SERVICE DELIVERY WITHIN THE CRIMINAL JUSTICE SYSTEM: THE EXPERIENCES OF ADULT FEMALE RAPE SURVIVORS AND SERVICE PROVIDERS

BY

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DECLARATION

I, Nigel Bradely Bougard, declare that the thesis entitled *Service delivery within the criminal justice system: The experiences of adult female rape survivors and service providers*, submitted in fulfilment of the degree Doctor of Philosophy Criminology at the University of Pretoria, is my own work has not previously been submitted for a degree at another university. Additionally, all sources cited were acknowledged and indicated.

_____ 31/08/2022

NB Bougard Date

ETHICS STATEMENT

The author, whose name appears on the title page of this thesis, has obtained, for the research described in this work, the applicable research ethics approval. The author declares that he has observed the ethical standards required in terms of the University of Pretoria's Code of ethics for researchers and the Policy guidelines for responsible research.

ABSTRACT

The aim of the study was to investigate the quality of post-rape services rendered to adult female rape survivors within the criminal justice system. The population comprised of both adult female rape survivors and service providers in the Gauteng province, South Africa. From this population the sample consist of 17 adult female rape survivors and 28 service providers. The data was gathered by means of a semi-structured interview schedule. The data was analysed by means of thematic content analysis.

The research paradigm was facilitated from a positivist approach since the researcher explored and described the lived experiences of rape survivors and service providers regarding the quality of post-rape services in South Africa. The research type was applied intervention research since the research proposed recommendations for improving the quality of post-rape services to adult female rape survivors. Different types of probability sampling were used in this study. Stratified probability sampling was followed to document the perspectives of service providers while convenience sampling was implemented to explore the experiences of adult female rape survivors regarding the quality of service rendering.

The study found that although certain modes of service were satisfactory, discrepancies in the quality of perceived post-rape services emerged across three medico-legal research sites. In the end, the researcher proposed key components of a post-rape service delivery prototype model emanating from the participants' perceived advancements, challenges, and recommendations regarding rendering post-rape services to adult female rape survivors within the criminal justice system.

KEY TERMS: Service Delivery, Rape, Survivor, Service Providers, Service quality, Criminal Justice System.

DEDICATED TO ALL RAPE SURVIVORS

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LIST OF ACRONYMS

AIDS- Acquired Immunodeficiency Syndrome

CJS- Criminal Justice System

DNA- Deoxyribonucleic Acid

HIV- Human Immunodeficiency Syndrome

NGO- Non-governmental organisations

NPA- National Prosecuting Authority

NPO- Non-profit organisations

PEP- Post-exposure Prophylaxis

PTSD-Posttraumatic Stress Disorder

RS-Research site

SAPS- South African Police Service

STI- Sexually Transmitted Infection

CHAPTER ONE: INTRODUCTION AND ORIENTATION TO THE STUDY

1.1 INTRODUCTION

Various services are available to assist rape survivors and their families in coping with the aftermath of rape. Services may be based at police stations, courts, health facilities and non-profit organisations (NPOs). In rendering post-rape services, the different stakeholders seek to address the health, psychosocial and legal needs of rape survivors. Unfortunately, significant shortfalls (financial challenges, human resources and unequal distribution of resources) in these services and substantial variations in the quality of services in practice create the impression that not all survivors of rape receive the same array and quality of services and care (NACOSA, 2021). In response to addressing the gaps in post-rape services to adult female rape survivors within the South African criminal justice system (CJS), the Thuthuzela Care Centres emerged, which connect the police, health services and psychosocial services under one roof. The motivation for rendering services (medical, medico-legal, legal, and psychosocial services) within one facility was prompted by South African government agencies (National Prosecuting Authority [NPA], Department of Health, Department of Social Development and South African Police Service [SAPS]) with the prospects to reduce secondary victimisation, reduce case cycle time and advance conviction rates. The number of Thuthuzela Care Centres has been steadily increasing, and by 2013, there were 52 centres, with 51 of these Thuthuzela Care Centres fully functional (Waterhouse, Artz, Vetten, Lalu, Rezant, Valentine & Van Niekerk, 2013:7).

In 2010 the highest incidence of rape globally, was recorded in South Africa namely 132.4 incidents of rape per 100,000 people. During this time, there appeared to be a lack of support services offered to rape survivors. A lack of support services may be influenced amongst others by the underlying stigma in reporting the crime of rape, which leaves complainants frustrated in reporting the incident, unwarranted negative treatment by service providers within the CJS that

creates a lack of trust in victims towards the CJS, and limited referral to specialised post-rape services. Other African countries such as Botswana indicated 92 incidents per 100,000 individuals, followed by Lesotho projecting 82.6 incidents per 100,000 people within sub-Saharan Africa in 2022. Sweden presented 63.5 incidents per 100, 000 people during 2022 (NACOSA, 2015:2; Rape Statistics by Country, 2022; Reimagining services for rape survivors, 2021). In the Gauteng province, being the largest of the nine provinces (according to population density) in South Africa, it is predicted that more than half of women (51.3%) have been exposed to or experienced some form of emotional, financial and/or sexual violence and abuse in their lifetime, with a staggering 75.5% of men within the same province having self-confessed to committing some form of violence against women. A significant number of men (37.4%) admitted that they had raped someone. One in 13 women conveyed non-partner rape, whereas only one in 25 rapes had been reported to the police (Machisa, Jewkes, Lowe-Morna & Rama, 2011:9).

Rape inflicted upon women remains a staid challenge in South Africa. The annual rape statistics in South Africa for the year 2018/2019 increased by 4.6%, compared with the previous year (54 420 reported cases) (South African Police Service [SAPS] Crime Statistics April to March 2018/2019). Despite the high incidence of rape, victims may be reluctant to report the incident, as seen in the 2019/2020 Victims of Crime Survey, which indicated that 60% of survivors of a sexual offence reported the incident to the police. This is a decrease from 88% of survivors who reported a sexual offence in the previous financial year (2018/2019) (Statistics South Africa, 2020:24). Furthermore, a comparative statistical analysis regarding statistics from the SAPS and Statistics South Africa found that the 2016/2017 SAPS statistics, which comprised 80% of reported sexual offences, aligned with Statistics South Africa's projection that 68.5% of victims of sexual offences were women, with a crude approximation of 138 incidences reported per 100 000, which is considered as being the highest globally (SAPS Crime Statistics April to March 2018/2019; Statistics South Africa, 2018:8).

More recent figures regarding the incidence and prevalence of rape in South Africa indicated that 10 006 individuals were raped from April to June 2021. The year 2021 marked an increase of 4 201 reported rape incidences, with an increase of 72.4% compared to the same period of the previous year. Furthermore, an analysis of a sample of 5 439 rape cases indicated that 3 766 of the rape incidents occurred at the victim's home or the home of the alleged rapist. Notably, 487 reported rape cases were deemed the result of domestic violence since domestic violence soared during the lockdown period imposed during the year 2020 due to COVID-19 (SAPS Crime Statistics April to March 2020/2021).

Rape is classified to be a form of maltreatment. The scope and extent thereof remain limited and questionable, as official crime statistics relating to the phenomenon do not always accurately reflect crimes committed. In addition, a lack of separate figures on sexual offence cases from the SAPS has been limited by changes in reporting offences by the Department of Justice and Constitutional Development, including the NPA. The Department of Justice and Constitutional Development and the NPA do not exclusively separate conviction rates for different sex crimes due to the underreporting of crime, known as the dark figure. No separation of statistics within the various categories of sexual offences affects the capacity to evaluate the functioning of the CJS in its response to the broader scope of sexual offences in general. We have knowledge pertaining to the nature of sexual offences but not the true extent thereof within the South African context (Booyens, Beukman & Bezuidenhout, 2008:51; Spies, Delport & Le Roux, 2015:672; Townsend, Waterhouse & Nomdo, 2014:76).

After a sexual offence, the victim may experience medical, medico-legal, psychosocial and legal consequences that service providers must address. The researcher will briefly highlight these consequences and their respective victim needs. Rape can lead to various medical or health-related challenges, including physical, reproductive and psychological ailments. Additionally, medical consequences of rape, such as sexually transmitted infections (STI), prevention of pregnancy, and other chronic medical conditions, present challenges for the adult female rape survivors and their families (Jina & Thomas, 2013:16; World Health Organization [WHO], 2019:1). The burden on the healthcare system

regarding post-rape services can be broadly grouped into immediate effects directly emanating from the rape, whereas medium- to long-term consequences surfaces over a more extended period (Jina & Thomas, 2013:16: WHO, 2019:23-26). The medico-legal examination comprises a detailed and systematic physical examination of the survivor of rape, inclusive of a genito-anal examination. Forensic evidence is only substantial in legal proceedings if collected within 96 hours (4 days) of the rape, although the likelihood of finding any evidence significantly reduces after 72 hours (3 days). Anogenital injuries may create the impression that finding the basic evidence of genital injury to corroborate an allegation of rape may lead to a successful report, trial, or conviction, with a skewed effect resulting in converse expectations. In addition, using micro-visualisation technologies may increase the chances of a conviction, although it may also contribute to secondary victimisation. Micro-visualisation may present itself due to the intrusive and possibly chastening nature of the use of technology (Jina, Jewkes, Munjanja, José & Dartnall, 2010:88; White, 2013:114). The psychosocial challenges of rape vary and depend largely on the individual rape survivor. The psychosocial consequences of rape may be immediate (expressive and tearful emotional outbursts, ensued by shock, denial, guilt, self-blame and feelings of distress), medium (fear and unease) and long-term (posttraumatic stress disorder [PTSD], depression, substance-facilitated ailments, and suicidal thoughts and attempts) (Mason & Lodrick, 2013:31; Parcesepe, Martin, Mclean, García-Moreno, 2015:16; Ullman, Filipas, Townsend, & Starzynski, 2006:129).

Lastly, the legal aspects that come into play for the rape victim entail the delay of or simply refraining from reporting the rape incident, emanating from the perceived fear that the role players within the CJS will treat them differently or even place some form of fault regarding their actions, before the occurrence of the alleged crime of rape (Skinnider, Montgomery & Garret, 2017:vii). More importantly, cases can be removed from the criminal justice process during four imperative points within the justice process being the initial reporting phase (when the police decide if an alleged rape had occurred based on the statement of the rape survivor); the investigation phase (identification of the offender and collection of evidence); pre-trial phase (when the legal service providers finalise

the merits of the case); and the trial phase (when a presiding officer delivers a judgement). Moreover, criminal proceedings can become long and exhaustive for adult female rape survivors within the CJS. The role players in the CJS focus primarily on physical and forensic evidence, as well as the credibility of the victim, while oftentimes presumably neglecting the stance of the adult female rape survivors' absence of consent in relation to the crime of rape (Banovic & Vujosevic, 2019:32-33, 39: Skinnider et al., 2017:xi).

Due to the extent, seriousness, and impact of sexual offences on the victim, post-rape services offered to survivors are imperative. Regarding the perceived quality of post-rape services within the CJS globally, research conducted by Rossetti, Mayes and Moroz (2017) found that rape survivors' satisfaction levels towards the CJS are substantially divided, depending on their personal experience. Although the majority of victims of rape experienced favourable outcomes regarding being treated fairly and with sensitivity, regrettably, many are also disappointed with the outcome of their case in the CJS. Moreover, victims of rape prefer high-quality support, which in return serves as a motivation for restoring confidence within the CJS (Rossetti et al., 2017:8, 20).

There exists a dearth of information regarding an integrated mode of post-rape services for adult female rape survivors. As a result of this dearth, the current study will investigate the four spheres of service rendering to adult female rape survivors, namely the medical, medico-legal, psychosocial, and legal spheres within the CJS.

1.2 DEFINITION OF THE KEY CONCEPTS

For the purpose of this study, the key concepts rape, survivors/victims, service providers, service quality, and CJS must be conceptualised from the outset:

1.2.1. RAPE

> According to South African law, specifically, Section 3 of the Criminal Law (Sexual Offences and Related Matters) Amendment Act 32 of 2007, any person who unlawfully and intentionally commits an act of sexual

penetration with a complainant without the consent of the complainant is guilty of the offence rape. In Section 1 of this Act, sexual penetration is described as:

(a) the genital organs of one person into or beyond the genital organs, anus or mouth of another person;

(b) any other part of the body of one person or any object, including any part of the body of an animal, into or beyond the genital organs or anus of another person; or

(c) the genital organs of an animal, into or beyond the mouth of another person.

As this study focuses on the South African adult female rape survivor, the researcher will utilise the definition of rape provided in the Criminal Law (Sexual Offences and Related Matters) Amendment Act 32 of 2007 throughout the study without any amendments and/or additions.

1.2.2. SURVIVORS/ VICTIMS

The concept of survivor transpires to the strength of a person who had been raped, which is further ascribed to bear meanings of optimism, activity, resilience and positive coping mechanisms in dealing with a potentially life-threatening encounter (Papendick & Bohner, 2017:2). More importantly, survivors are individuals who experienced an adverse incident; and survived despite adversity. Additionally, survivors do not necessarily perceive themselves as victims; they have gained, to an extent, strength and reliance in coming to terms with the ordeal they had suffered (Mason & Lodrick, 2013:27; Victim or Survivor: Terminology from Investigation Through Prosecution, s.a.). A victim refers to an individual subjected to a crime that aspires to provide recognition and intervention under the law. At the same time, a survivor relates more to a sense of empowerment within the CJS (Victim or Survivor: Terminology from Investigation Through Prosecution, s.a.).

The researcher defines a survivor as an individual who opts to persevere, despite having suffered harm but does not necessarily perceive themselves as victims. In contrast, the term victim is a legal connotation assigned to an individual who suffered loss or harm as recognised by prescribed laws. For the study, the terms survivor and victim will be used interchangeably.

1.2.3. SERVICE PROVIDERS

A service provider is regarded as an individual, professional entity or organisation that renders subsidised or sponsored services to a specific group of individuals. Service providers have various areas of expertise (i.e., medical, medico-legal, psychosocial and legal experience within the CJS) (National Disability Insurance Agency, s.a.). A service provider can also be a person or organisation assigned to provide services to a specific party (i.e., adult female rape survivors within the CJS). The rendering of services between a service provider and a company is characteristically regulated by a service contract (CooleyGo, 2022).

The researcher defines a service provider as an individual or entity (medical, medico-legal, psychosocial and legal practitioners) tasked with rendering a specific service to a designated group of individuals within the CJS.

1.2.4. SERVICE QUALITY

Service quality is directly linked to the perceived perceptions of the recipient of services (Prakash & Mohanty, 2012:3). Service quality typically seeks to address the ‘how’ and ‘what’ components of service rendering. The ‘what’ notion of service quality relates to the output/ impact of the service on the client (what kind of services are provided to adult female rape survivors within the CJS). The ‘how’ component of service quality entails processes of service delivery (i.e., the way in which the adult female rape survivor was treated within the CJS). There is a close relationship between the service provider and the recipient thereof, with the aim to achieve a certain purpose (i.e., service providers rendering a satisfactory level of services to adult female rape survivors within the CJS). Due to the presence of human involvement and interaction, the quality of services may vary

across various settings. Since services are insubstantial, applying all standards systematically and reliably might be challenging. Furthermore, it may also be problematic to determine definite standards of service rendering; categorise quality assurance measures, and facilitate the regulation and implementation of a set of services. Additionally, service quality is problematic since it operates and functions within different structures (Gandhi, Sachdeva & Gupta, 2018:456).

The following four factors pertaining to service quality in relation to the study have been identified (Gandhi et al., 2018:464-465):

- *Dependability* refers to the notion of rendering services to adult female rape survivors within the CJS swiftly and honestly;
- *Agility* is the ability to effectively respond to unexpected changes in necessities and external disturbances when rendering services to adult female rape survivors within the CJS;
- *Professionalism* denotes the enthusiasm and values service providers emanate when rendering services to adult female rape within the CJS; and
- *Understanding* implies that the service provider needs to be familiar with the needs of the recipient of their services, being adult female rape survivors within the CJS.

For this study, service quality is defined as the satisfaction levels perceived by the recipient of services, guided by dependability, agility, professionalism, and understanding.

1.2.5. CRIMINAL JUSTICE SYSTEM

The CJS is a system of legal procedures within courts that deals with implementing criminal laws, including laws that forbid sexual violation. Key mechanisms and role players are the plaintiff (the victim/survivor of the sexual violence), the accused (the alleged perpetrator), the police, lawyers, presiding officers and the court system itself. Forensic evidence collection (medico-legal services) is also part of this system. In South Africa, the CJS functions under the

directives of the Department of Justice and Constitutional Development, which serves as an all-encompassing structure governing justice-related structures which strives to protect the rights of both the accused and victims of crime (Booyens, 2020:67; Mossman, Jordan, MacGibbon, Kingi & Moore, 2009:68; Regoli, Hewitt & Kosloski, 2018:296). The CJS comprises of three phases namely (a) reporting the crime to police by the complaint, (b) the investigation of the case by the police and the arrest of the alleged offender, and (c) the prosecution of the case (An overview of the South African Criminal Legal Justice System, 2021; The Criminal Justice and You: A Guide to the South African Criminal Justice System For Refugees and Migrants, s.a.:14-16).

The researcher defines the CJS as in an interdisciplinary mechanism which predominantly deals with offenders and victims of crime, procedural processes and intervention strategies to uphold the law.

1.3. RATIONALE AND PROBLEM STATEMENT

The rampant prevalence of rape in South Africa and the desire to eradicate these crimes as a priority problem are well documented (Ministerial Advisory Task Team on the Adjudication of Sexual Offences Matters, 2013:8). Conversely, the policy framework addressing the prevalence of rape is insufficient (Waterhouse et al., 2013:2). Policies drafted to manage and eradicate sexual offences such as rape in South Africa derived from the Department of Justice and Constitutional Development and the NPA. Despite these policies, South Africa has seen a setback in policy decisions over the years, discrepancies and shortfalls in responses, and inadequate budgeting and operational planning to combat sexual offences (NACOSA, 2018:10; Triangle Project Policy Brief, 2016:3). Statistics on the performance of role players in the CJS in relation to sexual offences are scant, making it challenging to assess the impact of the change in legislation and policy framework, which are ingenuities designed to curb sexual offences (Sibanda-Moyo, Khonje & Brobbey, 2017:6). Regardless of the challenges in rendering post-rape services being viewed as a priority, the lack of concrete, detailed planning to address sexual offences by the Department of Justice and

Constitutional Development and the National Prosecuting Authority's strategies and the implementation of policies and legislation becomes questionable (Waterhouse et al., 2013:2).

Notwithstanding the concealed subsidisation of the CJS's response to rape by stakeholders, certain role players are not remunerated for the services they provide in the Thuthuzela Care Centres or the psychological assessments and other documents they prepare for courts. In the current economic situation, this occurrence may lead to deserting these services, as non-governmental organisations are forced to close or reduce the scope of their mode of service rendered to survivors of sexual violence. Meaningful consultation with non-governmental organisations providing these services within the domain of policies and operational plans addressing sexual offences is thus warranted. Additionally, it was anticipated by service providers within the CJS that the National Policy Framework be amended to address numerous gaps in policy within the Department of Justice and Constitutional Development in addressing rape (Waterhouse et al., 2013:2). A succinct and detailed overview of the duties and onuses imposed upon all role players in managing sexual offences also needs consensus. Developing a comprehensive policy pertaining to aspects of the terms of reference in rendering services within the CJS is thus crucial. These facets within the CJS include but are not limited to the prosecution of sexual offences; court preparation; psychosocial services; the proficiencies and training of personnel working in this field; the infrastructure and resources required to make the policy a material reality; and the satisfactory payment of services rendered (which is inclusive of the Department(s) responsibilities for the financing of such services) (Waterhouse et al., 2013:2). The study contributes to law, social work, medicine and forensic medicine (medico-legal).

Nazma Hendricks, Director of Rape Crisis in South Africa, believes that the Thuthuzela Care Centre model is costly; and an adaptive, improved, and consistent mode of service rendering to rape victims should be of essence (NACOSA, 2021). Advocate Bonnie Currie-Gamwo, Special Director of Public Prosecutions, NPA, responded to the inconsistencies in service rendering within the Thuthuzela Care Centre model by indicating that the NPA was exploring new

methods in facilitating a uniform mode of service rendering to rape survivors in South Africa. Furthermore, the Director of Clinical Forensic Medicine Services, Department of Health, Mohau Makhosane, articulated that no single model should be perceived as being fully effective; and a need for adaption is crucial in this regard (NACOSA, 2021). Considering the assertions by Hendricks and Makhosane, the researcher believes that post-rape services for adult women should be more flexible and adjustable with the prospects of a uniform mode of service rendering, which the current study investigated.

After a review of all the deliberations relating to an all-encompassing mode of service rendering to adult female rape survivors within the CJS, the research question was:

- What are the experiences of adult female rape survivors and service providers regarding the quality of service delivery within the CJS?

The following sub-research questions guided the research:

- What are the protocols, processes and legislation that the different service providers within the CJS employ in relation to quality service rendered to adult female rape survivors within the CJS?
- How can a proposed all-encompassing service delivery model to adult female rape survivors within the CJS benefit both service providers and the recipients?

1.4. AIM AND OBJECTIVES OF THE STUDY

The aim and objectives are directed by the research question, with a clear perspective of what the researcher intends to achieve (Nieuwenhuis, 2016:73; Holloway & Galvin, 2017:30). The research aim is thus to explore and describe the experiences of adult female rape survivors (being the recipients of services); and stakeholders (being the providers of services) regarding the quality of service delivery within the CJS.

In order to achieve the aim of the study, the following objectives guided the research being undertaken, namely:

- To conceptualise and describe a global view on the quality of service delivery to adult female rape survivors in the CJS.
- To contextualise and ascertain the roles and duties of the various service providers in terms of the quality of service delivery to adult female rape survivors within the CJS;
- To explore and describe the various protocols, processes and legislation that the different service providers within the CJS apply in relation to quality service rendering to adult female rape survivors within the CJS;
- To identify the needs in terms of service delivery of adult female rape survivors within the CJS;
- To examine and explore the achievements and challenges in rendering services to adult female rape survivors from the point of entry to exit within the CJS; and
- Emanating from the research findings, propose components of a holistic prototype model pertaining to the quality of service rendered to adult female rape survivors within the CJS (inclusive in legalisation and policies).

1.5. OVERVIEW OF METHODOLOGY

To accomplish the aim and objectives of the current study, the researcher adopted the qualitative research approach. This approach was chosen as the researcher wished to investigate a complex phenomenon such as rendering services to adult female rape survivors within the CJS (Leedy & Ormrod, 2019:88). The type of research was applied research since the researcher investigated challenges in rendering services to adult female rape survivors within a certain practical setting to suggest applied solutions that most probably might be considered for implementation (Bless, Higson-Smith & Sithole, 2013:389; Grinnell & Unrau, 2011:20; Neuman, 2011:27). The research design employed in this study was a multiple case study design since the researcher collected information pertaining to the experiences of both service providers and

the recipients thereof (being adult female rape survivors) within the CJS (Piekkari & Welch, 2018:345).

As two groups of research participants participated in this study, namely adult female rape survivors and service providers in the CJS, the researcher utilised two sampling techniques. Through purposive sampling, the researcher recruited and interviewed adult female rape survivors. The adult female rape survivors were recruited according to specific criteria with the assistance of service providers, such as the site coordinator, at the Thuthuzela Care Centres (Gravetter & Forzano, 2016:138). Stratified sampling was employed to explore service providers' perspectives (being medical, medico-legal, psychosocial and legal) in rendering services to adult female rape survivors (Engel & Schutt, 2014:101-102; Maree & Pietersen, 2020:195). In the end, 17 adult female survivors and 28 service providers participated in the study.

The data was gathered using telephonic and face-to-face interviews and analysed using thematic content analysis. Trustworthiness in relation to the study was achieved through credibility, confirmability, transferability, and dependability to safeguard the data quality.

1.6. DEMARCATION OF THE CHAPTERS

The demarcation of the thesis can be summarised as follows:

Chapter 1 was an introduction and orientation to the study. The key concepts were operationalised, the origin and rationale of the study were described, and the aim and objectives were stated. The chapter concluded with a synopsis of the research methods employed in this study.

Chapter 2 will highlight the dynamics and complexities of rape as a social phenomenon. The researcher will focus on the types of rape, the universal culture of rape, victim-blaming and the role of substance abuse. This chapter will also address the factors that determine the reporting of rape, provide an exposition of the consequences of rape and state the needs of adult female rape survivors in the CJS.

In Chapter 3, the researcher will present an exposition of the various modes of service rendered to adult female rape survivors, locally and abroad. Legislation, policy, guidelines and directives guided the researcher in explicating the current practice of service rendering to adult female rape survivors in South Africa.

Chapter 4 presents the theories applied in relation to the study. Several victimological theories, namely the routine activities theory; the lifestyle exposure theory; and the extended balance control theory, are explained. Furthermore, the ecological systems theory will be used to highlight the developmental needs and capacity of adult female rape survivors, inclusive of the impact (effect) of the CJS on adult female rape survivors in South Africa.

In Chapter 5, the researcher will explain the research methods and procedures used in the study regarding the research paradigm and the approach, the type of research and the research design. The study population, sampling, data collection method and instrument used, and data analysis are expanded. The chapter will also state the measurement quality, pilot study, and ethical considerations.

Chapter 6 will focus on the empirical findings of adult female rape survivors in accessing post-rape services. The biographic and demographic information of the participants will be outlined, and their experiences in relation to the medical, medico-legal, legal and psychosocial spheres of the services they received will be explored.

Chapter 7 disseminated the empirical findings of service providers in rendering post-rape services to adult female rape survivors in South Africa. The various service providers (medical, medico-legal, legal and psychosocial) highlighted the challenges, successes and innovations in rendering post-rape services to adult female rape survivors within the CJS.

Chapter 8 captures the conclusions and recommendations in rendering post-rape services to adult female rape survivors within the CJS. This chapter also showcases the prototype model for rendering services to adult female rape survivors within the CJS.

1.7. SUMMARY OF THE CHAPTER

The chapter highlighted the nature and extent of the crime of rape within the South African context, which led to the introduction of the Thuthuzela Care Centre model. Furthermore, the researcher highlighted service providers' challenges in addressing the medical, medico-legal, psychosocial, and legal needs of adult female rape survivors within the CJS. The key concepts in relation to the study were conceptualised and applied within the context of the study: rape, survivors/victims, service providers, service quality and CJS. The aim and objectives guided the researcher in exploring the mode of service rendered to adult female rape survivors within the CJS. Lastly, the research methodology in relation to the study was also outlined. The next chapter will investigate the dynamics and complexities of rape as a social phenomenon.

CHAPTER 2: THE DYNAMICS AND COMPLEXITIES OF RAPE AS A SOCIAL PHENOMENON

2.1. INTRODUCTION

Regardless of cumulative global acknowledgement and awareness of the problem of violence against women, one in every three women across the world continue to fall prey to various types of violence, including sexual violence, perpetrated against them, irrespective of their age, education, or income (Fattah & Camillia, 2017:2; United Nations, 2015; World Health Organization [WHO], 2019:4).

Violence perpetrated against women is considered an abuse of human rights, perceived as a distinctive result of gender inequality, a public health concern and an obstacle to sustainable development worldwide. Adolescent girls, young women, women from marginalised groups, and women with disabilities are subjected to numerous forms of violence. Universally, it is projected that 15 million adolescent girls (aged 15-19 years) have been exposed to sexual violence such as rape. In contrast, 30% of women have suffered physical and/or sexual violence at the hands of an intimate partner or stranger during their life (UNICEF, 2017:73, 82; WHO, 2019:4-5).

Of notable importance, most adolescent girls are vulnerable to the risk of coerced sexual penetration, usually inflicted by a boyfriend or former partner (UNICEF, 2017:73,78). Women with disabilities are the most affected individuals by sexual violence (Miles-Cohen, 2016:13). Due to various degrees of disabilities (i.e., cognitive impairment and/or physical disability), it becomes problematic to determine the precise prevalence and incidence rate of rape perpetrated against women with a disability. In addition, unequal access for women living with a disability is also greatly compounded in reporting the crime of rape (Miles-Cohen, 2016:13, 39). Violence adversely affects women’s physical and mental health and well-being. Women's mental health and well-being also adversely impact the social and economic costs within a community (WHO, 2019:4-5).

This chapter will provide an overview of the prevalent dynamics and complexities surrounding the crime of rape, aligned with the consequences and needs of adult female rape survivors within the CJS, more specifically, the medical, medico-legal psychosocial and legal spheres of service rendering.

2.2. THE DYNAMICS OF RAPE AS A SOCIAL PHENOMENON

In the subsequent section, the following dynamics of rape will be discussed: the types of rape, the universal culture of rape, victim-blaming, the role of substance abuse and rape, a synopsis of the victim and offender characteristics, and the factors determining the reporting of rape. Although this is not the focus of the study, it is important to refer to these dynamics as it will provide a more comprehensive understanding of the complexities of rape as a social phenomenon.

2.2.1. TYPES OF RAPE

Since the act of rape can transpire in various forms, the following discussion below outlines the types of rape within the context of the study.

2.2.1.1. Acquaintance rape

Acquaintance rape is committed by a person known to the victim, with whom the victim may or may not be involved intimately. It was found that in South Africa, acquaintance rape most often occurs in residential areas, hostels, or entertainment settings such as parties, nightclubs and bars (Machisa, Jina, Labuschagne, Vetten, Loots, Swemmer, Meyersfeld & Jewkes, 2017:18). Similarly, the term acquaintance rape has also been coined in instances whereby there has been some limited interface between the parties concerned before the alleged rape had occurred (Temkin, Gray & Barrett, 2018:208). Acquaintance rape is thus a category of a sexual offence in which unlawful sexual intercourse occurs without the consent of the victim by a perpetrator known to the victim.

Research conducted in the United States of America among female university students; found that they are more at risk of acquaintance rape, with an estimated

25% of college women becoming victims of rape in their lifetime. However, rape estimates vary depending on the type and region of the educational setting. University environments which may act as a compound for rape to ensue include but are not limited to unsupervised parties, access to alcohol, single students living alone in private rooms, and the presence of date rape drugs such as Rohypnol. The victim does not always report acquaintance rape due to possible unwanted publicity, fear of an unsavoury reputation and familial reactions to the crime (Hagan, 2011:225-226).

A national study conducted in 2012 aimed at identifying the attrition of rape through the CJS aligned with factors associated with rape found that sex offenders used non-violent tactics to subdue their victims. The sample comprised 3 952 cases of rape reported in the year 2012 at 170 police stations nationwide in South Africa. These strategies involved making the rape survivor feel as though they owed the alleged rapist (i.e., the alleged perpetrator bought the victim a gift or gave money); by badgering; tenacious attempts to have sexual contact when the victim had already refused; by threatening the victim or making them feel afraid; or employing drugs or alcohol to lower the victims' inhibitions, or react adversely to refusal. In 78.1% of the sample, the perpetrators also used non-violent methods to force their victims, whereas the most prevalent form of force imposed on the victim by a sex offender was exercising power or control over their victims (66.9%). This was most common when the alleged rapist was a family member, intimate partner or acquaintance (Machisa et al., 2017:18).

The nature of acquaintance rape influences the reporting of this sexual offence and the subsequent arrest of the sex offender. Most survivors of rape withdrew the case prior to the arrest of the alleged rapist (54.4%), followed by those survivors who withdrew the case because the perpetrator was a relative (35%). Rapes comprising a relative as the offender had the largest proportion of non-arrests (50.9%). However, police were most likely to secure an arrest (70%) when compared with stranger rapes (Machisa et al., 2017:18; *State v Ndlovu and Others*. ZASCA 70: All SA 760 (SCA), 2002:331).

Approximately one in five women reported experiencing sexual violence in their lifetime, and 15-20% of men reported having committed sexual violence against an intimate partner (Mills-Fairweather, Gruber, Dartnall, Mathews, Abrahams & Nduna, 2013:10). In most scenarios, intimate partner rape only accounts for a portion of other controlling behaviours and violent acts perpetrated by an alleged rapist against their partner driven by sexual entitlement (Smythe, 2015:23).

2.2.1.2. Corrective rape

"*Corrective*" rape denotes a situation in which a woman is raped in an attempt to "*cure*" her of lesbianism. Currently, in South Africa, there are no official statistics to corroborate incidences of corrective rape (Koraan & Geduld, 2015: 1931; Thomas, 2013:3).

An important element of *"corrective"* rape is the intention with which it is perpetrated against the victim (to cure the victim of lesbianism). Correcting a person implies that something is wrong with a particular individual that has the effect of "*pathologising*" a person. The second element frequently used in *"corrective"* rape is the inhuman means of executing the rape. This element, combined with the violent behaviour of the rapist, merits the conduct of a hate crime (Hames, 2011:87-91; Koraan & Geduld, 2015:1938). An example of such violence is the brutal murder and rape of 24-year-old Noxolo Nogwaza. It is alleged that she had been gang-raped, stoned and stabbed to death with broken glass. Her lifeless body with crushed head and face was found in an ally in Kwa Thema, outside of Johannesburg, on 24 April 2011 (Dumse, 2013; Koraan & Geduld, 2015:1928). Hate crimes against lesbians are also known as 'message crimes' and are not specifically aimed at an individual but to maintain social order. Men who rape lesbians in South Africa may anticipate expressing a message through the act of rape as a '*warning*' to other lesbian women. The message of raping lesbian women may also be directed at other men, stressing patriarchal power over women and asserting aggressive masculinity. Punitive forms of hetero-normative patriarchy in the form of rape; and the continuous threat of rape are safeguarded and sustained, as perceived attributes serve as an imperative

facet in support of the current social order. In other words, if the "*corrective rape"* of lesbians is envisioned to '*turn*' them into heterosexual women, it is also assumed to disprove, symbolically and often physically, what comprises their identities and existence (Thomas, 2013:5-6,17). However, Gontek (2007:18) believes that growing up in settings with intensely rooted patriarchal structures and heteronormativity creates difficult living circumstances for lesbian women.

Black lesbian women are most vulnerable to corrective rapes since lesbianism is considered taboo and not inherent to South African culture (Lake, 2017:2; Morrissey, 2013:72-91). Although the perception that homosexuality is *un-African* and *unnatural* persists in the media, scholars indicate that same-sex behaviour has a history that emerged as far as the sixteenth century (Epprecht, 2008:37). Nonetheless. At the same time, the empirical evidence disproves the notion that homosexuality is *unAfrican. I*t remains evident that sexuality remains greatly politicised (Lake, 2017:9). Research conducted by Breen and Nel (2011:46) regarding the reasons why African lesbians in townships are predominantly more susceptible to being raped and murdered found that rape was a form of retaliation by men who seek to punish lesbian women challenging traditional gender norms.

2.2.1.3. Marital rape

Marital rape is a form of sexual violence in which unlawful sexual intercourse occurs without the consent of the victim, perpetrated by a spouse or ex-husband, with the aid of force or threat thereof (Meshesha, 2014:vi; Wallace & Roberson, 2011:102). Marital rape comprises three categories, namely force-only rape, battering rape and obsessive rape. *Force-only rape* ensues when a husband asserts sexual activity within a marriage, which is similar to power rape (rape is a way of showing authority and control over the victim). *Battering rape* entails an extent of humiliation and degradation upon the female spouse within a marriage setting, comparable to anger rape (the rapist holds intense feelings of hostility towards women and is likely to inflict physical pain on the victim). *Obsessive rape* emanates due to fantasies that consist of impulses such as sexual sadism and fixations. A contributing factor to marital rape is a man's previous attitudes

towards the family, with a view that anything that happens within a marriage should remain private, including rape. Another contributing factor is financial dependency which makes it difficult or almost impossible for a woman to report the rape due to her reliance on her husband and preoccupation with a ferocity that functions on the notion that a culture of violence is acceptable and a form of sexual expression (Klopper & Bezuidenhout, 2020:335; Wallace & Roberson, 2011:102).

According to the "*Hale Doctrine"* developed by Sir William Hale, "a husband cannot be found guilty of raping his lawful wife, since she has already committed herself to such relationship through her marriage contract" (Gupta & Gupta, 2013:19; Meshesha, 2014:1). Correspondingly, the American legal system espoused the "*unities theory*", which asserted that "the legal existence of the wife is suspended during marriage" (Russel, 1983:376), as quoted by Meshesha (2014:2). The *"Hale Doctrine"* theoretical paradigm regarded women as the property of their husbands, as not being independent, which is contributory to marital rape in the absence of any legal penalties. It was only in the 1970s that the debate pertaining to marital rape was elevated and given attention by the Feminist Movement, which purported that marital rape is a significant concern that should be given social and legal appreciation and recognition. As a result of the feminist movement, the *"Hale Doctrine"* and *"unities theory"* were abolished (Duffy, 2013:3; Meshesha, 2014:2; United States Department of Justice, 2011).

Additionally, it has been argued that the criminalisation of marital rape contravenes the right to marital privacy of the husband since it entails state intrusion in his marriage. Although marital rape is criminalised in South Africa, young girls in rural parts of Ethiopia are subjected to arranged marriages at an early age. After being forced to marry an older male partner, who is more experienced than themselves, they are further imperilled to unwanted sexual intercourse (Meshesha, 2014:8; Pracher, 2010:3).

Machisa et al. (2017:18) believe that rape in South Africa within marriage or dating relationships is linked to several individual factors. These over-arching factors are patriarchal perceptions about the ownership of women and wishes to

subdue them, particularly in incidences of resistance when wanting to leave a relationship or refusing sex within a relationship. Other societal factors raising the incidence of marital rape include societal norms that support patriarchy, male dominance and male sexual entitlement. A woman's right to refuse sexual intercourse with an intimate partner is considered undesirable, making it challenging for women to refuse sex. Consequently, women are often reluctant to disclose marital or partner rape. Similarly, men who hold vigorous patriarchal opinions feel entitled to sex; and are more likely to rape their intimate partner (Machisa et al., 2017:18).

2.2.1.4. Stranger rape

Stranger rape occurs when the contact crime between the victim and offender occurs without having a prior relationship before the attack. This type of rape is especially challenging for the police to investigate. The main reason for difficulties experienced in stranger rape investigations is the absence of evidence for follow-up, which may lead to an arrest. In addition, a victim of stranger rape is usually attacked ambush-style by their attacker or tricked, followed by the rape. Data from the Swedish National Council for Crime Prevention indicate that in most instances, alcohol consumption plays a pivotal role in leading to the crime of stranger rape, which makes it difficult for victims to provide a detailed account of their experiences of the attack (Corovic, Christianson & Bergman, 2012:765).

In a single-victim attack by a stranger, the rapist tends to be more violent, threaten the victim verbally, and inflict physical abuse upon the victim prior to engaging in anal, vaginal or oral penetration (Park, Schlesinger, Pinizotto & Davis, 2008:231). Burgess and Holmstrom have identified different categories of stranger rape (Corovic, 2013:22). A *surprise attack* is when the rape occurs without any planning, which is usually more violent. A *con approach* is when the perpetrator ascertains some form of trust before raping the victim. The *confidence approach* is one in which the victim is alluded to by the offender under false pretences (Corovic, 2013: 22).

Rape cases perpetrated by strangers do not necessarily adhere to the so-called '*real rape'* description. Estrich (1987), as quoted by Hohl and Stanko (2015:328), defines *"real rape"* as rape committed by a stranger in a surprise attack, outdoors location, involving the use of force and a weapon, which is encountered with resistance by the rape survivor and the presence of noteworthy and clear visible injuries. In addition, an array of influences have been found with *"real rape"* (when a victim is not believed) reliant on factors such as the victim-perpetrator relationship, absence or lack of victim resistance and visible injuries, late reporting of the incident, discrepancies in the victim's version of the rape, victim mental health challenges and voluntary alcohol usage prior to the attack. These features are all considered in *"real rape"* and "*respectable woman*" stereotypes, and their effects on attrition through the CJS are mediated through a cycle of self-perpetuating aftermath of these stereotypes on police, prosecution and judicial decision-making processes (Hohl & Stanko, 2015:328; Lundrigan, Dhami & Agudelo, 2019:2).

Most rape survivors in stranger rape had spent some time with the alleged rapist prior to the crime, thus not corresponding to the "*complete stranger"* that attacks in an *"alleyway"* stereotype. The victim and alleged rapist would typically have met in a pub or club before the rape incident occurred. This is predominantly noticeable in concurrence with research findings pertaining to alcohol consumption and the victims' and offenders' ages. This new research suggests that stranger rape is strongly concomitant with night-time recreational activity and that the victim was attacked due to their susceptibility to ensuing alcohol consumption with their alleged rapist (Waterhouse et al., 2016:7).

The relationship between the rape survivor and offender in stranger rape can be categorised as:

- Stranger Known: The perpetrator and victim had spent time together but less than 24 hours;
- Stranger Recognised: The perpetrator and victim had never met, but the victim knew or could identify the offender by sight as they may have briefly met before the incident; and

- Stranger: The alleged rapist and survivor had never met, and the victim could not identify the offender (Waterhouse et al., 2016:4).

2.2.1.5. Gang rape

Gang rape, also known as multiple perpetrator rape, is a form of sexual violence perpetrated against a victim in which two or more sex offenders are involved (Horvath & Woodhams, 2013:1; Jewkes, Sikweyiya, Dunkle & Morrell, 2015:1). Multiple perpetrator rape is ascribed as a mode of recreation and means of coerced gender discipline exercised by young men. This is prominently concealed in the perception of gender hierarchy and a perpetrator's perception to avert this extreme form of sexual violence as a way of commanding a highly unequal gender order. Additionally, women and girls are anticipated to be sexually unassertive and subservient to men, including agreeing to their sexual intentions (Jewkes et al., 2015:1-2). This type of rape is predominantly viewed as a form of retaliation for rejection or "non-adherence" to the norms of society. A victim may be indiscriminately selected because she is perceived as promiscuous, considers herself "better than others" (snobbish), or is linked to perceived infidelity. Streamlining rape (a type of gang rape) takes the form of entertainment when several men rape a single woman/girl upon the instruction of a recent ex-boyfriend. Multiple perpetrator rape, as a distinctive type of sexual violence, is linked with unemployed or young men still within the educational setting (school) executing the act of rape to prove their masculinity. The consequences of multiple partner rape are severe and may lead to serious harm and death (Dunkle, Jewkes, Nduna, Levin, Jama, Khuzwayo, Koss & Duvvury, 2006: 13; Horvath & Woodhams, 2013:4; Jewkes et al., 2015:1-2).

Jewkes et al. (2015:5-7, 9) conducted a study among single and multiple rape offenders and found the following key attributes of men who are most likely to engage in multiple partner rape:

- Men who had participated in multiple partner rape were keener to reveal having ever had a transactional sexual relationship or encounter;

- Participants of multiple partner rape were more likely to be physically violent towards a partner;
- Men varied in their frequency pertaining to substance use, with those who had raped being more likely to be binge drinkers than those who had not, accompanied with drug usage over a period of at least a year;
- Gang affiliation and being bullied at school also contributed significantly to the practice of multiple partner rape;
- Men differed in their substance use, with those who had raped being more likely to be heavy drinkers than those who had not; and
- The majority of men susceptible to engaging in multiple partner rape have been raised in environments of poverty and hardship, with prior personal victimisation histories in the form of sexual abuse or trauma inflicted by caregivers.

2.2.1.6. Date rape

Date rape occurs within the context of a current romantic relationship; or prospects of engaging with another individual within an intimate relationship. The alleged offender within the prescripts of date rape is usually an acquaintance (i.e., current or potential boyfriend) (MedicineNet, 2021). Date rape may involve using drugs or excessive alcohol to overcome a victim's defences. Mainstream research on date rape drugs emphasises the effects of these drugs on individuals. Rohypnol, Gamma hydroxybutyrate, and Ketamine comprise several depressant effects that resemble the effects of alcohol.

Consequently, neither the victim nor others accompanying them are likely to be aware that the potential victim had been drugged since the drug is odourless and colourless. The victim may experience confusion, dizziness, nausea, visual instabilities, physical and/or motor dysfunctions, limited inhibition, drowsiness, diminished judgment, slurred speech, amnesia, and an inability to stop the perpetrator from committing the sexual assault as they are unable to resist. Drugs conceivably may have greater sedation properties when compared with alcohol,

which may be seen as a distinct class of circumstances in which *"voluntary"* use by a woman decreases their merit as being viewed as a *"victim"* (Girard & Senn, 2008:5, 15).

Research conducted by Ogunwale and Oshiname (2015) at a local university in Nigeria comprising of female students (with an age range of 20-25 years) found that most victims were raped by their boyfriends, who are unmarried males with whom the rape survivors had a dating relationship. The survivors recounted the deeds of the perpetrators as a betrayal of trust. All the participants, except for one, articulated that their date rape experiences were made probable after they had been physically overpowered by the perpetrator ensuing in their refusal of gestures of a sexual nature. Other strategies employed by the perpetrators in relation to the aforementioned sample of research participants indicated that for them to complete the date, their objectives comprised a combination of coercion, manipulation or dishonesty. The survivors of date rape disclosed that the coerced sex was ensued by fondling or caressing. The use of sleep-inducing drugs to enable date rape was conveyed by one survivor. All the research participants, except for one, had been raped in the homes or rooms of their alleged rapist. Relatedly, some date rape survivors revealed that initial kissing and caressing prompted by their rapist acted as a catalyst for the experienced rape. Similarly, their forbearance of the perpetrator's sex-related foreplay prior to the rape may have sent the erroneous message that they were interested in sex, regardless of their verbal refusal to engage in any form of sexual activity (Ogunwale & Oshiname, 2015:233-238).

2.2.1.7. Serial rape

Serial rape denotes multiple rapes committed by a single individual. For serial rape to be categorised as such, the emphasis is placed on a person who has raped two or more victims during separate incidents over an extended period of time. The rapist may be linked to separate incidents by means of forensic evidence (such as deoxyribonucleic acid [DNA]) (De Wet, Potgieter & Labuschagne, 2010:36; Encyclopedia of Interpersonal Violence, 2017). The

serial rapist may also have a cooling-off period, which occurs when the perpetrator does not commit a sexual offence during this phase (Bougard & Hesselink, 2021:6). Serial rapists use force as a means of instrumental purpose (to threaten or physically assault the victim), which is merely to ensure compliance from the victim (de Heer, 2016:599-601; 607). In addition, Park et al. (2008:233) believe that serial rapists plan their attack with meticulous sophistication and attention, are well-informed regarding forensics, predominantly employ the surprise attack when they rape and are keen to ask the victims questions during the attack.

Although serial sex offenders emanate from a diverse group and cannot be seen to comprise a definite type of individual (Evans & Ward, 2019:2), most serial rapists are male, and their race is restricted to a specific geographic position (implying the location where they are residing). The mean age of a serial rapist is between 29 and 35 years of age, and little is known about their occupation. Generally, serial rapist uses the con, blitz or surprise approach when attacking their victims (Wright, Vander & Fesmire, 2016:448-449). The *con approach* is a strategic approach in which the victim is deceived and persuaded to gain the victim's trust. Common strategies of the *con approach* involve settings such as needing assistance or wearing a police uniform. The *blitz approach* is a direct and sudden attack in which the victim is suddenly toppled and is opportunistic with little or no planning. The *surprise approach* is very well planned, which entails the pre-selection of the target. However, it is also important to note that the blitz approach is used less commonly when compared with other modes of attack by serial rapists (Wright et al., 2016:449).

The researcher is of the opinion documented above that the typologies of rape incidences are varied and specific to the culmination of a traumatic event of rape as such. It can also not be assumed that the severity of one type of rape can be considered more violent and traumatic than another. It is, however, of noteworthy importance to be cognisant that rape by multiple offenders can be ascribed as being more traumatic and violent due to the number of offenders involved. The same notion could be applied regarding serial rape if underlying aggressive and violent tendencies such as sadism seemed to have been present during the rape.

Nonetheless, given the various categories of the crime of rape, it is pivotal to focus on the needs and consequences of the rape survivor to expedite the recovery of the victim.

2.2.2 UNIVERSAL CULTURE OF RAPE

Suran (2014) states rape culture is a systematic and shared challenge globally. Cultural explanation of rape has prompted the causality from a micro to a macro level, presumed to emanate from predominant heterosexual power structures (Gundersen, Baes, Estupinian & Vergara, 2016:923; Suran, 2014:277-278). A proposition of rape culture first emerged in the 1980s and later expanded into the 1990s to quantify rape myth acceptance.

Rape myths are defined as descriptive or prescriptive beliefs about rape (about its causes, context, consequences, perpetrators, victims, and their interaction) that serve to deny, downplay, or justify sexual violence that men commit against women (Bohner, Eyssel, Pina, Siebler,Tendayi & Viki, 2009:19).

Moreover, rape myth attitudes are defined as a pattern of false beliefs regarding the incidence of rape and thus tend to excuse men for rape by shifting the blame for rape onto the victim. Likewise, rape myths pertain to the characteristics of the victim, which implies that if she does not conduct herself within the spheres of the stereotypical *"good girl,"* she might become prone to be blamed for the rape, or it may be assumed that the rape survivor incited it (Bohner et al., 2009:19; Grubb & Harrower, 2012:9; Johnson & Johnson, 2017:1; Tavrow, Withers, Obbuyi, Omollo & Wu, 2013:2156-2157; Waterhouse, Reynolds & Egan, 2016:2).

A debilitating myth that propagates a rape culture with the purpose of silencing rape survivors is an erroneous belief that women falsely report rapes. While false rape claims exist, they account for two percent of false rape claims. As such, the notion that women "*cry rape*", with prospects of tarnishing the accused's reputation, is deemed flawed. Nonetheless, rape survivors are greatly affected by this myth and do not report the crime for fear that they will not be believed (Messina-Dysert, 2015:74).

The culture of rape model suggests that five fundamental propositions support rape culture: traditional gender roles, adversarial sexual beliefs, hostility toward women, sexism, and acceptance of violence (Johnson & Johnson, 2017:1). These propositions of rape will be discussed below.

2.2.2.1. Traditional gender roles and rape

Stereotypical perspectives about women that are commonly false but widely endorsed within a culture serve as a means to legitimise the devaluing of women and approval of male dominance over women. Beliefs are infused within society, which in turn are mounted within informal language, and reinforced during the process of socialisation. The consequences of restraining women's potential in social, cultural, political, and economic spheres, as they can be internalised by both men and women alike, thrive predominantly in patriarchal cultures where male dominance and sexist ideology are the acceptable norms (Husnu & Mertan, 2017:3738). An individual's probability of engaging in interpersonal aggression differs. However, certain opinions and standards nurture violence-supportive attitudes, including robust gender role expectations and male-perceived general sexist attitudes and hostility towards women (Fox & Potocki, 2016:1916).

Gender role conformity and attitudes about traditional gender role stereotyping play a role in the creation of attributions about rape victims. People who project more traditional gender role attitudes are keener to display higher levels of victim blame, in line with the argument that women who diverge slightly from what is perceived as the traditional female role are therefore responsible to a certain degree for their victimisation (Grubb & Turner, 2012:449-450).

2.2.2.2. Adversarial sexual beliefs and rape

Individuals who believe in a more overt adversarial view of the female gender appeared to be more likely to believe in rape myths. An unambiguous hostile attitude toward women embraces the endorsement of rape myths, whereas benevolence toward men abates the offender's fault. Contradictably, the myth that "*she asked for it*", based on the notion that the victim's preceding behaviour

had incited sexual violence, fortified the attribution to the woman concerned. This diminished the discernment of men's responsibility, proposing that the woman wanted sex and thus caused the rape (Rollero & Tartaglia, 2019:216).

The sexual victimisation of women in pornography tends to increase attitudes supportive of sexual violence and whether pornography plays a role in sexual offences depends both on the type of pornography and offender characteristics (Bartol & Bartol, 2017:386; Brown & L'Engle, 2009:3; Malamuth, Hald & Koss, 2012:7). Pornography can be defined as portrayals of sexual acts where one partner is depicted as powerless and non-consenting and is little more than an object for pleasure. Furthermore, in some pornography, persons may be depicted in physically violent or degrading and humiliating situations (Bartol & Bartol, 2017:386). Pornography is thriving and has become a major addiction worldwide, exceeding illicit drugs, gambling and alcohol (Messina-Dysert, 2015:67). "*Hentai"* (commonly practised and widely accepted in Japan) is a dangerous form of pornography illustrated in cartoon format that is widely accessible in computer games, comic books and online entertainment mediums. Incest, rape and other forms of sexual abuse are common themes of "*Hentai*" (Messina-Dysert, 2015:67).

There subsists some indication that pornography plays a contributory role in sexual violence (Sigal & Denmark, 2013:191). Consumers of pornography, irrespective of age, vary in terms of culture, pre-existing perceptions and attitudes about sex, sexual orientation, and personality attributes, which might have a reasonable impact on the outcomes of interest when viewing pornography (Hald & Malamuth, 2015:106; Rothman & Adhia, 2015:2).

As an alternative to laboratory-based experimental approaches, researchers (Fisher, Kohut, Gioacchino & Fedoroff, 2013) investigated the relationship between the availability and use of sexually explicit materials aligned with anti-woman attitudes and acts in natural settings, known as observational studies (among sex offenders). Observational enquiries comprising of sexual offenders and non-offenders have offered little support for a pornography—aggression link. Likewise, observational studies in the wider population also seem to show no

influence of increased availability of diverse sexually explicit materials in relation to the incidence and prevalence of rape, or even reduced sex crimes in the context of having had to access to sexually explicit pornography, prior to committing the crime of rape (Fisher et al., 2013:361).

2.2.2.3. Hostility towards women and rape

Men who approve of hostile sexist principles may be more susceptible to the influence of the hostile sexism of their peer group and demonstrate high levels of self-reported rape proclivity (Durán, Megías & Moya, 2018:2183). Defensive attribution of rape may also play a role, whereby audiences do not want to believe that a comparable outcome could befall them and therefore distance themselves from the prospect of blaming the victim and concluding that they would never put themselves in the same situation. The rape survivor must be to blame (Grubb & Turner, 2012:450). Even though there are numerous facets at interplay leading to the crime of rape, victim-blaming and questioning may be the catalyst of rape culture in social media, as it generates hostility and discourse within the comment threads inciting commentary (Gundersen, 2016:926).

The role of the media in fuming a culture of rape is a reality which continues to grow and evolve over time (Messina-Dysert, 2015:75). The media may perpetuate and promote social constructions of masculinity, fortify rape myths and inspire violence towards women. Given that images and concepts of violence against women are easily accessible on various media platforms, society tends to accept rape as a norm (Messina-Dysert, 2015:76). Sexual images and violence are interweaved and imaginary violence against women. Within a culture of rape, women do not have access to full legal, economic and social equality with their male counterparts; instead, women are perceived as inferior, which justifies sexual violence committed against them (Messina-Dysert, 2015:67).

Traditional gender roles require that an individual act according to specific behaviours, which are sexually prescribed and prohibited by both genders. Men are portrayed as sexual objects and perceived as predators, while women are viewed as sex objects and prey. Men are taught to be aggressive, while their

female counterparts are expected to be submissive according to traditional gender norms. Most importantly, men are expected to uphold culturally defined attributes that endorse maleness according to their socio-historical environment. Rape culture is fumed when masculinity is projected to entail power, superiority, control and dominance. The former characteristics are thus contributory to a rape culture endorsing men to be physically aggressive and threatening towards women (Messina-Dysert, 2015:70).

Although partially empirically supported, a notion exists that men who are prone to adhere to the three norms of hegemonic masculinity, such as anti-femininity, status and robustness, bear a positive association with men's hostility towards women in general. Furthermore, it is speculated that masculine gender roles would be determined by adhering to the norms of hegemonic masculinity (Gallagher & Parrott, 2011:7).

2.2.2.4. Sexism and rape

A surfeit of research has established that humans keenly interpret their reality according to their attitudes and traditional background (Süssenbach, Eyssel, Jonas & Bohner, 2017:2324). Sexism is connected to rape and sexual assault, as it retains the power imbalance between men and women and thus restricts women's ability to have their voices heard through victim-blaming. In addition, negative societal perceptions of women combined with desensitisation and acceptance of violence may justify the perpetration of rape and sexual assault (Johnson & Johnson, 2017:3).

In a rape case, the role players within the CJS usually receive information about two conflicting parties, the alleged offender and the victim. Their behaviour, such as preceding alcohol consumption, their characteristics (status or attractiveness), and their relation to one another, influence the outcome of legal proceedings. Perceptively, the direction of potential bias may thus be guided by stereotypical rape-related belief systems that shift the focus away from the alleged offender toward the rape victim (Süssenbach et al., 2017:2324; Temkin & Krahé, 2008:8).

Sexual behaviour is generally linked to the notion of perceived manhood, creating the impression that men perceive women as objects to conquer and sex as an article of trade to be secured by all means necessary. This notion creates a social construction that facilitates the existence of rape while providing excuses and rationalisations for rape (Messina-Dysert, 2015:71). Rape perpetrated against women is thus overlooked, normalised, and strengthened by prevalent norms and attitudes. Misogynistic practices are authenticated and rationalised through numerous acts of sexism (Messina-Dysert, 2015:66-67). Moreover, the association between dominant gender socialisation of young men and rape directs that the phenomena cannot be merely explicated in terms of an antisocial sub-culture. At the same time, this is imperative but also suggests ways in which certain facets of mainstream culture among pubertal boys augment the proclivity to rape (Jewkes, Nduna, Shai & Dunkle, 2012:5).

Generally speaking, *'traditional'* perceptions of masculinity are understood to have been susceptible and destabilised by historical changes in the social and economic hierarchy. As such, it is contended that men experience a crisis of gender identity that may surface through the re-assertion of violent masculine power (Everitt-Penhale & Ratele, 2015:14). Furthermore, progress in gender equality is indirectly recognised as contributing to violence emanating from crises in masculinity. Women's perceptions of gender inequality are circumvented (Buiten & Naidoo, 2013:539).

Hegemonic masculinity is used to elucidate male power's prevalence, types and subtleties (Morrell, Jewkes, Lindegger & Hamlall, 2013:12). Hegemonic masculinity derives from a notion drawn from the Gramscian view of class hegemony, which demands upholding a particular alignment of power not necessarily through coercion, but rather through the inducement of most individuals in a community of legitimacy of the presiding group's position (perceived as male domination). Likewise, the Gramscian hegemony viewpoint explicitly emphasises power without violence, while in Southern Africa, this occurrence is not the case (Everitt-Penhale & Ratele, 2015:7; Morrell et al., 2013:20).

Gender inequalities provide men with substantial interpersonal power over women (due to their vulnerability and low social status), predominantly in situations of poverty and where sex is materially compensated. Young women are often labelled as victims of men, but this ineffectively explains women's observed sexual autonomy (Jewkes & Morrell, 2012:1).

2.2.2.5. Acceptance of violence and rape

Significant levels of sexual violence occur when men suffer fewer sanctions, whether it may be social, psychological, or legal punitive sanctions for coercing women to have sex. In communities where sexual violence is prevalent, men are expected to be sexually aggressive, and some coercion may be perceived as normal. Offenders of sexual violence themselves may not feel guilt or remorse if they interpret their actions as being justifiable (Muchoki & Wandibba, 2009:17; Tavrow et al., 2013:2157).

Rape perpetrated against women may also exist to maintain the boundaries between male and female gender categories. Rape can therefore serve a purpose and function as a sexualised act of humiliation and punishment of women who fail to adhere to feminine gender stereotypes (i.e., drinking and going out or wearing specific types of clothing). Violence against women, as an occurrence of historically unequal power relations between men and women, has permitted men to dominate over and discriminate against women (Vetten, 2014a:5-6). Furthermore, it would also appear that the higher a man's level of acceptance of rape myths is, the more prone he might be to report an inclination to rape (Vetten, 2014b:6).

2.2.3. VICTIM BLAMING ATTRIBUTABLE TO RAPE

There subsists a close link between rape myth acceptance and victim-blaming, and survivors of rape are frequently vilified for their apparent role in the rape incident, which may even escalate to circumstances in which the rape survivors are held responsible for the rape (Grubb & Turner, 2012:444). Victim-blaming usually takes place when a rape survivor is challenged with discernments from

the general public or outside persons not involved in the crime. Characteristics such as the clothing of the victim or alcohol consumption preceding the alleged rape serve as "*causes*" to hold the victim partly accountable for the crime of rape perpetrated against them (Grubb & Turner, 2012:6; Hayes, Lorenz & Bell, 2013:203; Oswald & Russel, 2016:5; Seibold-Simpson, McKinnon, Mattson, Ortiz, Merriwether, Massey & Chiu, 2018:3; Tyson, 2019:175). Correspondingly, victim-blaming also occurs when a survivor of rape is accused of not responding to the attack with more resistance or behaving in a seductive manner before the alleged rape occurs (Duff & Tostevin, 2015:10, Tyson, 2019:175). Rape survivors are subjected to positive and negative reactions when disclosing their alleged assault to formal and informal service providers. At the same time, it cannot be generalised that all rape survivors perceive social reactions regarding the circumstances surrounding their rape in similar ways (Kirkner, Lorenz & Ullman, 2017:2).

Victims of rape are often blamed by significant others such as friends, family, or legal personnel in the aftermath of an attack, with men ascribing greater blame on average than women on the rape survivor. Victims' experiences of being blamed may create a vicious cycle in which they may be continuously blamed for alleged rape in future. Likewise, belief in a just world has been deliberated upon extensively as an underlying cognitive mechanism that predicts greater blame (Pinciotti & Orcutt, 2017:1). Scholars such as Lerner (1970, 1980); Peplau (1973) and Lerner and Miller (1978) articulate the belief in a just world as victim-blaming bias that supports individuals to uphold their beliefs in a foreseeable and unchanging environment- consequently allowing victim blame to amount to situations that threaten belief in a just world (Gravelin, Biernat & Bucher, 2019:8).

Research conducted by Seibold-Simpson et al. (2018:7) concluded with the following key findings:

- Notwithstanding the gender and sexual orientation of their research participants, service providers within the CJS gave more blame to the victim, and victims were more reluctant to report the incident in instances in which the victim was male and/or when the offender was female;

- Male gender and heterosexual orientation attracted more blame being placed on victims as opposed to perpetrators, and would therefore be less willing to report the crime of rape;
- Sturdier commendation of masculine gender ideologies predicted higher levels of victim blame, lower intensities of perpetrator blame, and lower rates of disclosure/reporting, and that the foreseeable effects of gender and sexuality would be partly accounted for by greater adherence to traditional masculine ideals; and
- Similarly, higher levels of victim blame and lower levels of perpetrator blame predicted lower likelihoods of disclosure/reporting.

2.2.4. THE ROLE OF SUBSTANCE ABUSE AND RAPE

Research on the specific role of alcohol intake and its relation to rape has focused primarily on the general public's perceptions, concentrating on the effects of alcohol consumption being either pharmacological or psychological (Abbey, 2011:3). Pharmacological inferences of alcohol consumption refer to a decline in cognitive functioning and an influx in inhibitions. After alcohol consumption, offenders lose sight of cues such as empathy for the victim and the long-term implications of their actions, and the focus is on immediate cues such as sexual arousal, rage, and frustration. This influence has been documented to be more prevalent in men inclined to sexual aggression (Abbey, 2011:16). The psychological interferences pertaining to alcohol consumption denote the interface between the perpetrators' views about the effects of alcohol on their own behaviour and the pharmacological consequences of alcohol abuse. For example, if a man wishes to engage in sexual activity, they might interpret an available target's willingness to dance as a gesture to be intimate (Abbey, 2011:3; Greathouse, Saunders, Matthews, Keller & Miller, 2015:23).

Previous research found that in approximately half of rape incidences, the victim, the perpetrator, or both consumed alcohol prior to the rape. However, research documenting the interplay between alcohol usage and rape indicates that alcohol consumption can contribute to rape. In addition, alcohol consumption increases

misunderstandings of female sexual interest (Greathouse et al., 2015:x-xi). The occurrence of rape in which only the offender(s) were using substances prior to perpetration was more likely to involve the presence of a weapon, the use of force or threats of force and intimidation than assaults with the absence of substance use (inclusive of both parties using substances at the time of the alleged incident). Rape involving acquaintances most likely involved the use of substances by both parties concerned. Rape in the absence of substance use led to less victim injury than assaults with substance use. When only the perpetrator of rape was under the influence of substances, victims were more likely to seek medical attention than when no substances were used or when both parties were using substances at the time of the alleged sexual assault. Victims' current age, marital status, employment, assault location, and completed intercourse did not differ prior to pre-assault substance use status (Brecklin & Ullman, 2010:1512).

Victim responsibility concerning rape is widely interpreted by actors within the CJS. While rape survivors were not directly blamed for being intoxicated when the rape occurred, they were blamed for consuming alcohol in the first instance, thereby making themselves susceptible to becoming a victim of rape. Through this modification of the traditional rape myth, role-players within the CJS are able to uphold a position in which women are blamed for their own victimisation, but in a conceivably more socially acceptable way. It seems attributable that if a rape survivor is seen as having done something that leaves her vulnerable, such as consuming alcohol or accepting a lift with a stranger, then she may prospectively be blamed for being raped, and therefore, the consequence being that she had effectually consented (Gray, 2015:351).

Waterhouse et al. (2016) conducted a document analysis of 400 reported rape cases in the United Kingdom and found that alcohol consumption remains a substantial factor in instances of stranger rape. There seems to exist a statistical association between the victim being reported as drinking alcohol alone (i.e., the offender was not reported as having consumed any alcohol) and the rape category (i.e., acquaintance or stranger). However, in most cases of rape (104 cases, 48.6%), data supported that both the victim and offender were reported as having consumed alcohol at the time of the rape. In 31.3% (67) of cases, only

the victim was recounted as having consumed alcohol, while in 14% (30) of cases, the offender was reported to have been the only one doing so preceding the offence of rape (Waterhouse et al., 2016:6).

Presiding officers in the court who perceived a victim as intoxicated at the time of the alleged rape were less likely to hand down a guilty verdict and made lower assessments of victim credibility. Moreover, if the alleged rapist purchased the drinks, presiding officers were more likely to find them guilty of the rape and made more negative rulings about the defendant than when the victim bought the drinks themselves before the alleged rape. Although intoxication can have negative outcomes for a victim's experience with the CJS (i.e., the case failed to be prosecuted successfully), the background of the victim's intoxication may also influence role-players within the CJS perceptions of rape cases (Lynch, Wasarhaley, Jonathan, Golding & Simcic, 2013:3205, 3207). Victim credibility considerably interceded the effect of perceived victim intoxication on the verdict. Alcohol usage also influences the anticipated conviction of an offender prior to the sexual assault or rape, which places further doubt on the credibility of the victim. Overall, when the victim was intoxicated, both male and female actors within the CJS viewed her as having low credibility (Lynch et al., 2013:3217).

A few studies also investigated the link between the use of drugs and sexual offences. One such study was conducted in the United States of America, comprising a sample of 851 men attending tertiary education who were surveyed five times over a period of four years. It was found that regular consumption of alcohol, coupled with the use of marijuana (cannabis) and other illicit drug use, contributed to their willingness to engage in sexually aggressive behaviour. Furthermore, alcohol use gradually turned into drug use prior to the rape of their victim. Similarly, in a 2016 South African study conducted by Jewkes et al. with 1147 men aged 15–26 years in the Eastern Cape province, it was found that marijuana and sniffing benzene (an industrial chemical found in crude oil) were commonly used prior to coerced sexual penetration (Jewkes et al., 2012:5). More research is, however, warranted to fully comprehend the relationship between assailant drug use and rape (Greathouse et al., 2015:22; Swartout & White, 2010:1720).

Floyd (2017:1) highlights the specific role that marijuana can play when it is used together with alcohol in relation to sexual violence:

- Marijuana is a widespread drug reported (besides alcohol) when drugs were detected during the commission of rape;
- Marijuana is regularly used with alcohol in rape; and
- Marijuana and alcohol used together might have a greater result on cognitive functioning than whichever substance alone. Cognitive functioning comprises a person's ability to recognise and respond to risky situations.

It is opined by Pacula and Sevigny (2014:5) that future research still needs to investigate the specific role of marijuana in the absence of other illegal drugs in relation to sexual violence.

2.2.5. SYNOPSIS OF VICTIM AND OFFENDER CHARACTERISTICS

Vetten, Jewkes, Sigsworth, Christofides, Loots and Dunseith (2008) investigated 11 926 rape cases reported at the 128 police stations in Gauteng province. A sample was selected for the study using a two-phase process. During the first phase, a sample was drawn from 70 police stations using probability sampling based on rape cases captured in 2003. Only closed rape cases were considered, with a random sample of 30 dockets selected (Vetten et al., 2008:6). The researchers found that 60.2% of reported rape incidences involved adult female survivors. Notably, the mean age of rape survivors in this particular study was 20 years (Vetten et al., 2008:7; Vetten, 2014a:16).

According to Vetten et al. (2008:7-8), age influenced a number of factors in relation to the incidences of rape reported in Gauteng. While 61.8% of rapes were executed in a home (commonly that of the offender), girls younger than 11 years were more prone to be raped in their own homes (28.5%) when compared with adolescent girls (17.1%) or adult women (19.6%) who were raped at the offender's home. Approximately 49.5% of the rapes committed against adults involved an abduction. The alleged rapist met the woman in one location and then

forcibly took her to another location. Adult women were susceptible to being attacked outdoors, with an estimated one in four rapes befalling in an open space (24.9%); and a further 7.8% happening in an alleyway or alongside a road. One in ten adult women reported being raped during a home invasion (Vetten et al., 2008:7-8). The relationship between the alleged rapist and victim also echoed variances regarding age lines. Strangers were responsible for 14.6% of rapes reported by girls, and in 48.1%, strangers were responsible for the rape of adult females, including gang rape. Likewise, half of the young girls (52.1%) were raped by those known to be a friend/acquaintances/neighbours. Relatives responsible for rape accounted for 31.8% of young girls and 14.0% of adolescents as opposed to 3.4% of adults. Approximately one in five adult women (18.8%) was raped by their present or former intimate partner (Vetten et al., 2008:34).

In another study conducted in the Gauteng province, Machisa, Jewkes, Lowe Morna, and Rama (2010) targeted a sample of 1 568 households. From this particular sample, most women experienced rape for the first time as a child, with 64.7% experiencing rape for the first time at the age of 17 years and younger. On average, one in five women (19.6%) were aged between 18 and 24 years, while 15.7% were 24 years and older when the rape occurred (Machisa et al., 2010:41-42).

Although research into sex offenders is scant in South Africa, the researcher will refer to two pertinent studies. The first is the study conducted by Vetten et al. (2008), which also provides some insight into the offenders arrested for rape. In this study, one in eight defendants (13.1%) was a child in conflict with the law (aged 17 years and younger). Four out of five (81.2%) children accused of rape fell between the age bracket of 12-17 years of age. The oldest offender from the study was 76 years, with 27 years of age being the median age. Almost one in five (17.8%) of alleged rapists arrested had beforehand been found guilty of other crimes, with one-third of these previous convictions (6%) for rape (Vetten et al., 2008: 32). In the second study, research was conducted by Jewkes et al. (2010:25-26). In their study, comprising of male sex offenders, it was found that

27% completed their schooling, 85% were African, nearly 60% were single, and one in twenty specified that they had raped a child under the age of 15 years.

According to international literature, sex offenders are a heterogeneous group. Their diversity is evident in terms of individual demographics, traits, histories, motivations for the sexual offence, and future risk to re-offend (Bartol & Bartol, 2017:380). What is, however, apparent is that sex offenders tend to be young. When separating sex offenders' age demographics, 50% are 30 years of age and older, 25% are between the ages of 21–29 years, 9% are 18–20 years of age, and 15% are seventeen years old or younger (Evans & Ward, 2019:2). According to Bartol and Bartol (2017:381), 42% of offenders arrested in 2013 for a sexual offence were under the age of twenty-five years. Likewise, a Turkish study found that more than 60% of their sample comprised sex offenders aged between eighteen and thirty-five (Tulu & Erden, 2013:2).

2.2.6. FACTORS DETERMINING THE REPORTING OF RAPE

Conceivably, the paramount barrier to self-reporting sexual assault and rape is attributable to shame and blame. Rape survivors are not only blamed by society at large. They also battle with self-blaming. Victim-self-blaming transpired when the victim herself had intensely internalised preconceived societal rape myths that she was responsible for the crime of rape she had suffered (Harsey, Zurbriggen & Freyd, 2017: 659; Russel & Hand, 2017:154). Numerous reasons are cited for not reporting rape, namely: unsatisfactory services for rape survivors; preceding experience whereby the SAPS were not helpful and attributed blame towards the victims; stigma and shame; distrust in the CJS; dependence on/or fear of the perpetrator; lack of information about support services for rape survivors within the CJS and fear that the case will not be handled confidentially (Jordaan, 2017:29; Soul City, 2013).

The stigmatisation of sex and sexuality pertaining to women, children, racial minorities, and lesbian, gay, bisexual, transgender, queer, and intersex (LGBTQI+) members of the community fumes further feelings of shame infused with repressed emotions and delayed cognition of being a survivor of rape.

Furthermore, the stigma relating to sex and sexuality makes it difficult for rape survivors to report the crime emanating from negative stereotypical perceptions of the police, which in turn influences the decision-making processes of rape survivors (Tyson, 2019:175). Concerningly, service providers rendering services to rape survivors may subject themselves to homophobic discriminatory practices, may deny rape survivors access to services, decline to promote inclusive policies, or emasculate same-sex sexual violence (Richards & Marcum, 2015:184). There is a dearth of research about the experiences of invisible or socially marginalised members of the community, such as LGBTQI+ persons reporting a sexual offence within the CJS. Corrective rape may attract substantial public attention, yet only a few studies have been conducted to highlight their needs within the CJS. A convenience sample of 591 women from the LGBTQI+ community, mainly recruited by community-based organisations in Botswana, Namibia, South Africa, and Zimbabwe, found that 31.1% have had an experience of forced sex, 14.9% by men only, 6.6% by women only and 9.6% by both men and women (Sandfort, Baumann, Matebeni, Reddy & Southey-Swartz, 2013:5; Vetten, 2014b:4). In addition, apparent homophobia by practitioners within the CJS plays a deterrent effect in the underreporting of same-sex sexual violence (Richards & Marcum, 2015:186).

Frequently the role players within the CJS are susceptible to factors influencing their perceptions of a culture of rape, such as language, myths and the portrayal of the media and general public. These attributes come into play when a rape survivor reports the crime of rape. Role players within the CJS may hold intrinsically negative attitudes towards sexuality and are ominously suspicious and insensitive towards rape survivors. If the victim is incoherent, inconsistent or seems to fulfil the perceptions held by rape myths, then the police are often reluctant to escalate the case further. Investigators engage in the CJS by placing the victim on trial before reviewing the merits of the case brought forth before them. The role of the victim's personal life as being contributory to the alleged rape is looked at closely and judged on characteristics such as her manner of dress, past sexual behaviour, personality and the location where the alleged rape occurred. Irrespective of the type of rape, the survivor is treated with the same

misapprehensions since the crime of rape is unique in the ability of the rape survivor to prove her own innocence before the judicial system considers her victimisation. Furthermore, rape survivors must continuously recount the traumatic event that transpired during the actual investigation or legal proceedings. The process of seeking assistance from law enforcement agents strengthens cultural perspectives that women should blame themselves and feel ashamed for their own victimisation (Messina-Dysert, 2015:78-79; Watson, 2015:5-6).

Rape Crisis and the Women's Legal Centre in South Africa highlights five challenges within the CJS that prevent or delay rape survivors from seeking justice. Firstly, most rape survivors do not receive information from the time of reporting a sexual offence to the time that it is heard in court. Secondly, victims mostly do not have access to case-specific information regarding the progress of the investigation of their case; and whether additional information is required of them by the police. Thirdly, a lack of psychosocial support is a noteworthy obstacle in terms of reporting an incident such as rape. Where sufficient and supportive psychosocial support is not being provided, the process of reporting the crime of rape can be emotionally overwhelming for the rape survivor, with a tendency to refrain from seeking assistance from the CJS. Fourthly, a lack of coordination between the various service providers such as the Department of Social Development, SAPS, Department of Health and Department of Justice and Constitutional Development contributes to an ineffective mode of service delivery and frustration experienced by the rape survivor. Lastly, there currently exists no "real complaint mechanism" for adequate investigation practices and power relations against rape survivors. When service delivery is poor or unsatisfactorily, rape survivors do not know what to do next and abandon any further attempts due to frustration from seeking assistance within the CJS (Watson, 2015:4). The facets mentioned above are thus crucial in investigating the experiences of adult female rape survivors within the CJS.

Rape survivors fear being accused or perceived of reporting false rape, which can lead to further secondary victimisation within the CJS (Watson, 2015:3). It is crucial to be cognizant that just because the police find a rape complaint

insignificant, it does not necessarily imply that the alleged incident of rape did not occur. Divergent to the notion that men are at risk of being falsely accused of rape, it is more common for alleged rapists to allude to prosecution (Watson, 2015:3).

In instances whereby rape survivors may be in conflict with the law, any anticipated benefits of reporting an offence such as rape may be outweighed by the risk of attracting themselves to the attention of the law. This barrier may apply to illegal immigrant women (who possibly run the risk of arrest and deportation) and women participating in illegal activities (such as sex workers). Small, non-random surveys suggest that sex workers are subjected to a substantial degree of rape perpetrated against them by their clients and the police. In addition, rape perpetrated against sex workers remains underreported due to the illegal nature of their work (Jordaan, 2017:32; Vetten, 2014b:16; Watt, Aunon, Skinner, Sikkema, Kalichman & Pieterse, 2012:9).

Some alleged sex offenders may keep the victim from reporting the incident of rape by locking them up, threatening or intimidating them (Machisa et al., 2017:51). Nonetheless, one of the greatest challenges of underreporting rape is aggravated when the alleged perpetrator is known to the rape survivor (i.e., an intimate partner, family member, friend, neighbour, teacher, or community leader) (Mpani & Nsibande, 2015:7).

The table below highlights the most prevalent barriers preventing the victim from reporting the rape but also includes the reasons put forward for reporting the crime of rape.

Table 1: Barriers preventing the reporting of rape and reasons for reporting rape

Reasons for not reporting rape	Reasons for reporting rape
Fear of not being believed or being accused of lying Feelings of shame, guilt, humiliation and embarrassment Feelings of pity and love towards the offender Problems with physical access to the police or social workers Fear of retaliation or intimidation by the offender, especially when combined with a lack of confidence that the legal process will result in a conviction Fear of legal processes, including experiencing rudeness and poor treatment by the police Fear of having to relive the trauma in court and during the investigation Fear of upsetting the stability of the family Fear of the power and authority of the abuser Fear of loss of economic support by the abuser Preference for cultural means of resolving disputes (such as the payment of damages by the offender) Fear of exclusion or mockery by peers Want to avoid the stigma attached to being raped (being labelled as 'damaged') The belief that the crime of Is not a serious offence; and that it should not be reported	To ensure personal safety and future protection from the offender To prevent the offence from being repeated or the offender is harming others To make the offender take responsibility for his/her actions To ensure the offender is brought to justice and punished To obtain help To regain a sense of control To gain compensation

Source: (Vetten, 2014a:3).

2.3. CONSEQUENCES OF RAPE FOR ADULT FEMALE RAPE SURVIVORS WITHIN THE CRIMINAL JUSTICE SYSTEM

In this section, the researcher will reflect on the consequences the victim may experience after a rape. The consequences of rape will be discussed according to the medical, medico-legal, psychosocial, and legal spheres. It is important to

note that few South African studies have been carried out in this regard, further necessitating the importance of the current study.

2.3.1. MEDICAL (PHYSICAL) CONSEQUENCES OF RAPE

Globally, the reported incidence of genito-anal injuries after rape is between 9% and 87%, depending on the ages of the survivors, the technique of examination and the type of injuries (Astrup, Ravn, Thomsen & Lauritsen, 2013:525–529; Lincoln, Perera, Jacobs & Ward, 2013:884–901; McLean, Roberts, White & Paul, 2011:27–33). Furthermore, it is estimated that 40% of rape survivors had sustained injuries on their arms, legs and face. In addition, rape cases were likely to comprise injuries to almost every bodily location (in descending order of variance) the face, chest, head, arms, feet, legs, abdomen/pelvis, hands, neck and back (Zark, Hammond, Williams & Pilgrim, 2019:1542).

In South Africa, genito-anal injuries have been cited in 7% to 58% of rape cases. As not all women who report rape sustain injuries, understanding the factors related to injury patterns and what these influences (injuries sustained during the rape) may have upon the victim thereof is significantly valuable (Jina, Jewkes, Vetten, Christofides, Sigsworth & Loots, 2015:2). Visible physical injuries can range from mild to severe. Bruising, tearing, abrasions, swelling, and *petechiae* (small red or purple spots from minor capillary bleeds) may also be visible in external and internal injuries. Pain, alone and/or with motion, and decreased range of movement are injury symptoms that patients frequently experience after rape, even in the absence of visible injury (Schafran, 2015:5).

