies have shown that poverty can predispose some people to sexual abuse and expose the more vulnerable to abuse of their sexual rights (WHO, 2002:158)

3.9 Thematic analysis

In this section the themes and sub-themes that emerged from the research are presented and analysed thematically. Findings from the research interviews are corroborated with the participants' direct quotes, as well as information from literature.

The table below presents the themes and subthemes that emerged from the data analysis.

Table 3. 1: Themes and sub-themes

	Themes	Sub-themes
1	Healthcare centre support services	1.1 Limited or inadequate counselling 1.2 No examinations or limited medical attention 1.3 Long waiting periods at healthcare service centres 1.4 Negative perceptions and stereotypes of healthcare providers
2	Physical health support challenges	2.1 Diseases and infections 2.2 Pregnancy and gynaecological problems 2.3 Physical injury and pain.
3	Mental health/psychological support challenges	3.1 Fear and threats 3.2 Self-blame, loss of self-esteem/self-worth, shame 3.3 Anger, depression, suicidal tendencies and general mental trauma. 3.1 Relationship and trust issues
4	Social and economic support challenges	5.1 Culture and traditions relating to sexual acts between man and women. 5.2 Stigma and shame family members and community. 5.3 Lack of economic independence
5	Challenges with support from the police/legal justice system	5.1 Offenders not arrested, released on bail/poor conviction rates 5.2 Police not supporting victims effectively

Subsequently each theme with its sub-themes will be discussed.

3.9.1 Theme 1: Healthcare centre support services

Victims of rape present at any point or sector of the healthcare system and expect to be provided with support services for their situation. Healthcare facilities should therefore be in a position to recognize sexual abuse and provide services to victims of sexual violence (or at least refer patients to appropriate services and care) irrespective of whether a forensic examination is required. Healthcare facilities are expected to have specific policies and procedures for dealing with victims of sexual violence. Survivors of sexual violence, especially rape, experience complex needs. (Kilonzo et al., 2009:555). The ecological model suggests that if victims are able to receive the

services they need and are treated in an empathic, supportive manner, then social systems can help facilitate recovery. However, if victims do not receive needed services and are treated insensitively, then these systems can magnify victims' feelings of powerlessness, shame, and guilt.

An analysis of the interviews revealed that participants faced a number of challenges relating to the delivery of healthcare support services. The findings of this research document the concerns of victims over how the health system dealt with their expectations. Sub-themes that emerged in relation to this theme were:

1	Healthcare centre support services	1.1 Limited or inadequate counselling 1.2 No examinations or limited medical attention 1.3 Long waiting periods at healthcare service centres 1.4 Negative perceptions and stereotypes of healthcare providers

In the following section these subthemes are expanded on and exemplified by verbatim quotes from the participants as well as literature substantiation.

3.9.1.1 Sub-theme 1.1: Limited or inadequate counselling

The challenge of limited or inadequate support counselling for the rape survivors is depicted by the following narratives from the survivors:

> *P5: "I only received one (counselling session). Only that one day."*
>
> *P8: "No I did not see any social workers. They did not talk to me. They only asked me my story that's all…They did not counsel me, not at all."*
>
> *P7: "They just gave me counselling and they let me go... one day or two days I think".*
>
> *P1: "We just had a little talk…. It didn't help anything because they only asked me a few questions. Like it was only a 10 minute talk or five minute talk."*
>
> *P2: "I think counselling could have been done better... If I had gone for counselling in the beginning, like when it happened, I think I would have been better.")*

The participants in this research reported that it was difficult for them to quickly be able to access adequate post-rape counselling. Furthermore, in cases where some counselling was done it was reported to have been either too short or ineffective. Counselling is however essential for rape victims given that the psychological trauma may affect the victim in many ways and for a prolonged period of time. As evidenced from the participants' narratives the rape victims in this study faced challenges relating to the provision of counselling services.

Counselling is however a valuable service for victims of rape and helps them to address the widely recognised consequences of the crime (Victims Support Agency, 2011:58). Rape is a crime that impacts survivors on multiple levels. As the survivor manages these multiple levels of impact, her usual coping system may not be sufficient to support her as it would without such an intense and violent event. At those times, the survivor therefore needs effective counselling support which can help with coping (California Coalition Against Sexual Assault, 2008:25). The rape victims in this research however reported that often the counselling support that they received was either inadequate or not effective.

The literature has widely recognised the importance of attending to two important areas when counselling rape survivors: 1) acute post-sexual assault needs, and; 2) the enduring effects of sexual assault (Astbury, 2011:11; Poirier, 2002:53). Regarding acute post-sexual assault care, counselling is of great value when it assists the survivor with decision-making and the provision of social support (Astbury, 2011:11; Poirier, 2002:53). For survivors presenting early to a centre after experiencing rape assistance may be offered for the survivor to report the crime to the police which may contribute to a successful prosecution (Fernandez, 2011:599).

3.9.1.2 Sub-theme 1.2: No examinations or limited medical attention

The quotes below indicate participants' views in relation to this sub-theme:

> *P8: "… the doctor came but he did not examine me. He just asked me questions…They could have examined me. It's what I wanted. That's what I wanted, but they only prescribed for me pills."*

> *P7: " … I was sent to the hospital for testing but did not go for pregnancy test. For the pregnancy test I did it myself."*

P3: " But the psychiatry people what they used to do to me is feed me with medicine to shut me up. But the social worker did so much because they forced me … to come to a point where I started pouring my emotions and crying and they comforted me."

P2: " No I wasn't placed in a shelter. I was just at home."

P4 " … after two weeks she came to me on a Sunday and said I am going to place you in a shelter where you will stay for a few days and will check on your case."

P1: "..and then they called the doctor and the doctor came to check me. He didn't examine me…I don't know. I think he only took my blood. Then they said they would get back to me, but they didn't."

P8: "Then he said but you washed. Then I said I did not bath, it was just clean water (that I poured over myself. Then I said… you can still examine me because he slept with me without a condom). When I woke up I felt the wetness, it was running out. But still he refused (to examine me)."

Participants in the research indicated dissatisfaction with the medical attention and services that they received. This ranged from complete neglect, refusal to provide services and unsatisfactory medical attention. Client exit interviews in research conducted in Kenya on victims of rape also found out that victims often do not receive adequate medical attention (Kilonzo et al., 2009:557).

Campbell et al., (2009:15) found that as a result of their contact with medical care personnel, most rape survivors stated that they felt bad about themselves, guilty, depressed, violated, distrustful of others and reluctant to seek further help. Similar to what the participants in this research expressed, victims who did not receive basic examination rated their experiences with the medical system as hurtful. This may turn to be associated with higher PTSD levels (Campbell & Raja, 2005:104).

Performing an examination without counselling and addressing the primary healthcare needs of patients is regarded as being negligent. (WHO, 2003:17). Furthermore, the WHO (2003:18) argues that the ideal situation is that the medico-legal and the health services are provided simultaneously; that is to say, at the same time, in the same location and preferably by the same health practitioner. Findings from this research however indicate that this appears not to be the case in the Khomas region of Namibia where the health and medico-legal components of the service are often provided at different times, in different places and by different people. Such a process is however

regarded as “inefficient, unnecessary and most importantly, places an unwarranted burden on the victim.” (WHO, 2003:18).

3.9.1.3 Sub-theme 1.3: Long waiting periods at healthcare service centres

Participants’ views relating to long waiting periods at healthcare support centres are expressed in the quotes below:

> *P9: “ Yaa it’s like that day on a Sunday when I reported the case, when we came to the hospital, it’s like we were waiting for the doctor the whole time but then the doctor didn’t show up. So they told me I must come back again on Monday.”*
>
> *P1: “It’s like they didn’t want to help me. They were taking long because I was sitting there (at the women and child protection unit) for a long time. It was like I was begging them to help me.”*
>
> *P10: “When I got there (at the women and child protection centre) I had to sit and wait for help. … but I thought I can’t sit and wait. My need is very urgent. I went straight… I decided that I should go to any room. I decided to knock at the door and I opened the door. She didn’t say come in. While I was there she was busy with other people. I asked her why she was ignoring me, because my need was very big. I needed to talk to somebody.”*

The rape survivors in this study indicated that they often experienced long waits in hospital emergency departments. This was probably due to the fact that rape is rarely considered as an emergent health threat. Most of the victims reported that they had to wait for long periods of time before they could get any medical attention. When they finally got attention, the service that they obtained was seen as largely unsatisfactory.

Delaying the provision of medical attention, as was the case for most of the rape survivors in this study, can have several negative consequences for the survivors. The WHO (2003:18), states that the timing of the physical examination should largely be dictated by what is best for the patient (particularly where injury intervention is required) but for a number of reasons is best performed as soon as possible after the patient presents. Delay in accessing services may result in:

- lost therapeutic opportunities (e.g. provision of emergency contraception);

- changes to the physical evidence (e.g. healing of injuries);
- loss of forensic material (e.g. evidence of contact with assailant including blood and semen).

In a number of instances however, victims in this research failed to present for treatment for some considerable time after the assault, thus compromising on the identification of evidence. This may also have resulted in the medical personal being reluctant to offer assistance and support due to lack of evidence.

3.9.1.4 Sub-theme 1.4: Negative perceptions and stereotypes of healthcare providers

The participants experienced a number of negative perceptions and stereotypes from healthcare providers' as follows:

> *P6: "…I knew that ok, even if they don't give me that help, I can try on my own because some people are rude. If you tell them your story then they love to talk behind your back. It's like they say this is a dirty person and what is she doing here. But at the end of the day I will have given them my information… for them to do their job… but they are discriminatory. They have certain manners that lead a person not wanting to get help."*
>
> *P6: "The counselling service I think they could improve by helping people and completely cut out the discrimination. They must cut it out and help people like they would help their own people."*
>
> *P1: "It's like they didn't believe me or something. And it made me feel sad."*
>
> *P8: "They did not. They did not believe at all. They did not believe."*

The rape survivors who participated in this study felt that there was also some negative perceptions and stereotypes, as well as discrimination from some healthcare providers. Some rape survivors appeared to be afraid to visit healthcare centres on the basis that healthcare providers such as nurses and other clinic staff stigmatise people who have been raped. According to the survivors, it was at times difficult for healthcare providers to believe their story.