Research has proven that age, race, educational status, postmenopausal state, prior sexual experience, previous exposure to violence, contraceptive use, alcohol consumption prior to the rape incident, relationship with the offender, location of the alleged rape, reported anal penetration, coercion and the use of violence and type of opposition during the rape, the presence of non-genital injuries, time that lapse since the examination was conducted, and levels of knowledge of examiners are predominantly aligned with the documentation of genito-anal injuries in multivariable analysis, although these relations have not

been constant across all studies (Adams Girardin & Faugno, 2000:13:88; Adams, Girardin & Faugno, 2001:175–180; Jina et al., 2015:2; Jones, Rossman, Wynn, Dunnuck & Schwartz, 2003:872–877; Palmer, McNulty, D'Este & Donovan, 2004:55–59; Sugar, Fine & Eckert, 2004:71–76).

In South Africa, the pattern of genito-anal injuries is recorded according to the type and location of the injuries as listed on the J88 form (a form designed to document the injuries a victim sustained during an assault which is completed by a healthcare practitioner) with certain groupings being merged (clitoris and frenulum of clitoris, urethral orifice and paraurethral folds, labia majora and labia minora, posterior fourchette, fossa navicularis, perineum, hymen, vagina and cervix, skin around the orifice, orifice and sphincter/anus). Healthcare practitioners are not required to report their examination methods and techniques on the J88 form. Very few practitioners would do so at their own discretion. In addition, only one or two specialised amenities in the province of Gauteng were using toluidine blue dye (the dye used by the forensic examiner to document injuries not visible to the human eye) or colposcopies (procedure to closely examine the cervix, vagina and vulva) for examination at the time (Jina et al., 2008:4; Jina et al., 2015:2). With the aid of a speculum examination, it was noted that rape victims presented with vaginal and cervical injuries at most crisis centres.

Anoscopic investigations are very rarely conducted for post-rape examinations and are not recommended if a healthcare practitioner has not undergone recent training. In similar studies, medical practitioners and mental health practitioners have self-reported that training enhanced their clinical practice (Donohoe, 2010:9–18; Parekh, Currie & Brown, 2005:121; Young, Wells & Summers, 2004:441–445). Treatment for STIs and adherence to post-exposure prophylaxis (PEP) should thus be closely monitored upon the admission and care of the client/ patient. Of concern is that adherence to PEP to prevent HIV after rape is low in sub-Saharan Africa. This non-adherence to PEP may be ascribed to the fact that rape survivors get 'lost' in the healthcare system prior to the completion of post-PEP (NACOSA, 2018:11,14).

2.3.2. MEDICO-LEGAL CONSEQUENCES OF RAPE

Medico-legal evidence plays a crucial role in proving that rape occurred and is regarded as one of the best forms of evidence the prosecution can present during legal proceedings (Niriella, 2018:23). The main purpose of medico-legal evidence is to verify the events that transpired during the rape, according to the statement(s) of the rape survivor, injuries sustained documented by the medical examiner and the outcome of the DNA analysis. Subsequently, the probative value of medico-legal evidence presented by a medical practitioner should be reliable and high-quality. Therefore, the efficiency of medic-legal services within the CJS, the quality of available medico-legal services, and the evidence collected and presented are paramount. The presiding officer and defence can raise concerns if the collected forensic evidence does not coincide with the claims made by the adult female rape survivor (Du Mont & White, 2016:4, 6; Niriella, 2018:23).

Investigations in the field of post-rape care have indicated that genito-anal injury acknowledgement is complex, and service providers are limited to the availability of the required equipment and resources to conduct examinations and identify injuries as such. This is a challenge in South Africa as limited facilities have colposcopies, and even if a colposcope is available, it is not fully utilised during forensic examinations. Furthermore, the utilisation of toluidine blue dye has been problematic, with a large number of facilities not having dye available to conduct a forensic examination. Additionally, the J88 form does not clearly require service providers to document the examination methods they used, thus relying on perceptive service providers to document this information at their own discretion (Jina et al., 2015:5).

2.3.3. PSYCHOSOCIAL (PSYCHOLOGICAL) CONSEQUENCES OF RAPE

The adverse mental health consequences of sexual assault emanate from numerous factors, not just the individualities of the victim. Facets of the assault itself, post-rape admissions and help-seeking, and sociocultural norms help define how this trauma affects women's psychological well-being. The

victimisation of women is accumulative, and the response from the social world is collective, both of which affect how anyone event of sexual assault will affect women's mental health. If rape survivors turn to formal systems, such as the legal, medical, and mental health systems, they could face incredulity, blame, and refusals of help instead of support. The trauma of rape encompasses far beyond the actual assault, and society's response to this crime can also affect women's overall functioning (Campbell, Dworkin & Cabral, 2009:4).

In 1975, Lynda Holmstrom and Ann Burgess coined the term rape trauma disorder, a grouping of emotions comparable to PTSD, frequently experienced in response to being a survivor of a violent sexual assault such as rape (YANA Mental Health, 2021). Rape trauma disorder denotes the immediate phase following rape since the survivor experiences psychological and physical symptoms such as aggravated fear, constant crying and sleep disturbances, and other responses to the actual assault, such as rape, as well as the shared fear of being killed during the assault. Survivors in consequential phases of recovery may experience a loss of self-esteem, inconsistent guilt, and clinical depression. Numerous rape survivors repudiate the aftermath of rape because they do not want to be exposed to the negative stigma associated with being a rape victim. Furthermore, one of the central reasons most rape crisis advocates refer to clients as survivors rather than victims is to reduce this stigma by converging on the strength it takes to survive sexual assault such as rape (Campbell, Goodman-Williams & Javorka, 2019:4768).

Countless rape survivors may experience more drawn-out distress and, as a result, develop PTSD, substance abuse, anxiety, irritability, anger and depression. PTSD can only be diagnosed after a traumatic incident, depending on diagnostic classification systems. In May 2013, the American Psychiatric Association revised the criteria for PTSD as set out in the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision* (DSM-5-TR). PTSD is now considered under *"trauma- and stressor-related disorders"* and is no longer regarded as an anxiety disorder as per updated in the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision* (DSM-IV-TR) (Pai, Suris & North, 2017:1). The type of event that constitutes trauma is

exposure to actual or threatened death, serious injury, or sexual violence, as directly experienced, witnessing the event, learning that the event happened to a loved one, or experiencing "extreme exposure to aversive details," which are notable among first responders (Holmes, Facemire & DaFonseca, 2016:314). Exposure to a traumatic event makes up Criterion A of PTSD. In the DSM-V, the number of symptom criteria groups increased from three to four, and the number of symptoms increased from 17 to 20. Accordingly, the symptom criteria groups are intrusion, avoidance, negative alterations in cognition and mood, and alterations in arousal and reactivity. The three new symptoms that were added are persistent negative emotional state, persistent distorted thoughts about the cause or consequences of the traumatic event, which may lead to self-blame or blame of others, and reckless or self-destructive behaviour (Pai et al., 2017:4). Two subtypes of PTSD have been added, namely: a clinical subtype with prominent dissociative symptoms for persons who, in addition to meeting the criteria for PTSD, experience depersonalisation and derealisation symptoms; and PTSD in children six years old and younger (American Psychiatric Association, 2013; Institute of Medicine of the National Academies, 2014:31-33).

PTSD consists of four major criteria groups (Criterion B – Criterion E). Criterion B is known as *intrusion* and comprises recurrent and intrusive memories of the traumatic event, nightmares, flashbacks, intense or prolonged psychological distress and physiologic reactions. *Avoidance* makes up Criterion C and includes active avoidance of memories, thoughts and circumstances that are *aides-mémoires* of the trauma the person had suffered, as well as social withdrawal and limited emotional responses. An individual must experience at least one avoidance symptom to meet the PTSD diagnostic criteria. Criterion D is *negative alterations in cognition and mood*. The symptoms in this criterion are amnesia, diminished interest, detachment from others and the world, distorted cognitions that may lead to self-blame or the blame of others and a negative emotional state. The final criterion, namely Criterion E, is *arousal and reactivity*. The symptoms in this criterion are hypervigilance, exaggerated startle reactions, problems with concentration, sleep disturbance and reckless or self-destructive behaviour

(American Psychiatric Association, 1994; Foa, Gillihan & Bryant, 2013:2; Mason & Lodrick, 2013:31; Weathers, Marx, Friedman & Schnurr, 2014:98-99).

A diagnosis of PTSD can be challenging due to the changeable inception of symptoms and the intrinsic heterogeneity in presentation (i.e., symptoms of PTSD may surface soon after exposure to a traumatic event or may be delayed even for years) (Bryant, O'Donnell, Creamer, McFarlane & Silove, 2013:843). In incidences of rape, circumstances depend on the victim's response to the traumatic incident; and do not occur in a vacuum. Firstly, the victim's personality and background can and will influence her reaction to trauma (i.e., the victim's susceptibility to therapeutic intervention). Secondly, the victim might suffer a traumatic event within a cultural context or personal relationships that may or may not be supportive (i.e., in some cultures, the rape of a woman can be seen as a dishonour to the victim's family; even if the conditions for the incident to occur were beyond her control). In relation to personal relationships, an intimate partner could withdraw emotionally or possibly abandon their partner, who is the rape survivor.

2.3.4. LEGAL CONSEQUENCES OF RAPE

In an analysis of court case files by Heath, Artz, Odayan and Gihwala (2018), it was found that the specific vulnerability of the plaintiff within the CJS can influence the period of time of a sexual offence case and role-players within the CJS, which requires an explicit skill and knowledge aimed to improve case results for susceptible groups. Most service providers within the CJS opined that they had received social sensitisation training, although 20% indicated that they did not receive any training. Contrariwise, those who had undergone the training experienced difficulty applying sensitisation techniques acquired during training in practice. The excessive caseloads and a limited number of prosecutors, intermediaries, court preparation officers and courtrooms were key challenges for all role-players within the CJS. Stemming from heavy workloads, prosecutors conveyed that they do not have sufficient time to conduct in-depth consultations with rape survivors (Heath et al., 2018:11).

Reported incidences of rape indicate that most cases were heard in regional courts in most provinces in South Africa. There is still much unease about the overall efficiency of case flow management within the dedicated sexual offences courts (Heath et al., 2018:13). The following challenges were documented as requiring urgent revisions to facilitate case flow management in the sexual offences courts (regional courts that give priority to sexual offences matters):

- Judicial officers and prosecutors share comparable challenges, namely that defence lawyers often opt to use the defendant's constitutional right to silence as a foundation for declining to discuss any issues in a case before it is set for trial. This obstructs passable pre-trial preparation for all parties concerned;
- Many postponement requests due to delays in collecting evidence and witnesses not appearing or ready to testify by both state and defence. There are also limited interpreters, court preparation officers and intermediaries;
- Insufficient investigations by the SAPS and a lack of forensic analysis capacity by staff from the Forensic Science Laboratories;
- Absence of legal representation during trial dates;
- Inadequate use of court time, often due to challenges in coordination and preparation among all key court stakeholders;
- Although all the regional courts have common practice directives that set minimum time, among other essential steps for effective case flow management, in practice, many of these directives are problematic to implement. This may be due to diverse performance indicators set for various court officials such as clerks of the court and court managers over whom the Regional Court magistrates have little control;
- Limited ability for court stakeholders to provide feedback to Regional Court magistrates for quick redress; and

- Insufficient human capacity to deal with the influx in the backlog and enrolment of new cases (Heath et al., 2018:13-14).

In an analysis of court case files, Heath et al. (2018:9) found the following:

- The period of time from the apprehension of the accused to sentencing fluctuated between 1 month and 64 months, with an average of 9.1 months. However, of those cases finalised within an average of 9.1 months, 65.2% were removed from the court roll or withdrawn by the victim or complainant.
- Verdicts attained within nine months were mainly from cases in which the alleged rapist conveyed a guilty plea.
- Most rape cases (90.5%) were finalised within 18 months.
- Moreover, 91.8% of rape cases that rendered convictions concluded within 18 months, with 34,5% of convictions for cases that took between 10 and 18 months to finalise.

The number of matters reported at the Thuthuzela Care Centres during the financial year 2017/2018 increased by 5.4%, compared with the number of reported sexual assault and rape cases from the previous financial year. This figure projects a total number of 33 973 sexual offences reported in 2017/2018, an increase of 1 734 reported cases. The conviction rate of offenders in the cases where the rape was reported at the Thuthuzela Care Centres was 74.5% for 2017/2018, an improvement of 3.4% from the previous year's conviction rate (Annual Report National Director of Public Prosecutions 2017/2018:72). Although statistics may project notable conviction rates and rapid finalisation of rape cases, they fail to explicate other domains of case finalisation. Traditional pointers of the accomplishment in the CJS in the form of conviction rates do not necessarily portray an accurate overview of the throughput in conviction rates pertaining to sexual offences. The value thereof might be more plausible by investigating the manner in which the court dealt with the case aligned with the overall experiences of rape survivors pertaining to service provisions and their overall levels of satisfaction regarding the outcomes of their case (Heath et al., 2018: 9). The

researcher concurs with Heath et al. that the experiences of rape survivors within the CJS should also be included in capturing the attribution of rape cases.

2.4. THE NEEDS OF ADULT FEMALE RAPE SURVIVORS WITHIN THE CRIMINAL JUSTICE SYSTEM

The next section will outline the four spheres of needs that adult female rape survivors have within the CJS voice, namely medical, medico-legal, psycho-social and legal needs. Scant research exists, especially regarding the legal needs of adult female rape victims, which further necessitates the current study.

2.4.1. MEDICAL NEEDS OF ADULT FEMALE RAPE SURVIVORS

It is estimated that half of rape survivors choose not to seek medical treatment for their injuries (Centres for Disease Control and Prevention, 2012). Furthermore, rape victims are reluctant to seek medical assistance if the assailant was someone they knew. For those seeking professional care ensuing rape, nurses might sometimes be the first point of entry for a rape survivor into the medical domain (Campbell, Patterson & Bybee, 2012:225). Research from the United Kingdom shows that rape cases whereby rape survivors were examined by a nurse who had been trained in the Sexual Assault Nurse Examiner programme (a sexual assault training model centring on psychological and medical care) have a higher chance of securing a successful prosecution (Campbell et al., 2012:226).

Once a rape survivor enters the rape crisis centre, the patient is first examined, assessed, and treated for acute medical needs. If the patient conveyed drug-facilitated rape, urine and blood samples are collected immediately. The patient may consent to one part of the examination but not another or may decline to consent to the examination entirely, or any phase of it, at any given time. The medical forensic sexual assault examination is, first of all, a medical examination dedicated to attending to the patient's immediate medical needs, short-term and long-term health, safety needs, as well as physical and mental observation (Schafran, 2015:1, 3).

The commencement of PEP is time-sensitive, with the first dose of drugs necessitating to be administered within 72 hours (3 days) after the rape. Undeniably, PEP is often the last step in the treatment chain. In instances whereby rape survivors were not able to give consent to a medical examination, a three-day starter pack of PEP is provided, and the patient is asked to return for testing and a further course of post-exposure prophylaxis for 28 days (if eligible). Eligibility implies that the rape survivor tested human immunodeficiency virus (HIV) negative upon representation (NACOSA, 2018:16).

2.4.2. MEDICO-LEGAL NEEDS OF ADULT FEMALE RAPE SURVIVORS

The crucial aids to visualising and documenting genital injuries are the colposcope with photographic competencies, digital camera, Toluidine blue dye and Sexual Assault Evidence Collection Kits. The forensic tools will be briefly discussed as follows:

- *Colposcope*: A magnification device used to detect possible external and internal genital injuries, such as abrasions and lacerations, which are challenging to see or easily missed with the naked eye;
- *Digital Camera*: Photographing genital injuries is contentious because of the risks to patient privacy;
- *Toluidine blue dye*: This is a staining technique in which dye abides by small areas of abraded skin and microlacerations, resulting in the identification of invisible injuries; and
- *Sexual Assault Evidence Collection Kit*: The equipment and containers (either cardboard box or envelope) within the Sexual Assault Evidence Collection Kits may vary. A typical kit comprises detailed instructions for each step in the collection and storage of evidence; bags and sheets of paper for evidence such as victims' clothing; swabs for collecting fluids from lips, cheeks, thighs, vagina, anus, buttocks; combs to collect hair and fibres; envelopes for samples collected as evidence (i.e., hair and fibres; blood collection) and documentation forms. Healthcare professionals

> conducting the examination should change gloves between each step to avoid cross-contamination of evidence and store the biological and non-biological evidence from the patient's body and clothing (Schafran, 2015:6).

The care and examination of an acute rape victim need to be carried out by a certified healthcare practitioner with knowledge of the psychological response to rape. The practitioner must be a capable communicator so that a relevant history of the assault or rape can be documented accordingly. They must be knowledgeable in collecting biological trace evidence and how to interpret and report these findings verbally and in writing. The examination should take place in a quiet setting with access to the necessary equipment and assistance. From the victim's perspective, treating injuries and prompt medical examination by a healthcare provider is seen as crisis intervention (Ingemann-Hansen & Charles, 2013:92). Indicators of forensic medical interest to support corroborating findings are the victim's general health, use of prescriptive medication or drugs, menstrual period, former sexual relationships, time since last voluntary intercourse, and recent genital lesions (Ingemann-Hansen & Charles, 2013:93).

It is sensible to conduct the physical examination and the trace-evidence collection concurrently according to a standard protocol and document injuries using body maps (J88 form) and photography during the examination. The general appearance of the victim should also be documented. The systematic top-to-toe examination should be conducted consistently, and the victim's entire body should be inspected. The victim is then asked to recline so that the breast and trunk can be assessed, followed by the extremities (Ingemann-Hansen & Charles, 2013:94).

With the rape survivor in a supine position, knees were drawn and legs apart, an inspection of the external genitals and perineum was accomplished and ensured by inserting a speculum to inspect the vaginal wall and cervix. Trace evidence is collected prior to the insertion of instruments in order to avoid contamination. However, specimens from the vagina (foreign bodies) and samples from the cervix are collected while the speculum is inserted. The anal examination can

also be conducted with the victim still in the supine position or turned in the lateral position. After initial inspection and trace-evidence collection, an anoscopy should be conducted depending on the assault history or signs of visible injury (Ingemann-Hansen & Charles, 2013:94).

2.4.3. PSYCHOSOCIAL NEEDS OF ADULT FEMALE RAPE SURVIVORS

The psychosocial needs of victims of violent crimes (inclusive of rape) may include the following (Martin, 2016:280):

- Constructing formal and informal social support systems;
- Strengthening ways to gain a sense of safety;
- Educating survivors of crime to manage their emotions such as anger, sadness and fear;
- Attaining physical and psychological constancy;
- Structuring skills that will help survivors reclaim a sense of personal power and control over their lives;
- Informing the client about the nature of the crime victimisation, so they know what to expect;
- Servicing victims to minimise negative eliciting of the traumatic incident;
- Aiding victims through the mourning process; and
- Pursuing resolution and closure, which leads to personal growth and allows the victim to salvage the confidence and strength to trust people once again.

By disseminating these core concerns, as well as addressing the dynamics and needs specific to each type of crime victimisation, the helping professions such as social workers will contribute to harnessing healing and growth in victims of crime in order for them to begin the process of seeing themselves no longer as victims but survivors (Martin, 2016:280).

Research related to trauma and its impact has elevated awareness about the needs of victimised individuals, giving rise to the *"trauma-informed practise"* undertaking. The Substance Abuse and Mental Health Services Administration (SAMHSA) explicates trauma-informed practices as initiatives that recognise the impact of trauma and probable paths for recovery, recognise the signs and symptoms of trauma, react by assimilating knowledge about trauma into their approach, and repel re-traumatisation (Campbell et al., 2019:4765; SAMHSA, 2014). The trauma-informed care movement challenges service providers to centre survivors' well-being in all interfaces and choices, and this approach is taking root in health care, the CJS, and many other service domains (i.e., psychosocial services provided by NGOs and non-profit organisations NPOs (Bowen & Murshid, 2016:223-224; Campbell et al., 2019:4767; International Association of Chiefs of Police, 2015; International Association of Forensic Nurses, 2018; Randall & Haskell, 2013:503).

According to the SAMHSA, trauma can be defined as:

Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional or spiritual well-being (SAMHSA, 2014:7).

Trauma-informed services are guided by an understanding of the consequences of victimisation on an individual's life. In trauma-informed methods, it is highlighted that service providers comprehend the impact of sexual violence on individuals who approach them to reduce re-traumatisation. The trauma-informed paradigm renders a convincing and humane principle for theorising and attending to the various difficulties and challenges confronting those seeking mental health and other services (Butler, Filomena & Rinfrette, 2011:177; Elliot, Bejelajac, Fallot, Markoff & Reed, 2005:9; Kirkner, Lorenz & Ullman, 2017:3). In addition, trauma-informed care is necessary for planning and rendering service systems to comply with the requirements for working with the vulnerabilities of trauma victims and to enable their involvement in treatment (Butler et al., 2011:177).

Trauma-informed and trauma-specific services are not the same and cannot be used interchangeably. Trauma-informed services are cognizant of and sensitive to the trauma-related challenges articulated by the client, irrespective of whether these challenges are directly or indirectly related to the client's current circumstances. Likewise, trauma-informed services are not conducive to treating traumatic experiences. Trauma-specific services, however, are considered to treat the symptoms and conditions related to existing or past trauma. Trauma-informed services are grounded on understanding the pervasive exposure to trauma among service providers and the users (Butler et al., 2011:178-179; Esaki, 2013:4).

Trauma-informed services aim to improve service users' experiences, advance working settings for staff, escalate job satisfaction and ease stress levels by improving the relationships between staff and clients through better understanding, respect and trust (Sweeney, Filson, Kennedy, Collinson & Gillard, 2018:319). The principles of trauma-informed practices are steered by the following ten principles, as outlined by Sweeney et al. (2018:323-324).

- Seeing through a trauma lens

Trauma-informed approaches concede and understand the high incidence, collective signs and prevalent consequences of trauma. There is an appreciation of the manner in which trauma can affect emotions and, consequently, behaviour, leading to the advancement of coping strategies that might seem extreme, unsafe or destructive without a holistic understanding of the manifold dimensions of trauma.

- Appreciation of invisible trauma and intersectionality

A comprehensive understanding of trauma is endorsed, including contributory factors such as the role of the communal, societal, cultural and historical traumas such as homophobia and sexism and their intersectionality. Service providers should be able to comprehend the context and circumstances of individual lives and be culturally and gender cognisant.

- Paths to trauma-specific support

When survivors are able to report a trauma history, trauma-specific services should be requested and facilitated by the designated service providers within the CJS.

- Preventing trauma in the mental health system

Trauma-informed approaches are informed by the notion that coercion and control in mental health services might lead to re-traumatisation and vicarious trauma. Thoughtful and considered steps should thus be taken to minimise and/or alleviate potential sources of coercion, force, and associated triggers.

- Trustworthiness and transparency

Trusting relationships should be shared between service users and providers by stressing the value of openness, transparency and respect. This is crucial because trauma victims may have been subjected to secrecy and betrayal within their relationships.

- Collaboration and mutuality

Trauma-informed practices should be aware that there is a self-governing aspect to relationships in mental health care, with one person acting as the "*helper*" to a ''*helpee*''. These roles can duplicate power disparities and underpin a sense of incapacity and helplessness in the person seeking assistance from a service provider. As a result, relationships and intervention strategies should aspire to include collaboration through transparency and authenticity and should also be aware of the attributes that the service provider and the recipient thereof deem useful.

- Empowerment, choice, and control

Trauma-informed practices use strengths-based initiatives that enable and support individuals to take control of their lives and service use. Practices are imperative since countless trauma victims will have experienced a complete breakdown of power and control. Coming to terms with the trauma suffered by

the survivor should receive preference over symptoms and resilience over pathology.

- Safety

Essential to trauma experiences are intimidating to an individual's safety and frequently the integrity of their identity. Trauma-informed practices anticipate that the service provider and recipient are emotionally and physically safe, with both parties engaging, negotiating, and reaching a consensus in this regard. The safety of the rape survivor includes psychological, social, gender and cultural safety and is shaped through processes such as informed choice and cultural and gender proficiency.

- Survivor partnerships

Trauma-informed practices attempt to achieve shared and cooperative relationships between service providers and recipients through a joint partnership. Furthermore, services can be managed and delivered by service providers with a direct understanding of trauma and mental health services. Widespread trauma is a persuader for organisational change and enriched relationships within trauma-informed practices, aligned with a desire to address trauma-related needs.

The researcher is of the opinion that a trauma-informed approach in rendering post-rape service promotes the notion of a victim-centred (consequences of the rape on the individual) approach of service rendering within the CJS. Numerous psychosocial service providers guide the rape survivors through the CJS, aided with directives such as collaboration, ensuring the safety of the adult female rape survivor, and shared approaches in identifying and addressing the needs of adult female rape survivors within the CJS.

2.4.4. LEGAL NEEDS OF ADULT FEMALE RAPE SURVIVORS

The CJS approach to addressing rape and assisting female survivors of rape are evident in the conviction rates of rapists and, at the same time preventing secondary trauma. This embraces the provision of support and supporters for

victims throughout the CJS process; expansion of expert knowledge and skills among police, prosecutors, judiciary and other CJS personnel through training; specialist courts; entrenching multi-sectoral working practices; and sufficiently funded and evidence-based approaches that nurture further progress (Walby, Olive, Francis, Lombardo, May-Chahal, Franzway, Sugarman & Agarwal, 2013:18).

Heath et al. (2018) conducted a pilot project (comprising a document analysis) in South Africa to investigate the all-encompassing objective of improving case conclusions for sexual offence cases in piloted sexual offences courts. This study comprised a needs assessment of each court role player's training needs pertaining to the scope of their present knowledge, gaps in training and planned ways in which the skills themselves or their colleagues could be improved. Concerning the content of training, service providers within the court identified the following needs:

- Debriefing and educating senior staff on how to manage debriefing with junior staff;
- Assessing and presenting forensic evidence;
- Communicating with the rape survivor who was not able to communicate clearly for themselves; and
- Interconnecting and consulting with complainants with intellectual, physical or mental disabilities (Heath et al., 2018:13).

Due to the dearth of an all-encompassing approach to post-rape service delivery to adult women in South Africa, this current study intends to investigate the medical, medico-legal, legal and psychosocial modes of service rendering.

2.5. SUMMARY OF THE CHAPTER

The intricacies of rape comprise an array of factors. Although not the focus of this study, it was important for the researcher to explain the dynamics of rape as a social phenomenon. In this regard, the researcher provided an overview of the types of rape, the universal culture of rape, which consists of facets that are

intertwined, each within its own capacity being contributory towards the crime of rape, and victim-blaming was discussed as well as the factors that may hinder a rape survivor from reporting the offence.

The medical aspects of service rendering to adult female rape survivors encapsulate the immediate to long-term physical consequences of rape. The medico-legal paradigm focuses on accumulating forensic evidence to secure a successful conviction. The psychosocial sphere of service rendering to adult female rape survivors seems to be pivotal, yet the literature suggests it is receiving less attention when compared to the medical, medico-legal and legal dimensions of assisting victims of rape within the CJS.

Moreover, it is of pivotal importance to notice that although major strides have been made from medical, legal, medico-legal and psycho-social paradigms of intervention strategies for survivors of rape within the CJS, numerous gaps in this regard still need to be addressed. The next chapter will elucidate service rendering to adult female rape survivors with the CJS.

CHAPTER 3: SERVICE RENDERING TO ADULT FEMALE RAPE SURVIVORS

3.1. INTRODUCTION

The necessity for medical, legal, and psychological support following rape prompted the progression of specialised centres dealing with rape survivors globally (Larsen, Hilden & Lidegaard, 2014:577). The South African government, together with numerous international organisations, civic society and mutual funding contracts, reacted to the circumstances in which rape may occur in manifold ways, as is evident in several acts proclaimed and legislative revisions endorsed. Different government agencies were tasked to address rape either through services, policies, or movements. These initiatives are driven by the Department of Social Development, Department of Health, Department of Justice and Constitutional Development and Department of Basic Education. There are also several awareness programmes in South Africa (i.e., the Sixteen Days of Activism for no violence against women and children from 25 November to 10 December each year and Women's month in August), with other activities to address rape being facilitated by NGOs and NPOs nationally (Jordaan, 2017:18).

During her visit to South Africa in December 2015, the United Nations special rapporteur on violence against women, Dubravka Šimonovic, advised the South African government to fortify the fight against rape as a form of sexual violence through awareness and education within society. She asserted that:

> *despite an arsenal of progressive laws and policies to deal with gender-based violence put very ably in place, there has been little implementation, hence impact and gender-based violence continue to be pervasive and at the level of systematic women's human rights violation … I have heard on many occasions that violence against women is normalized in South Africa. The violence inherited from apartheid still resonates profoundly in today's South African society dominated by deeply entrenched patriarchal attitudes towards the role of women in society, which makes violence against women and children an almost accepted social phenomenon (Centre for the Study*

of Violence and Reconciliation, 2016:4; South Africa's Still Long Walk to Free Women from the Shackles of Violence – United Nations Expert Calls for Change, 2015).

Women who have been exposed to rape have three main needs: medical care, psychosocial care, and assistance from the CJS. Evidence indicates that negative experiences by survivors of rape are linked with long waiting periods to undergo forensic examination and negative encounters with the forensic examiner (a distrustful account of events). Responding to rape entails addressing various modes of care in medical, medico-legal, psychosocial, and legal spheres of service rendering. How service providers respond to clients' needs can substantially affect accessing appropriate care and recovery. Most of the literature available globally concentrates on urban patterns of rape and services, mostly prompted by accessibility to these urban areas. When designing models for intercession, 'one-size-fits-all' models are not recommended (Comparing Sexual Assault Interventions across Europe, 2013:5; Kanan, 2018:2).

Many forms of service delivery are utilised to adhere to the forensic, medical, psychosocial, medico-legal, and legal needs of survivors of rape in diverse countries and regions within countries. These consist of:

- ***Coordinated services*** that deliver psychological, health, forensic and legal services in a distinctive location. Structured services, also often referred to as 'dedicated' or 'specialist' services, harmonise service providers such as the police, prosecutors, doctors, nurses, social workers, and rape victim advocates. The purpose of such structured services is to deliver psychological, health and forensic services in a single location, commonly a centre in a hospital setting. Usually, an individual can access these services through the police, a health care provider, or self-referral. An important aspect of one-stop centres is that the examination for medical and forensic purposes is done as a single examination; all services are available in a single location, and a multidisciplinary team of service providers work together to meet the needs of survivors of rape (Comparing Sexual Assault Interventions across Europe, 2013:15; Kanan, 2018:9).

- ***Non co-ordinated services*** can be accessed independently as part of a mainstream service provision. These services include access to emergency departments in hospitals, sexual health clinics, forensic medical services, counselling and psychiatric services, the police and the courts. Frequently, service providers may refer women to other services, but they are delivered in different locations where medical and forensic examinations are done separately; and the extent of communication between the victim(s) and service providers are usually restricted (Comparing Sexual Assault Interventions across Europe, 2013:15; Kanan, 2018:9).
- ***Integrated services*** are integrated within other applicable services (i.e., sexual health or violence against women). At the same time, structured models have facets of integration that provide multidisciplinary services. They are devoted to the needs of women who have experienced rape. Integrated service models also cover various forms of violence against women, including services provided by NGOs and NPOs (Comparing Sexual Assault Interventions across Europe, 2013:16; Kanan, 2018:10).
- ***Information and advice telephone helplines*** **are services** that afford survivors of rape support, including information on how to access services, legal information, and psychological assistance. These services are anonymous and confidential and are delivered by government entities, NGOs, and NPOs, funded through government, charitable organisations, and/or private funding. Some helplines are entirely aimed at women who are survivors of various forms of gender-based violence, including rape (Comparing Sexual Assault Interventions across Europe, 2013:16; Kanan, 2018:10).
- ***Support services*** are provided by third-party entities such as NGOs and NPOs. The scope of these services is dedicated to the broader domain of rape as a category of gender-based violence. Support service providers predominantly focus on providing guidance and counselling for women. Most are also affiliated with advocating for improved services to victims of

rape and awareness around sexual offences. These NGOs and NPOs also have close relationships with structured services; and might serve as a mode of referral between them (Comparing Sexual Assault Interventions across Europe, 2013:16; Kanan, 2018:10).

Regarding the discussion above, it is appropriate to briefly refer to the medical and medico-legal spheres of services rendered to adult female rape survivors. Healthcare services for adult female survivors of rape could be incorporated into:

- Primary health centres and clinics;
- District, regional and tertiary healthcare facilities; and
- One-stop centres (WHO, 2017:27).

The researcher became aware of the advantages and disadvantages of rendering healthcare services to adult female rape survivors within the CJS. The table below provides an exposition of the advantages and disadvantages of the models of healthcare for women subjected to rape.

Table 2: Advantages and disadvantages of models of care for women subjected to rape

Model	Advantages	Disadvantages
Primary health centres and clinics	Accessible within close vicinity of the community Offer numerous essential services Permits access to follow-up services If an insufficient network is proven, it can advance access to an inter-sectoral network of services, inclusive of legal, social, and other services	May not be able to attend to severe injuries or complications Laboratory or specialised services may be absent Services in small communities, in which service providers are members of the community, confidentiality may be compromised, and providers' fear of retaliation may be challenging due to safety concerns

District, regional and Tertiary hospitals	Intended to provide 24-hour services Accessibility of specialised services Forecasts to be centralised in one department (emergency department, gynaecology, reproductive health, HIV/STIs or distributed within the hospital	May lessen accessibility If services are categorised across departments, can obstruct services, especially if some services are only accessible during working hours
One-stop Centres	More effectual and structured services Render an array of services (police, prosecutor(s), social worker, counsellors, psychological support)	Supplementary space and resources imperative Client load may be small (in rural areas), cultivating concerns on cost-effectiveness May necessitate external staff and resources from other services Might conceivably not be fully integrated into general health services If administered by the judicial system, it might focus primarily on prosecution; and not on the well-being of the client Costly to sustain

Source: (WHO, 2013:37).

The researcher believes South Africa has adopted a hybrid model of service rendering to adult female rape survivors within the CJS, ranging from coordinated, non-co-ordinated and integrated methods combined within a single model of service rendering known as the Thuthuzela Care Centre. Services offered to the victim are linked with NGOs and NPOs, which serve as entities of referral should the need arise or complement existing models of victim support services within the CJS. The nature and extent of service provision are highly dependent on budgetary allocations, specialisation of staff and the geographical

location of the crisis centre. Moreover, South Africa has made major strides in adopting universal practices and principles pertaining to service delivery for adult female rape survivors within the CJS. Regrettably, the implementation and the continuous standardised evaluation of these services require commitment from all stakeholders concerned.

The researcher further asserts that the choice of a service delivery model impacts the anticipated outcomes when rendering services to adult female rape survivors in South Africa. Although a one-stop centre is predominantly utilised, there are challenges regarding the sustainability and cost-effectiveness of such a model. Nonetheless, rape survivors are allowed to access and receive services at a single location close to high-risk areas (an area known to have high criminal activities). A one-stop centre is also ideal for mitigating secondary victimisation since the client is assisted by multidisciplinary service providers as enshrined within the Thuthuzela Care Centre model.

The next section of this chapter will explore the international and national trends in service rendering to adult female rape survivors.

3.2. RESPONSE AND SERVICES AVAILABLE TO ADULT FEMALE RAPE SURVIVORS LOCALLY AND ABROAD

Services offered to victims of rape differ across countries. In this section, the researcher will describe the services available to victims internationally by referring to Europe, the United States of America, Australia, Nordic countries, India, and a selected African country (Kenya). The South African model will also be explained.

3.2.1. AN INTERNATIONAL PERSPECTIVE

Globally, there are variations pertaining to the nature and extent of in-service structures and the provision of services to survivors of rape, which are aligned with distinctive protocols and legislation of a specific country. Some countries have a single model of post-rape services. However, in most countries, there are numerous models and less structured forms of service to adult female rape

survivors within the CJS. Hence, the responses that service users' experiences are influenced not only by the directives set forth within the country they reside but also by specific geographic settings (urban vs rural areas), and as in the case of the United States of America, variances in state legislation can also have substantial outcomes on service provision (Kanan, 2018:9).

In Europe, sexual assault centres are referred to by different names but aspire to render similar models of receptive care for those who necessitate access to services at a time of vast personal crisis. In the Republic of Ireland, such centres are referred to as Sexual Assault Treatment Units, while in the United Kingdom, they are usually termed Sexual Assault Referral Centres. Notwithstanding the terminology used, models of service rendering should be standardised, patient-focused, and function on the auspices of best practice principles that can be applied within various settings (Eogan, McHugh & Holohan, 2013:48). Regarding the sexual assault referral centres in the United Kingdom, the principal mandate in rendering services to adult female rape survivors within the CJS is a clear pathway from intake to exit (with no definite timeline attached to the time of the incident and reporting it to the relevant authorities) (Kanan, 2018:32-33).

In the 1970s, the United States of America introduced a move away from mainly using central models of managing sexual offences such as rape to a one-way approach in rendering services to adult female rape survivors within a single location. This one-way approach aimed to harmonise post-rape care under one structure; and enhance shared collaborative approaches vis-à-vis the inter-disciplinary context of post-rape care among the service providers involved in providing, planning and financing post-rape interventions and programmes. Consequently, a post-rape coordinated model of care has since been adopted globally (Comparing Sexual Assault Interventions, 2012:33).

However, prior to enacting this well-defined mode of post-rape services, the forensic medical examination of the plaintiff was done at a police station when a complaint of rape was reported. As scholarly interest began to evolve in relation to the medical examination of survivors of rape, health professionals criticised the inappropriateness of conducting a forensic examination on a rape survivor in the

common setting of police facilities. Consequently, the provision of an adequate environment for the forensic examination of the victim at the police station was the origin of sexual assault centres, first seen in the United States of America. The original service (forensic examination of rape survivors) was most often led by a dedicated professional within the framework of a support team. However, in the absence of a strategic approach to post-rape service development over a period of time (being the medical and criminal investigation of rape cases), other sexual assault centres, similar to Nordic countries, emerged in the United States of America, known as centres of excellence (Eogan et al., 2013:48).

Sexual assault centres have been one response that surfaced due to disapproval of prevailing post-rape services by women's groups and rape survivors, including the challenges in service delivery by entities such as the police. Documented challenges within sexual assault centres are as follows: limited or no choice in relation to the gender of the forensic examiner, inadequate forensic facilities, and delays between referral to a service and the execution of a forensic examination. Sexual assault centres are intended to render an efficient level of care to individuals who experienced recent rape. Privacy and confidentiality are crucial values in service delivery. Sexual assault centres emphasise the importance of preference and choices, implying that a staff member will be allocated to explicate the procedures and the choices to the victim, although numerous sexual assault centres offer services, irrespective of a formal complaint being laid with the police. Service providers from sexual assault centres also offer an option of taking forensic evidence samples, with the intention for a rape survivor to report the matter to the police at a later stage (Eogan et al., 2013:48; Kanan, 2018:11-12).

In Nordic countries (Norway, Iceland, Sweden and Denmark), the model of service rendering to adult female rape survivors within the CJS is referred to as a Centre of Excellence. Such Centres of Excellence, which are interdisciplinary and victim-focused, emerged as early as 1986 and were initially hospital-based and often advanced through the apparition and leadership of a dedicated female doctor. Today these centres function under the auspices of predetermined sets of standards; and specialise in the emergency response to rape through the provision of essential services for emergency medical treatment and care,

forensic examination, and crisis counselling through referral to a psychosocial service provider, who treats the rape survivor immediately after the rape, ensued with further follow-up care. Additionally, these centres also render services surrounding secondary victimisation within the CJS. Victim outcome evaluations are implemented through a follow-up questionnaire six months after the alleged rape. If the victim does not respond to the survey, a phone call will be placed to the victim.

Furthermore, these crisis centres also afford adult female rape survivors an opportunity to be accommodated overnight in a safe environment. The centres comprise adequately skilled and trained staff, including the availability of trained nurses, in assisting the rape survivor through the entire justice process, namely the questioning by police, safeguarding of medical evidence and psychological and legal procedures in the after-effect and follow-up of rape. Important and distinctive characteristics of these centres also revolve around their focus on research and evaluation, which includes service satisfaction surveys with victims and treatment assessment outcomes in terms of PTSD symptoms, psychological and relational modification and family coping following the crime of rape (Comparing Sexual Assault Interventions, 2012: 24-25; Kanan, 2018:14).

The Australian model of rendering services to rape survivors is termed Sexual Assault Services, which focuses on an extended mode of post-rape care rather than just focusing on crisis intervention and forensic examination. This model operates under the auspices of the Department of Health. All Sexual Assault Services centres have direct relations with a hospital to provide medical care and medico-legal services, while in some cases, these services are offered on the premises of the Sexual Assault Services centre. As such, the Australian model of post-rape services has adapted its mode of service provision to a hospital and crisis intervention network. The Sexual Assault Services model in Australia shares commonalities with well-established rape crisis centres, sharing common principles in rendering long-term support for adult female rape survivors compared to other sexual assault centres internationally. The communal localities of Sexual Assault Centres in Australia afford services distinctive to the needs of adult female rape survivors. One advantage visible within these services is that

their location allows for self-referral, with no prescripts of either recent rape incidents or engaging with the police. This approach is commendable given its ability to reach a greater number of service users, although delays and a lack of choice pertaining to the gender of the medico-legal examiner were highlighted as being a frequent issue of concern (Kanan, 2018:12).

Rape is a serious challenge faced by women in India (Equality Now, s.a.). It is a challenge for adult female rape survivors to access justice, with women from marginalised communities subjected to even further barriers in accessing assistance from the relevant agencies. These barriers include, but are not limited to:

- Communal interference and pressure not to report the crime of rape;
- Discriminatory attitudes of service providers within the CJS:
- Unsatisfactory resources to empower legal aid services, which affects conviction rates negatively;
- Predominantly and widely accepted cultural norms and practices pertaining to patriarchy and male entitlement; and
- Victim blaming seems prevalent, encountered by the broader society and/or the rape survivors' next of kin. Regrettably, this culture of shame suppresses the rape survivor within the CJS, further silencing the ordeal they had suffered (Access to Justice for the Victims of Sexual Violence, 2017; Equality Now, s.a.; UNWomen, 2021:2-4).

In India, integrated modes of service rendering are available for adult female survivors of rape, comprising of the police, legal aid, medical and counselling services. These rape crisis centres came into existence after public protests ensuing the gang rape and murder of a young woman in Delhi in 2012, coupled with demands from women's rights advocacy lobbying groups. Scepticism persists, however, that these centres are not functioning as anticipated in rendering services to adult female rape survivors within the CJS (Human Rights Watch, 2017).

Largely in Southern and East Africa, essential services forming the basic response to rape are grounded on the enactment of one-stop-centres, which renders combined, interdisciplinary services in a single physical location, commonly a medical facility. At the core of this approach is a system of integrated medico-legal and psychosocial services offered at the one-stop centre and a referral network that guarantees access to other vital services for adult female rape survivors within the CJS. These one-stop-centres render adult female rape survivors with an opportunity to access services pertaining to medium- and long-term health and legal support (Keesbury, Onyango-Ouma, Undie, Maternowska, Mugisha, Kageha & Askew, 2012:1). An example of a service rendering to rape survivors in Africa is the Gender-Based Violence and Recovery Centre in Kenya. This centre renders services to adult female rape survivors (including emergency healthcare) comprising mental health support, paralegal services, and integrated collaboration with police, judiciary, local leaders, and the broader community. Rape survivors can expect to receive services on a 24-hour basis within a public hospital in Mombasa, Kenya, inclusive of its advancement, implementation, attainments, and challenges. Manifold progressive national policies to address rape against women have been identified in Kenya (Temmerman, Ogbe, Manguro, Khandwalla, Thiongo, Mandaliya, Dierick, MacGill & Gichang, 2019:1-2).

Although legislation and policies regarding rape exist in Kenya, the implementation thereof remains a challenge being the following:

- Rape perpetrated against women is not taken seriously;
- Victim-blaming and criticising the credibility of rape survivors;
- Ignoring the numerous facets that an adult female rape survivor would consider before reporting the matter to the relevant agencies is further driven by shame and fear; and
- Delaying or postponing justice for adult female rape survivors within the CJS (Equality Now, 2017:6).

The researcher believes various approaches and modes of service rendering have been employed by various countries globally. Although they are unique in practice, with a desire to serve a common purpose, underlying factors such as discriminatory and unequal practices pertaining to women's rights are still prevalent, which might hinder prospects in providing conducive modes of service rendering to adult female rape survivors within the CJS.

3.2.2. A SOUTH AFRICAN PERSPECTIVE

The South African perspective on service rendering available to rape victims will revolve around the Thuthuzela Care Centre model. The subsequent discussion will focus on the development of the Thuthuzela Care Centre model, the goals of the Thuthuzela Care Centres, the Thuthuzela Care Centre Blueprint, services provided at the Thuthuzela Care Centres and service delivery values based on the Thuthuzela Care Centre model.

3.2.2.1. The development of the Thuthuzela Care Centre model

Women's organisations initiated specialised services for rape survivors in South Africa in 1976. State responses dawdled behind, with the first of these government initiatives in rendering services to adult female rape survivors within the CJS only surfacing in 1992. The arrival of democracy in 1994 both observed an increase in such post-rape services initiatives (often pursued in partnership with women's organisations) in rendering services to adult female rape survivors within the CJS, as well as an increase in the number of rape incidences reported to the police. Emanating from this background, the most momentous and persistent means of state responses to rape emerged, namely the Thuthuzela Care Centre model. The first Thuthuzela Care Centre was established in 2000 at GF Jooste Hospital in the Western Cape and concomitant to the Wynberg sexual offences court (Vetten, 2015:8).

In response to the urgency necessitating for a multi-sectoral, integrated, and more sensitive approach to post-rape care services in South Africa, the Sexual Offences and Community Affairs Unit of the NPA endorsed Thuthuzela Care

Centres in 2000 as a site for prevention, response, and support for rape survivors. The formation of Thuthuzela Care Centres at the time was perceived as being a crucial constituent of South Africa's anti-rape strategy that would aid in addressing countless shortfalls related to rendering post-rape services within an isolated sphere of service rendering. Thuthuzela is an *isiXhosa* word meaning 'comfort'. Likewise, the Thuthuzela Care Centre model warrants coordination, cooperation, and the involvement of all the pertinent service providers in the provision of numerous services afforded at the Thuthuzela Care Centres nationwide (Bougard & Booyens, 2015:21; NACOSA, 2018:10; Thuthuzela Care Centres Compliance Audit and Gap Analysis, 2016:23).

Thuthuzela Care Centres function as multi-sectoral one-stop facilities that adopt a holistic approach in rendering essential post-rape services in one location, empowering rape survivors to report the incident and receive healthcare and psychosocial support. Furthermore, Thuthuzela Care Centres are deliberately located in or near communities where the incidence of rape is remarkably high. These centres are usually located within primary or secondary health facilities. A small number of Thuthuzela Care Centres are situated within detached structures known as park homes and not within a health facility. It was also envisioned that Thuthuzela Care Centres are linked with or close to sexual offences courts (Bougard & Booyens, 2015:21; NACOSA, 2018:10). The South African sexual offences courts will be discussed towards the end of this chapter.

The three primary goals of the Thuthuzela Care Centres are:

- Decrease secondary victimisation of gender-based violence survivors;
- Increase conviction rates of sex offenders; and
- Lessen case management time is mandatory to finalise a case of rape (Bougard & Booyens, 2015:21; NACOSA, 2018:10).

The NPA established the Thuthuzela Care Centre Blueprint as a directive for governmental and NGO stakeholder agencies who rendered services at Thuthuzela Care Centres. The Blueprint summaries the steps and processes for the management of rape survivors who enter Thuthuzela Care Centres, and

pursues to address the following (Bougard & Booyens, 2015:22; National Prosecuting Authority, 2008:6; NACOSA, 2018:11; Uniform Protocol For the Management of Victims, Survivors and Witnesses of Domestic Violence and Sexual Offences, 2008): disseminates an ideal example or model depicting the manner in which Thuthuzela Care Centres should be structured; standards for service rendering in an effort to reduce secondary victimisation; norms and standards for managing rape incidences; render a constant and conducive working document for service providers within a multidisciplinary setting; ensure directives on the application of a proficient, effectual and confidential data management system; referrals to Thuthuzela Care Centres within all nine provinces are efficient; and manage stakeholder cooperation at Thuthuzela Care Centres and Regional Courts designated to manage sexual offences; the roles and responsibilities of service providers within the Thuthuzela Care Centre model. Although the Thuthuzela Care Centre Blueprint outlines the functioning of Thuthuzela Care Centres in theory, in practice, the implementation of the model is unique to service rendering between and within provinces in South Africa (NACOSA, 2018:11).

The following table provides an overview of services provided at Thuthuzela Care Centres in South Africa.

Table 3: Services provided at Thuthuzela Care Centres

Initial reception/ intake	Prevention Medical Care	Psychological First Aid Containment of Survivors	Follow-up (Psychosocial care)	Evidence and investigation
Admission	HIV Testing Services	Initial crisis counselling	Long-term psychosocial support	Assistance and support during the medico-legal examination
Information on the nature and extent of services provided	STI screening and referral Information dependent upon PEP support administration (based on HIV Testing Services outcome) Anti-retroviral treatment services (contingent on HIV Testing Services outcomes)	Bath/ shower/ opportunity to change clothing/ care pack (Comprising of toiletries and something to eat) Other referrals Victim support	Long-term psychosocial support- referral to a designated social worker Other referrals Adherence to PEP support	Assistance in reporting the incident to South African Police Service Court preparation services
Community outreach and awareness				
Norms: effectual service flow; passable staffing; satisfactory resources available; space availability; practical working relationships between agencies and service providers; and client records upheld and sustained.				
Initial reception/ intake	**Prevention Medical Care**	**Psychological First Aid Containment of Survivors**	**Follow-up (Psychosocial care)**	**Evidence and investigation**
A social worker should remain on call for 24 hours- 7 days a week.			Long-term psychosocial support	Monitoring, reports and assessments Victim Impact Statements)
			Long-term psychosocial support Adherence to post-exposure prophylaxis support	Legal services

Adopted: (NACOSA, 2018:13).

One of the ultimate strengths of the Thuthuzela Care Centre model is its multi-sectoral approach that brings all services under one entity and brings all service providers together (National Prosecuting Authority, Department of Health, Department of Social Development, SAPS, and numerous NGOs and NPOs). This is also the model's greatest weakness since not all service providers are equally engaged within the Thuthuzela Care Centre model, which necessitates mechanisms to ensure accountability (Thuthuzela Care Centres Compliance Audit and Gap Analysis, 2016:18).

The Foundation for Professional Development was approached by the United States Agency for International Development to execute a compliance audit and gap analysis of the 55 Thuthuzela Care Centres in South Africa. The purpose of the compliance audit was to investigate the various levels of functioning within the Thuthuzela Care Centres, quality of service rendering; equipment available; staffing within the Thuthuzela Care Centres; and the nature of relationships between the service providers. The assessment of the Thuthuzela Care Centres comprised of both quantitative and qualitative methods (although the sample size is unclear), which included staff from the National Prosecuting Authority, as well as NGOs and NPOs (Thuthuzela Care Centres Compliance Audit and Gap Analysis, 2016:14). Unfortunately, the recipients of services (i.e., adult female rape survivors) did not form part of the assessment of the Thuthuzela Care Centres nationwide, which might not necessarily depict or highlight encompassing challenges and level of satisfaction pertaining to services at the relevant Thuthuzela Care Centres. This current study intends to fill this gap by including all service providers involved in the Thuthuzela Care Centre model, as well as adult female rape survivors receiving services at Thuthuzela Care Centres.

The following table provides an overview of the successes of the Thuthuzela Care Centre model in South Africa as found by the Thuthuzela Care Centres Compliance Audit and Gap Analysis.

Table 4: Successes of the TCC model

INDICATOR	NOTES
Human Resources	Most Thuthuzela Care Centres (95%) had a site coordinator, and 70% had a victim assistant officer.
Accessibility and structures of Thuthuzela Care Centres	92% of Thuthuzela Care Centres had a waiting room for clients, 87% had a counselling room, and 75.9% had an office utilised by the South African Police Service and victim assistant officers. 74.4% of Thuthuzela Care Centres had an office designated for NGOs and NPOs.
Health services	All Thuthuzela Care Centres provided HIV counselling and testing (61.1% had room for HIV counselling and testing) and HIV referral services. 98% provided forensic examinations (98.1% had a designated room).
Psychosocial support	90% of Thuthuzela Care Centres offered short-term psychological support, while 98.1% made provisions for long-term psychological support.
Equipment and supplies	Most Thuthuzela Care Centres have the equipment to ensure operational functioning.
Security	7% of all Thuthuzela Care Centres were contracted with a private company to provide security; 20% had security guards, and 18.5% had closed-circuit cameras installed. 90% of security guards knew the location of the respective Thuthuzela Care Centres within hospital settings.
Maintenance of facilities	88.9% of Thuthuzela Care Centres had cleaning services. There was, however, no indication of endeavours to upgrade facilities (since some Thuthuzela Care Centres are park home structures adjacent to hospitals).
Supplementary services provided	The majority but not all services were provided at the respective Thuthuzela Care Centres. All Thuthuzela Care Centres provided reception services, HIV counselling and testing, and HIV referral services. 98% reported case reporting services, 92.6% court preparation services, and 75.9% provided statement-taking services. 70% of Thuthuzela Care Centres were concomitant with a sexual offences court, 83.3% provided comfort packs, 96.3% had facilities for showering/taking a bath, and 83.3% provided clean clothes. Services not provided before at half of the Thuthuzela Care Centres included age estimation, suspect deoxyribonucleic testing and shelter services, although some of these services are provided at adjacent hospitals or police stations.

Adopted: (Thuthuzela Care Centres Compliance Audit and Gap Analysis, 2016:15-17).

The next section will discuss service delivery values within the Thuthuzela Care Centre model.

3.2.2.2. Service delivery values based on the Thuthuzela Care Centre model

Batho Pele is a Sesotho word devoted to the viewpoint of “people first” and delivers guidelines to government organisations when rendering services to the wider population. It is relevant to the study as services are provided to adult

female rape survivors within the CJS. The eight principles of *Batho Pele,* as delineated by the Department of Public Administration in 2010, are as follows:

- **Consultation**

Consultation with service providers is an influential approach envisioned to guide and facilitate government policies and their operational functioning in local government (Department of Public Administration, 2010:1). It is anticipated that all legal systems need to respond to the varied needs of adult female rape survivors within the CJS (Women's Access to Justice: A Practitioners Guide, 2016:26). Service providers must be prepared to deal with the various needs of rape survivors and make specific recommendations to avert prejudice or discrimination. Services afforded to adult female rape survivors should thus be rights-based and reactive to the distinctive needs of individual adult female rape survivors within the CJS (Global Fund to Fight AIDS, Tuberculosis & Malaria, 2015:10).

- **Service standards**

This principle strengthens the necessity to benchmark services which are consistent and standardised (Department of Public Administration, 2010:1). International indicators pertaining to capability, competence, individuality, and impartiality must be met. It is further proposed that the CJS should be contextualised, forthcoming, participatory, susceptible to innovation, and advance gender sensitivity (Women's Access to Justice: A Practitioners Guide, 2016:34). Furthermore, organisations should safeguard that their staff are equipped with the necessary skills when delivering a service to recipients. Services should be reasonable, and the same standard of care should be applied across all entities within the CJS, irrespective of the social identity and circumstances of the recipients thereof (Global Fund to Fight AIDS, Tuberculosis & Malaria, 2015:10).

- **Promoting accessibility**

The focus should be on the uniform distribution of existing services (Department of Public Administration, 2010:1). Adult female rape survivors should be afforded

access to services and informed of their rights, roles and responsibilities within the CJS. It is also imperative that adult female rape survivors be informed of legal proceedings in a timeous manner (Molina & Poppleton, 2020: 240).

- **Promoting courtesy**

Service providers should be empathetic towards recipients of services and treat them with respect and due consideration (Department of Public Administration in 2010:1). Adult female rape survivors should receive services from the police or at the healthcare facility, with long waiting periods to be avoided. All individuals seeking assistance within the CJS should be treated with respect, and interviews should preferably be conducted in the language of the recipients of services (Know- your- rights- TCC, s.a.:14). Adult female rape survivors should also be treated with sensitivity, fairly and taken seriously. Service providers should thus opt to provide the best possible standards of support to adult female rape survivors (Molina & Poppleton, 2020: 4). Services should seek to reinstate control the adult female rape survivor; and facilitate their participation in decision-making processes within the CJS (Global Fund to Fight AIDS, Tuberculosis & Malaria, 2015:10).

- **Providing information**

Information about services should be readily available to the client to access services. Adult female rape survivors should receive information about their rights and the services available to them within the CJS (Department of Public Administration, 2010:1). It is also further advisable to provide information about services in the native language of the recipient of services. The police, medical practitioners and court officials should inform adult female rape survivors about the services available to them and inform them about the progress of the investigation (Know- your- rights- TCC, s.a.: 14; Molina & Poppleton, 2020:23).

- **Openness and transparency**

The public should be made aware of the operations of institutions on national, provincial and local governmental levels, how well these institutions utilise their resources, who is in charge and what entity of a specific department. Adult female

rape survivors always have the right to receive services and be informed of such services (Know- your- rights- TCC, s.a.:14). Service providers should uphold records of their interventions; and be willing to make this information available to the recipients of these services, according to the prescripts of confidentiality. It is also crucial for recipients of services to be well-informed of actions taken by service providers, and recipients should be provided with reasons for certain actions if needed (Global Fund to Fight AIDS, Tuberculosis & Malaria, 2015:10).

- **Redress**

It is essential to swiftly and efficiently identify modes of service rendering that experience challenges. Redress refers to remedial action to address shortfalls and should also be implemented efficiently. Adult female rape survivors have the right to be protected from intimidation, harassment, bribery and abuse (Know-your- rights- TCC, s.a.:14). Suitable and effective measures, including protection from and eloquent redress to the harm suffered, must be conveyed and imposed in a human manner (Women's Access to Justice: A Practitioners Guide, 2016:34).

- **Value for money**

Working proficiently might save money and time, which necessitates progress in service delivery to the public (Bougard, 2014:119-120; Department of Public Administration, 2010:1). State agencies must guarantee the appointment of the necessary much-needed human resources; and invest in satisfactory financial and technical resources to fund the CJS, institutions and organisations; to ensure accountability for all the stakeholders concerned (Women's Access to Justice: A Practitioners Guide, 2016:36). Most importantly, there is a restricted budget from the government to support the Thuthuzela Care Centre model in future, and no all-embracing policy has so far been drafted to keep all stakeholders within the CJS accountable (Triangle Project Policy Brief, 2016:3).

The service delivery model, as mentioned above, is enshrined within the Victim's Charter (which will be discussed towards the end of the Chapter), which is endorsed by the National Prosecuting Authority. The rights provided to victims are also aligned with the values of *Batho Pele* and are as follows*:*

- Be treated with equality and with respect in relation to dignity and privacy;
- Render and receive information; and
- Afford protection, assistance, and restitution (Kirchengast, 2018:195).

3.3. Thuthuzela Care Centre mode of service rendering to adult female rape survivors: Roles and duties of service providers

The next section of the chapter will explore the modes of service rendered to adult female rape survivors within the CJS.

3.3.1. LEGAL MODE OF SERVICE RENDERING TO ADULT FEMALE RAPE SURVIVORS

Within the legal mode of service, rendering attention will be focused on the investigation and prosecution services available to victims of rape. The researcher will describe the role and functions of the SAPS and the prosecution.

- **South African Police Service**

The investigating officer who received the rape complaint should either notify staff at the Thuthuzela Care Centre; or inform the Family Violence, Child Protection and Sexual Offences Unit of the SAPS. The responsibilities of the investigating officer are to inform the rape survivor not to bathe or shower prior to the medico-legal examination; a collection of physical evidence; take statements from the victim; complete the SAPS 308 form; transport the victim to a place of safety if necessary; take the evidence collected to the Forensic Science Laboratory of the SAPS for analysis; keep the adult female rape survivor abreast of the legal proceedings pertaining to her case; continuously engage with the prosecutor and case manager regarding the case, and facilitate the identification parade if the alleged rapist has been apprehended. In addition, the investigating officer is also mandated to execute the compulsory HIV testing of the alleged sex offender(s); if there are reasonable indications that the rape survivor might have been exposed to HIV; prior to her consent. It is also anticipated that the investigating officer will make a copy of the whole docket (referred to as a dummy document), which must be presented in court on the first day of legal proceedings. The

dummy document is sent to the bail court, and the original document goes to the case manager, who is responsible for escalating the document to the investigating officer (Department of Safety and Security, 2008: 19-24; Uniform Protocol For the Management of Victims, Survivors and Witnesses of Domestic Violence and Sexual Offences, 2008:19-24).

- **Prosecutor at first appearance**

It is the responsibility of senior prosecutors to ensure they can attend to enquiries from the district courts about new dockets. It is also mandatory that prosecutors be available for consultation with the investigating officer and the Family Violence, Child Protection and Sexual Offences official on a 24-hour basis (Uniform Protocol For the Management of Victims, Survivors and Witnesses of Domestic Violence and Sexual Offences, 2008:28). The Uniform Protocol for the Management of Victims, Survivors and Witnesses of Domestic Violence and Sexual Offences is the only document in South Africa highlighting the functions of the prosecutor in relation to sexual violence such as rape.

Senior Public Prosecutors are responsible for allocating a specific sexual offence's prosecutor to a specific docket. Once the office of the Sexual Offences and Community Affairs Unit of the Public Prosecutors receives a docket, they must ensure that the investigation is adequately conducted and give the docket to the case manager, who then delivers it back to the police. Once a prosecutor completes a consultation, the comprehensive notes must be kept and filed in the docket. In addition, once a prosecutor has consulted with a complainant, he/she must conclude the trial as quickly as possible to avert secondary victimisation. Prosecutors should not proceed with any case on trial unless they have consulted adequately with the complainant and have assured that they are fully prepared to testify. At every appearance date, the docket must be forwarded to the regional court control prosecutor, and he/she must forward it to the case manager on the same day. Upon receipt, the case manager must sign for it and forward it to the Sexual Offences and Community Affairs prosecutor, who must validate that the investigation was done properly and forward the dockets to the regional court control prosecutor after every postponement at the end of the court day. The

regional court control prosecutor is also accountable for transferring the docket (within 24 hours) to the case manager to update the database and return it to the SAPS (within 24 hours) (Uniform Protocol For the Management of Victims, Survivors and Witnesses of Domestic Violence and Sexual Offences, 2008: 28-29).

3.3.2. MEDICAL MODE OF SERVICE RENDERING TO ADULT FEMALE RAPE SURVIVORS

Sexual violence is a serious and common problem universally. The abrupt and long-term health outcomes of sexual violence include physical injuries, unwanted pregnancy, abortion, gynaecological complications, STIs, PTSD and depression (Cybulska, 2013:142). Rape is also linked to increased pregnancy-related complications such as miscarriage, premature labour and low birth weight related to violence during pregnancy. Also, high-risk behaviours such as alcohol and drugs and unsafe sex are suggestively more frequent among survivors of intimate partner violence and rape. Most importantly, the median medical costs for women experiencing at least one incidence of physical intimate partner violence were twice the costs of their male counterparts. When the costs of an individual not reaching their full productive potential are considered, the total costs to society are presumably even greater (WHO, 2010:3, 5-6) (*Cf Chapter 2 discussion on the medical services for adult female rape survivors)*.

In Section 66(3)(a)(i) of The National Directives and Instructions on conducting a Forensic Examination on survivors of Sexual Offence cases (2009:2-3), provision is made for the administration of post-exposure prophylaxis. In sub-Saharan Africa, dual epidemics of HIV and sexual violence make the implementation of post-exposure prophylaxis an imperative part of the public health response to sexual assault and rape. Furthermore, genital trauma related to rape increases the likelihood of HIV transmission. Understanding the uptake and use of PEP could inform strategies to capitalise on the effectiveness of post-exposure prophylaxis (Chacko, Ford, Sbaiti & Siddiqui, 2012:338; Draughon, 2012:85; Muriuki, Kimani, Machuki, Kiarie & Roxby, 2017:255; Wheeler, Anfinson, Valvert & Lungo, 2014:26).

Few studies have documented PEP completion rates among South African victims, and it was found that most victims lack comprehensive information about post-exposure prophylaxis regimens, follow-up visits, negative side effects and rate of seroconversion. Factors linked with a considerably higher risk of post-exposure prophylaxis non-completion were low-risk perception, a known assailant commencing with PEP delayed, and self-refusal. Additional factors included the stigmatisation of HIV infection, psychological trauma after rape, absence of proper multidisciplinary healthcare approach in healthcare facilities, and a lack of psychosocial support (Inciarte, Leal, Masfarre, Gonzalez, Diaz-Brito, Lucero, Garcia-Pindado & García, 2019:44; Scannell, MacDonald, Berger, Boyer & Boston, 2017:121).

The table below highlights the PEP treatment of STIs following a sexual assault or rape.

Table 5: PEP and treatment of STIs

PEP and treatment of STIs
Consider rendering PEP for women presenting within 72 hours of a sexual assault and rape. Employ collective decision-making with the rape survivor to determine whether HIV and post-exposure prophylaxis are warranted.
Discuss HIV risk to determine the use of PEP with the survivor, inclusive of:
HIV prevalence in the geographic area;
limitations of post-exposure prophylaxis;
the human immune deficiency virus status and features of the alleged assailant if known:
assault characteristics, inclusive of the number of alleged rapists;
side-effects of the antiretroviral drugs used in the post-exposure prophylaxis regimen
probability of human immune deficiency virus transmission.
If HIV PEP is provided:
initiate the regimen as soon as possible and before 72 hours
provide HIV testing and counselling at the initial consultation to ensure patient follow-up at regular intervals
two-drug regimens (comprising a fixed-dose combination) are usually preferred over
three-drug regimens, prioritizing drugs with fewer side-effects
an example of a triple post-exposure prophylaxis regimen in instances of multiple alleged assailants if available (lamivudine, zidovudine, and lopinavir-ritonavir).
the choice of drug and regimens should follow national guidance.

Adherence counselling should be an important component of PEP provision.
Female survivors of sexual assault should be offered prophylaxis for:
chlamydia
gonorrhoea
trichomonas
syphilis, depending on the prevalence and the choice of drug and regimens, should follow national guidance.
Hepatitis B vaccination without hepatitis B immune globulin should be afforded as per national guidelines.
Take blood for hepatitis B status before administering the first vaccine dose.
If immune, no further course of vaccination is necessitated.

Adopted: (Muriuki et al., 2017:256; WHO, 2013:6).

The treatment of STIs, including gonorrhoea, chlamydia, hepatitis B and HIV, comprises an important part of the management of survivors of rape. STI can be prevented instantaneously by rendering bacterial and viral prophylaxis followed by sexual health screening two weeks later if the victim is symptomatic. The choice of treatment is highly dependent on the local incidence and prevalence of infections, and resistance to antibiotics should be considered (Cybulska, 2013:142).

Another medical need experienced by rape survivors is the availability of emergency contraceptives following a sexual offence. Emergency contraception should be provided to survivors of rape and sexual assault presenting within five days of the incident, preferably as soon as possible, to make the most of its effectiveness. Healthcare practitioners should offer levonorgestrel, if available. A single dose of 1.5 mg is recommended since it is as effective as two doses of 0.75 mg given 12–24 hours apart. If levonorgestrel is not available, the combined oestrogen–progestogen regimen may be offered, along with anti-emetics if available. If oral emergency contraception is not available and it is feasible, a copper-bearing intrauterine device may be afforded to women seeking continuous pregnancy prevention. Given the risk of sexually transmitted infections, the intrauterine device may be inserted up to five days after a sexual assault for those who are medically eligible. If a woman presents after the time required for emergency contraception (five days), emergency contraception fails,

or the woman is pregnant due to rape, she should be offered safe abortion, in accordance with national law (WHO, 2013:5).

3.3.3. MEDICO-LEGAL MODE OF SERVICE RENDERING TO ADULT FEMALE RAPE SURVIVORS

The significance of both anogenital and physical wounds has been well-documented. Yet, there still exists a lack of consensus on the documentation of medico-legal information and its implications concerning the legal facets of sexual assault and rape. The risk of acquiring a physical injury is proportionately higher for women who were attacked by a stranger. Women with the greatest probability of sustaining both a physical and an anogenital injury were those above 45 years of age (Kulhari, Saini, Saini & Buri, 2017:20076-20077). Research conducted by Astrup, Ravn, Lauritsen and Thomsen (2012) suggests that irrespective of the victim's relationship with the alleged offender; women are more likely to report the incident to the police if they sustained physical injuries during the attack (Astrup, Ravn, Lauritsen & Thomsen, 2012:50–56; Astrup, Ravn, Thomsen & Lauritsen, 2013:525–529; Larsen, Hilden & Lidegaard, 2014:580).

In terms of the Thuthuzela Care Centre model, the duties of the staff from the Department of Health are outlined as follows:

- **Forensic nurse / Medical examiner**

When the rape survivor presents at the Thuthuzela Care Centre, the site coordinator and forensic nurse will meet the victim. When the forensic nurse receives a call, he/she must notify the site coordinator that the victim is on her way to the Thuthuzela Care Centre. The forensic nurse is then mandated with the duty of explaining to the victim that she will be examined, as well as clarifying the processes and purpose of the examination (Uniform Protocol For the Management of Victims, Survivors and Witnesses of Domestic Violence and Sexual Offences, 2008:29). After the investigating officer has taken a statement from the victim, the forensic nurse should take the victim's information and open a hospital file to be captured into a register with a Thuthuzela Care Centre file number to the case. The details of admission are conveyed to the site coordinator

or victim counsellor. The forensic nurse should advise the site coordinator or victim counsellor of admissions that took place after hours or over weekends. The forensic nurse or the lay counsellor is accountable for the pre-and post-HIV counselling, including trauma containment. The forensic nurse is also responsible for pregnancy testing, HIV testing, sexually transmitted infections testing and other tests obligatory by national or provincial guidelines. In addition, the forensic nurse calls the district forensic surgeon or the centre's forensic examiner on call, who needs to be a medical doctor within the Thuthuzela Care Centre model, to inform him/her that a rape survivor has arrived. The forensic nurse or lay counsellor must prepare the docket (if available) and provide the centre forensic examiner or district forensic surgeon with the SAPS Sexual Assault Evidence Collection Kit. It is envisioned that no rape survivor should wait for periods exceeding more than two hours for a medical examination to be conducted. The centre forensic examiner or district forensic surgeon must explicate the process of the medical examination to the rape survivor in a subtle and educational manner and obtain informed consent from the victim to execute the medical examination (Uniform Protocol For the Management of Victims, Survivors and Witnesses of Domestic Violence and Sexual Offences, 2008:29). The investigation and examination of a sexual offence patient entail the following:

a) The Sexual Assault Evidence Collection Kit must be used when conducting a forensic medical examination in sexual offence cases. There are differential kits for adults and children under the age of 12 years.

b) The kit has a checklist of all the evidence required to be collected for forensic purposes and instructions, which need to be followed accurately.

c) The rights of the patient should be respected during the course of the forensic examination.

d) Informed consent is crucial before forensics examine clients with sexual violence.

e) A comprehensive history of the patient should be documented.

f) Physical examinations should be conducted by an experienced and skilled forensic

g) Healthcare practitioner. Correct positioning of patients and techniques should be consistent and according to national and international directives.

h) Forensic healthcare practitioners must sufficiently complete the required documentation (inclusive of the J88 form), and concrete conclusions should be corroborated with the physical examination of the rape survivor according to the Sexual Assault Evidence Collection Kit, and all items in the kits are bar coded with their unique number. Consequently, sections of different kits should not be exchanged or mixed.

i) Unused constituents of the Sexual Assault Evidence Collection Kit must be destroyed.

j) The collection of forensic evidence should instantaneously follow a medical examination.

k) Only medically stable patients should be escalated to a forensic medical examination evidence collection procedure.

l) Emergency treatment should be afforded before the forensic examination of the rape survivor (Uniform Protocol For the Management of Victims, Survivors and Witnesses of Domestic Violence and Sexual Offences, 2008:29).

m) Forensic evidence collection in female adult rape survivors comprises the following:

- Conclusion of consent forms accompanying the Sexual Assault Evidence Collection Kit;
- An all-encompassing history taking involving genital procedures, symptoms since the rape, details of the rape incident, number of attackers, specific forms of intimidation employed by the offender(s), the form of penetration, non-genital acts, loss of awareness, amnesia, events after the rape had occurred;

- Control swabs;
- Toxicologic testing to be conducted preferably within 72 hours, particularly if a loss of consciousness had been noted, to determine the kind of drugs the patient used or consumed;
- Blood or saliva swabs to determine the patient's DNA;
- Oral swabs/smears within less than 24 hours after oral penetration;
- Fingernail debris collection if the patient scratched the alleged rapist;
- Foreign material should be collected with the aid of collection sheets on the exam table and/or from an ambulance to be used as evidence;
- Collection of clothing. If cutting clothes off the patient, service providers should pay meticulous attention to tears in clothing and stains that could validate the use of force inflicted on the rape survivor;
- Full body examination of the adult female rape survivor to determine the nature and extent of injuries, lesions, and secretions. Evidence should be captured with the aid of photographs. If bite marks are observed, the area should preferably be swapped twice for DNA;
- Collection of head-to-hair combings;
- Pubic hair combings and the collection thereof;
- For female patients, the anogenital injuries should be examined in the lithotomy position. It is also imperative to take external genital swabs, vaginal swabs and perianal swabs; and
- The completed documentation accompanying the sexual assault examination collection kit should be placed in a sealed envelope with collected specimens (Ladd & Seda, 2021:2-3).

n) The samples collected should be correctly packed (and stored for a minimum of six weeks, if necessitated) and transferred. (Uniform Protocol

For the Management of Victims, Survivors and Witnesses of Domestic Violence and

o) Sexual Offences, 2008:31).

p) Mishandling of the evidentiary chain may result in the court ruling the evidence as excluded (Uniform Protocol For the Management of Victims, Survivors and Witnesses of Domestic Violence and Sexual Offences, 2008:31).

q) Likewise, evidence collected by a non-expert will be rejected by the court (National Directives and Instructions on conducting a Forensic Examination on survivors of Sexual Offence cases in terms of the Criminal Law (Sexual Offences and Related Matters) Amendment Act, 2007:14-15).

From a legal standpoint, police reports should entail the following: comprehensive history taking to substantiate that the alleged sexual offence indeed occurred; documents of observations; forensic trace evidence collection; explanation of the findings; a standardised and objective medico-legal report; and provision of expert opinion in legal proceedings (Ingemann-Hansen & Charles, 2013:92-93).

The following tables summarise the medico-legal processes for adult female rape survivors within the CJS regarding the recording of post-assault history and the contents of the forensic report.

Table 6: Recording post-assault history

Post-assault history of the complainant
▪ Date and time of the alleged assault ▪ Pertinent patient medical history. ▪ Events that transpired. ▪ Recent consensual sexual activity.

- The exact position of the victim and the alleged rapist during the attack.
- Nature of physical attack and surroundings.
- Nature and extent of coercion employed and restraints used to subdue the victim.
- Whether weapons were utilised or neck compression perpetrated, these have legal implications.
- Removal of victim's and attacker's clothing.
- Oral, vaginal, rectal, penetration by penis, fingers or objects.
- Ejaculation.
- Kissing of the victim's face or body by the perpetrator.
- Segments of the plaintiffs' bodies touched by the alleged rapist.
- Post-sexual assault and rape activities (i.e., bathing, changing clothing, visiting the toilet).
- Assault-induced patient history (i.e., genito-anal discharge, bleeding or pain symptoms.

Adopted: (Ingemann-Hansen & Charles, 2013:93; Mulla, 2014:45-47; Savino & Turvey, 2011:303-304).

The following table outlines the content of the forensic report within a particular order.

Table 7: Contents of the forensic report

Contents of the forensic report
▪ Victim demographics ▪ Assault history (i.e., from victim and police) ▪ Alcohol and drug history ▪ Post-assault activities ▪ Medical and gynaecological history ▪ Rape survivors' overall appearance ▪ Signs of inebriation, impairment, and illness ▪ Injury depiction ▪ Particulars of all specimens collected ▪ Processes of the examination entailed and specimens collected ▪ Material for laboratory investigation/storage ▪ Instantaneous test results ▪ Medications and referrals provided ▪ Interpretation and conclusion of forensic findings emanating from alleged sexual assault and rape o force infliction o life threat o health outcomes

Source: (Ingemann-Hansen & Charles, 2013:99).

3.3.4. PSYCHOSOCIAL MODE OF SERVICE RENDERING TO ADULT FEMALE RAPE SURVIVORS

The staff executes the following duties at the relevant Thuthuzela Care Centres in terms of psychosocial services rendered to rape survivors.

- **Site coordinator**

The site coordinator is accountable for coordinating services at the Thuthuzela Care Centre. Once a call has been dispatched from a referral institution, the site coordinator must inform all the service providers, such as the SAPS and health clinics. If the site coordinator obtains details that an emergency vehicle needs to be sent to transport the victim, the site coordinator, with the support of the forensic nurse, should make the required arrangements. Once the victim arrives at the Thuthuzela Care Centre, the site coordinator must ensure that the victim is not offered anything to eat or drink or relieve herself without the knowledge of the site coordinator in order to ensure that no evidence is lost prior to the medico-legal examination. Furthermore, the site coordinator should also explain all the processes that will follow to the survivor of rape. The site coordinator is then required to open a Thuthuzela Care Centre file for the victim, and the victim's details are captured accordingly (Bougard & Booyens, 2015:23; Uniform Protocol For the Management of Victims, Survivors and Witnesses of Domestic Violence and Sexual Offences, 2008:24).

The site coordinator must also oversee that the client receives short-term emotional support and debriefing and, if necessary, make the required arrangements with a psychologist or counsellor for long-term counselling. After the initial early psychosocial support, the rape survivor is examined by the forensic nurse or forensic district surgeon. For the conclusion of the physical forensic examination, the victim may be offered an opportunity to take a bath or shower at the Thuthuzela Care Centre and, if necessary, be provided with comfort packs, toiletries and clothing. Members of the SAPS can now proceed to take a victim statement, and the site coordinator will arrange transport back to the residence, shelter or place of safety for the victim. The site coordinator must report all new cases to the case manager twice daily at 09:00 and again at 15:00 from Monday to Friday. The site coordinator is also accountable for facilitating and steering implementation meetings, public education interventions and awareness programmes (Bougard & Booyens, 2015:23; Uniform Protocol For the Management of Victims, Survivors and Witnesses of Domestic Violence and Sexual Offences, 2008:24; WHO, 2013:4).

- **First Responder**

First responders are usually counsellors who assist rape survivors when they report the incident at a Thuthuzela Care Centre. The function of the first respondent is to serve as a victim's advocate and assist the rape survivor with the CJS. Furthermore, the first responder is also tasked with providing information pertaining to post-exposure prophylaxis, conducting HIV screening, maintaining the records of patients, and liaising with rape survivors and stakeholders concerned (NACOSA, 2018:13). The role and mandate of the first responder are, however, not included in the Thuthuzela Care Centre model protocol.

- **Victim Assistant Officer**

The responsibilities of the victim assistant officer are to finalise the rape survivors' intake at the Thuthuzela Care Centre; establish the victim's psychological, physical, social and safety well-being; and expedite the placement of the victim in a place of safety or shelter, in circumstances whereby it is warranted to do so, in collaboration with the assistance and support of a social worker and/or investigating officer (Bougard & Booyens, 2015:23; Uniform Protocol For the Management of Victims, Survivors and Witnesses of Domestic Violence and Sexual Offences, 2008:24).

With the assistance of the forensic nurse, the victim assistant officer must make long-term counselling arrangements for the client; and inform the site coordinator of all the related matters of relevance to the victim's well-being. Furthermore, the victim assistant officer is expected to request a progress report from the respective service providers rendering services to the client. The victim assistant officer should ensure that court preparation programmes are accessible to rape or sexual assault victims. Another duty of the victim assistant officer comprises continuously informing the victim about their cases (bail application made by an offender and the conditions thereof, court dates and outcomes of legal proceedings). The victim assistant officer may also be expected to participate in activities aimed at prevention, protection, promotion, rehabilitation and outreach about victim empowerment (Bougard & Booyens, 2015: 23; Uniform Protocol For

the Management of Victims, Survivors and Witnesses of Domestic Violence and Sexual Offences, 2008: 25-26).

- **Case Manager**

The case manager is responsible for providing oversight regarding the investigation of the alleged sexual assault and rape. The case manager should evaluate and assess dockets and provide directives to the investigating officer, who is responsible for the successful apprehension of an alleged suspect(s), and take them to court within 48 hours. The case manager also acts as a link between the courts, manage referrals, and transfer cases from the lower courts to the High Court. The case manager also communicates directly with the Office of the Directorate of Public Prosecutions for decisions on the merits of reported sexual offence cases and informs the control prosecutor with a daily statistics form. In addition, the case manager is responsible for discussions with witnesses to make a decision relating to the merits of the case and reports on the progress of all cases presented at the Thuthuzela Care Centre. The case manager is also accountable for accelerating information relating to the outcomes of proceedings to the victim assistant officer daily (Bougard & Booyens, 2015:23-24; Uniform Protocol For the Management of Victims, Survivors and Witnesses of Domestic Violence and Sexual Offences, 2008:27).

The next section will outline the role and responsibilities of the Department of Social Development in the psychosocial mode of service rendering within the Thuthuzela Care Centre model.

- **Victim counsellor**

Entities within the Department of Social Development, such as the victim counsellor, deliver a crucial service to survivors of sexual offences. The function and duties of the victim counsellor are to support the victim assistant officer with the psychological well-being of the rape survivor within the CJS. The victim counsellor must ensure that short-, medium- and long-term psychosocial services are available for survivors of rape and, as such, holds the following responsibilities: notify the site coordinator weekly of any pertinent information

relating to the well-being of the client; accountable for court support programmes; ensure that a suitable service provider prepares the rape survivors prior to legal proceedings (if the service is not rendered at the respective Thuthuzela Care Centre); and refer the victim for statutory interventions and follow-up visits (Bougard & Booyens, 2015:27; Uniform Protocol For the Management of Victims, Survivors and Witnesses of Domestic Violence and Sexual Offences, 2008:29-31).

3.4. CHALLENGES IN RENDERING SERVICES TO ADULT FEMALE RAPE SURVIVORS WITHIN THE CRIMINAL JUSTICE SYSTEM

The following section of the chapter will highlight the numerous challenges in rendering services to adult female rape survivors, namely legal, medical, medico-legal and psychosocial.

3.4.1. CHALLENGES IN RENDERING LEGAL SERVICES TO ADULT FEMALE RAPE SURVIVORS WITHIN THE CRIMINAL JUSTICE SYSTEM

An array of challenges is experienced by adult rape survivors regarding the legal services offered to them. This section will explore the protective measures within the CJS, the re-establishment of the Sexual Offences Courts, and the investigation and prosecution of sex offenders.

- Protective measures for the adult female rape survivor within the criminal justice system

Protective measures that should be in place for rape survivors during legal proceedings include:

- Limiting the time spent in court;
- Facilitating a safe environment for rape survivors; and
- Improving the experience of rape survivors in the CJS through implementing a victim-centred approach and reducing secondary victimisation (Legal Aid Society, 2020:61; Zia, Shallum & Randhawa, 2021:55).

These protective measures are ideal, but the challenges that victims continue to experience include court preparation and cross-examination by the defence. There seems to be limited-to-no court preparation for adult female rape survivors within the CJS. Often, a rape survivor may have challenges recalling events related to the incident over a certain period. Thus, the adult female rape survivor must be prepared for court; review the statements made; and refresh their memory before legal proceedings (Zia et al., 2021:39).

Cross-examination within a criminal trial has the prospects of undermining the narrative and credibility of the victim. Discrediting rape victims during legal proceedings usually refers to incidences in which the defence is trying to establish a consensual relationship between the accused and the victim or the discrediting of the rape victim concerning questions of an inappropriate nature (a reference to clothing at the time the alleged rape had occurred) (Zia et al., 2021:55).

- **Challenges in the re-establishment of the sexual offences courts**

As of 2020, South Africa established 106 sexual offences courts. Despite this re-establishment, various challenges continue to be experienced, namely: a limited legal outline to institute and sustain the formation of these courts; insufficient resources to fund the range of services required by victims of sexual offences, resulting in a scarcity of prosecutors, intermediaries and court preparation officers; poor visibility of the courts in isolated and rural areas; limited space capacity required for private consultation; insufficient and inconsistent delivery of skills training and debriefing programmes for court personnel; and inadequate monitoring and evaluation of the efficacy of the sexual offences courts (Sexual Offences Courts National Strategic Draft Plan, 2016-2020:18).

- **Challenges identified within the investigation of sexual offences and prosecution of sex offenders in South Africa**

Machisa, Jina, Labuschagne, Vetten, Loots, Swemmer, Meyersfeld and Jewkes (2017) conducted research based on an analysis of a nationally representative randomly selected sample of rape cases documented by the SAPS in the year 2012. Their study comprised 3 952 cases of rape reported to the SAPS in 2012 at 170 police stations. Regarding the completion of case dockets, it was found

that the address of the victim was not readily recorded (2.1% of cases), the plaintiff statement was not signed (13.4% of cases), and the telephone number of the victim or victim's guardian was captured in only 21.5% of cases. A mere 7% of cases contained the name and contact number of the investigating officer and had been conveyed to the victim. Arrests were made in 57% of cases, and often no arrests were not made due to the victim deciding to withdraw the case.

Moreover, in 23.7% of dockets without arrests, the alleged offender had been identified, and the victim wanted to pursue the case. It is thus unclear why the police did not arrest the alleged offender(s) (Machisa et al., 2017:14). The empirical findings of this study further found that prosecutors were hesitant to prosecute 1 217 of 2 579 cases (47.7 %) transferred by the investigating officer for prosecution, representative of 34.4% of all rape cases in the study. Other cases were placed on the court roll before trial, and half of the enrolled cases were withdrawn. Reasons for abating to prosecute were that the victim wanted to move on with their life (67.6%), followed by inadequate evidence (32.4%), and often both. Evidence also existed that the SAPS improperly referred cases where the victim had not identified an alleged sex offender. A prosecutor's decision not to prosecute was determined by the thoroughness of the police investigation, evidence collection, and apparent severity of the rape incident (Machisa et al., 2017:14).

It was further found in the study of Machisa et al. (2017) that pleading guilty to a sexual offence was less frequent among sex offenders who had previous convictions; and when adult rape survivors were involved. An offender pleading guilty was twice as likely if the perpetrator's DNA matched the DNA found on the crime scene or the victim; and if the police had visited the crime scene. Generally, the accused was found guilty of a sexual offence in 46.5% of all cases going to trial. Numerous sentences handed down by presiding officers strayed from the prescribed minimum sentence of life imprisonment for rape (Machisa et al., 2017:15). Furthermore, within certain courts, the translators did a poor job, and there is substantial potential for courts to be misinformed about the merits of a rape case due to poor translation. Evidence of rape myths and gender stereotypes bears significant negative outcomes in rape cases. Some

prosecutors led unrelated evidence on the complainants' sexual history and neglected to challenge the same from the defence. This was concomitant with some magistrates deriving incongruous conclusions. There was also evidence of inapt weight given to the offenders' family's views in legal proceedings and sentencing (Machisa et al., 2017:15).

Lastly, Machisa et al. (2017:14) found that the medical examination of rape victims and the collection of evidence using the Sexual Assault Evidence Collection Kit were only properly executed in 76.7% of rape cases. In addition, over a fifth of all cases where the Sexual Assault Evidence Collection Kit was completed it was not sent to the Forensic Science Laboratories for analysis. More recently, it surfaced that the National Forensic Science Laboratories had been unable to process DNA samples for two (2) months (during the period of January and February 2021), despite having a backlog of 117 738 cases waiting to be finalised. According to Mark Rogers from the National Forensics Oversight and Ethics Board, by March 2021, the backlog had increased to 172 787 unprocessed DNA samples sent to the National Forensic Science Laboratories. Police Minister Bheki Cele justified the backlog in DNA cases to be processed due to supply chain management, while the then National Police Commissioner General Khela Sithole cited financial constraints as the main reason for this bottleneck within the CJS. During a Police and Civil Rights Union conference in November 2019, Minister Bheki Cele also cited corruption as being to blame for a shortage of Sexual Assault Evidence Collection Kits at police stations (Gerber, 2021; Mallene, 2019).

3.4.2. CHALLENGES IN RENDERING MEDICAL SERVICES TO ADULT FEMALE RAPE SURVIVORS

A factor obscuring follow-up processes ensuing rape is the availability of after-hours health services at the Thuthuzela Care Centres. Rape survivors who presented at the centres after hours have to wait for hours to see a healthcare practitioner. Only 50% of Thuthuzela Care Centres had a designated healthcare practitioner (primarily during the day). At some centres, rape survivors were only referred for a medical examination the following day. By then, some rape

survivors may no longer have the desire to pursue the case (Thuthuzela Care Centres Compliance Audit and Gap Analysis, 2016:16; Vetten, 2015:34, 41).

There also exists a serious concern relating to the availability of medical equipment. Although 82% of Thuthuzela Care Centres have speculums, only 61% have colposcopes, and 37% have either a gynae couch or lithotomy table (both being used for the physical medico-legal examination of rape survivors). The absence of critical medical equipment to conduct medico-legal services thus influences the quality of services rendered at Thuthuzela Care Centres (Thuthuzela Care Centres Compliance Audit and Gap Analysis, 2016:16).

3.4.3. CHALLENGES IN THE MEDICO-LEGAL EXAMINATION OF ADULT FEMALE RAPE SURVIVORS

Research conducted by Machisa et al. (2017) in South Africa found that most adult rape survivors (92%) underwent a medico-legal examination within 72 hours. The presence of injuries was documented in two-thirds of all cases within the sample- with no variance by age group of the victim. Twenty-six percent of rape survivors had non-genital injuries captured on the J88 medical form, and 56% had genital-anal injuries. There were numerous instances in which the J88 form was insufficiently completed- which affects the evidentiary value and the prospects of the police in tracing the health practitioner who completed it. The aforesaid should be averted by utilising only the 2017 revised J88 form, and further training for health service providers on completing this form is recommended (Machisa et al., 2017:14).

3.4.4. CHALLENGES IN RENDERING PSYCHOSOCIAL SERVICES TO ADULT FEMALE RAPE SURVIVORS WITHIN THE CRIMINAL JUSTICE SYSTEM

The remuneration of counsellors by the Department of Social Development is a cause for concern, with some counsellors receiving between R500 per month to R2 500 per month. Numerous NGOs hold the view that their counsellors, due to the lowest-paid category of staff within the Thuthuzela Care Centre model, enjoyed the least status and authority within their respective facilities (Vetten,

2015:11). Should this poor remuneration continue, it may lead to a loss of experienced counsellors, and the effect may be the following:

- Availability of psychosocial services after hours and on weekends. A timeline in which healthcare practitioners are most unavailable, and clients are most in need of care.
- The quality of psychosocial services may suffer, leading to the complete abolition of such services. This will limit the functioning of Thuthuzela Care Centres to health and legal services only (Global Fund to Fight AIDS, Tuberculosis and Malaria, 2019:2).

Not only do counsellors receive poor payment, but they are also assigned various roles and duties, which creates a problematic environment for the standardisation of psychosocial services and follow-up care (Thuthuzela Care Centres Compliance Audit and Gap Analysis, 2016:16).

At some Thuthuzela Care Centres, the counsellor was the last person to see the victim before she left the centre. It is the counsellor's role to explain the processes to the rape survivor upon entry and support her through the process. Other forms of disrespect were subtler and revolved around space usage in Thuthuzela Care Centres. While space was available, some NGOs and NPOs were only provided one office, regardless of having requested more space. This made counselling extremely challenging as only one person could be assisted at a time if her confidentiality was to be maintained. It has been noted that healthcare practitioners would regularly walk in and- out of counselling sessions, even when 'do not disturb' signs had been posted on the door. All other staff would have to wait in the reception or go outside. Under these circumstances, the debriefing and supervision of counsellors are also challenging (Vetten, 2015:39).

A further concern is the unavailability of debriefing services for staff within a stressful and emotionally challenging setting. Recurrent exposure to cases of sexual violence has an impact on most individuals, irrespective of their role and function within the CJS. Some professions necessitate consistent support and debriefing to be amalgamated into professional practice. This helps in two ways.

Firstly, it protects staff from 'vicarious' traumatisation and the negative impact on their personal and emotional lives; secondly, it helps curb additional secondary victimisation (Waterhouse et al., 2013:25; Thuthuzela Care Centres Compliance Audit and Gap Analysis, 2016:16).

The researcher will subsequently conclude this chapter by addressing the policies, directives and guidelines that protect victims' rights in the CJS and highlight the framework of service rendering to crime victims and, in particular, rape victims. Policies, directives, and guidelines identify the mandate and role of key players within the CJS; and further provide instructions relating to the roles and duties of both service providers and the recipients thereof; intended to facilitate an adequate mode of service rendering to adult female rape survivors within the CJS. Furthermore, the South African sexual offences courts will be described as these designated courts that were established to reduce secondary victimisation while also protecting the rights of the rape survivor. Sexual offences courts also play a substantial role in the Thuthuzela Care Centre model, forming part of service delivery to rape survivors.

3.5. POLICIES, DIRECTIVES AND GUIDELINES FOR PROTECTING VICTIMS' RIGHTS AND RENDERING SERVICES TO ADULT FEMALE RAPE SURVIVORS WITHIN THE CRIMINAL JUSTICE SYSTEM

The policies, directives and guidelines of importance when discussing victims' rights and service rendering in the CJS are the Victim Empowerment Programme, with reference to the Victims' Charter and the victim impact statement, the National Policy Framework, and lastly, the Victim Services Bill. The researcher chose these specific policies, directives and guidelines as they are contemporary in addressing the rights and needs of adult female rape survivors within the CJS. The researcher will conclude with a discussion of the sexual offences courts and their role in the Thuthuzela Care Centre model. Sexual offences courts are special courts that preside over sexual offences to avert secondary victimisation within the courtroom.

3.5.1. THE VICTIM EMPOWERMENT PROGRAMME

The Victim Empowerment Programme in South Africa started as a programme of the National Crime Prevention Strategy in 1996 and was fully implemented in 1999 (Nel, 2019:96). The National Crime Prevention Strategy became one of the country's first ingenuities that pursued redress of the retributive nature of South Africa's CJS; by attending to the needs and welfare of victims of crime and embracing them as being composite of the procedures involved in the CJS. After the formation of the National Crime Prevention Strategy, the Victim Empowerment Programme has been restructured to include the Justice, Crime Prevention and Security Cluster that further combining methods that seek to attain an incorporated response that prioritises violence against women. Hence, it was through the Victim Empowerment Programme and Justice, Crime Prevention and Security Cluster structures that the assimilation of inter-departmental and inter-sectoral programmes for the support, protection and empowerment of victims of crime and violence was first instigated (Commission for Gender Equality, 2016:14; Department of Social Development, National Policy Guideline for Victim Empowerment, 2007:3).

The vision of South Africa's Victim Empowerment Programme is to prioritise crime reduction and acknowledge victims' rights and needs within a restorative justice framework. Restorative justice is a means of accessing justice to include all the parties concerned, being the victims, offenders, families affected by the crime(s) and community members affected by the harm caused by the criminal act. It is furthermore envisioned that all parties mutually identify the injuries inflicted upon the victim, endorsing restitution, taking preventative measures to avert similar incidents from occurring, and reconciliation (A Dialogue Between Government and Civil Society, 2013:13; Nel, 2019:89). The mission of the Victim Empowerment Programme is to ensure an integrated and holistic approach and coordinated service delivery to victims of crime (Nel, 2019:97).

Receiving assistance and support after victimisation bears numerous benefits for rape survivors (*Cf Chapter 2 discussion on the needs of adult female rape survivors within the CJS*) and prevents further trauma in several ways:

- Improves the willingness of the victim to cooperate with officials within the CJS, advancing crime investigations and prosecutions;
- Significantly reduces the long-term consequences of trauma and victimisation; and
- Avert repeat victimisation and the occurrence of victims taking justice into their own hands when trauma interventions are available shortly after the incident, thus breaking the cycle of violence, which aids crime reduction initiatives (Nel, 2019:91).

The Victim Empowerment Programme has undergone various assessments throughout the years. The researcher will, however, only refer to the recent 2013 evaluation. In October 2013, the Gender Health and Justice Research Unit were approached by the Western Cape Provincial government to investigate the Western Cape Department of Social Development's Victim Empowerment Programme, with specific directives to describe and explore victim empowerment. More specifically, the focus was on service rendering; ascertaining and describing legislation, strategies and policies pertaining to the victim empowerment sector; explicating and evaluating existing procedures and mechanisms for the identification and referral of victims to suitable service providers; detecting and explicating shortfalls in the Victim Empowerment Programme grounded upon a review of policies and legislation, the need for services, the suitability and location of existing services, exit strategies for service recipients, as well as service delivery ability (both in the Department and the provincial victim empowerment sector); and render recommendations for the development and advancement of services provided by the Victim Empowerment Programme sector (Western Cape Department of Social Development, 2014:ii).

The following aspects were identified as being potential weaknesses within the domain of Victim Empowerment Programmes, emanating from research conducted in the Western Cape province:

- There is an inadequate and informal partnership between service providers that render services to victims within the Department of Social

Development, with partnerships being dependent upon the eagerness and interest among stakeholders within the programme.

- The provincial Victim Empowerment Programme is functioning in isolation from regional Department of Social Development offices, restricting all-inclusive planning and implementation and the feedback mechanisms to inform the provincial office.
- Individual departments and organisations within the victim empowerment sector tend to work in isolation, and there is subsequently a limited integrated and coordinated mode of service rendering for victims of crime.
- Notwithstanding the presence of good relations between the various actors concerned, the Victim Empowerment Programme has a tendency of visibility among communities and even certain service providers, causing many prospective clients not to know that victim empowerment services are available to them.
- The Department of Social Development (regional offices) and non-profit organisations face human and material resource limitations, which impact their ability to render wide-ranging services.
- Current referral systems are ad-hoc and not evenly spread. A referral protocol is believed to facilitate the identification and referral of victims applicable to Victim Empowerment Programmes.
- The rural populace still experiences restricted access to Victim Empowerment Programme services, and the variety thereof remains restrained even where these services are available.
- Current legislation does not apply to the needs of all victims, and there is a need for a holistic victim empowerment law. (Western Cape Department of Social Development, 2014:ii-iii).

The strengths of Victim Empowerment Programmes can be highlighted as:

- The programme is well-coordinated and managed and has assembled robust relationships between crucial stakeholders within the victim empowerment sector.
- The Western Cape provincial Victim Empowerment Programme Forum is a valuable instrument for victim empowerment since service providers can share best practices within the sector, find shared solutions to challenges confronted by numerous departments and agencies, and coordinate an alliance based on mutual principles.
- A good relationship exists between the Western Cape provincial Victim Empowerment Programme and the non-profit organisations it funds.
- The Victim Empowerment Programme services in the Western Cape province include providing services to a larger number of men and perpetrators (where appropriate) and escalating services specifically to women's shelters in rural areas.
- While the impact of service provision was further than the scope of this evaluation, participants reported that services had a constructive impact on the recipient thereof (Western Cape Department of Social Development, 2014:iii-iv).

Even though a victim-centred approach has been practised worldwide, it has unvaryingly contributed to a reduction of victimisation while instantaneously improving service standards in the CJS. Numerous services are also not yet inclusive or of the essential standard. Actors within the CJS render pockets of services without directives from an institutional structure, thus often subjecting the victim to further victimisation and dissatisfaction with service delivery. How the Victim Empowerment Programme functions have partially contributed to a victim-friendly criminal justice and related system, hence averting the undesirable impact of victimisation (National Policy Guidelines For Victim Empowerment, s.a.:1).

3.5.1.1. The Victims' Charter

Central to the Victim Empowerment Programme is the Services Charter for Victims of Crime (known as the Victims' Charter) which was approved by the South African Cabinet in 2005. South Africa is the only country on the African continent with a comprehensive Victims' Charter, which is a policy addressing the rights of crime victims (Artz & Smythe, 2019:66; Nel, 2019:99). The Department of Justice and Constitutional Development was assigned as the principal department for the implementation of the Victims' Charter, aligned with its Minimum Standards for the Treatment of Victims within the CJS. The Victims' Charter and the Minimum Standards for the Treatment of Victims within the CJS afford an important agenda for the alliance of all laws and policies concerning the rights of and services provided to victims of crime and violence. Service providers working with victims of crime are also anticipated to support excellence in service delivery, thus stimulating client satisfaction with the services delivered (Commission for Gender Equality, 2016:15).

The strategic objectives of the Victims' Charter are:

- To eradicate secondary victimisation in the criminal justice process;
- To warrant that victims remain significant in the criminal justice process;
- To elucidate the service standards that can be probable by and are to be rendered to victims when they come into contact with the CJS and concomitant systems; and
- To make provision for victims' opinions when standards required for service rendering are not met (Commission for Gender Equality, 2016:15-16).

Moreover, the Victims' Charter plays a crucial role in the functioning of the CJS as follows:

- The policy and legislative context and access to justice: An increased incidence and prevalence of rape in South Africa has sparked communal dissatisfaction, protests and civil movements, which were followed by

parliamentary deliberations. Subsequently, the South African government was prompted to consider numerous forms of law reform, which ultimately led to the introduction of new policies and legislation envisioned to safeguard the general public from becoming victims of sexual offences such as rape. Moreover, in recent years many African countries, including South Africa, have seen the urgency to strengthen their institutional and legislative framework in endorsing several innovative strategies for curbing sexual violence. However, despite changes and advancements in legislation and policy development, many obstacles hinder plausible efforts meant to manage post-rape services (discriminatory and stereotypical practices within the CJS, lack of skills and training by service providers, and gaps in relation to the investigation and prosecution of rape-related matters) (Guidelines on combating sexual violence and its consequences in Africa, 2018:6-7; Vetten, 2014:1).

- Government and public sector programmes and service delivery: There seems to exist converted willpower and motivation to facilitate the effective arrangement and coordination of planning across all compasses of government, national, provincial and local, and more notably, the investigation of the effectiveness of the implementation of government policies and programmes through incessant performance monitoring and evaluation. Government agencies must shift their efforts and resources regarding post-rape services collaboratively. Co-operative engagement among key role players within the CJS requires the mutual sharing of skills and resources in improving effectual services for adult female rape survivors within the CJS (Commission for Gender Equality, 2009:8; Koma & Tshiyoyo, 2015: 31,36).

- Civil society efficacy: Onica Makwakwa, director for the Feminists united to advance Women Inspired Solutions for Empowerment Collective and civil society activist, believes that numerous systemic challenges (i.e., a build-up of gender-based violence cases, absence of evidence collection kits at police stations, the end of sexual offences courts, and the drafting of inadequate legislation in dealing with sexual offences such as rape),

need urgent attention within the South African context (Commission for Gender Equality, 2009:8; Shoba, 2020).

- Identification and elimination of discriminatory practices, customs and beliefs (Commission for Gender Equality, 2009:8).
- Gender consciousness and the enablement of women (Commission for Gender Equality, 2009:8).

In 2009 the Commission for Gender Equality evaluated the implementation of the Victims' Charter by the SAPS and found the following:

- There was no constancy regarding training provided to the SAPS personnel on implementing Victims' Charter-related programmes nationwide.
- While police officers often escorted victims to places of safety, some police stations needed transport resources, while other regions did not have places of safety at all. The study also found those police officers were confronted with obstacles when places of safety were full, with limited space to accommodate rape survivors.
- Most facilities of safety had gender restrictions that led to the exclusion of certain groupings of victims (i.e., male rape survivors).
- The short supply and scarcities of the sexual offences evidence kits were a major concern for police stations across the facilities that the Commission for Gender Equality had visited.
- Due to the deficiencies in the supply of kits, forensic evidence was occasionally unavailable to be presented for sexual offences court cases (Commission for Gender Equality, 2016:15-16).

The outcomes of the 2009 Commission for Gender Equality evaluation and the implementation of the Victims' Charter by the Department of Justice and Constitutional Development specified that:

- There existed inadequate knowledge about the Victims' Charter among the magistrates interviewed at the regional Sexual Offences Courts.
- The Department of Justice and Constitutional Development had not extended any form of training pertaining to the Victims' Charter to its personnel. It was also established that the Justice College had not included modules about the Victims' Charter in any of the prosecutors' training courses.
- There were discrepancies in terms of resource allocation across the different courts, since participants interviewed in some provinces felt that the courts were sufficiently resourced, while others articulated an aspiration for more resources.
- Under-staffed capacity, a lack of special rooms for victims of sexual offences and domestic violence, and unsatisfactory administrative resources were highlighted as significant challenges (Commission for Gender Equality, 2016: 16).

A 2011 study conducted by the Commission for Gender Equality concentrating on assessing the application of the Victims' Charter by the NPA found that:

- The NPA, through the Thuthuzela Care Centres, had established systems, policies and programmes that were noticeably re-directed from national and provincial levels- and increased facility levels to address the needs of the victims of sexual violence.
- The funding policy for Thuthuzela Care Centres was ambiguous, as participants had no accurate information about the budget allocated to Thuthuzela Care Centres.
- While some site coordinators had undergone training on numerous facets of the Victims' Charter, some had indicated that they had never received training.

- There existed a deficiency of uniformity among Thuthuzela Care Centres in terms of complaints mechanisms as well as monitoring and evaluation systems (Commission for Gender Equality, 2016:16).

The researcher believes that the Victims' Charter is a fundamental principle for engaging with victims of crime within the CJS. The literature suggests that although it is utilised widely in working with victims of crime, there subsists evidence that it is applied and implemented inversely within various spheres of the CJS. Training remains a key challenge in implementing and advancing a standardised mode of service rendering for adult female rape survivors within the South African context.

In order for the true benefits of the Victims' Charter to be appreciated by the beneficiaries thereof, the South African government should adhere to the following:

- Guarantee that the rights within the Victims' Charter are more ambitious; that the basic right to information, security and assistance in daily practice at all levels of the CJS are implemented.
- Respect the objectives and recommendations of oversight bodies (i.e., the Independent Police Investigative Directorate and Office of the Public Protector).
- Involve informal mechanisms of social control that function within communities, interceding the relationships between survivors of crime and the CJS (Artz & Smythe, 2019:66).

3.5.1.2. Victim impact statement

In line with victim empowerment and victim participation in the CJS, the victim of a crime can submit a victim impact statement during the trial phase. A victim impact statement is a written or oral statement submitted on behalf of the victim or by the victim that captures the impact of the crime(s) on the victim (inclusive of financial, social, physical and psychological effects); and depicts the victim's experiences about the crime, the offender, and the anticipated sentencing of the

offender (James & Cronje, 2019:130; Ovens, 2020:581; Regoli et al., 2018:180). The main reasons for including the victim impact statement during court proceedings include the following:

- Rendering the presiding officer with information about the actual harm caused by the crime in order for the sentencing of the offender to be proportionate to the crime.
- Facilitating a therapeutic outcome for crime victims, thus assisting recovery in bringing closure to the victim after the incident.
- Informing the offender about the true aftermath of the crime.
- Provide the court with an equal picture of both the victim and the offender to determine a just, appropriate and individualised sentence.
- The surviving family of the victim are also presented with the opportunity to express the impact of the crime on their lives.
- Advancing perspectives of fairness at sentencing, comprising the offender and the state (James & Cronje, 2019:133; Ovens, 2020:581; Regoli et al., 2018:180).

Critiques against the victim impact statement include:

- The victim impact statement is in conflict with the considerate understanding that the state, and not the individual person, is the victim of crime.
- Victim impact statements may distract the presiding officer’s focus away from the offence and the offender's individualities.
- The victim impact statement may be exceedingly prejudiced towards the offender, which may induce strong emotional responses, thus implying a bias obstinacy might influence the outcome of legal proceedings.
- The inclusion of a victim impact statement during the sentencing phase may increase the sentencing severity imposed by the presiding officer.

- Sentencing judgements may be predetermined in relation to the perception of the value of the victim within the CJS (James & Cronje, 2019:133; Regoli et al., 2018:180).

3.5.2. NATIONAL POLICY FRAMEWORK

Section 62 of the Criminal Law (Sexual Offences and Related Matters) Amendment Act 32 of 2007 entails the implementation of the National Policy Framework as a mode of enabling a reliable and inter-sectoral response to the prevention of sexual violence. The National Policy Framework was introduced by role players from the Department of Justice and Constitutional Development, Department of Social Development, Department of Health, Department of Correctional Services, SAPS and the NPA. Through this approach, a multidisciplinary framework was endorsed in rendering services to rape survivors in the CJS (Department of Justice and Constitutional Development, 2012:13). The objectives of the National Policy Framework are as follows:

- Warrant a constant and co-ordinated mode in service rendering by all government departments and institutions tasked with managing sexual offences;
- Facilitate the execution, implementation and administration of the Criminal Law (Sexual Offences and Related Matters) Amendment Act 32 of 2007; and
- Improve the delivery of services, as envisioned in the Criminal Law (Sexual Offences and Related Matters) Amendment Act 32 of 2007, through the expansion of a plan for the progressive comprehension of services for survivors of violence aligned with accessible resources (Department of Justice and Constitutional Development, 2012:13).

3.5.2.1. Application of the National Policy Framework

The National Policy Framework assigns directives for all role-players within the CJS to mutually react to and- prevent sexual violence by endorsing a five-year

plan. In addition, the National Policy Framework delivers direction on what victim-centred approaches should be and how the delivery of services should be implemented. The National Policy Framework is the first policy document that explicitly deals with the management of sexual offences through the following:

- A comprehensive outline that informs initiatives, plans and programmes that must be presented to promote the objectives of Criminal Law (Sexual Offences and Related Matters) Amendment Act 32 of 2007;
- An extensive framework of responsibilities and duties of the numerous stakeholders in facilitating the provision of operative, appropriate, efficient, co-ordinated and victim-centred services;
- Providing directives in the development of present and future service models and processes deemed appropriate to cater for the special needs of the victims; and
- Necessitating a progressive approach that allows for the broadminded outset of the aims and objects of Criminal Law (Sexual Offences and Related Matters) Amendment Act 32 of 2007, through the anticipated principles that have been presented (Department of Justice and Constitutional Development, 2012:16, 25).

3.5.2.2. Principles of the National Policy Framework

The National Policy Framework functions according to four (4) principles, which emanate from the objectives of the Criminal Law (Sexual Offences and Related Matters) Amendment Act 32 of 2007:

Principle 1: Adoption of a Victim-Centred Approach to Sexual Offences

This principle signifies the importance of providing services to survivors of sexual violence based on a victim-centred model. This approach recognises the victim's central point in managing sexual offences and thus supports the provision of services, procedures and institutional methods that improve the emotional and psychological well-being of the victim. Moreover, the principle addresses the susceptibility of victims, demonstrated in gender power, which is unequally

distributed regarding disability, age, sexuality and cultural constraints. The development of rights-based approaches affords victims with levels of standing that transpose them as noteworthy to judicial processes. This comprises service providers within the CJS, taking into account the needs and well-being of the victim pertaining to crucial decisions made throughout the pre-trial and the trial process. Nonetheless, the atmosphere of enforceable rights as being genuine, the practicality of gaining access to justice must be understood in the context of how these rights and powers transmute the role of the victim within existing powers and structures within the CJS (Department of Justice and Constitutional Development, 2012:17; Kirchengast, 2018:226).

An effective and effectual victim-centred response depends heavily on all service delivery facets within the chain of sexual offences; to provide victim-friendly services which are supplemented with sensitive and responsive attitudes. Working with survivors of sexual assault and rape may reduce secondary victimisation. The National Policy Framework thus anticipates improving the outcomes (victim-centred responses) and the public's discernments about the response of the CJS toward sexual violence (Department of Justice and Constitutional Development, 2012:17).

Principle 2: Adoption of a Multidisciplinary and Inter-Sectoral Response to Sexual Offences

This principle proclaims the proposition that an efficient and all-inclusive response to the management of sexual offences requires a multidisciplinary and inter-sectoral approach. It entails participation based upon shared consensus among all service providers, such as health care professionals, social workers, police officials, prosecutors, judicial officers, correctional officials, educators and traditional leaders. Inter-sectoral collaboration delivers not only continuous care and delegated response to victims' needs but also allows continuing oversight, feedback and evaluation, which might lead to the improvement of intended services. At the societal level, the assimilated response should involve NGOs and NPOs, yet not exclude religious-based organisations (Department of Justice and Constitutional Development, 2012:13,18).

Principle 3: Provision of Specialised Services to the Victims of Sexual Offences

Global and national research studies continue to intricate upon the staid consequences of sexual violence on both the direct and indirect survivors of sexual assault and rape. The universal trend in addressing these issues anticipates a need to adopt specialised services when dealing with rape and sexual assault victims. The essential requirement for specialisation is extensively recognised for its achievement in advancing the quality and quantity of services. Subsequently, it can be contended that the specialisation of staff could eradicate unsatisfactory and poor outcomes of services while instituting greater consideration for the victim's needs (Department of Justice and Constitutional Development, 2012:18-19). Service providers tend to specialise in one particular form of support, while others provide an all-encompassing array of services. Even though receiving assistance from policymakers, service providers and survivors of rape alike, there are numerous and significant matters pertaining to the degree of victim support services. Firstly, notwithstanding the range and nature of services rendered to victims, very few victims essentially seek assistance from support organisations. Some explanations for why victims don't seek assistance are their inability to access services (due to lack of transport or geographical location of the service provider) and apparent or tangible disentitlement for these services. Another important concern is whether victims are satisfied with the services they have received. Although research provides evidence that victims who receive services are usually satisfied, there are some dissimilarities in terms of victims' expectations and what they essentially receive, as well as what service providers are willing and able to provide (Roberson, 2017:3). Additionally, low-and- middle-income countries, such as South Africa, face the challenge of not having adequate skilled personnel, particularly for counselling, mental health and advocacy or support services. NGOs depend more on these crucial services when advocacy and support services are in diminutive supply (WHO, 2013:36-37).

Examples of these specialised services, which appeared as a direct result of the Criminal Law (Sexual Offences and Related Matters) Amendment Act 32 of 2007, are as follows:

- Clinical Forensic Medicine Centres in the Department of Health;
- The Family Violence, Child Protection and Sexual Offences Unit within the SAPS;
- The National Prosecuting Authority established Thuthuzela Care Centres;
- Court preparation officers provided by the National Prosecuting Authority;
- Sexual offences courts that are equipped with witness testifying rooms, one-way mirrors, and intermediaries; and
- One-Stop facilities are coordinated by the Department of Social Development (Department of Justice and Constitutional Development, 2012:18-19).

Principle 4: Equal and Equitable Access to Quality Services for Victims of Sexual Offences

Equal access to services should be encouraged through non-discriminatory accessibility to the services provided to victims, regardless of race, class and gender. This equal treatment should be linked with the principle of the provision of services to all. Reasonable access to quality services is not only determined by geographical location and/or the availability of transport but also by the time of day (implying that services should be afforded 24 hours, 7-days a week); when an individual needs to access services. Services and amenities should be made reachable and accessible to persons of all spheres, inclusive of individuals living with disabilities (Department of Justice and Constitutional Development, 2012:19). Regrettably, the role of the Thuthuzela Care Centres in rendering services for rape survivors is also not inclusive in the National Policy Framework, subjecting these crucial facilities prone to personal interpretation (Bougard, 2018:55; Waterhouse et al., 2013;16).

3.5.3. THE VICTIM SUPPORT SERVICES BILL

In line with section 35 of the Constitution of the Republic of South Africa, emphasis is placed on the rights of the rape accused, whist limited importance is placed on the rights of adult female rape survivors. The Victim Support Services Bill surfaced in 2020, which became a fundamental form of legislation addressing the scourge of gender-based violence and violent crimes in South Africa. As such, the Victim Support Services Bill seeks to acknowledge survivors of crime, including rape survivors, as being central to the CJS; and to facilitate and safeguard that both the rights of the adult female rape survivor and the accused receive equal treatment within the CJS (Public Comment Sought on Victim Support Services Bill, 2020).

The mandate of the Victim Support Services Bill thus serves as the legal framework for the advancement and continuation of uplifting the rights of survivors of violent crimes; averting secondary victimisation of complainants by offering protection, intervention, support and re-integration programmes; providing a legal framework for a holistic approach in rendering victim empowerment programmes; to provide for the implementation and registration of victim empowerment and support services; to provide for the expansion and enactment of victim empowerment services norms and required standards; to outline, specify and describe the relevant roles and duties of the service providers (i.e., medical, medico-legal, psychosocial and legal) within the CJS (Public Comment Sought on Victim Support Services Bill, 2020; Victim Support Services Bill, 2020:609). The following section will outline the various duties of the service providers to rape victims as set out in the Victim Support Services Bill.

3.5.3.1. The Victim Support Services Bill in relation to the legal domain

It is envisioned that upon reporting the crime of rape to the police, the adult female rape survivor is received by a representative of the Family, Violence, Child Protection and Sexual Offences Unit of the SAPS. The victim should be provided with a case number, and the details of the investigating officer should be conveyed to the complainant. The rape survivor should also be continuously

informed of the case's progress if an arrest has been made and the conditions of the bail application set forth by the presiding officer, if applicable. A copy of the victim's statement should be made available if needed, and the case should be escalated to the NPA within thirty days since the incident occurred. In circumstances whereby a case cannot be escalated to the NPA, the victim should be informed by the police regarding the reasons not to proceed with the charge of rape against the alleged perpetrator. The Civilian Secretariat for Police is expected to provide oversight with regard to the monitoring of rape cases; ensure that adult female rape survivors are treated with respect and dignity; and safeguard that witness fees are provided to the complainant as prescribed in the Criminal Procedure Act 51 of 1977 (Victim Support Services Bill, 2020:19-20).

3.5.3.2. The Victim Support Services Bill within the Ministry of Health

The Department of Health should ensure that adult female rape survivors receive adequate access to healthcare facilities for the provision of medical care (i.e., the provision of PEP, treatment of STIs, attention given to physical injuries, termination of pregnancy if requested by the victim, and facilitating the compulsory HIV testing of an alleged sex offender). It also remains the mandate of the Department of Health to facilitate the medico-legal examination of adult female rape survivors (Victim Support Services Bill, 2020:18).

3.5.3.3. The Victim Support Services Bill within the domain of psychosocial support for adult female rape survivors

It is envisioned that the Department of Social Development ensure that adult female rape survivors have access to post-rape psychosocial programmes and services according to prescribed norms and standards. Services provided by the Department of Social Development should include, but are not limited to, court preparation; legal, and social work services; detailed information of psychosocial service providers within the area of the victim; provide a toll-free number for reporting crimes such as rape from any member of a community (24 hours 7 days a week), and ensure that all adult female rape survivors receive an acknowledgement of receipt with a reference number for any further

correspondence. It is also the mandate of the Department of Social Development to collaborate with other state agencies, such as the Departments of Education, Health, Justice and Constitutional Development, in developing the appropriate policies regulating victim support services and ensuring that victim support programmes and services are accredited. The Department of Social Development is also expected to evaluate the efficacy of victim support programmes and services and to ensure that adequate resources are available for all service providers in a standardised manner (Victim Support Services Bill, 2020:14-17).

3.5.4. SEXUAL OFFENCES COURTS IN SOUTH AFRICA

The first sexual offences court came into existence in South Africa in 1993 at the Wynberg Regional Court in Cape Town. It was initially part of a pilot project aimed at addressing the significant rate of sexual offences and foreseeable reduction in secondary trauma encountered by survivors of rape within the CJS (Ministerial Advisory Task Team on the Adjudication of Sexual Offences Matters, 2013:8; Sexual Offences Courts National Strategic Draft Plan 2016-2020:11). By March 2003, 20 sexual offences courts had been established, and in March 2004, this number increased to 47 courts. By the end of 2005, there were 74 such courts, which led to an increase in sexual offence cases being finalised, better handling of sexual assault and rape survivors, enhanced court cycle times and improved conviction rates (Claymore, 2020). The Baragwanath Thuthuzela Care Centre in Johannesburg is aligned with the Soweto Court, which had at least three courts devoted to sexual offences, and in 2005 were accomplishing conviction rates of between 65% and 73%. Regrettably, these courts closed between January to March 2008 (these special courts were phased out of the CJS due to budgetary constraints and re-introduced in August 2013). The conviction rate for sexual offence cases in 2007 was 78%, and this figure then plummeted to 67% after the closure of the aforesaid courts (Ministerial Advisory Task Team on the Adjudication of Sexual Offences Matters, 2013: 23; More sexual offences courts for South Africa, 2014). However, since 2005, there has been a notable demise

in sexual offences courts across South Africa (If only sexual offences courts hadn't gone away, 2013).

3.5.4.1. Overview of the re-establishment of the sexual offences courts in South Africa

During 2012 and 2013, various concerns were conveyed in Parliament regarding the excessively high incidence of rape in South Africa and a lack of satisfactory response by the3 numerous stakeholders concerned. More importantly, enquiries were brought forth pertaining to the demise of the sexual offence courts in South Africa. Criticism regarding the lack of response towards sexual violence was further corroborated by stark disapproval directed against South Africa by the United Nations Committee on the Convention on the Elimination of Discrimination Against Women in January 2011. The disapproval stemmed from the low number of sexual offences courts, as these courts had been endorsed as part of international best practices in curbing the prevalence of sexual violence against women and children. Project Oversight Committees were also erected on national, provincial and local levels to aid the rollout process of sexual offences courts (Ministerial Advisory Task Team on the Adjudication of Sexual Offences Matters, 2013, 2013:8, 22; Sexual Offences Courts National Strategic Draft Plan 2016-2020:8).

In response to the above apprehensions, the former Minister of Justice and Constitutional Development, Minister Jeff Radebe, re-iterated in May 2012 his plans to institute a task team to examine the feasibility of re-establishing the sexual offences courts in South Africa. The Chief Directorate: Promotion of the Rights of Vulnerable within the Court Services branch in the Department of Justice and Constitutional Development was tasked to facilitate the activities of the task team, which came into practice in June 2012; and named the Ministerial Task Team on the Adjudication of Sexual Offences Matters. In establishing the task team, the key role players in the management of sexual offences, as well as stakeholders that offer court-based victim support services, were identified (Ministerial Advisory Task Team on the Adjudication of Sexual Offences Matters, 2013:7; Sexual Offences Courts National Strategic Draft Plan, 2016-2020:8-9).

Subsequently, the Ministerial Advisory Task Team on the Adjudication of Sexual Offences Matters, 2013 included agents from the Chief Directorate: Promotion of the Rights of Vulnerable within the Court Services branch in the Department of Justice and Constitutional Development; the NPA; Legal Aid South Africa; and the Regional Court Presidents Forum; as well as representatives of the Justice Sector Strengthening Programme and the Foundation for Human Rights. In its endeavours, the task team approached the respective departments and agencies that fall within the domain of the management of sexual offences to assist the investigations of re-establishing the sexual offences courts inclusive of collaborative inputs of the various pivotal stakeholders concerned (Ministerial Advisory Task Team on the Adjudication of Sexual Offences Matters, 2013:8; Sexual Offences Courts National Strategic Draft Plan, 2016-2020 8-9).

The primary mandate of the Ministerial Advisory Task Team on the Adjudication of Sexual Offences Matters was to investigate the feasibility and practicality of re-establishing the sexual offences courts with the prospects of providing the appropriate prescripts to the former Minister of the Department of Justice and Constitutional Development on the suitable intervention strategies to be implemented. Various investigations were initiated, including literature studies, field research and a national audit of regional courts in South Africa to identify the availability of resources to endorse the re-establishment of the sexual offences courts. In its initial report, the Ministerial Advisory Task Team on the Adjudication of Sexual Offences Matters highlighted the re-establishment of the sexual offences courts and developed a model that pursued addressing the challenges pertaining to the lack of sexual offences courts while reinforcing their key areas of success. The costs attributed to re-establishing the model for the efficient functioning of the sexual offences courts were determined and aligned with the National Regional Court Resource Audit to regulate the sexual offences courts. The Ministerial Advisory Task Team on the Adjudication of Sexual Offences Matters identified 57 regional courts, which were endorsed for the initial amalgamation into sexual offences courts over a three (3) year period, commencing in August 2013 (Ministerial Advisory Task Team on the Adjudication

of Sexual Offences Matters, 2013:6; Sexual Offences Courts National Strategic Draft Plan, 2016-2020:8-9).

The Judicial Matters (Second Amendment Act) 43 of 2013 was promulgated on 22 January 2014 and made provision for the institution of the sexual offences courts. Section 2 amends Section 55 of the Criminal Law (Sexual Offences and Related Matters) Amendment Act 32 of 2007 to include section 55A, which reads as follows:

(1) Subject to subsection (2), the Minister may by notice in the Gazette designate any Division of the High Court or the main seat or any local seat of a Division or Magistrate's Court, as defined in section 1 of the Superior Courts Act, 2013 (Act No. 10 of 2013), as a sexual offences court exclusively for the purposes of the trial of any person or other proceedings arising out of –

(a) an alleged commission of a sexual offence in terms of the common law, any offence in terms of the Sexual Offences Act, 1957 (Act 23 of 1957), or any offence in terms of this Act; or

(b) any act or omission which constitutes some offences in terms of any other law which has a bearing on sexual offences, as the Director of Public Prosecutions having jurisdiction, may, in writing, authorise."

By August 2020, South Africa saw 106 sexual offences courts nationally. These courts function as either a hybrid or a pure sexual offences court. A hybrid sexual offences court can be defined as a regional court dedicated to adjudicating sexual offence cases in any specified area. While the regional court will also deal with other cases, priority is given to sexual offences (Department of Justice and Constitutional Development, 2022).

3.5.4.2. Successes of the sexual offences courts

Two of the central accomplishments of the sexual offences courts were an increase in conviction rates and a reduction in turnaround time from the date of reporting to the police to the finalisation of the case. The conviction rate for rape cases during 2014 in all regional courts was 42%, while the conviction rate in

sexual offences courts was 62%. The Sexual Offences and Community Affairs Unit of the NPA also conveyed that the turnaround time in finalising sexual offence cases at some courts had been finalised in less than six months. This was ascribed to the utilisation of specialist prosecutors, case managers and victim assistant officers, as well as the consensus between the respective stakeholders and the norm of prosecution-led investigations. Witnesses were afforded separate waiting rooms, intermediaries, closed-circuit television facilities, and specific victim support services. Furthermore, multidisciplinary training has improved the skills of court personnel and other role players. As such, sexual offences courts contributed considerably to the effective prosecution and arbitration of sexual offences (If only sexual offences courts hadn't gone away, 2013; Ministerial Advisory Task Team on the Adjudication of Sexual Offences Matters, 2013:23).

3.5.4.3. Practical implementation of the sexual offences courts

Sexual offences courts are close to a Thuthuzela Care Centre since they form part of service delivery for adult female rape survivors within the CJS. The sexual offences courts model sets forth standard specifications for equipment and facilities to be utilised within these courts, subsequently creating a set of minimum standards to which courts must conform within the domain of the sexual offences court model. The sexual offences court model is derivative of the notion of providing victims of sexual offences with specialised facilities, personnel and services to protect survivors of sexual offences and their families from secondary victimisation and trauma. The sexual offences court model thus affords minimum standards for the infrastructure, personnel and services that must be accessible for survivors of sexual offences. The following summarises the key components of the sexual offences courts applicable to adult female rape survivors within the CJS (Sexual Offences Courts National Strategic Draft Plan, 2016-2020:6).

- ***Infrastructure***

A crucial component of the sexual offences courts is the availability of the main courtroom and a testifying room connected to closed-circuit television systems.

The courtroom must be adjacent to a separate waiting room for adults and children who have to testify. It is an important standard of a sexual offences court model that direct contact between a survivor of sexual violence and an alleged sex offender be averted as much as possible (Sexual Offences Courts National Strategic Draft Plan 2016-2020:21).

Monitoring and evaluation research conducted by Shukumisa (2012) which consisted of 28 courts in South Africa (convenience sampling), distributed across selected provinces being (Eastern Cape [7]; Western Cape [4]; Gauteng [5]; Limpopo [11] and KwaZulu-Natal [1]) found that 25 of the 28 courts (89%) included in their sample, were accessible by public transport. Because, to a great extent, most people in South Africa use public transport, this is an optimistic finding. Clear indicators with visible street signs indicating the route to the courts were evident within 16 courts (57%), 23 courts had wheelchair ramps (82%), and five courts had no ramps. Given the crucial role of the staff at the information desk, which is to direct and inform the public, it should preferably be staffed by two individuals who are familiar with the layout of the court building. However, only 14 of the 28 courts (56%) had an information desk. Noticeably, 12 courts (48%) did not have an information desk. Where there were no information desks, visitors to the court found it challenging to find the waiting rooms. At certain courts, the security guards were tasked with monitoring the information desks, although they were unfamiliar with the settings and services provided at the respective courts.

Additionally, closed-circuit television cameras permit witnesses to testify without being in the same room as the accused, thus decreasing re-traumatisation and intimidation. It was found that 22 of the 28 courts (88%) of the sample had closed-circuit cameras. It is important to note that the closed-circuit television camera equipment was in working order in 20 of these 22 courts (Shukumisa, 2012:57-60,63).

- ***Restrooms***

Witnesses must have access to toilets as witnesses spend considerable time in court. These facilities should be close to the courtroom or waiting room so that

witnesses do not wander around the court building and risk being confronted by an accused in the passage. With regards to restroom facilities, 19 of the 28 courts (76%) were open to the public, all toilets at the respective courts being monitored had toilet seats, while only 16 had toilet paper, and 7 of these toilets were broken (Sexual Offences Courts National Strategic Draft Plan 2016-2020:23-24; Shukumisa, 2012:64).

- ***Waiting room for adults***

It is suggested that there should be a separate waiting room for adults. The waiting room for adults should contain the following:

- Window dressings in the form of blinds or curtains should be available if these are necessitated, although they should be fully operational if available.
- Information brochures, materials and pamphlets must be displayed.
- There should be information screens in the waiting room to facilitate the empowerment of rape survivors.
- All testifying rooms' doors should be locked to protect the equipment and contents (Sexual Offences Courts National Strategic Draft Plan 2016-2020:23-24).

Private waiting rooms are imperative for all rape survivors waiting for legal proceedings, necessitating private confinement to ensure that the adult female rape survivor is comfortable (Mkhwanazi, 2016). Witness waiting rooms serve numerous purposes. They deliver a private and secure room for witnesses to wait when they are at the court for extended periods of time. A private place selected for witnesses reduces the chances of the victim encountering their alleged accused. In Shukumisa's (2012) study, it was found that 16 of the 28 sexual offences courts (64%) had witness waiting rooms. The remaining 10 courts had no witness waiting rooms. A mere two out of a total of 28 courts had witness waiting rooms with pamphlets available, being the Sibasa court in Limpopo and the Pietermaritzburg Magistrates Court in KwaZulu-Natal. Furthermore, eight witness rooms had posters visibly on display. None of the courts in the Western

Cape had pamphlets or information material for adult female rape survivors (Shukumisa, 2012:61).

- ***Personnel***

The minimum personnel mandatory to resource sexual offences courts are as follows:

- Presiding officers: Challenging views and stereotypes surrounding rape survivors within the CJS can discourage the victim from reporting the rape incident, which in turn may affect the investigation and prosecution of sexual crimes. Permitting the victim to relive prior sexual history can be traumatising, humiliating and inhumane. Moreover, having to go through inappropriate questioning may discourage adult female rape survivors from reporting the incident in the first stance. Preceding the enactment of the Criminal Law (Sexual Offences and Related Matters) Amendment Act 32 of 2007, which altered sections of the Criminal Procedure Act 51 of 1977, section 227, preceding sexual evidence was forbidden in South African law, in which the credibility of the victim comes under scrutiny. Former sexual history evidence is also not permitted to prove that the victim consented to the alleged sexual encounter. Additionally, questioning the rape survivor on prior sexual history is still granted in certain situations, including when one of the parties makes an application to cite such evidence. The evidence above is permitted by the presiding officer or in instances where the prosecution has presented such evidence. When prosecutors introduce prior sexual history evidence, presiding officers debatably must consider this. Until now, transcripts indicate that presiding officers refer to complainants' prior sexual history based on their own insinuations from the evidence presented before them and on questionably inaccurate views that are ingrained in a discourse of rape myths and gender stereotyping. As such, presiding officers may convey biased judgments that are imprudent, reliant on myth, and not necessarily based upon corroborating evidence (Swemmer, 2020:2,5-6).

- The cautionary rule is another key area of concern in which gender stereotyping affects the decisions made by presiding officers, which influences prosecution, defence and presiding officers' perspectives toward adult female rape survivors as complainants. The use of the cautionary approach was debated for relying on innumerable stereotypes in the case of S v Jackson, in which the court stated that the cautionary rule in rape cases is based on illogical and out-of-date perspectives. It thus runs the risk of viewing adult female rape survivors as being untrustworthy within criminal proceedings (S v Jackson 1998 (1) SACR 470 (SCA)67; Swemmer, 2020:11). It is argued by Spies (2016:390-391) that rape myths and gender stereotyping in the CJS reflect the notions of communities and are used in rape cases to complicate the experiences of adult female rape survivors within the CJS. She further opines that the way judicial attitudes in the sentencing of rape offenders can redirect, legitimise and impose rape myths, concerting male aggressiveness and punishing female submissiveness, which in turn may influence decisions surrounding the sentencing of sex offenders.
- Two prosecutors: Conclusions about whether or not to prosecute a case of rape are inclined by the prosecutor's beliefs concerning the chances of securing a conviction for that particular case. Frequently perceptions relating to the prospects of conviction are essentially linked to the credibility of the rape survivor. Rape survivor credibility becomes important in cases whereby the rape survivor is most likely to be the principal witness or the only witness. Consequently, the ability of the rape survivor to express the dynamics of the victimisation in court- in a substantial manner remains crucial to the case. In matters of an intimate and/or sexual relationship with the accused, prosecutors may question whether the account of events on behalf of the adult female rape survivor may be adequate within legal proceedings. Additionally, victim credibility is aligned with personal characteristics, inclusive of whether or not the rape survivor has a history of criminal behaviour or challenges with drugs and alcohol usage or was believed to have engaged in other activities at the time of

the rape that could have been contributory toward their own victimisation (Richards & Restivo, 2015:76). Certain prosecutors and magistrates are specifically trained on the legal, psychological and social issues pertaining to sexual offences such as rape. Such trained prosecutors and magistrates might lessen the trauma of the court experience and avert the risk of re-victimising witnesses or rape survivors. Skhukumisa (2012) found that 15 out of 28 sexual offences courts assessed, 60% of the sample, had devoted prosecutors. Additionally, in 12 of the 28 courts observed, 48% had specialised sexual offences prosecutors (Skhukumisa, 2012:66).

- Designated social worker: A designated social worker should preferably be present at all Thuthuzela Care Centre facilities to provide psychosocial services (Skhukumisa, 2012:66). (Cf Chapter 2 - discussion on psychosocial services for adult female rape survivors within the CJS).

- ***Capacity Building***

As a specialised service to all survivors of sexual violence, all role-players must receive specialised and intensive training. The sexual offences courts model is dependable on the following capacity building of personnel when working with adult female rape survivors within the CJS:

- The mandatory continuous training of all court personnel on the ever-changing aspects of sexual offences. Provisions of Criminal Law (Sexual Offences and Related Matters) Amendment Act 32 of 2007, National Policy Framework and the Victim's Charter (Sibanda-Moyo, Khonje & Brobbey, 2017:6).

- Support after disclosure of abuse: Women who reveal any form of sexual abuse, such as rape, should be afforded immediate support. Service providers should, at minimum, offer first-line support when an adult female rape survivor seeks assistance. A non-judgmental and reassuring approach is necessitated in confirming what the rape survivor is

conversing (WHO, 2013:16) (Cf Chapter 2 on the barriers to reporting rape).

- Staff within sexual offences courts must receive professional; and specific training that will empower them with adequate skills and expertise in executing their roles and duties. While the government, the police, and civil society may have dissimilar sentiments in certain spheres of service rendering to adult female rape survivors within the CJS, all parties agree that better collaboration and coordination are crucial. There exists frustration emanating from a lack of concrete actions, insufficient resources, lack of skills and training, and acuities that the various sectors do not fully comprehend and agree on certain matters relating to service rendering services to rape survivors within the CJS (A Dialogue Between Government and Civil Society, 2013:7; Sexual Offences Courts National Strategic Draft Plan 2016-2020:24).

- ***Services***

Survivors of rape necessitate specialised services within the sexual offences courts, such as:

- Court preparation programme: The programme seeks to support the rape survivor in understanding the court processes, services and benefits of testifying in court. It aims to empower the rape survivor to be an effective witness during legal proceedings. On the date of the trial, it is envisioned that the rape survivor will be welcomed and assisted by the court preparation officer of the Thuthuzela Care Centre (Mkhwanazi, 2016; Skhukumisa, 2012:66). Emanating from a convenience sample of 28courts in selected provinces in South Africa, 14 of the 28 courts included, 56% offered court preparation, while in 8 of these 14 courts, court preparation was provided entirely by the NPA, and within two courts, the service was provided solely by NGOs (Skhukumisa, 2012:66). Interestingly, the NPA and NGOs collectively provided court preparation (Cf discussion on the Thuthuzela Care Centre model earlier in the chapter).

- Intermediary services: An intermediary transfers questions from the court to the rape survivor comprehensibly (Mkhwanazi, 2016). If a rape survivor is challenged with a mental disability, the prosecutor is encouraged to apply to the court for the victim to testify within a private setting with the support of an intermediary. Monitoring and evaluation research conducted by Skhukumisa (2012) found that 17 out of 28 courts (68%) provided intermediary services. In 6 of these courts, intermediaries were provided by the Department of Justice and Constitutional Development. In two instances, the rape survivors were referred to as court intermediaries who are likely to be Department of Justice and Constitutional Development staff members. The NPA provided this service in four courts. Only eight of the 17 courts made this service available to adult female rape survivors. These courts also permit the provision of intermediary services based on the assumption that rape can be traumatic and rape survivors may be too traumatised to be in the same room as their alleged rapist. Hence access to intermediaries might significantly reduce secondary trauma during court proceedings. On a positive note, 12 of the 17 facilities provided intermediary services for mentally disabled survivors of sexual offences (Skhukumisa, 2012:68).

- Information services include text, audio-visual and braille (Skhukumisa, 2012:68).

- Victim support services: The purpose of victim support services is to assist rape survivors in coming to terms with emotional trauma and is envisioned to be participatory, facilitating reparation and coping with the problems concomitant with victimisation (Integrated Social Crime Prevention Strategy, 2011:27). Pre-and-post- trial debriefing services should be rendered to assist the rape survivor in coping before, during, and after legal proceedings (Mkhwanazi, 2016). A lack of clear and succinct understanding of the workings of current victim funding restricts the ability of the various spheres within the CJS to work more efficaciously in rendering support to adult female rape survivors and detecting the underserved populace. Victim services warrant comprehensive,

dependable and accurate information about the variety of services being provided each year; and the number of adult female rape survivors seeking unavailable services. Likewise, with a few exclusions, incomplete information relating to the scope of organisation and agencies that might negatively affect victim services are interrelated to how they are funded and the organisational resources essential in rendering an array of services to adult female rape survivors within the CJS. Conversely, a dearth of information exists in explicating the extent and effectiveness of this service infrastructure; or pinpointing areas in which adult female rape survivors still need post-rape services (Roberson, 2017:260). Services focusing on service delivery for adult female rape survivors are managed by multiple stakeholders that might lack coordination. Interventions designed to address sexual violence, such as rape, even where they have been demonstrated to be effective, are highly localised and often underfunded. The lack of resources and systematic exploration of what has worked and why has made it challenging to advance positive ingenuities in rendering services to adult female rape survivors within the CJS. Furthermore, civil society has also criticised the state for lack of will-power and leadership in rendering services to adult female rape survivors within the CJS; as well as a lack of clarity on the roles, duties and designated mandate of the various service providers in rendering post-rape services within the South African context (A Dialogue Between Government and Civil Society, 2013:6).

- Compensation programmes: Compensation programmes are problematic to access, with the burden of proof on the distressed party and eligibility mainly restricted to the classification of so-called ‘genuine’ rape survivors. In light of the minority of rape survivors being considered for compensation in relation to the enormous amounts usually allocated to injuries resulting from accidents or medical malpractice, it is not surprising that often these programmes are not advertised. In addition, prolonged bureaucratic processes and investigations affect witness fees negatively since the aforesaid at times may be an interplay between political agendas and

efforts to conciliate civil conscience- rather than to ease the distress of interpersonal and widely communal conflict efficiently (Peacock, 2019:15). The Department of Justice and Constitutional Development provides witness fees to cover travelling expenses and a meal while attending court proceedings (Mkhwanazi, 2016).

- Vicarious trauma programmes (debriefing): Such programmes must be afforded to all staff working with sexual offence cases. Owing to a lack of debriefing programmes, many court officials became writhed with vicarious trauma resulting from constant and prolonged exposure to sexual offence cases. Furthermore, there also seems to exist a lack of agreement regarding the roles and responsibilities of the various stakeholders rendering debriefing services; due to insufficient consulting between all role-players concerned (Ministerial Task Team on the Adjudication of Sexual Offences Matters, 2013:8; Sexual Offences Courts National Strategic Draft Plan, 2016-2020: 33-36).
- Case flow management and screening policy to identify cases that fall within the sex offences category; utilised to direct the functioning of sexual offences courts (Sexual Offences Courts National Strategic Draft Plan 2016-2020: 25). (cf discussion on the challenges of the Thuthuzela Care Centre model earlier in the chapter).

From the above, it can be deduced that sexual offences courts are an important tool in managing sexual offences. The sexual offences courts accomplished the following achievements in addressing sexual violence:

- Reduce the trauma experienced by the survivor;
- Expedite the hearings of court cases pertaining to sexual offences;
- Court decisions and judgements in relation to sexual offences improved;
- More convictions for sexual offences are imposed;
- Restored hope within the CJS (Mhlungu, 2018).

Post-rape services developed gradually since the 1970s, with countries such as the United States of America and Australia being the first to implement coordinated services for adult female rape survivors within the CJS. Numerous policies, directives and legislation guide the implementation of post-rape services locally and abroad, although these services are rendered unstandardised in pockets. Moreover, the Thuthuzela Care Centre is the predominant model of post-rape services within the South African context. However, further consultation between the relevant key stakeholders (i.e., NPA, Department of Health, Department of Social Development, NGO and NPO necessitates collaborative engagement aligned with the Victims' Charter, National Policy Framework, Victim Empowerment Programmes, and more recently, the adoption of the Victim Support Services Bill introduced in 2020 in South Africa. Most importantly, the sexual offences courts significantly increased the prosecution rate of sexual offences such as rape since the actors within legal proceedings specialised in dealing with rape-related matters prior to its gradual demise as of 2005.

3.6. SUMMARY OF THE CHAPTER

Various approaches were highlighted in the chapter in relation to policies, guidelines, norms, and standards in rendering post-rape services to adult women. Both local and international modes of service rendering to adult female rape survivors focus predominantly on the medical, medico-legal, psychosocial and legal, although these post-rape services are not standardised internationally and locally. Numerous challenges recognised the need for post-rape services to be aligned and offered comprehensively within all Thuthuzela Care Centres. Nonetheless, major strides have also been achieved in South Africa regarding the amendment of legislation and the introduction of various policies, directives and the Victim Support Services Bill. Even though the Thuthuzela Care Centre model provided a significant sense of relief to adult female rape survivors in seeking post-rape services, an evaluation of the model in comparison to its global counterparts; indicates a necessity for post-rape in South Africa to be victim-centred based on the needs of adult female rape survivors. It is also essential that the Batho Pele Principles guide post-rape service*s*, Victims' Charter,

National Policy Framework, and relevant legislation, which implies putting the adult female rape survivor first. The thesis's next chapter will explicate the study's theoretical framework.

CHAPTER 4: THEORETICAL FRAMEWORK IN RENDERING SERVICES TO ADULT FEMALE RAPE SURVIVORS WITHIN THE CRIMINAL JUSTICE SYSTEM

4.1. INTRODUCTION

A theory can be defined as a set of logical values or statements intended to construct our observation, comprehension, and description of the world (Nilsen, 2015:2). Furthermore, a theory is a set of sensibly interconnected gestures clarifying how phenomena are interrelated; and from which numerous assumptions can be consequential and confirmed. Theories provide understandable and coherent reasoning for the existence of a certain phenomenon since they can be linked with applicable empirical findings and provide practical directives for researchers seeking further clarity about a research problem under question (Walsh & Hemmens, 2011:9). Likewise, theories provide an agenda for explaining human behaviour (Siegel, 2016:7). Theory affords a coherent flow and scientific clarification of detailed realities that relate to certain events or occurrences (i.e., criminal victimisation) (Maxfield & Babbie, 2016:50). Additionally, theories forecast the manner in which concepts are interrelated with each other and the way certain factors can be clarified in facilitating and understanding criminal behaviour. A well-formulated theory provides a clear explanation of how and why certain relationships or actions of individuals may contribute to certain events or manifestations. Hence, theories can be ascribed as a construct of the continuum and a way to understand a phenomenon (Nilsen, 2015:2).

A theoretical approach to exploring the probable causes of victimisation can offer the researcher a framework to understand and describe victim policies, ease victimisation risk, and be cognizant of the wider context of victimisation risks as criminal justice actors, first responders, and service providers (Zaykowsk & Campagna, 2014: 453).

A theoretical framework used in the implementation of science has three predominant intentions: (i) describing and/or facilitating the process of translating research into practice (process models); (ii) being thoughtful and explicating the

contributing effects relating to implementation outcomes (determinant frameworks, classic concepts, implementation principles); and (iii) evaluating and implementation of various endeavours (evaluation frameworks) (Nilsen, 2015: 1). Overall acknowledged perception of social theory is a set of interconnected and intellectual ideas, concepts, notions, descriptions, declarations, principles and proposals that outlines a systemic perspective of a detailed occurrence by stipulating reasonable relations among constructs, with the view of explicating, forecasting and authenticating the specific phenomenon by making use of existing data in the social context (Babbie, 2016:44-45; Grinnell, Gabor & Unrau, 2016:504; Neuman, 2014:9).

Both theories and paradigms can affect how an enquiry continues. The distinction between the two terms becomes inherently ambiguous because an individual can become so embedded in one specific theory that they tend to comprehend an array of occurrences from a single viewpoint. Although the concepts of theory and paradigm are used interchangeably, they have noteworthy dissimilarities (Rubin & Babbie, 2013:53,59; Strydom & Fouché, 2021:509). Hence, constructing a scientific base for any human services profession necessitates that practice models recommended in literature or practice can be scholarly authenticated to ensure validity (Strydom & Fouché, 2021:508).

The researcher supports the above researchers' views, namely that theories or theoretical frameworks are concepts, ideas and perceptions that may be interrelated in explaining a certain phenomenon.

The next section will discuss selected victimological theories such as the lifestyle exposure theory, routine activities theory and the extended control balance theory. Additionally, the ecological systems theory will also be applied within the context of the study.

4.2. VICTIMOLOGICAL THEORIES WITHIN THE CONTEXT OF THE STUDY

The lifestyle exposure theory highlights the interactions between a potential victim, their lifestyle and interaction within their environment. The routine activities theory explicates the vulnerability of potential victims in relation to their daily

activities, subjecting them to becoming victims of a particular crime (i.e., rape). The extended control balance theory emphasises the link between the likelihood of victimisation occurring if a control deficit and control surplus present themselves over time, predisposing a suitable victim to the likelihood of being victimised.

In the next section, the lifestyle exposure theory will be described.

4.2.1 Lifestyle exposure theory

The lifestyle exposure theory was developed by Hindelang, Gottfredson and Garofalo (1978) to investigate the unequal distribution of violent crime risk profiles, although the theory has since been extended to describe dissimilarities in the risk of property crime. According to the lifestyle exposure theory, certain demographic features are linked with role expectations and limitations, which might emanate into lifestyle differences across demographic groupings. The lifestyle mentioned above attributes might contribute to exposure to victimisation. Familial ties and duties may cause married individuals to spend more time with family members at home, while their single counterparts may be more likely to engage in activities other than with their significant others. These contradictory lifestyle patterns may result in distinctive variations of exposure to victimisation when comparing single and married individuals (Bunch, Clay-Warner & Lei, 2012:1183-1184).

Lifestyle influences the nature and extent of the degree of risk individuals might be exposed to, such as in the case of a motivated offender without capable guardianship. The higher the degree of exposure to a motivated offender, the higher the risk of being victimised. Furthermore, the lifestyle exposure theory also submits that lifestyles differ across demographic settings, which explicates why certain individuals are more prone to becoming targets of victimisation when compared with others in different demographic settings (Madero-Hernandez & Fischer, 2017:328).

A risky lifestyle has been attributed as indicative of predicting offending behaviour rather than victimisation (Engström, 2018:901; Pauwels & Svensson, 2011:168).

Demographic facets such as age, sex, race, marital status, level of income, education, and occupation, are perceived as bearing significance since the influence of the attributes above, role expectations, or behaviours that people are anticipated to engage in; and structural restrictions on individual behaviour; inclusive of financial, legal, or familial limitations. As per the lifestyle exposure theory, a person's lifestyle influences their possibility of victimisation, emanating from their lifestyle and exposing them to high-risk places and motivated offenders during times when criminality is most likely to transpire. Likewise, lifestyle may also influence the efficiency of security facets that may provide effective means of deterring crime to a certain extent (visible policing) to mitigate a crime from occurring (McNeeley, 2015:32).

Victimisation is more likely to occur within structural conditions since motivated offenders often move around searching for a suitable target. Residents in low-income areas are thus less motivated to change their behaviour to safeguard against potential victimisation (Pratt & Turanovic, 2016:340). Additionally, although not to a greater extent, individuals have the propensity to self-select the various forms of risky behavioural routine (voluntary participation in crime and defiant behaviour, drinking in excess in public domains, and being negligent concerning their belongings). The activities above might presumably make an individual more prone to becoming an attractive target by a motivated offender (Turanovic, Reisig, & Pratt, 2015:187). The behaviours described above are also expected within certain disadvantaged structural conditions that might harness more levels of criminal motivation. Additionally, capable guardianship is less likely to be present in marginalised structural conditions whereby the communities' access to quality public resources is inadequate (resources that promote formal social control such as a security guard and adequate street lightning) and cooperative efficiency (resources that promote informal social control), which is commonly not adequately addressed within disadvantaged communities (Wright, Pratt, Lowenkamp, & Latessa, 2013:98). While activities such as shopping and embarking on public transport to work can be easily distinguished as moderately low-risk behaviours, an issue that more recurrently occurs as being a risky lifestyle indicator is the tendency of individuals to frequent social establishments

at night away from their residential dwelling; placing them at risk of being victimised (Averdijk, 2011:133; Bunch, Clay-Warner & McMahon-Howard, 2014:576). Research by Engström (2018:898) also indicates that violent forms of victimisation and offending often overlap and that both outcomes may be ascribed to a risky lifestyle.

It is proposed in the lifestyle exposure theory that victims with similar characteristics as potential offenders (male, minorities and young individuals) are at greater risk of victimisation (McNeeley, 2015:33). Thus, the former implies that their circumstances and lifestyle may be contributory to their own victimisation.

The following are elements of the lifestyle exposure theory:

- **Role expectations**

A person's social role is influenced by their demographic characteristics, including age, gender, marital status, education and profession. The role of a man would therefore be distinctive from that of a woman, and the role expectations for married and single individuals would also be different. Role expectations vary according to an individual's age (Peacock, 2019:24).

- **Structural constraints**

It is argued that familial, economic and legal structures can influence a person's behaviour. For example, economic features might diminish the choices available to an individual as regards their residential area, choice of recreational activities and access to educational prospects. Also, a person from a higher social class is less likely to partake in routine activities that will bring them into contact with a street-level offender (Peacock, 2019:24). Scholars such as Gibbs, Dunkle & Ramsoomar (2020:2-3), and Jewkes, Fulu, Naved, Chirwa, Dunkle, Haardörfer & Garcia-Moreno (2017:7) suggest that structural influences on the occurrences of crimes such as rape are lacking. Yet, a recent analysis on drivers of physical and sexual intimate partner violence highlighted three crucial structural factors that influence intimate partner violence both on an individual level and collectively: (1) lesser socioeconomic status motivated by poverty, inclusive of low educational levels and food instability; (2) gender inequality emanating from beliefs

characteristic of male privilege, and (3) widely accepted tolerance of the assertion of violence in social interactions. Additionally, these structural constraints, in turn, affect individual-level risk factors for interpersonal partner violence, such as adverse childhood experiences (neglect and abuse, observing the abuse of a parent); deteriorating mental health; substance abuse; and a lack of communication in intimate relationships (Gibbs et al., 2020:2-3).

- **Adaptations**

Adaptations to role expectations and structural constrictions may surface at both individual and group levels. An individual's decisions may restrict her routine behaviour to moderately safe activities. Otherwise, the risk related to certain harmful activities may be accepted. Young individuals are inclined to elevate their risk of victimisation by partaking in activities associated with high levels of risk (spending time at nightclubs). Routine behaviour may also contribute to victimisation being averted (not walking around alone at night). When subjected to the risk of being victimised is inevitable, the risk of being injured may be averted by employing methods such as moving in groups rather than alone. Attitudes and perspectives learned during adaptation can also escalate into adopting behaviours that would avert certain harmful behaviours (i.e., heavy consumption of alcohol). In certain circumstances, these restrictions are comparatively minor, such as making sure that relatives don't arrive home after dark (Peacock, 2019: 24).

- **Exposure**

A direct relationship exists between a high-risk lifestyle and the probability of victimisation. Since it is accepted that victimisation is not evenly distributed, it may be contributory to lifestyle variations in which being subjected to high-risk circumstances might inevitably lead to victimisation. A young woman walking alone at night would be one such example in the context of the study (Peacock, 2019:25).

- **Associations**

A direct association between lifestyle and exposure to victimisation may be directly linked to negative associations. Associations with potential perpetrators who unreasonably have specific characteristics would increase the likelihood of a person's victimisation. Hindelang, Gottfredson and Garafalo (1978), as quoted by (Peacock, 2019:25), believe that eight (8) propositions on exposure to victimisation may be connected to a specific lifestyle being:

> *The prospect of personal victimisation is linked to the amount of time a person spends within a public domain*

Streets and communal facilities such as parks increase the chances of personal victimisation compared to other settings such as the home. Additionally, victimisation is more likely to occur at night; and/or in the early hours of the morning compared to the risk of victimisation during the day. The prospects of victimisation are thus not uniformly equated in relation to time and space (Peacock, 2019:25).

> *The possibility of a person being in a public place at night differs as a form of lifestyle*

Various lifestyles subject individuals to diverse degrees of victimisation, which further explains why certain people are more vulnerable to individual victimisation, whereas others may not be (Peacock, 2019:25). For example, young people are more likely to go out at night than elderly people, thus increasing their vulnerability to victimisation.

> *Social exchange and interaction transpire most regularly among persons with comparable lifestyles*

Demographic features such as race, gender, age and marital status forecast a characteristic lifestyle. Individuals are more likely to engage with peers of a similar age, race and socioeconomic position (Peacock, 2019:25). For example, women who have been subjected to rape are likely to be less educated and reside in informal housing structures or rural areas than women who have not been raped

(Abrahams, Mhlongo, Chirwa, Lombard, Dunkle, Seedat, Kengne, Myers, Peer, García-Moreno & Jewkes, 2020:6).

> *The probability of victimisation may be contingent on the extent to which individuals display similar demographic characteristics as a potential offender*

Perpetrators are more likely to engage and victimise persons with similar demographic characteristics. Motivated offenders are more likely to target individuals with similar demographic characteristics (unemployed, young, from a low socioeconomic standing, and most likely to have been abused themselves) (Peacock, 2019:25).

> *The proportion of time that individuals spend with non-relatives differs as a way of lifestyle*

As minors mature from birth to adolescence, a reduced amount of time is spent with family members, while the contrary is true in relation to elderly persons. The amount of time a person spends with non-family members is consequently linked to their lifestyle (Peacock, 2019:25).

> *The likelihood of personal victimisation intensifies as a function of the proportion of time that a person spends with individuals, not from their own household*

Hindelang et al. (1978), as quoted by (Peacock, 2019:26), believe that the more time people spend with non-relatives, the higher the risk of personal victimisation.

> *Dissimilarities in lifestyle are associated with disparities in the capacity of individuals to segregate themselves from individuals with criminal tendencies*

Persons with a higher income can choose to live in a safe neighbourhood with security, and elderly individuals may choose not to go out at night, thus decreasing their exposure to persons with criminal motivation (Peacock, 2019:26).

Differences in lifestyle are related to discrepancies in the desirability and vulnerability of an individual as a target for personal victimisation, as well as the effortlessness with which victimisation may occur

Communal spaces such as streets and parks render a potential offender the opportunity to victimise individuals with almost no real defendable space. It is thus easy to commit crimes within these places. The desirability of the victim denotes the notion that the perpetrator believes that the survivor of a specific crime would not report the incident to the police. Vulnerability, however, relates to the presence of alcohol and other illicit substances, which may further debilitate the victim from protecting herself (Peacock, 2019:26) (*Cf discussion in Chapter 2 regarding substance abuse and rape).*

A qualitative study conducted in South Africa by Bougard, Booyens and Ehlers (2015) comprising 45 adult female rape survivors, found similar characteristics regarding the socioeconomic status, education, living arrangements, marital status, and choice of residence, which further indicated similar patterns as highlighted within the lifestyle exposure theory. Within this study, most of the respondents were single (n=30; 66.7%), followed by a relatively lower number of respondents (n=5; 11.1%) having indicated being divorced or living with a partner. Only a few respondents (n=4; 8.9%) were married, and one respondent (n=1; 2.2%) conveyed that she was separated from her partner. A high number of respondents (n=18; 40%) indicated they lived with their parents, whereas 11 (24.4%) of the respondents revealed that they lived with a husband or partner. Very few respondents (n=6; 13.3%) cohabitated with other relatives, and 5 of the respondents (11.1%) were living with their children or lived alone (n=4; 8.9%). One of the respondents, however, did not indicate her living arrangement(s). Most of the respondents (n=26; 57.8%) resided in the township (*eKasi*). Only 9 (20%) of the respondents lived in either the city (metro) or informal settlements (*Mkhuku*). Only one respondent did not specify her residence. Regarding the socioeconomic stance of the respondents, most (n=32; 71.1%) expressed that they earned a low income of R 25 000 or less per annum. An average income of R50 000-R100 000 (n=4; 8.8%), and R150 000-R200 000 (n=6; 13.4%), had emerged as indicative of the median income per household per annum. Only one

respondent had an income of R250 000 (n=1; 2.2%) per annum, while two (n=2; 4.4%) specified that they earned an income of R300 000 or more per annum (Bougard, Booyens & Ehlers, 2015:61).

The next section will explore the routine activities theory.

4.2.2 Routine activities theory

Cohen and Felson (1979) originally developed the routine activities theory to highlight how victimisation patterns were linked to criminality over time and across places (Drawve, Thomas & Walker, 2014:2). Routine activities theory depicts the circumstances that are essential for criminal incidences to occur. The routine activities theory bears similarities to the lifestyle-exposure theory, although the routine activities theory explicates the circumstances surrounding the crime rather than individual characteristics contributory to crime. According to the routine activities theory, in order for a crime to occur, three elements must come together in space and time being (a) motivated offenders, (b) suitable targets, and (c) the absence of capable guardians. The routine activities theory was originally developed to elucidate changes in property crime incidences across time in the United States of America. Cohen and Felson contended that macro-level changes in routine activities commencing in the 1960s led to an upsurge in the availability of suitable targets; and a decline in the presence of capable guardians; being contributory to a higher incidence of criminal activity being reported at the time (Bunch et al., 2012:1184).

Even though the primary intention of the routine activities theory is to describe the elements needed for a crime to occur, it is recognised as being predominantly explanatory in nature (Pratt & Turanovic, 2016:335; Engström, 2018:901). The activities of persons during the day may surmount or reduce opportunities for the significant elements (motivated offenders, suitable targets, and absence of capable guardians) to join in space, thus inducing the prospect of a criminal event. An increase in activities that take individuals away from their homes or safe spaces is thus associated with increased criminal opportunities. Cohen and Felson (1979) also specified that individuals have three broad activities: their

home activities, work-related activities away from their home, and other activities away from home (i.e., social event activities) (Drawve et al., 2014:4-5).