As seen from the narratives of some of the survivors, fear of being stigmatised as someone who has been raped increases the likelihood that survivors will avoid disclosing their predicament to healthcare providers and family members, or seeking

treatment and care, thus compromising their health and wellbeing (Nyblade et al., 2009:2). Stigma and stereotyping of victims by healthcare providers has potentially devastating consequences on care-seeking behaviour. Stigma represents a major problem for both individuals and public health. Both experienced and perceived stigma and discrimination are associated with reduced utilization of services (Nguyen, et al.,, 2009:9; Varga et al, 2009:2), provision of counselling services (Obermeyer & Obsorn, 2007:1768; Kalichman et al., 2006:9) as well as the assessment of care and treatment (Kinsler et al., 2007:589).

The ecological model notes that if survivors receive unexpected negative reactions from healthcare service providers, they will often get quite upset. It is further noted that what happens in one instance of seeking support has implications for further help seeking and distress (Campbell et al. 2009:233). Campbell, (2006:2) has documented in multiple studies that survivors often encounter victim-blaming treatment from legal and medical system personnel, and not surprisingly, even survivors in this research also stated that they do start to blame themselves for the assault (Koenig et al., 2006:137; Campbell, 2008:703).

3.9.2 Theme 2: Physical health support challenges

The sub-themes for physical support challenges were:

2	Physical health support challenges	2.4 Diseases and infections 2.5 Pregnancy and gynaecological problems 2.6 Physical injury and pain.

Subsequently each sub-theme will be presented.

3.9.2.1 Sub-theme 2.1: Diseases and infections

The statements below reflect the challenges faced by rape survivors in relation to diseases, illness and infections:

> *P8: "The worst thing was that he slept with me without a condom. I have two boys and I am apparently sick. …Since then I don't eat properly. I even lost weight."*

P3: "And it was so painful… when I found out that I was HIV positive, that he had infected me…."

P2: "HIV test was done, STD test was done and then, the bad thing was that my uncle was HIV-positive, so I also got to be infected with HIV."

P12: "They found that I was HIV-positive… and STIs."

P11: "… when it happened my immediate worry was like, okay what if…these men are HIV positive for example? Or (have) other diseases that are spread, STIs."

Participants in the research noted that they experience a number of challenges in relation to contracting diseases and other sexually transmitted infection for which they need to seek healthcare support services. Rape victims are at an increased risk from Sexually Transmitted Infections (STIs), including HIV/AIDS, sexual dysfunction, infertility, pelvic pain and pelvic inflammatory disease and urinary tract infections (WHO, 2012:2; WHO, 2014:15). Data collected in this research indicates that many of the victims contracted HIV as a result of the rape. Some of the victims also indicated that the rape resulted in them contracting sexually transmitted infections. This is consistent with finding by Harris & Freccero (2011:2), which indicate that rape is also associated with a higher risk of contracting a Sexually Transmitted Infection (STI) including HIV/AIDS, and Hepatitis B and C. Furthermore, the data collected shows that rape was perpetrated by people who were known to the victims. This is also consistent with findings from literature which report that studies from several countries have found that HIV-positive women report higher rates of intimate partner violence (Osinde et al., 2011:5) and there is increasing evidence that HIV risk is linked to exposure to sexual violence (Campbell et al., 2008:9).

Data collected in this research indicates that rape survivors have other medical needs, such as information on the risk of STIs/HIV and prophylaxis (preventive medications to treat any STIs that may have been contracted through the assault. The Centers for Disease Control and Prevention (2002) recommends that all sexual assault victims receive STI prophylaxis and HIV prophylaxis on a case-by-case basis after risk assessment. Data collected in this research however indicates that only three out the 12 victims received STI and HIV prophylaxis. Campbell et al., (2008:707) notes that victims of non-stranger rape are significantly less likely to receive information on

STIs/HIV or STI prophylaxis, even though knowing one's assailant does not mitigate one's risk. This tends to support findings in this research where basically all the victims were known to the assailants and little attention was paid to the provision of prophylactic measures for them.

As indicated by the participants, rape victims in the Khomas region face numerous challenges in relation to accessing healthcare support services that can help them to deal with diseases and infections. If a victim comes to the clinic after 72 hours, treatment alternatives are more limited. At this point, the victim may have acquired an STI, in which case treatment should be provided in addition to conducting a complete physical examination and providing psychological assistance. Victims should also be referred to voluntary testing and counselling services to learn about their HIV status and to take appropriate measures (Harris & Freccero, 2011:5). If survivors seek medical care for a forensic examination and evaluation and management of sexually transmitted infections and pregnancy at the individual, interpersonal, community and social level of the ecological model, they will typically encounter fewer difficulties obtaining needed assistance, but may still be treated in ways that exacerbate their post-assault distress (Campbell et al., 2009: 237).

3.9.2.2 Sub-theme 2.2: Pregnancy and gynaecological problems

The following narratives indicate the challenges faced by the survivors in relation to pregnancy and other gynaecological complications:

> *P7: "When I woke up… I saw blood coming out but it wasn't my menstrual period time."*
>
> *P3: "…I even fell pregnant in that period and he even forced me again to do an abortion against my will. So I had to take some substances that I had to drink just to get rid of this pregnancy because I was under his control. I couldn't do anything."*
>
> *P4: "I told him I am pregnant with your baby and I am also your child. What should I do. I said I am going to tell my grandmother about this or my stepmother. So he said no you shouldn't do that, I will help you out…When he came from work he took me to a place in Khomasdal. So there was a lady there… that lady said I should lie down. I lay down, the woman put pills inside me… and something which is very bitter. So she said I should go home and lie down. So in the middle of the night… I got a heavy pain that I couldn't even handle, so I started crying. When I stood up from the bed something like meat came out. So he heard me crying and came in…he found a lot of blood on the*

floor and that thing like meat.. So he said oh, thank God…its out. You were pregnant."

P12: "…when it happened my immediate worry was like, okay what if… I am pregnant now."

Pregnancy may result from rape, though the rate varies between settings and depends particularly on the extent to which non-barrier contraceptives are being used. Most medical experts and published studies report that a woman's chances of becoming pregnant are roughly the same after rape as they are after consensual intercourse (Coleman, 2015:3). Some of participants in this research fell pregnant as a result of the rape.

Most of the participants in the research indicated that they had serious concerns about falling pregnant as a result of the rape. Pregnancy is one of the most common concerns for women who have been sexually assaulted (Harris & Freccero, 2011:5). Emergency contraceptive pills can reduce this risk between 56 and 95 percent depending on how soon medication is taken. Research indicates that it should be taken as soon as possible after exposure and within 120 hours of the incident to have any effect (Harris & Freccero, 2011:5). Unfortunately for eight out of the twelve rape survivors in this research this however appeared not to have been the case.

Narratives from the research participants suggest that post-assault pregnancy services were inconsistently provided to rape victims. This also appears to be in line with research findings by Campbell et al., (2001:1240) indicating that 40% to 49% of victims receive information about the risk of pregnancy. Furthermore, Campbell and Raja, 2005, Campbell, 2006) indicated that only 21% to 43% of sexual assault victims who need emergency contraception actually receive it. In this research only three of the victims received contraception. Healthcare support services that help victims to deal more effectively with pregnancy and other gynaecological complications need to be put in place.

3.9.2.3 Sub-theme 2.3: Physical injury, pain and other disorders.

The narratives below indicate the participants' experiences regarding physical injury and pain:

P1: "My throat was hurting and my arm. I was in pain. I didn't receive any help (for the pain). Yes (I just nursed the wound and pain at home)."

P7: "I just went home and I slept since I was tired. Then when I woke up… I just saw blood coming out but it wasn't my menstrual period."

P8: "He is a big man and he hurt me also. It was painful."

P3: "And there were times when he would even tie me up. And then he would start sleeping with me (having sex with me) and beating me around while he is raping me…"

P12: "…they also gave me treatment for my eyes because I also ended up having problems with my eyes when my husband beat me. One of my eyes was affected and not functioning well. …The beating and the force of rape (is what I always remember) I ended up having injuries, scars."

Participants in the research reported having experienced various forms of injury and/or pain. These results are supported by research findings which noted that the majority of sexual assault survivors experience moderate or severe pain during the early aftermath of rape (McLean et al., (2012:740).

Research has consistently shown that injury plays a significant role at multiple decision-making points during criminal justice proceedings such as the decision to report, file, prosecute, and convict (Sommers, 2007:275). Furthermore, according to the ecological approach, the perceived life threat during rape and perceived dangerousness of the assault results in negative outcomes for the rape survivor such as depression, anxiety, and PTSD (Campbell et al, 2009:230). Forensic evidence documenting the existence of injury following sexual assault can be used as part of a larger constellation of factors of evidence to enhance the government's case in allegations of sexual assault and allows the jury or judge to make an informed decision to convict or not. Findings in this research indicate that lack of evidence in some of the cases resulted in either the victims not wanting to report or the service providers not having an interest or finding it difficult to take the case further.

3.9.3 Theme 3: Mental health/psychological challenges

The sub-themes that emerged for theme three were:

3	Mental health/psychological support challenges	3.1	Fear and threats
		3.2	Self-blame, loss of self-esteem/self-worth, shame
		3.3	Anger, depression, suicidal tendencies and general mental trauma.
		3.4	Relationship and trust issues

Participants in this research experienced a variety of strong emotions (fear, anxiety, depression, guilt, disorientation, powerlessness, shame, shock, disbelief, embarrassment, denial, anger). Many of them also felt confused and alone, wondering if they should tell their family and friends or how they should tell them.