The routine activities theory intercedes the relationships between demographic characteristics and victimisation (Bunch et al., 2012:1181). The three elements of the routine activities in relation to the current study are applied as follows:

- ***Motivated offender***

Closeness to motivated offenders refers to the physical location of prospective targets to an offender. Individuals who are in closer proximity to a larger populace of motivated offenders are thus more likely to be victimised. Proximity refers to neighbourhood attributes, suggesting that individuals residing in crime-ridden and disorganised surroundings are more likely to be targeted by motivated offenders due to their vulnerability being in such close proximity to the aforesaid grouping of individuals (McNeeley, 2015: 33).

- ***Suitable targets***

Environmental and spatial aspects such as overcrowded living conditions and poor service delivery result in the overexpansion of unsafe public spaces and may also contribute to feelings of a lack of safety. Four categories are evaluated as being a preferred target by a motivated offender, namely *value* (the financial attractiveness and desirability to target a specific individual); *physical visibility* (the risk of being noticed by a potential offender); *accessibility* (effortlessness in confronting a potential victim without attracting attention); and *inertia* (refers to the easiness of targeting a potential victim) (Peacock, 2019:28).

The Council for Scientific and Industrial Research has formerly used community mapping to assist affected communities in ascertaining, prioritising, and providing plausible intervention strategies regarding communal environmental risk factors. During this process, communities themselves were able to identify troublesome areas, for example, dense areas where sexual violence such as rape occurs frequently or places that felt unsafe to visit. Sometimes minor solutions can be implemented by the community themselves, for example, working together to eradicate overgrown and dense vegetation, or create a pathway to make it less

probable to have overgrowth vegetation and dilapidated infrastructure, thus increasing perspectives toward safety (A Dialogue Between Government and Civil Society, 2013: 6,13). *(cf discussion in Chapter 2 pertaining to the vulnerability of women in becoming victims of rape).*

- ***Capable guardianship***

Capable guardianship denotes any form of mechanisms (i.e., security devices), human presence, and any other form of direct or indirect means of rendering protection from criminal activities. Capable guardianship can thus be described as a crime prevention initiative, whether it might comprise physical, structural mechanisms or human visibility (Peacock, 2019:28).

Guardians are responsible for defending impending victims from potential offenders when the parties join in time and space. Guardianship may be formal (legal regulation and implementation regarding the practicality of appropriate security features) or informal (neighbours, friends, bystanders). Additionally, alarms, locks, and other security processes (security companies) that protect a residence; are perceived as being capable guardians (since the former modes of capable guardianship are regarded as formal responses pertaining to crime prevention). While efficacious guardians are those who would come to the assistance of a victim, it is problematic to assess the effectiveness of a guardian who may be competent in preventing a crime from occurring. That said, numerous crimes are forestalled merely due to the presence of someone or something (i.e., a closed-circuit camera) apparent to be a guardian. Moreover, another individual's presence might aid as a preventative measure of would-be guardianship purely because a third party is present (Drawve et al., 2014:6; Felson & Boba, 2010: 96).

Felson and Cohen (1980) assert that criminal activities do not occur unpredictably and unexpectedly, although various communities' social structures can contribute to crime. According to Garofalo (1987), the routine activities theory also cannot explain the existence of certain criminal patterns in isolation since it does not explicitly account for the motivations to commit certain criminal acts. It is further also argued that violent crimes, such as physical contact crimes, are

predominantly executed in privacy (homes of the offender or victim); and can occur vividly, instinctively and impetuously (Reyns, Henson, Fisher, Fox & Nobles, 2016:1723; Peacock, 2019:27). In the next section, the researcher will outline the extended control balance theory as another victimological theory to explain the balance differences that might be perceived as contributing to the occurrence of crime within various settings (a motivated offender coming into contact with a suitable target).

4.2.3 Extended control balance theory

The extended control balance theory by Piquero and Hickman builds on Charles Tittle's control balance theory of crime, in which Tittle delineates deviant behaviour as being: *"*any behaviour that the majority of a given group regards as unacceptable or that typically evokes a collective response of a negative type*"* (Tittle, 1995:124). According to Tittle (1995), control comprises two distinguishing fundamentals: the amount of control a person is subjected to; and the intensity of control a person can assert upon another. Within the domain of the control balance theory of crime, it is proposed that the amount of control a person is exposed to in relation to the level of control that they can sanction affects both the prospect and form of non-conforming behaviour (Peacock, 2019:35).

The key principle of the control balance theory lies within the belief that if a person has an absence of control at their disposal, they may find an opportunity to participate in criminal activities in an effort to obtain control, and a surplus of control, in turn, may also be causative towards partaking in criminal activities (Siegel, 2016:315; Newburn, 2017: 256; Jones, 2017:240).

At the time, Tittle rejected existing theories as ineffective in clarifying crime and therefore concentrated on five causal factors: control ratio, control surplus, control deficit, constraint, and opportunities (Jones, 2017:239). According to Tittle, control is a constraint on behavioural opportunities. Tittle is further of the opinion that divergent criminal motivations emerge from situational effects and influences such as a desire for autonomy and the *control ratio. Control ratio* is the amount of control one is able to exert relative to the extent of control one perceives to experience. Individuals who, in accord with their status or personal

strengths, can exert more control over others are described as having a *control surplus*.

Similarly, persons of lower social status, with little influence to control others but who themselves are subjected to assert inconsiderable control, have a *control deficit*. Therefore, for criminal motivations to transpire, an individual who enjoys a control surplus must be motivated to exert and extend it to another, and individuals who experience a control deficiency must be able to eradicate it. The fourth causal factor, *constraint*, or the probability that there will be controlling inferences, is a result of the control ratio, the gravity of a certain act and the chances of the crime being detected by authorities. The last factor is *opportunities*, which relate to circumstances in which criminal activities are most likely to occur (Jones, 2017:240; Peacock, 2019:35).

The ability to exert control and be controlled are continuous entities. An individual with excess control has the ability to coerce another individual who seems to lack control and hence becomes passive in this regard (Peacock, 2019:35). For this study, the control surplus and the deficit will be explained.

As mentioned earlier, Tittle assumed that a surplus or deficit disparity could progress into criminality. The five casual factors must overlap and correspond for a crime to occur. Firstly, there must be motivation evoked by provocation, and there should also exist a lack of constraint prompted by an opportunity to commit a crime. Provocation could be depicted as a challenge, an insult, or a seemingly undesirable or annoying perception regarding the control deficit (or surplus). Tittle also argues that persons with a control surplus are keener to scout and target individuals subordinate to themselves, who would seize the opportunity to their advantage.

Similarly, an individual who experiences a surplus of control may also engage in abusive behaviour (influencing others to commit crimes on their behalf) or abuse their power by participating in hate crimes. The inconsistent control by persons with a control surplus may perhaps itself be causal and controlling, which in turn intensifies into retaliation in the form of criminal conduct (Jones, 2017:240; Peacock, 2019:35). When a person experiences a control deficit, they may make

use of three strategies to restore the balance, namely predation, defiance or submission. Predation surfaces when an individual resorts to violence to restore balance (Peacock, 2019:35). A medium level of control deficit is denoted in the form of defiance. Defiance is labelled as being escapist deviant acts, which Tittle describes as deviant actions such as alcoholism, drug abuse, suicide, family abandonment or mental illness. In this instance, the person challenges the control without resorting to the use of violence. Moreover, the most life-aggressive form of control deficit, submissive deviance, is explicated by Tittle as a usual reaction (an impulsive violent attack aimed at a certain individual) (Jones, 2017:240). Submission thus occurs if an individual complies unreceptively with the offender's demands (Peacock, 2019:35).

Three levels of imbalance were initially labelled by Tittle for both control surplus and control deficit. The first level of imbalance refers to an individual who exerts only a considerably amount of control over what they are inclined to and are believed to be engaging in the exploitation of others. Tittle believes it is considered the most collective form of crime for persons with a control surplus. The second level of imbalance occurs if an individual has the ability to employ a greater amount of control over another individual. The third level of imbalance transpires if a motivated offender inflicts excessive force upon a victim, resulting in deviance (Jones, 2017:240).

During the amendment of his theory, Tittle (2004) yielded a recommendation from Braithwaite (1997), who contended that it would be desirable to imply a simpler approach that everyone is pursuing more control. Tittle thus admitted that the variances among the categories of deviance were indefinite and should be combined. The application above led to one continuum of control balance desirability, which implies that individuals with either control surpluses or control deficits can opt to engage in comparable forms of non-conformity, particularly those individuals confirmed to be in the middle range (between control surplus and deficit). Tittle also recognised Braithwaite’s proposal that passivity should be considered a unique and different category of crime (Jones, 2017:240-241).

Piquero and Hickman (2003:286) expanded on Tittle's control balance theory to explain victimisation. The interpretation by Piquero and Hickman found that the elements of victimisation in the extended control balance theory presented similar trajectories of non-conformity as in the control balance theory. Similarly, diminished and elevated levels of control might transpire into deviant behaviour and victimisation. Contrawisely, the theorists did not attempt to explicate that all persons with control deficiencies will be prone to victimisation; or more likely to become vulnerable victims themselves - but merely articulated that individuals may emanate a sense of weakness to which probable perpetrators may be subject (Peacock, 2019:36). Additionally, Piquero and Hickman (2003:286) are of the opinion that control imbalances are also connected to the possibility of victimisation. According to Piquero and Hickman, the control ratio can lead to victimisation, but for completely dissimilar reasons. If a control deficit is present, an individual will become weak due to an incapability to have control over their circumstance, making the individual prone to submissive, acquiescent behaviour, making them susceptible to being victimised. Since offenders are inclined to target vulnerable individuals, the defenselessness of potential victims is comparable with their assessed likelihood for the victim to resist. The victim's inability to resist is noticed by offenders, who exploit such persons for their own benefit (Jones, 2017:240; Peacock, 2019:35). An example would be the rape of a woman after being threatened and subdued by a motivated rapist due to her physical vulnerability.

When the extended control balance theory is applied within the context of this study, women may become victimised by men who perceive themselves as being in a position of superiority with surplus control (authority, influence and eminence), who in turn use their position, further exacerbated by self-control in accomplishing their immediate gratification to rape, without weighing their actions against the impact of the crime of rape on the survivor thereof. The end result will be control imbalances between the parties concerned. Additionally, rationalisation of their criminal actions is thus driven by sexual entitlement, rape stereotypical beliefs and normalisation of sexual violence such as rape within a

broader community (Jones, 2017:362). (*Cf discussion on the universal culture of rape in Chapter 2 of the thesis).*

Arguably, one of the dominant subjects that arise from research into rape is whether the crime is based on a principal desire for forcible sex; or is fundamentally motivated by the need for power and control. Conversely, Felson (1993), as quoted by (Jones, 2017:362), voiced that most rapists have a strong desire for sexual intercourse and observe themselves as being sexually disadvantaged. While they would reasonably choose consensual intercourse, they are willing to use force if provoked. Feminists are, however, of the opinion that rape is the end result of individual pathology and asserts that it is an inevitable concern of the power discrepancies between men and women (Jones, 2017:362). The proclamation above thus supports the interaction between the control imbalances within society *vis-à-vis* men and women. Similarly, emanating from feminists' perspectives, women are the noticeable rape survivors within the sphere of cultures driven by patriarchy, which is believed to be further fumed by power and control, although this view does not explain the reasoning as to why men do commit rape. Additionally, it is anticipated that violent rapists have challenges establishing consensual forms of sexual intimacy with their female counterparts, whom they perceive need to be punished and humiliated if their sexual advances are refused by women (Jones, 2017:367).

The researcher believes that victim support services such as victim impact statements and victim empowerment programmes necessitate advancement in empowering adult female rape survivors within the CJS. The aforesaid forms of support would allow the adult female rape survivor to be the centre of the CJS, providing them with an opportunity to gain back a sense of control over their lives and foreseeably move past the ordeal they had encountered (*cf discussion in Chapter 3 referring to victim empowerment programmes and victim impact statement).*

4.2.4. SUMMARY OF THE VICTIMOLOGICAL THEORIES

The victimological theories used to explain the underlying factors inclusive to rendering services to adult female rape survivors within the CJS can be summarised as follows: The lifestyle exposure theory, with an emphasis on the role of lifestyle being contributory towards sexual violence such as rape, while the routine activities theory highlights the role of daily activities and interaction with motivated offenders, which is anticipated to transpire into victimisation. The extended control balance theory outlines the discrepancies in power relations that exist among individuals, being control surplus and control deficit, which occur within a domain of continuum that is thought to be linked with the eventuality that victimisation might occur due to the presence of imbalanced power relations. The victimological theories emphasise the notion that women are vulnerable to crimes such as rape during the execution of their daily tasks and exposure to criminality, which are further exacerbated by an imbalance regarding gender relations between women and men.

Another theory, known as the ecological system theory, may explain the contributory factors in relation to the developmental needs, capacity (in terms of seeking assistance within the CJS) of adult female rape survivors, and the impact of the CJS, which will be discussed below.

4.2.5. ECOLOGICAL SYSTEMS THEORY

Urie Bronfenbrenner (1979) introduced the ecological systems theory, which classifies an individual's environment into five overlapping domains, all with cumulative levels of interface with the individual. For this study, emphasis will be placed on the *microsystem, mesosystem, exosystem, macrosystem* and *chronosystem*. The *microsystem* comprises the individual and her family, the *mesosystem* includes one's immediate surroundings, the *exosystem* consists of facets such as the state government, and the *macrosystem* denotes cultural perspectives within its entirety. It is crucial to acknowledge that the essential basis of the ecological systems theory revolves around the notion that a person can be best understood in the context of their relationships with several structures in their

lives. By adding the *chronosystems*, Bronfenbrenner anticipated exploring changes in the individual over time; and the developmental effects on an individual. An all-inclusive comprehension of the dynamics in the interaction between the numerous relations in a rape survivor's pathway to recovery is entrenched within a reciprocal relationship; further intended to capture an individual's experiences, approaches and behaviours in relation to the systems they are exposed to (Alaggia, Regehr & Jenney, 2012:309; Eriksson, Ghazinour & Hammarstrȍm, 2018:420; Martin, 2016:10). Similarly, the ecological systems theory denotes an understanding that individual behaviour can only be understood by taking into consideration the various facets at an intrapersonal level that comprises personal characteristics and formative history (Alaggia et al., 2012:309). The ecological systems theory is thus imperative in understanding the factors as being contributory for the rape incident to transpire; and further highlights the capacity of adult female rape survivors on their journey to recovery.

The ecological systems theory accepts that individuals try to uphold a good level of stability between themselves and their environment as they progress through their life course. Adaptedness is indicative of a positive and healthy way of life between the person and the environment. Furthermore, adaptedness also signifies an environment in which individuals sense that their environment provides the essential and useful resources to enhance their needs, personal strengths, resources, and the capability to mature, develop, and be content. When a person believes that their environment is not providing the required resources due to the absence or unavailability of resources, they may believe that they do not adequately nurture the strengths, resources, or capability to grow and advance, thus subjecting them to experiencing stress. Facing stress projects an undesirable level of adaptive fit, often prompting the affected individual to seek assistance (Teater, 2014:4).

From an ecological framework, a *microsystem* ascribes to the first set of actions by a rape survivor in disclosure, and help-seeking is regarded as being intrapersonal in nature. One facet of intrapersonal factors that affect disclosure is a woman's present mental health and emotional status. Two other significant factors are resistance and resilience (Alaggia et al., 2012:305-307). Moreover,

empowerment emerges from individuals' capacities and strengths to advance their social capital. Social capital is proclaimed as being the basis for resilience, and resilience is a prerequisite for empowerment (Peeters, 2012:11).

According to the ecological systems theory, *mesosystems* are developments that enable connections between an individual and formal systems, being *exosystems* (Wadsworth, Krahe & Searing, 2018:42). Nevertheless, Neville and Heppner (1999) and Campbell, Dworkin, and Cabral (2009), as quoted by (Wadsworth et al., 2018:42), believe that merging these two systems is important since both formal and informal support systems are often interrelated. A victim/survivor may opt to seek assistance from a community rape crisis centre (mesosystem), which may, in turn, connect her with formal systems ecosystem) (law enforcement or healthcare) (Wadsworth et al., 2018:42). Similarly, the Thuthuzela Care Centres render a multidisciplinary approach in rendering services to adult female rape survivors within the CJS.

At the *macrosystem level*, the effect of the larger communal cultural influences is significant since it explores the impact of “rape prone” communities on the adult female rape survivor (Wadsworth et al., 2018:42-43). Aligned with the macrosystem are stereotypical belief systems of patriarchy and machoism (*Cf discussion in Chapter 2 pertaining to the universal culture of rape of the thesis*). In an effort for service providers to render services to adult female rape survivors, they first need to understand the survivor’s experiences within the CJS (Wadsworth et al., 2018:38).

The *chronosystem* predominantly denotes the impact of the crime on the individual, being the outcome(s) of the CJS on the adult female rape survivor since it influences the changes in an individual and the effects thereof on the person. The chronosystem thus depicts the relationship and processes between key legal stakeholders and adult female rape survivors within the CJS (Eriksson et al., 2018:422).

The ecological systems theory provides a framework for exploring the following domains within the context of the study:

- **The developmental needs (with a focus on developmental relationships, in which service providers and adult female rape survivors outline the way for developmental advancement):**

Healthcare is crucial for adult female survivors with a specific need in terms of HIV and sexually transmitted infections treatment (Bornman, Dey, Meltz, Rangasami & Williams, 2013:27). Rape is perceived to be both a human rights and public health matter since it affects not only an individual but also their significant others and state agencies rendering services to adult female rape survivors within the CJS. On an individual level, the aftermath of rape may include but is not limited to physical injuries such as bruising, broken bones, chronic pain, headaches, unwanted pregnancy, miscarriage, early labour or injuries to a foetus in the case of a pregnant woman, or the end-result being death (Mpani & Nsibande, 2015:8). Rape also bears significant financial implications for both the adult female survivor and government agencies (i.e., health and psychosocial services). Since adult female rape survivors and their significant others often seek health- care support to deal with the physical and/or mental harm produced by the crime, adult female rape survivors also run the risk of losing their employment due to the negative consequences of the rape ordeal they had suffered (Mpani & Nsibande, 2015:14). An all-encompassing query thus exists surrounding the accessibility of services; and the uptake thereof. Agencies responding to the needs of adult female rape survivors find that many of them prefer not to seek assistance due to stigma, shame, fear of rejection, dearth of information relating to their role in the CJS, extensive travelling distances from the treatment facility; and absence of time and/or money; are considered to be some of the barriers. While numerous fundamentals of response have been anticipated, the foremost basics seem to be assuring safety, confidentiality and increasing awareness about service availability (Schopper, 2014:590). (*Cf Chapter 2 discussion on the medical, medico-legal and psychosocial needs of adult female rape survivors).*

- **The capacity of the adult female rape survivor in responding to specific needs:**

Adult female rape survivors have the capacity to seek assistance and treatment (Schafran, 2015:1,3). Additionally, female survivors of rape also have the right to

be afforded information pertaining to their role within the CJS. Service providers within the CJS are obligated to perform a needs assessment that is specific to the needs of the adult female rape survivor. It is also important for adult female rape survivors to be referred to the respective service providers within the CJS, with an emphasis on a trauma-informed response to rape (Lorenz & Ullman, 2017:3). Adult female rape survivors are also entitled to receive regular updates about the progress of their case, aligned with ongoing support irrespective of the outcome thereof (Molina & Poppleton, 2020:53-61). It is thus foreseeable that by addressing the crucial needs of adult female rape survivors (i.e., access to health, medico-legal examination, psychosocial care, and legal services); the all-important gap between what ought to be done; and what needs to be done, are implemented within the CJS (Molina & Poppleton, 2020:53-61).

Interdisciplinary stakeholders within the CJS (police, prosecutors, medical/forensic examiners, rape victim advocates) are obligated to coordinate and improve the response to crimes such as rape. Resources could be beneficial in developing accountability systems that monitor the effective implementation of the protocols and legislation, which would enable service providers to take the necessary corrective action steps to safeguard that correct procedures are followed within a standardised and uniform manner to implement system-level measures that increase implementation of legislation and protocols. Resources that enable service providers with practical strategies in developing infrastructure that is able to adapt and respond to rape within the prescripts of a interdisciplinary team are thus crucial in facilitating changes within contextual factors over a period of time. The initiative above would aid service providers within rape crisis centres (Thuthuzela Care Centres) in working collectively when rendering services to adult female rape within the CJS (Greeson & Campbell, 2014:1,16).

- **The impact of the CJS in addressing the needs of adult female rape survivors:**

Rape survivors have a lack of confidence in the CJS. Empirical evidence suggests that rape survivors who reported the incident in more recent years may feel adequately supported by the police, courts and other service providers within the CJS, while many also reported ill-treatment (Machisa, Jina, Labuschagne,

Vetten, Loots, Swemmer, Meyersfeld & Jewkes, 2017:14; Molina & Poppleton, 2020:57-61). Even when no successful prosecution occurred, rape survivors may still appreciate how service providers within the CJS treated them. Being believed is one of the most significant aspects for rape survivors, but numerous rape complainants may still feel that their credibility is questioned through numerous stages within the CJS (Martin, 2016: 280). Rape survivors need prompt and proactive communication relating to the progress of their case.

Additionally, information should be conveyed to adult female rape survivors in a sensitive manner. Consequently, adult female rape survivors desire to be treated with sensitivity, fairly, and respectfully and want to be believed. It is also crucial for service providers working with adult female rape survivors to be cognisant of the aftermath of trauma on the individual and to afford improved access to support services within the CJS (Molina & Poppleton, 2020:57-61).

Rape survivors can withdraw their case at any stage of the criminal justice process, often prompted by delays and a lack of trust in the CJS. Numerous adult female rape survivors are also subjected to increasing social pressure from family members and the community to withdraw the case since they believe that seeking justice would be costly for the rape survivor (Machisa et al., 2017:20) (*cf Chapter 2 discussion on the legal needs of adult female rape survivors in the CJS).*

The present subjective or random approach to adult female survivors of rape has been indicated to be unsuccessful and, in most instances, leaves the rape survivor with feelings of betrayal by the courts (often denoted as being secondary victimisation). Only a few adult female rape survivors are adequately prepared for the courtroom, and their role as key state witnesses is neglected (Bornman et al., 2013:37).

4.2.6. SUMMARY OF THE CHAPTER

The theoretical framework chapter comprises three victimological theories: the lifestyle exposure theory, routine activities theory and the extended control balance theory. The lifestyle exposure theory explicates the role of lifestyle in relation to victimisation, while the routines activities theory outlined the impact

role of daily activities and influences on women, making them more vulnerable to victimisation such as rape. The extended control balance theory explicates the power relation that exists in the form of an interplay being control surplus and control deficiency, prompting the victimisation of an individual. The ecological systems theory comprises the various processes and interactions that an adult female rape survivor is subjected to in the CJS, with a focus on the developmental needs and capacity of adult female rape survivors, in relation to their interaction within the CJS; being the impact, it might have on the adult rape survivor pertaining to her road to recovery. The ecological systems theory is guided by five levels of overarching domains known as the microsystem, mesosystem, exosystem, macrosystem and chronosystem, which highlights the various approaches of intervention required at distinctive levels in rendering services to adult females within the CJS.

The methodology and relevant ethical considerations in relation to the study will be discussed in the next chapter.

CHAPTER 5: RESEARCH METHODOLOGY AND ETHICAL CONSIDERATIONS

5.1. INTRODUCTION

Research methodology is a methodical mode of solving a research phenomenon and is perceived as the science of practically executing research methods and procedures aligned with the collected data. The methodology entails the actions and measures researchers adopt in describing, explicating and envisaging the phenomenon under question (Chinnathambi, Philominathan & Rajasekar, 2013:5). Similarly, Patel and Patel (2019:48) believe that research methodology is a scientific and orderly method of conducting research and exploring research scenarios. Research methodology outlines how information is obtained, how the collected data is comprehended and understood, and how the data is interpreted. Research methodology thus structures a plan of action for a research project (Patel & Patel, 2019:9). Research methodology can also be defined as a set of actions used to collect research findings from a definite research initiative with the prospects of producing knowledge. The most important facet of research methodology derives from its ability to generate definite conclusions about a social phenomenon (Ahmed & Opoku, 2016:1). In addition, research methodology is a method applied to conduct social methodical enquiries to facilitate improved comprehension of crime and the CJS (Maxfield & Babbie, 2018:6).

The present chapter delineates the research methods utilised in this study. A discussion of the research paradigm, approach, purpose, research type, and research design is provided. Furthermore, the methods, including sampling, the data collection instrument and data analysis, are also expounded. The chapter concludes with an exposition of the measurement of quality, the pilot study and ethical considerations.

5.2. RESEARCH PARADIGM

The scientific frameworks that theoretically underpin this study consist of the eco-system approach and victimological theories such as the lifestyle exposure

theory, routine activities theory, and the extended control balance theory, which formed the research paradigm that the researcher followed. Various interpretations exist regarding the meaning of a paradigm (Bertram & Christiansen, 2020:24). Generally, it can be defined as a distinct set of concepts or thought patterns, including theories, research methods and standards for what constitutes contributions to a specific field of study. Thus, a conceived method of executing research (Sefotho, 2021:9) and thinking in a certain way during the analyses of the collected data. This paradigm creates a positivist approach to exploring social reality based on the idea that one can best understand human behaviour through observation and reason. Positivism denotes the perception that a specific actual reality is present, necessitating being determined and comprehended. A positive mindset permitted the researcher to interpret, predict and explicate the empirical research findings within a causal framework, implying that the researcher wished to investigate the mode of service rendering (i.e., medical, medico-legal, psychosocial, and legal) to adult female rape within the CJS (Merriam & Tisdell, 2016:9; Park, Konge & Artino, 2020:690). Positivists are also of the opinion that new knowledge can be generated objectively without the ideals of the researcher and the participants affecting its development. Likewise, positivists proclaim that research participants and researchers can essentially be divided (dualism). Furthermore, the researcher followed the aim and objectives of the study to avert bias within the context of the study (objectivity) (Park et al., 2020:691-692; Sefotho, 2021:9).

The researcher's purpose was to think and search constructively for ways to render effective post-rape service to adult female rape survivors within the CJS. As such, the paradigm guided the researcher in drawing conclusions derived from the lived experiences of adult female rape survivors seeking services; and service providers rendering services within the CJS (Merriam & Tisdell, 2016:9; Sefotho, 2021:9). Observations conveyed by both adult female rape survivors and service providers within the CJS were considered to be of value in achieving the aim of this study (Sefotho, 2021:9)

5.3. RESEARCH APPROACH

The researcher employed a qualitative research approach. The researcher's choice for utilising the qualitative approach flows from the interest in studying the lived experiences of adult female rape survivors and service providers concerning the quality of post-rape service rendering within the CJS. Additionally, the qualitative research approach permits the researcher to document and interpret the perspectives of the participants from a holistic approach (Fouché, 2021:42). Qualitative research is regarded as non-numerical means of studying a research problem; and subsequently employs a narrative approach which propagates the deeper meanings of specific human experiences and "produces theoretically richer observations" (Dantzker, Hunter & Quinn, 2018:61; Rubin & Babbie, 2013:40).

Qualitative research is often used to obtain detailed information from participants about their created realities. Information was personally collected from participants through their lens and their unique lived experiences. Additionally, qualitative research draws upon conclusions derived from explanatory processes regarding the data collection process. Interviews were conducted to highlight information about the experiences of service providers and adult female rape survivors within the CJS (Wincup, 2017:4). Qualitative research explicates empirical findings in the form of words, which are based on the corresponding perspective of the research participants. Qualitative research creates new concepts and theories by combining information and intellectual concepts. Consequently, the researcher interviewed service providers and adult female rape survivors to describe their experiences rendering post-rape services to adult female rape survivors within the CJS (Schurink, 2021:392). Additionally, Kumar (2019:16-18) believes that qualitative research is unique in facilitating the data collection process of acquiring perspectives of both adult female rape survivors and service providers within the CJS since the research approach was planned according to the aim and objectives of the study, which facilitated the research process.

5.4. RESEARCH PURPOSE

The purpose of the current study comprised descriptive and exploratory research (Fouché, 2021:65). The researcher wished to investigate the nature of a certain phenomenon, such as the perspectives of adult female rape survivors and service providers regarding post-rape services within the South African context.

Exploratory research is regarded as the primary phase of research, with the vision of attaining new insights into a research problem. Exploratory research predominantly focuses on conducting an accurate investigation into a certain phenomenon. Exploratory studies are generally more suitable for exploring a research problem with limited available information (Akhtar, 2016:73). They can be applied to gain an understanding of the needs of adult female rape survivors within the CJS, while descriptive research was practically useful in investigating the broader context of challenges and innovation regarding the perspectives of service providers in rendering services to adult female rape survivors within the CJS (Fouché, 2021:65; Neuman, 2014:38).

A qualitative descriptive approach was deemed suitable for the study since it described the subjective experiences of service providers in rendering post-rape services; and the experiences of adult female rape survivors in accessing post-rape services within the CJS, which were further linked with the research question, aim and objectives of the study (Doyle, McCabe, Keogh, Brady & McCann, 2020:444). Descriptive research creates information that describes the 'who, what, and where of the subjective perspectives of service providers (Kim, Sefcik & Bradway, 2017:23). This is mainly relevant in describing the quality of post-rape services rendered by various role-players within the CJS; and associated related medical, medico-legal, psychosocial, and legal modes of interventions. Furthermore, descriptive research was also conducive to obtaining a comprehensive understanding of a specific phenomenon, the quality of post-rape services for adult female rape survivors within the CJS (Doyle et al., 2020: 444; Rubin & Babbie, 2016:154-155).

5.5. TYPE OF RESEARCH

Applied research seeks to address definite obstacles within a certain practical setting to suggest solutions that can be used within a short period (Bless, Higson-Smith & Sithole, 2013:389; Grinnell & Unrau, 2011:20; Neuman, 2011:27). The execution of applied research affords the researcher to acquire new information within a practical setting since the researcher was dependent on the shared experiences of adult female rape survivors and service providers rendering services within the CJS (Marotti de Mello & Wood, 2019:339). Applied research can also be conducive to investigating a complex research problem, with the prospects of influencing specific policy-related challenges (i.e., the quality of post-rape services in South Africa). Applied research also bears significant value pertaining to new knowledge advancement since the outcome of the study proposed a prototype model for rendering services to adult female rape survivors within the CJS, guided by the aim and objectives of the study (Bless et al., 2013:389; Marotti de Mello & Wood, 2019:338; Fouché, 2021:61).

The study was further supported by intervention research as a sub-type of applied research. Intervention research comprises a series of planned activities with an envisioned outcome of improving or changing a social setting that would be beneficial in improving the perceived quality of post-rape services to adult female rape survivors within the CJS (Roestenburg & Strydom, 2021:462). The first phase of intervention research identifies the adult female rape survivors and service providers within the CJS. Problems are identified and aligned with the goals and objectives of the study. The second phase entails the gathering and integration of new information with existing information with the aid of a literature study. The third phase involved designing the key components of a prototype model to render services to adult female rape within the CJS. The fourth phase comprises the early development of an intervention strategy, conducting a pilot study, and adopting a specific criterion for implementing the proposed intervention strategy. Evaluation and advanced expansion of the experimental design is implemented, and the mode of intervention is refined. The final phase comprises analysing and disseminating the research results, creating a demand for the proposed intervention, and providing support for implementing the

intervention strategy (Roestenburg & Strydom, 2021:466; Wight, Wimbush, Jepson & Doi, 2016:521).

For the purpose of this study and aligned with the aim and objectives of the study, the researcher only focused on the first three phases of intervention research. The early development and pilot testing (Phase 4), evaluation and advanced development phase (Phase 5) and interpretation and dissemination phase (Phase 6) were not included in the current study. The justification for only focusing on the first three phases of intervention research is that approval must first be obtained from the NPA, Department of Health, Department of Social Development, and the SAPS being the gatekeepers and governmental agencies rendering services to adult female rape survivors within the CJS, to implement a model which may be time-consuming and outside the scope of the current study (Roestenburg & Strydom, 2021:467-484). The key components of a prototype model in rendering services to adult female rape survivors within the CJS will be made available to the NPA, Department of Health, Department of Social Development, and the SAPS for pilot testing and implementation.

5.6. RESEARCH DESIGN

A research design serves as an anticipated plan, structure and strategy for steering exploration into a specific topic. The design is essential as a means of constructing responses in relation to the research questions that are being explored, which is perceived as being an all-inclusive and detailed examination of a certain research topic (Abutabenjeh & Jaradat, 2018:237; Bryman, 2016:60). The aim and objectives also steer a study towards a certain design. This study aimed to investigate the quality of post-rape services for adult female rape survivors within the CJS (medical, medico-legal, psychosocial and legal), which facilitated the researcher in selecting the case study design, deemed the most appropriate research design for this study (Rankin, Sprowson, McNamara, Akiyama, Buchbinder, Costa, Rasmussen, Nathan, Kumta & Rangan, 2014:1582) A significant feature of a research design, is how conclusions are analysed. The manner in which these empirical findings are conveyed (Anderson,

2015:14). Case studies are mainly useful for generating theory and new knowledge, which might inform policy development. Similarly, case studies can be utilised for description and theory development since the researcher developed a prototype model of rendering services to adult female rape survivors within the CJS. One of the key characteristics of a case study is the use of multiple data sources to develop a full understanding of the phenomenon in question (Schwandt & Gates, 2018:351; Schurink, Schurink & Fouché, 2021:303,305). Additionally, cases can be positioned at the micro-level (individuals and interpersonal relations), the meso-level (institutions), or the macro-levels (communities), to mention a few, which is of relevance to the study since the researcher also made use of the ecological systems theory in explicating the mode of service rendering to adult female rape survivors within the CJS (Rossman & Rallis, 2017:81).

More specifically, the current research employed the instrumental case study design, which provided more clarity into a specific subject matter, revisited generalisations derived from multiple cases, built upon theory or simply to obtain comprehension into the broader scope of the research problem (i.e., perceived quality of post-rape services in South Africa) (Ridder, 2017:289). The instrumental case study design guided the researcher in understanding various aspects of a research problem, such as the experiences regarding service delivery to adult female rape survivors; and service providers who provide these services within the CJS (Baker, Bunch & Kelsey, 2015:221; Crowe, Creswell, Robertson, Huby, Avery & Sheikh, 2011; Grandy, 2010). An instrumental case study was selected since it provided insight into the research question, which further enabled the researcher to reconstruct the own experience(s) of the participants about the research problem). The instrumental case study method was most suitable for this study since it afforded the researcher with an opportunity to gather data in natural conversation with a group of participants at their place of employment (being service providers), providing further insights into the perceived experiences of adult female rape survivors in accessing post-rape services in South Africa (Nolin, 2019:89-91).

5.7. RESEARCH METHODS

The discussion which follows provides an overview of the research methods used in the study, with specific reference to the study population and sampling strategy, the data collection method and instrument, as well as the data analysis process.

A study population refers to a sample of participants with similar characteristics (adult female rape survivors and service providers rendering post-rape services within the CJS) (Gravetter & Forzano, 2016:135, Strydom, 2021:228). Sampling denotes the perception that a small sample of the total population with similar characteristics of interest to the study was selected according to a predetermined selection criterion (Barker, 2014:375; Stangor, 2015:112).

Bhardwaj (2019:158) indicated that sampling refers to a specific number of research participants selected from a broader population, implying that a sample comprises individuals intended for a specific study (Stangor, 2015:112). For the purpose of this study, the research participants were divided into two groups, and a different sampling technique was employed for each participant group. The division of the two groups was motivated by two different groupings of perspectives in relation to the mode of post-rape service rendering within the CJS: adult female rape survivors (recipients of services); and service providers (providers of services). The researcher aligned the objectives of the perspectives of adult female rape survivors and service providers by exploring global trends, challenges, and innovations in rendering post-rape services to adult female rape survivors within the CJS. More specifically, the study explored and described the perceived quality of post-rape services in four domains: medical, medico-legal, psychosocial and legal.

Research group 1: Service providers in the criminal justice system

For the purpose of research group 1, the researcher used probability sampling since the researcher randomly selected the service providers rendering service to adult female rape survivors within the CJS. Additionally, probability sampling permitted the researcher to select a sample of service providers (medical, medico-legal, psychosocial and legal) representative of the various role-players

within the CJS, further facilitating the researcher to compare and derive conclusions from the various perspectives of the service providers. A random selection procedure of the participants was thus employed (Gravetter & Forzano, 2016:138; Grinnell & Unrau, 2014:298; Strydom, 2021:233).

Stratified random sampling was utilised for the service providers, as it was anticipated to include a representation of the sample according to a stratum of ten participants for each of the categories of service providers (medical, medico-legal, psychosocial and legal). As a holistic approach to service rendering to adult female rape survivors, the stratified sample was more representative of role players rendering post-rape services to adult female rape survivors within the CJS (Engel & Schutt, 2017:115; Rubin & Babbie, 2016:217). An identical selection of cases can thus be captured, representing each homogenous grouping. Stratification thus involved the process of aligning the units comprising a specific population into similar groups (or strata) before sampling (Maree & Pietersen, 2020:195; Rubin & Babbie, 2016:217).

The strata were divided into four categories (legal, psychosocial, medical and medico-legal), representing various key role players rendering services to adult female rape survivors within the CJS. Moreover, ten participants from each one of the categories were selected. The legal category of the strata comprised investigating officers, court preparation officers, and prosecutors (case managers), although the legal strata only achieved four participants in relation to the anticipated ten participants. The psychosocial grouping of the research participants comprised of site coordinators (who are tasked to oversee the general functioning of the Thuthuzela Care Centres); victim assistant officers (their function being to assist victims at the Thuthuzela Care Centre); lay counsellors/auxiliary social workers (who assist victims with their counselling needs); victim counsellors; social workers; psychologists and first responders (assist rape survivors with acute counselling and human immunodeficiency virus testing and counselling at Thuthuzela Care Centres). The psychosocial strata exceeded the envisioned strata of ten participants, with a final stratum of fifteen participants. The medical and medico-legal included forensic district surgeons and forensic nurses since both the district surgeons and forensic nurses received

training in medicine. The final strata for the medical and medico-legal sphere comprised nine participants, from an anticipated ten participants.

The criteria for inclusion of all categories in the study were as follows:

- Should at least have six months of working experience in the field of sexual violence;
- Proficient in English; and
- Both male and female participants (gender-neutral).

Research group 2: Adult female rape survivors in the criminal justice system

The researcher used the non-probability sampling technique for the study's second group of participants, adult female rape survivors within the CJS. This sampling technique is used when the probability of including each element of the population in the sample is not known and is suitable in situations where the research question does not involve a large population (Bachman & Schutt, 2012:118; Grinnell & Unrau, 2014:298). Additionally, the chosen sampling method is ideal for the study under question, as it included only adult female rape survivors accessing post-rape services within the CJS, representing a similar grouping of individuals. The researcher used both accidental (also known as convenience, availability or haphazard) sampling and purposive sampling (Strydom, 2021:383). Convenience sampling was selected since it is a common approach in exploring a research question of a developmental approach (i.e., rendering services to adult female rape survivors within the CJS) (Jager, Putnick & Bornstein, 2017:2). The researcher selected a sample based on the availability of the participant; and who meets the specific requirements, which the researcher considered to be inclusive of the study (Bless et al., 2013:176-177; Sedgwick, 2013:1). Purposive sampling is commonly applied in qualitative enquiries to identify and select evidence-rich cases related to the study under question. Moreover, the criterion sampling afforded the researcher to select the research participants according to a certain criterion (i.e., service providers and the

recipients thereof within the CJS (Palinkas, Horwitz, Green, Wisdom, Duan & Hoagwood, 2015:1).

These two non-probability sampling techniques were thus suitable for this study since the researcher interviewed adult female rape survivors with the aid of a semi-structured interview schedule. Non-probability sampling was also feasible in executing the study since it was cost-effective, participants were selected pending on their availability and accessibility; and addressed the developmental approach of the research (i.e., the development of a prototype model of service rendering to adult female rape survivors within the CJS (Jagner et al., 2017:1,3). The modes of service rendering (medical, medico-legal, legal and psychosocial) were explored and described; and were directly linked to the mechanisms of service rendering to adult female rape survivors within the CJS.

The selection criteria of the adult female rape survivors comprised of:

- Basic proficiency in English;
- The alleged rape should have occurred within the past two (2) years (2020-2021);
- The participant was mentally capable of providing informed consent; and
- The participant should be undergoing court preparation.

The sample size is presumably large, with a total of 45 participants within the context of this study. It can be applied to investigate an occurrence (perspectives of adult female rape survivors and service providers about the quality of service rendering within the CJS) (Fouché, 2021:40). A large sample size permits the researcher to include information that is representative of the population being studied, which further facilitates a greater sense of meticulousness, although large sample sizes can be costly and time-consuming to investigate and interpret (Bless et al., 2014:174; Gravetter & Forzano, 2016:136-137; Mitchell & Jolly, 2013:310).

5.8. DATA COLLECTION METHOD AND INSTRUMENT

Data collection is a significant step in executing research, including collecting and interpreting information to highlight the outcomes (Kabir, 2016:202). In line with qualitative research, data were collected in a natural setting (the setting of the research participants, namely the Thuthuzela Care Centre, with the aid of semi-structured interviews (according to predetermined themes identified in accordance with the literature study) (DeJonckheere & Vaughn, 2019:2; Flick, 2018:7). Semi-structured interviews comprise a mixture of both closed- and open-ended questions, often complemented with preceding why or how questions. The conversation revolves around a predetermined research problem (the experiences of adult female rape survivors accessing post-rape services and service providers rendering post-rape services) (Adams, 2015:493). Moreover, semi-structured interview schedules are conducted once with a single person, with a duration of approximately 30 minutes to an hour, since all interviews conducted fell within the timeframe of an hour. The semi-structured interview schedule thus represents a representation of the questions or themes which need to be investigated by the researcher (Jamshed, 2014:87). Semi-structured interviews were conducive to gathering the perspectives of adult female rape survivors and service providers within the CJS since specific themes guided the researcher in a semi-structured manner (DeJonckheere & Vaughn, 2019:2).

The researcher visited three research sites, namely (Lenasia South Thuthuzela Care Centre (research site one [RS1]), Laudium Thuthuzela Care Centre (research site two [RS2]) and Masakhanye Thuthuzela Care Centre Tembisa (research site three [RS3])**.** Data collection ensued during July 2021-October 2021, except for two investigating officers, who were only interviewed in March 2022, pending permission from SAPS, according to a predetermined arrangement with the site coordinator, who facilitated the data collection process. The researcher interviewed the service providers and adult female rape survivors, depending on their availability, according to a semi-structured interview schedule, simultaneously at the respective Thuthuzela Care Centres. The researcher gathered data from adult female rape survivors and various stakeholder's/role players within the CJS as discussed below:

5.8.1. RESEARCH 1: SERVICE PROVIDERS IN THE CRIMINAL JUSTICE SYSTEM

The researcher recruited the first group of research participants as service providers at the relevant affiliated Thuthuzela Care Centre, where they are employed. In addition, a list of prospective participants was requested after obtaining permission from the relevant gatekeepers (namely NPA, Department of Health, and SAPS), according to a stratum. This stratum was limited to Pretoria and Johannesburg.

Although the researcher initially intended to only use face-to-face interviews, COVID-19 restrictions regarding visitors (including researchers) to the Thuthuzela Care Centres compelled the researcher to change the data collection method to telephonic interviews. Telephonic interviews were conducted with five service providers (case manager, victim assistant officer, site coordinator, first responder and court preparation officer) from the Laudium Thuthuzela Care Centre (RS2). An interview with the aid of a telephone (landline or cellphone) can be used to investigate experiences with the aid of semi-structured and unstructured interview schedules. Participants can be interviewed over long distances, which is cost-effective since the researcher and the participant(s) do not need to travel, and also serves as a safe mode for engaging with a sensitive topic; or if the participant is shy and feels more comfortable within a safe proximity to reveal information (Farooq & De Villiers, 2017; Geyer, 2021:358).

The researcher asked the site coordinator to ask the service providers for their official work numbers and to be contacted by the researcher for a telephone interview. The researcher scheduled a day and time with the service provider to conduct the telephonic interview. Due to the low response rate from telephonic interviews, which is a known disadvantage of telephonic interviews, the researcher opted to return to face-face interviews. Telephonic interviews can also be costly, and only participants with access to a phone can be included in the study (Maree & Pietersen, 2020:199).

The researcher abandoned the telephonic interviews and diverted to face-face interviews after the daily COVID-19 infection rates in South Africa steadily declined by early August 2021. Twenty-nine service providers were interviewed from the three research sites medical, medico-legal, psychosocial and legal practitioners. The interview schedule for service providers comprised of the following:

- Section A: Biographic information (All research participants).
- Section B: Determinants for adult female rape survivors to report the crime of rape (All research participants).
- Section C: Risk factors contributory towards rape.
- Section D: Protective factors in providing assistance to adult female rape survivors within the CJS.
- Section E: Medical aspects of service rendering to adult female rape survivors (Forensic district surgeons and forensic nurses only).
- Section F: Medico-legal aspects of service rendering to adult female rape survivors (Forensic district surgeons, forensic nurses and case managers only).
- Section G: Psychosocial aspects of service rendering to adult female rape survivors (Site coordinator, victim assistant officer, auxiliary social workers and social workers and case managers only)
- Section H: Legal aspects of service rendering to adult female rape survivors (All participants).

Data were collected until saturation was reached for both group 1 (service providers) and group 2 (adult female rape survivors), up to the point where no new information further emerged (Schwandt & Gates, 2018:351). In the end, 28 service providers participated in the study.

5.8.2. RESEARCH GROUP 2: ADULT FEMALE RAPE SURVIVORS IN THE CRIMINAL JUSTICE SYSTEM

When exploring a sensitive research phenomenon such as rape, individual interviews may be more effective than focus group interviews (Geyer, 2021:356). The adult female rape survivors, who accessed health and psychosocial services at the Thuthuzela Care Centre, were recruited by the staff of the Thuthuzela Care Centre working within the psychosocial domain (site coordinator, victim assistant officer, social worker, and auxiliary social worker), approached the adult female rape survivor on behalf of the researcher, when she arrived at the Thuthuzela Care Centre in a private office. Adult female rape survivors accessed post-rape services through a walk-in, referral, or scheduled appointment with a service provider. The researcher informed and briefed the psychosocial service providers on the aim and objectives of the research in order for the adult female rape survivor to be fully aware of the context of the study and their engagement with the researcher in relation to the study. After the adult female rape survivor agreed to participate in the study, she was accompanied by the psychosocial service provider to a private office where the researcher was based. Semi-structured interviews were conducted by the researcher at three research sites, namely (Lenasia South Thuthuzela Care Centre (RS1), Laudium Thuthuzela Care Centre (RS2) and Masakhanye Thuthuzela Care Centre Tembisa (RS3)**.** Before the interview, the participants were informed of the scope of research; and the researcher further informed the participant that the information conveyed would be kept confidential. The interview commenced after the completion of the informed consent forms. The semi-structured interviews lasted approximately 30-60 minutes for both group 1 (service providers) and group 2 (adult female rape survivors). Only group 2 (adult female rape survivors) received compensation for participating in research for transport purposes. The interview schedule for adult female rape survivors comprised of the following:

- Section A: Biographic information.
- Section B: Determinants for adult female rape survivors to report rape.

- Section C: Protective factors in providing assistance to adult female rape survivors.
- Section D: Medical aspects of service rendering to adult female rape survivors.
- Section E: Medico-legal aspects of service rendering to adult female rape survivors.
- Section F: Psychosocial aspects of service rendering to adult female rape survivors.
- Section G: Legal aspects of service rendering to adult female rape survivors.

Only face-to-face interviews were conducted with adult female rape survivors (group 1). Face-to-face interviews can provide the researcher to conduct the research with flexibility in relation to the ability to ask probing questions, and face-to-to-face interaction also permits room for engagement from both parties concerned. A small group of participants can produce rich data, and the researcher also has control of the interview process (Braun & Clark, 2013: 80; Geyer, 2021:356). The disadvantage in relation to face-to-face interviews is that it requires travelling, and the amount of time spent on the interview can be time-intense for both the researcher and participant (Braun & Clark, 2013: 80; Geyer, 2021:356). Additionally, the transcriptions of interviews can be time-consuming; not all participants are keen to share their experiences (Braun & Clark, 2013:80). Data were collected until saturation was reached since no new information emerged (Schwandt & Gates, 2018:351). In the end, 17 adult female rape survivors participated in the study.

5.9. DATA ANALYSIS

The data collected were coded, separated into smaller units, which were then further labelled and coded respectively, and grouped into themes (Creswell & Plano Clark, 2011:208). Braun and Clarke's (2006) thematic analysis process will be discussed in this study. Phase 1: The researcher became familiar with the

data. The transcribed data necessitated the repetitive reading of the data collected. The researcher studied the data to identify the relevant main themes (Braun & Clarke, 2006:16; Braun, Clarke, & Rance, 2015, 188). Phase 2: Coding was the phase in which the researcher arranged the data in an organised and orderly manner. The researcher coded the data with predetermined codes according to the responses of the research participants (Braun, Clarke, & Rance, 2015, 188; Schurink, Schurink & Fouché, 2021:406; Neuendorf, 2019:213). Furthermore, the researcher employed a reasonable approach in coding the data to facilitate theme progression based on the relevant literature (Braun, Clarke & Weate, 2016:3; Linneberg & Korsgaard, 2020:13; Neuendorf, 2019:213). An in-depth literature review of policy, directives, legislation, guidelines, standards, and norms in rendering post-rape services to women within the CJS was documented from the perspectives of service providers and adult female rape survivors (Roestenburg & Strydom, 2021:470). In addition to the literature review, the researcher also conducted interviews with service providers rendering services; and adult female rape survivors receiving services to determine their needs regarding the quality of service rendering.

Scholars such as Braun, Clarke & Weate (2016) believe that a logical method of coding the data results from the empirical findings that can be considered theory-driven. Moreover, preparatory and interpretative coding allows the researcher to develop the data analysis, which applies to the content of the study. Consequently, the researcher applied codes which were similar to the phrases or themes that emanated from the responses of the participants themselves (Braun, Clarke & Weate, 2016:3; Linneberg & Korsgaard, 2020:13). Phase 3: Searching for themes, the researcher analysed the codes and classified them into various themes. The researcher assigned numbers to a group collectively and further categorised the data according to certain themes derived from the responses of the research participants (Braun et al.,2015:189; Schurink et al., 2021:407; Neuendorf, 2019:213). During phase 3, the prototype model was based on the developmental needs of adult female rape survivors within the CJS, the capacity of adult female rape survivors within the CJS, and the effect/impact of the CJS on adult female rape survivors (Fraser & Galinsky, 2010:463). (*Cf discussion of*

the Cf Chapter 2 discussion on the ecological systems framework within the context of this study). The experiences of service providers guided the researcher in exploring the successes, challenges, and innovations, in rendering services to adult female rape survivors within the CJS, which were included in the design of the conceptual framework. Phase 4: Revising themes which involves improving and enhancing the themes as documented in the previous phase (phase 3). The researcher examined the themes concerning the codes and then ascertained whether the themes portrayed the data set correctly. The themes were examined in the context of rendering services to adult female rape survivors within the CJS, as depicted by both adult female rape survivors and service providers (Braun & Clarke, 2006:20-21; Neuendorf, 2019:213). Phase 5: Describing and assigning headings to themes guided the researcher to define and refine the themes by distinguishing the fundamental nature of every single theme. During this phase, the researcher also identified sub-themes (Braun & Clarke, 2006:22; Braun et al., 2015:189). Phase 6: Writing the report is the final phase of the data analysis process, in which the researcher presents the collected data in a structured, understandable and consistent manner. The researcher further corroborated the findings (literature study) with evidence to support the results that surfaced from the main theme and sub-themes (Braun & Clarke, 2006:23; Braun et al., 2015:189).

5.10. DATA QUALITY

It is a requirement in research to continuously ensure a high level of accuracy to ensure data quality. Assessing the research process is essential, a term coined by trustworthiness (Noble & Smith, 2015:34). Trustworthiness concerning empirical results should be applied by other researchers within a different setting. Transferability should thus seek to promote reflexiveness and reliability during the research process (Schurink Schurink & Fouché, 2021:393; Tracy, 2013:239). To verify the accurateness and trustworthiness of a measuring instrument (semi-structured interview schedule), the researcher focused on credibility, confirmability, transferability and dependability to ensure data quality.

- **Credibility**

Credibility is dependent on research findings that are corroborated by robust scientific evidence. Tracey (2013:235) believes that the potential prospect of qualitative research is to be exploratory and descriptive within a setting or procedure. Credibility can be safeguarded by collecting rich and abundant data instead of apparent, low-quality information that renders limited prospects of plausible interpretation and analysis (Lincoln, Lynham & Guba, 2018:140). To ensure the trustworthiness of the study's qualitative group(s), the researcher concentrated on clarifying researcher bias by keeping a journal and peer debriefing. The researcher created a reflexive research diary to engage in reflexive practice during the research process. Peer debriefing was accomplished by engaging with colleagues and the researcher's promotors', who were familiar with the research (Best, 2012:110; Strydom & Delport, 2011:381).

- **Confirmability**

Confirmability ensures that empirical findings can be confirmed if other researchers carry out a similar study (Mohamed, 2017:88). Equally, confirmability suggests that other researchers can validate the resultant findings that emerged from the procedures used (Schurink et al., 2021:394). Therefore, the researcher conveyed the findings that emerged from the data collected from the service providers and adult female rape survivors; and then subjected these to the literature review. Conformability was also ensured by maintaining an audit trail to keep track of the research findings and conclusions made by the researcher. An audit trail is a systemic method of capturing the researcher's thoughts, actions, and perceptions during the research process. The researcher used a diary (fieldnotes) to record actions taken; and interpretations made during the data collection process (Schurink et al., 2021: 395).

- **Transferability**

Transferability denotes the application of research findings in a different context (diverse research participants) (Tracy, 2013:239; Lemon & Hayes, 2020:605). Consequently, transferability as a means of qualitative research must be

detectable not only by professionals in the field but the setting within which the research was conducted (Leavy, 2018:5). Within the context of the current study, transferability was assured since the context of the research findings can be repeated within a different setting.

- **Dependability**

Dependability refers to the reliability of research results; and if the research results are plausible after an audit, with an emphasis on the stability of research findings over a certain period (Korstjens & Moser, 2018:121; Mohamed, 2017:88). The dependability of qualitative research is determined by inspecting the data collected concerning its documentation and audit trail (Schurink et al., 2021:394). The audit trail should indicate the interaction between the researcher and participants and verify whether the research results are accurate, and the researcher should also specify how the empirical results were linked. As such, the researcher made use of a good quality tape recorder for recording the interviews and kept an audit trail that can account for the researcher's thoughts, decisions and choices that were noted during the research process (Nowell, Norris, White & Moules, 2017:3).

5.11. PILOT STUDY

A pilot study tests and verifies an instrument before proceeding with the principal study (Barker, 2014:324; Rubin & Babbie, 2016:296). Similarly, Bless et al. (2013:36) believe that a pilot study is a small study effected to determine if the methodology, procedures and processes, and data analysis are acceptable and adequate for the purposes of the core study. Furthermore, a pilot study can also be used to make amendments to the measuring instrument to ensure the efficient completion of the data collection process (Mitchell & Jolly, 2013:203-204). For this study, a pilot study was conducted with one female rape survivor and a service provider (site coordinator) at the Lenasia South Thuthuzela Care Centre (RS1). The responses of both the adult female rape survivor and service providers were included in the main study. No amendments were made to the measuring instrument after concluding the pilot study.

5.12. ETHICAL CONSIDERATIONS

Ethics is a set of universally recognised values that guide the researcher and endorses acceptable directives when conducting research with participants (Kumar, 2014:282). Ethics refer to the influence of human behaviour concerning the interaction with others (i.e., research participants), in which the researcher is expected to abide by principles and a code of conduct (Bless et al., 2013:28-29; Monette, Sullivan & DeJong, 2014:50; Strydom & Roestenburg, 2021:118). The following aspects were of importance during the execution of this study:

5.12.1. INFORMED CONSENT

It is required when conducting research to have participants sign a document signifying that they agree to participate in a study (Maxfield & Babbie, 2016:27). Informed consent is when the researcher conveys important information to the research participants, allowing potential research participants to freely decide whether to participate in the research study (Farrimond, 2013:109). A detailed letter of consent was drafted explicating the purpose of the study, the procedures to be followed in the study, the risks and discomforts which may be anticipated, the benefits of the research, the participant's rights, confidentiality, data storage and the release or publication of research findings (Annexure A). All of the research participants signed the informed consent form. Before conducting the telephonic interviews, the researcher sent the informed consent forms via registered mail to the respective Thuthuzela Care Centres (with the details of the site coordinator who received the documentation) for the staff to complete. The researcher ensured verbatim with the research participant that the informed consent form was signed and handed over to the site coordinator for safekeeping before the telephonic interview. The researcher collected the signed informed consent form from the site coordinator. In this study, informed consent was utilised to ensure that the research participants comprehended why they had been selected for participation and how the information they provided would assist the researcher. The research aim and objectives were explicated both verbally and in writing (informed consent letter) to ensure that the research participant fully comprehended the nature and extent of the research.

Furthermore, the researcher requested a tape recorder during the interviews, with the participants' consent (Babbie, 2016:70-71).

The researcher made use of a tape recorder to record conversations after informed consent was granted by the participant, lasting approximately an hour for both groups 1 (adult female rape survivors) and group 2 (service providers) (Silverman, 2016:32).

5.12.2. VOLUNTARY PARTICIPATION

Participation in a research study should not be coerced (Kumar, 2014:285). The researcher explained the notion of voluntary participation and made the research participants aware that they have the right to freely choose to participate without being pressured to do so. The decision to participate was thus voluntarily, and the participants had the decision to withdraw from the study at any point of the interview without any penalties (Marshall & Rossman, 2016:55). If the participant wished to withdraw from the study at any given point in time, the respective audio recording would have been destroyed with immediate effect. All the research participants, except for one investigating officer who declined, participated in the study until the end of the interview.

5.12.3. RISKS AND DISCOMFORT

Participants were provided information about the study, the risks and discomfort, and any procedures for dealing with unforeseen undesirable emotional experiences that may emerge during the semi-structured interview. However, if the researcher noticed that the information the participants had shared had left them feeling emotionally distressed or anxious, the researcher would have referred the participant (with their prior permission) to a counsellor (psychologist or social worker) affiliated with the respective Thuthuzela Care Centre for debriefing or counselling (Babbie, 2017:64). None of the research participants experienced any adverse effects during the data collection process. Were the adult female rape victims provided with contact details/how to get in touch with

the psychologist/social worker should they need debriefing immediately after the interview.

5.12.4. PRIVACY AND CONFIDENTIALITY

Privacy is the platform upon which research participants allow the researcher to reveal their thoughts, beliefs, feelings and experiences (Farrimond, 2012:126). The research participants in this study have a right to privacy, and the researcher explained it to them. He also explained how this would be safeguarded through confidentiality, although anonymity could not be guaranteed during face-to-face interviews. The researcher used codes so that the research participants were not identified. The research participants were ensured that the researcher, promotor and co-promotor would manage the information they had provided confidentially. The information provided by the research participant was stored securely during the data collection process (field notes, electronic copies of the interviews and data set, and hard copies of the interview schedule). It will be stored at the University of Pretoria for 15 years. In addition, the data captured electronically are password protected and stored on the researcher's personal electronic device.

5.12.5. COMPENSATION

It is not deemed unethical to compensate research participants as a form of reimbursement for expenses incurred to participate in a research project (Strydom & Roestenburg, 2021:125). Two principles concerning the study apply here: (a) the time at which an incentive is provided; and (b) the incentive amount. The incentive was given to the research participant after participation as it was given as a token of gratitude. An incentive prior to participation, which might interfere with consent, is undesirable. An incentive prior to the data collection might misrepresent a participant's response (Hardwick & Worsley, 2011:38; Strydom & Roestenburg, 2021:125-126). An example where incentives were used as a means of motivation can be seen in studies involving rape such as Jewkes, Sikweyiya, Morell and Dunkle (2010:23-31); titled 'Why, When and how

men rape', which investigated men as perpetrators of rape. Another study is Ahrens et al. (2009:83) titled 'Healing or hurtful: Sexual Assault survivors' interpretations of societal reactions from support providers', which explicated the responses of rape survivors. In the current study, compensation in the amount of R150,00 (approximately $15) was handed to the adult female rape survivor at the end of the interview to cover their transport costs.

5.12.6. PERMISSION TO CONDUCT THE RESEARCH

After ethical clearance was obtained from the Faculty of Humanities Ethics Committee (Annexure A), the University of Pretoria, the researcher approached the relevant gatekeepers (stakeholders) for permission to conduct research. Permission to conduct research was obtained from the NPA (Annexure B), the Department of Health (Annexures C-F), and the SAPS (Annexure G). It is important to note that permission to access service providers at the Thuthuzela Care Centre employed by non-profit organisations and non-governmental organisations was granted verbatim or via email communication as a gesture of courtesy since the NPA granted permission for the staff from non-profit and non-governmental organisations.

5.12.7. ACTIONS AND COMPETENCE OF THE RESEARCHER

Research participants were guaranteed the researcher's competence to conduct the research, as he gained experience during his Master's Degree in Criminology when he conducted research with vulnerable participants, namely adult female rape survivors. Both promotors for the study have extensive research experience in sexual violence.

5.12.8. DECEPTION OF THE RESEARCH PARTICIPANTS

An absence or a lack of transparency or deception denotes misleading participants by intentionally distorting information; or covering the nature of the study (Farrrimond, 2012:119; Padgett, 2017:79). Deception may involve concealment of information, participants not being completely or entirely

informed, or being presented with misleading information, which in turn may lead to false expectations and probable complaints by participants (Engel & Schutt, 2014:55-56; Neuman, 2014:151; Stangor, 2015:52-53; Strydom & Roestenburg, 2021:123). The researcher did not misinform or deceive the research participants in this study, as the purpose of the study was outlined in the cover letter of the informed consent form presented to the participant before commencing with data collection.

5.12.9. COVID-19 PROTOCOL

Before entering the healthcare facilities where the research was conducted, the researcher, service providers and rape survivors' hands were sanitised and screened for COVID-19 symptoms (temperature checks). The researcher and participants also completed a roster on the day of the interview (for the purpose of contact tracing) in the event of COVID-19 transmission being detected by health officials. To further reduce the risk of COVID-19 transmission and comply with mandatory legislation, the researcher and participants wore face masks during the interview. The researcher also provided hand sanitiser at the entrance of the office where the interviews were conducted. Social distancing was ensured, with a distance of 1.5 meters between the researcher and the research participant. After each interview, the researcher disinfected the pen used by the participant to sign the informed consent form, the surface of the table, and the recording device. The researcher also ensured that the office space was ventilated by opening all windows. No COVID-19 transmission had been detected by health officials during the data collection process.

5.13. SUMMARY OF THE CHAPTER

Qualitative research was adopted in gathering data pertaining to the experiences of adult female rape survivors and service providers within the CJS. A positive approach as paradigm was followed during the study since the researcher envisioned developing and proposing key components that can form part of a prototype model in rendering services to adult female rape survivors within the CJS, emanating from the empirical findings. Applied research was implemented since the researcher focused on intervention research, being the type of research in relation to the study. Probability sampling, more specifically stratified sampling, enabled the researcher to capture interdisciplinary perspectives from service providers rendering services to adult female rape survivors within the CJS. Non-probability sampling, more specifically purposive or convenience sampling formed the basis for the data collection of adult female rape survivors within the CJS. After the site coordinator introduced the researcher to the participants, the data was gathered by means of a semi-structured interview schedule. Data quality, known as trustworthiness, was ensured through aspects that support credibility, conformity, transferability, and dependability during the study. Furthermore, the participants were informed about certain ethical considerations such as informed consent, voluntary participation, compensation, risks and discomfort, privacy, confidentiality, and COVID-19 regulations, which were all adhered to during the research. The next section will explore the empirical findings relating to the perceptions of adult female rape survivors regarding the quality of post-rape services in Gauteng, South Africa.

CHAPTER SIX: EMPERICAL FINDINGS: PERSPECTIVES OF ADULT FEMALE RAPE SURVIVORS ACCESSING POST-RAPE SERVICES

6.1. INTRODUCTION

Social justice research is associated with the ability to comprehend, interpret, and present qualitative research findings in exploring the lived experiences of participants. As such, the research results are based on the lived experiences of adult female rape survivors regarding their perceived quality of services received at Thuthuzela Care Centres. It is intended that the research results will highlight the gaps between research and practice in rendering services to adult female rape survivors within the CJS (Schurink, Jordaan & Schurink, 2021:311). For the purpose of this chapter, the researcher will outline the empirical findings of perceived post-rape services experienced by adult female rape survivors according to themes and sub-themes. A qualitative research approach was followed for the current study, and therefore, qualitative data analysis was employed according to an interview schedule. Braun and Clarke's thematic analysis was used to analyse the interviews conducted with the rape survivors. During the data collection process, the researcher used an audio recorder and field notes to ensure that the data was collected effectively. Afterwards, the audio-taped information was transcribed, and relevant themes and sub-themes were identified according to the interview schedule. The discussion of the chapter provides an overview of the biographic and demographic information of the participants, ensued by the dissemination of seven themes, namely: (1) circumstances under which the rape occurred, (2) reporting the crime of rape, (3) protective factors in providing assistance to adult female rape survivors, (4) perceptions of adult female rape survivors towards the quality of medical services received, (5) perceptions of adult female rape survivors regarding the quality of medico-legal services received, (6) perceptions of adult female rape survivors relating to the quality of psychosocial services received, and (7) the experiences of adult female rape survivors pertaining to the quality of legal services received. For the purpose of this chapter, the researcher indicated the correct spelling of words in brackets, as articulated by the survivors.

6.2. DISCUSSION OF THE FINDINGS

In the next section, the researcher will put forward the verbatim responses of the rape survivors. In order to protect the identity of the research participants and to ensure confidentiality, the researcher will refer to them as “Survivors” when propounding their responses. The interviews were conducted in English. Before the discussion of the themes and sub-themes, the researcher will first give an exposition of the biographic and demographic profile of the participants. This information emerged from the interview schedule.

6.2.1. BIOGRAPHIC AND DEMOGRAPHIC PROFILE OF THE ADULT FEMALE RAPE SURVIVORS

Table 8: Biographic and demographic profile of the adult female rape survivors

Participant	Age	Race	Home Language	Citizenship	Highest level of education	Marital status	Current living arrangements	Area of residence	Type of residence	Thuthuzela Care Centre
1	46	African	isiXhosa	South African	Grade 9	Single	Staying alone	Township *ekasi*	House	RS 1
2	43	African	isiZulu	South African	Grade 10	Relationship	Staying with children	Residential	Shelter	RS 1
3	41	African	Sepedi	South African	Grade 9	Single	Staying with mother	Semi-rural	House	RS 2
4	21	African	isiZulu	South African	Grade 12	Single	Staying alone	Residential	Renting a room	RS 2
5	36	African	Tswana	South African	Grade 11	Single	Staying with mother	Township *ekasi*	House	RS 2
6	27	African	Sepedi	South African	NCV Level 4 Certificate Marketing	Single	Staying with children	Township *ekasi*	House	RS 2
7	39	African	Shona	Zimbabwean	Grade 11	Single	Staying with daughter	Residential	House	RS 2
8	20	African	Sepedi	South African	Grade 12	Single	Staying with parents	Residential	House	RS 2

9	27	African	Sepedi	South African	LLB	Single	Staying with son	Township *ekasi*	House	RS 2
10	36	African	Tsonga	South African	N5 Financial Management	Single	Staying with children	Informal settlement	*Mkhukhu*	RS 2
11	37	African	isiXhosa	South African	Grade 11	Single	Staying with relatives	Informal settlement	*Mkhukhu*	RS 2
12	27	African	Sepedi	South African	Grade 12	Single	Staying with relatives	Residential	House	RS 3
13	30	African	Tsonga	South African	Grade 11	Single	Staying with sister	Township *ekasi*	*Mkhukhu*	RS 3
14	25	African	Sepedi	South African	Grade 12	Relationship	Staying with boyfriend	Township *ekasi*	House	RS 3
15	44	African	Southern Sotho	South African	Diploma in IT	Single	Staying alone	Township *ekasi*	Flat	RS 3
16	27	African	isiZulu	Zimbabwean	Grade 12	Relationship	Staying with mother	Township *ekasi*	Renting a room	RS 3
17	23	African	isiZulu	South African	Grade 10	Relationship	Staying with relatives	Township *ekasi*	House	RS 3

The biographic and demographic profiles of adult female rape survivors are delineated below.

- **AGE GROUPS**

The age distribution of the survivors was varied, with survivor 1 being the oldest participant (46 years of age); and survivor 8 being the youngest (20 years of age). The majority of the participants (n=8; 47.1%) were in their twenties (survivors 4, 6, 8, 9, 12, 14, 16 and 17), ensued by a smaller number of participants (n=5; 29.4%) in their thirties (survivors 5, 7, 10, 11 and 13), and four (23.5%) of the participants indicated that they were their forties (survivors 1, 2, 3 and 15). Research conducted in the Gauteng province by Machisa et al. (2010:41-42), comprising a sample of 1 568 households, found that approximately one in five women (19.6%) aged between 18-24 years had been raped, while 15.7% were 24 years and older when the rape occurred. A more recent study conducted by the Rape Impact Cohort Evaluation study, comprising 852 women aged 16–40 years who accessed post-rape services at five Thuthuzela Care Centres in Durban, South Africa, found that the median age of the adult female rape survivors accessing post-rape services were 25 years of age (Jewkes, Mhlongo, Chirwa, Seedat, Myers, Peer, Garcia-Moreno, Dunkle & Abrahams, 2022: 331-332). These findings correspond with the results of the current research since the majority of adult female rape survivors were in their twenties.

- **LANGUAGE**

The home language of the survivors is representative of the province where the research was conducted, with the most preferred choice of languages being Sepedi (n=6; 35.3%) and IsiZulu (n=4; 23.5%). IsiXhosa (n=2; 11.8%) and Tsongo (n=2; 11.8%) were spoken by only a few survivors, with South Sotho (n=1; 5.9%) Tswana (n=1; 5.9%) and Shona (n=1; 5.9%) being the least spoken language. Sepedi and IsiZulu are the languages spoken the most by individuals in Gauteng, with approximately 4.7 % of people speaking Sepedi (Fact Sheet Gauteng, s.a; SA-V, 2022; South African Provinces by size, languages and capital cities, s.a.).

- **NATIONALITY AND RACE**

Regarding the nationality of the survivors, most were South African (n=15; 88.2%), with survivors 7 and 16 (n=2; 11.8%) being Zimbabwean nationals. All of the adult female rape survivors were African. This is primarily due to the location of the Thuthuzela Care Centres being in areas in which individuals of African descent reside.

- **EDUCATION**

The levels of education of the survivors were widely distributed, with four survivors (23.5%) having a post-school qualification. Survivor 9 has an LLB degree, while survivors 10 and 15 have a diploma in Financial Management and Information Technology, respectively, and survivor 6 has a certificate in Marketing. Interestingly, a slightly similar distribution of survivors had completed Grade 12 (n=5; 29.4%) being survivors 4, 8, 12, 14 and 16; and Grade 11 (n=4; 23.5%) being survivors 5, 7, 11 and 13. Survivors 2 and 17 completed Grade 10 (n=2; 11.8%), while survivors 1 and 3 completed Grade 9 (n=2; 11.8%). This finding of the current study is similar to a quantitative study conducted by Bougard (2015:117), comprising 45 adult female rape survivors. From Bougard's study, it was found that the majority of the respondents (n=17; 37.8%) completed or were busy with Grades 11-12, while 17.8% (n=8) completed their Grades 8-10. Only 11.1% (n=5) of the participants completed a certificate or diploma, while 8.9% (n=4) of the respondents completed a Bachelors/BTech degree. Two respondents (4.4%) indicated having completed school up to the primary level (Grades 1-7). Research conducted by Jewkes et al. (2022:331) found that from their sample of 852 adult female rape survivors accessing post-rape services, 484 (56.8%) were in possession of matric or post-matric qualification, while 386 (43.2%) did not complete their schooling.

- **MARITAL STATUS**

Regarding the marital status of the participants, a noteworthy number of survivors (1, 3-13 and 15) indicated that they are single (n=13; 76.5%), with the exception of survivors 2,14,16 and 17 (n=4; 23.5%) having indicated as being in a

relationship. None of the survivors was married. The 2015 study by Bougard comprising 45 adult female rape survivors also found that the majority of the respondents were single (n=30; 66.7%) (Bougard, 2015:61). In contrast, Jewkes et al. (2022:331-332) found in their study that although most of the rape survivors were in a relationship (82.1%), only 7.8% were staying with a partner.

- **LIVING ARRANGEMENTS**

The living arrangements of the survivors from the current study are quite diverse, with survivors 1, 4 and 15 staying alone (n=3; 17.6%); while survivors 2, 6, 7, 9 and 10 (n=5; 29.4%) resided with their child(ren). Survivors 11-13 and 17 indicated that they resided with a relative (n=4; 23.5%), while survivors 3, 5 and 16 stayed with their mother (n=3; 17.6%). Only survivor 8 (n=1; 5.9%) stayed with both parents, while survivor 14 (n=1; 5.9) stayed with her boyfriend.

- **RESIDENCE**

With reference to the area of residence of the participants, more than half of the survivors being 1, 5, 6, 9, 13-17 (n=9; 52.9%) stayed in a township (*ekasi*), while survivors 2, 4, 7, 8 and 12 resided within a residential area (n=5; 29.4%). Survivors 10 and 11 conveyed that they resided in an informal settlement (n=2; 11.7%), while only one survivor, namely survivor 3, indicated that the area of her residence could be described as being semi-rural (n=1; 5.9%).

More than half of the respondents, namely survivors 1, 3, 5-9, 12, 14 and 17 (n=10; 58.8%), stayed in a house, while survivors 4 and 16 (n=2; 11.8%) were renting a room. Survivors 10-11 and 13 (n=3; 17.6%) resided in a *Mkhukhu*. A *Mkhukhu* is regarded as being an informal housing structure comprising mostly of zinc or iron, erected predominantly in the informal settlements of South Africa (du Plessis-Faurie, Poggenpoel, Myburgh & Jacobs, 2020:4). Survivor 2 (n=1; 5.9%) stayed in a shelter for abused women; and survivor 15 (n=1; 5.9%) stayed in a flat.

Demographic indicators such as race, gender, age, and marital status predict a lifestyle in which individuals are more likely to interact with peers of similar class, socio-economic stance, and race (Peacock, 2019:25). Additionally, women who

have been raped are less likely to be educated and reside in informal housing and rural areas than their female counterparts who have not been a victim of rape (Abrahams, Mhlongo, Chirwa, Lombard, Dunkle, Seedat, Kengne, Myers, Peer, García-Moreno & Jewkes, 2020:6).

In the next section of the chapter, the researcher will discuss the emerging themes and sub-themes regarding rape survivors' experiences with the CJS. It is also important to take note that for this chapter, the correct spelling of the words was placed in brackets, emanating from the responses of the participants.

6.2.2. THEMES AND SUB-THEMES: THE CRIMINAL EVENT, SURVIVORS' EXPERIENCE OF REPORTING THE CRIME AND POST-RAPE SERVICES

The researcher asked questions regarding rape survivors' experience of reporting the incidence of rape, as well as the post-rape services they received from role players in the CJS.

THEME 1: CIRCUMSTANCES UNDER WHICH THE RAPE OCCURRED

The researcher initially probed the survivors regarding their reasons for reporting the crime of rape. From their responses, the circumstances surrounding the rape emerged *(Cf interview schedule for adult female rape survivors).* The circumstances under which the rape was perpetrated are explained by seven survivors (41.2%) being survivors (4, 6, 7, 10, 12, 13 and 15). Survivors 1-3, 5, 8, 9, 11, 14 and 16-17 (n=10; 58.8%), however, did not share the circumstances surrounding the rape. From the interviews, it transpired that the victims were raped in an array of circumstances supporting the finding that rapists are not a heterogeneous group and that rape can occur as a result of different triggers and motives.

SUB-THEME 1.1: HOME INVASION

Survivors 7 and 13 articulated that they were the victims of rape during a home invasion. They opined:

Survivor 7: *I was raped. A guy climbed through my window into the house. He raped me and took my things and R200 I had. I first went to the police, then came here with the police.*

Survivor 13: *Because it was a housebreaking, so the other little brother, he jumped and ran away into the street asking for help. And then when he was on the street, he meet [stopped] the police van. So, he came back with the police at home. That's why they started to take a statement and they take me here to hospital.*

Regarding the responses conveyed by survivors 7 and 13, it is not unusual for a woman to fall victim to rape during a home invasion Vetten, Jewkes, Sigsworth, Christofides, Loots and Dunseith (2008:7-8) investigated 11 926 rape cases reported at the 128 police stations in the Gauteng province and found that one in ten of adult women reported being raped during a home invasion.

SUB-THEME 1.2: PRIOR HISTORY OF CHILD RAPE AND NEGLECT

Survivor 4 was victimised as a child, and she asserted the following:

I have been a rape victim since I was three years old. Here at the Laudium Thuthuzela Care Centre, they started to accept me when I was five years old. My file is available since 2005, with my last case happened in 2020. Because those people, they used to rape me during epileptic [seizures] attacks. These people even bought me a watch for my 21st birthday, I never got so much love from these people. And my mother, she always neglected me. When I would tell her about the rape, she would call me bad names. I am one of those children that suffered from emotional neglect. I am one of those kids, my mother used to do the best for me, but when I needed emotional care, she would run away from me. But strangers from outside, they are the ones that are grooming you. So, I want to say thank you to the Laudium Thuthuzela Care centre. Before I came here, I was not employed. But with their love and hope, now I am employed. I am currently working

at……, if it wasn't for them, I would not be employed today. Thank you so much.

From the revelation made by survivor 4, child sexual abuse remains a reason of concern in South Africa (Artz, Ward & Leoschut, 2018:791; Venketsamy & Kinear, 2020:791-792). In a study conducted by Machisa et al. (2010:41-42) with a sample of 1 568 households, it emerged that the majority of women experienced rape when they were a child, with 64.7% who experienced rape for the first time at the age of 17 years and younger. In relation to experiences shared by survivor 4, it is most likely that she had been exposed to motivated offenders during her lifetime, which further increased her vulnerability in becoming a victim of rape while suffering epileptic seizures, due to her close physical proximity to potential offenders in high-risk areas, due to neglect (McNeeley, 2015:33). Likewise, due to the vulnerability of survivor 4, guardianship was evidently absent during her lifetime due to neglect, which exposed her to numerous opportunities of being raped when she had epileptic seizures. Guardians serve as a deterrent for offending to occur, thus safeguarding victims from probable offenders when the parties coincide in time and space. Guardianship may be formal (the presence of another individual and the visibility of appropriate security features) or informal (i.e., friends, bystanders). Furthermore, alarms, locks, and other security entities (i.e., the presence of community members) that protect a residence; are perceived as being capable guardians (since the latter modes of capable guardianship are seen as formal intervention strategies in preventing crime). While effective guardians are those who would come to the aid of a victim, it is challenging to assess the effectiveness of a guardian who may be capable of preventing a crime from occurring. That said, many crimes are prevented simply by the presence of a security feature (streetlights or a person). Additionally, the presence of another person might serve as a preventative measure of potential guardianship merely due to the presence of a third party (Drawve et al., 2014:6; Felson & Boba, 2010:96).

It is noteworthy to acknowledge that survivor 4 completed her matric, despite numerous challenges in her life. Furthermore, the staff at the Laudium Thuthuzela

Care Centre took on the role of guardians by looking after the well-being of survivor 4.

SUB-THEME 1.3: INCEST

Survivor 10 conveyed that she was raped by a family member over a period of time. She expressed the following:

> *The reason why I came here, it's because uhm…...by 2007, my uncle raped me. Yes. Then again, he raped me in 2009. Then from there again in 2012. Then at first, he told me I mustn't tell anyone, because the family know that he has to do that thing, yes, it's a culture. Yes. Then I keep quiet, but at first my mother knew about it. I told her and his wife. But they told me to keep quiet. I mustn't tell anyone.*

In light of the response from survivor 10, incest started at a young age and persisted for a period of time (with the average time of abuse being approximately four years), which may lead to avoidance-based coping mechanisms (i.e., avoiding intimate relationships). These trauma-induced coping skills shape the foundation for present and future interpersonal relationships; and may become initial responses to most perceived distress-producing settings (Lawson, 2018).