The mental health effects of rape have been extensively studied, yet it is still difficult to convey just how devastating rape is to victims' emotional well-being (Campbell et al, 2002:1332). In this research most of the victims reported that the incidence of rape took away their sense of dignity and respect. Similar finding were also reported by (Moor, 2007:25) who reported that "many women experience this trauma as a fundamental betrayal of their sense of self, identity, judgment, and safety". Victims of rape have extensive post-assault mental health needs, and several researchers/practitioners have called for increased use of empirically supported treatments in rape crisis centers and other community-based mental health services settings (Edmond, 2006; Russell & Davis, 2007; Sprang et al., 2008).

3.9.3.1 Sub-theme 3.1: Fear and threats

The participants' narratives in relation to this sub-theme are indicated below.

> *P12: "I was afraid to leave him, the home. I had nowhere to go."*
>
> *P7: "The first thing that I did was I didn't want to say what happened. I stayed with it for two days and I did not say anything because I was afraid of saying it."*
>
> *P11: "Prior, when it happened my immediate worry was like, okay what if I am a…, these men are HIV-positive for example, or other diseases that are spread, STIs, or what if I am pregnant now. So those are the questions, those are the questions that constantly came to my mind, but I never got answers to that."*
>
> *P4: "So I even fear that when I grow up and if I am lucky to get a husband one day I future I will be ashamed to tell him what happened."*

> *P5: "I was a bit scared when the people were touching me. I didn't want to be touched. I was even fighting with the doctor that was doing these tests on me. … I didn't want to be seen by people…What would they say to me again if they saw me in the street."*
>
> *P9: "… he asked me if I was going to tell the police. The I said no I will not tell the police because then I was still scared why he was asking me those questions."*

Some of the most common fears that rape survivors develop include the fears of repeated assault, fear of situations reminiscent of the assault and fear of the social and medical consequences of the assault (Josse (2010:184). Victims also often fear that the traumatic event that they experienced may recur (Sable et al., 2006:158). In this research the fear of repeated assault was evidenced by the fact that one of the participants was forced by the perpetrator to say that she would not report the incident to the police or anyone. Survivors' narratives also indicate that some of the victims feared contracting sexually transmitted diseases and infections. An analysis of the participants' narratives shows that these fears are fully justified by the existence of a genuine risk.

Fear of situations reminiscent of the assault is characteristic of posttraumatic syndromes. Depending on the circumstances of the assault, the survivor might develop a fear of strangers and men in general (Lebowitz and Wigren, 2005:7). This notion supports the expressions of some of the rape survivors in this study who indicated that they feared to be examined by medical personnel and were apprehensive about the prospect of getting married in future. Fear of social consequences includes fear that others will find out about the assault, fear of their reactions, fear of being rejected by one's spouse or being denied the opportunity to marry, fear of being ostracized by the community, and fear of being thrown out of school (Sable et al., 2006:158; Naidoo, 2013:210). As seen from the participants' narratives, these fears are entirely justified in traditional societies where victims of sexual violence are often made to feel ashamed and unwanted by their spouses, families, and communities.

3.9.3.2 Sub-theme 3.2: Self-blame, loss of self-esteem/self-worth, shame

The participants' narratives regarding this sub-theme are indicated below.

P1: "I thought maybe he thinks I am a prostitute because he bought me drinks… and he is going to tell a lot of people about it then my name will be tarnished."

P12: "(I feel)… low self-esteem… I felt dirty and unwanted."

P3: "I feel like it is as if I have become a prostitute…I feel like I don't care. I don't respect marriage (anymore). …But I started blaming myself like, maybe I was the cause of it."

P4: "The other feeling that I felt is that I was ashamed of myself."

P2: "The way I looked at myself I kind of felt like I am dirty you know, because then you start feeling so dirty from the inside. That's how I felt and just have some sort of low self-esteem."

P9: "It's like I gave up on my life that time."

P7: "Then I look at myself and start blaming myself even though I can't change anything."

Research suggests that victim/survivors may experience a range of medium-to-long-term impacts, like feelings of low self-esteem, self-blame and guilt can endure for months and years after the assault (Suprakash et al., 2017:4). This supports findings from this research where some of the victims indicated that they had since developed feelings of low self-esteem, self-blame and guilt.

The ecological model (Campbell et al., 2009:17), identifies two types of self-blame at the individual level, namely, characterological self-blame and behavioural self-blame. Findings from this research confirm the existence of these two types of self-blame. From the survivors' narratives we see the characterological self-blame evidence in survivors' statements such as:

P3: "..I started blaming myself like, maybe I was the cause of it."

and the behavioural self-blame evidenced through statement such as:

P1: "…What did I do? I mean, why did I go with him?"

Survivors' self-blame comes both from internal and external forces, as multiple ecological factors directly contribute to victims' negative attributions. For example,

certain assault characteristics (e.g., greater severity of the assault, using alcohol/drugs) contribute to an increase in self-blame and thereby more post-assault distress (Koss et al., 2002:936). This notion also supports findings from this research in which the survivors of rape who blamed themselves the most were those who were abused after taking alcohol. This is more evident especially in cases where the victim had been offered the alcohol by the perpetrator.

> *P1: "I thought maybe he thinks I am a prostitute because he bought me drinks… and he is going to tell a lot of people about those things."*

Jacques-Tiura et al., (2010:175) reported that survivors with higher behavioural self-blame were less likely to reach out to both informal and formal support providers, perhaps out of concern that they would receive more criticism of their behaviour or choices. As seen from some of the participants' narratives, survivors in this study were also concerned that people might blame them for drinking alcohol and exposing themselves to situations that would lead them to being raped. Such apprehension may be warranted, as negative social reactions from informal supports have consistently been found to be associated with increased self-blame (Ahrens, 2006:263). It is argued that self-blame transcends any one level of the of the ecological approach, as it stems from individual, interpersonal, community and societal-level processes (Campbell et al. 2009:232).

Survivors are also likely to receive negative reactions from formal support providers (Ahrens, 2006:264). Negative reactions from professional sources may be particularly harmful for survivors. When "experts" doubt survivors, hold them responsible for the assault, or refuse to provide assistance, survivors may question both the effectiveness of such services and the use-fullness of reaching out for help to anyone at all. In this research, negative reactions from formal support providers were also noted by the participants:

> *P1: "It's like they didn't believe me or something, and it made me feel sad."*

As already indicated earlier results from this study also revealed that participants have a challenge of self-blame, and in line with this, Campbell et al., (2009:235) point out

that victims of partner rape blamed themselves because their experiences did not fit the typical rape stereotype (i.e., violent stranger rape), since the rape was perpetrated by someone known to them. Likewise, and also as evidenced by the research findings, women often reported that they cared about the perpetrator and thus did not believe he had meant to cause them harm. Harned (2005) argued that these beliefs signify the impact of rape myths on female victims and teaches them to blame themselves for the assault, while taking away the responsibility from the perpetrator's actions.

3.9.3.3 Sub-theme 3.3: Anger, depression, suicidal tendencies and general mental trauma.

The following quotes support the sub-theme:

> *P12: "Yes I am healed but it's difficult to forget. But I am healed."*
>
> *P1: "Yaa when it happened I felt like angry… and later I felt sad, depressed. Yaa confused.. I don't know…. I became scared and angry. I felt hatred and suicidal also at times."*
>
> *P7: "I was so depressed I cried each and every day. ..I was angry let me say that. I was angry and when I am angry I can't even talk. Sometimes when I find myself alone I just shout at nobody because I am angry. I am angry with myself. I am angry with everything."*
>
> *P3: "And I started getting nightmares to a point where anger grew within me and I wanted to take my life or even just to harm him as well because he turned me into a monster…. I felt like my life had come to an end. I felt like I wanted to take my life."*
>
> *P5: "I was so stressed that my hair started falling off also and I was depressed. I just used to staid in my room."*
>
> *P6: "It's like those things are coming back. This is a thing that you never forget. It always comes back. You can try to forget but it always comes back. It's not easy."*

Rape survivors exhibit depression, fear and anxiety, problems with social and work adjustment, and problems with sexual functioning subsequent to their assault (Suprakash et al., 2017:5; WHO, 2003:13). Findings in this research show that participants also experienced similar symptoms, namely nightmares, anger, suicidal thoughts and depression. The ecological model notes that, at the interpersonal/relationship level, negative social reactions from informal support providers such as family and friends, predicts multiple negative outcomes such as

depression, anxiety, and posttraumatic stress (Campbel, 2009:230).

Research has noted that rape victims may feel anger against the perpetrators, against all men or against their husbands and communities for having rejected them (WHO; 2003:14). In this research some of the participants also indicated that they felt angry:

> *P1: "Yaa when it happened I felt like angry…"*

Some of the survivors in this research also reported that they suffered from flashbacks. These are memories of all or part of the traumatic event that suddenly intrude on the victim's thoughts and seem real.

> *P6: "It's like those things are coming back. This is a thing that you never forget. It always comes back."*

Suicidal thoughts and tendencies after the rape were quite evident from the participants' responses. Many rape survivors often do not have the support they need at the time and they may see suicide as a way of escaping from over-whelming pain and distress; or as a way of taking back control (Rape Crisis Scotland, 2013:3; WHO, 2003:14). The ecological approach notes that such issues as anger and hostility towards other as well as the desire for isolation from others manifest at the personal level.

3.9.3.4 Sub-theme 3.5: Relationship and trust issues

The narratives provide support of this sub-theme:

> *P1: "I don't trust guys anymore. It's like difficult for me to love a guy" (Mary)*

> *P3: "I realise that through this, I have lost so much trust in men. Men will come to me. They will propose but yet my heart will not be open because I don't know…. I don't want and I have so many rules. .. I even sometimes like have a lot of rules in my life…… It hurt me so much that I sleep with men but yet my heart is so far from them. I don't feel emotional. I don't care even if he doesn't call me the next day."*

> *P5: " I am not dating anymore. I'm not going out. I'm not the person who stays with friends anymore. I am just on my own."*

P2: "… you can't just come and touch me especially if you are a man. … just hugging for me has become weird. It has become very suspicious that kind of thing…. I cannot get myself to get into a relationship because…I just don't trust."

P11: "Yaa I think it did, with my family, with my father because there was a time when I resented him a bit because I was of the opinion that he knew, and he should forgive me for that because he didn't know. So with my relationships, even with my brothers, it's only that they are still young, I think they even noticed even if they are still very young. I became a bit withdrawn, so I could spend most of the time on my own, or I could just be standing there even at school, my friends would be like I can see your mind is somewhere, though I never shared with anybody, but I knew something was going on, they could tell that something is going on when I was so quiet and alone."

P10: "…it breaks your life down. You lose your identity. You don't feel like looking up anymore because your own husband raped you time and time again. Over and over again so you lose your identity, you lose your pride as a woman, so you don't know, you don't feel like looking up to yourself or people any more. Because in the past went through that, now you and married, I feel I am a woman I can get my identity back, but in the marriage you lose it again and again. Over and over again."

Rape Crisis Scotland (2013:3) points out that rape is a major experience which can change a person's view of the world. It can result in a person having difficulties in trusting anyone, even oneself, or relate to people in the way they used to. This is consistent with some of the participants' narratives, which clearly show that they no longer had trust in some of the people that they used to believe in or easily relate to. The trauma of rape affected their relationships with other people, including their friends, intimate partner, children and wider family. It also resulted in isolation from friends and family and made it difficult for some of them to make new friends and relationships.

Relationships can be further complicated if the person who sexually assaulted the victim is a family member/intimate partner. Other family members may be reluctant to provide support or cause 'upset' in the family, or find it hard to believe that someone they know/love could do this (Rape Crisis Scotland, 2013:4). Instances reported by some of the survivors in this research are also consistent with this as evidenced by the fact that some family members who knew about the rape incident did nothing, or kept quiet about it as they were either related to or new the perpetrator in some way.

From the survivors' narrative, it is evident that the rape incident caused them to feel that the world was not a safe place anymore. They no longer trusted others or even themselves at times. For some of them, relationships started to feel dangerous and intimacy almost next to impossible. Healthcare support services that enable victims to easily have access to support on how to deal with relationship issues should therefore be established.

3.9.4 Theme 4: Social and economic challenges.

Three sub-themes emerged for the social and economic challenges:

4	Social and economic support challenges	5.4 Culture and traditions relating to sexual acts between man and women. 5.5 Stigma and shame family members and community. 5.6 Lack of economic independence

3.9.4.1 Sub-theme 4.1: Culture and traditions relating to sexual acts between man and women.

The following interview quotes support this sub-theme:

> *P9: "The worst thing I can say that, he is my cousin,… and we stayed in their house for almost two years. But I remember in the first year it almost happened again. I told the mother, but then the mother didn't take it seriously. So to me when it happened, it's like I was thinking maybe he was sent to do this to me or something. So I really felt bad about it because then I was just thinking that maybe it's the mother who told him (to do it) because when at first he tried to do it I told his mother, but then the mother didn't take it seriously."*

> *P11: "When uncle came he just said, don't worry my daughter. It is sorted. I apprehended them, I caught them and I sent them to jail. For me it's did not make sense "as much I don't know the court things. But how can you just send people to jail. But because I was also just in another state of mind, I just thought maybe he is referring to the police station and and and and… So when he said he sent them to jail, I trusted him but I also had queries that. Like how in the evening sending them to jail."*

Ideologies of male sexual entitlement tend to create belief systems that grant women extremely few legitimate options to refuse sexual advances (WHO, 2010:29). In many cultures women, as well as men, regard marriage as entailing the obligation on women to be sexually available virtually without limit (WHO, 2010:29). These notions are supported by data collected during the research which indicated that some of the

women felt that they, in some way, had no choice since they were either married or related to the perpetrator.

The findings also support the notion that in societies such as Namibia, where the ideology of male superiority is strong – emphasizing dominance, physical strength and male honour – rape is more common (WHO, 2010:30). This is further supported by the theory rape and sexual violence tends to be promoted by the maintenance of patriarchy or male dominance within a society (WHO, 2010:25; Taft, et al., 2009:50). The ecological approach notes that, at the individual level, existing power inequalities between man and women reinforce existing subordinate or privileged positions. Patriarchal and male dominance norms reflect gender inequality and inequities at a societal level, and legitimize sexual violence and rape perpetrated by men (Russo & Pirlott, 2006:187). Culture plays an important role in how certain populations and societies view, perceive, and process sexual acts, as well as sexual violence (Kalra, & Bhugra, 2013:5). In Namibia, for example, some cultures consider sexual relationships between cousins as normal. So when a cousin rapes his cousin, as was the case with one of the participants in this research, this can be regarded by the relative as acceptable behaviour. In line with this, the ecological approach assets that notions relating to cultural and social norms about gender roles, attitudes towards women and the legal and political frameworks that govern behaviour, and attitudes towards using rape manifest at the society leve**l.**

3.9.4.2 Sub-theme 4.2: Stigma and shame from family members and the community.

The following interview quotes support this sub-theme:

> *P9: "Yaaa I do think about it especially that people that are surrounding me where I stay, they try to take advantage of me again, and so I really feel uncomfortable most of the time and sometimes I start thinking of it. Sometimes I even ask myself if I am having a problem or why people keep wanting to take advantage of me."*
>
> *P8: "And the people are checking me out. They are just talking bad things. And I don't feel comfortable. …He (my boyfriend) doesn't trust me. He is saying apparently I just went and slept with the guy out of the blue, but it was not like that…. And the people are checking me out. They are just talking bad things. And I don't feel comfortable."*

P11: "You feel like okay, people might even say I am one who started the whole thing, so I did not seek help."

P6: "Yaa it was like, you know when I go into that room to go and get it (PEP medication), it's like it's an ARV drug. Then if I am going in there and the people are looking at me, then I feel like these people are looking at me with the same image as they look at HIV-positive people. But I am not like that. So I decided let me just leave this."

P5: "The worst thing that happened is when my family started pushing me away and it was like a stigmatization… Stigmatization, yes. And they were always calling me names and all those things. And even now it is difficult for me to take my tablets because sometimes they give me food but sometimes they don't give me food."

P5: "With my family members I am staying behind the house in my on shack because I cannot stay with the people. If I go to use a cup then you will see that they are scrubbing the cup and all those things. So for me it's better to stay in my own room at the back. We don't communicate as much as we used to do."

Ahrens (2006:270) argues that for most survivors, no matter what they did or how they behave, they are likely to be blamed for the assault. For some survivors, this blame may be so traumatizing that they are effectively silenced by the negative reactions they receive. This notion is supported by the findings in this research where we see that family members and other associates of the victim often blamed them for the assault to some extent. Stigma and shame manifest at the community level according to the ecological approach. As a result of such stigma and shame, rape victims therefore find it challenging to seek for support or be provided with support from the community.

In a qualitative study in Congo, Claude et al., (2013:2) showed that stigmas for victims of sexual violence are associated with the perception of rape and rigid social norms to the detriment of women. Additionally, these stigmas were rooted in fears of the spread of sexually transmitted infections, as well as the shame and guilt felt because of the families and communities. This relates to findings from this research where participants indicated that they feared to be stigmatised by family members and the society.

Often the rape victim is prevented from expressing her opinion. In addition, old friends may stop talking to her or refuse even to see her. This position corroborates evidence from this research, which showed that some rape survivors were rejected by their

families and denied food and general support. Furthermore the survivors reported that people started looking at them in an uncomfortable manner, as if to suggest that there was something wrong with them. Some of the survivors could not easily associate with family and friends after the rape.

3.9.4.3 Sub-theme 4.3: Lack of economic independence

This sub-theme is supported by the following quotes:

> *P9: "And while I was laying there, with my two children, grandchildren, people came at 9 o'clock in the morning and they started to take the shack off. When I asked them what they were doing the told me that your husband sold the place to us. So I said what must I do? Where must I go? I've got two children. So I then decided that I would go to my daughter's house. When I got my daughter's house, she said she hasn't got place for me to stay. So I asked you to phone somebody just to give me a place to sleep with my two children. So she phoned and the person said I must go. I was staying there for a month. I was sleeping on the floor. I lost my house. I lost everything. I lost my furniture."*
>
> *P8: "Yes like, I can't see, I can't work anymore. I've got a problem like the money that I get it is only.. Like you know food is expensive. If I can get more help like for my children for clothes, for myself, for clothes. You see I lost a lot, like furniture, like things. I was a woman who had everything. I was supporting myself. But during the abuse I lost everything, so I need to be on my feet again."*
>
> *P6: "Yes I'm taking medication. For now I haven't taken it for two months because where I am working there is financial problems and I have to pay the rent and so on. By the way where I am staying is also very far from the hospital…. So there is also the problem of money for the taxi so now I haven't taken the medication for two months."*
>
> *P9: "Yaa it's like I feel they didn't create a place for me where I could stay, where I would be more free and where I would feel protected. Because now also, like when it comes to the docket they will ask you everything where you are staying. So I don't know where they take that information to since they don't tell me. So sometimes I am scared at what if this person happens to see where I am staying. What will happen in the end? So sometimes I was feeling like why don't they take me somewhere where it's safe, where that person would not be able to find out where I am staying."*

Lack of economic independence was one of the challenges faced by rape survivors in this research. The survivors faced a challenge of lack of proper accommodation and financial resources to look after themselves and their children. In line with the ecological approach, lack of economic independence is a factor that manifest at the individual level. Such lack of economic independence make it difficult for the rape

victims to access healthcare services, enhance their self-worth, access funds to leave a relationship, or have access to resources for things such as therapy, counselling, and other community resources.

As can be expected, in poor communities in the Khomas region such as Katutura, the rural areas and Khomasdal where most of the participants came from, economic structural factors disproportionately impact women's lives and are identified as being an ongoing concern for most women as well as a source for gender discrimination and disharmonious relations between the sexes (LeBeau, 2004:29).