SUB-THEME 1.4: ACCESSING UNSAFE PUBLIC TRANSPORT

Survivor 12 was kidnapped and raped while accessing public transport in the form of a mini-bus taxi. She describes her ordeal as follows:

> *Oh, the main reason is I got raped on the 15th of August 2020, in the morning, around 05:00. I was going to work. I was catching a taxi to my place of work. So, it happened that I got into a Quantum [mini-bus taxi], and then this guy just decided to take his own way. So, I don't even know what was he thinking, and then from there, he took out uhm..., a screwdriver. So, he told me to undress my clothes, and then after he raped me. After he raped me, he took my bags.*

In light of the response provided by survivor 12, women are vulnerable to the crime of rape when accessing urban public transport in South Africa (Sonke

Justice Project, 2018:18). Women make use of public transport in the early morning hours as well as in the evening to get to and from their employment, which makes them vulnerable to the crime of rape. They are continuously subjected to violence on their way to work since it is still dark, with limited street lighting in certain locations. Likewise, women are also subjected to sexual violence when returning from work at night. (taxi ranks, unavailability of streetlights) (Sonke Justice Project, 2018:18-19). Mini-bus taxis are the preferred choice of public transport among African commuters since they are considered to be convenient, save time standing in long queues at bus and train stations, are easily accessible, and, most importantly, represent an affordable means of transport in South Africa (ArriveAlive, s.a.). Mini-bus taxis are considered to be the most viable mode of public transport for most women in South Africa (30,6% in 2013 and 33,6% in 2020) to get to and from work (Statistics South Africa, 2022). Black Africans are more subjected to rape than other populace groups, and one contributing factor could be because Black women make the most use of public transport, such as mini-bus taxis. Sexual violence, sexual harassment and unwarranted attention increase for women, irrespective of social stance, when they have to access public transport points (taxi ranks and bus stops) (Statistics South Africa, 2022). In comparison to their male counterparts, women accessing public spaces (such as taxi ranks and bus stops) are considered “open persons”, making them susceptible to unwelcome gestures, which oftentimes results in harassment. Women may therefore feel a sense of uncertainty and fear when accessing public transport, irrespective of whether it might be during the day or at night (Sonke Gender Justice, 2018:1-2; Statistics South Africa, 2022). Likewise, according to the routine activities theory, in order for a crime to transpire, three elements must interact in space and time being (a) motivated offenders, (b) suitable targets, and (c) the absence of capable guardians (Bunch et al., 2012:1184). In relation to the incident that transpired, according to the description provided by survivor 12, she came into contact with a motivated offender when she entered the vehicle, and due to their vulnerability, being a woman alone in a mini-bus taxi, without the presence of other commuters who might have acted as guardians in preventing the crime of rape from transpiring.

An increase in activities that takes a person away from their homes or safe spaces is linked with an increase in criminal prospects. Cohen and Felson (1979) also indicated that individuals have three basic activities, namely their home activities, work-related responsibilities away from their home, and other social activities (Drawve et al., 2014:4-5). In relation to the ordeal suffered by participant 12, she became a victim of rape, accessing unsafe public transport on her way to work.

SUB-THEME 1.5: BETRAYED BY TRUST (SURPRISE ATTACK)

Survivor 6 was raped by a stranger. She explained her ordeal as follows:

> *It is because on the 13th of February this year (2021), I was raped. It was a Saturday night. I was on my way home, like from a pub. It was around 11:00 in the evening. This guy, he acted friendly at the beginning, then, he started attacking me. He did what he did, then, but I did not report it immediately, I reported it in the morning. I went home, I slept. In the morning when I woke up, I didn't take a bath, I just woke up and went straight to the police station.*

As can be seen in the response of survivor 6, a strong relationship exists between stranger rape and attending social activities at night (going to a pub) since the victims are attacked due to their vulnerability (walking in the dark, alcohol consumption) by a motivated rapist (Waterhouse et al., 2016:7). A *surprise attack* is one in which the rape transpires in the absence of any planning, which is further perceived as being more violent (Corovic, 2013:22).

According to the lifestyle exposure theory, lifestyle affects the nature of the risk a person might be exposed to (being subjected to a potential rapist without capable guardianship being present). Exposure, as an element within lifestyle exposure, omits that a robust relationship exists between a high-risk lifestyle (walking with a stranger at night) and the possibility of becoming a victim of rape. Personal victimisation is associated with the amount of time a person spends within a public domain. Streets and communal areas such as parks increase the likelihood of rape when compared to other spaces such as the home. Furthermore,

victimisation is also more expected to occur at night; and/or in the early hours of the morning when compared to the risk of being victimised during the day (Peacock, 2019:25).

SUB-THEME 1.6: INTIMATE PARTNER VIOLENCE

Survivor 15 had been raped by an intimate partner. She explained the following:

> *Because I felt like, I had to, so that it does not happen to somebody else. And it wasn't the first time he was abusing me. But, this time, it was extensive.*

In relation to the response of survivor 15, approximately one in five women reported experiencing rape in their lifetime and on average, 15-20% of men reported having perpetrated rape against an intimate partner (Mills-Fairweather et al., 2013:10). Intimate partner rape may only account for a percentage of other controlling behaviours, and violent acts inflicted upon a woman by an alleged rapist, being her intimate partner, is regarded as being solely driven by sexual entitlement (Smythe, 2015:23).

According to the extended control balance theory, the capacity to exert control and be controlled are constant entities. A person with excess control can coerce another person who may lack control and becomes passive (Peacock, 2019:35). If a control deficit is present, a woman will become weak due to an inability to have control over her circumstance, making the person vulnerable to becoming submissive to the demands of her rapist. Since motivated rapists tend to target vulnerable women, the defenselessness of potential victims is directly linked with their inability to exert any form of resistance. The powerlessness of a woman to resist is observed by the rapist, who exploits such individuals for their own benefit (Jones, 2017:240; Peacock, 2019:35). Survivor 15 was threatened and raped due to her physical vulnerability being a woman.

THEME 2: REPORTING THE INCIDENCE OF RAPE

The researcher asked and probed the survivors about their reasons for reporting the rape, their experiences when reporting the rape and if their rights were explained to them during the reporting of the incident.

SUB-THEME 2.1: MAIN REASONS FOR REPORTING THE RAPE

In analysing the responses of the research participants, the researcher identified the following sub-themes as reasons for the reporting of the rape.

Sub-theme 2.1.1: Access to medical care

Survivors 1, 4, 6, 9, 11-12, and 16-17 (n=8; 47.1%) indicated that they reported the rape in order to get access to medical care. They asserted the following:

> Survivor 1: *The reason I came is to get treatment. I came so I don't get sick.*
>
> Survivor 4: *I suffer from epilepsy and sugar diabetics, and since then the person who helped me, is the social worker, Ms…., she is always caring about me like the rest of the staff, and what I like the service from here, is that if you are a victim of rape, they do the test to confirm if you are HIV positive or negative. If you are negative, you wait for the doctor to check if you were raped with the DNA as usual. After that, they send you to the social worker. You get dates for follow-up, first it is three months, then six months, then a year.*
>
> Survivor 6: *To get medical care.*
>
> Survivor 9: *I wanted to get the medical care needed.*
>
> *Survivor 11: I also wanted help to prevent possible diseases.*
>
> *Survivor 12: Medical care, I firstly went to the police station, to report the case. And then from the police station, they are the ones that took me here for medical attention.*

Survivor 16: *I wanted medical care, so with medical care they can check whether we got pregnant, or got an infection, something like that.*

Survivor 17: *I also came for medical reasons.*

Regarding the information provided by the survivors, it is anticipated that once a rape survivor enters a healthcare facility, she is first examined, assessed, and treated for immediate, acute medical needs. If the rape survivor conveyed drug-facilitated rape, then urine and blood samples are collected for further analysis. A rape survivor may consent to one part of the examination but not another or may opt not to give consent at any time during the medical examination. The medical forensic sexual assault examination is, first of all, a medical examination devoted to attending to the rape survivor's immediate medical needs, short-term and long-term health, safety needs, as well as her physical and mental condition when she reports to a healthcare facility (Schafran, 2015:1, 3). The start of PEP is time-sensitive, with the first dose administered within 72 hours (3 days) after the rape. Unquestionably, PEP is often the last step in the medical treatment chain. If the rape survivor was not in a mental state during the acute phase of rape to give consent for medical care, a three-day starter pack of PEP is administered, and the rape survivor is asked to return for testing and a further course of PEP for 28 days (if eligible). Eligibility implies that the rape survivor tested HIV negative upon representation (NACOSA, 2018:16).

With regards to the ecological systems theory, a survivor may choose to seek assistance from a community rape crises centre being predominantly medical care (*mesosystem*), which could, in turn, link her with formal systems (*ecosystem*) (i.e., law enforcement), being SAPS and the case manager at the Thuthuzela Care Centre (Wadsworth et al., 2018:42).

Sub-theme 2.1.2: Access to counselling services

The prospects of accessing counselling services became notable during the responses of two participants. Survivors 3 and 11 (n=2; 11.8%) were prompted

to report the crime of rape to access counselling services. They conveyed the following:

> Survivor 3: *I was feeling bad, and I came for the pain for that. I came for medical care and counselling to help me with that pain.*
>
> Survivor 11: *I wanted counselling.*

In light of the assertions made by survivors 3 and 11, the psychosocial needs of rape survivors may include the following (Martin, 2016:280): constructing formal and informal social support systems; reinforcing ways to gain a sense of safety; educating survivors of rape to manage their emotions such as anger, sadness, and fear; achieving physical and psychological constancy; structuring skills are also required since it will assist adult female rape survivors in reclaiming control over their lives. Rape survivors also need to be informed of what is required from them and what to expect within the CJS. Supporting rape survivors through the mourning, resolution and closure process is of prime importance in order for them to regain their confidence and trust in other individuals (Martin, 2016:280).

From the ecological systems theory perspective, a *microsystem* denotes initial actions by a rape survivor in disclosure, and help-seeking is perceived as being intrapersonal in nature. A key factor that influences a rape survivor to disclose the ordeal she had suffered is linked with her current mental health and emotional state. Two other noteworthy factors are resistance and resilience (Alaggia et al., 2012:305-307). Moreover, empowerment arises from the capacities and strengths of adult female rape survivors for them to advance their social capital (Peeters, 2012:11).

Sub-theme 2.1.3: Access to justice

In access to justice, the participants indicated the arrest of the alleged rapist and the protection of further potential victims as prominent reasons for reporting the rape. They cited the following:

(a) Seek the arrest of the alleged rapist

Survivors 5-6, 8-9, 11, 14, 16 and 17 (n=8; 47.1%) indicated that the arrest of the alleged rapist was important to them. They expressed the following:

> Survivor 5: *The day I came to the police station to report the crime of rape, they told me that they have to close the station due to coronavirus, I must come back in two days. When I get there, the people were standing outside, the police were still busy removing that coronavirus from inside the building. So, I come day four. When I come there, they asked me why I took so long, so I told them they were closed due to corona virus. So, they took me to Laudium Thuthuzela Care centre, everything was fine. The guy, they arrested him. He is too old for me, a 56-year-old madala [elderly man]. So, they take him to the police station, to the jail there. So, when they took [arrested] him, they took him to jail, they called me to come and show them if it was the right guy. So, I said, this one is the right guy. Okay, so they said fine. After ten days, they send me a message, they said that my file is not there, it is missing. I said how? They said that the madala, he [took] take him out, there is no court case for rape, it is cancelled. I wanted justice.*
>
> Survivor 6: *I was hoping that the guy would be found*.
>
> Survivor 8: *To get justice.*
>
> Survivor 9: *My area is a mess. There is a lot of gunshots, there is a lot of criminals, and there is a lot of unemployed people. I was hoping that he could be found, and probably, maybe answer to what he did.*
>
> Survivor 11: *I wanted to arrest the perpetrator.*
>
> Survivor 14: *Uhm…, you know that after you have been raped, you want justice to take its course.*

> Survivor 16: *Like rape first, maybe they can put those guys in jail who did rape us. And we were beaten too much by those two guys. So, I wanted to report to the police.*
>
> Survivor 17: *I went to report the crime, because I want them to catch those men.*

Within the South African context, the majority of rape survivors withdrew the case preceding the arrest of an alleged rapist (54.4%), followed by rape victims who withdrew the case because the alleged offender was a relative (35%). Rape perpetrated by a relative had the highest inclination of no arrest being made (50.9%). Police are more successful in securing an arrest if the alleged rapist was known to the victim (70%) when compared to stranger ape (Machisa et al., 2017:18; *State v Ndlovu and Others*. ZASCA 70: All SA 760 (SCA), 2002:331). Notably, instances of stranger rape investigations are challenging to investigate due to follow-up leads in collecting forensic evidence, which might secure an arrest of the alleged offender. (Corovic et al., 2012:765).

In light of seeking justice, from an ecological perspective, at a *macrosystem level*, the influences of the larger communal culture are important since they explicate the impact of "rape prone" communities on the adult female rape survivor. To facilitate the process of rendering service to adult female rape survivors, service providers first need to be cognizant of their needs within the CJS (Wadsworth et al.,2018:38, 42-43). Likewise, the *chronosystem* mainly signifies the impact of the crime on the adult female rape survivor, being the anticipated or perceived outcome(s) of the CJS since it has an impact on the changes in a person and the effects thereof on the person. The *chronosystem* thus portrays the relationship and processes between key legal service providers and adult female rape survivors within the CJS. Emanating from the response of survivors, securing an arrest is an anticipated expectation of adult female rape survivors seeking justice within the criminal justice system (Eriksson et al., 2018:422).

(b) Protecting future potential victims

Survivors 2, 16 and 17 (n=3; 17.6%) wished to report the rape to protect potential victims and prevent the same incident from happening to others. They voiced the following:

> Survivor 2: *Because I protected myself till the age of 42 years, then I got raped. I think that reporting the rape was a good thing because those people who did they rape, they will do it to other people. That is why I reported the rape.*
>
> Survivor 16: *For the police to catch those guys and prevent them from doing it to another person. You see, that is why I came to the police.*
>
> Survivor 17: *I don't want those men to rape another girl, or kill someone else, because they were carrying guns. I don't know if it was really guns, or fake guns. But I know that they are dangerous to everyone.*

Rape survivors anticipate that by reporting the crime, they would be protected from future victimisation, with prospects of also ensuring that the offender does not rape another individual (i.e., women and children) (Vetten, 2014a:3).

SUB-THEME 2.2: THE EXPERIENCES OF THE ADULT FEMALE RAPE SURVIVORS IN REPORTING THE CRIME OF RAPE

The researcher initially probed the challenges in reporting the crime of rape according to the interview schedule, although surfacing from the responses of the participants, they interpreted challenges as experiences (*Cf interview schedule for adult female rape survivors on challenges in reporting the crime of rape*). Subsequently, the participants articulated both positive and negative experiences in reporting the crime of rape. They shared the following:

Sub-theme 2.2.1: Positive experiences at the time of reporting the rape

Survivors 1-3, 7-8, 10, 12-13, and 16-17 (n=10; 58.8%) had a positive experience when they reported the crime of rape to the authorities. They opined:

> Survivor 1: I didn't experience any problems.
>
> Survivor 2: *The treatment I got from the police and here, it was good. That is why I got healed so quick, because of the support I got here. They treated me very well.*
>
> Survivor 3: *I was explaining everything to the police, and they take me here. I had to receive counselling, but it was already late. The social worker, she gave me another date to come for counselling.*
>
> Survivor 7: *I just reported the case and the police helped me.*
>
> Survivor 8: *There was no problem. The police treated me good.*
>
> Survivor 10: *No, they treated me like well. They just welcomed me; I feel like I just came to the right [people] persons.*
>
> Survivor 12: *The police were helpful.*
>
> Survivor 13: *No, I had no challenges, the police they treat us well, they take the statement at home. They brought me here and took me back home again. Yes, I was satisfied.*
>
> Survivor 16: *I did not have a problem; it was my first time. When they broke in, it was 11h00, so they leave us 01:00, so it was two hours they were raping us. The police took the case, but we had to wait for the guy that is doing raping cases. And then, the guy, he took us to the hospital, after we were done with police, that was when they came and take us to the clinic.*
>
> Survivor 17: *The police was good. There was nothing wrong. Yes, I was satisfied.*

Regarding the positive responses of the survivors in interacting with the police, research conducted by Molina and Poppleton (2020:14), comprising 491 rape

survivors' experiences within the CJS in the UK, found that 48% of their participants were treated with sensitivity, respect, and dignity by the police. In the current study, however, more than half of the participants (58.8%) had a positive encounter with the police when they reported the crime of rape. This finding is positive since it is indicative that the police were helpful to a certain extent in addressing the needs of the survivor when she reported the crime of rape.

Sub-theme 2.2.2: Negative experiences at the time of reporting the rape

Survivors 4-6, 9, 11, and 14-15 (n=7; 41.2%) conveyed that they had a negative experience when they reported the crime of rape. They articulated the following:

> Survivor 4: *Yes, there were many challenges regarding my cases. Because when I used to report my rape cases, they used to judge me and call me a 064, which is a code referring to the person reporting, is a mental case person, they can't accept these cases. Many cases I have reported are written withdrawn, I don't know why, since I was not the one who withdraw those cases. I still see suspects every day of my life, but still today, no action taken. Until these people groomed me and put me where I am, because even them, when they call the police, when they arrive here, they say; Oh…. is it still this same person, we are tired of you, why do like to play with police facilities and so on… But these people at the Thuthuzela Care Centre still groom me; and treat me like my own parents.*

> Survivor 5: *It is very sad to me and even to my mom, and even the father of my kids, he was not happy. He said, eish, this case, it not only happened to you. Outside there, even small kids, they rape them and kill them. But you, eish, you are lucky because they did not kill you. Some of the kids, they rape them, and then they kill them. So, you, you are lucky, you know how to fight for yourself. God is good for you. He said I must go for counselling. I took time to sleep because when I sleep, I see the face of the guy, even the body of the guy, I was so scared. It took me two weeks, after that, I started to be fine.*

Survivor 6: *When I reported the case, the lady who handled it, she was fine. She asked me questions and she did everything, she was fine. She told me to wait there for someone who is supposed to bring me here, and then that person, he was a bit harsh, like, uhm……. You know that you are not suppose to be out on the street this time, and wena [you], you were there, things like that, but I didn't want to listen to him, or answer him, because I was not in a good state. But then he drove me here, he dropped me here. I did lay a charge against the person, but uhm…, the police send me an SMS, saying that they dropped the charge because they cannot find the person. Uhm... I don't know the person, and it was dark. I didn't see the person clearly, on his face, I can't even draw him because of I didn't remember his face very well, so they dropped it. On the SMS they said that they would continue, if they find any more leads. From the police side, nobody phoned me, they only came, two weeks before they closed my case. They wanted to ask me about the person, then I told them that I don't remember.*

Survivor 9: *When I went to the police station, the police officials were not helpful for my liking. Firstly, I reported the case to Pretoria West police station; and they told me that it is not within their jurisdiction. They then send me back to Atteridgeville police station, of which was fine. Then when I got there, the person handling my case, started judging me. He said to me: - This is what happens when you do the things that you are doing, that's what he said to me. From then on, I felt like I could not continue with the person, because he did not even hear my side of the story, and already he was judging me and making me feel, like I deserved it. From there on, they took me back to the police station I was coming from, where I got help and opened the case. Then they told me that they have to transfer the case to the other police station that brought me back, because it was within their jurisdiction. And haven't gotten any news since I got the SMS that it was transferred. It is now eight months, and I have heard nothing.*

Survivor 11: *Here, by the clinic, I did not experience any challenges, they treated me very well. But the problem, it was there at the police station. When I come there to open a case, actually, I have opened two cases because they raped me two times. In the first case I came here they say I must go to the police to open a case, then I was complaining about the pain, and they gave me painblocks. I went to the police station to open the case. Even when I went to the police station, they did not treat me very well. There was an old policeman, and he kept on asking me: Why did you go to the tavern?, you know, Ramaphosa closed the tavern, but I said: Why did the tavern owners, open the tavern: I must go because they opened, so when I come back, like that guy, I was fighting with, guy, he nearly killed me. So, they did not take me, I had to take myself back here, while I wasn't safe, maybe I could [meet] met the guy so that he could finish me off. So, when I get here, the person who was attending me, she called the police station, and they said, no we are sorry, we are very sorry, we made a mistake. That was a challenge, but here at the clinic, I did not have any challenges. They treated me very well, even now, when I have a problem, they say come; we'll talk to you. When I go out of here, I am always happy.*

Survivor 14: *Not really challenges, but it is not easy because the suspect was unknown. So, once when the suspect is unknown, you know how the case is dragging, and you just learn to tell yourself that; let me just let it go because this case is not going anywhere, because the suspect is unknown. My interaction with the police, yoh, it wasn't good. The person was having a gun, and he managed to get the door wide open, he could not open the burglar bar. Obviously, when you see the gun, your mind does not become good, and you do whatever the person says, right, and after that from the police station, we went to where I was staying, where it happened. The questions they asked was like…., they didn't let me explain. They were like no; if this person is 2 meters away then you have to jump. I could not jump; the door*

was open, and the person had a gun. But I was thinking if I did what he told me to do, maybe the person would have mercy and not gun me down. I got a child, the first thing that came in my mind was my child. Where I can just do this, then I can be safe. My chances of survival were higher in doing what the guy was telling me to do. After that, okay, I had a stalker, who seemed to know what happened. So, I went to the police with the text and all that, and they told me that I was supposed to do a copy. I asked what copy? Should the phone not be taken to IT or somewhere to investigate? They couldn't do that, then I thought; you know what, I'm done, they are not going to help me. I just told myself that what happened, it's fine, let me learn to live with it.

Survivor 15: *I was feeling ashamed and felt like I was going to be judged. And I was feeling alone, but I had to do the right thing for me. And, to protect the next person.*

Given the strongest responses of the adult female rape survivors, the most important barrier to the self-reporting of rape are related to both feelings of shame and blame, commonly further exacerbated by the blaming of rape survivors by the community at large and victim-self-blaming. Victim-self-blaming occurs when the rape survivor herself has deeply internalised predetermined societal rape myths that she is responsible for the rape she endured (Harsey et al., 2017: 659; Russel & Hand, 2017:154). Victim blaming seems to be widespread, infused from within the wider community and/or from the rape survivors' next of kin. Unfortunately, this culture of shame overwhelms the rape survivor within the CJS, further silencing the torment they had suffered (Equality Now, s.a.). Additionally, rape survivors may also be blamed by important persons in their lives (i.e., friends, family, or legal service providers), with men assigning greater blame on average than women on the rape survivor. Rape survivors' experiences of being blamed might generate a vicious cycle in which they may unceasingly be blamed for alleged rape in future (like in the case of survivor 4). Similarly, the belief in a just world has been reflected upon broadly as an underlying cognitive mechanism that forecasts more blame (Pinciotti & Orcutt, 2017:1).

Further challenges in reporting rape are highlighted by Soul City (2013). These include disappointing services for rape survivors; prior experience in which members of the SAPS were not helpful and attributed blame towards the victims; stigma and shame; distrust in the CJS. The notion of confidentiality also elevated serious concerns, which may serve as a reason for adult female rape survivors not to report the crime of rape (Jordaan, 2017:29).

Moreover, the Rape Crisis and the Women's Legal Centre in South Africa identify five challenges within the CJS that avert or delay rape survivors from seeking justice. Firstly, most rape survivors receive limited information from initially reporting the rape to the time that it is heard in court. Secondly, victims predominantly do not have access to case-specific information with regards to the progress of the investigation of their case; and if further information is needed from them by the police. Thirdly, limited psychosocial support is a notable impediment in terms of reporting an incident such as rape. Where adequate and supportive psychosocial support is not being offered, the process of reporting the crime of rape can be emotionally overwhelming for the rape survivor, with an inclination to desist from seeking justice within the CJS. Fourthly, a deficiency of coordination between the various service providers such as the Department of Social Development, SAPS, Department of Health and Department of Justice and Constitutional Development contributes to an inadequate mode of service delivery and frustration experienced by the rape survivor. Lastly, there is presently no "*real complaint mechanism"* for satisfactory investigation practices and power relations against the rape survivor. When service delivery is poor or insufficient, rape survivors do not know what to do next and might opt to abandon any further efforts to seek justice due to frustration and perceived limited trust toward the CJS (Watson, 2015:4).

SUB-THEME 2.3: THE EXPERIENCES OF ADULT FEMALE RAPE SURVIVORS REGARDING THE MANNER IN WHICH THEIR RIGHTS WERE EXPLAINED TO THEM BY SERVICE PROVIDERS

The researcher probed the survivors regarding the manner in which their rights were explained to them when they reported the rape. The majority of the survivors (1-3, 5, 7-8, 10-11, 13-17) (n=12; 70.6%) had their rights explained to them. Survivor 7 (n=1; 5.9%) did not respond, while survivors 4, 6, 9 and 12 (n=4; 23.5%) expressed that their rights were not explained to them.

> Survivor 1: *They did explain to me that I can open a case, but I focus on medical treatment.*
>
> Survivor 2: *Uhm…. They did tell me about all the procedures, and they gave me the medication to prevent me from becoming HIV positive. They also told me that if I don't get treatment, I can also get pregnant by that time he raped me.*
>
> Survivor 3: *Yes, the lady working here, she was explaining it for me, and I was understanding.*
>
> Survivor 4: *Police did not explain any rights to me. Like I said, they neglected me. Some would even say, is this a 064. Why should we assist a 064. Some will even ask; is this not a 064? It is not right for a person to rape me. That is why I take a taxi to come here because it is these people who groomed me here at the Thuthuzela Care Centre, and put me to where I am.*
>
> Survivor 5: *Yes, they did. When I came to the Thuthuzela, the police lady who was helping me, told me that if that thing that happens to you, it is a big case, and the guy, we can arrest him for many years. Yes, but my mom told me that if I got the right police, they would arrest him, if I got a thief police, they can take him out. And maybe after a week, you can see him walking in the street. After a day, the guy was walking in the streets. The neighbours asked me:- Is it not the madala [elderly*

man] that raped you?, I said that it was him. They said eish, it is too painful. They even go to the father of my kids and tell him:- Look at your wife, she was trying to go find money to buy 12.5 kg of mielie meal, but look at her, she was raped because she was running for R10 on the streets like a prostitute, look at herself. Even the community, they came to our house and said that they were going to burn down the house and kill my kids, if I don't cancel the case. I said do whatever you want to do, but my case is on the police. So, when I went to the police, they told me that the case was cancelled, I said how? …. They said the old madala [elderly man], he is too old enough to stay in the cell. Because, anytime he can die, and your case will be dismissed. They send the message to me; they said your case is dismissed.

Survivor 6: *Okay, that lady at the police, she didn't explain my rights to me. If I remember, but she only asked me questions, like what happened, what time was it, uhm…, where did it happen, how did it happen? How did the guy look like? I don't remember like her telling me of my rights. When I came to the hospital, everyone was good, they were nice to me. Some of the things at the hospital I don't remember if they explained my rights to me, but they did a lot of things.*

Survivor 8: *The doctor explained to me. And the police explained that it was right for me to report the rape, because what he did, is not right.*

Survivor 9: *No, none at all by the police, also at the hospital.*

Survivor 10: *Yes, they did explain to me. Uhm.., like they just told me it was not the wrong way I took, but the right way to come and report.*

Survivor 11: *Yes, they did. They say I must open a case, they say I must test for HIV, if I'm positive, can you please accept it? You can still go on with your life. If you are pregnant, we can terminate it if you want, that's what they told me.*

Survivor 12: *No, my rights was not explained. They just took my statement, cause it was early in the morning, so they did not explain anything.*

Survivor 13: *It was the police and someone working here at the Thuthuzela Care Centre who explained to me what I must do. They explained all my rights about this case, and I did understand.*

Survivor 14: Not really by the police. But at the hospital, yes, they did.

Survivor 15: *Yes, because I remember I went to the clinic. And the doctor, he came to me and asked, because my hands were painful, and my collar bone was broken. So, like, I was a mess. Because I had to run from his place to get help. If I didn't run, I don't know what would have happened to me. Then the doctor took me to another room, and asked me what happened to me, because there were other people sitting there. That's when I told him that I was raped and beaten. Then he asked me by whom, I answered my ex-boyfriend. Then he told me he was going to examine me, and take me to x-ray for my hand, and then he was going to call the cops. Then I said yes, it's fine.*

Survivor 16: *Yes, they did explain us the rights. Even the hospital, they did explain us the rights.*

Survivor 17: *Yes, they did, even at the hospital.*

Given the assertions made by the survivors, the Victims' Charter entails a set of seven rights in rendering services to survivors of crime, inclusive of the Minimum Standards for the Treatment of Victims within the CJS. As such, the rights cited by the survivors were to be treated fairly, to be afforded an opportunity to receive and ask questions, and the right to be protected by the state and receive assistance. Rape survivors also have a need for compensation and restitution within the CJS. Likewise, The Victims' Charter and the Minimum Standards for the Treatment of Victims within the CJS also integrate legislation and policies in rendering post-rape services to adult female rape survivors within the CJS. Service providers working with adult female rape survivors are also anticipated

to render quality services in inspiring and motivating client satisfaction with the services delivered (Commission for Gender Equality, 2016:15).

The fact that most of the survivors were informed of their rights in the CJS is a notable finding since the survivors can only make an informed choice if they are fully aware of the services available and aligned with the processes and procedures within the CJS.

THEME 3: PROTECTIVE FACTORS IN PROVIDING ASSISTANCE TO ADULT FEMALE RAPE SURVIVORS

The researcher probed the survivors to obtain their understanding of protective factors in victim empowerment, with the prospect of capturing their opinions in relation to the importance of victim empowerment programmes and the use of a victim impact statement in post-rape services.

SUB-THEME 3.1: PERSPECTIVES OF ADULT FEMALE RAPE SURVIVORS REGARDING VICTIM EMPOWERMENT PROGRAMMES

Only one respondent, namely survivor 1 (n=1; 5.9%), was not provided with the option of victim empowerment programmes, while survivors 2-17 (n=16; 94.1%) had positive opinions towards Victim Empowerment Programmes. They shared the following:

Sub-theme 3.1.1: Not provided with the option of victim empowerment programmes

> Survivor 1: *I didn't know, but I would like to go to a place that would help me.*

The researcher is of the opinion that although survivor 1 was cited as not aware of victim empowerment programmes, she indicated a positive attitude with regards to the willingness to be assisted within the CJS.

Sub-theme 3.1.2: Positive opinions regarding victim empowerment programmes

Survivor 2: *I think women who want help, are the ones you can help, because you cannot force people to talk. With people you can't see anything, they hide, but we are willing to help victims of rape, but because those people they do dirty things to us. They will never stop until we do something about them.*

Survivor 3: *It was very right with the counselling, it allowed me to come down.*

Survivor 4: *What they can assist me with, is the workshops they do on victims all the time. Do the check-ups, and also do motivational talks, so that when the victim needs them, they are there for them. Maybe they can start a show for victims of rape, I am ready for that. Many victims are shy to speak, if they see women are talking on TV, it will open up a platform for them to talk, it will make many lives better. There are programmes on TV that assist people with substance abuse. Why can't we also have programmes that will turn victims into survivors.*

Survivor 5: *They can go to the psychologist and talk to them what had happened to them; and encourage them to seek help for gender-based violence against women and children. They can also go the social worker to help make their minds okay.*

Survivor 6: *Okay, I think it can help because since, uhm…, my incident, uhm…, I've been under a lot of stress. Not only because of my rape issue, but also life in general. So, after I got raped, everything, it got worse. My level of stress, it was worse. I am not even comfortable for my daughter to play outside, or like going to school for her, I make sure that I escort her. So, the campaigns, I think they will help a lot, even if I send my daughter to the shop, I wait for 10 min, then I go out and look for her. The fear, you know, and I only stay with my children. I don't feel safe anymore.*

Survivor 7: *It benefits them because they talk out. I think you will be free when you talk out.*

Survivor 8: *We need to report what had happened to us.*

Survivor 9: *They can work, if they actually see a need for it. Because we suffer from different flashbacks, all of us, although some they say can heal quicker, or for some it is a prolong thing you never even forget about it, and it leads to other mental issues as well. So, I think it will help whereby someone needs to avoid getting any mental issues, because it is going to be another issue in itself.*

Survivor 10: *Yes, I can participate. I can experience that women mustn't keep quiet if things happen.*

Survivor 11: *It will benefit them, like, most of us feel like we are not like others. Some they committed suicide, others like, they end up drinking a lot because of the stress. But if you come here, they advise you, can you please do this and that, and you keep on going on with life.*

Survivor 12: *Uhm…, guess it could help women, because this cases, they are just so many. And the police need to take us seriously when we report such matters, cause at the end of the day, like, the police, they just don't care. You just go there and report the matter. And from there, they don't do any follow-up. So, the only thing that I want to say is that the police should take us seriously when we report such a matter.*

Survivor 13: *It will help us because like me, like coming here, it helped me a lot to forget, to be relieved about what happened to me and not to be stressed. For now, I used to have some anger issues, so but when I start to came here, it started to go down. Yes.*

Survivor 14: *Women, why should it always be about women? I think…. as much as you want to protect us, there is something wrong with the boy child, hence, we as parents and as a nation, we focus only on the girl child, then the boy child, but if we can try to have a word with the*

boy child, I think this thing will be lesser. I am not saying that it is going to stop, but it might be lesser. If it can happen that you can tell the boy child; that we as women are abusers as well, but we as a nation are not ready to talk about that. Right, so if we can tell the boy child that if she says no, it is no. Maybe it is going to help.

Survivor 15: *Yes, it can benefit women, so that they can be able to stand for themselves. And to be able to know what is wrong and what is right. And, don't feel ashamed if something like that happens to you, it's not like you for it to happen to you. It just happened. I think that is going to equip them to be stronger, yes.*

Survivor 16: I *think that if you can find social counselling, so that you can speak what happened, so that you don't put that thing inside you. Because it is killing like thinking each and every time what happened. So, if you can find help, you can find closure.*

Survivor 17: *It will benefit women, because if you don't report, sometimes maybe you can get sick, or end up killing yourself, because of that thing, the experience. It is not easy, but they have to report. They have to go hospital or clinic, after getting raped. They have to go to the police station. They must come here and ask for help and get check-up and everything else. I think it is better that way.*

Emanating from the positive responses of the survivors, Victim Empowerment Programmes seem to be a relevant protective factor in the CJS. These programmes are offered by selected service providers to provide rape victims with the necessary care and support. Furthermore, Victim Empowerment Programmes are programmes in which the management of survivors of crime is supported by the expertise and the aid of a professional service provider in mapping their way to recovery (Nel, 2019: 90-91).

SUB-THEME 3.2: PERSPECTIVES OF ADULT FEMALE RAPE SURVIVORS REGARDING THE VICTIM IMPACT STATEMENT

Survivors 2-5, 7-10 and 12-15 (n=12; 70.6%) had a positive response towards a victim impact statement, while survivors 11 and 16 (n=2; 11.8%) expressed a need to verbally explain in court themselves the impact of the rape on their lives. Survivors 6 and 17 (n=2; 11.8%) echoed negative opinions towards a victim impact statement and survivor 1 (n=1; 5.9%), did not respond. The research participants expressed the following:

Sub-theme 3.2.1: Positive opinions pertaining to the victim impact statement

Survivor 2: *Yes, I think it will heal me also. I think to cough out, it is a better thing and better healing. Yes, I think so.*

Survivor 3: *Yes, I can benefit from it, if the social worker can tell the court.*

Survivor 4: *I think it will help the rape survivor, if they can see the person live. So, they can put in headphones so the victim can talk far away from the rapist; and tell the court what the rapist have done to them. If they can give them that, so that victims can talk freely and give them hope not to be shy. Things will be very much better, because most people are shy to look at the suspect, and talk in front of him, regardless of any age, because they also feel much shock, what if the case is cancelled; and the victim fears that if they go home the rapist can kill them. So, if they can do things separate, the fear will start going out.*

Survivor 5: *Yes, if they can give me chance to go to the court to talk to the magistrate about the thing that happened to me; and to protect the other kids. This thing is too painful, because when you see a small child get raped, what about we ladies and guys, the guys like gay and lesbians. It is painful, because that thing, when it goes inside to you, when you come back, you still remember, it is not an easy thing.*

Survivor 7: *Yes, I think it will benefit the victim, because it will lead out to others. It will help to heal, but they must take the person to court. It will be you and who? I think it will give a woman relieve.*

Survivor 8: *Yes, it will work. If I was the victim in court and the person was here, I will tell the court that the guy must punished. I don't want to see him outside, I want justice.*

Survivor 9: *I think it may help, at the end of the day talking about it does help. Uhm…, yes, so I think it will help.*

Survivor 10: *Yes. Like I think the social worker understand the person. Yes, they can explain more. Yes, I would like such an opportunity.*

Survivor 12: *Uhm…, oh, I think it could help them, because sometimes uhm…you find out that a person is not coping very well at work, but once you find someone and talk to, you'll be able to be free. Just like for example, even me, I was so stressed but, the moment like…. I talk to someone, that's how I get a relieve. Yes.*

Survivor 13: *It will benefit them not keep quiet if you are in situation like this, you must report it. It will help more women to talk, cause if you don't talk, this thing is killing you inside. So, if you talk, you can help another woman and children.*

Survivor 14: *It depends on how do you take it. For me, this was not my first time, it was my second time. And then the first time, I didn't report it. I actually had to live with it, right? And I attended a psychologist a year later, because I have a child through that. So, the thing is, you need to talk to someone. Like when you don't take it out, there is a thing that you are building, for your health, your mental health, for yourself. So yes, it is best you have someone to talk with.*

Survivor 15: *I think it is going to give the victim closure, once the court decide on what to do. Because, I think by telling the court, even though I have never been in that situation before. So, I was hoping that I am going to tell through a social worker, or a psychologist, because sitting*

there and explaining, every time, because after it happened, I had to say it the way it is. And even when I think about it, it is still painful.

Sub-theme 3.2.2: A desire to inform the court themselves about the impact of the crime of rape

Survivor 11: *No, I want to explain it myself, because that thing, it is eating me, but if I explain it myself, it will come out. I will forget about it. It will give me healing in a way.*

Survivor 16: *Me, I prefer to talk for myself. Yes, I can speak. I can talk everything. So that when I talk, that is when I am getting closure. I don't want to kill myself with that thing inside me. It's a problem.*

The researcher is of the opinion emanating from the responses of survivors 11 and 16 that there is a need for rape survivors to be afforded an opportunity to inform the court themselves verbally about the impact of the rape on their lives. In addition, the researcher is also of the opinion that being willing to stand in court and explicate their accounts of the ordeal that they have suffered is closely linked with resistance and resilience, which emerges from the capacity and strength of survivors 11 and 16 to stand-up for themselves, which from an ecological framework asserts the influence of the *microsystem* on survivors 11 and 16, being their positive approach and assertiveness to be part of legal proceedings within the CJS.

Sub-theme 3.2.3: Negative opinions regarding the victim impact statement

Survivor 6: *I don't know if it would be a good thing, for me, unless if only they find the person. Because I heard that in the area that I got raped, someone was almost also raped too. So, I suspect it is the same person, but they can't find him. And I don't think in any way if I say anything to the court, because the police can't find him anyway; and I don't even know how far they are with the DNA results, of that person, they don't tell me anything. They don't do any follow-ups, nothing.*

> Survivor 17: *I don't think they will benefit, because they don't take small things, only big, unless if they kill me. That's why I don't know, but they won't benefit from it. The only thing I want is for the police to catch them because they are dangerous.*

The researcher is of the opinion that in light of the assertions made by survivors 6 and 17, there is a predominant need to be informed about the progress of her case (survivor 6), while survivor 17 is of the opinion that only serious cases such as murder receive more attention within the CJS.

A victim impact statement is a document or verbal account that highlights the impact of the crime(s) on the adult female rape survivor (i.e., financial, social, physical and psychological effects); and depicts the victim's experiences with the crime, the offender, and the envisioned sentencing of the alleged rapist (Regoli et al., 2018:180). The main reasons for including a victim impact statement during court proceedings are, firstly, to provide the presiding officer with information about the actual harm inflicted on the crime victim in order for the sentencing of the offender to be equivalent to the crime. Secondly, enabling a therapeutic outcome for crime victims, thus supporting recovery in bringing closure to the victim after the incident (James & Cronje, 2019:133; Ovens, 2020:581; Regoli et al., 2018:180).

THEME 4: PERSPECTIVES OF ADULT FEMALE RAPE SURVIVORS REGARDING MEDICAL CARE

The researcher explored the perceived quality of post-rape medical care experienced by adult female rape survivors within the CJS. All of the survivors (n=17; 100%) had a positive experience regarding the medical care they received. No follow-up probing regarding recommendations for medical care was warranted, given the positive response. They conveyed the following:

SUB-THEME 4.1: PERCEIVED QUALITY OF POST-RAPE MEDICAL CARE

In the analysis of the verbatim quotes, the researcher identified three further sub-themes under the perceived quality of post-rape medical care, namely the survivors' experience regarding PEP treatment for HIV and STIs as well as

medication received, experiences in coping with the side-effects of the medication and general perception toward the treatment received by the medical staff.

Sub-theme 4.1.1: Experiences regarding treatment for HIV and STIs (PEP and medication received)

Survivor 2: *Yes, that medication that prevent HIV, it made me nauseas and vomiting. Uhm… and disliking food, that was what I experienced from the medication. But they gave me something to take with it for 28 days. After that they asked me how do I feel, and I said okay.*

Survivor 3: *It was very right, I was satisfied. They also gave me something to make me better, if the medication made me sick.*

Survivor 4: *I received very nice medical here, like I explained. If you come here, they test you for HIV. If you are HIV-negative, they give you the capsules that prevent you from getting HIV. They also treat you for STI's and pregnancy in the best way. If you are one of those victims who feel fear to go home, they look for you a place to stay until you are back to normal.*

Survivor 5: *Uhm….. it is fine. I drink the medication, and after that, I tried to sleep.*

Survivor 6: *Okay, uhm…, it was fine, but, when I was taking the pills, they gave the pills that I should take for 28 days, it was okay. The only thing is that I was sleeping a lot; and I gained a lot of weight. But otherwise, everything was fine.*

Survivor 7: *Yes, the medical care was fine. I was also fine with the medication. I had no problems.*

Survivor 10: *Yes, but they did not tell me about the medication.*

Sub-theme 4.1.2: Experiences in coping with the side effects of medication

Survivor 12: *Yoh, first, uhm…, for three days, yoh, yoh, yoh, I felt so nauseous, vomiting, dizzy. The medication was strong, too much. I did not even have appetite to eat. Eish, it was so hard for me, but after a week, I felt better, but I didn't have appetite at all, until the end of the first week, but now I'm fine. They also gave me antibiotics, injections and other pills. The say it was antiretroviral treatment, that is used to clean the body. I drank it for 28 days. Yes.*

Survivor 13: *Sjoe, that one, it was hard for me to take it. Yes, the medication, it was hard for me to take it. But then I sat down and realised that I am doing it for myself and my future. I started to drink that treatment. It was hard, but I did drink it and I finished it. I was happy because I did see the results for drinking that medication. Yes, it helped me a lot.*

Sub-theme 4.1.3: General perception towards the treatment received by medical staff

Survivor 1: *It went fine. Everything I didn't know was explained to me. I am fine.*

Survivor 8: *They treated me well, but sometimes I sleep too much*.

Survivor 9: *When I got here, everything according to me was ok, like everyone was nice and considerate. I did not have any problem.*

Survivor 11: *They treated me very well, I did not have any problem.*

Survivor 14: *Everyone was so friendly; I remember my first day. It was like everyone was like in my shoes and everything just went smoothly.*

Survivor 15: *I think it was best, because they made me feel comfortable. The sisters, everybody, even the first time. Even the other times I came, they made me feel that I mustn't beat myself up, and that it shall pass. They made me feel like I'm important.*

Survivor 16: *It was good, because they treat us nicely. Even the doctor, he did a good job.*

Survivor 17: *Uhm…, I think it did help me, because I did not know what will happen after I get raped. I didn't know if I got sickness, or anything like pregnancy. They really helped me, because now I know.*

Regarding the responses of the adult female rape survivors, the Thuthuzela Care Centres provided them with medical care such as STI screening and referral; information reliant on PEP support administration (based on HIV Testing Service result); and antiretroviral treatment services (contingent on HIV Testing Services outcomes (NACOSA, 2018:13). In Section 66(3)(a)(i) of The National Directives and Instructions on conducting a Forensic Examination on survivors of Sexual Offence cases (2009:2-3), provision is made for the management of PEP. In sub-Saharan Africa, dual epidemics of HIV and sexual violence make the administration of PEP a crucial part of the public health response to the management of rape. Moreover, genital trauma resultant from rape intensifies the probability of HIV transmission. Comprehending the uptake and use of PEP could facilitate initiatives to improve the efficiency of PEP (Chacko et al., 2012:338; Draughon, 2012:85; Muriuki et al., 2017:255; Wheeler et al., 2014:26).

The treatment of STIs, including gonorrhoea, chlamydia, hepatitis B and HIV, entails a crucial component within the management of survivors of rape. STIs can be prevented promptly by administering bacterial and viral prophylaxis, which ensues by sexual health screening two weeks later if the rape survivor is symptomatic. The choice of treatment is highly influenced by local incidence and prevalence of infections; and resistance to antibiotics (Cybulska, 2013:142). Moreover, emergency contraception should be offered to rape survivors representing within five days of the incident, preferably as soon as possible, to make the most of its effectiveness (WHO, 2013:5).

THEME 5: PERSPECTIVES OF ADULT FEMALE RAPE SURVIVORS REGARDING MEDICO-LEGAL CARE

The researcher asked the survivors about their experiences during the medico-legal examination. Most of the survivors (2, 3, 6, 10, 12, 14-15 and 17) (n=8; 47.1%) had a positive experience regarding the medico-legal examination. Six survivors, namely survivors 4, 5, 7, 9, 11 and 13 (n=6; 35.3**%**), stated that they experienced the medico-legal examination as painful, traumatic, and invasive. Survivors 1, 8 and 16 (n=3; 17.7**%**) did not respond. They opined the following:

SUB-THEME 5.1: POSITIVE EXPERIENCES REGARDING THE MEDICO-LEGAL EXAMINATION

The survivors indicated the fact that they were made to feel comfortable, that they were treated with respect and dignity and that the medical procedures were explained to them before the commencement of the medico-legal examination as positive.

Sub-theme 5.1.1: Survivors were made to feel comfortable

Survivor 2: *Yes, I was comfortable because they told what they were going to do. I was comfortable.*

Survivor 6: *It was okay, I did not feel uncomfortable. It was fine.*

Survivor 10: *Uhm…, yes, they did explain it me before, so I was comfortable.*

Sub-theme 5.1.2: Survivors were treated with respect and dignity

Survivor 3: *Yes, they treated me with respect, 100%.*

Survivor 12: *Yes, everything was fine. They did explain to me and treated me with dignity. Yes, and they are so very patient.*

Sub-theme 5.1.3: Procedures were explained to the survivor

Survivor 14: *They did explain before they examined. When I went for the examination, I knew what was going to happen, I could ease my mind.*

Survivor 15: *It wasn't hard, because they told what they are going to do. And they told me to relax and don't feel scared and ashamed. And*

then they made me feel like, even though I was raped, because I was raped for three days. I didn't bath. And they made me feel like a woman.

Survivor 17: *Yes, they did explain, and I think everything went well.*

SUB-THEME 5.2: NEGATIVE EXPERIENCES REGARDING THE MEDICO-LEGAL EXAMINATION

Unfortunately, some survivors also relayed negative experiences during the medico-legal examination such as the fact that the examination was painful and that they experienced the examination as traumatic and invasive.

Sub-theme 5.2.1: Examination was painful (physically and mentally)

Survivor 5: *Uhm… it was painful, but not that much.*

Survivor 7: *It was painful, because you can't stop thinking about what happened. They did explain to me, but it was not a nice experience. But they treated me good.*

Survivor 13: *That was first time experience, but I didn't feel bad. But after when I went home, when I start to bath, it was when I start to feel pains, and ask myself why, but I don't know like what to say, but is was okay.*

Sub-theme 5.2.2: Traumatic experience

Survivor 4: *Like, when the doctor starts to check you. You start to feel traumatised, and that thing comes back. But at the end of the day, you tell yourself, let me just be strong. You encourage yourself from the inside, let the doctor finish. Whether is a male or female, they are there to save your life, let the trauma get outside of you. The doctor will always be there for you, alongside the Thuthuzela Care Centre staff.*

Sub-theme 5.2.3: Invasive procedure

> Survivor 9: *I didn't like it. I did not like it at all. Because I did not bath, and it felt like someone else now has to touch my body, I just wanted to go home at that point, because I had to undress again and answer questions. At that time, I was not okay. I didn't like it, I just wanted to go home.*
>
> Survivor 11: *They took my blood, and they took my underwear also. Like they put something in my private parts. I think they were collecting the sperms for evidence. They said that, that thing was going to help on my case. This is the guy that did it to you.*

In light of the response of the survivors, in South Africa, genito-anal injuries have been identified in 7% to 58% of rape cases. Since not all adult female rape survivors sustain injuries, a comprehensive understanding relating to patterns of injury, and the consequences thereof, is valuable (Jina et al., 2015:2)

Medico-legal evidence plays a vital role in corroborating evidence that the alleged rape did indeed occur and is perceived as being one of the most crucial forms of evidence the prosecution can present during legal proceedings (Niriella, 2018:23). Consequently, the efficacy of medico-legal services within the CJS, the quality of available medico-legal service, and the evidence collected and offered are of supreme importance. Concerns can be raised by the presiding officer and defence if the collected forensic evidence does not accord with the claims made by the adult female rape survivor (Du Mont & White, 2016:4, 6; Niriella, 2018:23).

Research conducted by Machisa et al. (2017:14) found that the medical examination of rape victims and the collection of evidence by means of the Sexual Assault Evidence Collection Kit were only correctly implemented in 76.7% of rape cases. Furthermore, in over a fifth of all cases where the Sexual Assault Evidence Collection Kit was completed, it was not sent to the Forensic Science Laboratories for analysis. More recently, it became evident that the National Forensic Science Laboratories had been unable to process DNA samples for two (2) months (during the period of January and February 2021), notwithstanding having a backlog of 117 738 cases waiting to be prioritised (Gerber, 2021; Mallene, 2019).

SUB-THEME 5.3: RECOMMENDATIONS OF ADULT FEMALE RAPE SURVIVORS REGARDING MEDICO-LEGAL SERVICES RECEIVED

The survivors were probed about recommendations they might have for medico-legal services. Only survivor 4 made a meaningful contribution being:

> *When it comes to collecting evidence from your body, I think that is very very important. And what this people can do is, even if the suspect raped you three years ago, what they can do together with the police, let them come up with a forensic team, and let them check the sperm between you and that guy for clarity. What has happened to me, is there are many many people that raped me since I was five years old till today, but those people are not arrested. What happens is, that we as girls, are shy to report such cases, because we know that most police are ignorant, then we end up washing and most of the DNA is gone. If they can do DNA and check the person that raped you, things will become very easier.*

Given the response of the survivor, post-rape investigations highlighted that genito-anal injury acknowledgement is multifaceted, and service providers are restricted to the availability of the essential equipment and resources to conduct examinations and categorise injuries as such. Furthermore, the J88 form does not explicitly compel service providers to document the examination methods they employed during the examination of the adult female rape survivor, and thus dependent on the skills and expertise of service providers in capturing this information at their own discretion (Jina et al., 2015:5).

The care and examination of an acute rape victim need to be carried out by a certified healthcare practitioner with the expertise and comprehension of the psychological response to rape. The practitioner must be a proficient communicator so that the nature and extent of the injuries of the rape are documented accurately. They must be well-informed in collecting biological trace evidence and how to interpret and report these conclusions verbally and in writing. The examination should take place in a quiet room with access to the required equipment. Adult female rape survivors perceive the treatment of injuries

and swift medical examination by a healthcare service provider as a mode of crises intervention (Ingemann-Hansen & Charles, 2013:92). Pointers of forensic medical interest to highlight substantiating evidence are the rape survivors' overall health, consumption of prescriptive medication or drugs, menstrual period, prior sexual relationships, time since last voluntary intercourse, and current genital lesions (Ingemann-Hansen & Charles, 2013:93).

With the rape survivor in a supine position, knees were drawn and legs apart, an inspection of the external genitals and perineum was conducted and ensued by the insertion of a speculum to inspect the vaginal wall and cervix. Trace evidence is collected preceding the insertion of instruments in order to avoid contamination. Specimens from the vagina (i.e., foreign bodies) and samples from the cervix, however, are collected while the speculum is inserted. The anal examination can also be carried out with the rape survivor still in the supine position or turned in the lateral position. Ensuing the initial inspection and trace-evidence collection, contingent on the assault history or signs of visible injury, anoscopy should be conducted (Ingemann-Hansen & Charles, 2013:94).

THEME 6: PERSPECTIVES OF ADULT FEMALE RAPE SURVIVORS REGARDING PSYCHOSOCIAL SERVICES

The researcher probed the survivors about the perceived quality of psychosocial care they received. Survivors 3, 4, 5-6, 7-8 and 9-17 (n=15; 88.2**%**) indicated a positive encounter in relation to psychosocial services received. Survivors 1 and 2 (n=2; 17.8) did not respond to this question. No negative experiences with the psychosocial services received were expressed by any of the survivors.

SUB-THEME 6.1: POSITIVE EXPERIENCES IN ACCESSING COUNSELLING SERVICES

The survivors expressed positive experiences in accessing counselling services in terms of the bond they formed with the service provider and the quality of follow-up services. The researcher also includes the generally positive feedback by the rape survivors.

Sub-theme 6.1.1: Positive bond formed with the service provider

Survivor 10: *I think now we are friends, me and the social worker, I am open to talk to her and she is like my sister. Yes, I am happy. The counselling helped me too much. Like before I couldn't talk to anyone, I was always sitting alone crying, since I came here, I am free. At work I can work, at home I can do my work and stay with my children, I can play with them, before I couldn't.*

Survivor 11: *Yoh, I don't want to lie to you… I have two ladies..., those two ladies, they are like my friends, like every time when I am here, we are always laughing, and they keeping on calling and checking on me; are you alright sister?; yes, I'm ok. How are you coping in life, no I'm right, I'm eating. There was a time my brother committed suicide after my rape, I did come here, neh [you understand], they talked to me and told me that everything will be alright. They treated me very well, very well.*

Sub-theme 6.1.2: Follow-up services

Survivor 4: *Sjoe, I don't want to lie. Those were very excellent services. That is why for those services, I thank the social worker Ms…. she was the one who has been with me for many years, assisting me with counselling. The social worker who have been helping is also worried about what is the best solution to assist me. At the shelters they only keep you for a certain period of time, then you must go. The social worker is always trying to help me find the best solution to find justice.*

Survivor 6: *I have the number of a lady to escort me here, if I don't have money for transport to come here, I only talk to her. But it is not related to my case. The only people who call me is from here, Thuthuzela Care Centre, they call me to check on me, and all that. I was referred here by the police, from there, I come here every month.*

Survivor 15: *They are the best because even the guy, I don't know his name. He even asked the second time I came if I got my case number. And I said no, did not get an SMS. I was told that I will get an SMS.*

And the detective that is taking my case, said he would call me and check my case, which he didn't. He even called the prosecutor……, and he made sure that he gives us the case number. And he also told me that when the guy was out of prison, it is like they only arrested him for a week, and then theygave him bail, and then he came out. But I was never told, until he showed up again at my gate. I was coming back from work, and it was a bit dark. I got shocked, because I felt like he was in prison, but however, I already entered the gate. Then, there he is, and I locked the gate. Then he wanted to talk to me, and I said I don't want to talk to him, and there are people that I stay with. Then I just left and went into my room, but I was scared. That night I didn't sleep, because I know he was stalking me, and I leave my place 06:30, sometimes between 06:00 and 06:30. I comeback late. At work I had to tell them everything, that when they changed me and gave me another position, to start Monday to Friday, 08:00-17:00. And they are understanding at work, they are also supportive. And they said that they will see me through till the end of case at the centre.

Sub-theme 6.1.3: General perceptions towards the treatment received by medical staff

Survivor 3: *It was alright.*

Survivor 5: *It was very excellent.*

Survivor 7: *They are friendly, I don't want to lie, they are so friendly. Yes, they did help me.*

Survivor 8: *They treated me well. They asked me how do I feel, I feel good. But sometimes when I am alone, I think too much. I only focus on a positive mind, I don't go to a negative mind.*

Survivor 9: *It was good.*

Survivor 12: *Okay, the counselling was very good, and the woman is very understanding, and she explained everything to me.*

Survivor 13: *Counselling services, it was good because it made me feel to come down myself, to handle my stress. It is good having a counselling. It did help me a lot.*

Survivor 14: *It was okay. They take their own time since they listen to you. It's all in your mind, when it hits, it hits back. But it's all in your mind, if you tell yourself that you are a survivor, then you are a survivor, either way.*

Survivor 16: *It was good, even though I was like scared. Like I don't like talking, but today I was relieved to talk. It was nice, and they were asking nicely, so that good. The counsellor told me that if you talk, that is how you release step by step.*

Survivor 17: *It is good, because I think it is helping me. Because this is the first time, I get raped. It helped me not to remember that much, and not to think too much.*

In light of the assertions made by survivors 3, 5, 7-9, 12-14 and 16-17, research conducted by Rossetti, Mayes and Moroz (2017) found that rape survivors' satisfaction levels concerning the CJS are noticeably divided, surfacing from own their personal experience. Although most rape survivors experienced favourable outcomes regarding being treated fairly and with sensitivity, unfortunately, many are also disappointed with the outcome of their case in the CJS. Most importantly, rape survivors favour high-quality support, which in return aids as a motivation for restoring assurance within the CJS (Rossetti et al., 2017:8, 20).

SUB-THEME 6.2: RECOMMENDATIONS FOR ADULT FEMALE RAPE SURVIVORS REGARDING PSYCHOSOCIAL SERVICES

During the interviews, the survivors highlighted valuable recommendations in terms of addressing their psychosocial needs in service rendering. They shared the following:

Sub-theme 6.2.1: A need for healing

Survivor 2: *What can I say, guys the services, it was healing for me. I would recommend it. I hope that what they are doing here, they will do it more and more. I also want people to open their mouth and tell what had happened to them. Up to so far, your services are good. Honestly.*

Survivor 7: *Yes, it is better to come for counselling if you have a problem. They did give me a paper with dates that I was suppose to come. Yes, it is working for me. I am eating and sleeping better.*

Survivor 8: *They were good at me. Talking to another person, it relieves me, yes.*

Sub-theme 6.2.2: A need for more shelters

Survivor 4: *Counselling services, like I said, they are really nice. What I can recommend is that the social worker who is helping me continue what she is doing, and assist more and more victims and let Departments of Social Development and Human Settlement open up more space for platforms to create more shelters to assist more victims because most of them cannot admit due to space. So, let them create more shelters and assist the victims.*

Sub-theme 6.2.3: A desire more for more counselling sessions

Survivor 6: *Uhm…, counselling, cause like, I only came here once a month, if at least once a week. It will be better, because here is bit far for me, if they can transfer me that side of ……., it is closer. At least once a week, if I can find someone that I can talk to because, to be honest, I thought I was ok, but I'm not. I only want to talk to one person. It was fine, but I want to only talk to one person, I don't want too many people, only one person.*

Survivor 10: *Yes, counselling is good, it helps a lot. I use a taxi. Like today, I wasn't having money for transport. Yes. I think counselling should be given two times a month.*

Sub-theme 6.2.4: A need for financial assistance

Survivor 11: *To help us with the taxifare. Yes.*

Survivor 12: *Maybe I would recommend, just like the last time I came here, neh (you understand), I didn't get any social worker. So, I would like them to reschedule their time with the patient. Maybe if he or she cannot see me, he or she must just call and tell me, no don't come today, so I don't waste my money, only to find out they are not here.*

Survivor 13: *Government must help. If you come to the social worker or tell someone that I don't have money for transport, and government should bring stipend for those who can't afford the transport. Like if you know today is your day to come, you must report to the counsellor or the doctor or nurse and tell that I cannot come. Maybe they should use WhatsApp, because these days you have technology. Maybe you can counsel me on WhatsApp, or like SMSs, yes.*

Survivor 15: *I think women should get more support on that. They should be asked if they have that support, like money to come. If you are working, then it is fine. But if you are unemployed, you would love to come, but find out that you don't have money, for taxifare and so forth, because you stay a bit far. So, I think they should support people like that, who are unemployed, and they don't have any support of income. I think it helps to talk, because when you talk, yes, you are going to cry, and you are going to feel like you are being taken back to something that you want to forget. But one thing that I have seen, is that I am not going to forget about it now, I'm still going to have a long way to go. So, what do I need to do for myself? I cannot let this defeat me and make me feel like a victim. No, I am going to be strong and pray that God can help to be strong till the end, because I believe that it is not my fight, it is God's fight.*

Survivor 16: *Others don't work and suffering to come, even if she is willing to come. Just because she does not have money to come. I think that government should look at ways to help, it is better this way.*

> Survivor 17: *For me it is not too far to come here, yes, but even if it is far, you can go and borrow money to get help. So, you can come and get help. Not to stay at home, and in the end, maybe you don't know you are sick, or you are HIV-positive, you know.*

Sub-theme 6.2.5: A need for group counselling sessions

> Survivor 14: *I think through group sessions, we, as survivors, can hear each other's stories. We can heal through someone's story, you can. Yes, the psychologist and social worker can take us on a day, because not all are open during one-on-one sessions. So, if you can hear somebody talking about it, then it becomes easier for you to open up.*

In light of the assertions made by the survivors above, transport remains one of the issues of fundamental concern when it comes to rendering services at Thuthuzela Care Centres. SAPS officials escort survivors of rape to the Thuthuzela Care Centres but cannot wait to take them home or to a place of safety. Many rape survivors cannot return to Thuthuzela Care Centres for follow-up PEP and psychosocial support. Additionally, NGOs and NPOs also find it challenging to render continuous support psychosocial support at the homes of adult female rape survivors, nor can they participate in community awareness bearing noteworthy value to sexual violence such as rape due to a shortage of vehicles (Thuthuzela Care Centres Compliance Audit and Gap Analysis, 2016:16).

While SAPS sometimes accompanied rape survivors to places of safety, some police stations had limited vehicles, while other provinces did not have places of safety at all. SAPS also have challenges when they are confronted with shelters being full (Commission for Gender Equality, 2016:15).

Trauma-informed care remains a challenge to service providers, although this approach is gaining momentum in health, the CJS, and many other service spheres (i.e., psychosocial services provided by NGOs and NPOs (Bowen & Murshid, 2016:223-224; Campbell et al., 2019:4767; International Association of Chiefs of Police, 2015; International Association of Forensic Nurses, 2018;

Randall & Haskell, 2013:503). Additionally, trauma-informed services are facilitated by a comprehension of the consequences of rape on the lives of women. In trauma-informed approaches, it is emphasised that service providers understand the impact of rape on women who approach them in an attempt to reduce re-traumatisation. The trauma-informed paradigm renders a substantial and humane principle for theorising and prioritising the numerous challenges for adult female rape survivors in seeking mental health and other services (Butler et al., 2011:177; Elliot et al., 2005:9; Kirkner et al.,2017:3). Furthermore, trauma-informed care is required to apply an understanding in planning and rendering service systems to be adherent to the requirements essential in working with the vulnerabilities of trauma victims, and to facilitate their involvement in treatment (Butler et al., 2011:177).

The availability of psychosocial services after hours and on weekends remains an issue of concern at Thuthuzela Care Centres. A timeline in which healthcare practitioners are oftentimes not available to cater for the psychosocial needs of the adult female rape survivor. Consequently, the perceived quality of psychosocial services may be affected, which may lead to the complete closure of such services. This will restrict the functioning of Thuthuzela Care Centres to health and legal services only (Global Fund to Fight AIDS, Tuberculosis and Malaria, 2019:2).

The next section will highlight the perceived quality of legal services received by adult female rape survivors.

THEME 7: PERSPECTIVES OF ADULT FEMALE RAPE SURVIVORS REGARDING THE LEGAL SERVICES

The participants were asked about their experiences with SAPS and legal practitioners (case managers). Survivors 2-3, 7-8, 10and 13 (n=6; 35.3%) had a positive experience with legal service providers. However, survivors 4-6, 9, 11, 14 and 15 (n=7; 41.2%) indicated negative encounters with the service providers from the legal domain (SAPS and case managers). Survivors 1,12 and 16-17 (n=4; 23.5%) did not respond. They expressed the following:

SUB-THEME 7.1: POSITIVE EXPERIENCES WITH LEGAL SERVICE PROVIDERS

Survivor 2: *I did speak to the prosecutor many times, but because we cannot find that guys. He used to come and see me. I am happy with him.*

Survivor 3: *They was treating me nicely, the police. It was following my problem. I withdraw the case, because he was my boyfriend, he was asking me. I was feeling the pain for him. He was in jail for 2 months, then he came back and spoke to me.*

Survivor 7: *No, I was okay with the treatment received.*

Survivor 8: *They called me, and I told me that they will go through my case. I was called by Sergeant …….*

Survivor 10: *Yes, my conversation with the police was good. They give me a chance to explain.*

Survivor 13: *My experience with the police was good.*

SUB-THEME 7.2: NEGATIVE EXPERIENCES WITH LEGAL SERVICE PROVIDERS

The survivors expressed negative experiences with the legal service providers in terms of a lack of communication, cases being dismissed, secondary victimisation and lack of trust in the police.

Sub-theme 7.2.1: Lack of communication

Survivor 4: *The prosecutor I only met with one case. It was a woman from Pretoria Central, I don't remember from what case that I have reported of my life. For many years, only one suspect was arrested.*

Survivor 15: *I called the detective and asked him: - You did not even tell me that he is out? Just for somebody to tell me he is out, just be careful. And even before they caught him, he used to stalk me. So now, I felt very very bad. But the guy working at the centre called the detective and he took a second statement, because he was stalking*

me. He told me that we will go to court next week to evoke his bail. Because to me, it sounds like he is a psycho, because he even stalked me with my WhatsApp. Because of the guy that was doing counselling for me, he called the prosecutor, and that's how I got the case number. But we must also still go to court because he violated the protection order. They said they will summon me.

Sub-theme 7.2.2: Case being dismissed

Survivor 5: *I did not see anyone when they communicate with me about my case. They send a SMS that they cancelled it. I did not go to court; they said my case was already dismissed. I feel betrayed by the criminal justice system. It is very sad and disappointing.*

Survivor 6: *It was fine with police, ok the lady, who wrote everything down when I came in, she was okay, she did not judge me in any way. Which was nice, and then, I am not happy that they are not telling me how far they are with the case, they just closed the case, like it's a cold case. Which is not nice.*

Sub-theme 7.2.3: Secondary victimisation

Survivor 6: *But the male policeman, I was already crying before he came, and then he just made me feel worse. Because of, yes, it was past hours where I was not supposed to be, yes, I was wrong to be outside that time, but he did not have to rub it in.*

Survivor 9: *I am only going to direct my message at the Atteridgeville police. They need to up their game. They need to do better. Because when a person is coming there to report rape, no matter what the circumstances are, nobody should be judged for it. Especially a grown ass policeman, a man, saying, this is……, no, that was not okay. That point when he said the things that he said, I just got up and left. At that time, I felt disrespected again, when I am trying to open a case. I felt violated. A man comes to me tell and tell me about the merits of my case, he needs to do better. He really needs to do better.*

> Survivor 11: *In my experience with the police, I was crying. I walked from the police to here. I was crying. I was scared. I was thinking, what if I met with that guy, and he finished me off? I was crying, I was feeling bad, I was thinking that maybe I am a loser, that is why they did not want to take me to the clinic. When they took the statement, it was okay.*

Sub-theme 7.2.4: Lack of trust in the SAPS

> Survivor 14: *It's best to report it, but it is also best not to report it. If maybe, you know the person, then they will follow the case. Once the suspect is unknown, nothing. I no longer trust the police.*

Considering the responses of survivors 4, 5, 6, 9, 11, and 14-15, the majority of rape survivors do not receive information from the time of reporting the rape to the time that it is heard in court. Rape survivors also do not have adequate access to case-specific information concerning the progress of the investigation of their case; and whether supplementary information is required of them by the police (Watson, 2015:4). Rape survivors' fear of not being believed can lead to further secondary victimisation within the CJS (Watson, 2015:3). It is important to be aware of the fact that just because the police find a rape complaint as being irrelevant; it does not necessarily imply that the alleged incident of rape did not transpire. A lack of trust between society and the police originates from perceived corruption, although a lack of capacity and skills are also contributory to both a lack of trust and efficacy (A Dialogue Between Government and Civil Society, 2013:10).

SUB-THEME 7.3: OPINIONS OF ADULT FEMALE RAPE SURVIVORS REGARDING COURT PREPARATION

Prior to data collection, the researcher was informed by NPA staff that a limited number of cases had been finalised for the court (NPA Staff, 2021). Nonetheless, the researcher felt the need to explore the opinions of adult rape survivors regarding court preparation. The researcher explained the process of court preparation to the research participants. Survivors 1-3 and 6 did not respond (n=4**;** 23.5%). Only survivor 4 had been in court, but she did not receive any court

preparation. Most of the survivors' cases were still pending a police investigation. Despite their cases only being in the police investigation phase, a significant number of the survivors had positive opinions concerning court preparation, being survivors 7-17 (n=11; 64.7%). They articulated the following:

Sub-theme 7.3.1: No court preparation received

> Survivor 4: *I was never prepared, because the police officer was just telling me like, two days before, you know what, you are going to court on this date. They were taking me from the shelter where I was staying at the charit organisation, but they didn't prepare me and tell me what will happen at the court, and then, the devil is a liar, and the magistrate just believed the suspect together with his lawyers. I was just told that the case was unsuccessful. The suspect was never found guilty.*

Evidently, from the response of survivor 4, she had never been prepared for court. Research conducted by the Justice Inspectorate (2022) in the UK, comprising eleven telephonic interviews with adult female rape survivors, found that adult female rape survivors articulated concerns about giving evidence during legal proceedings. The rape survivors further expressed a need to know in advance what to expect in the courtroom. Furthermore, the evidence presented in court may also have negative effects on the psychological well-being of an adult female rape survivor. (Justice Inspectorate, 2022:5).

Sub-theme 7.3.2: Court preparation in terms of seeing the rapist in court

> Survivor 9: *If they were to catch the perpetrator, then I will be willing to go. At some point I need to see that justice is done, and I also feel like that if I see him on the stand, telling the court why he did, what he did, for me, it would bring some form of closure and help me to progress, you understand. At this point I feel like I need to see him, to move onto the next step.*

> Survivor 11: *I think that thing, it can work, because you can see that guy, and ask him a question, why did you rape me. Maybe he will answer, or maybe he will say no, it was a mistake, I am sorry, or*

whatever. But it will help, because you will be healed, and at least you saw the guy that did this to you in court.

Survivor 15: *Yes, it is going to benefit us because the thought of me going to see him, it scares me. But one thing that I have seen, is that he knows that I am scared of him. So, he is using that to get to me. This time, I [wanted] wanna make sure, that when I see him, I'm [going to] gonna make sure that even though I am scared, I will not show him that I am scared. And I don't know how it is going to be, because it is going to be my first experience. But I wish that I can be brave and don't let him scare me, even when I see him. I haven't seen him till the day he got arrested. Court preparation, it is going to help because it is going to boost your self-esteem. You know, in knowing that even if he can look at you, because he used to call me and threaten me, but he is not allowed to contact me. But now he does not do that anymore, because every time he does that, I will report him. And then I will block all the numbers that he was using, he will go and get another number. And when I answer and hear its him, I drop the call. I can't let this guy do this to do, and make me feel like I'm owing him something, I'm not owing him anything, and I did not come to Joburg for him. I came alone, I had just met him here. And he claims that he did to me claiming that he loves me, but that's not love So, I cannot give him that power; that I'm scared of him. So next time when I see him, God help me, so that I don't get scared. Because I think he uses that with me. I would be googling how to get rid of a psycho boyfriend, but I see now, I'm not checking them anymore.*

Sub-theme 7.3.3: Court preparation in terms of testifying in court

Survivor 10: *Yes, I think it will benefit because sometimes I got a fear I am going to court, then when you stand there, you are scared, and sometimes you can't talk when you stand there. Then I think maybe preparation before, it will help.*

Survivor 12: *I have never been in court before. Uhm…, it would benefit me so that I don't get scared, not being able to talk, that shiver, yes, so that I don't get it. I will know what I will be facing in court and answer all the questions.*

Survivor 14: *I think it does, cause when you do something, you need to prepare. So, yes, it does. Mentally, then you know what is going to happen. So, when you get there you don't get a shock, and be surprised that you didn't know that this is how it was going to be. Then you start to change and start to shake. So, you are being prepared for that because there are a lot of people.*

Survivor 16: Yes, it can benefit people in court, because others, there are a lot of people outside. Like my younger sister was raped, and it was three of us, but she didn't come because she is scared, she does not want to talk. But if she can find someone to talk to and prepare, maybe she can open, and then start talking. You see. Now she is raped, she is staying the same. Nobody knows what is happening, she is screaming during the night, and she is seeing those guys, you see. But she didn't come, she was suppose to come. She was too scared. You see. If you can find someone, you must talk, so they can understand, because if you see that thing, it is going to be a problem. At least if you talk, things will be fine.

Sub-theme 7.3.4: General perceptions toward court preparation

Survivor 7: *It can I think, because justice will be served. And the victim will be prepared in court.*

Survivor 8: *Yes, I will be able to benefit from it.*

Survivor 13: *It will benefit women, cause if you [are] was strong, and you show another woman that you can stand for yourself, there is nothing that can beat that, because even me, I will go for that. They will see, yoh, that woman, she can stand for herself at court, how must*

I be scared? It must push and lead us to go there and fight for our rights.

Survivor 17: *Uhm…, It will benefit women to be able to talk in court. As for me, at work, they are all talking about us. It's hard to cooperate, because everyone, even people we don't know, they know that I was raped. That thing is hard. But I think, if they catch those men, it will be better, because now I can't even go to that street, I'm scared to go there. I want closure.*

Regarding the positive opinions shared by the adult female survivors indicated above, there is a need for court preparation. Court preparation programmes are envisioned to support the rape survivor in comprehending the judicial process, services, and benefits. It further envisions empowering the rape survivor to be an effectual witness during the court process. On the date of the trial, it is anticipated that the rape survivor will be welcomed and assisted by the Court Preparation Officer of the Thuthuzela Care Centre (Mkhwanazi, 2016; Skhukumisa, 2012:66).

A rape survivor may be confronted with challenges in remembering the chain of events that transpired during the rape incident due to an array of psychological influences (i.e., PTSD). It is thus crucial for the adult female rape survivor to be prepared for court, revisit the statements made, and rejuvenate their memory prior to entering the courtroom. Cross-examination during legal proceedings has the ability to discourage the narrative and credibility of the victim (Zia, Shallum & Randhawa, 2021:39,55).

SUB-THEME 7.4: RECOMMENDATIONS OF ADULT FEMALE RAPE SURVIVORS REGARDING LEGAL SERVICES

The researcher probed the survivors if they had any recommendations regarding the legal services they had received. From their responses, it emerged that they have needs in terms of DNA to be prioritised, to be kept abreast with the progression of their case, and treatment received by the police. They shared the following:

Sub-theme 7.4.1: A need for DNA to be processed timeously

Survivor 4: *What they can do is, they should always listen to the victim, like I said, even DNA helps quite a lot. They should always believe the victims, because if they release the rapists just like that, and never found them guilty, it is like rape victims are just playing with their own time, they are just playing with their own resources. Because, according to law, cases such as rape, they should have been arrested for more than five years those people, but our world is cruel these days. They arrest somebody today, after two days you see them out on the streets. They really, really have to do something about such people.*

Sub-theme 7.4.2: A need to be informed about the progress of their case

Survivor 6: *At least they must keep in touch with the victim, even if they can't find the person, but at least like, tell them how far, like, yes, we are working on it. Yes, we are busy with the DNA. Things like that, they just keep us, they must tell us like how far they are with solving the case, and all that. They don't have to just stay silent, and not tell us anything, because it is sad. Just imagine if I was not this age, I was younger than that, it will be worse, because just imagine a child being raped, at least now I'm old, I can handle it. They are not even saying anything, you see.*

Survivor 10: *Like for now, I was the one who was calling them, they never call me. Yes, I was the one who was calling them asking how far are you? I was started to get worried why they didn't call me, what is going on. I have not been to court. They said they need to take statement from the social worker and my mother.*

Sub-theme 7.4.3: Treatment by the police

Survivor 11: *The way they did to me, I don't like going to the police station if I have a problem. For example, for the second rape, I took*

days to come here, because I was scared to go to the police, because of the way they treated me. That was the first time. For the second time I was scared to go to the police station, then I said eish, they will treat me like first time. But I end up coming, but I was late. Fortunately, even the second time, I did not have any disease, and I did come again to do the test.

Survivor 12: *The police should treat victims in a good way, and if it happens, maybe there are some of the things that I forget when I have to take the statement. It sometimes happens that I forget to say something, so the police they just don't have the patience, even if you tell the person:- No why didn't you say like this in the first place? Now you are saying like this. Like, they just don't get it. When you are in this situation, your memory just don't work well, so they just need to be patient, even if maybe I can tell them that I made a mistake here, I was suppose to say this, but like my memory is not working very well. So, those people, they just don't understand, you know if something like that didn't happen to you, you never know how does it feel.*

Regarding the responses received from survivors, it is anticipated that upon reporting the crime of rape to the SAPS, the adult female rape survivor is handed over to a representative of the Family, Violence, Child Protection and Sexual Offences Unit of the SAPS. The rape survivor should be provided with a case number, and the details of the investigating officer should be communicated to the plaintiff. The rape survivor should also be uninterruptedly informed of the progress of the case if an arrest has been made and the conditions of the bail application set forth by the presiding officer, if applicable. A copy of the victim's statement should be made available if warranted, and the case should be expedited to the NPA within thirty days since the alleged rape had occurred. In instances where a case cannot be handed over to the NPA, the adult female rape survivor should be informed by the investigating officer. The Civilian Secretariat for Police oversees the monitoring of rape cases and safeguarding that adult female rape survivors are treated with respect and dignity. Further, witness fees are offered to adult female rape survivors within the CJS, as set in the Criminal

Procedure Act 51 of 1977 (Victim Support Services Bill, 2020:19-20). The researcher believes that the directives outlined within the Victim Support Services correspond with the expectations of the survivors, as set above. The following table outlines the themes and sub-themes in relation to the survivors.