Victims of rape in this study indicated that they faced challenges when it comes to finding a safe place to live or finding means to support themselves and their children. As a result the affected survivors felt that they did not receive enough support to enable them to have somewhere to stay where they would not feel threatened or scared. This finding show that women lack economic security, which is described as the availability of a steady and reliable source of income to sustain daily living for oneself and one's family and to allow planning for the future (National Advisory Council on Violence Against Women, 2002:142). The ecological model notes that the socio-economic status of women impacts on women's ability to cope with the effects of rape (Campbell et al., 2009:231).

3.9.5 Theme 5: Challenges with support from the police/legal justice system.

The following sub-themes emerged under this theme:

5	Challenges with support from the police/legal justice system	5.3 Offenders not arrested, released on bail/poor conviction rates 5.4 Police not supporting victims effectively

The challenges that participants faced in relation to support form the police and/or the legal justice system are substantiated by the following quotes from the participants:

3.9.5.1 Sub-theme 5.1: Offenders not arrested or released on bail/poor conviction rates.

Participants' narratives in relation to this sub-theme are indicated below

> *P4: "Yaa from there I just went.... I tried calling the police but the police didn't come… So I went the next morning (to the police) but nothing. Because they said there is no evidence of what…, I don't know… I'm just like it's unfair that the person did not get caught… I think they could have arrested guy. It would have made me feel better. Because then I know at least he is behind bars or he is paying for his crime. Maybe he can do also to another person."*
> *P3: "No he is not in prison, he was arrested at the time that I was in the shelter. So I could not bear my father being in prisoned. I know what he did was a crime, but I was having that fear, he is still my father no matter what he has done. So they came and asked me, Kelly do you agree, do you want a bail? So I said yes I will give you a bail."*
>
> *P12: "I would say the police did not help because the man was not arrested and they took a long. They sent me from one office to another but until now this man was not arrested."*
>
> *P5: "They could have done better to help me if they had not taken out the man from the prison because it was almost 2 lives that he took. Not actually two that three, because my friend was infected, me I was infected, I had an abortion for the baby, and it was..."*
>
> *P6: "So he understood. So he supported me in every move. They later called me, like he was also locked up for a week (the guy who raped me). After that the case was gone, nothing happened at all with him. But I'm still having that fear."*
>
> *P9: "I think what they were supposed to do….., because then until now I don't really feel safe, especially when we go to court now and then. It's like, I don't know how they took it, but it's like to me the way they extended his bail again, it was too long."*

Participants in this research strongly felt that the police did not do enough to arrest and prosecute the perpetrators of rape. In cases where offenders were arrested, they were either quickly given bail, or the cases were dismissed and not taken any further. As a result the survivors faced the challenge and fear of potential threats from the offenders.

Overall, it is noted that the case attrition for perpetrators of rape is high. This tends to be corroborated by research findings by Crandall & Helitzer (2003) which concluded that for every 100 rape cases reported to law enforcement, on average 33 would be referred to prosecutors, 16 would be charged and moved into the court system, 12

would end in a successful conviction, and 7 would end in a prison sentence. Campbell et al., (2008:704) nevertheless notes that successful prosecution is not random, but is more likely for those from privileged backgrounds and those who experienced assaults that fit stereotypic notions of what constitutes rape. It is therefore not surprising that in this research where basically all the victims were from poor backgrounds, the conviction rates were quite low. As Campbell et al., (2008:704) notes, younger women, ethnic minority women, and women of lower income groups are more likely to have their cases rejected by the criminal justice system. Alcohol and drug use by the victim significantly increases the likelihood that a case will be dropped (Campbell et al, 2001). In this research it is also noted that a number of the victims experienced rape after having taken alcohol, hence this could have also influenced police's perceptions about the incidence and the rates of prosecution.

3.9.5.2 Sub-theme 5.2: Police not executing their duties as expected

*P12: **"**The process took long. I was referred from one office to another… the police process took too long. I did not have anywhere to stay."*

P5: "So for me the case went on, but with the things going on in our country, the police were very slow and when I saw that man again in the location, it made me fear and I was angry, and I wanted to hurt him also."

P5: "Yes, in cases of rape I would like the justice system to be fair. Even for murder and all those things, the justice system is not doing anything at all. If I go and take someone's cow or cattle I will go to prison for 20 to 30 years. But for someone that does the rape and murder, then it is only, they are getting bail or we just hear that they get three years and sometimes you hear that there is no case, or that the dockets were lost and all those things. So it's very difficult."

P6: "I went back to them and I went to ask them like how is it possible that this man is outside. Then they said no, this file is not with us, but it's with the person that was taking the statements that day. So we are giving like how many files, like those ones, the one who will work on your case. And apparently the person was out on leave. So I tried going back but I could not find him and you later, it was also just a lot of taxi money for every day since I stay far. So I just stopped there."

P6: "I think that they should have taken this thing more serious. And they should maybe, I don't know what they must do, but to ensure that the man becomes afraid to rape a woman. Even just by, she is not yours you must not just touch her. You must just know this is not mine and I cannot touch. So they must also get a certain punishment, just to know that if I do this then I will end up again in prison and I will get a serious punishment."

P8: "They did not. They did not believe at all (the police)."

The scenarios above are substantiated by findings from several studies which have indicated that Namibia's Woman and Child Protection Units, intended as specialised police units which can provide sensitive responses to gender-based violence, have not yet fulfilled their full promise – because of training shortcomings, frequent transfer of personnel in and out of the units, lack of adequate transport, some inexperienced or unsympathetic staff, lack of support and supervision for staff, a shortage of social workers, and lack of adequate facilities and equipment (Legal Assistance Centre, 2012:29).

Research has noted that across multiple samples, 43% to 52% of victims who had contact with the legal system rated their experience as unhelpful and/or hurtful (Monroe et al., 2005:770; Campbell et al, 2001). Rape survivors have been said to described their contact with the legal system as a dehumanizing experience of being interrogated, intimidated, and blamed (Logan et al., 2005:6). Similar findings were also apparent in this research where most of the women felt that the police did not believe in their story and did not do much to help them.

It has been reported that rape survivors have complained that as a result of their contact with legal system personnel, they felt bad about themselves, depressed, violated, distrustful of others and/or reluctant to seek further help (Campbell & Raja, 2005:103). This scenario is consistent with some of the victims' narratives above where the participants in this research also indicated that secondary victimisation had a toll on their psychological feelings. This is also in line with the ecological model which points out that post-assault help-seeking from formal social systems can become a "second rape," that is, a secondary victimization to the initial trauma. These experiences of secondary victimization can have a negative impact on victims' psychological wellbeing (Campbell et al, 2009:234).

3.10 Summary

Chapter three presented the research methodology that was utilised in the research as well as an overview of the ethical considerations and principles that were adhered to. The empirical findings were also presented in this chapter by exploring the personal

narratives from the research participants and substantiating them with findings from literature. Participants' biographical information was presented in the form of charts. The findings were presented under the various themes and sub-themes that emerged from the analysis of data.

The next chapter presents the conclusions and recommendations for the study.

CHAPTER 4

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

4.1 Introduction

The previous chapter presented empirical research findings as obtained by means of a qualitative approach and phenomenological design. In this chapter the extent to which each of the research objectives was met and research question answered, will be discussed. The chapter also presents the limitations of the study, the key findings and conclusions, and recommendations.

4.2 Summary

The main goal of this study was to explore and describe the challenges faced by survivors of rape in the Khomas region of Namibia in accessing *health* and support services.

The objectives of this study were:

1. To describe rape as a form of gender based violence and explore the socio-economic, emotional and psychological challenges experienced by rape survivors in the Khomas region of Namibia.
2. To identify the health care support services that are available in Namibia for survivors of rape.
3. To assess the challenges that the survivors of rape face in accessing health and support services.
4. To make recommendations for intervention.

4.2.1 Objective 1

To describe rape as a form of gender based violence and explore the socio-economic, emotional and psychological challenges experienced by rape survivors in the Khomas region of Namibia.

The first objective was met by means of conducting an in-depth literature review on rape and sexual violence on women). The theoretical framework, namely the Ecological approach, provided the context in which rape of women can be understood (section 1.3). The literature review provided a description of the concept of rape and sexual violence (section 2.2), prevalence and incidence of rape (section 2.3), factors contributing to rape (section 2.4) as well as the consequences and the impact that rape has on survivors (section 2.5). In this research the ecological approach underpinned the study, for examining the combination of factors that result in women facing challenges as a result of rape as well as the nature of challenges that they face (Morrison, Ellsberg & Bott, 2007:26). In order for any intervention that is used to help rape survivors cope with the challenges that they face to be effective, it will generally necessary to address factors at the different levels as identified in this approach, that is, at the individual, interpersonal, community and societal levels.

4.2.2 Objective 2

To identify the healthcare support services that are available in Namibia for survivors of rape.

This objective was achieved through an in-depth literature review undertaken under sub sections 2.2.2, 2.2.3, 2.2.6 and 2.9. Rape and other sexual assaults or violence are some of the most common and perverse crimes in Namibia (Namibia Crime Statistic, 2013:35). This therefore calls for the need for robust efficient healthcare support services that can support victims and help them to deal with effects of rape. The literature explored the role of health care in dealing with rape. The nature and extent of provision of health and support services locally and internationally was explored. The literature also provided some insights into how health and support services for rape survivors can be improved, as well as the need for national plans and policies against rape and gender based violence.

4.2.3 Objective 3

To assess the challenges that the survivors of rape face in accessing health and support services.

This objective was achieved through the key findings as evidenced in Chapter three of the study. The empirical findings provided the perspectives on rape and the challenges that they encounter in trying to find health and support services. In line with the ecological approach, participants' narratives revealed that survivors encounter challenges at the individual, interpersonal and family, neighbourhood and community, as well as at the policy, systems and societal levels. The participants generally indicated there was inadequate or limited support at all the levels. The challenges encountered by the survivors of rape include support with service delivery at healthcare facilities, support for their physical and mental health, social and economic support as well as support from the police and legal justice system.

4.2.4 Objective 4

To make recommendations for intervention.