Table 9: Themes and subthemes

THEME ONE: CIRCUMSTANCES UNDER WHICH THE RAPE OCCURRED	THEME THREE: PROTECTIVE FACTORS IN PROVIDING ASSISTANCE TO ADULT FEMALE RAPE SURVIVORS	THEME FOUR: PERSPECTIVES OF ADULT FEMALE RAPE SURVIVORS REGARDING MEDICAL CARE	THEME FIVE: PERSPECTIVES OF ADULT FEMALE RAPE SURVIVORS REGARDING MEDICO-LEGAL CARE	THEME SIX: PERSPECTIVES OF ADULT FEMALE RAPE SURVIVORS REGARDING PSYCHOSOCIAL SERVICES	THEME SEVEN: PERSPECTIVES OF ADULT FEMALE RAPE SURVIVORS REGARDING LEGAL SERVICES
SUB-THEME 1.1: HOME INVASION SUB-THEME 1.2: PRIOR HISTORY OF CHILD RAPE AND NEGLECT SUB-THEME 1.3: INCEST SUB-THEME 1.4: ACCESSING UNSAFE PUBLIC TRANSPORT SUB-THEME 1.5: BETRAYED BY TRUST (SURPRISE ATTACK)	SUB-THEME 3.1: PERSPECTIVES OF ADULT FEMALE RAPE SURVIVORS REGARDING VICTIM EMPOWERMENT PROGRAMMES Sub-theme 3.1.1: Not aware of victim empowerment programmes Sub-theme 3.1.2:	SUB-THEME 4.1: PERCEIVED QUALITY OF POST-RAPE MEDICAL CARE Sub-theme 4.1.1: Experiences regarding treatment for HIV and STIs (PEP and medication received) Sub-theme 4.1.2:	SUB-THEME 5.1: POSITIVE EXPERIENCES REGARDING THE MEDICO-LEGAL EXAM Sub-theme 5.1.1 Survivors were made to feel comfortable Sub-theme 5.1.2 Survivors were treated with respect and dignity Sub-theme 5.1.3:	SUB-THEME 6.1: POSITIVE EXPERIENCES IN ACCESSING COUNSELLING SERVICES Sub-theme 6.1.1: Positive bond formed with the service provider Sub-theme 6.1.2: Follow-up services Sub-theme 6.1.3: General perceptions towards the treatment	SUB-THEME 7.1: POSITIVE EXPERIENCES WITH LEGAL SERVICE PROVIDERS SUB-THEME 7.2: NEGATIVE EXPERIENCES WITH LEGAL SERVICE PROVIDERS Sub-theme 7.2.1: Lack of communication Sub-theme 7.2.2 Case being dismissed Sub-theme 7.2.3: Secondary victimisation Sub-theme 7.2.4:

SUB-THEME 1.6: INTIMATE PARTNER VIOLENCE	Positive opinions regarding victim empowerment programmes SUB-THEME 3.2: PERSPECTIVES OF ADULT FEMALE RAPE SURVIVORS REGARDING THE VICTIM IMPACT STATEMENT Sub-theme 3.2.1: Positive opinions pertaining to the victim impact statement Sub-theme 3.2.2: A desire to inform the court themselves about the impact of the rape Sub-theme 3.2.3: Negative opinions regarding the victim impact statement	Experiences in coping with the side effects of medication Sub-theme 4.1.3: General perception towards the treatment received by medical staff	Procedures were explained to the survivor SUB-THEME 5.2: NEGATIVE EXPERIENCES REGARDING THE MEDICO-LEGAL EXAM Sub-theme 5.2.1: Examination was painful (physically and mentally) Sub-theme 5.2.2: Traumatic experience Sub-theme 5.2.3: Invasive procedure SUB-THEME 5.3: RECOMMENDATIONS OF ADULT FEMALE RAPE SURVIVORS REGARDING MEDICO-LEGAL SERVICES RECEIVED	received by medical staff SUB-THEME 6.2: RECOMMENDATIONS BY ADULT FEMALE RAPE SURVIVORS REGARDING PSYCHOSOCIAL SERVICES Sub-theme 6.2.1 A need for healing Sub-theme 6.2.2: A need for more shelters Sub-theme 6.2.3 A desire for more counselling sessions Sub-theme 6.2.4: A need for financial assistance Sub-theme 6.2.5: A need for group counselling sessions	Lack of trust in the SAPS SUB-THEME 7.3: OPINIONS OF ADULT FEMALE RAPE SURVIVORS REGARDING COURT PREPARATION Sub-theme 7.3.1: No court preparation received Sub-theme 7.3.2 Court preparation in terms of seeing the rapist in court Sub-theme 7.3.3: Court preparation in terms of testifying in court Sub-theme 7.3.4 General perceptions toward court preparation SUB-THEME 7.4: RECOMMENDATIONS BY ADULT FEMALE RAPE SURVIVORS REGARDING LEGAL SERVICES Sub-theme 7.4.1 A need for DNA to be processed timeously Sub-theme 7.4.2: A need to be informed about the progress of their case

					Sub-theme 7.4.3: Treatment by the police

6.3. SUMMARY OF THE CHAPTER

In this chapter, the researcher analysed the data collected from rape survivors. An exposition of the qualitative data was given by identifying themes and sub-themes. Verbatim quotes were included to indicate the lived experiences of the rape survivors. The age distribution of the rape survivors was broadly distributed, with most being in their twenties. All the participants were African, with the majority being South African. Most of the survivors spoke Sepedi**,** while only a small number of survivors had post-matric training. Most survivors were single, with only a few staying with their children. More than half of the survivors resided in the township (*ekasi*). Notably, quite a significant number of survivors stayed in a house, with only a few residing in a *Mkhukhu*.

Circumstances surrounding the rape were mostly driven by a home invasion, prior history of child rape and abuse, incest, unsafe public transport, and intimate partner violence, and one survivor was raped while walking home with a stranger. Almost half of the survivors opted to report the crime of rape to access medical care. A small number of the survivors wanted psychosocial care, while less than half of the survivors wanted access to justice.

Regarding the satisfactory levels of post-rape services received at the respective Thuthuzela Care Centres, less than half of the survivors reported a negative experience when interacting with legal service providers in reporting the crime of rape. More than half of the survivors cited a positive experience when they interacted with legal service providers in reporting the crime of rape. A momentous number of the survivors had their rights explained to them when they reported the crime, whereas most of the survivors had a positive attitude toward Victim Empowerment Programmes. Of interest, most of the survivors indicated a willingness to partake in a victim impact statement. Remarkably, all the survivors had a positive experience regarding post-rape medical care, while a notable number of survivors had a positive experience during the medico-legal examination. A noteworthy number of the survivors conveyed that they had a positive experience accessing psychosocial services. Most survivors had no

court preparation, primarily due to their cases still being investigated, whereas more than half of the survivors had positive opinions concerning court preparation.

The next section of the thesis will focus on the empirical results regarding the quality of the services rendered to adult female rape survivors within the CJS.

CHAPTER SEVEN: EMPERICAL FINDINGS: PERSPECTIVES OF SERVICE PROVIDERS IN RENDERING POST-RAPE SERVICES

7.1. INTRODUCTION

The interchange between adult female survivors and service providers rendering post-rape services (medical, medico-legal, psychosocial, and legal) is indicative of the perceived quality of services received, which directly or indirectly affects a survivor's over-all level of functioning and road to recovery (Rockowitz, Flowe & Bradbury-Jones, 2021:2). This chapter highlights the challenges (infrastructure, human resources, and capacity); and achievements (innovation and advancements) as cited by service providers in rendering post-rape services to adult female rape survivors within the CJS. The research results are derived from the lived experiences of post-rape service providers in rendering services to adult female rape survivors at Thuthuzela Care Centres. For the purpose of this chapter, the researcher will discuss the empirical findings regarding the quality of post-rape services rendered by service providers in South Africa according to certain themes and sub-themes. A qualitative research approach was followed during the study, and therefore qualitative data analysis was applied according to an interview schedule. Braun and Clarke's thematic analysis was utilised to analyse the interviews conducted with the service providers. An audio recorder was used during the data collection process with field notes to further substantiate the findings. The audio-recorded information was transcribed, and applicable themes and sub-themes were identified according to the interview schedule. The discussion of the chapter provides an overview of the biographic and demographic profile of post-rape service providers, followed by a discussion of seven themes, namely: (1) determinants for adult female rape survivors to report the crime of rape, (2) risk factors contributory towards rape, (3) protective factors in providing assistance to adult female rape survivors, (4) perceptions of service providers in rendering medical services, (5) perceptions of service providers in rendering medico-legal services, (6) perceptions of service providers in rendering psychosocial services, and (7) the perceptions of service providers in rendering legal services.

7.2. DISCUSSION OF THE FINDINGS

In the next section, the researcher will outline the verbatim responses of the service providers. Interviews were conducted with 28 post-rape service providers. To protect the identity of the research participants and to ensure confidentiality, the researcher will refer to them as “Service Provider” when submitting their responses. In addition, where multiple similar professions were presented, the researcher further coded the responses with the professional status of the participant within the CJS (forensic nurse (a)). The interviews were conducted in English. Before the discussion of the themes and sub-themes, the researcher will first give an overview of the biographic and demographic profile of post-rape service providers within the CJS. This information emerged from the interview schedule.

7.2.1. BIOGRAPHIC AND DEMOGRAPHIC PROFILE OF SERVICE PROVIDERS

The following table outlines the biographic and demographic profile of the service providers rendering post-rape services at Thuthuzela Care Centres, which will be discussed in detail below.

Table 10: Biographic and demographic profile of service providers

SERVICE PROVIDER	GENDER	PROFESSIONAL STATUS WITHIN THE CRIMINAL JUSTICE SYSTEM	YEARS OF EXPERIENCE	THUTHUZELA CARE CENTRE AFFILIATION
PSYCHOSOCIAL				
1	Female	First responder (a)	3	RS 1
2	Female	Clinical psychologist	20	RS 1
3	Female	Site coordinator (a)	8	RS 1
4	Female	Social worker (a)	13	RS 1
5	Male	Victim assistant officer (a)	7	RS 1
6	Female	Site coordinator (b)	13	RS 2
7	Female	Auxiliary social worker (a)	11	RS 2
8	Female	Auxiliary social worker (b)	3	RS 2
9	Female	Auxiliary social worker (c)	2	RS 2
10	Female	Auxiliary social worker (d)	3	RS 2
11	Female	Auxiliary social worker (e)	5	RS 2
12	Female	Social worker (b)	6	RS 2

13	Female	Victim Assistant officer (b)	6	RS 2
14	Female	First responder (b)	3	RS 3
15	Female	Site coordinator (c)	12	RS 3
16	Male	Social worker (c)	3	RS 3
MEDICAL				
17	Female	Forensic nurse (a)	12	RS 1
18	Female	Forensic nurse (b)	19	RS 2
19	Female	Forensic nurse (c)	6	RS 3
20	Female	Forensic nurse (d)	1	RS 3
21	Female	Forensic nurse (e)	33	RS 3
22	Female	Forensic nurse (f)	37	RS 3
23	Male	Medical doctor (a)	12	RS 1
24	Female	Medical doctor (b)	20	RS 2
25	Male	Medical doctor (c)	20	RS 3
LEGAL				
26	Male	Case manager	13	RS 1

27	Female	Court preparation officer	14	RS 1
28	Male	Investigating officer	35	RS 2

- **GENDER**

The majority of the participants (n=22; 78.6%) were female (service providers 1-4, 6-15, 17-22, 24 and 27), followed by a small number of participants (n=6; 21.4%) being male service providers (5 [victim assistant officer(a)], 16 [social worker (c)], 23 [medical doctor (a)], 25 [medical doctor (c)], 26 [case manager] and 28 [investigating officer]). This is primarily due to most service providers rendering post-rape services within the CJS being female. This finding coincides with a qualitative study by Skhosana (2016) focusing on the perceptions of service providers (comprising 17 medical personnel and lay counsellors rendering post-rape services at one Clinical Forensic Medical Service Centre and two Thuthuzela Care Centres in Ekurhuleni Gauteng province) where the majority of service providers (82.3%) were also female (Skhosana, 2016:V).

- **PROFESSIONAL STATUS WITHIN THE CRIMINAL JUSTICE SYSTEM**

Three spheres of post-rape service providers are represented in this study, namely the psychosocial sphere, the medical sphere and the legal sphere. The medical sphere of participants comprised six (21.4%) forensic nurses (being the highest represented group within the cumulative sample) and three medical doctors (10.7%). Within the psychosocial domain of post- rape service rendering, most of the service providers were auxiliary social workers (n=5; 17.9%) (being the second highest represented group within the cumulative sample), ensued by social workers (n=3; 10.7%) and site coordinators (n=3; 10.7%) respectively. A relatively small number of first responders (n=2; 7.1%) and victim assistant officers (n=2; 7.1%) were included in the study, while one (3.6%) clinical psychologist contributed to the research. The legal field of post-rape service providers comprised of one (3.6%) court preparation officer, one (3.6%) case manager, and one investigating officer (3.6%).

- **YEARS OF EXPERIENCE**

The years of experience of service providers within the CJS varied. Participants with 1-4 years' experience (n=7; 25%) were service providers 1, 8-10, 14, 16 and 20; participants with 5-10 years (n=6; 21.4%) were service providers 3, 5, 11-13, and 19; participants with 10-15 years (n=8; 28.6%) comprised of service providers 4, 6-7, 15, 17, 23 and 26-27; participants with 15-20 years (n=4; 14.3%) were service providers 2,18 and 24-25); and participants with more than 20 years' experience (n=3; 10.7%) were service providers 21 [forensic nurse (e)], 22 forensic nurse (f) and 28 [investigating officer].

Considering the above exposition pertaining to the levels of experience of service providers rendering post-rape services to adult female rape survivors, the service providers are reasonably experienced, with the majority (28.6%) having 10-15 years of working experience within the CJS.

- **THUTHUZELA CARE CENTRE AFFILIATION**

Regarding the collective distribution of the participants in relation to their affiliation with the respective Thuthuzela Care Centres, most of the participants were recruited at RS 2 (n=11; 39.3%) being service providers (6-13 18, 24 and 28), ensued by RS 1 (n=9; 32.1%) which were service providers (1-5, 17, 23, 26-27) and RS 3 (n=8; 28.6%) comprising of service providers (14-16, 19-22 and 25). It is of interest to take note that within the domain of psychosocial service providers, the distribution of participants in relation to social workers and auxiliary social workers were widely distributed between the three research sites, with RS 2 having five auxiliary social workers and one social worker on a full-time basis provided by an NGO operating 24 hours, while RS 1 and 3 only had one social worker, with the social worker at RS 1 provided by the Department of Health (Wednesdays and Fridays), and the social worker at RS 3 provided by an NGO on a part-time basis (Mondays and Wednesdays). RS 1 and 2 are open on a 24/7 basis, while RS 3 is not operative after 18:00.

In the next section of the chapter, the researcher will discuss the emerging themes and sub-themes regarding the experiences of service providers in

rendering post-rape services within the CJS. The content of the table will highlight the main themes and sub-themes in rendering post-rape services to adult female rape survivors.

Table 11: Themes and subthemes in rendering post-rape services to adult female rape survivors

THEME ONE: DETERMINANTS FOR ADULT FEMALE RAPE SURVIVORS TO REPORT THE CRIME	THEME TWO: RISK FACTORS CONTRIBUTORY TOWARDS RAPE	THEME THREE: PROTECTIVE FACTORS IN PROVIDING ASSISTANCE TO ADULT FEMALE RAPE SURVIVORS	THEME FOUR: MEDICAL CARE AS PART OF SERVICE RENDERING TO ADULT FEMALE RAPE SURVIVORS	THEME FIVE: MEDICO-LEGAL ASPECTS OF SERVICE RENDERING TO ADULT FEMALE RAPE SURVIVORS	THEME SIX: PSYCHOSOCIAL SPHERE OF SERVICE RENDERING TO ADULT FEMALE RAPE SURVIVORS	THEME SEVEN: LEGAL ASPECTS OF SERVICE RENDERING TO ADULT FEMALE RAPE SURVIVORS
SUB-THEME 1.1: MAIN REASONS FOR REPORTING THE CRIME **Sub-theme 1.1.1:** To access medical and counselling services **Sub-theme 1.1.2:** To seek justice **Sub-theme 1.1.3:**	**SUB-THEME 2.1:** CIRCUMSTANCES ASSOCIATED WITH RAPE **Sub-theme 2.1.1:** Alcohol consumption and drug-facilitated rape **Sub-theme 2.1.2:** Crime of opportunity **Sub-theme 2.1.3:** Exposure to unsafe places **Sub-theme 2.1.4:**	**SUB-THEME 3.1:** VICTIM EMPOWERMENT PROGRAMMES **Sub-theme 3.1.1:** Positive opinions regarding victim empowerment programmes **SUB-THEME 3.2:** VICTIM IMPACT STATEMENT **Sub-theme 3.2.1:** Positive opinions regarding victim impact statement **Sub-theme 3.2.2:**	**SUB-THEME 4.1:** CHALLENGES IN RENDERING MEDICAL CARE TO ADULT FEMALE RAPE SURVIVORS **Sub-theme 4.1.1:** Default in follow-up visits **Sub-theme 4.1.2:** Designated facilities for the termination of pregnancy **Sub-theme 4.1.3:** Initial reluctance by the patient to undergo HIV screening **Sub-theme 4.1.4:**	**SUB-THEME 5.1:** CHALLENGES IN RENDERING MEDICO-LEGAL CARE TO ADULT FEMALE RAPE SURVIVORS **Sub-theme 5.1.1** Being examined by a male clinician **Sub-theme 5.1.2** Taking a bath prior to the medico-legal examination **Sub-theme 5.1.3:** Refusal to undergo medico-legal examination	**SUB-THEME 6.1:** CHALLENGES IN RENDERING COUNSELLING SERVICES TO ADULT FEMALE RAPE SURVIVORS **Sub-theme 6.1.1:** Accessing psychological services **Sub-theme 6.1.2:** Socioeconomic constraints in accessing counselling services **Sub-theme 6.1.3:** Age of the psychosocial service provider **Sub-theme 6.1.4:**	**SUB-THEME 7.1:** CHALLENGES IN RENDERING LEGAL SERVICES TO ADULT FEMALE RAPE SURVIVORS **Sub-theme 7.1.1:** Assistance for survivors in accessing legal services **Sub-theme 7.1.2**: Treatment by the police **Sub-theme 7.1.3:** A need for more sexual offences courts **Sub-theme 7.1.4:** Lost dockets

Protecting future potential victims **Sub-theme 1.1.4:** Extent of psychological trauma experienced **SUB-THEME 1.2:** PERSONAL CHALLENGES FOR ADULT FEMALE RAPE SURVIVORS IN REPORTING THE CRIME **Sub-theme 1.2.1:** Victim blaming, stigma and secondary victimisation **Sub-theme 1.2.2:** Lack of information in reporting the crime of rape	Poverty and unemployment **Sub-theme 2.1.5:** Accessing unsafe public and private transport **Sub-theme 2.1.6:** Financial dependence **Sub-theme 2.1.7:** Rape as a perceived crime of power	Negative opinion regarding victim impact statement	Shortage of medical staff **Sub-theme 4.1.5:** Refusal or failure to take PEP treatment **Sub-theme 4.1.6:** Unwillingness to be examined by a male clinician **SUB-THEME 4.2:** MANAGEMENT OF THE MEDUIM-TO-LONG TERM MEDICAL EFFECTS OF RAPE **Sub-theme 4.2.1:** Secrecy regarding HIV-seropositive status **Sub-theme 4.2.2:** Side-effects of medication **Sub-theme 4.2.3:** Referral for specialist post-rape care **Sub-theme 4.2.4:** Clinical and psychosocial monitoring	**Sub-theme 5.1.4:** Shortage of female clinicians in the field of medico-legal **Sub-theme 5.1.5:** Admissible evidence **SUB-THEME 5.2:** CHALLENGES IN IMPLEMENTING PROTOCOLS AND PROCESSES IN RENDERING MEDICO-LEGAL SERVICES TO ADULT FEMALE RAPE SURVIVORS **Sub-theme 5.2.1:** Reluctance to undergo medico-legal examination due to the presence of *muti* **Sub-theme 5.2.2:** Absence of rape kits **Sub-theme 5.2.3:** Facilitation of transport between facilities **Sub-theme 5.2.4:**	Postponement in accessing counselling services **Sub-theme 6.1.5:** Establishing rapport **Sub-theme 6.1.6:** Secondary victimisation by service providers in the CJS **Sub-theme 6.1.7:** Shortage of social workers **Sub-theme 6.1.8:** Language as a barrier within counselling services **Sub-theme 6.1.9:** Transportation between facilities **Sub-theme 6.1.10:** Male social worker **SUB-THEME 6.2:** CHALLENGES IN IMPLEMENTING THE PROTOCOLS AND PROCESSES PERTAINING TO	**Sub-theme 7.1.5:** Communication pertaining to case progression **Sub-theme 7.1.6:** Delay in DNA results **Sub-theme 7.1.7:** Police burnout **Sub-theme 7.1.8:** Postponement of cases **Sub-theme 7.1.9:** Quality of completed J88 medical **Sub-theme 7.1.10:** Quality and readiness of the survivor to give a statement **Sub-theme 7.1.11:** The role of infrastructure in the investigation of cases **Sub-theme 7.1.12:** Provision of false information by the victim

Sub-theme 1.2.3: Reluctance to report if the alleged rapist is known to the victim **Sub-theme 1.2.4:** Victim is concerned that she will not be believed **Sub-theme 1.2.5:** Fear of being rejected by significant others **Sub-theme 1.2.6:** Fear of retaliation by the alleged rapist **Sub-theme 1.2.7:** Access to facilities rendering post-rape services			of the patient for 6 months SUB-THEME 4.3: CHALLENGES IN IMPLEMENTING THE PROTOCOLS AND PROCESSES IN RENDERING MEDICAL SERVICES TO ADULT FEMALE RAPE SURVIVORS **Sub-theme 4.3.1:** Patient comprehension with regards to medication and adherence to follow-up appointments **SUB-THEME 4.4:** TECHNOLOGICAL AND MEDICAL ADVANCEMENTS AND PRACTICES PERTAINING TO MEDICAL POST-RAPE CARE FOR ADULT FEMALE RAPE SURVIVORS **Sub-theme 4.4.1** Improvement of PEP regimen	The newly revised J88 as a challenege **SUB-THEME 5.3:** PERCEIVED TECHNOLOGICAL ADVANCEMENTS AND PRACTICES PERTAINING TO MEDICO-LEGAL CARE FOR ADULT FEMALE RAPE SURVIVORS **Sub-theme 5.3.1:** Improvement of the J88 medical form **Sub-theme 5.3.2:** A need for more specialised sexual offences courts **Sub-theme 5.3.3:** Efficiency of the colposcope in detecting injuries	COUNSELLING SERVICES FOR ADULT FEMALE RAPE SURVIVORS **Sub-theme 6.2.1** Confidentiality **Sub-theme 6.2.2:** Distribution of human resources **Sub-theme 6.2.3** Preferred demographics in accessing counselling services **Sub-theme 6.2.4:** Adjustment of Thuthuzela Care Centre Care Model to cater for the survivor **Sub-theme 6.2.5:** Engagement with service providers **Sub-theme 6.2.6:** Telephonic counselling **Sub-theme 6.2.7:**	**Sub-theme 7.1.13:** Allocation of more staff **SUB-THEME 7.2:** CHALLENGES WITHIN THE IMPLEMENTATION OF LEGISLATION IN RENDERING LEGAL SERVICES TO ADULT FEMALE RAPE SURVIVORS **Sub-theme 7.2.1:** General opinions regarding the implementation of legislation **Sub-theme 7.2.2:** Role of the case manager in court preparation of service providers **SUB-THEME 7.3:** ADVANCEMENTS AND PRACTICES REGARDING LEGAL SERVICES FOR ADULT FEMALE RAPE SURVIVORS **Sub-theme 7.3.1:**

Sub-theme 1.2.8: Fear of the survivor being discriminated against by the community **SUB-THEME 1.3** MEASURES TO INFORM ADULT FEMALE RAPE SURVIVORS ABOUT THEIR RIGHTS WITHIN THE CRIMINAL JUSTICE SYSTEM **Sub-theme 1.3.1:** Inform victims during counselling sessions **Sub-theme 1.3.2:** Guided by the Victims' Charter			**SUB-THEME 4.5:** RECOMMEDNATIONS IN RENDERING MEDICAL SERVICES TO ADULT FEMALE RAPE SURVIVORS **Sub-theme 4.5.1** Improvement of staff allocation **Sub-theme 4.5.2:** Financial support for patients accessing medical post-rape services		Vicarious trauma **Sub-theme 6.2.9:** Employment obligations of rape survivors as a barrier in accessing post-rape counselling services **SUB-THEME 6.3:** ADVANCEMENTS AND PRACTICES REGARDING COUNSELLING SERVICES FOR ADULT FEMALE RAPE SURVIVORS **Sub-theme 6.3.1:** Continuous training **Sub-theme 6.3.2:** Telephonic counselling **Sub-theme 6.3.3:** Continuous engagement among service providers **Sub-theme 6.3.4:** Support systems to helpers **Sub-theme 6.3.5:**	Centre-needs-approach in rendering post-rape services **Sub-theme 7.3.2:** Testifying in camera at sexual offences courts **SUB-THEME 7.4:** PERSPECTIVES IN WORKING IN A MULTIDISCIPLINARY TEAM IN RENDERING LEGAL SERVICES TO ADULT FEMALE RAPE SURVIVORS **Sub-theme 7.4.1:** Opinions regarding a positive working relationship within a multidisciplinary team **Sub-theme 7.4.2:** Challenges in working in a multidisciplinary team **SUB-THEME 7.5:** PERSPECTIVE IN RENDERING COURT PREPARATION SERVICES TO ADULT FEMALE RAPE SURVIVORS

Sub-theme 1.3.3: General measures of informing the victims of their rights **Sub-theme 1.3.4:** Public awareness campaigns					Buddy system in rendering post-rape counselling services **Sub-theme 6.3.6:** Tracing correct information of the survivor **Sub-theme 6.3.7:** Pre-and-post HIV counselling by first responders **SUB-THEME 6.4:** RECOMMENDATIONS IN RENDERING COUNSELLING SERVICES TO ADULT FEMALE RAPE SURVIVORS **Sub-theme 6.4.1:** A need for more campaigns **Sub-theme 6.4.2:** A need for accessibility in post-rape counselling services **Sub-theme 6.4.3:** A need to provide rape survivors with financial	**Sub-theme 7.5.1:** Opinions regarding court preparation **Sub-theme 7.5.2:** Challenges regarding court preparation **SUB-THEME 7.6:** RECOMMENDATIONS IN RENDERING LEGAL SERVICES TO ADULT FEMALE RAPE SURVIVORS **Sub-theme 7.6.1:** Attitude of legal service providers in rendering post-rape services **Sub-theme 7.6.2:** Monitoring of legal services **Sub-theme 7.6.3:** Prioritising court preparation for survivors **Sub-theme 7.6.4:** Court preparation of service providers **Sub-theme 7.6.5:**

					assistance to access services **Sub-theme 6.4.4:** A need for group therapy **Sub-theme 6.4.5:** A need for more psychosocial service providers **Sub-theme 6.4.6:** Assistance with transportation for outreach initiatives for service providers Sub-theme 6.4.7: A need for continuous training in rendering post-rape counselling services **Sub-theme 6.4.8:** Assistance with comfort packs **Sub-theme 6.4.9:** Training of the police **Sub-theme 6.4.10:** A need for protocols in rendering counselling	Training of police officials **Sub-theme 7.6.6:** Safety of service providers in providing evidence in court **Sub-theme 7.6.7:** Resources in terms of legal services **Sub-theme 7.6.8:** A need for more sexual offences courts **Sub-theme 7.6.9:** A need for stakeholder engagement **Sub-theme 7.6.10:** A need for continuous debriefing of service providers **Sub-theme 7.6.11:** A need for a designated police official at Thuthuzela Care Centres

					services to be revisited	

7.2.2. THEMES AND SUB-THEMES: EXPERIENCES OF SERVICE PROVIDERS IN RENDERING SERVICES TO ADULT FEMALE RAPE SURVIVORS

The researcher asked questions regarding service providers' experiences in rendering medical, medico-legal, psychosocial, and legal services to adult female rape survivors within the CJS.

THEME 1: DETERMINANTS FOR ADULT FEMALE RAPE SURVIVORS TO REPORT THE CRIME

Numerous reasons may prompt a rape survivor to report the crime to the relevant authorities. Service providers were probed regarding their understanding as to why adult female rape survivors reported the crime.

SUB-THEME 1.1: MAIN REASONS FOR REPORTING THE CRIME

Emanating from the responses of the service providers, the researcher identified the following sub-themes as reasons for reporting the crime.

Sub-theme 1.1.1: To access medical and counselling services

Service providers 3-5, 7-9, 11-14, 16-17, 19-25 and 27 (n=20; 71.4%) indicated that adult female rape survivors reported the crime to access medical and counselling services.

> Site coordinator (a): *For medical reasons, since they want to be "cleaned", a perception that they have by taking PEP.*
>
> Social worker (a): *They come for medical care and counselling services.*
>
> Victim assistant officer (a): *They need assistance. They need counselling.*
>
> Auxiliary social worker (a): *According to my experience, when I contain them, I can see the pain that they are feeling after someone forced himself on her. You can see they are crying, traumatised, sad, you can*

see emotionally, this person needs help. That is why they come here for help. They want to heal also inside.

Auxiliary social worker (b): *Many are suffering because of depression, loneliness, and then like… low self-confidence because of what=happened to them. Many decide to come and open a case because they want to be safe and get counselling.*

Auxiliary social worker (c): *Secondly, it is for healing.*

Auxiliary social worker (e): *Secondly, to get medical attention. For some of them, it is for counselling. Some will say that they do not want to open a case, they just want counselling.*

Social worker (b): *In most instances, they need medical treatment and medication. They need medication to prevent those STI's and HIV. Some of them need psychosocial services for them to be able to heal.*

Victim Assistant officer (b): *They come to seek medical assistance as soon as possible. Some of them, they come because they have been raped and they are afraid of contracting HIV.*

First responder (b): *I think some of them already they are pregnant. They need counselling in order to cope with what had happened to them.*

Social worker (c): *Yoh, in most instances, they just want the medication, PEP, and move on with their life, and sometimes don't want to speak to a social worker. Some of these cases, are long-time cases, and they did not initially get counselling. Now they come back because they are struggling with psychosocial symptoms because of the rape. Sometimes, they were still young when the rape happened, but now they are old enough to seek help on their own. Now they start understanding why they are going through all these symptoms of trauma. Now they want to open a case, and then they go for it.*

Forensic nurse (a): *They report it because they want access to medication such as PEP.*

Forensic nurse (c): *Most of the time they don't know about forensics, they go the police station. Some are walk-ins, they don't want to open a case. They are here for the medication. They know that if they were raped, they must go to the clinic.*

Forensic nurse (d): *They want to be examined and the specimens to be collected. They need the social worker for counselling.*

Forensic nurse (e): *It is usually for counselling for treatment. Some of them don't want counselling, and we explain to them the importance of counselling. Some are not ready at that moment, and we would always advise them to come back any moment that they feel that they are ready for counselling. Some do come back, we also have a psychologist and a psychiatrist at the hospital, so we do a referral if we see the need.*

Forensic nurse (f): *I think it is for them to get back their self-esteem. Secondly, for them to get medication.*

Medical doctor (a): *Most of them are seeking treatment. Treatment encompasses your counselling. Treatment is the primary one.*

Medical doctor (b): *They are very worried about the outcomes such as HIV infection and pregnancy.*

Medical doctor (c): *Because there are now more reliable services to report it. It is not like the older days where there were no services to report the crime of rape. They are becoming more aware of the services through campaigns and community members.*

Court preparation officer: *The fact that we have HIV also, and STI's taking place during unconsented sex and unprotected sex, they opt to go to the hospital to get treatment, to protect themselves and their partner.*

In light of the strongest responses of the service providers regarding the initial medical treatment, the initiation of PEP is time-sensitive, with the first dose of drugs required to be administered within 72 hours (3 days) after the rape occurred. Unfortunately, PEP is sometimes the last step in the treatment chain. If a rape survivor was unable to consent to PEP, a three-day starter pack of PEP is offered, and the patient is asked to return for testing and an additional course of PEP for 28 days (if eligible) (NACOSA, 2018:16). The treatment of STIs, inclusive of gonorrhoea, chlamydia, hepatitis B and HIV, necessitates a central component within the management of survivors of rape. STIs can be prevented by administering bacterial and viral prophylaxis, followed by sexual health screening two weeks later if the rape survivor is symptomatic. The choice of treatment is vastly dependable on local incidence and prevalence of infections; and resistance to antibiotics (Cybulska, 2013:142). Additionally, emergency contraception should be provided to rape survivors presenting within five days or sooner after the incident at a healthcare facility (WHO, 2013:5).

According to the responses of the participants, this finding coincides with an earlier outcome in which the adult female rape survivors seek medical and psychosocial assistance on a microsystem within the domain of the ecosystem's theory (*Cf discussion in sub-theme 2.1.2: Access to counselling services in chapter 6*).

Sub-theme 1.1.2: To seek justice

Service providers 4,10-11, 13, 15, 20-21 and 26 (n=8; 28.6%) indicated a desire to seek justice is an important reason for adult female rape survivors to report the crime. They conveyed the following:

> Site coordinator (a): *There are many reasons. Firstly, they want justice to prevail. For closure, in knowing that they had reported the incident and that justice would do good.*
>
> Auxiliary social worker (d): *Most of the time, they need these perpetrators to be arrested.*

Auxiliary social worker (e): *Firstly, for most of them is to open a criminal case.*

Victim Assistant officer (b): *And some of them, they come because they want the perpetrators to account to what they have done to them.*

Site coordinator (c): *Mostly because they are worried that what had happened to them, might happen again. For some, they want justice. They just want to make sure that something happens to that person. Some people, they report by default, because they know that they have to go to the police, but they are not sure if they want to go through the court proceedings. But once they come to us, we explain to them why it is better to report.*

Forensic nurse (d): *They need help. They want the perpetrator to be arrested.*

Forensic nurse (e): *Some are opening cases.*

Case manager: *To get justice. Something illegal happened to the victim, so they want somebody to assist them. That will include everybody in the criminal justice system. For instance, they will go to our Thuthuzela Care Centres for medical purposes, then we will introduce them to the police, we will interview them. So, their reason for reporting basically surrounds justice. To get justice for what had happened to them.*

Emanating from the responses of the service providers, the option to seek justice coincides with an earlier finding in the thesis (chapter 6), in which the adult female survivors shared that their decision to access legal services on a macrosystem was influenced by their interaction with legal service providers (case manager and investigating officer) (*Cf discussion in sub-theme 2.1.3: Access to justice in chapter 6*).

Sub-theme 1.1.3: Protecting future potential victims

Service providers 1, 9-10 and 13 (n=4; 14.3%) were of the impression that adult female rape survivors opted to report the crime in order to protect potential victims from victimisation. They cited the following:

> First responder (a): *I think they report because they need a way to deal with it. You know, some of them are afraid that it will also happen to your children again. So, if they don't get help, they will sit with anger because they did not deal with the pain.*
>
> Auxiliary social worker (c): *Firstly, it is for awareness, yes. They feel that if they don't report it to and make the police aware of it, it will continue.*
>
> Auxiliary social worker (d): *They are afraid that if they don't report it, this thing might happen again.*
>
> Victim Assistant officer (b): *And some of them, they have kids, they are scared that if the person is not arrested, they might do it to kids.*

With reference to the responses shared by the service providers, survivors of rape envision that by reporting the crime, they are hopeful that the rapist will be caught and other potential victims will be protected from suffering the same ordeal they had been subjected to (Vetten, 2014a:3). (*Cf discussion in sub-theme 2.1.3: Access to justice in chapter 6*).

Sub-theme 1.1.4: Extent of psychological trauma experienced

Service providers 2, 17 and 24 (n=3; 10.7%) shared that the nature and extent of the trauma suffered by the survivor is a reason for accessing psychosocial services.

> Clinical psychologist: *Often, what we find is that once they are admitted to the hospital, it is through attempted suicide because of the trauma. But when it comes to reporting, they come through to us either through trauma, depression, or attempted suicide.*

> Forensic nurse (a): *The challenge would be mentally coping with the case, because now we find them saying that they feel like they want to kill themselves, suicidal idealisations. Also, after terminating pregnancy from the offender, it becomes a psychological challenge for them. Some would also say, ever since I have been raped, my husband never touches me, there is no intimacy anymore.*
>
> Medical doctor (b): *I think mostly because they are traumatised from the act itself. But mostly, they report it because of the trauma. You can clearly see the trauma when they come in.*

The responses of the service providers above show that a rape survivor's ability (capacity) to seek help (on a microsystem within the ecosystem) surfacing from the effects of the trauma they had suffered is closely linked with a similar finding shared by the survivors (*Cf discussion* in *sub-theme 2.1.3 in chapter 6*). In light of the aftermath of rape, the circumstances of the survivor are dependable on their response to the incident; and do not occur in a vacuum. Firstly, the survivor's personality and background can affect her reaction to trauma (i.e., the victim's predisposition to therapeutic intervention). Secondly, the survivor may further suffer a traumatic event within a cultural context or personal relationships that may not be supportive. Regarding interpersonal relationships, an intimate partner might withdraw emotionally or abandon their partner, the rape survivor.

SUB-THEME 1.2: PERSONAL CHALLENGES FOR ADULT FEMALE RAPE SURVIVORS IN REPORTING THE CRIME

The researcher probed the service providers regarding their perceptions of the challenges rape survivors may face when reporting the crime.

Sub-theme 1.2.1: Victim blaming, stigma and secondary victimisation

Service providers 1, 3, 6, 12, 18, 22 and 24-25 (n=8; 28.6%) were of the impression that victim blaming had a significant influence in reporting the crime. They shared the following:

> First responder (a): *Sometimes, they are afraid that we may judge them. If they go to the police station, they will ask them questions like*

where were you and stuff, so they don't report because of those reasons. Some of them don't know about the services that we have here at the Thuthuzela Care Centres. Thuthuzela Centres is a place of safety for everyone, but still, they are afraid that we will judge them.

Site coordinator (a): *Even though we expect them to report, I think the system itself has got a lot of loopholes. The first thing is judgement, or secondary victimisation, because most of the time, there exists a misconception whereby the victim is blamed with remarks such as: What were you doing there; or what were you wearing? The aforesaid are the comments that come very often come through when talking to adult female rape survivors.*

Site coordinator (b): *In the past they used to have a lot of challenges, but since the Thuthuzela Care Centres were established, the rate for them to report the crime has also increased significantly. The biggest challenge that they have is stigma. They would tell someone they trust about what happened, but at the end of the day, that same person tells others, and they just feel unsafe. So, the main challenge is the manner in which the community react to the rape.*

Social worker (b): *But what I have also realised is that some of them do not want to continue because the way in which their cases are handled by our colleagues. Let me rather say that some of the SAPS members, they are too judgmental, and recently I had to step and say that this is not going to happen. The officer said that the case is not strong, and it will stand in court, why are you reporting? Maybe it is your boyfriend? Now, such comments, it breaks the rape survivors' spirit and heart, and they do not wish to continue with the case since they see it as useless; and will not help them with anything. So, they become reluctant and do not report the case.*

Forensic nurse (b): *Stigma. Maybe also the perpetrator threatened the victim not to tell anyone. Maybe they also promised them that they can kill them if they tell others. Maybe if they stay with their parents, they*

are scared that the parents will shout at them and judge them. Maybe they are also scared to go to the police station, there you know is no confidentiality, they just talk in front of other people like: Were you raped? It is going back to the stigma.

Forensic nurse (f): *Firstly, it is their encounter with the police officers. Maybe discrimination. Maybe they are afraid of secondary victimisation.*

Medical doctor (b): *Most of the time, they report because they were grabbed somewhere. It is the ones who delay that becomes a problem. They delay because they think they won't be believed, especially if the alleged rapist was known to them. The problem is also when they get to the police, especially ones who might have been at a party, so the judgement starts there. They are scared. Most will say they went to the police, but the police told them to come back tomorrow, or the police will ask them: What were you doing there? It seems to be getting better, though. We encourage them to come here first before going to the police. Then we call the police ourselves.*

Medical doctor (c): *Lack of support from the family and community members. It's a multi-faceted problem. Most of the women always feel that they are guilty of the crime of rape. They have the impression that they are at fault. Victim blaming. There is also victim resistance to reporting such things. People don't want it to be made public. For most of them, it will happen, and they will just sweep it under the carpet. The resistance to reporting is directly related to stigma.*

In light of the contributions made by the service providers, it is evident that after the crime of rape, survivors may experience feelings of shame, guilt, humiliation, and embarrassment (Vetten, 2014a:3). Victim blaming is believed to be widespread in society. Unfortunately, this culture of shame overpowers the rape survivor within the CJS, further silencing the torment they had suffered (Access to Justice for the Victims of Sexual Violence, 2017; Equality Now, s.a.; UNWomen, 2021:2-4). Conforming to specific gender roles and attitudes in

relation to traditional gender role stereotyping plays a significant role in the construction of ascriptions about rape victims. Individuals who portray more traditional gender role attitudes are determined to project higher levels of victim blame, in line with the perception that women who deviate marginally from what is perceived as the traditional female role are consequently more responsible to a certain extent for their victimisation (Grubb & Turner, 2012:449-450).

Sub-theme 1.2.2: Lack of information in reporting the crime of rape

Service providers 1, 7, 9 and 23 (n=4; 14.3%) cited that a lack of readily available information in reporting the crime of rape is of importance. They expressed the following:

> First responder (a): *It is information. Most of them, they are not informative. They don't know where to go.*
>
> Auxiliary social worker (a): *Some people, they don't know about Thuthuzela Care Centres because we do awareness before COVID-19, we go into the communities, we introduce ourselves, we tell them about the Thuthuzela Care Centres, how it works, we give them pamphlets. Other people, they just come for help, even after fifteen years, she just came, boom, like a few hours ago. When she comes here to seek help, you can see that it is real for her. Sometimes they know the person, sometimes they threaten them. Others just want to let it go and not think about it.*
>
> Auxiliary social worker (c): *So far, the challenge they have is that they don't know where to go. They are also not sure if they want to report this or what? So, they really don't know about the services being delivered here at the Thuthuzela Care Centres.*
>
> Medical doctor (a): *The challenge is a lack of knowledge. Some of them don't know that such crisis centres exist. They just come to the hospital to seek treatment. I have been raped. What can be done? During that limbo, they don't know whom to contact, and when it is the right time to go to the hospital.*

In light of the contributions by the service providers, information about services should be easily available to survivors accessing services. Service providers should inform adult female rape survivors about the services available to them, preferably in the local language (Know- your- rights- TCC, s.a.: 14; Molina & Poppleton, 2020:23). Service providers were also of the opinion that rape survivors should also be informed of who the service providers are, where to access post-rape services, and highlighted the notion of confidentiality when accessing post-rape services (Comparing Sexual Assault Interventions across Europe, 2013:16; Kanan, 2018:10). Information on post-rape service is crucial in making the general public aware of who the service providers are, and where to access services within a certain timeframe.

Sub-theme 1.2.3: Reluctance to report if the alleged rapist is known to the victim

Service providers 1 and 13 (n=2; 7.1%) indicated that survivors were reluctant to report the crime if the alleged perpetrator(s) were known to them. They shared the following:

> First responder (a): *Sometimes, it depends on who is the perpetrator. If the perpetrator was a family member, it is not easy for them to report. Remember, for some of them that person is a breadwinner, uhm… you know the family issues. So, reporting a family member, becomes a difficult thing.*
>
> Victim Assistant officer (b): *Especially when they were raped by the people that they know, if maybe the perpetrator is known to the victim.*

The responses of the service providers above show that survivors are reluctant to report the crime if the rapist was known to them or may either withdraw a case prior to the arrest of the alleged rapist (Machisa et al., 2017:18).

Sub-theme 1.2.4: The victim is concerned that she will not be believed

Service providers 2-5, 8,10-11, and 13-14 (n=9; 32.1%) expressed concerns that victims may not report the crime as they fear not being believed by either the service provider or the community at large. They cited the following:

Clinical psychologist: *They don't report immediately after the incident occurred, because of the fear; and have a perception that it doesn't matter since these cases are not taken seriously. There won't be convictions and all of that. And if they don't have evidence, it's basically my word against his. They sit with the pain and trauma instead of going directly to report it. It becomes a challenge for them when they decide later to report, because there is no longer evidence that they can produce, and even those that have evidence, these cases take forever to be attended to. The victim is the one going and asking what is happening. The perpetrator is still out there…. In the end, it becomes so frustrating for them that they opt to just leave the case, and it just ends nowhere.*

Site coordinator (a): *Most of the time, as service providers, we tend not to believe their stories. Simply, the fear of not being believed becomes a challenge for them.*

Social worker (a): *Maybe when the rape survivor goes to the police station, they don't receive enough services. Maybe because of fear of the other community members that they will discriminate against them.*

Victim assistant officer (a): *I think the stigma is the fear that they have of not being believed.*

Auxiliary social worker (b): *Firstly, when they come, they think that we are not going to believe them since rape also occurs between partners in a relationship. Sometimes, it will depend on the person who is assisting them when they come to report the rape.*

Auxiliary social worker (d): *Not being believed.*

Auxiliary social worker (e): *Stigma from the communities and the family, especially if the perpetrator is known to the family. They think that they are being labelled. Some people will go to the extent of telling the rape survivor that they asked for it. Some will ask: Why did you go there? Such things. The other thing will be the police officers,*

regarding the treatment that they get at the police stations. The rape survivors are asked so many questions that make them feel uncomfortable, especially when the victim is interviewed by a male police officer. Most rape survivors prefer to be interviewed by a female police officer.

Victim Assistant officer (b): *Uhm..., other challenges that they have raised is how people will see them. They think that people will judge, people will know and not belief them, and people will think that they are cruel for having the perpetrators arrested. And then sometimes you find that the perpetrator is a friend to the victim, and people will think that she, as a victim, was also interested. Maybe she has something against the perpetrator. Now she is opening a case. Maybe she is having a relationship with the perpetrator, and she found out the perpetrator was also having a relationship with somebody else, and now she is opening a case. These are the issues that have been raised.*

First responder (b): *They are judged, and sometimes they are not believed if they say that they were raped. Because for some people they might think that you wanted it. You know that when it comes to rape cases, you ask why you didn't report on time. They will tell you that it is night, and they are scared that people will ask them what you were expecting going to a tavern alone. It's when they realise the consequences when they are alone.*

In light of the responses of the service providers, survivors may opt not to report the crime of rape out of fear of not being believed or being accused of lying in relation to the crime of rape (Vetten, 2014a:3).

Sub-theme 1.2.5: Fear of being rejected by significant others

Service providers 4 and 26-27 (n=3; 10.7%) shared that fear of being rejected influenced a survivor's perception of reporting the crime. They highlighted the following:

Social worker (a): *Other women are married, maybe she was raped by someone somewhere, and they are scared to tell their husband or partner. Maybe their partner will reject them, or their relationship will no longer work.*

Case manager: *Some of the victims are married, and now that they have to disclose to their partner that they were raped, it's a challenge. Some of the victims have got chronic illnesses, and they never want to disclose them. Now, if they have to disclose the rape, they might also have to disclose their illness. Some of the rape victims actually depend on the rapist financially, and otherwise, they think that if I report this guy, I will be losing my source of income and a father to my children. They are under the pressure of the families in our African culture. I don't know of other cultures. But marriage is considered sacred. So, it is a bigger impact on her.*

Court preparation officer: *Sometimes, it is fear when a person has got a partner, fear that their partner will leave them if they found out they were raped. They fear not being trusted by their partner.*

Considering the assertions made by the service providers, a survivor might be subjected to a traumatic event within a cultural context or personal relationships that may or may not be supportive (in certain cultures, the rape of a woman can be perceived as an attempt to dishonour to the survivors' family, even if the incident occurred beyond her control).

Sub-theme 1.2.6: Fear of retaliation by the alleged rapist

Service providers 5, 12, 22 and 27-28 (n=5; 17.9%) indicated that fear of retaliation from the alleged accused could hinder the survivor from reporting the crime. They expressed the following:

Victim assistant officer (a): *Others are scared. They think maybe the suspect is out there watching them as well. Others might think that after reporting, the perpetrator can come after them again.*

Social worker (b): *The main challenge is that some are scared for their lives. You find that some of them are abused and raped by people that they know from the same facility. So, they are scared that if they report the case, their lives will be in danger.*

Forensic nurse (f): *Secondly, is for them to be afraid of their rapist.*

Court preparation officer: *Fear of being killed by the accused.*

Investigating officer: *Uhm…, not all of them do report because of being afraid of the perpetrator or the suspect.*

Given the opinions shared by the service providers, survivors may not report the crime of rape due to fear of retaliation or intimidation by the alleged rapist, especially when shared with a lack of confidence that reporting the crime might lead to a possible conviction (Vetten, 2014a:3).

Sub-theme 1.2.7: Access to facilities rendering post-rape services

Service providers 5 and 21 (n=2; 7.1%) opined that access to facilities and the services provided to survivors could be a challenge. They opined:

Victim assistant officer (a): *So far, it is clients who don't show up for their follow-ups. Remember, we have several sessions with the clients, but some, they don't show up on those dates. Some of the reasons for not showing up may be related to finances, some have relocated to another area, or others opt to go to other Thuthuzela Care Centres closer to them. Others are just not interested anymore; they want to move on with their lives.*

Forensic nurse (e): *It's our institution. It's just the waiting period at the police station. They report then they are sent home. We are open from 08:00 to 18:00 every day, not 24 hours. We are a Thuthuzela Care Centre, but we don't have staff. We are only open till 18:00. Some will go to another Thuthuzela Care Centre, such as Baragwanath Nthabiseng Thuthuzela Care Centre. We lose patients when the police say that the Family Violence, Child Protection and Sexual Offences*

> *are not available, and they go home. Some come to post 72 hours, and we cannot give them PEP, that's the problem with the police. Here, we have a social worker on an alternate day, which is a problem for us. Sometimes we get a patient on that day, and the social worker is not here. We can do the basics, but it needs a skilled person. Now with COVID-19, the NPA also work alternate weeks, so sometimes we don't have them. Sometimes you get a suicidal patient. What do you do? The medical staff is always on duty, so there is not a problem in examining the patients.*

Regarding the assertions made by the service providers, survivors encounter challenges in accessing the police or social workers (Vetten, 2014a:3).

Sub-theme 1.2.8: Fear of the survivor being discriminated against by the community

Service provider 28 raised concern over fear of discrimination by the community. He shared:

> *When it comes to adults, there are a few elements that we have actually identified, such as fear of discrimination and discrimination in general by the community. They fear how the community is going to look at me and how I am going to be treated.*

The viewpoint of service provider 28 shows that survivors of rape delay or are reluctant to report the rape due to the stigma attached (being perceived as 'damaged') (Vetten, 2014a:3). At the *macrosystem level*, the outcome of the greater communal cultural effects is substantial, since it explores the impact of "rape prone" communities on the adult female rape survivor (Wadsworth et al., 2018:42-43). Associated with the *macrosystem* are stereotypical belief systems of patriarchy and machoism. In an attempt for service providers to render services to adult female rape survivors, they first need to comprehend the survivor's experiences within the CJS (Wadsworth et al., 2018:38). Communal intrusion and pressure not to report the crime of rape also play a role when a victim decides to report the incident (Access to Justice for the Victims of Sexual Violence, 2017).

Rape survivors are constantly subjected to numerous barriers in reporting the crime of rape, such as uncertainty, access to facilities and knowledge pertaining to the correct procedures to follow when they chose to report the crime of rape. The need to access medical and counselling services seems to be of significant importance, although the service providers in this study also indicated a desire for justice to prevail. Individual factors are also influenced by communal attributes in reporting the crime of rape (shame, fear of being blamed, discrimination, or not being believed). On a positive note, service providers also shared a need by rape survivors to protect themselves and others by reporting the crime of rape.

SUB-THEME 1.3: MEASURES TO INFORM ADULT FEMALE RAPE SURVIVORS ABOUT THEIR RIGHTS WITHIN THE CRIMINAL JUSTICE SYSTEM

The researcher probed the service providers relating to the way they explicated victims' rights within the CJS to the adult female rape survivor. Emanating from their responses, the researcher documented various initiatives.

Sub-theme 1.3.1: Inform victims during counselling sessions

Service providers 2, 5 and 8 (n=3; 10.7%) indicated that they inform survivors of their rights during counselling. They cited the following:

> Clinical psychologist: *So, what normally happens when they come for therapy? We often ask them if they had reported the case. You know. And if they are aware that they can report the case if they want to. Most often you find that they are very reluctant to report, but we do inform them from our side to report the case. I also don't think that there is a lot of information out there to make them aware of their rights, you can take control back of your life and make sure that this person is attended to. This person goes to jail. Uhm…, so, you find it becomes difficult for them since there is no readily accessible information, which implies that they only get it when they come here. They are aware that they can go to the police station when this happens, but still, there exists a fear that they won't be taken seriously. So, is there information that we give them? Are there pamphlets we give them? No.*

Victim assistant officer (a): *Whenever they come for follow-ups, even on the first day of entry, I usually inform them of their rights as victims of crime. We inform them about their rights and responsibilities within the criminal justice system.*

Auxiliary social worker (b): *Firstly, when we do containment with them, we tell them that at the Thuthuzela Care Centre, we are here to give them counselling. It is their right to open a case. We don't force a person to open a case, we give them that option.*

Sub-theme 1.3.2: Guided by the Victims' Charter

Service providers 3, 7 and 12 (n=3; 10.7%) were guided by the Victims' Charter in explicating the rights of survivors. They shared the following:

Site coordinator (a): *We are guided by the Victim's Rights Charter. It explains in detail the rights of the victim, and what are the rights of the perpetrator. So, we explain to them what each and every right entail.*

Social worker (b): *In our offices we do have those Bill of Rights and Clients Rights, the Victim's Charter. In our sessions, that is what we always do. We remind them and tell that; you have the right to receive information, you know all those rights they need to know. We always empower them and tell them their rights. We also inform that they have the right not be forced to do what they don't want to do. If they come and tell you that you can settle out of court with the person that abused you; sort it out and give you money, it is your right to say no. We also liaise with the case manager to give information on the legal side. I also research information; and inform the client, even in court.*

Auxiliary social worker (c): *Okay, actually, we first create a safe environment for the client, and you also make them aware of their rights. Sometimes, they really don't know their rights. We have the Victim's Charter, which stipulates the rights of the victim. We explain and clarify everything to them and ask at the end if they understand.*

Given the assertions made by the service providers, the Victims' Charter comprises a set of seven rights in rendering services to survivors of crime, inclusive of the Minimum Standards for the Treatment of Victims within the CJS. The rights cited by the service providers were to be treated fairly, to be offered an opportunity to receive and ask questions, and the right to be protected by the state and receive assistance. Service providers also cited a desire by survivors to receive restitution within the CJS (Commission for Gender Equality, 2016:15).

Sub-theme 1.3.3: General measures of informing the victims of their rights

Service providers 1, 4, 7, 14-15, 17-20, 23, 26-28 (n=13; 46.4%) used general measures of informing the survivors of their rights within the CJS. Although the intention of the question was to explore the measures used by service providers to inform survivors of their rights, some of the responses were related to the effect that the service provider had in informing the survivors of their rights in the CJS, while the measures to inform them were unclear. They expressed the following:

> First responder (a): *Luckily, since we have NPA here, so we will refer them, and the NPA will give more information that they will be protected, because some people are afraid without knowing the procedure of opening a case; and some will say that it is the same; I will open a case today and next week he will be out. So, the representative from the NPA will assure them that they will try their best that justice is served. The NPA gives them the information that they don't have.*
>
> Social worker (a): *They have the right to report the case. They have the right to do the medical test. They have the right to close the case if they have it already opened. We also explain the advantages and disadvantages.*
>
> Auxiliary social worker (a): *It is her right to say no. Yes. And it is her right to wear any clothes that she feels comfortable with. It is her right. There is no no-yes. It is also their right to come early before seventy-two hours. We tell them that as soon as when the incident happens;*

you must come. And the evidence is still there, for the police to come and collect everything. They also have injuries. It is their right to get the medication, as soon as possible. It is their right also, that if the incident happened maybe two months ago, and she fall pregnant, it is her right to terminate because it is stranger, it is her right to decide what to do. It is thus her right to do, what she needs to do.

First responder (b): *I usually tell people that is not your fault, and you are not the first one. And then most of the time, you should just stand up for yourself. But if you keep it all to yourself, you not just hurting yourself, but you are giving the perpetrator an opportunity to do it other people outside. So, if one person report, we can find out who has been doing whatever, because most of the perpetrators is not the first time that they rape and will go on to do what they want.*

Site coordinator (c): *You know, at the Thuthuzela Care Centre, we are focused on the psychosocial and medical part of the criminal justice system, so, of the rights we inform them, is in relation to services that we offer at this facility, as per other rights within the criminal justice system, to inform them when they go to court. Hence, we have our case managers. Basically, we inform them of their right to medical care, and also the rights to refuse the tests that we may have here. Sometimes they are unsure because they are still in a traumatic state, so we also inform them of their rights, if they want to make changes to their statement with the police, they need to know that they can do that, because sometimes we can pick up that they say more things to us, then what they say to the police initially. So, they need to know that they have a right to elaborate more their statement, and that they can do it with the investigation officer. And also, the right to refuse counselling, if they don't want counselling, or they are not ready to talk to somebody about their experience. We also inform that if they want to terminate a pregnancy, they also have the right to do so.*

Forensic nurse (a): *From the medical staff, we do inform them about the medical side of their rights. The victim assistant officer or site coordinator from the NPA will inform them of their legal rights within the criminal justice system.*

Forensic nurse (b): *I can tell them that they have the right to get treatment. They need go for counselling. They need to be free. Maybe if we can get the pamphlets to give them, so that they can have enough information, we, as service providers, we need not be judgemental. We must not judge them; just accept everything she is telling you. Because that person can tell another, if this happened to you, you must go to the clinic. She can give information to the others.*

Forensic nurse (c): *We explain to them that work with the police, NPA, social workers and doctors. So, the reason for this institution, is to help the survivor or the victim. As a victim, you have the right to open a case, to get the medication, to be safe, we can also arrange a place of safety. We also tell them that the DNA we collect is going to make the case strong. We also tell the patient that she must come follow-ups for six months to check for pregnancy, HIV….*

Forensic nurse (d): *We tell them that they have the right to report the rape. They have the right to know of our services, the right to partake in the decision-making, the right to sign informed consent for the examination and treatment, the right to refuse treatment.*

Medical doctor (a): *To explain to them their rights are protected, as well as the rights of the alleged perpetrator. Until both sides of the incident are explored by the police, and scrutinised by the court, nobody is either right or wrong.*

Case manager: *One is the Thuthuzela Care Centre model, that is actually one of the best models to inform them of their rights. Because within that model, you have got all departments, which are within the criminal justice system. You have NPA, Health, then we have SAPS*

that does the investigation, and Department of Social Development that does the counselling. You can like myself, according the Thuthuzela Care Centre, inform the doctor on what to do, you can tell the police what to do, you can tell the social worker what to do at a Thuthuzela Care Centre level. My offices are linked with the Sexual Offences Courts. The Sexual Offences Courts have got a number of role players such as court preparation. It is my responsibility to make sure that the victim is informed of their rights and the court process. We have closed-circuit camera, what we now have under COVID-19 virtual meetings and virtual testifying. So, we explain all those. So, the Thuthuzela Care Centre model exposes the victims to a lot of their rights. We also explain to them, if you want to terminate the pregnancy, we will assist you with that, treatment of STIs, we will assist you with that.

Court preparation officer: *They are informed of their rights as soon as they appear at the hospital. On the very first day, everything is explained to them. The victim assistant officer must inform the victims of their rights in the criminal justice system, according to the Victim's Charter, and explain to them their rights in detail, so that they understand. They should also know what they are entitled to; and what they can do if things do not go accordingly.*

Investigating officer: *What we are doing at SAPS, is that we treat the victims the same. Take the victim to the doctor for medical treatment, taking the necessary statements, if there were witnesses, attend to the crime scene, taking the crime kit to the forensic lab for DNA testing, charging the suspect, taking the suspect to court, then the court is the one to decide, whether to withdraw or not. We as police officials, we cannot withdraw cases. The procedure stays the same.*

Sub-theme 1.3.4: Public awareness campaigns

From the responses of service providers 6, 10-11, 13 and 21-22 (n=6; 21.4%) it is clear that public awareness campaigns play an important role in informing survivors of their rights within the CJS. They opined:

> Site coordinator (b): *We promise them confidentiality, because some of the people coming here, the incident might have happened within their family. Maybe it's the father or an uncle, or someone close to them. We mostly do campaigns. We are trying harder to go to the communities. We go to shopping centres, and schools, were people gather in large numbers, to educate them about the Thuthuzela Care Centres. Even if we do the public campaigns, we cannot reach everyone. We also use the media to inform people about the Thuthuzela Care Centres.*
>
> Auxiliary social worker (d): *Normally what we do, we have awareness campaigns. When we have those campaigns, we have pamphlets, we get a chance to talk to them, one-on-one; or we even have door-to-door information sessions, where we get into a family and find a grandmother and her grand kids, we inform them to report the crime of rape, regardless of the circumstances. That person needs to get arrested, and it is within their right, so they can be free of fear; living with the same person in the same community, seeing them all the time.*
>
> Auxiliary social worker (e): *We mostly do our campaigns. We go out to the communities, especially during those 16 days of activism, we go out to the communities on a daily basis, just to inform them about our services at the Thuthuzela Care Centres. We inform them about their rights, if they are raped. We also inform of the processes when they want to report the rape. We focus on the roles of the NPA, the police, and health.*
>
> Victim Assistant officer (b): *We do conduct awareness campaigns, we go to the communities where we find men and women, as well as the*

youth. We go to the mall and give out pamphlets, which contains information about human rights. You take our time. When we come in contact with the victim, we inform them about their rights. We also inform them on how to inform other community members if they fall victims of rape, what they can do to assist them, so that they can get assistance as soon as possible.

Forensic nurse (e): *We explain to them all the protocols that are in place. We give them a lot of advice, but they have to make the decision at the end of the day. We also do campaigning in schools and the community, we also have pamphlets on PEP and domestic violence. When they come here, we attached all of that to their comfort pack. It also comes in all the languages in South Africa, if its available. Even if we give them treatment; they must tell us back exactly what we said. We also provide them with phone number, and they can come anytime, if they have a problem, not to wait for the dates.*

Forensic nurse (f): *We have pamphlets, sometimes we try to use the media, to encourage them to report the cases. Sometimes when they are here, we just encourage them to report.*

Adult female rape survivors expect to receive information about their rights and the services available to them within the CJS (Department of Public Administration, 2010:1), and considering the views shared by the participants, information about post-rape services should be easily available to the victim accessing these services. It is also further sensible to provide information about the services provided in the native language of the recipient of services. Not only should service providers inform adult female rape survivors about the services available to them they should also inform the survivors with regard to the progress of their case (Know-your-rights- TCC, s.a.: 14; Molina & Poppleton, 2020:23).

Service providers utilised an array of methods in informing the survivors of their rights within the CJS. Although their efforts are satisfactory, they highlighted the importance of awareness campaigns surrounding post-rape services in reaching the broader community.

The next section of the chapter will explore the risk factors in relation to the crime of rape.

THEME 2: RISK FACTORS CONTRIBUTORY TOWARDS RAPE

The researcher asked the service providers their views about the risk factors being contributory to rape. From their responses, the risk factors were varied and are described below as sub-themes.

Sub-theme 2.1: Alcohol consumption and drug-facilitated rape

Service providers 1, 8, 11, 13, 17-18 and 20 (n=7; 25%) identified alcohol consumption and drug-facilitated rape as being contributory to the crime of rape as follows:

> First responder (a): *I think most of the risk factors is alcohol. In my experience those are the most cases. I am not saying that women who have been raped that they were drunk. In most of cases, they first start the sentence that we were drinking. After drinking, they would go home, say after 01:00 in the morning. So, I think alcohol is one of the risk factors, because people like to have fun; and we cannot stop people from having fun. But if I was even a chance, I will tell women, that if you go out drinking, to be alert, because some of them, they drug them, like when someone goes to the bathroom, they pour something in their drinks. Some don't even remember what happened to them.*
>
> Auxiliary social worker (b): *Eish, maybe, like going out at night. Going to parties and are exposed to drinking alcohol too much.*
>
> Auxiliary social worker (e): *Another thing, women go out to night clubs to enjoy themselves, but they don't have money for alcohol. The person who is buying alcohol will end up to say, if I buy you alcohol, you have to sleep with me. In other instances, the man will buy them alcohol, and when it is time to go home, the man will say that I bought you alcohol, so you must sleep with me. They end up raping them. They get drugged and taken wherever where they rape them.*

Victim Assistant officer (b): *What I have realised is that most of the women, especially young women, not older women, one of the risk factors is alcohol. They will go the taverns and decide to go back home in the early hours of the morning. That's when they come in contact with the rapist.*

Forensic nurse (a): *And mostly, it happens at weekends, when they go on drinking spree, they come here to report, they say it's my ex-boyfriend. They then later come to drop the charges, to say it's my boyfriend's friend or my friend's boyfriend has raped me. So, at weekends, the rape occurs during a drinking spree. Drinking and leaving those nightclubs very late.*

Forensic nurse (b): *According to my experience, most of them alcohol abuse*

Forensic nurse (d): *Through drinking alcohol, they become easy targets there at taverns. Because when we had lockdown, we hardly had victims here. When the lockdown regulations changed, the incidences of rape went up again.*

Emanating from the responses shared by the service providers, empirical findings from the Swedish National Council for Crime Prevention have found that in the circumstances prior to the crime of rape, alcohol consumption was contributory within the context of stranger rape, which makes it problematic for survivors to provide a detailed explanation of their experiences pertaining to the attack (Corovic et al., 2012:765).

According to the lifestyle exposure theory, lifestyle effects the nature and extent pertaining to the degree of risk individuals may be subjected to (i.e., being in close contact with a motivated offender in the absence of capable guardianship) (Madero-Hernandez & Fischer, 2017:328). The greater the degree of exposure to a motivated offender, the higher the risk of being wronged. In addition, the lifestyle exposure theory also proposes that lifestyles are varied across demographic locations, which elucidates why certain individuals are more prone

to becoming targets of crime such as rape when equated with others in different demographic settings (Madero-Hernandez & Fischer, 2017:328). A person's lifestyle impacts their probability of victimisation stemming from their lifestyle, subjecting them to high-risk places and motivated offenders during times when wrongdoing is most likely to occur. The service providers shared that frequenting certain places, such as taverns, poses a risk of becoming a victim of a crime such as rape (McNeeley, 2015:32-33). Frequently, the survivor and alleged rapist had met within a social setting before the rape incident transpired (Waterhouse et al., 2016:7).

Regarding the assertions made by service providers 1 and 11, Rohypnol, Gamma hydroxybutyrate, and Ketamine consist of numerous depressant effects that seem to be like the effects of alcohol. Subsequently, neither the victim nor others accompanying them are expected to be aware that the potential victim had been drugged since the drug is odourless and colourless. The survivor may experience confusion, dizziness, nausea, visual instabilities, physical and/or motor dysfunctions, limited inhibition, drowsiness, diminished judgment, slurred speech, amnesia, and an incapacity to escape the potential rapist from perpetrating the crime of rape. Drugs induce sedation properties in the survivor when compared with alcohol, which may be seen as a distinctive class of instances in which *"voluntary"* use by a woman decreases their merit as being viewed as a *"victim"* (Girard & Senn, 2008:5, 15).

Sub-theme 2.2: Crime of opportunity

Service providers 2, 4, 5, 13, 17 and 23-24 (n=7; 25%) cited that rape occurs as a crime of opportunity. They articulated the following:

> Clinical psychologist: *I think it depends; it depends because you know that especially with our adult victims, you find that they were raped coming from a place of fun, or they are raped in their own home through home invasion and burglaries, I have seen a few of them whereby the perpetrator comes inside the house and rob and rape them. Uhm…, some of them, it happens within the workplace, and*

some of them are raped by their own husband, in their own homes, you know. So, those are the most risk factors that I have found.

Social worker (a): *Usually self-employed women, they would open, for example a tuckshop at home. During the same time at night, the perpetrator come looking for the money, and they rape them.*

Victim assistant officer (a): *Maybe the person was watching her (stalking), and the person could see the routine activities of person, and the suspect break into the house and do whatever he wants to do.*

Victim Assistant officer (b): *And some of them, especially those that live in informal settlements, they will be sleeping their houses and then somebody just break into the house, and then rape them.*

Forensic nurse (a): *We will constantly hear also of cases where the victim will say that somebody has invited to his place, I went there, I'm not here to judge, somebody invites you, did you go there before, they would say, maybe about three times, but when she got there the last time, he forced himself on her.*

Medical doctor (a): *That one is a controversial issue because I won't say that there is a specific risk factor. Perpetrators they rape kids, they rape the elderly, they rape women in their own houses. Uhm.., whether you are wearing next to nothing; or whether you are fully covered. The most cases we see occur within a social context. The perpetrator and the victim might have known each other previously, or they might have known each other for a few hours. But there is that link that they maybe knew each other. For example, the victim was introduced to the alleged rapist, and they went somewhere where the incident took place.*

Medical doctor (b): *It is difficult for me to say that are definite risk factors because it is very broad. The women that come in here, you never know what was in the mind of the perpetrator. There is also this new trend that they grab young girls and women walking in the street,*

> *they park the car, push them in the car, and drive with them. You really don't know what the risk factors are. We are seeing fewer cases of adult female rape survivors that were partying and drinking. This thing of grabbing young girls and women is becoming so common. I don't know. We get a woman getting off a taxi and walking home, who gets grabbed.*

In light of the responses received by the service providers, other researchers (Gibbs et al., 2020:2-3; Jewkes et al., 2017:7) are of the opinion that structural factors (residing in an area riddled with poverty and unemployment, limited- to-no services such as the lighting of streets at night or early morning hours, no visible security or policing within certain public domains), being contributory to the crime of rape as an opportunity being scarce.

Sub-theme 2.3: Exposure to unsafe places

Service providers 2, 3, 5, 8, 11, 17-19 and 25 (n=9; 32.1%) indicated exposure to unsafe places as a risk factor for rape to transpire. They conveyed the following:

> Clinical psychologist: *Some will also say that they were at a taxi rank, and the men were hauling, and the next thing the rape occurs. It depends on the setup they are in, so it remains very difficult to pinpoint the risk factors for an adult female to be raped. One of the incidents that I found most interesting, is this lady was going somewhere, walking with another lady, and through the talk, she could only remember this lady asking for directions, and she woke up somewhere in Sunnyside in some flat, she was raped, but she does not know how. So, there are numerous contributing factors such as criminal activities etc.*

> Site coordinator (a): *It is unfortunate that we live in a society in which safety is an area of concern. I usually advise young women to enjoy within the safety of their home. When going to places of entertainment such as a tavern, you place your life at so much at risk. The risk is*

being outside of your comfort zone, or in a foreign place, which places a person at risk, such as being at a shebeen at night. These are the things that we always tell women. We understand that you also want to be happy and go out but do it in such a manner for you to be able to assess your surroundings, with regard to the risk that might be involved.

Victim assistant officer (a): *Regarding adult female rape survivors, when they go out in evening, others go out to strange places. So, you find out that this person was walking at night alone.*

Auxiliary social worker (b): *Some stay at places like the Mkhuku which is not safe.*

Auxiliary social worker (e): *The other thing is sex workers. Most of them also report rape cases, they are raped out there on the streets.*

Forensic nurse (a): *When they also looking for jobs, jobseekers, some might even lure them to say I have got a job for you, and something happens along the way.*

Forensic nurse (b): *Others, they just grab them from the street.*

Forensic nurse (c): *You know, most of the cases happen at night, coming from a tavern. You know, at weekends and Mondays, we experience a lot of rape cases. They walk at night.*

Medical doctor (c): *In my opinion, some of them are at the wrong place at the wrong time. Indulging in risky behaviour, such as walking alone at 01:00 in the morning. I mean, really, in an area that is known to give problems. Stuff like that, that's the bulk. You know, people are at the wrong place, at exactly the wrong time. there are those victims who are attacked at places where they are supposed to be. Others they would go to the shebeens and walk around at night, that should happen in a normal society, but there is nothing normal here. Most of the perpetrators seeing a woman walking alone at night assume that the coast is clear, and they will attack.*

In relation to the revelations made by the service providers, the crime of rape is most likely to occur within structural circumstances since motivated offenders are constantly in search of a suitable target. Residents in low-income areas are thus less motivated to modify their behaviour to protect themselves against any form of probable victimisation (Pratt & Turanovic, 2016:340). Moreover, although not to a greater extend, certain persons' have the tendency to self-select the different forms of risky behavioural routines (i.e., drinking in excess in public places and being negligent with their belongings). These activities might make an individual more prone to becoming an attractive target to a motivated offender (Turanovic et al., 2015:187).

According to an element (associations) within the lifestyle exposure theory, there occurs a direct association between lifestyle and exposure to victimisation that may be directly linked to negative associations. Associations with potential offenders who unduly have specific characteristics would increase the likelihood of a person's victimisation. Differences in lifestyle are interrelated to inconsistencies in the desirability and vulnerability of an individual as a target for personal victimisation, as well as the effortlessness with which victimisation may occur. Communal spaces such as streets and parks afford a potential rapist an opportunity to victimise women who have almost no real defensible space. It is, therefore, easy to be subjected to contact crimes such as rape within these areas. The desirability of the victim ascribes to the notion that the offender believes that the survivor of a specific crime would not report the crime of rape to the police. Vulnerability, however, denotes the presence of alcohol and other illegal substances, which might further incapacitate the survivor from protecting herself (Peacock, 2019:26).

Sub-theme 2.4: Poverty and unemployment

Service providers 4, 7, 11-12, 21-22 and 28 (n=7; 25%) are of the opinion that poverty and unemployed are contributory to the crime of rape. They opined the following:

> Social worker (a): *Uhm…, financial so, the socioeconomic conditions of the person. Many women are unemployed or self-employed.*

Auxiliary social worker (a): *Unemployment, poverty, because they are in need.*

Auxiliary social worker (e): *Due to the rate of unemployment in the country at the moment, women would apply to a company, and the supervisor will them that she can get a job if she is willing to do this and that, and they end up agreeing.*

Social worker (b): *Sjoe, unemployment and poverty, it makes them dependent.*

Forensic nurse (e): *I think it is the home environment. Poverty plays a big role, inclusive of unemployment.*

Forensic nurse (f): *Sometimes, it is because of poverty. Women are poor. They are looking for someone who can help them.*

Investigating officer: *It can be poverty.*

Emanating from the contributions made by the service providers, the South African labour market seems to favour men over women, with unemployment projections among women being 36.8% when compared to their male counterparts being 32.4% (South African women bear the brunt of unemployment, 2021). Likewise, men are more likely to receive full compensation for their labour when compared to their female counterparts, irrespective of race (South African women bear the brunt of unemployment, 2021). The Federation of Unions of South Africa is of the opinion that, when it comes to gender, a discrepancy in compensation between men and women serves as a strong indicator of socio-economic inequalities. The greatest contributory factor to inequality between women and men in South Africa is unequal access to education and training opportunities. The data provided by the Federation of Unions of South Africa further substantiates the claim that women comprise most of the poor, the unemployed, and the deprived (South African women bear the brunt of unemployment, 2021). Service providers rendering post-rape services are of the opinion that women are subjected to the crime of rape due to their low

socioeconomic status within communities, making them dependent on others for survival.

Sub-theme 2.5: Accessing unsafe public and private transport

Service providers 6, 13, 15 and 17-18 (n=5; 17.9%) opined that accessing unsafe public and private transport were issues of concern. They highlighted the following:

Site coordinator (b): *Using public transport.*

> Victim Assistant officer (b): *There are also ladies that catch early transport to work say those that need to catch a train by 04:00, then they meet those rapists in the early hours on their way to work.*
>
> Site coordinator (c): *Basically, women get raped in places where they are alone with no one to assist them. For example, one would be walking very early in the morning, going to transport to work, and sometimes women are also attacked by transport people, like taxi drivers and maybe people transporting them.*
>
> Forensic nurse (a): *There is also this Taxify and Ubers, which there are plenty of perpetrators from those. We've got a lot of cases from them and the taxi drivers. Trust, if they trust too much, there is this grooming thing, they groom them.*
>
> Forensic nurse (b): *The others, due to transport, because most of them get raped when they go to work.*

In relation to the responses received from the service providers, the public transport industry is recognised for its culture of abuse that subjects women to numerous forms of violence and abuse (Eagle & Kwele, 2019). When women have to wait longer to access public transport, they become more vulnerable to gender-based violence. As trains, buses, and taxis are cost-efficient and readily accessible in townships, they are the main modes of transport that black women in townships make use of.

According to the routine activities theory, circumstances surrounding the crime, rather than personal characteristics, may lead to crime. According to the routine activities theory, in order for a crime to ensue, three elements must come together in space and time being (a) motivated offenders, (b) suitable targets, and (c) the absence of capable guardians (Bunch et al., 2012:1184). The initial intention of the routine activities theory is to explicate the elements essential for crime to occur since it is assumed to be primarily explanatory in nature (Engström, 2018:901; Pratt & Turanovic, 2016:335). As such, the activities of an individual during the day may transcend to or reduce opportunities for the substantial elements (motivated offenders, suitable targets, and absence of capable guardians) to join in space, thus, provoking the prospect that a criminal event will occur. An increase in activities that take people away from their homes or safe spaces is thus linked with an increase in criminal activities (Drawve et al., 2014:4-5). Hence, when women access unsafe public transport, they are subjected to becoming easy targets for the crime of rape since they are in close contact with a motivated offender in the absence of capable guardianship.

Sub-theme 2.6: Financial dependence

Service providers 6, 7-9, 11-12, 21 and 27-28 (n=9; 32.1%) believed that financial dependence could place a woman at risk of being raped. They opined the following:

> Site coordinator (b): *Most of the time, it is women who are not independent. So, the person might depend on the husband, who in return takes advantage of the situation. They are also exposed to other relatives such as an uncle or step-siblings that rape them.*
>
> Auxiliary social worker (a): *Other women are forced to be in a relationship because of the finance. Who is going to support me?, I am not working?, I have three kids. He just abuses her, but she continues to stay with that guy, that abusive guy.*

Auxiliary social worker (b): *Maybe you are staying with someone, like you depend on that person, and that person can rape the victim at any time.*

Auxiliary social worker (c): *I think it is the principle of dependence. Women are too dependent, which makes this problem to go on and on. They depend on the perpetrator.*

Auxiliary social worker (e): *Most women become rape victims because of the circumstances that they find themselves in. They are in a relationship, but don't want to be there, but they have nowhere to go. The husband ends up raping them because they have no other place to go. They are bound to stay within an abusive relationship, and they (men) take advantage of that.*

Social worker (b): *Some of them are abused by family members, and for them to report, it becomes difficult for them, because in certain cases you find that the abuser is the breadwinner of the house. For them to be able to get those needs, they start hiding it. They depend, so that they maybe can receive something.*

Forensic nurse (e): *Women also stay in abusive relationships because of financial dependence.*

Case manager: *A lack of independence, financially, mostly. Ithink, we need to get to stage of raising our girl children to be independent. Because with a lack of independence, they can look for a boyfriend that is going to take care of them, and it goes through even into marriage. Most rape victims are raped by people that they know. They are subjected to inferiority, its patriarchy again. Men think they are powerful, they don't treat women well, with regards to poverty. In general, a lack of independence.*

Investigating officer: *Perpetrators are the ones who are supporting or maintaining them, and they are being victimised in the form of threats or intimidation.*

In relation to assertions made by the service providers, financial dependency makes it difficult for women to report the crime of rape due to their dependence on the rapist (Klopper & Bezuidenhout, 2020:335; Wallace & Roberson, 2011:102). The aftermath of limiting a women's potential in social, cultural, political, and economic domains can be internalised by both men and women alike and is broadly more acceptable predominantly in patriarchal cultures where male dominance and sexist ideology are the tolerable norms (Husnu & Mertan, 2017:3738).

Sub-theme 2.7: Rape as a perceived crime of power

Service providers 10, 12,14, 16, 22 and 28 (n=6; 21.4%) identified power, in terms of men being able to inflict physical coercion upon the victim, as influential in the crime of rape. They shared the following:

> Auxiliary social worker (d): *That is a challenging question, because most often for the rapist, it is all about power, for them. So, when a woman is dressed in a miniskirt, they may not be raped, while a woman in church clothes can be raped. So, it is not always what they do, that get them to be raped. However, I could also advise to say, eish…, because you can't really say that a person must dress like this or that, if they can be raped within their own home, while they are in their pyjamas, it is long dress. So, it is challenging for to really respond to that because most of the time it is about power for the perpetrator, not necessarily what the woman did, for the guy to rape them.*
>
> Social worker (b): *Females are also not perceived as people who have rights. But they are perceived as objects, per say, whereby, men perceive themselves as being as more powerful as females; and they do as they please. So, they become vulnerable, especially with our culture. Our cultures as well, makes it difficult for men to understand that women are not objects. Women cannot be misused; they are people and need to be respected. Some will say that I can do whatever, she is a woman. Men think they are above, and women are below, and some do whatever they please because of culture. At home*

they are taught that with women, you can do whatever. Or, at the house the parents are abusing each other, and when the boy child grows up, he will apply the same principle in life. They are brought up to belief that women should be treated like children, that they should be beaten to put them back in line.