Objective four was achieved by means of intervention strategies as recommended in the below sections of this chapter. These intervention strategies are outlined under each theme in the recommendations later in this chapter. They speak to the improvement of health and support services for survivors of rape at the individual, family, community and societal level in line with the ecological approach.

4.2.5 Research question

The research question in this study was:

What challenges do survivors of rape in the Khomas Region of Namibia encounter in accessing health and support services that are necessary to help them heal from the trauma of rape?

The above question was answered through conducting a qualitative research study which involved interviewing twelve survivors of rape in the Khomas region of Namibia who had experienced the violation during the past two years. One-on-one interviews were conducted and these helped to collect data which the researcher then analysed and generated themes and sub-themes as discussed in detail in chapter three of the study. Five themes with their sub-themes emerged to answer the research question.

4.3 Limitations of the study

Some of the limitations of this research resulted from its qualitative nature. The following limitations were therefore be taken into consideration when the data were analysed.

- As the qualitative data was collected by means of open-ended questions, the participants had more control over the content of the data they provided. So the researcher could only verify the contents of the data through member checking and not against other facts such as police statements.
- It should be noted that the study was carried out in only one out of the fourteen regions of Namibia (Khomas), and thus the results cannot be generalised. But it could be applied in similar populations.
- Furthermore, since the study was based on collecting subjective information from survivors of rape in their own words, the possibility that some of the participants gave limited or biased information was high. Rape is a very personal and sensitive issue and participants may have been cautious in providing all details about their cases. However in order to mitigate this limitation, participants were assured of the fact that their identities would be protected and the information would remain confidential.

4.4 Conclusions

This section will present some conclusions drawn from the literature study.

4.4.1 Conclusions from the literature study

In order to enhance understanding of the phenomenon under study, the ecological approach was considered relevant in underpinning this study. This was because the ecological approach combines factors operating at the individual, relationship, community, and society levels, making it an appropriate framework for examining the combination of risk factors that increase the likelihood of rape in a particular setting. It allowed the researcher to examine the challenges faced by rape survivors at the different levels. Since the ecological approach considers the complex interplay between individual, relationship, community, and societal factors, this allowed the researchers to understand the range of factors that act as contributory factors for rape or that can prevent them from experiencing rape. The overlapping circles, as demonstrated in Figure 1.1 in chapter 1, illustrate how factors at one level influence factors at another level. Besides helping to clarify these factors, the approach also suggests that in order to effectively deal with challenges affecting rape survivors, it is necessary to act across multiple levels of the model at the same time. The empirical findings of the researched revealed that survivors of rape face significant challenges in accessing health care and support services across all the levels. It can therefore be concluded that the ecological approach was appropriate in underpinning the study and was successfully used to understand the challenges encountered by survivors of rape.

The literature revealed that the incidence and prevalence of rape in Namibia is quite high and affects a significant part of the female population. Many factors contribute to the incidence and perpetration of rape including myths and stereotypes about rape, social stigma, cultural beliefs and socioeconomic conditions. Literature also emphasised that the consequences of rape are a multitude and survivors face different challenges in their endeavour to seek health and support services. Thus the literature highlighted that there is need for the healthcare support sector to play a critical role in supporting survivors of rape and offers suggestions as to how such support can be improved. Apart from healthcare support, literature also notes the inadequacy and limited nature of support from other sectors such as the community, legal services and at policy level. Literature suggests some integrated models for post rape support and also alludes to the need for implementation of national plans and policies that are aimed at improving support for survivors of gender-based violence and rape. It can therefore be concluded that the literature study conducted was relevant and appropriate to the subject that was being investigated.

In the following section the key findings and conclusions regarding the empirical findings will be presented and recommendations are made in relation to each of the key findings.

4.5 Key findings, conclusions and recommendations from the empirical study

In this section the key findings and conclusions for the research findings from each theme will be presented. Recommendations will be made in relation to the empirical findings.

Table 4.1 below provides an overview of the themes and sub-themes that emerged from the empirical results.

Table 4. 1: Themes and sub-themes

	Themes	**Sub-themes**
1	Healthcare centre support services	1.1 Limited or inadequate counselling. 1.2 No examinations or limited medical attention. 1.3 Long waiting periods at health care service centres. 1.4 Negative perceptions and stereotypes of healthcare providers.
2	Physical health support challenges	2.1 Diseases and infections. 2.2 Pregnancy and gynaecological problems. 2.3 Physical injury and pain.
3	Mental health/psychological support challenges	3.1 Fear and threats. 3.2 Self-blame, loss of self-esteem/self-worth, shame. 3.3 Anger, depression, suicidal tendencies and general mental trauma. 3.4 Relationship and trust issues.
4	Social and economic support challenges	4.1 Culture and traditions relating to sexual acts between man and women.

		4.2 Stigma and shame family members and community. 4.3 Lack of economic independence.
5	Challenges with support from the police/legal justice system	5.1 Offenders not arrested, released on bail/poor conviction rates. 5.2 Police not supporting victims effectively.

Figure 4. 1: Overview of themes and sub-themes

4.5.1 Theme 1: Healthcare support services

This theme focused on those challenges that survivors of rape encounter at healthcare centres. Four sub-themes were identified under this theme: limited or inadequate counselling, no examinations or limited medical attention, long waiting periods at health care service centres and negative perceptions and stereotypes of healthcare providers.

4.5.1.1 Key findings

The research participants revealed that the support that they expected to receive at the healthcare centres was generally limited or inadequate. Limited post-rape counselling was indicated as one of the major shortcomings at the healthcare centres. Survivors would have preferred more counselling to support them with their trauma. The participants also sited that medical examinations were at times not done or simply neglected

Survivors of rape in this research indicated that they experienced long waiting periods at healthcare centres, as they sought support and medical assistance. Survivors also reported that when they finally got attention, the help that they got was largely unsatisfactory.

Participants also experienced some negative experiences and stereotypes, as well as discrimination from healthcare providers. According to the survivors this was evident

in the way the healthcare personnel reacted towards them and also through the fact that at times their stories were not believed or taken seriously.

4.5.1.2 Conclusions

It can be concluded that survivors of rape did not receive adequate support and assistance at healthcare centres as expected. Such lack of support can exacerbate the suffering of survivors as their medical, psychological and social needs might not be addressed in time. Such lack of attention also contributes to negative perceptions towards healthcare providers, thus making it difficult for survivors to seek continued support. At all levels of the ecological approach, victims need to receive the services they require from healthcare providers and to be treated in an empathic, supportive manner, so as to facilitate their recovery. However, if victims do not receive the needed services and are treated insensitively, then these systems can magnify victims' feelings of powerlessness, shame, and guilt.

4.5.1.3 Recommendations

- The health care professionals rendering services to rape survivors in health care settings such as clinics and hospitals should be constantly reminded of the rights of patients and their ethical conduct. Continuing professional development is required in this regard.
- There is an urgent need to develop basic minimum standards and procedures for aiding victims of sexual violence in Namibia that can be applied in (and are mindful of) varying cultural and social settings. Such a protocol should uphold fundamental human rights, including the right to seek legal remedies.
- There is also a need to break down the barriers that prevent healthcare providers from providing care to survivors of rape and sexual violence. Some of these barriers include lack of capacity of hospitals/clinics, insufficient medicine or resources, cultural barriers, lack of education about the clinical management of rape, confusion and lack of awareness of the 72-hour window for treatment and stigmitisation.

- Health workers should be free of bias or prejudices and maintain high ethical standards in the provision of services to survivors of rape.

- There is need to strengthen both the capacity and resources of the current health system. This can be achieved through the work of policymakers and administrators within the health system.

4.5.2 Theme 2: Physical Health Support Challenges

This theme focused on the physical health challenges that rape survivors encountered. The sub-themes identified under this theme were: diseases and infections, pregnancy and gynaecological problems and physical injury and pain.

4.5.2.1 Key Findings

Participants faced a number of challenges relating to their physical health as a result of the rape perpetrated on them. These included having to deal with such issues as diseases and infections, pregnancy and gynaecological problems, as well as physical injury and pain.

Diseases and infections were related to contracting HIV as well as STIs. The victims needed urgent support to deal with these diseases and infections, but unfortunately at times they received very limited support from healthcare providers in this regard. At times treatment or post-exposure prophylaxis was delayed, which tended to increase the possibility of infections and complications. Some of the participants in the research fell pregnant and some had other gynaecological complications as a result of the rape. The survivors indicated that post-assault pregnancy services were inconsistently provided. Furthermore the research participants also faced challenges of having to deal with the physical injury and pain caused by the assault. This resulted from forced penetration and/or being beaten during the assault.

4.5.2.2 Conclusions

The aftermath of rape can have a number of acute and chronic physical health effects. Exposure to rape is associated with a range of health consequences for the victim. It is important that victims receive comprehensive care that addresses both the short and long-term physical health effects of rape as they become apparent. The physical health challenges can have long term effects on the victims, some of which are not reversible. Victims might have to look after children that they did not plan to have or deal with physical conditions that have been created for the rest of their lives. Support for rape survivors at different levels identified in the ecological approach (individual, interpersonal, community and societal) is therefore essential so as to assist them to cope with their physical health challenges.

4.5.2.3 Recommendations

- Healthcare support services that help victims to deal more effectively with pregnancy and other gynaecological complications need to be put in place.
- Where necessary, measures to ensure that treatment and/or post exposure prophylaxis is provided to victims as soon as possible need to be put in place.
- Health workers should discuss the risks and benefits of HIV post-exposure prophylaxis, so that they can help their patients reach an informed decision about what is best for them.

4.5.3 Theme 3: Mental health/psychological support challenges

This theme focused on the mental health/psychological challenges encountered by the rape survivors. The sub-themes under this theme were: fear and threats, self-blame, loss of self-esteem/self-worth, anger, depression, suicidal tendencies and general mental trauma as well as relationship and trust issues.

4.5.3.1 Key Findings

Participants experienced a number of mental and psychological health problems for which they needed support. Participants indicated that they experienced a variety of strong emotions such as fear, anxiety, self-blame, loss of self-esteem/self-worth, shame, anger, depression, suicidal tendencies and general mental trauma. A number of them also developed relationship and trust issues. Furthermore, many of them also felt confused and alone, wondering if they should tell their family and friends or how they should tell them.

The participants confirmed that there is a general fear of repeated assault and of contracting HIV and other sexually transmitted diseases. Participants also indicated that they feared stigma and discrimination from their family, friends and the society at large. Fear of social consequences, included fear that other people will find out about the assault, fear of people's reactions, fear of being rejected by one's spouse and fear of being ostracized by the community.

Research findings showed that victims at times blamed themselves for the rape. This appeared to be more evident in cases where alcohol was involved, especially in cases where the perpetrator had bought or offered alcohol to the victim. Such self-blame resulted in some of the victims not wanting to seek the necessary help.

The rape survivors also experienced some anxiety, nightmares, anger and depression. Many of the rape survivors however noted that they did not receive the support they needed at the time and they at times considered suicide as a way of escaping from their pain and distress.

Many of the victims also developed trust issues as a result of the rape. They no longer trusted others, especially men or even themselves at times. The fact that in most cases the perpetrator was known to the victim, made it even more difficult for the survivors to trust other people since they now believed that if someone who they trusted could violate them in such a manner, then anyone else could also do the same.

4.5.3.2 Conclusions

Rape can have a variety of short- and long-term effects on a victim's mental health. Many survivors reported flashbacks of their assault, and feelings of shame, isolation,

shock, confusion, and guilt. People who were victims of rape or sexual assault are at an increased risk for developing depression, PTSD, substance use disorders and anxiety disorders.

Having a history of being a victim and the negative reactions from family, friends, and professionals, worsen the impact of rape on the mental health of survivors. Because sexual trauma can have such a serious impact on mental health, it is important that services and supports consider and address the trauma that the individuals have experienced. At the individual level, rape awareness programmes need to provide information for informal support providers about the varied reactions survivors may exhibit. In addition, such programmes should emphasize to informal support providers that positive reactions such as emotional support and tangible aid are for recovery, and negative reactions, such as egocentrism and blame, may overshadow any positive efforts.

4.5.3.3 Recommendations

- There is need to build health workers' capacity to respond to cases of rape in a sensitive and comprehensive manner.
- Social support and counselling are important for recovery. Survivors should receive information about the range of normal physical and behavioural responses they can expect, and they should be offered emotional and social support.
- Where possible, survivors should be offered access to follow-up services, including a medical review and referral for counselling and other support services.
- Health care workers need to be empowered with the knowledge and skills that is necessary for the management of victims of rape.
- There is a need to develop and implement rape awareness programmes that provide information to informal support providers about the varied reactions survivors may exhibit and how they can help them to cope.

4.5.4 Theme 4: Social and economic support challenges

The social and economic challenges experienced by survivors where evidenced through three sub-themes that emerged from the findings, viz: Culture and traditions relating to sexual acts between man and women, stigma and shame family members and community and lack of economic independence.

4.5.4.1 Key Findings

Ideologies of male sexual dominance and entitlement tended to create belief systems that grant women extremely few legitimate options to refuse sexual advances. This went to the extent that some of the women felt that they, in some way, had no choice since they were either married or related to the perpetrator. Some cultures in Namibia consider sexual relationships between some relatives as normal. So when rape was perpetrated by a relative, as was the case with some of the participants in this study, this appeared to be regarded by the victim's relatives as acceptable behaviour. In such cases support for the victim from family members was therefore limited.

Survivors also faced challenges of stigma and shame from family members and the community in which they stayed. Such stigma resulted in some of the survivors being rejected by their families and denied food and general support. Furthermore the survivors reported that people started looking at them in an uncomfortable manner, as if to suggest that there was something wrong with them. Some of the survivors could not easily associate with family and friends after the rape.

The results revealed that economic dependency of women and poverty, also tend to have an impact on women in their endeavour to seek for health and support services. Lack of economic independence resulted in some of the survivors not having proper accommodation and financial resources to look after themselves and their children.

4.5.4.2 Conclusions

Culture plays an important role in how certain populations and societies view, perceive, and process sexual acts, as well as sexual violence and rape. Cultural and social norms are highly influential in shaping individual behaviour, including the

use of violence. From the research it is therefore evident that rules or expectations of behaviour – norms – within a cultural or social group can encourage rape. Interventions that challenge cultural and social norms supportive of violence can therefore prevent acts of violence.

Victims of rape are often stigmatised by their family members and people from the communities that they live in, which makes it difficult for them to obtain the support that they need. Stigma from family and friends resulted in the survivors being more isolated and having to face the challenges on their own. Lack of economic independence and security further deepened the victims' plight. This calls for a need to consider improving the socioeconomic status of women at the individual, interpersonal and community levels so that they are better able to look after themselves and their families.

4.5.4.3 Recommendations

- Awareness campaigns that encourage individuals and communities to learn more about rape and sexual violence need to be promoted.
- Nationwide anti-violence campaigns and behaviour-change intervention programmes should target awareness creation to reduce gender biases and encourage gender-sensitive behaviour, eradication of health and gender-related illiteracy and ensure men's participation at levels of such programmes.
- Provide well-funded shelters and relief support for women subjected to rape to enable them to recover and find a means of subsistence after rape.
- Formulate and implement, at all appropriate levels, plans of action to eliminate violence against women.
- Develop and implement programs that are targeted at improving the socio-economic status of women.

4.5.5 Theme 5: Challenges with support from the police/legal justice system

Challenges in relation to support from the police and/or the legal justice system were evidenced through two sub-themes. These were: offenders not being arrested, released on bail/poor conviction rates and police not supporting victims effectively.

4.5.5.1 Key Findings

Participants in this study noted that they faced challenges in trying to seek support from the police and/or the legal justice system. The main challenges faced by the survivors were linked to the fact that the perpetrators were often not arrested or were quickly released on bail. Victims also felt that they did not receive enough support from the police as they would have expected.

The failure to arrest offenders or their quick release on bail, resulted in the survivors fearing potential threats or reprisals from the offenders. As noted in the research basically all the survivors were from poor backgrounds, which made it difficult for them to have enough security and systems to protect themselves against further perpetration of violence. Most of the rape survivors in this research felt that that the police did not believe their story and did not do much to assist them. The police took too long to deal with the victims' plight, which resulted in the victims feeling that their issues were being neglected and not being taken seriously.

4.5.5.2 Conclusions

The police and the legal justice system occupy a crucial role in the handling of sexual assault cases. However, police officers and other criminal justice personnel hold attitudes toward rape case victims, which may result in victims feeling that they have been denied the justice which they deserve. Victims also tend to feel that they did not receive enough protection and service from the police and the legal justice system. It would appear that the vigour with which police investigated a case, largely depended on their perception of the strength of the evidence, and at times on their perceived conditions of the circumstances under which the rape was committed. There is therefore a need to create an environment where the police and the legal justice system are more supportive of the victims of rape. Interventions at the systems level need to look at effecting policy change, organizational change, systems advocacy,

media campaigns, and rape awareness/prevention education, to create broad-based systemic change. Similarly, efforts that focus on the prevention of rape reduce the likelihood of multiple victimizations in women's lifetimes, thereby curbing negative effects.

4.5.5.3 Recommendations

- Create or strengthen institutional mechanisms so that women and girls can report acts of violence against them in a safe and confidential environment, free from the fear of penalties or retaliation, and stigmatisation.
- Provide women who are subjected to violence with access to the mechanisms of justice and, as provided for by national legislation, to just and effective remedies for the harm they have suffered; and inform women of their rights in seeking redress through such mechanisms.
- Ensure the provision of free or low-cost legal aid, where it is needed, as well as appropriate assistance to enable survivors to deal with their plight.
- Ensure that there are programmes that continuously remind police of their obligation to ensure that victims should always be prioritised and their concerns taken seriously at all times.

4.6 Recommendations for future research

One of the limitations of this research was that the study was carried out in only one out of the fourteen regions of Namibia (Khomas), which means that the results cannot be generalised. It is therefore recommended that the study be carried out on a bigger scale or replicated in other regions so that the results obtained can be generalised with greater confidence. Furthermore similar research could also be conducted across countries in the SADC region, so as to obtain even wider insights into the challenges faced but the rape survivors.

It is further recommended that further research could focus on the challenges that are faced at institutional level in trying to support the plight of rape survivors. This will

enable the identification of some of the probable reasons why the challenges faced by rape survivors are not being addressed as expected.

4.7 Final concluding remarks

It is finally concluded that, in spite of the limitation identified, this research has managed to achieve its key objectives. Survivors of rape in the Khomas region of Namibia face many challenges in accessing health and support services and these need to be addressed at various levels. Close collaboration is required between relevant stakeholders such as healthcare workers, police, communities, the legal justice system and policy makers. This will assist in the development of more effective policies and the building systems and institutions that are more effective in offering support to survivors of rape.

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APPENDICES

APPENDIX 1: ETHICS APPROVAL LETTER

UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA

Faculty of Humanities
Research Ethics Committee

7 September 2018

Dear Ms Tambo

Project:	**Challenges in accessing health care support services encountered by rape victims in Khomas region, Namibia**
Researcher:	**P Tambo**
Supervisor:	**Dr CL Carbonatto**
Department:	**Social Work and Criminology**
Reference number:	**15262520 (GW20180829HS)**

Thank you for the application that was submitted for ethical consideration.

I am pleased to inform you that the above application was **approved** by the **Research Ethics Committee** at the meeting held on 6 September 2018. Data collection may therefore commence.

Please note that this approval is based on the assumption that the research will be carried out along the lines laid out in the proposal. Should the actual research depart significantly from the proposed research, it will be necessary to apply for a new research approval and ethical clearance.

We wish you success with the project.