First responder (b): *One will be, you know people go out partying, they go without having their own money, and when they get there, this person offers to buy whatever, and at the end of the day, they find out that person who is doing this, they are not doing it out of their heart, they are expecting something. So, when they do not consent to what that person wants, then they force to do whatever they want to.*

Social worker (c): *I think that it is their social status, you know. Patriarchy. Because most of them will find it very difficult to deal with this issue, because especially if it happened within the family, the uncle of the grandfather is alleged rapist, the family try to discourage them from reporting the incident. They would tell the victim, what will happen to us as a family, don't do that, our credibility as a family…. The older women will there and try to convince the victim that it happened to me too, so, I'm okay, and you will be okay. Then they find out it is true, because they end up sitting where you are sitting, dealing with the symptoms that they were told they will never struggle with.*

Forensic nurse (f): *It is because of women's powers; they think they don't have powers. They don't have rights. Maybe, I don't know, it is the low self-esteem of the man.*

Investigating officer: *Men like to take power on themselves.*

In relation to the assertions made by the service providers, hegemonic masculinity is used to explicate the incidence, types, and intricacies of male power (Morrell et al., 2013:12). Hegemonic masculinity originates from a notion drawn from the Gramscian view of class hegemony, which asserts that upholding a specific arrangement of power, not necessarily through coercion, but rather

through the act of inducement, is perceived as male domination. Similarly, the Gramscian viewpoint of hegemony unambiguously places emphasis on power without violence, while in Southern Africa, this manifestation is not the case (Everitt-Penhale & Ratele, 2015:7; Morrell et al., 2013:20).

According to the extended balance control theory of Tittle (1995), control comprises two differentiating fundamentals, namely, the amount of control a person is exposed to; and the amount of control an individual can assert upon another. Within the sphere of the control balance theory of crime, it is suggested that the amount of control a person is exposed to in relation to the level of control that they can sanction impacts both the prospect and form of non-conforming behaviour (Peacock, 2019:35). Men who approve hostile sexist attitudes might be more prone to the influence of the hostile sexism of their peer group; and demonstrate high levels of self-reported rape inclination (Durán, Megías & Moya, 2018:2183).

Men are socialised to be aggressive, whereas their female counterparts are anticipated to be obedient according to traditional gender norms. Moreover, men are required to uphold culturally defined attributes that approve of maleness according to their socio-historical environment. Consequently, rape culture is emitted when masculinity is expected to entail power, superiority, control, and dominance (Messina-Dysert, 2015:70). While it is partially empirically supported, a perception exists that men who are predisposed to adhere to the three norms of hegemonic masculinity such as anti-femininity, status and robustness, which facilitates a link between men's hostility towards women in general. Additionally, it is assumed that masculine gender roles could be ascertained by obeying the norms of hegemonic masculinity (Gallagher & Parrott, 2011:7).

The next section of the chapter will elucidate the protective factors in rendering post-rape services.

THEME 3: PROTECTIVE FACTORS IN PROVIDING ASSISTANCE TO ADULT FEMALE RAPE SURVIVORS

The researcher probed the service providers in asserting their understanding of protective factors in relation to victim empowerment programmes and the victim impact statement in rendering post-rape services within the CJS.

SUB-THEME 3.1: VICTIM EMPOWERMENT PROGRAMMES

The researcher probed the opinions of service providers regarding victim empowerment programmes. Emanating from their responses, the researcher identifies the following positive responses in this regard.

Sub-theme 3.1.1 Positive opinions regarding victim empowerment programmes

The majority of service providers 1-9, 11-17, 19, 21, 23-28 (n=24; 85.7%) indicated a positive response towards victim empowerment programmes. They cited the following:

> First responder (a): *Victim empowerment, I think it will assist women a lot because they will know where to go. They will also know that it is a safe space for them, and nobody will judge them when they go there, because that place will be specific just for victim empowerment, then going to the police station. Remember, at the police station there are different people, reporting different cases. Victim empowerment is so important because it is a safe space especially when it comes to privacy, and it makes things much easier.*
>
> Clinical psychologist: *Most definitely, I think it is important. Uhm…, I think that if we could have that, it could work. Reality is, in government, we are short-staffed, we don't have human resources. But if government can put in place such programmes, and employ psychologists to be part of those programmes, employ social workers to be part of those programmes, I think it will make a huge difference. Victims and survivors will have a place to go. A place where they will feel supported, especially support systems within community levels*

that can be easily accessible and they don't have to pay anything, I think it will really assist them. We can come in as psychologists and empower them with skills and all that. We can even get people who are trained in martial arts, or some form of defence, we get them involved as well, so if they find themselves in those situations, they can respond appropriately. But with us, we deal mostly with the aftermath with what happened already.

Site coordinator (a): *I think that victim empowerment plays a very important role within the criminal justice system, because at the end of the day, we want to turn victims into survivors. So, we need victims that are empowered, and to be able to stand, after the rape incident had passed. Victim empowerment plays a role because it is a journey that the rape survivor has to undergo. You know, from transforming the victim into a survivor.*

Social worker (a): *Yes, it works for them. We do give them the information and empower them to report the case.*

Victim assistant officer (a): *I think that victim empowerment programmes must be strengthened, and they should also be freely available to the victims of crime. Although people are aware of these programmes, they are not that effective.*

Site coordinator (b): *Most of the police stations that work with the Thuthuzela Care Centres, offer victim empowerment programmes. NGOs facilitate the victim empowerment forums at police stations. Social workers and lay counsellors offer these services at police stations.*

Auxiliary social worker (a): *Yes. For psychosocial. They just come for counselling. For the first time they come, they think they are hopeless, they are nothing, they just lose hope about their lives. But, with counselling they soon come realise that life is so important. Even*

myself, I think it is important. Yes, victim empowerment is very important for the woman.

Auxiliary social worker (b): *Yes, they do, it is just that most of these people don't know about these services. They are usually at the police station, but I think we don't go out more to the community to inform them of these services. Even many people when they come here, they don't know about Thuthuzela Care Centres, where they can go and get help.*

Auxiliary social worker (c): *Yes, it will play a role in psychosocial support. It also supports the client in going to court. And, to prepare them for the investigations. To contain them, and to be open about the incident. Sometimes you will find that it is not easy for them to face the investigators. After containment, we refer them to a SAPS member.*

Auxiliary social worker (e): *Okay, victim empowerment programmes can assist women by giving them information. By informing them information on their rights and providing them with the correct information. We also need more shelters in the country, where women can go, because here at the centre, we find women who have nowhere to go. All shelters are full, so the woman don't know where to go. By having more shelters, it can help.*

Social worker (b): *To be honest, they empower women in the long run. There are also limitations, and perceived outcomes are based on the centre or an area where the centre is based. Uhm…, limitations might be where a centre is based, in area that is difficult to be reached. Like this centre that we are in, most cases are not coming from here, and public transport is very scarce. For example, survivors coming from Atteridgeville, they need to use three taxis to reach the hospital, and that is money. And, victims coming from Olievenhoudt, that is very far, they also need to use two to three taxis. Certain centres also operate differently, like this one is better since it*

operates 24/7. Some of them are not operating 24/7 at all. And another thing with our justice system, is it is just something, I don't know. Clients might get services of psychosocial and medication, but when it comes for their cases being successful in court, it is difficult, it's rare. It limits the rights of the client because, it seems like that two parts being medical and psychosocial, they did their part, but with psychosocial we are unable to [meet] the client's need because the perpetrator had been released, they stay in the same facility, the client every time comes across the perpetrator, and we are back to square one. It limits the developmental growth and healing of the client as well. Another thing is that with all the services that we have, the victim empowerment is very good, it is at the police stations, but the issue is that uhm…, our police officials are not trained to work with victims. They cause secondary victimisation, and it has an impact on the work being done and hinders the victims from receiving effective services. It limits in a way. So, maybe if people with victim empowerment centres should be capacitated and empowered to work with victims, so that they will be able to respect them and accept them as they are, to render effective and efficient services to them, for them to be self-actualised.

Victim Assistant officer (b): *I think that their role is to empower women, and to encourage women not to give up. And to assure them that we will work with them until the end of the case. Offering them continuous counselling; and anything at they need, if we do not offer it at our centre, then we will refer them to the relevant people. It is mainly empowerment. Empowering and assisting them to stand up; and maybe also to assist others with the same challenges that they have.*

First responder (b): *They do benefit them. For example, we usually get people who did not even know whether there is PEP, or termination of pregnancy, because you get people who are saying that they got a child through rape, and I never wanted to have it. But*

then they come to the Thuthuzela Care Centre. Others, they are HIV positive, but they were never positive. If only they had come, they would have gotten everything and they would be fine.

Site coordinator (c): *Our victim empowerment programmes that are there, are mostly offered by NGOs, and having them makes a lot of difference, since I've mentioned earlier that victim empowerment programmes at certain police stations, don't have anyone that can assist. At police stations where they are, you find they assist victims, because they also have a positive relationship with Thuthuzela Care Centres, and they will know who the Family and Violence police officer is on standby for that day, so we communicate that we have a victim, and people are helped quicker, than they would be helped at a police station where they do not have victim empowerment of a police officer, because the police will just say, queue and wait for your turn to assisted. Instead of queuing, they go straight to the victim empowerment officer, and that will speed up the process, and the police can bring them here to the Thuthuzela Care Centre.*

Social worker (c): *Yes, it helps them on the condition that they attend session, because most of them, they struggle with that. Attending sessions. I think, we are not the same, we are not trained the same way, in terms of theory. A person who is person-centred, actually delas with the person who is here. What are your challenges at this moment? How can you deal with it? Instead of just focusing on the past. It also depends on the counsellor.*

Forensic nurse (a): *It can assist women with campaigns highlighting these services. We normally do a lot of campaigns with them. Some psychosocial staff have got their offices at the police station. It will also benefit them, because in most cases, even now at SAPS, they are not properly trained about how to treat the rape survivor.*

Forensic nurse (c): *Yes, they help a lot. They help them to express their emotions after the rape. Some are depressed, so when we referring to the counselling part, it helps a lot.*

Forensic nurse (e): *It should be, but the problem is that our patients have financial and transport constraints. Even if you build up a support group, they don't turn up. Sometimes they don't even come for follow-ups. So, from the beginning we explain the follow-ups for six months, for example for HIV status, pregnancy, we need to do all that. We cannot even have a support group. We tried, we arranged everything, even the other stakeholders did the same thing over a weekend, only two turned up, and it is a lot of money or investment, with meals and pamphlets and comfort packs. Even in this area, transport is difficult, it takes two to three taxis. We refer others to centres closer to them for follow-ups. But it is always a choice. What I also find is that they would rather travel than go their closet Thuthuzela Care Centre, because of their perceived stigma.*

Medical doctor (a): *Its mostly about going to the public and teaching them about their rights; teaching them how the health system works, and the police work. The perception of most of our patients are that these cases, hey don't go to court. So, if we can change that perception that all cases reported with full evidence, they do go to court, and we do get justice out of that. Most of the patients, I don't like to use the term victims, will come and present them to us. The patient becomes hard down when she reported the case, but this person is still walking the streets, and they don't understand what happened. So, oing forward, information is very important.*

Medical doctor (b): *I think it will benefit them. It does not help for us to provide only medical care and collect specimens. It is psychosocial in dealing with what had happened. Victim empowerment will also teach a rape survivor to know that she did not do anything wrong, just to let her know.*

Medical doctor (c): *At the moment they play a minor role, which in fact they should be doing more. Bear also in mind, that most of these women, don't want much attention attracted to them. Most of them prefer by reporting, to be low key issue. Because when they go to court, it is everybody there. These cases are not actually held in camera to tell you the truth. These cases are heard in an open court, and this is what women don't want. This person's personal business is basically out there in public. Sometimes that when they hear of court, they become edgy. So, if we can address that part and make the courts victim friendly, such as people who got no business to be in court, should not be there. Sometimes it is numerous cases, and your cases is at the end, so they need to clear the court like they do with children, then they will feel more comfortable.*

Case manager: *It does a lot. As part of our court preparation, we do it. Even in campaigns, we do it. Victim empowerment makes them ware of their rights, and inform them where to go, and dealing with the fears that they have. For example, if a woman is married, and she does not disclose the rape to the husband, she is exposing the husband to diseases. I had a case of woman raped by a HIV positive person, she now does not disclose to her partner, that I was raped, and I could have contracted whatever illness. She does not disclose but continues to have sexual intercourse with the other person. Victim empowerment does a lot; the victim is also informed to report within 72 hours for DNA, so it does a lot.*

Court preparation officer: *I think the most initiative of the victim empowerment programme, is to inform the community, about what is happening around them, and what steps they can take, should they find themselves in a certain situation. Education is very much important, to get out people to understand.*

Investigating officer: *It's working because it reduces the trauma that our victims are having before coming to the police station. The victims*

> *do attend such programmes. They are informed about it. There are sessions and dates they need to follow. It is done by lay counsellors. If feel a need that they need to refer the victim to see a social worker, they will do that to. When it comes to counselling, some of the victims are given appointments or dates to come, but they only do one session, and they don't come again. We don't know. If that improves, then the issue of trauma in the victims, will definitely change. On the other side, if there is communication between the social worker and the investigating officer, we do assist, because the issue of a victim, being interviewed by the social worker, it assists, so as to know her position, to what she reported to us.*

In light of assertions made by the service providers, Victim Empowerment Programmes are aimed at improving the experiences of victims within the CJS, in relation to addressing the needs and rights when they seek post-rape services. Similarly, Victim Empowerment Programmes also facilitate the investigations and prosecutions of cases, avert the cycle of violence from continuing and prevent secondary trauma, with the focus being on a victim-centred approach in rendering post-rape services within the CJS (A Dialogue Between Government and Civil Society, 2013:13; Nel, 2019:89,91). Victim Empowerment Programmes are structured programmes in rendering services to survivors of crime (Nel, 2019:97).

SUB-THEME 3.2: VICTIM IMPACT STATEMENT

The researcher explored the opinions of service providers regarding the victim impact statement. In light of their response, the researcher captured positive and negative responses in this regard.

Sub-theme 3.2.1: Positive opinions regarding the victim impact statement

A large number of service providers, namely 1-4, 6-12, 14-15, and 22-28 (n=20; 71.4%), had a positive attitude towards the use of a victim statement in the CJS. They expressed the following:

First responder (a): *I think it will benefit adult female rape survivors because she will be able to tell what had transpired. To tell the story, everything that happened on that day. I think it will help a lot.*

First responder (b): *For someone, yes, they might think it is helpful, so that the person who give judgment, they know how it has impacted on that person. But I think that should be done in a written form, not in a way that a victim will have to go and stand in court and say everything in front of everyone. Remember that when we go to court, the perpetrator is also there, so it will bring everything back. Someone who is qualified must first talk to the victim, and then that person should tell the court according to what them victim has told them.*

Clinical psychologist: *Definitely it can, because I think that we should allow them to express their ordeal. When they come for therapy, they also articulate the manner in which the incident had impacted their life. We try and assist them by focussing on the areas that have been affected. We try and assist them in that manner. However, if within the court system, they could look at the impact the crime on the survivor, and from there look at ways to assist them. For example, if the rape occurred at work, the employer should employ services for the victims and further ensure that the environment is not traumatising and safe. Solutions can be found by focusing on the areas that had been impacted in your life. It should not end with criminal proceedings, the offender is sent to jail, and that's the end. It should be ongoing.*

Site coordinator (a): *Uhm…, I think the victim impact statement would benefit adult female rape survivors, because my understanding is investigating the impact of the ordeal on the rape survivor. I would say that is an important document envisioned to assist the victim in court. When a decision needs to be made.*

Social worker (a): *Yes, because if the victim is given a chance to say what happened in court, she will be satisfied. But if she was not given*

an opportunity to talk in court, it discourages them. They see the justice system as useless at the end of the day. So, it is very important.

Site coordinator (b): *Yes, we always make sure that their statement is not changing, since it can end up jeopardising the merits of the case. We encourage them to talk things that they can recall.*

Auxiliary social worker (a): *Yes, it will benefit them. They just lose hope and think that they are nothing. Yes. When she got somebody to explain to her, to encourage her, she can stand up for herself and explain in court what had happened.*

Auxiliary social worker (b): *Yes, I think that it will be a good idea. So that you know what to do there when you go to court. To be able to open up.*

Auxiliary social worker (c): *I think that is will be very important, because the state will be aware of the challenges that they experience after the violence. I really think that is important. It is affecting them psychologically. Actually, it is a big challenge for everyone.*

Auxiliary social worker (d): *In that regard, I think she should be allowed to say what happened to her in a court of law. Uhm…, but most of the time, they cannot really verbalise because they are still hurt and all that, but, for me it would be nice if they can articulate for themselves; and not have someone talk on their behalf because that they might not be able to really paint the picture of what happened to the victim. So, sometimes is it not possible for them, because they are still hurt and crying. It is a trauma factor at play here. So, I guess we can speak on their behalf. You must be able to say properly what happened to the client. But usually when we take the statement, you listen to them carefully, so that you can articulate what really happened to the client. So, you can do that; you can speak on their behalf.*

Auxiliary social worker (e): *I think it will be beneficial because we get a client raped as a child, who says that she was raped when she was*

two or four years old, and she is now about forty years old. They would also say that they are struggling with eating, in their marriage, because of what happened. When my husband tries to be intimate, I think about what happened to me. It will have an impact. Even regarding their surroundings, the rape survivor becomes more vigilant about their surroundings. If for example, she goes into a shop, and there are only men in the shop, she becomes more scared now. She thinks of what happened in the past. The incident is impacting her on her everyday life.

Social worker (b): *Yes, it will play a role in the criminal justice system. What the client or the victim is saying, we belief, because we were not there. She is the best person who knows what has happened. So, if the victim gives you that statement, impacted on her, we take it as it is. It is the duty also of the investigating officer because they are saying that cases should be proven beyond reasonable doubt. But it becomes a problem because, you find that they are thinking that her statement is not that strong to be able to stand in court. Now, my problem is that, why are they not taking the social worker who contained the victim, the first time the victim comes, and in the process of sessions. Because you find that they only take one statement, they are not coming for the second one. The first statement, it is not that good, because the victim might have forgotten to mention certain points of the case. Once after counselling, the victim is calm, and less traumatised, and is able to articulate the statement correctly. So, you find out that they are only using one statement, and not a second one, and it will definitely not have an impact in court.*

Site coordinator (c): *I think it's very important to hear what victims have to say. The positive impact that the victim might have, they would know the point of the victim, and everything they have to share about their experience.*

Forensic nurse (f): *It is beneficial for her because, I think that telling the court what happened to her openly, will help her psychologically. She starts to cope with the stress.*

Medical doctor (a): *We have different patients. Some of the victim impact statements might empower them, we understand what has happened to them; and we trust what they are saying to us. That victim impact statement will also place them under the perception that I am talking to somebody who can sympathise and empathise what had has happened to me. There are patients you can explain everything to them, with that, they are more concerned about their safety. You can empower them as much as you can, but they are mostly concerned about their safety. Some of them will tell you that my friend was raped last week but the perpetrator is still on the street. You cannot guarantee the victim that the offender won't get bail. The person that was raped, don't understand what has happened there.*

Medical doctor (b): *I think that will help, because it is not with all of them that you will find evidence of rape. You can examine her and find nothing. But if she can tell her story, the court would have a clue of what happened. I think that it will make a difference. I also think that sometimes language is a problem, I think that in the criminal justice system they can provide interpreters for her to tell her story. with some, it just becomes so traumatic, they just can't talk. You can see on their faces what the rapist did to them. Besides the medico-legal evidence, there is also the emotional part that the court must try to understand, what she is going through.*

Medical doctor (c): *Yes, to an extent. I'm probably being very subjective in this regard because the patient will always come back to say, yes, the court is listening to them, but they don't do anything. It should actually come in at the end of the sentence, when the rapist is eligible for parole, to let the victim give input and say no. If you feel aggrieved, you will always see that justice was never done. Its obvious*

there is no death sentence, so, how do we deter them? Ten years with good behaviour for example means four years; or 20 years with good behaviour means 10 years, we must move away from such things. You must remember, in three to four years, these guys get out. That is why people are inflamed when they hear that this guy is even applying for parole. There should be no parole, they should serve their sentence, because this is a scheduled offence, forget parole, no parole. The victims come back to say: He is out, was it worth all that effort? Rapists must know that 20 years is 20 years, 25 years, is 25 years. No discount. The guys know that nothing is going to happen, that is why this going on. As much as they say that the death sentence was not deterrent, that's nonsense, it was. Now, the alleged rapists have got many rights, and we have got problems.

Case manager: *The victim impact statement goes together with the victim impact report. The victim statement is written by the victim herself, the report is written by an expert. But they both tell us what the victim went through during the rape. So, the victim impact statement puts us in better position to secure the appropriate punishment for an accused person. The victim impact statement also has the potential to take the victim back to where she was, before the crime was done to her. The victim impact statement thus would seek the ultimate justice the victim is looking for. In the victim impact statement, she expresses herself to say: This is what I want, because I suffered.*

Court preparation officer: *It is very much helpful; I have assisted a lot of victims completing that. It helps them to get in touch with how they are feeling about what happened to them. It also helps to get closure, in terms of dealing with what happened to them. In court, the focus is on the incident itself. It is very difficult for the survivor to explain in court what had transpired. They feel more comfortable writing it down and reflecting on their emotions. In court they are under pressure, somebody is asking a question, they have to respond, and they are restricted also. You only answer questions that you are asked. So, with*

> *writing the victim impact statement, I find it very much healing therapeutically because they get to express themselves.*
>
> Investigating officer: *It does benefit the survivor. I will give you an example why I am saying this. After the case is being investigated, the suspect is then arrested, then the victim impact statement is being taken by the investigating officer to assist the court, so that the victim can tell what she went through, to reduce the trauma that she had. The victim impact statement would be afforded to the court to see what punishment they can give to the perpetrator. Most of the time, the prosecutor needs the victim impact statement after the trial, or when the court need it for sentencing. We as human beings are not the same, sometimes the impact comes after a while. For some of us, the impact comes immediately. Victims also had time to think about it, and they are also better, then after the commission of the crime.*

Regarding the information shared by the participants, victim impact statements serve a purpose in the CJS since it can inform the court of the harm suffered by the survivor, depending on the expectation of the survivors themselves (James & Cronje, 2019:133; Ovens, 2020:581; Regoli et al., 2018:180). The positive responses of service providers regarding victim impact statements are indicative that the survivors can benefit from compiling such a statement as they are provided with an opportunity to express themselves and be part of the CJS process.

Sub-theme 3.2.2: Negative opinion regarding the victim impact statement

Service provider 17 shared a negative opinion regarding the victim impact statement as follows:

> *I don't think so, and I would not encourage it as well because they normally break. Maybe in camera, she can do it with the court preparation officer. Most of them withdraw cases because of fear of going to court.*

The responses provided by the service providers support the definition of a victim impact statement being a written or oral statement presented on behalf of the

victim or by the victim that documents the impact of the crime(s) on the survivor (i.e., financial, social, physical and psychological effects); and explicates the survivors' experiences about the crime, the offender, and the expected sentencing of the offender (James & Cronje, 2019:130; Ovens, 2020:581; Regoli et al., 2018:180). The main reasons for including a victim impact statement during court proceedings include the following: Affording the presiding officer with information about the actual harm caused by the crime in order for the sentencing of the offender to be proportional to the crime; enabling a therapeutic outcome to crime victims, thus aiding recovery in bringing closure to the victim after the incident; notifying the perpetrator about the true consequences of the crime of rape and afford the court with an equal reflection of both the victim and the perpetrator in order to determine a reasonable, suitable and individualised sentence (James & Cronje, 2019:133; Ovens, 2020:581; Regoli et al., 2018:180).

Protective factors such as Victim Empowerment Programmes and victim impact statements are conducive to facilitating and aiding the survivors in taking control over their lives by affording them with an opportunity to engage with actors within the CJS in highlighting the effect of the crime of rape on their lives.

The next section of the chapter will explore the medical assistance by service providers as part of post-rape services available to survivors within the CJS.

THEME 4: MEDICAL CARE AS PART OF SERVICE RENDERING TO ADULT FEMALE RAPE SURVIVORS

The researcher investigated the perceived quality of post-rape medical care rendered by service providers to adult female rape survivors within the CJS, comprising of the challenges, management of medium-long term care, and application of policies and advancements in relation to rendering post-rape medical care. This section was only applicable to medical service providers, which implies that the total number of participants for the medical and medico-legal section of this chapter was nine (*Cf interview schedule for service providers*).

SUB-THEME 4.1: CHALLENGES IN RENDERING MEDICAL CARE TO ADULT FEMALE RAPE SURVIVORS

The researcher probed the service providers pertaining to their perceived challenges in rendering post-rape medical care to adult female rape survivors.

Sub-theme 4.1.1: Default in follow-up visits

Service providers 18, 21 and 23 (n=3; 33.3%) asserted that survivors default when it comes to follow-up visits. They shared the following:

> Forensic nurse (b): *We don't have a problem in providing medical care. The problem is those that don't come for their follow-up dates. They will tell you about the transport fee, that they didn't have money to come. Some will also say that they were going to school, we also give dates on the weekends. We also ask them to tell us if they cannot come on the dates, because our clinic is open 24 hours. The problem, most of our patients come for follow-ups, others, they just don't for a long-time, or they just don't come back.*
>
> Forensic nurse (e): *Most of them come for the treatment, but not for the follow-up. Even if we explain the importance of coming back.*
>
> Medical doctor (a): *It is basically accessing the facilities. Most of our populations are not working. And they don't come for all follow-ups to see us in terms of medication, the social worker, the psychologist, all the things that we need to do. We try to let them see all service providers on one day, but sometimes it is not possible, for obvious reason, because we don't have a social worker every day. Financially, they default to come due to limited resources.*

Considering the responses shared by the service providers, it seems that finances, school commitment and other responsibilities during the week make it difficult to go for follow-up medical care. Consultation with survivors should inform the patient to attend to follow-up at regular intervals (Muriuki et al., 2017:256; WHO, 2013:6).

Sub-theme 4.1.2: Designated facilities for the termination of pregnancy

Service provider 19 indicated a need for designated facilities for the termination of pregnancy. She conveyed the following:

> *The only problem we have is the termination of pregnancy. We don't have it here, we refer. With COVID-19, they closed that department. For us to send the patient, they did it as soon as possible. Now, they have to book a date. We also refer them to other places, but they need to take taxis to get there.*

Sub-theme 4.1.3: Initial reluctance by the patient to undergo HIV screening

Service providers 19 and 21 (n =2; 22.2 %) raised concerns pertaining to a reluctance by survivors to undergo HIV screening. They expressed the following:

> Forensic nurse (c): *It is also sometimes a challenge for us to test the patient for HIV, because we cannot give the full medication of 28 days, if we don't know the HIV status of the person. We give a three-day starter pack, to come back, because the first day, they think of a lot of things.*

> Forensic nurse (e): *Some patients don't want to be tested for HIV. Some of them know their status, but still, they don't want to tell us, even if we explain that the information is confidential. We give them the starter pack for three-days, to come back so that we can do everything else.*

In light of the responses conveyed by the participants, it is anticipated that medical service providers offer HIV testing and counselling at the initial consultation to guarantee patient follow- up at regular intervals (Muriuki et al., 2017:256; WHO, 2013:6).

Sub-theme 4.1.4: Shortage of medical staff

Service providers 20 and 25 (n = 2; 22.2 %) voiced a shortage of staff as follows:

> Forensic nurse (d): *We only have a shortage of staff.*

Medical doctor (c): *It more a matter of logistics, in the sense that there are constraints for government to employ doctors around the clock, but it is better for the patient to be seen sooner, rather than later. But the government can't provide services around the clock. Some medico-legal facilities can only be open for 8 hours, while the need is for them be functional 24 hours. Manpower challenges is thus directly related to financial constraints, they just cannot employ enough people. Its logistics more than anything else.*

Regarding the assertions made by the service providers, rape survivors who accessed services at Thuthuzela Care Centres after-hours still waited hours to be examined by a clinician, who might not necessarily be trained in the forensic examination of rape survivors or did not unavoidably perceive rape as a matter of urgency (Vetten, 2015: 41).

Sub-theme 4.1.5: Refusal or failure to take PEP treatment

Service providers 18 and 23 (n = 2; 22.2 %) stressed the refusal or non-completion of PEP treatment by survivors. They articulated their concerns as follows:

Forensic nurse (b): *Some don't take the treatment.*

Medical doctor (a): *The problem with the patients is that they come in, besides being under the influence of drugs, you explain the significance of the 72-hours period, in terms of the commencement of PEP. They will tell you that I am having a private problem. What happened to me, my partner, or my husband did not want me to go there. So, the mere fact that I am coming home with PEP, then I have to disclose for me to start this treatment. Some of them don't want to start treatment for those reasons not having to disclose, to those closer to them, what has happened to them. It goes back to the relationship that they come from. We had a case of a woman going job hunting, but the husband did not want her to work, he wanted her to stay at home. She got a job as a maid at a guy's place, however, the guy had*

> *ulterior motives and raped her. She also refused to take the treatment, because where she stays, everybody goes into everything. And then everybody is going to see the medication, and then what is she going to say to the husband.*

In relation to the views shared by the service providers, in Section 66(3)(a)(i) of The National Directives and Instructions on conducting a Forensic Examination on survivors of Sexual Offence cases (2009:2-3), provision is made for the management of PEP. In sub-Saharan Africa, dual epidemics of HIV and sexual violence make the application of PEP an important part of the public health response to rape. Additionally, genital trauma related to rape increases the prospects of HIV transmission. Comprehending the uptake and use of PEP could inform approaches to benefit from the efficiency of PEP (Chacko et al., 2012:338; Draughon, 2012:85; Muriuki et al., 2017:255; Wheeler et al., 2014:26).

Few empirical research studies have validated PEP adherence and completion rates in South Africa, with the majority of rape survivors not being well-informed on the importance of taking PEP, adhering to follow-up visits, negative side effects and rate of seroconversion. Factors linked with a significantly higher risk of PEP non-completion were low-risk perception, a known assailant, administration of PEP was delayed, and self-refusal. Other factors include, but are not limited to the stigmatisation of HIV infection, psychological trauma after rape, absence of appropriate multidisciplinary healthcare approach in healthcare facilities, and limited psychosocial support (Inciarte et al., 2019:44; Scannell et al., 2017:121).

Sub-theme 4.1.6: Unwillingness to be examined by a male clinician

Service providers 11 and 23 (n = 2; 22.2 %) were of the opinion that survivors do not want to be examined by a male clinician. They shared the following:

> Auxiliary social worker (e): *Being examined by a male doctor poses a challenge or adult female rape survivors. Some rape survivors refuse to be examined by a male doctor and will subsequently come back when a female doctor is available.*

Medical doctor (a): *Some female rape survivors, they don't want to be examined by a male clinician. Regulations don't speak them.*

SUB-THEME 4.2: MANAGEMENT OF THE MEDIUM-TO-LONG TERM MEDICAL EFFECTS OF RAPE

The views of service providers were explored regarding the management of the medium-long term medical effects of rape. From their responses, the researcher highlighted the main problems encountered within the health fraternity.

Sub-theme 4.2.1: Secrecy regarding HIV-seropositive status

Service provider 17 indicated that the secrecy of some rape survivors about their HIV status is a challenge in rendering medium-long term post-rape care. She articulated the following:

> *Some of our patients are already on antiretroviral medication. When we test them, they are negative due to the viral load being undetectable, virally suppressed, and then they don't tell us and take our medication. We take blood to the laboratory, and it comes back HIV-positive. But they say nothing to us. They are very secretive.*

Sub-theme 4.2.2: Side-effects of medication

Service provider 17 raised concern over the side-effects of PEP. She stressed the following:

> *Some medication makes them nauseas, and some will just not finish, particularly PEP.*

Given the information shared by the participant, few studies have recognised PEP completion rates among South African rape survivors, and it was found that most victims lack comprehensive information regarding PEP regimens, follow-up visits, negative side effects and rate of seroconversion. Factors related to a significantly higher risk of PEP non-completion were low-risk perception, a known assailant, initiating PEP late, and self-refusal. Other factors include but are not limited to: the stigma of HIV infection, psychological trauma after rape, absence of a proper multidisciplinary healthcare approach in healthcare facilities, and limited

psychosocial support (Inciarte, Leal, Masfarre, Gonzalez, Diaz-Brito, Lucero, Garcia-Pindado & García, 2019:44; Scannell, MacDonald, Berger, Boyer & Boston, 2017:121).

Sub-theme 4.2.3: Referral for specialist post-rape care

Service providers 21 and 25 (n = 2; 22.2 %) cited a need for specialist post-rape care. They shared the following:

> Forensic nurse (e): *Some come back, and we refer them to a psychologist or a psychiatrist, for example.*
>
> Medical doctor (c): *With medical care, we have follow-ups and assess the patient, if the need arises, we refer for the appropriate services such as referral to the psychologist, psychiatrist, or gynaecologist.*

Sub-theme 4.2.4: Clinical and psychosocial monitoring of the patient for 6 Months

Service provider 22 highlighted the timeframe of assisting the survivor with medical care. She shared the following:

> *Firstly, the patient arrives here, she goes for counselling. We examine the patient and give her medication. Then we give seven days date, to come for counselling again. Then we give another date to come after six weeks. We check whether the medication was taken properly. We check constantly whether the medication was fine for the patient, if she does not experience any nausea or vomiting. Then we give three months appointment to check the patient again. We do the pregnancy test, and the psychological well-being of the patient, and to give another dose of hepatitis injection, it's for the prevention of STI. Then we give six months appointment again, to come to review everything. When a person is HIV-positive at arrival, we give the medication, antiretrovirals, then we make monthly appointments to make sure that she is fine. We check the blood for viral load after three months and then after six months.*

Regarding the responses shared by service provider 22, the treatment of STIs, inclusive of gonorrhoea, chlamydia, hepatitis B and HIV, entails an imperative part of the management of survivors of rape. STI can be prevented promptly by rendering bacterial and viral prophylaxis followed by sexual health screening two weeks later, if the victim is symptomatic. The choice of treatment is highly reliable on the local incidence and prevalence of infections, and resistance to antibiotics should be considered (Cybulska, 2013:142).

SUB-THEME 4.3: CHALLENGES IN IMPLEMENTING THE PROTOCOLS AND PROCESSES IN RENDERING MEDICAL SERVICES TO ADULT FEMALE RAPE SURVIVORS

The researcher explored the views of medical service providers regarding the challenges in implementing protocols and processes in rendering post-rape medical care. In light of their responses, the researcher identified the two challenges in adhering to post-rape medical protocols and processes, namely patient comprehension with regards to the importance of follow-up visits and adherence to taking treatment as prescribed.

Sub-theme 4.3.1: Patient comprehension with regards to medication and adherence to follow-up appointments

Service providers 21 and 22 (n=2; 22.2%) voiced adherence to follow-up appointments and medication adherence. They articulated the following:

> Forensic nurse (e): *Sometimes, they don't ask, and they come back. Like with the medication for 28 days, they finished it in one week. Its strong medication, and they are severely sick. Trauma is something else, because you are here, but you are not here. At that point, they don't actually take in the information that you give them. We also call them to follow-up, some come, others don't.*

> Forensic nurse (f): *I don't think we have challenges, especially us health providers. The main problem can be the patient, some of them, they don't take the medication as prescribed. Some of them, they don't come on the days that are given. Some of them, they just disappear.*

In light of the information shared by the participants, in Section 66(3)(a)(i) of The National Directives and Instructions on conducting a Forensic Examination on survivors of Sexual Offence cases (2009:2-3), provision is made for the management of PEP. In sub-Saharan Africa, dual epidemics of HIV and sexual violence make the implementation of PEP an important part of the public health response to rape. Additionally, genital trauma related to rape increases the likelihood of HIV transmission. Comprehension regarding the uptake and use of PEP could inform strategies to improve the effectiveness of PEP (Chacko, Ford, Sbaiti & Siddiqui, 2012:338; Draughon, 2012:85; Muriuki, Kimani, Machuki, Kiarie & Roxby, 2017:255; Wheeler, Anfinson, Valvert & Lungo, 2014:26).

SUB-THEME 4.4: TECHNOLOGICAL AND MEDICAL ADVANCEMENTS AND PRACTICES PERTAINING TO MEDICAL POST-RAPE CARE FOR ADULT FEMALE RAPE SURVIVORS

The researcher probed the medical service providers regarding technological advancements in rendering medical post-rape care to adult female rape survivors. Although the question was intended to focus on technological advances, the research participants also offered medical advances. The researcher documented their responses according to the sub-themes that emerged.

Sub-theme 4.4.1 Improvement of PEP regimen

Service providers 17-18 and 24 (n =3; 33.3%)highlighted the positive effect of a new PEP regimen. The explicated the following:

> Forensic nurse (a): *As it is now, the clinic is changing to the new regimen for post-rape HIV prevention. We are still using the old regimen. We need to finish off the stock that we have and start giving the new tablet. They send us occasionally for trauma containment.*
>
> Forensic nurse (b): *The PEP treatment that we are giving now, is better than the treatment we were giving before. In the past they had to take several daily doses, now it's only one pill. It better now, they used to complain of vomiting and diarrhoea, but nowadays, it is much better.*

> Medical doctor (b): *We have a new PEP, a drug called TLD, it's taken once a day at night. TLD is a fixed-dose combination comprising of dolutegravir, lamivudine and tenofovir disoproxil fumerate. It suppresses the virus as quickly as possible, unlike the old ones, with very minimal side-effects. With the old drugs, its big, and the patient had to take two in the morning and two in the evening. Just imagine. It was difficult for them to take it.*

Considering the responses of the service providers, two-drug regimens (comprising a fixed-dose combination) are generally desired over three-drug regimens, stressing the use of drugs with fewer side-effects. An example of a triple PEP regimen in instances of numerous alleged rapists if available (lamivudine, zidovudine, and lopinavir-ritonavir). Importantly, the choice of drugs and regimens should be aligned with national and international directives (Muriuki et al., 2017:256; WHO, 2013:6).

SUB-THEME 4.5: RECOMMENDATIONS FOR RENDERING MEDICAL SERVICES TO ADULT FEMALE RAPE SURVIVORS

The researcher asked the medical service providers their recommendations regarding post-rape medical care; and documented their responses according to the relevant sub-themes.

Sub-theme 4.5.1 Improvement of staff allocation

Service providers 19, 22 and 24-25 (n=4; 44.4%) voiced a need for more medical staff. They shared the following:

> Forensic nurse (c): *Sometimes, on a weekend, I'm alone and sometimes spend with one person for up to two hours. Imagine. I can't make a mistake and the patient must understand. For example, if I don't explain on how to take the medication carefully, she is going to drink the whole container same day. That is why she must come back after 7 days for the review, to check if she is taking the medication properly. We also explain to them that if they have side effects, they must not wait for 7 days and come.*

Forensic nurse (f): *Maybe if we can have a designated doctor, it can become hectic for us. We are doing all the emergencies, we are attending to all the patients that are here, even weekends, day, and night. If maybe, they can give us more staff.*

Medical doctor (b): *There is always a need for improvement because they come at their most vulnerable and emotional state, so sensitivity is the main thing. It would also be better if staff is allocated just for them, because they would sometimes come 01:00 or 02:00 in the morning.*

Medical doctor (c): *You have to look at it from the medical management, and psychosocial aspect of the patient. Sometimes we have staff shortages and drug shortages. We must have adequate stock and medical and support staff, so that it can be truly a one-stop centre. The patient gets in and gets out within a short period of time. Everybody completes their job timeously.*

Emanating from the responses cited by the participants, state agencies must guarantee the appointment of the necessary much-needed human resources; and invest in satisfactory financial and technical resources to fund the CJS, institutions and organisations; in an effort to ensure accountabilities for all the stakeholders concerned (Women's Access to Justice: A Practitioners Guide, 2016: 36).

Sub-theme 4.5.2: Financial support for patients accessing medical post-rape services

Service provider 23 is of the opinion that survivors need to be supported financially to access post-rape medical services. He expressed the following:

Accessibility, that is one thing I have to recommend. Accessibility. I would also say social support, like our patients have financial problems, if we can support them socially. I would recommend that after the initial first visit, the patient is referred to the local clinic next to them to complete the treatment, or regimen that we give them, unless

> *there is a specific need that they need to come back for. So, if we are flexible in that regard, it's going to help them to complete and comply with the regimen that we give them.*

Considering the contribution made by service provider 23, the researcher is of the opinion that this information is new since the researcher could not find any supportive documentation highlighting the importance of assisting victims with financial assistance to access medical services and therefore adding value to the research.

The next section of the chapter will highlight the medico-legal sphere of post-rape services within the criminal justice system.

THEME 5: MEDICO-LEGAL ASPECTS OF SERVICE RENDERING TO ADULT FEMALE RAPE SURVIVORS

Medical service providers, namely forensic district surgeons and forensic nurses, were probed regarding their experiences in rendering medico-legal services, inclusive of challenges and advancements in the field of medico-legal post-rape service. From their responses, the researcher identified the relevant sub-themes.

SUB-THEME 5.1: CHALLENGES IN RENDERING MEDICO-LEGAL CARE TO ADULT FEMALE RAPE SURVIVORS

The researcher asked medical service providers about their challenges in rendering medico-legal services to rape survivors and captured their verbatim responses.

Sub-theme 5.1.1: Being examined by a male clinician

Service providers 17, 19-21, and 24 (n=5; 55.5%) indicated that adult rape survivors sometimes do not wish to be examined by a male clinician. They shared the following:

> Forensic nurse (a): *Our challenge will be medical male doctors examining females when there is no female nurse inside the room. We don't have male nurses, but they become so sceptical to be examined*

by male nurses. What if in the shift there is only a male doctor and male nurse?

Forensic nurse (c): *Sometimes the doctor is a male, and they don't want to be examined by a male person. They say that they were raped by a male, now you bring a male to examine me. You sit with that person and talk to her to understand that the male doctor will not do anything to you, just collect the evidence for the police. Even a male victim, they don't want to be touched by a female doctor. We refer the patients to another centre for the examination.*

Forensic nurse (d): *Sometimes a woman is scared to be examined by a male doctor.*

Forensic nurse (e): *Also, some of our female patients don't want to be examined by a male doctor, which is sometimes not possible if you have a male clinician.*

Medical doctor (b): *Sometimes the forensic examiner is a male nurse or doctor on duty, and we explain to them that a female nurse is present during the examination, the doctor still needs to see them. They are so uncomfortable if the forensic examiner is male. I think it is not attributory towards bias towards the male forensic examiner, but more related to the ordeal that they had suffered.*

In response to the information shared by the participants, the gender of the medico-legal examiner has been documented as being a frequent issue of concern (Kanan, 2018:12) since female survivors prefer to be examined by a female clinician.

Sub-theme 5.1.2: Taking a bath prior to the medico-legal examination

Service provider 21 raised concerns over taking a bath prior to the medico-legal examination. She highlighted the following:

When a person takes a bath, you lose forensics. Some will bath at the same time. Sometimes they even use enemas and stuff like that, just to cleanse themselves.

It is the responsibility of the investigating officer to inform the survivor not to bath or shower after the rape had occurred (Uniform Protocol For the Management of Victims, Survivors and Witnesses of Domestic Violence and Sexual Offences, 2008:19), but in some instances, the victim might already have taken a bath, prior to reporting the incident to the police or healthcare facility.

Sub-theme 5.1.3: Refusal to undergo medico-legal examination

Service providers 21-22 and 24 (n=3; 33.3%) voiced concerns over the refusal by some rape survivors to undergo a medico-legal examination. They expressed the following:

> Forensic nurse (e): *Sometimes the patient doesn't want to be examined. With adult women, it can also sometimes be a burst condom, so they will not tell us, sometimes, they come in as a walk-in, and they had sexual intercourse without using a condom, saying it was rape. We belief what the patient tells us. Some just want treatment, which we have to give them, even if they don't want to be examined.*
>
> Forensic nurse (f): *We don't collect the evidence in some of them because they don't want to report the case. They say they want to be examined and given medication, but I don't want to open a case. Then you cannot collect any evidence because she does not want to.*
>
> Medical doctor (b): *It is the environment, sometimes it is the influence of the parents, sometimes the parents, even with adult women, insist that they want to be in the examination room with the patient, then the patient freezes because the mother is there, but we always ask them to sit and wait outside. Some of them agree, others insist that they want to stay inside with the patient.*

Sub-theme 5.1.4: Shortage of female clinicians in the medico-legal field

Service provider 25 indicated a shortage of female medico-legal clinicians. He shared the following:

> *Some female clinicians also don't feel comfortable working in this field, being medico-legal, not even forensic pathology for that matter, because some might think that if this is happening to women, it might happen to me. Female doctors don't work long in medico-legal.*

Sub-theme 5.1.5: Admissible evidence

Service provider 25 highlighted admissible evidence as prime importance within the medico-legal sphere of post-rape services. He shared the following:

> *Whatever you do, it needs to be admissible. For example, if you use a coloscopy, it's a two-way stream. You need the patient's permission to enter those findings as evidence. This is the situation you are in. Remember, if you have to take a picture of the female's genitalia, it goes to court, and it becomes a problem. Those are things they need to think about, you know. Would a patient be happy with that sort of situation? While there is no name and face, you have taken a picture. The injuries are not documented because no pictures are taken. Like, if you see in the new J88, have you taken photographs, have you used the coloscopy? You can tick it, but you cannot use it. The police can take external pictures, but you cannot use anything else. Any form of privacy on the patient's side, you can't render as evidence. There are currently big delays with DNA. This is major concern, because you can go to court for about five to six times for the same thing. You know. Meaning that they haven't done biochemical aspect of the case. They are moving back and forth, hoping that they will get the DNA. We are doing cases dating back to 2014, only now in 2021, do we go to court seven years later, stuff like that. With serial rape cases, we are busy with cases dating back to 2010, we had a lot of serial rape cases.*

Research conducted by Machisa et al. (2017) in South Africa found that most adult rape survivors (92%) were subjected to a medico-legal examination within 72 hours. The incidence of injuries was captured in two-thirds of all cases within the sample, with no discrepancy by age group of the survivor. Twenty-six percent of rape survivors had non-genital injuries documented on the J88 medical form,

and 56% had genital-anal injuries. There were several instances in which the J88 form was inadequately completed, which influenced the evidentiary value and the prospects of the police in finding the clinician who completed it (Machisa et al., 2017:14).

SUB-THEME 5.2: CHALLENGES IN IMPLEMENTING PROTOCOLS AND PROCESSES IN RENDERING MEDICO-LEGAL SERVICES TO ADULT FEMALE RAPE SURVIVORS

The researcher probed the medical service providers regarding their challenges in following protocols and processes within the medico-legal domain of post-rape services. In analysing the responses of the research participants, the researcher identified the following sub-themes.

Sub-theme 5.2.1: Reluctance to undergo medico-legal examination due to the presence of muti

Service provider 17 indicated the refusal of survivors to undergo a medico-legal examination. She explicated the following:

> *I had a patient who was reluctant to be examined because of what was inside her vagina. It was put in deliberately by that person. It was muti, a ritual. We had to use forceps to remove it. The patient will tell you that she put it in there for my menstruation, but some will be having it for the boyfriend to come back, but they don't want to be examined.*

According to the information shared by service provider 17, the researcher is of the opinion that this information is new. The researcher could not find any related research to support the assertions made by the service provider that a rape survivor may be resistant to undergoing a medico-legal examination due to the presence of *muti. Muti* is a Zulu expression commonly applied in Southern Africa, which is ascribed to African medicine (Behrens, 2013:2; Louw & Duvenhage, 2016: 484; Minnaar, 2015:46; UTSS, 2013:1). It is a mixture made from herbs, plants and sometimes animal and human parts that are believed to have supernatural powers to heal and bring about the desired outcome (bring back lost love or to acquire wealth) (Roelofse, 2014:74).

Sub-theme 5.2.2: Absence of rape kits

Service providers 22 and 24 (n=2; 22.2 %) shared that they did not have rape kits readily available. They expressed the following:

> Forensic nurse (f): *We only have a problem with the rape kit if the police can always come with it.*
>
> Medical doctor (b): *The problem is when the patient is already here, and we have to wait for the police to bring the rape kit. Sometimes it takes a long time, and they feel that we have neglected them, but we can't do anything without the rape kit. We never tell them to go home and come back, we patiently tell them to just wait, and try and make them as comfortable as possible. I think it will be better if we have at least some kits here, for the patient that comes in, so that we can start with the process of collecting evidence from the patient.*

Considering the information shared by the participants, research conducted by Machisa et al. (2017:14) found that the medical examination of rape survivors and the collection of evidence by means of the Sexual Assault Evidence Collection Kit were only adequately applied in 76.7% of their sample of reported rape cases. Additionally, only a small number of rape kits were sent to the Forensic Science Laboratories for investigation.

Sub-theme 5.2.3: Facilitation of transport between facilities

Service provider 25 raised concerns over the transport of the survivor between facilities. He shared the following:

> *Facilitation of transport, to and from facilities, is one of our biggest problems. We also need support from SAPS, there are certain things that they should be doing, to ensure the patients' safety. The goods ones will take them home, do the basics that we would expect. The victims will always come back to us and ask what is happening to their case. They don't know what is happening, they don't know who the investigating officer is, but the alleged rapist is walking around. You see. With regards to medico-legal, the polices and directives were*

written by individuals from a broader angle, we don't really work with victims, we work with patients.

Sub-theme 5.2.4: The newly revised J88 as a challenge

Service provider 25 stressed the importance of the newly revised J88.

Like the J88, it was mostly probably written by people who are experts trained in medico-legal but do not necessarily have practical working experience when it comes to the nitty-gritty details. When you go through the J88, you realise that some of these things, some crazy person put them there, but because they have printed 50 million, now they are stuck. They did collaborate, but they should also consult with us working in the field and ask us what we wanted. What is it that you want us to do? That is how you improve things? Speak to us, we have to do what is expected of us, but we know where the mistakes are. The people actually working in the field will tell you exactly what is happening. The politicians can make all the rules, but they don't work here.

Participant 25 expressed concerns pertaining to completion of the original J88, when compared to the newly revised J88. Forensic clinicians are expected to complete the mandatory documentation satisfactorily (inclusive of the J88 form), and actual conclusions should be substantiated with the physical examination of the rape survivor according to the Sexual Assault Evidence Collection Kit, which adds value to substantiate claims made during legal proceedings (Ladd & Seda, 2021:2-3).

SUB-THEME 5.3: PERCEIVED TECHNOLOGICAL ADVANCEMENTS AND PRACTICES PERTAINING TO MEDICO-LEGAL CARE FOR ADULT FEMALE RAPE SURVIVORS

The researcher probed the medico-legal service providers regarding technological advancements in rendering medico-legal post-rape care to adult female rape survivors. Although the question was intended to focus on technological advances, the research participants referred to the revised J88

form, adoption of forms, efficiency of the colposcope in detecting injuries and specialised courts.

Sub-theme 5.3.1: Improvement of the J88 medical form

Service providers 21 and 24 (n =2; 22.2%) indicated the significance of the improved J88 medical form. They cited the following:

> Forensic nurse (e): *If you look at our J88, we find it totally different, we get to the point now. When you go to court, you have to include in the J88 a brief clinical finding, although some courts don't want that. Some just want the injuries written, and not the clinical history of the patient, but that is how we were trained. But now the difference with the J88, it is more detailed to the finer details. We also do an audit after the completion of the examination, with reference to the J88, to see where we might have gone wrong. That means, another medical staff member will audit mine, and I will audit theirs. We also audit our files, since we have a protocol of what to write. You improve yourself as well if somebody tells you. We thus have a checklist to review the J88.*

> Medical doctor (b): *At least the J88 now, is all-inclusive regarding the information that we put in is much better than what was required in the past. It will also be better if trained police officials working with rape cases are also based at the hospital or clinic. Sometimes when we call the police, it is a normal police officer not trained in sexual offences that is coming; and this police officer will take the statement. You find out the caseload for specialised police officers are huge within a certain district, so they take longer to come. There are also always delays when it comes to the processing of DNA. Even a case that you have seen in 2016, you will be called in now only in 2021, five years later.*

Considering the revelations made by service provider 21, the revised J88 form is a finding of interest since it captures a more detailed approach to documenting clinical forensic findings (Ladd & Seda, 2021:2).

Sub-theme 5.3.2: A need for more specialised sexual offences courts

Service provider 23 indicated a need for cases to be heard in specialised courts. He conveyed the following:

> *They have allocated specific courts for sexual offences. So, that is a good advancement because more cases go through the court system. Imagine if all the courts deal with different cases, including rape, with no specific court for rape. How long will it take with this thing of court rotation?*

In light of the information conveyed by the participant, two of the central achievements of the sexual offences courts were an increase in conviction rates and a decrease in turnaround time from the date of reporting to the police to the finalisation of the case (If only sexual offences courts hadn't gone away, 2013; Ministerial Advisory Task Team on the Adjudication of Sexual Offences Matters, 2013:23). The sexual offences courts also had the following positive effects on the CJS, being the following: reduced the trauma experienced by the survivor; accelerated the hearings of court cases pertaining to sexual offences; court decisions and judgements in pertaining to rape improved; additional convictions for sexual offences are executed; and it restored confidence within the CJS (Mhlungu, 2018).

Sub-theme 5.3.3: Efficiency of the colposcope in detecting injuries

Service provider 23 highlighted the efficiency of the colposcope in the post-rape examination. He shared the following:

> *A few patients have had some allergies when using the dye during the forensic examination. We have the colposcope, that has limited the need to use the dye, because with the colposcope you can also see invisible injuries to the naked eye. You can see injuries much better than using the dye.*

In light of the information shared by participant 23, a colposcope is a magnification device used to document probable external and internal genital injuries (abrasions and lacerations), which are challenging to see or easily missed

with the naked eye (Schafran, 2015:6). Although the use of the colposcope is definitely an advancement, there are a limited number of healthcare facilities in South Africa that have colposcopies; and even if a colposcope is available, it is not fully used during forensic examinations (Jina et al., 2015:5).

Medico-legal service is of paramount importance within the CJS since it entails the collection of admissible evidence such as DNA. It is noted that technological advances have been made, with coloscopy being at the forefront in identifying injuries inflicted upon adult female rape survivors. It is also more plausible for the survivor to be afforded an opportunity to determine their preference when it comes to the gender of the clinician conducting the forensic examination.

It is of crucial importance to take note that although the researcher probed the medical participants regarding recommendations for medico-legal services, none of the participants made significant contributions to the study in this regard.

The next section of the chapter will explore the psychosocial sphere of post-rape service within the CJS.

THEME 6: PSYCHOSOCIAL SPHERE OF SERVICE RENDERING TO ADULT FEMALE RAPE SURVIVORS

The participants were probed to gather information regarding their experiences in rendering post-rape psychosocial services. For this section of the interview schedule, the researcher targeted site coordinators, victim assistance officers and case managers.

SUB-THEME 6.1: CHALLENGES IN RENDERING COUNSELLING SERVICES TO ADULT FEMALE RAPE SURVIVORS

The researcher asked the service providers about their challenges in rendering post-rape psychosocial services within the CJS. From their responses, the researcher identified an array of challenges discussed below.

Sub-theme 6.1.1: Accessing psychological services

Service provider 2 highlighted the importance of accessing psychological services as a challenge experienced by rape survivors in the CJS. She voiced the following:

> *Uhm…, the problem is that we are dependent on them coming to us. So, it becomes difficult when we don't know who is out there. But when they do come to us, besides the fact that we do not have adequate resources, we may not be able to see them as frequently as we want to see them, because within the government system, we have so many patients that are coming. If we would love to see them every two weeks, we have to see them once a month due to limited resources. Some of them also don't have the financial means to come to the hospital, where they have to pay for these services. Remember, we also have psychologists at the clinics, and some of them they don't want to go the clinics, they want to come to the hospital. As a result, they default, since they don't have money for transport and to pay for the services. Overall, regarding therapy, if they are here and willing to start the process, it is usually not a challenge. If they are told, go see a psychologist, they usually don't understand what the process is about. In the beginning, it is difficult to come for them, but we work with them in therapy and put them at ease. Human resources and waiting time for an appointment is a challenge. If it is a rape survivor, we see them immediately and book a follow-up appointment.*

Sub-theme 6.1.2: Socioeconomic constraints in accessing counselling services

Service providers 3- 4, 6 and 16 (n=4; 14.3%) indicated the influence of socioeconomic conditions in rendering post-rape services. They cited the following:

> Site coordinator (a): *The victims availing themselves for counselling services, due to socioeconomic influences. Most often we find our victims cannot adhere to their follow-ups, due to money for transport.*

For example, a rape survivor only has R10, and she would rather use that money to buy something like bread, that would benefit them in the house, and subsequently counselling becomes a second priority.

Social worker (a): *It depends on the ages of the rape survivor. I don't have any challenges with adult female rape survivor. If they don't have money, they call us, I cannot come because I don't have money. I can only come on certain days.*

Site coordinator (b): *Thuthuzela Care Centres are based at local hospitals. So, some of them are not working and have to spend something like R100 per visit to come for counselling services. They are willing to come but financially, they are struggling.*

Social worker (c): *I think, the main one is finance. It is difficult for them to come for further counselling sessions. They don't have money for transport, and they stay far. Some of them, when they come, they did not even eat, and the nurses will give them something to eat. You know.*

Sub-theme 6.1.3: Age of the psychosocial service provider

Service provider 5 believed that the age of psychosocial service providers might influence the psychosocial mode of service rendering. He shared the following:

Okay, uhm…, you know sometimes the age factor might be a barrier to others. For example, you have an elderly woman coming seeing a young social worker, and the client is of the impression that this person might not tell me what I need to hear, because of the age.

Considering the revelations by servicer provider 5, the researcher is of the opinion that this information is new since the researcher could not find any empirical evidence to support the claim that the age of a psychosocial service provider might influence the expectation of the survivor in relation to counselling services.

Sub-theme 6.1.4: Postponement in accessing counselling services

Service provider 9 highlighted the postponement of survivors in accessing post-rape psychosocial services. She conveyed the following:

> *Like others, they will just postpone. They are not showing up, they are not coming for counselling sessions. With some, you must constantly change dates. They are not reliable with counselling sessions. Some they say they have financial instability; they don't have money come. It also depends on the circumstances of the case. For example, a married woman was raped by the husband, and they want to work on the relationship.*

Sub-theme 6.1.5: Establishing rapport

Service provider 10 considered that establishing rapport with the rape survivor is of prime importance within the CJS. She shared the following:

> *Uhm…, I don't find that it is challenging for me, it is really challenging for the client. But the communication at the time, because they are not in the right state of mind because of the trauma, and the emotions are taking over. It becomes hard because the dialogue is not two-way, sometimes you find out that you are encouraging her; but she is not telling how she is really feeling. You have to break the ice by asking her questions, and through that she can begin to be comfortable in telling you what happened.*

Sub-theme 6.1.6: Secondary victimisation by other service providers in the CJS

Service providers 11 and 12 (n=2; 7.1%) highlighted the effect of secondary victimisation in accessing counselling services. They cited the following:

> Auxiliary social worker (e): *The only challenge is that when adult female rape survivors go to the police, they were not treated well. Maybe the nurses also did not treat them well. So, when she is entering the counselling room, she will think that you will also do the same thing. They decide not to proceed because of that.*

Social worker (b): *Cases that are not properly handled, especially by our colleagues. Uhm… when the police are judging the victim. Maybe the victim goes to the police station before coming here, and when they reach the charge office, there are already officers who do not how to work with rape survivors, their duty is only to take down statements or whatever. They will ask all those personal things in front of everyone at the charge office, and the charge office does not have privacy per se. So, they will even say that: Look at how you dress, what were you expecting. Then comes a Family Violence, Child Protection and Sexual Offences officer, to take the rape survivor to the centre.*

Already along the way to the centre, the client has been judged, the client has been secondary victimised, and they will say that the case will not stand in court, it was your boyfriend, that is why you were raped because you are wearing like this. The client comes and already decided that they don't see importance of continuing or receiving other services. Mostly they will say, I just need medication. Another rape survivor stated to me that all of you civil servants are like that, I no longer want to continue with anything, not even counselling. So, it becomes difficult because of our colleagues have failed us before. It also becomes difficult to reach out to the client and calm the client down. But in most instances, I manage. I had several saying that with counselling, they are fine. Some will say, no, I have my own social worker and psychologist, but where? A person will say that they are fine, but how can a person be fine if they are being abused or raped? So, I would request them to come, and most of them normally do. They are still my clients, because I build a rapport with them. We build a relationship, and they come for sessions.

Sub-theme 6.1.7: Shortage of social workers

Service providers 19-20 and 25 (n=3; 10.7%) indicated that a lack of social workers influenced psychosocial services. They shared the following:

> Forensic nurse (c): *On weekends, we don't have a social worker here. Some cry non-stop. As a nurse, you must make sure you make the patient calm. They cry, and they can kill them themselves. We refer them to the hospital, psychiatry, I can't let the patient go, it will be dangerous.*
>
> Forensic nurse (d): *For now, it is a problem. It is lockdown. The social worker is not coming every day, only coming Monday, Wednesday and Friday.*
>
> Medical doctor (c): *No support that I know of for psychosocial. They bring in a forensic social worker on certain days, and that's the end of it. But in the criminal justice system, no. They just focus on their aspect being: to prosecute or not to prosecute, that's it.*

Given the views shared by the participants, a designated social worker should preferably be present at all Thuthuzela Care Centre facilities to provide psychosocial services (Skhukumisa, 2012:66). At the time of writing, the Department of Social Development acknowledged that South Africa has a critical shortage of social service professionals, emanating from an inability of government sectors (primarily due to budgetary constraints), to efficiently employ them across all sectors (Critical shortage of social workers in South Africa – here's how much they get paid, 2022).

Sub-theme 6.1.8: Language as a barrier within counselling services

Service providers 21 and 23 (n=2; 7.1%) were of the opinion that language served as a barrier within counselling services. They highlighted the following:

> Forensic nurse (e): *Language and the patient's level of understanding. We also don't know what is happening in counselling sessions, since some of our patients don't come back for counselling.*
>
> Medical doctor (a): *I think language. Maybe the counsellor speaks a specific language that the rape victim does not. You can't be fluent in all languages. And that person is the only counsellor that we have in the centre, so, it's going to be a problem for the patient to express*

> *herself, in the form that you both understand each other. In light of the information provided by the participants, survivors seeking assistance within the CJS should be interviewed preferably in their native language (Know- your- rights- TCC, s.a.:14).*

Sub-theme 6.1.9: Transportation between facilities

Service provider 26 opined that transportation between facilities is an issue of concern. He cited the following:

> *I would say, transportation. Within the Thuthuzela Care Centre model, we can assist them with transport, especially for their first appointment. But thereafter, I could actually move places close by to them. Now. It is financially straining to them. Now they can't attend sessions, and they will tell you that is because of poverty. If we can have counselling services everywhere else, we can have a referral system to the nearest place. That would to an extent, ensure continuity of services. If we can all agree on that, continuity of counselling services will not be lost. But now we don't know where to refer a victim, because she had moved, then that becomes a challenge. It can also lead to a victim withdrawing the cases or becoming discouraged. They do not complete their counselling sessions. The necessary infrastructure is in place at the Thuthuzela Care Centres and the Sexual offences Courts for counselling. We also make sure to refer to service providers who are operational.*

Considering the strongest responses of the service providers, long-term psychosocial support is inadequate; and the Department of Social Development is not providing sufficient social workers and psychologists to assist rape survivors (Thuthuzela Care Centres Compliance Audit and Gap Analysis, 2016:16; Waterhouse et al., 2013: 25). Likewise, service providers also play an important role in averting secondary victimisation through improving the experience of survivors in the CJS, by endorsing a victim-centred approach in rendering post-rape services (Legal Aid Society, 2020:61; Zia, Shallum & Randhawa, 2021:55).

Sub-theme 6.1.10 Male social worker

Service providers 15 and 21 (n=2; 7.1%) were of the opinion that a survivor does not want to be seen by a male social worker. They shared the following:

> Site coordinator (c): *In this Thuthuzela Care Centre, we have one social worker provided through an NGO. We have a male social worker, and most of our victims are female. We find that some of our female rape survivors do not feel comfortable being seen by a male social worker. Because of resources, we do not have another social worker that is in here, that can assist us. It is also one thing we have escalated to Department of Social Development, to work with us.*
>
> Forensic nurse (e): *We have a male social worker; patients don't want a male social worker. So, having a male social worker, it is a problem at times.*

With regards to the information shared by the participants, Bass and Davis (2008:45-52) are of the opinion that the adult female rape survivor has the option to receive therapy from a female social worker.

SUB-THEME 6.2: CHALLENGES IN IMPLEMENTING THE PROTOCOLS AND PROCESSES PERTAINING TO COUNSELLING SERVICES FOR ADULT FEMALE RAPE SURVIVORS

Service providers were probed regarding their perceptions of the implementation of policies and processes in relation to rendering post-rape counselling services. From their responses, the researcher identified the relevant sub-themes.

Sub-theme 6.2.1: Confidentiality

Service providers 1 and 16 (n=2; 7.1%) highlighted the importance of confidentiality in relation to counselling services. They shared the following:

> First responder (a): *It works, but the confidentiality, because I need to assure the survivor that it is confidential. But sometimes if your life is in danger, I will be forced to talk to someone else, because I can't be confidential if someone wants to commit suicide. But we explain to the*

client so that it is not a surprise. I would then tell her that I am going to speak to someone else because your life in danger.

Social worker (c): *When they compiled the protocol, they did not include experts in the area of Social Development. So, they did it for themselves, and sometimes it troubles me, especially when it comes to confidentiality. What has transpired between myself and the client is confidential, and the site coordinator would demand information. It is also included in the protocol that I have to discuss information about my client, with the site coordinator, it is breach of confidentiality. I can discuss it with the other auxiliary social workers, because they refer the matter to me, but her, it is something else. So, with this protocol, I don't know.*

Considering the revelations made by the participants, survivors' personal details, as well as information pertaining to the rape and related CJS processes, are to remain confidential. Agencies are tasked to safeguard that counselling and examination environments offer privacy; and that all information pertaining to rape survivors is kept in a protected place (NACOSA, 2018:10).

Sub-theme 6.2.2: Distribution of human resources

Service provider 2 believed that human resources served as a challenge in rendering post-rape counselling services. She cited the following:

I think that policies guide us, such as those from health, Batho Pele Principles. We don't have a challenge in adhering to policies, the only challenge is limited resources, and limited waiting time in accessing services. On a provincial level, it is advisable to look at the total number of populations being served by a designated number of service providers, in an effort to spread human capacity more fairly and adequately at hospitals, according to the specific needs of that population.

The *Batho Pele* Principles are guided by consultation, service standards, promoting accessibility, promoting courtesy, providing information, openness and

transparency, redress, and value for money. The rights provided to victims are also affiliated with the values of *Batho Pele* and are as follows*:* to be treated with equality and with respect in relation to dignity and privacy, to be afforded services and receive information; and the right to receive assistance and restitution (Kirchengast, 2018:195). Consequently, if there are limited resources, the quality of post-rape psychosocial services will also be negatively affected.

Sub-theme 6.2.3: Preferred demographics in accessing counselling services

Service providers 3, 10 and 26 (n=3; 10.7%) shared that the preferred demographics of counselling services influenced accessibility. They highlighted the following:

> Site coordinator (a): *It is always the case that policies or protocols will function the way in which it is intended to. Uhm…, I would believe that even if protocols are there, we also need ourselves some room to move away from the standard operating procedure, like for example, in terms of the procedure, we would expect the victim to come to the centre for counselling. So, if it is not working, we cannot continue doing something that is not benefiting us. So, we are innovative in suggesting that instead of coming here, refer them to a place closet to them. We have a clinic, where we have social workers there. So instead of coming here and use their taxi money, they can walk from their home to the clinic, and still receive the same service that they were supposed to get. I think that we are moving to ensuring the accessibility of services, with the intention of obtaining the same results.*

> Auxiliary social worker (d): *Not all the time, because sometimes, uhm…, clients live far from here, but we can refer them to their nearest facility where they can get counselling from. However, if you see the victim for the first time and they can tell you what happened to them, they want to continue talking to you, and not another person. Sometimes they live far, and you have to do the counselling over the phone. So, it becomes a bit of a challenge.*

> Case manager: *We have regular meetings. The challenge would be resources in the form of personnel. There are times when you have a Thuthuzela Care Centre, but you do not have a counsellor for instance, because an NGO who was providing a service, the contract expired, now we are looking for another one.*

Concerning the responses received from the participants, very few survivors seek assistance or support from the relevant agencies. Some of the reasons for not being able to seek or access post-rape services, are related to the inability to access services (due to a lack of transport or geographical location of the service provider) and seeming or perceptible exclusion from these services. It is also uncertain if the survivors are satisfied with the services they received. While empirical findings suggest that survivors who access post-rape services are relatively satisfied, some variations in terms of survivors' expectations and perceived outcomes of these services are of paramount importance (Roberson, 2017:3). Moreover, low-and- middle-income countries, such as South Africa, face the challenge of not having satisfactorily skilled personnel, especially for counselling, mental health and advocacy or support services. In circumstances in which advocacy and support services are in limited supply, there is a greater dependence on NGOs to provide these vital services (WHO, 2013:36-37).

Sub-theme 6.2.4: Adjustment of Thuthuzela Care Centre Care Model to cater for the survivor

Service provider 6 shared that oftentimes they had to adjust the Thuthuzela Care Centre model to address the needs of the survivor. She opined the following:

> *Every Thuthuzela Care Centre, their protocols differ. We can revise the protocol so that it can work for the need of the centre. We have a standard protocol, but we adjust it to the needs of the centre.*

In relation to the response of service provider 6, this information is new since service providers are expected to adopt the directives of the Thuthuzela Care Centre model across all facilities.

Sub-theme 6.2.5: Engagement with service providers

Service providers 8, 11-13 and 15 (n=5; 17.9%) believed that engagement with other stakeholders influenced the quality of counselling services rendered. They cited the following:

> Auxiliary social worker (b): *Sometimes, the police don't come, we have to call them to come here. The police are more like, I don't know, the victim will tell them their story, but they are not like us. In psychosocial services, we give you time to explain, and then we support you emotionally. So, the police sometimes, they will force someone to say, you are raped, or maybe it is because it is your partner. The rape victim will think; did my partner rape me or not, because of the police. But we at the Thuthuzela Care Centre won't judge you.*
>
> Auxiliary social worker (e): *Yes, we have that challenge, because when a client enters the centre, when it is a walk-in, the person does not go to the police station, then we have to call SAPS. They have to come. So, I am busy with containment, then SAPS come. I have to drop everything in the middle of the session and allow SAPS to take the client and do the interview because they don't want to wait till we are finish, when they come in, they have to take over the client. Also, with the doctors, they say the doctor is knocking of now, he or she wants to go home, I have to drop the counselling and allow the doctor to take over. Importantly, with counselling, we explain all the procedures to the client, regarding what is going to happen, at entry level. They need to have an idea of what is going to happen. Now, the police come, the doctor come. After five minutes the police or the doctor come, they are all over the place. After they are finish with the doctor, they must come back to me. It is chaotic in that way.*
>
> Social worker (b): *You know, I won't say they support each other. In some parts they do, but in other parts they don't. Protocols, this thing I have been asking, that was done by the NPA and other stakeholders, I could see that people who were drafting it, are not knowledgeable*

when it comes to psychosocial services. Because you find that here is NPA, which is the site coordinator of the services. It is NPA who is the victim assistant officer, then, it is the doctors and nurses, then us and SAPS. Our duty is to do containment, and the site coordinator is not a trained counsellor. She does not know how to contain the situation. But the protocol would say that the first person to see the client, is the site coordinator. How so? The person is traumatised and does not need to be asked a lot of questions and does not need to be send from pillar-to-post. The person is crying. The first person to contain the situation is us, social workers and auxiliary social workers, for the victim to be calm and tell their stories. So, you find that it also causes secondary victimisation. The site coordinator will just come and take the victim, she is not trained, she will just give the client whatever advice. By the time the client needs to see the social worker, the client is exhausted. So, the protocols are not complementing each other. With health, some nurses, they like to say that after the containment is done, they also want to do counselling, they are not trained. This is secondary victimisation, each and every person need to know their roles. I am working from here to here, others are working from here to here, but are we talking the same language? So, I don't see those protocols intertwining and working together, for the well-being of the victims. I think they should be revisited.

Victim Assistant officer (b): *We do have a protocol about counselling services, but because we are different stakeholders offering counselling services such as the NPA and NPO's, health, and SAPS. Sometimes the counsellor will be busy with the client, and maybe by that time we have called the police, but they are not coming, and the counsellor starts with the counselling process. Then the police just come and say that they have been called to do this and, then it just disturbs the whole process. I think it is matter of us being different stakeholders. With a walk-in, then we call the nearest police station.*

> *Sometimes a police officer will be coming at his own time, coming from attending to another case.*
>
> Site coordinator (c): *One of the most challenges that we have, is the change of staff. The police change their police officers, more than we would change at the Thuthuzela Care Centres. Every three months, you will see a new member working with victims, and also find out that that member is also less experienced. We need to teach them things all the time. Also, the protocol for health and the NPA, are not the same. If we experience challenges, we would usually refer challenges to the Commanders of the Police. We also once a year, sit together at look at protocols, to find ways in accommodating all protocols, and make sure that we know, that this is how we work. The change of staff from the police, is a challenge.*

In light of the assertions made by the participants, the National Policy Framework assigns directives for all role players within the CJS to mutually react to- and-prevent sexual violence through the support of a five-year plan. Additionally, the National Policy Framework provides direction on what victim-centred approaches should be and how the delivery of services should be implemented. A holistic framework of responsibilities and duties of the various stakeholders in facilitating the provision of operative, appropriate, efficient, co-ordinated and victim-centred services post-rape care should thus be of prime importance (Department of Justice and Constitutional Development, 2012:16, 25).

Sub-theme 6.2.6: Telephonic counselling

Service providers 10 and 16 (n=2; 7.1%) made reference to telephonic post-rape counselling. They shared the following:

> Auxiliary social worker (d): *But telephonic counselling, that one is challenge because, when you call the client, it's either she is busy, or there is noise, you can't talk to the client. The client is also reluctant to talk via telephone, because the people she is with does not know; she has kept it to herself.*

Even if you try to persuade the client to go to another room, she is also not comfortable talking there. That is why it is always easy to have them in a setup where they are comfortable, and not worry about overhearing the conversation that you are having with them. So, it is a challenge, it really is.

Social worker (c): *It depends on the individual, it can work, if the person is interested. It is recommended that we should phone them if they don't come. Some of them just don't answer the phone.*

Sub-theme 6.2.7: Vicarious trauma

Service provider 21 highlighted vicarious trauma suffered by service providers as being significant in rendering post-rape counselling services. She empathised the following:

Sometimes certain cases are even traumatic for us, so we have peer debriefing. It makes a difference. I would also recommend a full-time female social worker at our centre.

In light of the assertions made by participant 21, the consequences of rape on the survivor can create feelings in service providers of being burdened, overwhelmed and despondent in the face of excessive need and suffering experienced by the survivor. It can also cause service providers to extend themselves beyond what is reasonable for their well-being or the best long-term interests of survivors. Among other things, it may include emotional distress, social withdrawal, feelings of despair and hopelessness (NACOSA, 2018:30).

Sub-theme 6.2.8: Employment obligations of rape survivors as a barrier in accessing post-rape counselling services

Service provider 26 shared that some survivors cannot attend counselling services due to work obligations. He opined the following

Some work, and they would tell us the employer said that he will fire me, so I had to choose my work. Some will also say, if I report, who is going to attend because my employer wants me there 7 days a week.

Psychosocial services for adult female rape survivors are visible and applied within various contexts, although the quality of these services seems to be widely fragmented. There exists uncertainty with regard to the roles and duties of psychosocial service providers and when these services should be activated once the survivors enter the CJS. Barriers to counselling services include but are not limited to maintaining confidentiality, skills of service providers, resources; secondary victimisation; and transportation of the survivors between facilities (Thuthuzela Care Centres Compliance Audit and Gap Analysis, 2016:16).

SUB-THEME 6.3: ADVANCEMENTS AND PRACTICES REGARDING COUNSELLING SERVICES FOR ADULT FEMALE RAPE SURVIVORS

The researcher asked the service providers if they were aware of any new developments pertaining to post-rape counselling within the CJS. They shared the following:

Sub-theme 6.3.1: Continuous training

Service providers 5 and 8 (n=2; 7.1%) highlighted the importance of continuous training in keeping abreast with post-rape counselling services. They explicated the following:

> Victim assistant officer (a): *Yes, there are training, although now due to COVID-19, everything is paused. But usually, we receive training on a regular basis. We do receive updates more particularly on legislation regarding rendering to adult female rape survivors within the criminal justice system.*
>
> Auxiliary social worker (b): *Like for now, they give us the opportunity to go for different training to improve our services.*

Given the information shared by the participants, there seems to exist continuous frustration stemming from a lack of concrete actions, inadequate resources, lack of skills and training, and insights that the various sectors do not fully comprehend and agree on certain matters pertaining to service rendering services to rape

survivors within the CJS (A Dialogue Between Government and Civil Society, 2013:7; Sexual Offences Courts National Strategic Draft Plan 2016-2020:24).

Sub-theme 6.3.2: Telephonic counselling

Service provider 3 indicated that telephonic counselling played a role in advancing post-rape counselling services. She shared the following:

> *Site coordinator (a): Uhm…, I think some of the new techniques, is providing telephonic counselling. Sometimes we do recommend that. Now everything has become virtual, as well as some support groups. We have the toll-free number that we give for gender-based violence services; that they can access free of charge. We give them that option.*

Sub-theme 6.3.3: Continuous engagement among service providers

Service provider 6 shared that continuous engagement with other service providers was of prime importance. She highlighted the following:

> *Every Monday, or fortnight, we have a short meeting to discuss the challenges we experienced during the week. We try to have meetings, so that at the end of the day, we will be able to know the need to improve counselling services.*

Sub-theme 6.3.4: Support systems to helpers

Service provider 11 shared information about the different ways in which service providers assist each other in rendering post-rape counselling services. She shared the following:

> Auxiliary social worker (e): *We, ourselves, also go for counselling. The one that I benefit more from, is helping the helper. It is more of a debriefing session. We are also equipped in dealing with the trauma that we see on a daily basis. It also teaches us to deal with the stress at work. The other way is to talk to our supervisor. We are also affected in a way. So, that training, they do help a lot in dealing with stress at the centre.*

In light of the assertions made by the participants, the challenge for social workers in South Africa is to deal successful with stressful situations for which they simultaneously have to receive the necessary support to deal with it -(Van Wijk, Ntombela & Mabvurira, 2021:72). Likewise, Taylor (2016) cited in (Van Wijk et al., 2021:73), is of the opinion that helping professionals are regularly subjected to stressful events daily and should receive assistance, to be fully cognisant in dealing with trauma.

Sub-theme 6.3.5: Buddy system in rendering post-rape counselling services

Service provider 12 showcased the buddy system as a new advancement in post-rape counselling services. She mentioned the following:

> *With the buddy system, we find that we have problems with the contact details of the rape survivors. What we do in the first session, after doing containment, we would ask the client if there is anyone that the client is trusting, is closer to, that she can give the contact details, so that if she is not reachable, we will be able to reach the person she nominated. We then call the person to make a relationship, and we also ask the person to please support the victims and assist us if we need to contact the victim and cannot reach her. Even with medication, because PEP needs to be taken for twenty -eight days, without skipping a day. In most instances, they have symptom withdrawals. We also inform the buddy that we have given the victim information that they should adhere to. So, this system supports the well-being of the victim.*

Given the information shared by participant 12, the researcher is of the opinion that this information adds value to this study since the researcher could not find any supporting evidence relating to the buddy system in rendering post-rape services to adult female rape survivors.

Sub-theme 6.3.6: Tracing correct information of the survivor

Service provider 16 indicated that he had challenges in obtaining the correct information about the survivor. He shared the following:

> *Sometimes the client also gives us incorrect addresses and contact numbers, but SAPS and health assist us with this information. For SAPS to be able to do their work, they need proper addresses and contact details. So, some information we get from SAPS, or from the medical file of the patient because we work closely together. They are minimal, say less than ten percent that we cannot reach, the rest we can reach.*

Sub-theme 6.3.7: Pre-and-post HIV counselling by first responders

Service providers 13 and 14 (n=2; 7.1%) emphasised the need for HIV counselling services. They articulated the following:

Victim Assistant officer (b): Our counsellors are now also trained for testing for HIV. It is also improving our services at the centre.

> First responder (b): *As a first responder, I do trauma containment, and then I also do pre-and- post HIV test counselling. I also support them through the 28 days in taking PEP, to make sure that they take it. In the end, they test HIV negative. I also follow-ups of the dates, to remind them when they must come to the clinic.*

Emanating from the responses shared by the participants, in sub-Saharan Africa, two-fold epidemics of HIV and sexual violence make the administration of PEP a critical part of the public health response to the management of rape. Furthermore, in relation to the contributions shared by the service providers, genital trauma subsequent to rape, increases the prospects of HIV transmission. Understanding the commitment and use of PEP could enable measures to improve the efficacy of PEP (Chacko et al., 2012:338; Draughon, 2012:85; Muriuki et al., 2017:255; Wheeler et al., 2014:26).