Sincerely

Prof Maxi Schoeman
Deputy Dean: Postgraduate and Research Ethics
Faculty of Humanities
UNIVERSITY OF PRETORIA
e-mail: PGHumanities@up.ac.za

cc: Dr CL Carbonatto (Supervisor)
Prof A Lombard (HoD)

Fakulteit Geesteswetenskappe
Lefapha la Bomotho

Research Ethics Committee Members: Prof MME Schoeman (Deputy Dean); Prof KL Harris; Mr A Bizos; Dr L Blokland; Dr K Booyens; Dr A-M de Beer; Ms A dos Santos; Dr R Fasselt; Ms KT Govinder Andrew; Dr E Johnson; Dr W Ketleher; Mr A Mohamed; Dr C Puttergill; Dr D Reyburn; Dr M Soer; Prof E Taljard; Prof V Thebe; Ms B Tsebe; Ms D Mokalapa

APPENDIX 2: PERMISSION TO CONDUCT RESEARCH

REPUBLIC OF NAMIBIA

MINISTRY OF GENDER EQUALITY AND CHILD WELFARE

Tel: + 264 61 283 3111
Fax: + 264 61 238 941/240 898
E-mail: genderequality@mgecw.gov.na

Private Bag 13359
Windhoek
Namibia

Our Ref.: S.9/1
Your Ref.: .....
Inquiries: Mrs. H. Andjamba

15 June 2018

Ms. Prisca Tambo
Department of Social Work and Criminology
University of Pretoria
Student Number: 15262520
South Africa

Dear Ms. Tambo

RE: REQUEST FOR PERMISSION TO PERFORM EMPERICAL RESEARCH: PRISCA TAMBO STUDENT NUMBER: 15262520

We would like to hereby acknowledge receipt of your letter dated 24 April 2018 on the above mentioned subject.

The Ministry would like to commend you on undertaking this study in the Khomas region. Considering the objectives of the study as per your request, the Ministry would gladly support it since the outcome might also inform future programme formulation for the social workers that are providing support services to the survivors of abuse.

We are looking forward to receive a copy of the study once it is completed.

Yours sincerely,

Wilhencia Uiras (Mrs.)
PERMANENT SECRETARY

2018 -06- 16

APPENDIX 3: LETTER REQUESTING PERMISSION TO CONDUCT RESEARCH

UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA

Faculty of Humanities
Department of Social Work and Criminology

24 April 2018

Ref. P Tambo (15262520)
Tel. 0813668180
E-mail: Principal researcher: prisca.tambo@yahoo.com
Supervisor: Charlene.carbonatto@up.ac.za

The Permanent Secretary
Ministry of Gender, Equality and Child Welfare
Gender Based Violence Protection Unit Directorate
Private Bag 13359
Windhoek

Dear Madam/Sir

REQUEST FOR PERMISSION TO PERFORM EMPIRICAL RESEARCH: PRISCA TAMBO STUDENT NUMBER: 15262520

The above-named postgraduate student is registered for the Master in Social Work (Healthcare) programme at the Department of Social Work and Criminology, University of Pretoria.

A requirement besides the coursework modules in the first year, is to conduct research and write a mini-dissertation, resulting from a research project, under my supervision. The research will only proceed once a departmental Research Panel and the Faculty Research Ethics Committee has approved the proposal and data collection instrument(s). The following information from the research proposal is shared with you, although a copy of the research proposal will be provided to you if needed. The envisaged title of the study is: Challenges in accessing health care support services encountered by rape victims in Khomas region in Namibia. The goal of the study is: To explore and describe the challenges faced by survivors of rape in the Khomas region of Namibia in accessing health and support services. The objectives of the study are:

- To describe rape as a form of gender-based violence and explore the socio-economic, emotional and psychological challenges experienced by rape survivors in the Khomas region of Namibia.
- To identify the health care support services that are available in Namibia for survivors of rape.
- To assess the challenges that the survivors of rape face in accessing health and support services.
- To make recommendations for improved intervention.

The envisaged target group of the study is: Female survivors of rape between the ages of 20 to 50 years, who have reported and opened a case with the Gender Based Violence Protection Unit and the Police in the Khomas region in Namibia. The empirical part of the study will entail conducting personal interviews using an interview schedule with your clients. This request will require practical assistance from your staff in sharing the details of this study with your clients as potential participants, and if they are interested in partaking voluntarily, gathering their contact details which researcher will collect in order to contact them. They will be required to sign an informed consent form before an appointment for the interview is arranged with them. No costs will be incurred by this request.
Possible benefits for your organization can be summarised as follows:

The study will help professionals to better understand the challenges faced by rape victims in accessing services and will provide recommendations that will help to improve the delivery of service to victims of rape.

A copy of the final report results will be made available to your organisation after completion. It would be appreciated if you will please consider the above request favourably and grant permission on a letter with a formal letter head to proceed with the project, at your earliest convenient date.

Yours sincerely,

DR CL CARBONATTO: SUPERVISOR

MS P TAMBO: POSTGRADUATE STUDENT AND RESEARCHER

APPENDIX 4: INTERVIEW GUIDE

TITLE OF STUDY: Challenges in accessing health care support services encountered by rape victims in Khomas region, Namibia.

SECTION A: DEMOGRAPHIC INFORMATION

1. What is your occupation?
2. What is your highest educational qualification?
3. In what age range do you fall

18-20	21-25	26-30	31-35	36-40	41-45	46-50	51-55	56-60	60+

4. What is your marital status

Married	Single	Divorced	Widowed	Cohabiting

5. In which suburb of Windhoek do you stay?

SECTION B: INTERVIEW SCHEDULE THEMES

Primary Question

Tell me about the rape and the challenges you faced in accessing support services.

Secondary Questions for probing

The rape incident

- What were you doing prior to the incident?
- Is there anything about the rape incident that you will feel comfortable to share with me?
- What was the worst thing for you?
- What sticks to your mind?
- What were the feelings you remember?
- What thoughts went through your mind?

Directly after the rape

- What do you remember happening after the incident?
- Who was the first person you told and what was their reaction?

Seeking help

- Tell me how you went about seeking help
- What challenges did you encounter when you were trying to get help?
- Tell me about other assistance would needed and would have appreciated?
- What do you think could have been done better to help you?

Services utilised

Tell me about the services you accessed

- Domestic violence helpline

- Counselling services
- Treatment services
- Temporary shelter care services
- Police services
- Any other services

What is your perception of the adequacy and efficiency of the service that you received?

Consequences of the rape

Tell me of any challenges you encountered as a result of the rape?

Emotional
Personal
Relationships
Social
Health
Work
Other

Thank you very much. This is the end of our interview. Your participation is greatly appreciated. Please feel free to contact me if need be.

My telephone number is **0813668180.**

APPENDIX 5: LETTER OF INFORMED CONSENT

UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA

Faculty of Humanities
Department of Social Work and Criminology

PRINCIPAL INVESTIGATOR/RESEARCHER: Prisca Tambo
Telephone: +264813668180
E-mail: prisca.tambo@yahoo.com

LETTER OF INFORMED CONSENT

A. STUDY INFORMATION

TITLE OF STUDY

Challenges in accessing health care support services encountered by rape victims in Khomas region, Namibia.

1. INTRODUCTION

The researcher is currently studying towards a Master's Degree in Social Work (Healthcare) at the University of Pretoria. One of the requirements for the completion of this degree is to conduct research on a relevant topic in the field of study and present the findings in a mini-dissertation. You are being kindly requested to voluntarily take part in this research study. Before you decide to participate in this study, it is important that you understand why the research is being done and what it will involve. Please read the following information carefully. You can ask the researcher if there is anything that is not clear or if you need more information.

2. PURPOSE OF STUDY

The main goal of this study is to explore and describe the challenges faced by survivors of rape in the Khomas region, Namibia in accessing health and support services.

3. STUDY PROCEDURES

Participation in this study is voluntary. It will involve an interview of approximately 45 to 60 minutes duration and will be conducted at a mutually agreed upon location. With your permission, the interview will be voice-recorded to facilitate collection of information, and later transcribed for analysis. If you are willing to participate in the research, you will be requested to sign the informed consent letter at the end of this document, before the interview is conducted.

4. RISKS

Your participation in this study might re-awaken some emotions linked to the traumatic incident. Should you experience any emotional harm or discomfort as a result of the interview, you may withdraw from the study at any time. The researcher will do debriefing with you after the interview. If needed, you will be referred for counselling to the internal social worker of the organisation.

5. BENEFITS

Taking part in this research study may not benefit you personally, but will help the researcher to understand in order to make recommendations that will help to improve the delivery of services to victims of rape in the future. The outcome of the study will help professionals understand the challenges faced by rape victims in accessing services and thus be able to assist in this regard.

6. RIGHTS OF PARTICIPANTS

You are assured that this study has been approved by the Research Ethics Committee of the Faculty of Humanities, University of Pretoria. However, the final decision about participation is yours. If you have any comments or concerns resulting from your participation in this study, please contact the researcher at the contact details provided above. The researcher will share the main findings of the research with all participants, once the study is completed. You may with draw from the study at any time without any consequences. If you withdraw from the study your data will be destroyed.

7. CONFIDENTIALITY

Your study data will be handled with strict confidentiality and only the researcher and her supervisor will have access. You will be assigned a number before the interview, which will be used to protect your identity and ensure confidentiality. Only the researcher will know which number is linked to which participant. If results of this study are published or presented at a conference, no names or personally identifiable information will be used, only the number. All data will be saved with a code number. Data will be stored at the Dept. of Social Work and Criminology, University of Pretoria as required for 15 years for possible further research and archival purposes.

8. RIGHT OF ACCESS TO THE RESEARCHER

You will have access to the researcher for the duration of the study and for a period of three months after completion of the study. You can contact the researcher, Mrs Prisca Tambo at the following number: + 264813668180 at any time during office hours.

Please sign consent on the next page if you voluntary agree to participate in study.

Yours sincerely,

Prisca Tambo (Principle investigator)

B. INFORMED CONSENT

I have read and I understand the information provided above. I have had the opportunity to ask questions. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving a reason and without any consequences. I understand that I will be given a copy of this consent form. I voluntarily agree to take part in this study.

Participant's signature_____ Date_____

Principal Investigator's signature _____ Date _____