SUB-THEME 6.4: RECOMMENDATIONS IN RENDERING COUNSELLING SERVICES TO ADULT FEMALE RAPE SURVIVORS

Service providers were probed regarding their recommendations in rendering post-rape counselling services. From their revelations made, the researcher identified the subsequent sub-themes.

Sub-theme 6.4.1: A need for more campaigns

Service provider 1 specified a need for more campaigns. She shared the following:

> *I think we need more campaigns. People are not that much informed, especially older people. At least with the youth at school, there is life orientation, they are watching TV and have phones. The problem is with elder women, they don't have much information. Someone might say it is my husband, he paid labola for me, he has the right to sleep with me anytime when he wants. You know, it not right, but because of a lack of information, we need to mobilise more campaigns and give them information. I think it is information that is needed most.*

Sub-theme 6.4.2: A need for accessibility in post-rape counselling services

Service provider 2 raised concerns over accessing post-rape counselling services. She shared the following:

> *Let's just make sure these services are available to them, not just at hospitals but also clinics. These services should not only be available at clinics, hospitals, or Thuthuzela Care Centres. It should be available at community levels and easily accessible free of charge. They should start there. Even at schools and workplaces. Adults are often neglected, things like sexual harassment that might potentially lead to rape, are not taken into consideration. To make sure we strengthen our Employee Wellness Programme in all working environments. It is also imperative that a psychologist or social worker be available at*

police stations, to do containment before they go home, or referred adequately to a Thuthuzela Care Centre.

Sub-theme 6.4.3: A need to provide rape survivors with financial assistance to access services

Service providers 3, 7, 12-13, 15-16 and 26 (n=7; 25%) asserted the need for financial assistance in accessing post-rape counselling services. The voiced the following:

> Site coordinator (a): *Trying to go beyond in what we are providing at the present moment. You must remember that at the Thuthuzela Care Centre, we need to apply a holistic approach. I think we need to become more involved. A victim will take their last money to come for counselling, and when they go back home, there is nothing to eat. If we can provide them with grocery, usually we can only give them a comfort pack when they come on the first day. We lose them along the way, due their own challenges, due to poverty. We need to meet their each and every need such as financially, since it will increase their confidence in the system as well.*

> Auxiliary social worker (a): *And the others, they can't afford to came for the follow-ups. But we encourage them to come, as long as it is not every day. But we encourage them to come for follow-ups, according to the dates the doctor gave to them. And we also verify with them the dates for counselling, we follow-up with them. Yes.*

> Social worker (b): *Also, with the transport, it makes things difficult because for us it is difficult if the client cannot come because of transport money, we request her to borrow money to come, and we reimburse her because we have an emergency transport fund that we claim monthly for the client to come.*

> Victim Assistant officer (b): *Some of them, you will find that their financial background is not very good; and they struggle with money, to come to the hospital. If financial assistance can be provided for them*

to come for counselling services. Our services are open 24/7. There is always a counsellor or a social worker.

Site coordinator (c): *Sometimes, reaching a service, is always an issue of transport. We sometimes have to make use of transport from the hospital (Community Health Centre) they recently changed it to a District hospital, because during that time of crisis, we do not want to lose that person, because they need help to continue. We are not necessarily beneficiaries for transport, except for the medication. We ask the hospital to assist us with transport if we really need it.*

Social worker (c): *The problem that I have is follow-ups. Because now the problem is more financial for rape survivors to come for follow-ups, as well as shame. Some of them will come the medical follow-up, and don't come for counselling. Sometimes they also don't complete PEP, which is even more critical for them. Sometimes they belief that they can cope on their own, only to return months and months later. I would also recommend psychosocial education with the family members, so that they can understand the behaviour of the person, and how to support the rape survivor.*

Case manager: *Assistance with transport.*

Sub-theme 6.4.4: A need for group therapy

Service provider 4 conveyed a need for group therapy. She opined the following:

We are lagging behind in group work processes. I think that group processes will work. We are only doing individual counselling, I think that if we do group counselling, it will benefit them.

Sub-theme 6.4.5: A need for more psychosocial service providers

Service providers 4, 20 and 25-26 (n=4; 14.3%) asserted a need for more psycho-social service providers. They shared the following:

Social worker (a): *We are also only two social workers; we would like to have more social workers.*

Forensic nurse (d): *We need a social worker here every day.*

Medical doctor (c): *They need more manpower to provide such services. Now, we are running on critical stuff so to speak, and these guys are pushing numbers, you know.*

Case manager: *More counselling services.*

Sub-theme 6.4.6: Assistance with transportation for outreach initiatives for service providers

Service provider 6 indicated a need for assistance with outreach initiatives. She highlighted the following:

If maybe they can give each centre one car, to help with the transport needs of adult female rape survivors. The social workers also do home visits, but the stipend given for that, is not enough. Another thing is most social workers and lay counsellors don't have cars, and certain areas are not safe, since they themselves are also women.

Sub-theme 6.4.7: A need for continuous training in rendering post-rape counselling services

Service providers 12, 16 and 25 (n=3; 10.7%) believed that continuous training should be inherent in counselling service services. They shared the following:

Social worker (b): *If our colleagues can be properly trained in dealing with rape survivors, let me rather say gender-based violence. If our colleagues, the police, health and NPA be trained in how to handle the cases, it will make it easier for us, as psychosocial service providers, to render effective services as well. And, also, on our side, constant training, or workshops, for us to be up to date, to be effective, in everything that we are doing on a daily basis. It will be much better; and it will also avoid secondary victimisation.*

Social worker (c): *They however offer refresher course, which I attend often. We, however, need more focused subject and specialist training, such as trauma-informed approaches in working with rape survivors.*

Medical doctor (c): *They need to do it properly because people have serious issues after rape. If you are just going through your checklist, you are going nowhere. You send the person doing it for a job, you are wasting your time. The person needs to be skilled. You send the patient to the right person, with the right skills, that problem will be sorted.*

Sub-theme 6.4.8: Assistance with comfort packs

Service provider 7 expressed a need for more compact packs for survivors. She shared the following:

We have the comfort packs, but the comfort packs, it is not enough.

Sub-theme 6.4.9: Training of the police

Service provider 12 opined a need for the training of police officials. She highlighted the following:

It will also make a difference with clients, because if they are received with respect, from the first person such as SAPS, it will be easy for them to come and receive psychosocial services or counselling, because already, they have respected them, those people. Then they can see that the police are doing well. But if the police don't have enough information and capacitated, they won't be able to treat the client with respect, and it will become difficult for psychosocial services to continue.

Sub-theme 6.4.10: A need for protocols in rendering counselling services to be revisited

Service provider 12 indicated a need for protocols followed during the counselling process to be revised. She mentioned the following:

If the protocols can be revisited, so that all stakeholders can know what their role at the centre is; and for everyone to keep in their lane. I am doing psychosocial services, and I am not a doctor, and cannot involve myself in medical issues. The nurses also, they must do nursing and

leave the psychosocial part because they are not trained for that. Let containment be done by the auxiliary social workers, they are trained for that, not the site coordinator. It becomes secondary victimisation, it becomes complicated, because by the time the client comes for counselling services, she is exhausted because a lot of people listened to her story. The client becomes reluctant to participant in counselling services.

In light of the information shared by the participants, psychosocial services are heavily funded and endorsed by external agencies such as NGOs and NPOs. Some of the most encountered challenges would be the choice of the survivor to proceed with counselling services, information pertaining to these services and financial ability to access these services.

The next section of the chapter will explore the legal mode of post-rape services within the CJS.

THEME 7: LEGAL ASPECTS OF SERVICE RENDERING TO ADULT FEMALE RAPE SURVIVORS

Service providers were probed regarding the challenges and advances in rendering post-rape legal services. Additionally, they were also probed regarding their opinions on working in a multidisciplinary team. From their responses, the researcher identified the relevant sub-themes.

SUB-THEME 7.1: CHALLENGES IN RENDERING LEGAL SERVICES TO ADULT FEMALE RAPE SURVIVORS

The service providers offered various challenges in rendering legal services to rape survivors. These challenges are described in the sub-themes below.

Sub-theme 7.1.1: Assistance for survivors in accessing legal services

Service providers 1, 2 and 15 (n=3; 10.7%) indicated a need for survivors to receive assistance in accessing legal services. They shared the following:

First responder (a): *Uhm…, when it comes to legal services, most women, they fear. They are fearful, maybe with court preparation, like someone will go to court with them. I think they need that more.*

Clinical psychologist: *Survivors should get support; they should not struggle. From point of entry to departure, within the criminal justice system.*

Site coordinator (c): *Sometimes the victim is not given that information, which is the responsibility of the police. We find out that the person comes to us, and inform us that the person is walking around, without them being informed. It is really something we need to look into. To keep the victim up to date with everything that they need to know.*

Sub-theme 7.1.2: Treatment by the police

Service providers 2-4, 10, 12, 14, and 16-17 (n=8; 28.6%) expressed concerns about the treatment survivors received from the police. They conveyed the following:

Clinical psychologist: *Eish, what I have heard when it comes to our system is failing our survivors, is the treatment they get when they go to the police station. Uhm…, there is no privacy, you will asked to talk while standing in huge line. In that state, you are likely to be traumatised, your tone, your voice, it is going to be soft. And then someone is asking you: I can't hear you; What are you saying? You have to shout and scream your problems out at everyone.*

So, I think that is important. For example, if a wife wants to report her husband, she is told that it is a domestic issue, and to go and deal with it at home. So, it is very discouraging, very discouraging. Most of these cases are left unresolved, it is very discouraging. We need to desensitise our police officers, for the courts that this a traumatic experience for the person standing in front of you. For men it's even worse, the humiliation and everything that goes with it. Survivors are asked: How can your husband rape you? Of concern, there are no

communication after that. I have never heard one of my patients saying I am waiting for an SMS from the police, or, I haven't heard anything from the investigating officer. When the accused gets bail, they feel unsafe, and they would go and check with the police, but never get answers. There is never follow-up information given to survivor, for example, this is the progress of your case. It is the victims themselves that have to go and find out what's going on, when they get there, nobody knows what is going on. It can be very frustrating.

Site coordinator (a): *Yoh, when it comes to the police, it is known phenomenon that they are not being sensitive towards gender-based violence, and only transport them when they reported the case. After that, transport is out of their own pocket. The police are also not constantly informing them about the progress of their case. With the prosecutor, the challenge would be with the consultation, because the rape survivor would mention that she doesn't know if the prosecutor is on her side, or on the side of the perpetrator.*

The victim also has the perception that after reporting the case, they can go and demand that the case be dropped. The aforesaid is not an easy decision taken by the case manager (prosecutor).

Social worker (a): *Some are complaining about the services that they receive from SAPS. If they come and complain, I inform a NPA member, and we solve the problem as a team.*

Auxiliary social worker (d): *Okay, the challenges for me now, is that not everyone is as passionate as me to help a client, as you, as counsellor for me. Uhm..., like some of the clients feel that the police don't understand, like how they feel, or what is happening to them. More importantly, the tone that they use when they talk to them. The remarks they make, you know. That is the biggest challenge for me now, because the victim feels that they are not getting the support that they need from the police officer. After you have spoken to the client as a counsellor, she needs to sit with a police officer and be*

comfortable to tell them what happened. But if he is pushy and mean in that interview, that woman is not comfortable. When they leave that space, they feel like worse before they came in. Others feel like, this is the reason why I did not want to report, because I did not want to be made as a liar. For the victim, it sounds like I lied, because I forgot an element; because this person is traumatised. You know, when you ask them questions and they miss something, because their mind forgets, due to the traumatic experience. You know, some, they don't really remember, with others only remembering after a few days. And when they have to go and tell the officer, that this is what happened, it becomes an issue: Why didn't you say it in the first place? you know.

Social worker (b): *Some of them the police will say that they don't need to open a case.*

But I told that, were you there? because your duty is to take the statement, investigate and not judge the client. The role of the police are not to judge the victim. Their role is to open the case, investigate the case and take it to the magistrate to judge. Now, because of the police doing that, already the client becomes reluctant. Justice to the client has been failed. So, secondary victimisation as well, it makes the client to be reluctant. Like I said, there was this case, whereby the client was told by the police that your case will not stand up in court. And it is because of what you were wearing….; and you went to your boyfriend….; you wanted it to happen. So, the client also, becomes so confused and traumatised and feeling that justice is not going to be served. Maybe I have been judged, even before my case had even been heard. So, what is the use, the victim then withdraws the case. Victims are not believed by our officials, especially SAPS.

First responder (b): *You know, the challenge is with the police, they usually bring patients, and then they never come back to fetch them. The victim will also come back to us and inform them that they do not know anything about their case. No one has ever come back to me, to*

tell me this is what happened, whether they have arrested the perpetrator or not. People should be educated that perpetrators are eligible for bail, then they come and say that the perpetrator is out, we explain the process to them, and try to assure that their case is still on. When they see the perpetrator is out, they think that the case is gone.

Social worker (c): *I think it is the police. The police are a major challenge. Sometimes, they don't inform what is happening with the case. They don't usually go to court when the suspect appears for the first time, and the police don't inform them the alleged rapist got bail. They don't know what happens there, and some of them don't understanding the workings of the criminal justice system. For example, they don't understand that people have a right to bail. So, they think that the alleged rapist got away with it, and they had lost the case. Then the site coordinator or the victim assistant officer sits down with them and explain the whole process of the law. They also phone the investigating officer, to make sure that they communicate with the patient. They take time to come and fetch a patient. Sometimes the patients sit here the whole day, while others will tell us that the police told them to come back tomorrow, patient of rape, can you imagine. Sometimes they don't even tell them, don't wash. They forget that a woman can feel so dirty after rape. They forget that. Then she just washes. The next day they just bring her here in morning and she waits the whole day, they only come in the evening. You see, the site coordinator has complained how many times. You see.*

Forensic nurse (a): *With our police, I think they are mostly trained on how to deal with rape survivors, but they themselves, are not safe. Because we had a case here, by not being safe is my opinion, whereby, it's an adult patient to say the police official raped her, after coming to pick her up here. So, I don't think if they are safe picking up the patients here. Remember, we are a Thuthuzela Care Centre, we accept walk-ins, and then call the police wherever they are, to come and open up cases, and then they are suppose to take them back*

> *safely. So now, I don't know what was happening there for the survivor to come to say: He also raped me. My first week, I started to realise that some of the SAPS officials, they know about PEP. If the patient does not have PEP, they talk to them. I don't know how to put that. To say this one is safe, we can be intimate.*

Concerning the assertions made by the participants, if a survivor is confused, erratic or seems to adhere to the perceptions held by rape myths, the police are often reluctant to investigate the case. Additionally, the process of pursuing assistance from law enforcement agencies results in the strengthening of cultural viewpoints that women should blame themselves and feel ashamed for their own victimisation (Messina-Dysert, 2015:78-79; Watson, 2015:5-6).

Sub-theme 7.1.3: A need for more sexual offences courts

Service provider 5 articulated a need for sexual offences courts. He shared the following:

> *I think for now, where I am currently based, we don't have sexual offences courts, you understand…so we use normal courts to do sexual offences. But if you look at the situation, we need courts that only deal with sexual offences. We also need more prosecutors dealing with sexual offences. I think that will also assist.*

Regarding the contribution made by service provider 5, the Ministerial Advisory Task Team on the Adjudication of Sexual Offences Matters emphasised the need for the re-establishment of the sexual offences courts and developed a model that followed to address the challenges relating to the lack of sexual offences courts, while strengthening their key areas of success. The costs attributed to the re-launching of the model for the efficient functioning of the sexual offences courts were determined, and aligned with the National Regional Court Resource Audit to regulate the sexual offences courts (Ministerial Advisory Task Team on the Adjudication of Sexual Offences Matters, 2013:6; Sexual Offences Courts National Strategic Draft Plan, 2016-2020:8-9).

Sub-theme 7.1.4: Lost dockets

Service provider 6 voiced concern in relation to lost dockets. She mentioned the following:

> *The challenge we are experiencing, the police sometimes, they lose the dockets, they delay with the case, they don't record everything right in the system because the police work hand-in-hand with the case manager. When the case goes to court, there are so many gaps that end up challenging the merits of the case.*

Sub-theme 7.1.5: Communication pertaining to case progression

Service providers 8, 10, 12, 15, 21 and 23 (n=6; 21.4%) raised a need for communication regarding case progression. They shared the following:

Auxiliary social worker (b): Adult female rape survivors are not being informed more about the progress of their case.

> Forensic nurse (e): *Sometimes the investigating officer does not get back to them. Sometimes when they have to appear in court, they also do not have a subpoena. Patients also give wrong addresses and phone numbers. That is why if they come to report a rape, they don't want the legal route, only medication.*
>
> Medical doctor (a): *I think it's the information. The information that everybody has the right to get bail, until all proceedings are concluded in court. They, the victims, also need to be protected.*
>
> Auxiliary social worker (d): *Uhm…, the ones that we work with, they are knowledgeable. They know in terms of what should happen. The only problem is just the attitude.*
>
> Social worker (b): *Not all the time. The attitude of the service providers. The way, I don't know, they treat victims, it is inappropriate. Their actions infringe upon the rights of the client. The client has the right to receive information, right, now the client knows that the perpetrator is behind bars, he was arrested the previous week. The following week,*

the perpetrator is out on bail, and the victim was not informed. Nobody tells the victim the perpetrator is out on bail, do not be shocked if you see him. But what I always fight with them is that the perpetrator is not allowed to be within close parameter of the victim, but victims are complaining of the alleged perpetrator around their vicinity. So, they become at risk, bail is granted, and the perpetrator even makes sure that the victim sees he is out on bail. In other words, the perpetrator is intimidating the victim at the same time. Why is the bail not evoked? They will tell you this and that…, or that they will find out. You call later to call to find out what is happening, and they will say that the victim is lying. Yoh, such things, are really not on. You know, they are not following legislation the way they are supposed to. Some victims would even say that their cases were withdrawn without their knowledge. So, what should we do? You call and ask the case manager; and the case manager will tell you that the evidence is not enough. If the evidence is not enough, why don't they call the victim and inform them. They are only receiving this information when they come to us. I don't know, our legal system is just failing us.

Site coordinator (c): *We are different stakeholders, at NPA, I know what needs to applied. The challenge is when a person from the Department of Health will say, I am not going to see a patient based on one, two and three, and then I must come in say, but the law say…..The biggest challenge with NPA staff, is that we are only here during the week, and not weekends, so the biggest challenge would also be, not reaching to victims coming in weekends and public holidays. Even at night. But otherwise, all stakeholders have copies of our protocol. They know what needs to be done. All the legalities, they know how to do it, it is only the attitude that remains a challenge. Our biggest challenge is information, sometimes people are not getting all the information that they need, because when you don't know, you tend to assume. For example, if a person opens a case, they need to know when a suspect is being apprehended, and they need to know*

when the suspect was granted bail. So, sometimes the victim is not given that information, which is the responsibility of the police. We find out that the person comes to us, and inform us that the person is walking around, without them being informed. It is really something we need to look into. To keep the victim up to date with everything that they need to know.

The responses by the service providers show that survivors wish to be informed regarding the progress of their case on a continuous basis (Know- your- rights-TCC, s.a.: 14; Molina & Poppleton, 2020: 23). Additionally, survivors oftentimes do not have access to case-specific information pertaining to the progress of the investigation of their case; and if further information is necessitated of them from the police (Watson, 2015:4).

Sub-theme 7.1.6: Delay in DNA results

Service providers 11 and 12 (n=3; 10.7%) expressed concerns pertaining to delays in the processing of DNA. They articulated the following:

Auxiliary social worker (e): *The delay at the laboratories for DNA testing. The police would say that the case is breaking because they still waiting for the results from the laboratory.*

Social worker (b): *Now, DNA, it delays. The DNA results can take three to five years I don't know. They will say this or that is not there, so already, the case is not going forward. They are some will say that, because the doctor said maybe there was penetration, let us wait for the DNA results.*

Site coordinator (c): *A victim is supposed to go court today, then maybe someone is not there, and the case is postponed. An electronic system will work very well if a suspect is arrested, and they need to compare the sample of the DNA found on the victim; you find that DNA is delayed, the suspect is granted bail, only to find out that they did not bring the suspect to the Thuthuzela Care Centre for the collection of DNA. Then they go to court, only to be instructed by the court to take*

DNA from alleged suspect. At Mamelodi Thuthuzela Care Centre, they have a well organised system, for example, if the suspect is known, the police officer will bring the suspect in today for DNA collection. And when they go for bail application, already the sample is on its way to the lab, meaning that the time they go to court, they are just waiting for the results.

At Mamelodi Thuthuzela Care Centre, the cases move, with the timeline of cases being reduced from two to almost eight months, because of the DNA. DNA is the most delaying important factor when it comes to finalising cases, because sometimes without DNA, there is no definite proof that this is the suspect.

The responses by the participants are unfortunately not new, as Daniel (2021) opine that there exists a backlog in the processing of DNA results at the National Forensic Science Laboratories.

Sub-theme 7.1.7: Police burnout

Service providers 12 and 16 (n=2; 7.1%) believed that the police encountered burnout while performing their duties. They expressed the following:

Social worker (b): *Sometimes we also have sessions with SAPS members, because of the behaviours portrayed, are signs of stress, work overload, or whatever, so they will say that you as a social worker, you are not investigating, can't you see that these people are wasting our time. So, really, our police officials need training, and they need proper social workers from their department, who will be able to render psychosocial services to them, because all of these cases, I think it also traumatises them, because I think that it makes them even judge more than the magistrate in court. Because already they will say that this case will not stand up in court, and I ask them: How do you know that? Are you a magistrate?.*

Social worker (c): *The police are a problem here, honestly. They just do anything; they are no longer motivated. They are just burned out.*

In relation to responses shared by the participants, burnout is related to feelings of depression and vicarious traumatisation. It may also surface through workload, being overworked or limited resources, being time-stressed, or having conflicts with other stakeholders. Burnout also comprises emotional exhaustion, a sense of disaffection from work-related activities and limited work performance (NACOSA, 2018:30).

Sub-theme 7.1.8: Postponement of cases

Service provider 25 indicated that the postponement of cases is a challenge within the CJS. He opined the following:

> *The judicial system has got this problem; they can't get their work done. The big issue with this is postponements. It is not surprising to find a case postponed ten times. They can postpone ten times in a year. Ten postponements for them are not a problem.*

In light of information shared by the participant, any postponement requests may be due to interruptions in collecting evidence and witnesses not appearing or ready to testify by both state and defence. According to Heath et al. (2018:13-14), there are also inadequate interpreters, court preparation officers and intermediaries.

Sub-theme 7.1.9: Quality of completed J88 medical form

Service provider 26 shared that the quality of the completion of J88 forms plays a role in legal proceedings. He stressed the following:

> *Doctors complete what we call a J88, and sometimes that J88 is incorrectly completed. So, only when that J88 is incorrectly completed, do you have challenges in court. But my role is to ensure that whenever I read dockets, and I see that there is something that was done incorrectly, we can rectify such before trial, that's what we do. We also train doctors on coming to court, people are scared to come to court. Sometimes you may find someone has done an examination, but they make a mistake so that they do not come to court. So that would not complete the J88 with their details, so that nobody would*

know that they completed the J88. But, with the Thuthuzela Care Centre model, they can now ask anything legal that they don't know. The case manager would then be able to advise what should and should not be done. The also is, people come with needs, So, the challenge is explaining to them that this is how the legal system is suppose to be. It takes time, it takes a lot of convincing. But we have now created positions, like case manager positions. Because normal prosecutors that go court, does not have the time to explain everything.

But the case manager looking after the welfare of the victim, will be able to explain that. People also watch rape cases in the media, and people have their own interpretation of what is happening, and that is not legally correct.

Emanating from the contribution made by service provider 26, the J88 form does not visibly necessitate service providers to document the examination methods that they used, and thus dependent on perceptive service providers documenting this information at their own discretion (Jina et al., 2015:5).

Sub-theme 7.1.10: Quality and readiness of a survivor to give a statement

Service providers 14 and 28 (n=2; 7.1:**%)** indicated the quality and readiness of a victim to give a statement as being problematic in rendering legal services. They voiced the following:

First responder (b): *Sometimes a patient comes in, she was raped and beaten up, but the law says we must wait for the police to come. Sometimes, we decide to attend to the patient, and when the police come, we do everything. You know what happens with victims, they have different statements, with us they say this, and when the police arrive, they say another thing. So, imagine we have started with the patient, and then the same victim gives the police a different statement.*

Investigating officer: *You know, as an investigating officer, you need to interview your victim first. That will enable you to see if the victim is*

ready to can give a statement. I cannot say that the statement must be taken when you meet the victim for the first time, second or third time. You, as an investigating officer, must be able to see if a victim is ready to can give a statement. It also forms part of our training.

Considering the information shared by participant 28, the researcher is of the opinion that this information is new since the researcher could not find evidence to highlight the right time for a survivor to give a statement, given the fact that the nature and extent of rape experienced by the survivors varies.

Sub-theme 7.1.11: The role of infrastructure in the investigation of cases

Service provider 28 identified infrastructure as being an impediment when it comes to the investigation of cases. He expressed the following:

Regarding the informal settlement, most of our informal settlements do not have infrastructure, roads are bad, no electricity, houses are congested, not enough space to can drive through. Our victims or complainants does not have contact details. Some will tell they don't have houses or addresses. It's very difficult. You know, I can say 10-20 percent of our cases, victims will say, after taking the victim for medical examination, they will say, just drop me off here. Without us verifying if this the correct address.

The information that was shared by participant 28 can be considered relevant and new in the field of rendering services to rape survivors' studies, and it adds value to the study since no researched results regarding infrastructure were available at the time of writing the thesis.

Sub-theme 7.1.12: Provision of false information by the victim

Service provider 28 raised a concern regarding the provision of false information by survivors. He highlighted the following:

After a while when you need to call, or talk to that victim, its untraceable, because the contact details are not working, we don't have the address of the victim, to see the victim and get more clarity

> *concerning the case itself. We also give victims forms concerning perjury, if you give us wrong information, we are going to open a case of perjury. They do sign, but at the end of the day, they keep on giving us the wrong information. So, it means, somehow, that perjury forms, that perjury information, does not have an impact on changing their minds.*

In light of the contribution made by service provider 28, false rape claims do occur, although it accounts for two percent of false rape claims. Likewise, the perception that women "*cry rape*", with expectations of damaging the reputation of the accused, is considered as being inconsistent. However, rape survivors are vastly affected by this myth and do not report the crime stemming from fear that they will not be believed (Messina-Dysert, 2015:74).

Sub-theme 7.1.13: Allocation of more staff

Service provider 28 asserted the need for more staff within the legal sphere of the CJS. He shared the following:

> *If we were having more resources, we will have investigating officers that is on standby, a prosecutor working with sexual offences that is on standby, working together, so that, wherever there are some loopholes, the prosecutor should be able to see that there are loopholes, and we cannot take that particular docket to court because with a docket with loopholes going to court, we are not going to get conviction. The issue of taking the victim to the hospitals, few doctors, few forensic nurses, that makes us, as investigating officers, to wait long, before the victims are being medically treated.*
>
> *It is intended that after reporting the crime of rape to the police, the survivor is received by a representative of the Family, Violence, Child Protection and Sexual Offences Unit of the SAPS. The survivor should be afforded with a case number, and the details of the investigating officer should be provided to the plaintiff. The survivor should also be endlessly informed of the progress of the case, if an arrest has been*

made, and the conditions of the bail application set forth by the presiding officer, if applicable. A copy of the survivor's statement should be made available if needed, and the case should be escalated to the NPA within thirty days, after the rape occurred (Victim Support Services Bill, 2020:19-20).

SUB-THEME 7.2: CHALLENGES WITHIN THE IMPLEMENTATION OF LEGISLATION IN RENDERING LEGAL SERVICES TO ADULT FEMALE RAPE SURVIVORS

Service providers were probed regarding their perceived challenges in the implementation of legislation in rendering post-rape legal services. In light of their responses, the researcher captured the relevant sub-themes.

Sub-theme 7.2.1: General opinions regarding the implementation of legislation

Service providers 1, 3 and 11 (n=3; 10.7%) shared their opinions regarding the implementation of legislation as follows:

First responder (a): *Ahhh…., I think they do, but this is South Africa, especially when the alleged perpetrator has money and status. You know, if it is someone that is well-known and has status. When people have money, they use it to manipulate, and you end up asking yourself how come did that person win the case. Yes, I am not a lawyer or a judge, but you can see that this person did this thing.*

Site coordinator (a): *I think, the legislature is being applied. But with a little bit of leniency. I have seen a situation in which the police allow the victim to report, or not to report a case, especially when an offense had been committed. I do see that as a gap in system, since we at the Thuthuzela Care Centre sees all cases that come to us, as having potential to go to court. I do believe that rape cases should be reported, irrespective of the circumstances surrounding the case itself.*

Auxiliary social worker (e): *Not really, because clients come back here to ask us questions, which is for the police. We don't even know, then we have to call the case manager, to be able to explain further.*

Sub-theme 7.2.2: Role of the case manager in court preparation of service providers

Service provider 17 highlighted the role of the case manager in court preparation. She expressed the following:

> *The prosecutors in court, I am going to say everything in nutshell, I don't think they understand what they are doing sometimes, because the state is standing for the victim, for us, I have heard many encounters from what I have heard from fellow clinicians such as doctors complaining that the prosecutors are attacking them, I won't say attacking them, the duty of the prosecutor is to call you, to guide you to say, these are some of the questions that you must expect. Do you know how to answer this question? The magistrate would like to hear…..I am going to ask you this……. They normally guide us. They would call us most of the time to say: Sister….., this is what I picked up in the docket, so if I ask you, how are you going to answer it? We are working together as a state in protecting the victim. But some of them will come to you, firing, and firing, and firing, as if they are the defence, which is wrong according to me. But we have a case manager that look at the technical aspects and law, we have Adv…., who will always call us to say: Sister or doctor, your J88 is not clear here…., can you please write it clearly so that even if I decide to put the case on roll, I will be knowing what to do. You see, unlike the ones in court, you think that even with the defence, there is something they are playing. They make it difficult for doctors and nurses to testify there.*

SUB-THEME 7.3: ADVANCEMENTS AND PRACTICES REGARDING LEGAL SERVICES FOR ADULT FEMALE RAPE SURVIVORS

The researcher asked the service providers about their perspectives regarding advancements and practices in post-rape legal services. Numerous initiatives surfaced, which were documented by the researcher.

Sub-theme 7.3.1: Centre-needs-based approach in rendering post-rape services

Service provider 16 stressed a centre-needs-based approach in rendering post-rape legal services. She shared the following:

> *We try to adjust the Thuthuzela Care Centre model according to the specific needs of our centre, for example, me as the site coordinator, receive the victims as they walk in, interview, and inform them of the services. But for this centre, we adjust it a bit. To try to avoid interviewing, and just inform them of services as they walk in because the medical staff and social worker work with them. When everything is done, then we can check if they know what is going to happen. If they don't know if they want to open a case, then I will sit down and explain to them the importance of opening a case and make them ease and explain to them that we are always here for them. For example, if they don't have a positive relationship with the police officer, then I am the one who phones the police. I am more like advocating for them, so that they don't feel that there is nobody to assist them, when the police are also letting them down. Basically, coordinating the services and making sure that everyone is doing what they supposed to do. We also find ways of working around challenges, so that the victim don't suffer.*

Regarding the information relayed by service provider 16, the Thuthuzela Care Centres are governed by a single protocol. Improving the experience of rape survivors in the CJS through the implementation of a victim-centred approach and reduction of secondary victimisation should be of prime importance (Legal Aid Society, 2020:61; Zia et al., 2021:55). Additionally, it is sensible to improve the delivery of services, as intended in the Criminal Law (Sexual Offences and Related Matters) Amendment Act 32 of 2007, through the development of a plan for the progressive comprehension of services for survivors of rape, aligned with accessible resources (Department of Justice and Constitutional Development, 2012:13).

Sub-theme 7.3.2: Testifying in camera at sexual offences courts

Service provider 26 highlighted the need for testifying in camera. He stressed the following:

> *At court, we have the Sexual Offences Courts. They come in with CCTVs. They come with the aid of intermediaries. CCTV and testifying rooms will be for adults. But now you have to make an application for that to happen. But the law makes provision that even an adult does not need to testify in presence of an accused. Most importantly, access to the building at Sexual Offences Courts, we can actually hide our victim away from the suspect. Creating waiting areas that are safer for them and making sure that they do not have contact with the accused person. SAPS must also communicate to victim if cases are postponed, so that that are aware of the new date.*

With regards to the assertions made by service provider 26, rape cases in certain courts are finalised in less than six months. This was attributed to the intervention of specialist prosecutors, case managers and victim assistant officers, as well as the agreement(s) between the various service providers and the principle of prosecution-led investigations. Witnesses were given separate waiting rooms with intermediaries and closed-circuit television facilities, inclusive of certain victim support services (If only sexual offences courts hadn't gone away, 2013; Ministerial Advisory Task Team on the Adjudication of Sexual Offences Matters, 2013:23).

SUB-THEME 7.4: PERSPECTIVES OF WORKING IN A MULTIDISCIPLINARY TEAM IN RENDERING LEGAL SERVICES TO ADULT FEMALE RAPE SURVIVORS

Service providers were probed regarding their perceived working relationship with other service providers. While a noteworthy number of participants had positive responses, challenges in maintaining positive relationships between stakeholders also emerged, as captured by the researcher.

Sub-theme 7.4.1: Opinions regarding a positive working relationship within a multidisciplinary team

Almost half of the participants (n=13; 46.4%), being service providers 1-4, 5-7, 10, 14-16, 24 and 27, shared positive thoughts regarding their relations with other service providers. They conveyed the following:

> First responder (a): *The person who came up with the Thuthuzela Care Centre model, I think it was the best model because it makes things easier for survivors. You know, someone comes here, they get counselling, we do containment as first responders. We contain the person before they go to see the nurse or doctor. It makes things easy because even if I don't know anything about the law, NPA is here, so, it makes things simple. It makes the work easier with all of the stakeholders in one place, yes.*
>
> Site coordinator (a): *Uhm..., it is very beautiful thing to work within a multi-disciplinary environment, you have all these role players under one roof.*
>
> Social worker (a): *The working relationship is very good. We just refer the patient if there is a need, and work within a professional manner.*
>
> Victim assistant officer (a): *Yes, we are aware of our duties and responsibilities. Okay, within all organisations, it has its own ups and downs, but our relationship with other stakeholders is up to scratch.*
>
> Site coordinator (b): *We do have the implementation meeting, so we discuss everything with stakeholders. The implementation meetings are assisting us.*
>
> Auxiliary social worker (a): *On an individual side, it is not good, but we work perfect with the other stakeholders. Only individuals, yes. We don't have a challenge with Department of Health, we don't have a challenge with SAPS, and we also don't have any challenges with stakeholders who referred the client.*

Auxiliary social worker (d): *Uhm.., my experience is good because of the referrals occur among each other. It is good.*

First responder (b): *We have good relationships with different stakeholders, like the organisations that are around, they are aware of the Thuthuzela Care Centres, and they also refer clients, and are aware of which protocols to follow, before they can send a client here. So, sometimes they will first call, or even escort the victim to us. The relationship that we have built with NGOs and NPOs are good, because we work on referral, everything is okay.*

Site coordinator (c): *I would say, my relationship is good, based on the fact that if you are in this setting, you also need to be diplomatic as much as possible. You work with people because you still want to work with them tomorrow. So, you can't damage relationships, so you need to put it forward as polite as possible, even if the other person was wrong. Tomorrow we still wake up and what we have to do, and not create any animosity. I am also responsible for training that is multi-stakeholder orientated, making sure that all the stakeholders still know their rules, and what is important regarding various roles within the Thuthuzela Care Centre model. Once a year, we have our Thuthuzela Care Centre multi-stakeholder training, which is done by all the departments. We invite Department of Social Development, Department of Health, NPA, to come and do training on the Thuthuzela Care Centre model. This also gives an opportunity for new staff members just to know what is expected of them. I also have to identify needs and get someone to come and do the training with us.*

Social worker (c): *No, I think we are working very well. If only the police can be fixed. I mean they break the law intentionally, to tell a rape victim to go home and they will pay, the rapist will give you for example R5000. They come tell us here, and we say this is not going to happen, and the site coordinator takes over.*

Medical doctor (a): *It's very productive. Because before COVID-19, we used to have a monthly multi-disciplinary meeting. So, everybody gets an opportunity to express how they feel, and wants needs to be improved or changed. It also improves the input of other stakeholders into the case. It's not like we are working in silos, and we are wondering what the other one is doing. We actually have a sense of what FCS requires from us, what the social worker requires from us, it's more like a lucrative system that is working there.*

Medical doctor (b): *We are working much better now. Some things might still take time, but it is better if most stakeholders are at the centre, designated for working with rape survivors. You know who you are calling. In the past, it was just the emergency room. When a patient comes, you leave to attend to the patient, but don't know whom to call. They used to sit in casualty, with everybody walking pass them. At least now, we have a designated area for them.*

Court preparation officer: *I would rate it as satisfactory, since we have a stakeholders forum, where we meet on a monthly basis, to discuss the challenges; the progress that we have.*

Sub-theme 7.4.2: Challenges in working in a multidisciplinary team

Half of the participants (n=14; 50%), being service providers 3, 6, 8-13, 17, 19, 21, 25, 26 and 28, shared challenges with regards to engaging with other service providers. They expressed the following:

Site coordinator (a): *However, the challenge comes with the different reporting levels, that becomes a challenge because we find it difficult to hold other role players accountable, for a job not well done. I will just give you a practical example. For example, if they did not treat a victim within an appropriate manner, the police will say that I don't report to NPA, I report to SAPS. It is the reporting levels that is concerning, since matters need to be resolved within an amicable short space of time.*

Site coordinator (b): *The Department of Health are hosting us, but when we have a challenge with infrastructure, they will ask why NPA isn't helping you, but this is a healthcare facility. For example, if we don't have a phone, we won't be able to perform our work. Other stakeholders need to learn that it is not only the NPA responsible for the centres, they also have a responsibility towards the maintenance of the centres. Maybe the problem is with Department of Public Works, but then they involve NPA unnecessarily.*

Auxiliary social worker (b): *The problem is the police, especially at night. Sometimes we call FCS since we work with them, but then they tell us to call the police.*

Auxiliary social worker (c): *What I have experienced, is that other professions don't understand the protocol of service delivery at the Thuthuzela Care Centres. For example, you find that a doctor will first demand to examine the patient, when we must first do containment before the medical examination.*

Auxiliary social worker (d): *It is just sometimes you don't necessarily find the help that you need at that point. You will have to wait. If you send an email, you must wait until they return, and some issues are sometimes pressing, you know, but, that one is understandable sometimes.*

Auxiliary social worker (e): *The most challenge I have is with the police officers. That's where I struggle a lot. Because there is walk-in, we have to call SAPS, we cannot call FCS members. They will come and take a statement, then they have to call the FCS. The FCS, they have got this thing where they want to hear the case over the phone. After listening, they will instruct to tell the client to come back tomorrow, and chances of them coming back tomorrow are very very slim. Some FCS members will even state over the phone that that person was raped, tell her to go home, without any investigation. Sometimes we also have to wait for the collection kits. Sometimes the police will say that they*

are far, and they will bring it late during the day. Sometimes the rape survivor sit and wait for a long time, and they even go back home. With health, I don't have any challenges as yet.

Social worker (b): *Not all role players are aware of their duties, and they need to be capacitated, to be able to know their roles. Relationships with other stakeholders are very good. Like here, with the NPA, sjoe, it's a disaster to be honest. The only person here, from the NPA, is the victim assistant officer, she works good with all of us, but with the site coordinator, it's a disaster. I don't know, I have been here for six years. She is not communicating with me, and tension also affect our services, because clients are able to sense if there is pressure or tension. They pick it up immediately. It affects the environment. Our duty as a social worker, is to create a safe environment. And already if an environment is not conducive, it impairs in a way. So, that is that. We have been trying to sort it out for years, but it seems not be working. Even my colleagues, with me, she is not communicating, but she does it to a point that it affects auxiliary social workers. She will make them leave their own duties and responsibilities to come and clean and leave the duties that you are suppose to do. If they don't, she shouts. Our relationship is not that good. With other SAPS members also, it becomes a problem because, if you ask them, no, this is not the way we must communicate with a client in front of people, they throw tantrums. So, what I realise is the attitude of the individual which makes it difficult to engage with other people.*

Victim Assistant officer (b): *I would not describe it as very bad, although there are challenges. At our centre, we do not have a designated doctor or nurse who work at our Thuthuzela Care Centre. Sometimes we have to wait for a doctor who is busy with other patients at the hospital. I think that they are also overworked, so as a result, it causes some discomfort between the health staff and the Thuthuzela staff. And the police, the unit that works with rape cases is the FCS,*

but still, we end up having to call the nearest police station. When we call, they are attending to other cases in the communities. So, even that on its own, is also a challenge, because it is the FCS that should be attending to rape cases, and not the normal police.

Forensic nurse (a): *Everybody wants to be a boss. What I have realised now, except the NGOs, government structures like the Department of Health and NPA, everybody wants to be a boss here. Particularly, the people on top.*

Forensic nurse (c): *It's good, but not all the time, sometimes another staff member will make me feel like I don't know anything, but we received the same training.*

Forensic nurse (e): *Here we have a very good relationship because we have meetings and debriefings. It is just the working hours of other stakeholders, and they are not here, is a challenge for us.*

Medical doctor (c): *Most of the time it is good, although some stakeholders can become adversarial. For example, people at SAPS, they want to be told what to do. So, if they can do nothing, they will be fine with it like that. This is what we are experiencing here. SAPS personnel decide when a person must come, even sometimes when they are called, they don't come, we must tell the patient that they will need to come tomorrow. This is a lot what is happening.*

Case manager: *They are good and okay. We have monthly meetings. We also offer training. We call it stakeholder integrated training. We need to train more doctors about rape victims, we need to train more people about rape victims. I had a medical report where a doctor had written that no weapon was used, and I wondered, why did you write about no weapon was used: Who asked you about weapons? It is about what they write which they shouldn't write.*

Investigating officer: *A lack of communication between stakeholders. Because we as investigating officers have to communicate daily with*

public prosecutors. But you find out the public prosecutor are undermining the police because they feel that they are more educated than the police.

In relation to the assertions made by the service providers, post-rape service is mandated by several service providers, which may lack coordination. Interventions intended to address rape, even where they have been confirmed to be efficient, are exceedingly localised and oftentimes not adequately funded. Limited resources and the orderly exploration of what has worked and why have made it challenging to evolve positive initiatives in rendering post-rape services within the CJS. There exist relationship challenges between Thuthuzela Care Centres, NGO and NPO staff. Thuthuzela Care Centre staff are of the view that service providers from NGOs and NPOs are overstepping their directive in providing post-rape services within the CJS. Staff from the Department of Health also assigned reporting and administrative duties to staff from NGOs and NPOs (which does not form part of their duty within the Thuthuzela Care Centre model). NGOs and NPOs feel unappreciated, while without them, limited post-rape services would be offered at Thuthuzela Care Centres 24/7 (Thuthuzela Care Centres Compliance Audit and Gap Analysis, 2016:17).

SUB-THEME 7.5: PERSPECTIVE IN RENDERING COURT PREPARATION SERVICES TO ADULT FEMALE RAPE SURVIVORS

Service providers were probed regarding their perspectives regarding court preparation services. Both positive opinions and challenges emerged, which the researcher documented.

Sub-theme 7.5.1: Opinions regarding court preparation

A significant number of participants (n=20; 71.4%) being service providers 1-6, 8-11, 13-15, 17-18, 22, 24 and 26-28, had positive opinions regarding court preparation. They articulated the following:

> First responder (a): *I think it can benefit them, because when they get there, they know exactly what to say; and they know exactly what is expected of them. You know, that sometimes when they question you,*

some of the questions they ask feel a bit personal, but it's their work. It is important to prepare them to stick to their story. When a person is prepared for court, they will stand and say what they have said from day one.

Clinical psychologist: *Yes, I think it can, because going to court alone is scary for anyone. We know that some lawyers can be very very brutal. Most people haven't been to court, they don't how it works, what is expected of them…….It is important to take them in court and show them this is where you will be sitting, this is what is going to happen…. when give testimony, this is where you will be standing, you know, just those things, it eases them, so that they are prepared. Regarding to court preparation, it must be done all the time. It is never done or evaluated. I propose it to be standard for such vulnerable patients, because they are at their most vulnerable state. I also think the stakeholders rendering court preparation, must be trained within the criminal justice system, with subjects at university in Criminology, Psychology, Social Work, Philosophy, so that they are skilled and know the law. They should also have empathy towards the survivor, and explain the court processes in simple terms, so that they can understand.*

Site coordinator (a): *I think that is very much important, since it benefit victims in becoming effective and efficient witnesses in court. Although I have noticed that it is a service not well published. I think that if our rape survivors complete court preparation, we would have more effective and efficient witnesses in court.*

Social worker (a): *It works for them because they are prepared emotionally and know what to expect in court.*

Victim assistant officer (a): *Yes, it is beneficial for adult female rape survivors, because some of these people, they have never been to court. And if you throw a person in court without knowing what is happening, then this person automatically gets confused. Yes, and*

with court preparation they are told what will happen in court, and the major role players that they will find in court. And others are scared that others will come and listen to their case, making them scared, and that is where court preparation comes in.

Site coordinator (b): *Court preparation plays a big role. Remember, when the victim gets the date to appear in court, they end being scared and faced with so many uncertainties of what is going to happen in court. The court preparation officer gives them the information of what to expect in court. The Thuthuzela Care Centres will not be able to survive without the court preparation. They do assist us in preparing the victim to go to court.*

Auxiliary social worker (b): *Yes, it works, at least when you go to court, you are being prepared. You become confident, and not much being scary. You are aware of what is going to happen. I think that it is good.*

Auxiliary social worker (c): *It really benefits them, because last week I was doing court preparation. It is a new programme, but it did not succeed. It really benefits them; our clients really need them. It is just that it is not popular.*

Auxiliary social worker (d): *It does, in manner that it helps them when they step into the courtroom, they are not surprised. They are not surprised at who they see, and what happens in there. If they don't know what to expect, when she walks into that room, she panics. It becomes even more challenging with the presence of men, because the victim feels like that, they are going to ask them questions, and if they answer, nobody will believe them. It is important to explain the victim, that these are the type of questions that you can expect, give her picture of what will happen in there. It is better than walking into a room and realise: What is happening here?*

Auxiliary social worker (e): *I think that court preparation should start with us as first responders. We need to know the basic, since the client*

will always ask what will happen when they go to court. I don't know anything about that one. And we are working night shift and weekends. The victim assistant officer does not work at night or weekends. So, at night and over weekends, you are alone, you cannot refer them to the victim assistant officer. We need that information, just for start-up, for me to be able to inform the client. Then we can make the referral to the court preparation officer. I think we need that working relationship with them.

Victim Assistant officer (b): *I think it will prepare them for court, because many rape victims have never been to court. It prepares them to calm down and to address their fears that they may have regarding the court processes. It will familiarise them with the court environment and also, what to expect when they get to court.*

First responder (b): *I usually hear of court preparation, but I think it will benefit them, because most of them don't have information. People see things on TV, and they expect it will go the way they saw it. Since with court preparation, they are aware of what is going to happen. So, when they arrive at court, they will not expect something new.*

Site coordinator (c): *Court preparation is beneficial, especially for a lay person who has never been to court. The nerves that with being in court, may have a big impact on a person. So, court preparation is very important, even while they are at the Thuthuzela Care Centre, to be prepared to go to court. And, if they get to court, to be able to see, who is who in the court, and what is the procedure. It is just to put the victim at ease, so that they can see that it is not as difficult as they imagined.*

Forensic nurse (a): *It will benefit them dearly. I have had a patient saying: sister, it will be my first appearance in court, so I don't know what will happen to me. They are anxious about the kind the questions in court. Anxiety. Some of them would have watched cases on TV, so they think that is what they are going to undergo in court. They will be thinking, maybe I took a wrong decision in opening a up a case.*

Forensic nurse (b): *Yes, it benefits them.*

Forensic nurse (f): *They think they have to be prepared because now if the evidence was collected from you, as a survivor, you have to go to court. Now you be sitting at home not knowing what is happening to your case, or how far is your case.*

Medical doctor (b): *The patient should be prepared for court as soon as the investigation is done without any further delays.*

Case manager: *Very beneficial for them. Court preparation prepares you for court. It gives you information of what is going at court. Victim Impact statement is also done under court preparation. Victim impact report is also done under court preparation.*

Court preparation officer: *Not each and every person in my community have been exposed to the court environment. Court preparation thus affords victims of crime to engaged with the processes within the criminal justice system, because we take them step by step. Court preparation is one of the most important programmes that were introduced by the NPA. It is important to inform them that they have the right to legal representation, because most of them are afraid to actually come to court because they had never been exposed to the court environment. They don't know what is expected of them. So, court preparation has been one of the most important programmes, so that we can give them that information, and reassure them that they don't have to go out and find a lawyer themselves.*

Investigating officer: *It can benefit the victim; it can benefit the confidence of the investigating officer, it can also benefit the confidence of the public prosecutor. In doing one thing, you take that perpetrator out of the community, you take him to jail, it's a big achievement for all of us. It's a common purpose.*

As regards the responses of the participants, court preparation aims to prepare and support the rape survivor in comprehending the court processes, services,

and benefits of testifying in court. It aspires to empower the rape survivor to be an effective witness during legal proceedings (Mkhwanazi, 2016; Skhukumisa, 2012:66).

Sub-theme 7.5.2: Challenges regarding court preparation

Service providers 12, 21, 23 and 25 (n=4; 14.3%) cited challenges pertaining to the rendering of court preparation to survivors within the CJS. They expressed the following:

> Social worker (b): *With us, we don't do the court preparation, the NPA does it at court. We only do support. To be honest, for me, court preparation is not beneficial. Because most of the cases are referred back to me, only to find out that the client could not speak in court, while the same client went for several sessions, for court preparation. Another thing that I realise is, is that people doing court preparation, are not social workers, so it becomes difficult. They are just trained to do court preparation, but in the real sense, I don't even think they know what psychosocial is, for them to prepare the client, to listen to the client. You know, those basic things about counselling. I don't see the effectiveness of it because most of the clients, are referred back to me. If there was an impact, most clients would not have been returned. I don't see the impact of it.*
>
> Forensic nurse (e): *I do think it benefit women, even us. We can also go for court preparation. It's a frightening experience, even if we go all the time. For the patient, it is the first time being in court, and you need to prepare the patient, it is very important. Court preparation should be done for each and every victim.*
>
> Medical doctor (a): *The victim assistant officer is here, and the victims express their frustration with them. We try as much as we can to address those frustrations. Some of the patients are working, and some of them are working those jobs that are sensitive, if you lose two days, you lose money, or you are at the point of losing the job itself.*

The case itself, or what has happened to them, you cannot disclose to your employer that I was raped. Some people they don't like that kind of sensitive information be known by their employer. So, the employer don't understand why you constantly need to go the hospital, yet you are not on chronic medication, it's a bit of a challenge for the patient, the employer and even for us. Because we cannot assist you by disclosing to a third party that you frequently need to come to the hospital, you frequently have to go the court because of one, two, three.

Medical doctor (c): *They could do more, if their focus is on helping the victim. You have to convince the magistrate or the judge of what happened. So, if court preparation is more focussed on that, the victim will stand a better chance. The evidence is there in most cases, then it becomes an open and shut case, but there are cases without any evidence, and it becomes he- said- she- said. Some people feel cheated going to court, explain what happened, and then nothing happens. Legal service providers know what is expected in court, they need to prepare the victim for court. They need to inform the victim of what to do in court. This is the plan for you that justice was served. This is how you answer, you don't get emotional and go off the tracks.*

In response to information shared by the participants, there seems to be limited-to-no court preparation for the adult female rape survivor within the CJS. It is crucial for the adult female rape survivor to be prepared for court; analyse the statements made; and refresh their memory preceding legal proceedings (Zia et al., 2021:39).

SUB-THEME 7.6: RECOMMENDATIONS FOR RENDERING LEGAL SERVICES TO ADULT FEMALE RAPE SURVIVORS

The researcher probed the participants regarding recommendations for rendering post-rape legal services. From their responses, numerous recommendations emerged.

Sub-theme 7.6.1: Attitude of legal service providers in rendering post-rape services

Service providers 1, 10, 12, 17, 19-21 and 24 (n=8; 28.6%) are of the opinion that the attitude of legal service providers plays a role in rendering post-rape services. They conveyed the following:

> First responder (a): *Yes, uhm…, I think for now the legal services are doing their work. I think they can improve by not judging them, because at the end of the day when the survivors come here, they say that they are blaming me for why I went there, why didn't I report the first incident, because maybe it is a second incident.*
>
> Auxiliary social worker (d): *Sjoe, can they be please be lenient to the rape survivors. I know it's their job, they are doing their work. At the end of the day, they are dealing with a human being, who has been violated, and you must always remember that these cases are not always the same. There is a client who walks in here that has been raped by multiple people, and another one is a family member. If the rape happened in the family, it is even more traumatic if the perpetrator for example is an uncle. It is also traumatic that the rape happened, and it was four people. It is also traumatic that the rape happened, and I was hurt. I had a client whose hands were cut. Those elements I mentioned, can they just be considered towards the client. Please be lenient.*
>
> Social worker (b): *Protection needs to be provided by the legal system, for example, if the victim and the perpetrator stay in the same area or location. Sometimes they do not wish to proceed with the case after laying a complaint, either they are being or had been intimidated by the perpetrator, or sources linked to the perpetrator. They go and tell the victim that you are destroying a persons' life, all these things. The patient needs to know where to report such things when they happen. They must proceed with the case. Let's give our patients all the information, and let's have an open-door policy all the time. You*

understand. With rape, nobody knows what is going to happen, neither does anybody know when it is going to happen. Why I am saying that, with the DNA that we have collected, the turn-around time for the results might be a week, or it might be a month. Okay, it depends on the investigation and so forth. The cases differ. There is a backlog in DNA, if we have a victim who is anxious and don't know what is happening to the case, they lose interest. If we can let them know where we are with everything, regardless of the delays that is happening with DNA, at least then they know that their case is still receiving attention.

Forensic nurse (a): *Prosecutors must consult with the rape survivor before the trail starts. The police must not make the survivor feel as if she or he subjected himself or herself to this. Some of them will leave nightclubs early in the morning hours, and the police would say: Being a girl, what did you expect moving around 04:00 in the morning with Uber men, that person is a man. They mustn't be judgemental. Adult rape survivors must report the truth, some come up with stories, as a clinician, you can see that it is not true. For us as healthcare practitioners, opening or not a case is not of importance, it is crucial that the victim receive medical attention and PEP, it will later catch up with us, when the patient sero-converts, after coming to the Thuthuzela Care centre, to receive medication. Women must also know that reporting rape is a serious allegation against someone, you must be truthful in what you are saying, because the police will go and arrest that person for rape. A person is arrested, bail application is set within 48 hours. Courts are busy, it might even take longer, up to a week, what is going to happens to this person's job. The person is absent from his job with such allegations, and only for them to go there, most of them, and drop charges. Even the police will tell us, sister…., we know that you are working hard, but you don't know how these people are dropping charges.*

Forensic nurse (c): *Yoh, you know it is difficult for us because we work with the police. Ahhh…. You know what they are doing, a patient will go to them now, maybe the rape happened late, they go to the police station, they will not take the patient to the other nearest Thuthuzela Care Centre, Bara (Chris Hani Baragwanath Hospital), they are going to tell the patient to go and sleep, come tomorrow. Imagine, they tell you to go and sleep, and it is that time we are going to get the evidence. Sometimes, it is walk-in, the police will bring the rape kit. Afterwards, we call, they will say they cannot come, she must come and open a case. Imagine, and most of them, they don't go, and when you call again for them to collect the rape kit, they will say no, this patient did not open a case. But it is their job. Here, we don't have safety to put the rape kit, some rape kits will stay for up to three years, we end up putting it in the bin, because the police say they did not open a case. With a walk-in, we explain to the person right to open a case, whether the accused person is known don't she says she want to open a case, we call the police. Some they do come, but some, ag shame, its bad. Us, we end up collecting money for transport fee for the patient to go home. Sometimes the rape victim will tell the police that she knows the suspect, and maybe he is staying close to where she is staying, the police will just say, no, me, I'm not going there.*

Forensic nurse (d): *It is just that when we call the police, they take long to come.*

Forensic nurse (e): *I think it starts with the police, they need to be more tolerant and acceptance of patients because you cannot tell a victim that you are lying; or that there is no case. That is why the reporting number is so little, it's because of the police. We have a lot of challenges with the police. Then they leave patients here, we have to arrange transport to go home, and food for the patient. We close at 18:00, we cannot leave a patient out on the bench, if anything happens to her, then I am responsible. So, we have a lot of problems with the police, a lot, only with the police, nobody else. More prosecutors*

should call in the patient and discuss the case, I'm not sure if it is done. Sometimes a patient just go to court, no preparation is done, There is just this misstep of no court preparation. That is where they need to improve. We as staff, also don't have that court preparation with the prosecutor. We need him to prepare for the case, go over the J88, that is what we are supposed to do. Some just call us and then just firing away, and you just have to answer.

Medical doctor (b): *What I have also heard from the patient, is that once the case is opened, they do not get any feedback on the progression of their case, they stay for a long time without knowing what is happening. Even if they call to follow-up, they cited that they don't get the right person working with their case, they will be referred from this person to another, so, they just feel like the criminal justice system is not really working. Once a case is reported, that's it. There is nobody coming back to them. They are also stuck with the perpetrator. He is taken for a day or two, then he is back. You can imagine, it is traumatic for them. Communication with a patient or client should be better, even if there is a delay in case, let them know.*

In relation to the assertions made by the participants, equal access to services should be endorsed through non-discriminatory accessibility to the services provided to rape survivors, irrespective of race, class, and gender. This equal treatment should be linked with the principle of the provision of services to all (Department of Justice and Constitutional Development, 2012:19). Furthermore, the Victim Support Services Bill pursues to acknowledge that rape survivors should be central to the CJS; and to enable and protect both the rights of the adult female rape survivor and the alleged rapist within the CJS (Public Comment Sought on Victim Support Services Bill, 2020).

Sub-theme 7.6.2: Monitoring of legal services

Service providers 2-3, 12 and 28 (n=4; 14.3%) indicated a need for legal services to be monitored. They conveyed the following:

Clinical psychologist: *A tracking case system within the police and NPA is advisable, so that the victim knows what his happening to their case, and they are informed. That would give someone hope that something has been done. That is why they often give up and the case goes unresolved. I had a patient that informed me that she was suppose to go to court, but when she got there, she heard that the case was dismissed, without going to court. So, you never understand what is happening, the way they treat the survivors, it is not in the interest of the victim or survivor.*

Site coordinator (a): *The criminal justice system should be very friendly to our adult female rape survivors. What I have seen, is that the rape survivor goes to court for the first time and has a horrible experience in court. That person will also not advise anybody to go to court. This will tell you obviously, that the system was very cruel to the victim, or even to go back again. I had a client who was raped in 2018, in 2021 it happened again, and she stated that she only wanted medical care and counselling. She never wants to go through the court process again. I would like to recommend that measures be put in place, so that when the rape survivor reports the incident, they will have confidence in the criminal justice system, even though there might be technicalities and challenges here and there, they would still want to go through with the case.*

Social worker (b): *Legislation should be monitored when they are implemented, and for them to be effective. Because really, individuals are just doing their own thing. If an agency monitors it with a very close eye, I think that the effectiveness of the criminal justice system will be there. And, also, to avoid intimidating the victim, and asking them irrelevant personal things. Legal practitioners cross examining the client should also know their lane in this regard, and there needs to be directives in place to govern them.*

> Investigating officer: *The monitoring of crime trends is also there, but they are not that effective, not effective in one aspect, that you are being informed within a very short period of time, and not allowing more of people to attend. Ever since the issue of COVID-19, no, there was no such. They need to implement now, we must have Lekgotla's, we must have conferences, so as to improve ourselves.*

In accordance with the information shared by the participants, the Civilian Secretariat for Police is anticipated to provide oversight pertaining to the monitoring of rape cases; safeguard that adult female rape survivors are treated with respect and dignity; and ensure that witness fees are provided to the complainant as prescribed in the Criminal Procedure Act 51 of 1977 (Victim Support Services Bill, 2020:19-20). Additionally, government and public sector programmes and service delivery also need to facilitate the operative arrangement and coordination of planning across all areas of government, national, provincial, and local, and more particularly, the investigation of the effectiveness of the implementation of government policies and programmes through incessant performance monitoring and evaluation. Government agencies necessitate to shift and focus their efforts and resources regarding post-rape services collaboratively. Cooperative engagement among service providers within the CJS needs collaborative sharing of skills and resources to improve effective services for adult female rape survivors within the CJS (Commission for Gender Equality, 2009:8; Koma & Tshiyoyo, 2015: 31,36).

Sub-theme 7.6.3: Prioritising court preparation for survivors

Service providers 4-5, 8, 13 and 15 (n=5; 17.9%) expressed a need for court preparation of survivors. They shared the following:

> Social worker (a): *Court preparation is very important for adult female rape survivors. It is very important.*

> Victim assistant officer (a): *I think regarding court preparation, I think the officials sometimes doing the court preparation, they are overwhelmed by the workload. Yes, so it advisable to get more court*

preparation officers to assist them. Sometimes in the High Court, where these cases go, we find maybe only one or two court preparation officers there. So, it becomes a serious challenge. We need to have more court preparation officers, it will be so much better.

Auxiliary social worker (c): *I recommend that they should consider court preparation as an important thing.*

Victim Assistant officer (b): *I think that if the victim can be introduced to court preparation on time, I think that it can help a lot. According to my knowledge, court preparation starts at a later stage, and the trial process is about to start. If it can be done way before, because by the time the victim goes to court, she would have gotten use to the court environment.*

Site coordinator (c): *As much as we say things on paper, sometimes people are not booked for court preparation because maybe the police might have missed certain things that they had to do with the victim, because of the caseload and all of that, and only realise that they should have booked for the victim to undergo court preparation. We always tell the victim to inform us, as NPA, if they need to go court. I will contact the case manager and initiate the court preparation for the victim. We need an electronic automatic court preparation booking system, for a sense of accountability. Our court system is still using the old ways, and we are in a technical era with technology.*

Considering the views shared by the participants, there seems to be inadequate court preparation for the survivors within the CJS. Cross-examination within a criminal trial has the possibility of undermining the narrative and credibility of the survivor. Discrediting rape victims during legal proceedings typically denotes occurrences in which the defence is trying to establish a consensual relationship between the accused and the survivor or the discrediting of the rape victim in relation to questions of an inappropriate nature (Zia et al., 2021:55).

Sub-theme 7.6.4: Court preparation of service providers

Service providers 21 and 24 (n=2; 7.1%) expressed a desire for service providers to undergo court preparation. They highlighted the following:

> Forensic nurse (e): *We also need court preparation. If they are not doing it with us, imagine the survivors.*

> Medical doctor (b): *We as medico-legal service providers also need to be prepared for court, with the prosecutor, at least if they get there earlier, they sit with you and prepare you. It being there at court, it is quite intimidating. Unfortunately, we don't get any court preparation beforehand. Sometimes you just get the subpoena, there is no J88. At least if we can get the J88 beforehand to prepare for court. Even if we request the J88, they never come, you will get it in the morning of the case. Sometimes you do get the J88, which becomes so much better because preparation is directed to that. You can call the prosecutor and get some preparation; it becomes much better.*

Sub-theme 7.6.5: Training of police officials

Service provider 14 believed that police officials needed more training in post-rape services. She conveyed the following:

> First responder (b): *Yes, I think that our SAPS need to be more trained, more especially when it comes to adult female rape survivors. They should not judge, because with the police, I don't think we have that working relationship, they do things on their own. Sometimes you will find a patient; they will keep them for the whole night at the police station and bring them in the morning, while they know that there are other Thuthuzela Care Centres operating 24-hours. They will also say that the police did not attend to them, when they arrive here, the sisters give them something to eat, because they cannot take the medication on an empty stomach. The meals in some instances come from the staff.*

Sub-theme 7.6.6: Safety of service providers in providing evidence in court

Service provider 17 asserted a need for service providers to be protected while accessing the court. She relayed the following:

> *Even for us at court, we are not safe. I was once followed when I left the court. As clinicians and doctors, we are also not safe. We don't have escorts to and from court as well. With victims, it is not safe to go to court in gallery, in camera it will be safe. The criminal justice system is not doing much, the victim can also be followed after court.*

Sub-theme 7.6.7: Resources in terms of legal services

Service providers 12, 23, 25-26 and 28 (n=5; 17.9%) indicated a need for more resources in rendering legal services. They articulated the following:

> Social worker (b): *The police have limited numbers that are working with us, for example if we have twelve Family Violence, Child Protection and Sexual Offences officials that cater for the whole Tembisa, they cannot take the patient back home, all those things required from them. There will be a need for a prioritising kind of a system, to get the patient from the police station, but for the patient to get home, they will have to see how to get home. Now, imagine a person was raped, everything was taken from them, their clothes are, how will the victim get home. Sometimes on duty are three police officials for that day, it's a weekend, and maybe we are having four victims that are in the centre, and some of them are still coming.*

> Medical doctor (a): *It's a manpower issue, because if the prosecutor had more time, on one day, they don't go to court, and tell the patient to come in, before that court date, to talk to them, and to explain what is going to happen in court, it will be a relaxed environment when going to the court because you know your prosecutor and what will happen in court. The prosecutor can guide the victim to behave differently in the court room, like if they ask sensitive questions, just relax, they*

might ask…., you know. Then victim then goes into a situation knowing what is going to happen. If a prosecutor can have a day in the week to address those things, it's going to be much better, as much as we have a victim assistant officer, but the victim assistant officer cannot pre-empt everything about the case. Manpower in terms of the police also need to be beefed up.

Medical doctor (c): *The justice system should ensure that while cases are pending or being investigated, the victim must be protected from the alleged rapist. Restraining orders are a waste of time. You need something firmer in place. You know, with a restraining order, they have killed many people with the restraining orders in their hands. So, a restraining for me is a waste of time, for me, that guy, the court must warn the person, in open court that if something happens to this person, we are going to proceed with the case. The focus is more what the Department of Justice and Constitutional Development wants, with a focus more on successful prosecution, as opposed to what the patient wants. They should focus on what the patient wants. The weight scale between the wants of the criminal justice system and the victim are skewed. We should be servicing on what the patient wants.*

Case manager: *We also do not have court preparation officers in each and every single court, we need to have them in all the courts. And getting more case managers. Case managers are like your control person here, they lead the Thuthuzela Care Centre model, to the Sexual Offences Court. In the absence of case managers, there is a gap. Some case managers have up to ten dockets at once, that they need to deal with, and sometimes don't deal with it properly because there is nobody to assist them. If we have more centres, Sexual offences Courts, more case managers and more court preparation officer, then we will get the message out. But, the issue of resources, it will always be a problem.*

> Investigating officer: *The problem with DNA is that they are taking long to be provided to investigating officers and court. It is because of capacity and skills. Actually, increasing the capacity and skills to Family Violence, Child Protection and Sexual Offences unit of SAPS, NPA, Forensic Sciences Laboratory, it will minimise the period that we are finalising these dockets. For the criminal justice system to prolong the cases, it brings trauma to our victims. And it makes our witnesses who wanted to give the evidence, they will then withdraw in giving that evidence. You become tired. Like two weeks ago we had people from Saldanha Bay, they have been attending court since 2020, they flew from Cape Town to go to court in Atteridgeville, on arrival at court, apparently, the cases had been withdrawn, reasons, we don't know. You can see that they had been prepared, since 2020, but now at the end of the day when the cases need to be finalised, to finalise positively, then it was withdrawn. So, you can see that it breaks the morale of our witnesses, and confidence too. To be honest, the SMS system to inform the victim that cases are withdrawn is not working. It is not a good way of communicating with them. Let it be, you drive and inform the victim, and give reason why it was withdrawn. And the other thing is, in a written form, so that she or he can understand why the case was withdrawn. Says for instance it was due to lack of evidence or improper investigation, then it will make us to improve the investigation so that in the near future we will have no dockets are withdrawn, due to improper investigation.*

Considering the responses shared by the participants, the CJS approach in rendering post-rape services to adult female survivors is evident in the conviction rates of rapists and, at the same time averting secondary trauma. This entails provision of support and supporters for survivors throughout the CJS process; extension of expert knowledge and skills among police, prosecutors, judiciary and other CJS personnel through training; specialist courts; promoting multi-sectoral working practices; and adequately funded and evidence-based approaches that would facilitate further progress (Walby et al., 2013:18).

Sub-theme 7.6.8: A need for more sexual offences courts

Service provider 26 highlighted the need for more sexual offences courts. He shared the following:

> *The establishment of Sexual offences Courts, the establishment of Court Preparation services. Because with an ordinary court, it is depressing. But if you have a specialised Sexual Offences Court, then it actually motivates the rape victims to come forward and report the case.*

Regarding the opinion expressed by service provider 26, sexual offences courts are located within proximity of Thuthuzela Care Centres since they form part of post-rape services within the CJS. The sexual offences courts model stipulates standard requirements for the equipment and facilities to be used within these courts, generating a set of minimum standards by which courts must abide (Sexual Offences Courts National Strategic Draft Plan, 2016-2020:6). The Sexual offences and Community Affairs Unit of the NPA also documented that the turnaround time in the finalisation of sexual offence cases at some courts had been finalised in less than six months. This was credited to the use of specialist prosecutors, case managers and victim assistant officers (If only sexual offences courts hadn't gone away, 2013; Ministerial Advisory Task Team on the Adjudication of Sexual Offences Matters, 2013:23). As of 2020, South Africa established 106 sexual offences courts. Despite this re-establishment, numerous challenges continue to be experienced, namely: an inadequate legal plan to institute and sustain the formation of these courts; inadequate resources to fund the range of services required by victims of sexual offences, resulting in a scarcity of prosecutors, intermediaries and court preparation officers; poor visibility of the courts in isolated and rural areas; restricted space capacity required for private consultation; inadequate and unreliable delivery of skills training and debriefing programmes for court personnel; and unsatisfactory monitoring and evaluation of the efficiency of the sexual offences courts (Sexual Offences Courts National Strategic Draft Plan, 2016-2020:18).

Sub-theme 7.6.9: A need for stakeholder engagement

Service provider 28 felt the need for stakeholder engagement. He expressed the following:

> Investigating officer: *Coming to the issue of the Sexual Offences Act, it involves the duties of the police, doctors and social workers. Maybe to have a workshop one day, with all stakeholders, so that we can build up the morale and build up the communication between all stakeholders so that we can know what purpose of us is to assist the victims. We only deal with victims, no matter what direction you are coming from, the victims are our clients. We want to build the morale, and take out the trauma, that the victims are having. But now if we fight to one another, there is no way that we are going to win this fight. If we try to speed up to finalise our docket, uhm…, yes there are dockets that still need the DNA results from our Forensic Sciences Laboratory.*

In light of the information provided by service provider 28, there seems to be a lack of uniformity among Thuthuzela Care Centres in terms of complaints mechanisms as well as monitoring and evaluation systems (Commission for Gender Equality, 2016:16).

Sub-theme 7.6.10: A need for continuous debriefing of service providers

Service providers 12, 21 and 28 (n=3; 10.7%) identified a desire for continuous debriefing services for service providers. They shared the following:

> Social worker (b): *We do get debriefing, but funding will be running out soon. Others are not receiving debriefing, maybe once after every six months. All of the stakeholders are working with sensitive cases, and we are also working in a team as well. So, I think if we can have a combined, per say debriefing sessions, monthly, or bi-monthly, it will be better for us, so we can deal with the stressors, and so we will not have burn out as well. Vicarious trauma is also prevalent among us as service providers, we need debriefing sessions monthly, because we deal with these cases on a daily basis.*

> Forensic nurse (e): *For staff however, we need debriefing. There is wellness, but they don't want to go as much as we would like them too. Sometimes we would see absenteeism, always sick, there is something always behind it. Some just don't want to go; we have a lot of people with anger issues. We do have those programmes; and two staff members attended. Debriefing is once a year, we would like it twice a year and let all staff go.*
>
> Investigating officer: *Coming to us as investigating officers, we need to be debriefed, because of this what we are doing, it is giving us a trauma. You know, as an individual, you can opt for debriefing or even go outside, on your own. I would suggest that if you think you are traumatised, don't wait for someone to help you, help yourself, go and engage with the relevant people to assist you. Because if you wait for someone, whatever that is eating you, because one day you will fall, without knowing why you fell.*

In relation to the assertions made by the participants, the unattainability of debriefing services for staff within a stressful and emotionally challenging setting and continuous subjectivity to rape cases has an impact on most service providers, regardless of their role and function within the CJS. Some service providers within the CJS require continuous support and debriefing to be merged into professional practice. This nature of support assists service providers in two ways. Firstly, it affords protection to staff from 'vicarious' traumatisation and the negative effect thereof on their personal and emotional lives; secondly, it helps to limit further secondary victimisation (Thuthuzela Care Centres Compliance Audit and Gap Analysis, 2016:16; Waterhouse et al., 2013:25).

Sub-theme 7.6.11: A need for a designated police official at Thuthuzela Care Centres

Service providers 15 and 24 (n=2; 7.1%) indicated a need for a designated police official at Thuthuzela Care Centres. They shared the following:

> Site coordinator (c): *The Thuthuzela Care Centre is a multidisciplinary setting, as such, our centre is unique since we do not have all the*

> *stakeholders that we need here. For example, we do not have designated police officers. But it always helps to have the contacts of other service providers, and we invite them in if we have a pressing matter that need urgent attention.*
>
> Medical doctor (b): *It will be much easier if we have a designated investigating officer that we liaise with.*

The responses of the participants show that protective factors should be in place for survivors during legal proceedings inclusive of restricting the time spent in court; enabling a safe environment for survivors; and refining the experience of rape survivors in the CJS through the application of a victim-centred approach and reduction of secondary victimisation (Legal Aid Society, 2020:61; Zia et al., 2021:55).

The legal sphere in rendering post-rape services comprises numerous challenges in the treatment of rape survivors by the police, communication pertaining to the progression of cases, backlogs in the processing of DNA, stakeholder relations and the notable need for resources regarding specialised training, refresher courses, court preparation and vehicles.

7.7. SUMMARY OF THE CHAPTER

In this chapter, the researcher analysed the data collected from service providers rendering post-rape services. A discussion of the qualitative data was provided by means of different themes and sub-themes. Verbatim quotes were incorporated to indicate the lived experiences of different service providers in rendering post-rape care.

Service providers highlighted numerous factors prompting a rape survivor to report the crime of rape, such as access to medical and counselling services, among many others. Regarding the risk factors pertaining to women being subjected to the crime of rape, service provides opined alcohol consumption, drug-facilitated rape, accessing unsafe places and transport, unemployment and poverty, and unequal gender power relations as some of the main instigators for

the crime of rape to transpire within a community. The service providers cited an array of challenges for adult female rape services to access post-rape services, which were mostly driven by information pertaining to reporting, discrimination, stigma, and fear of not being believed, the most mentioned reasons. Of concern, the service providers also noted interaction with service providers, such as the police, as being a challenge in reporting the crime of rape. Most service providers had a positive attitude towards victim empowerment programmes and the use of victim impact statements. Likewise, a meaningful number of service providers also conveyed positive opinions regarding court preparation within the CJS. Of interest, half of the service providers conveyed positive opinions about working in a multidisciplinary team, compared with more than half citing challenges in working with other stakeholders in rendering post-rape care to adult female rape survivors within the CJS.

The next section of the thesis will provide an overview of the conclusions derived from the study and applicable recommendations.

CHAPTER 8: RECOMMENDATIONS AND CONCLUSION

8.1. INTRODUCTION

The aim of the study was to explore and describe the experiences of adult female rape survivors (being the recipients of services); and stakeholders (being the providers of services) regarding the quality of service delivery within the CJS. Firstly, the researcher made use of a literature study comprising Chapters 1-3. In Chapter 1, the key concepts of importance were conceptualised being rape, survivors/victims, service providers, service quality and CJS. The rest of Chapter 1 focused on the nature and extent of rape, the rationale and problem statement of the study, a brief overview of the methodology, and an outline of the thesis. Chapter 2 explored the various facets of rape as a social phenomenon, while Chapter 3 explicated the various modes of post-rape service rendering (inclusive of legislation, policies, and directives), locally and globally.

Chapter 4 comprised the theoretical framework for the study and included three victimological theories and the ecological systems theory. The victimological theories are the lifestyle exposure theory, routine activities theory and the extended control balance theory. The lifestyle exposure theory elucidates the role of lifestyle pertaining to the prospects of becoming victims of crime, while the routine activities theory focuses on the role of daily activities and the effect they may have on women, subjecting them to the crime of rape. The extended control balance theory explores the power relations that present an interplay being controlled surplus and control deficiency, instigating the victimisation of a person. The ecological systems theory encompasses the numerous processes and interactions that an adult female rape survivor is exposed to in the CJS, with an emphasis on the developmental needs and capacity of adult female rape survivors, pertaining to their interaction within the CJS; being the impact, it might have on the adult rape survivor. The ecological systems theory is directed by five levels of all-embracing spheres known as the *microsystem, mesosystem, exosystem, macrosystem and chronosystem*, which explicate the several approaches of intervention required at distinguishing levels in rendering post-rape services to adult female survivors within the CJS.

Chapter 5 focussed on the methodology in relation to the study. Qualitative research was applied by the researcher in gathering data regarding the lived experiences of adult female rape survivors and service providers within the CJS. The research paradigm was guided by a positivist approach since the researcher proposed components of a post-rape service delivery prototype model in rendering services to adult female rape survivors within the CJS, derivative from the empirical findings. Henceforward, applied research was utilised since the researcher wanted to employ intervention research (with a focus on the process of helping) (De Vos & Strydom, 2011:475; Roestenburg & Strydom, 2021:462), being the subtype of intervention research within the context of the study. The research purpose for the study was descriptive and exploratory in nature since the researcher investigated the perceptions of adult female rape survivors and service providers regarding post-rape services in South Africa. As this study comprised two groups of research participants, the researcher employed both probability and non-probability sampling. Probability sampling, more specifically stratified sampling, permitted the researcher to document multi-interdisciplinary perspectives from service providers rendering services to adult female rape survivors within the CJS. Non-probability sampling, more specifically purposive or convenience sampling, enabled the data collection of adult female rape survivors within the CJS. Data quality, such as trustworthiness, was safeguarded with the aid of credibility, conformity, transferability, and dependability.

Chapter 6 presented the empirical findings of adult female rape survivors accessing post-rape services in South Africa. The age distribution of the rape survivors varied, with the majority being in their twenties. All the participants were African, with most being South African. The majority of the survivors spoke Sepedi, and only a few survivors had post-matric training. A large number of survivors were single, with only a few cited as staying with their children. More than half of the survivors stayed in townships (*ekasi*). The majority of the survivors stayed in a house, with only a few staying in an informal dwelling (*Mkhukhu*). Circumstances surrounding the rape were predominantly attributable to home invasion, prior history of child rape and abuse, incest, accessing unsafe public transport, and intimate partner violence, and one survivor was raped walking

home with a stranger. Approximately half of the survivors chose to report the crime of rape with the idea of accessing medical care. Only a few survivors wanted psychosocial care, while less than half of the survivors wanted to access legal services. Most of the survivors had their rights explained to them when they reported the crime, while most of the survivors had a positive attitude towards victim empowerment programmes. Many survivors shared a desire to compile and present a victim impact statement. Only one of the survivors participated in court preparation. This is mainly due to the fact that the majority of survivors' cases are still being investigated by the SAPS. More than half of the participants had positive opinions regarding the willingness to engage in court preparation.

Chapter 7 outlined the empirical findings of service providers in rendering post-rape services to adult female rape within the CJS. The majority of the service providers were female, with only a few being male. A large number of service providers emanated from the medical and psychosocial sphere of post-rape service providers, with a few legal service providers. With regards to the number of years' experience within the CJS, most of the service providers had at least 10-15 years of service. Service providers cited several factors motivating a rape survivor to report the crime of rape, such as access to medical, counselling, and legal services. Pertaining to the risk factors in women becoming victims of the crime of rape, service providers cited alcohol consumption, drug-facilitated rape, accessing unsafe places and transport, unemployment and poverty, and unequal gender power relations as some of the key initiators of the crime of rape to occur. The majority of service providers had a positive attitude towards victim empowerment programmes and the use of victim impact statements. Similarly, most of the service providers also cited positive opinions regarding court preparation within the CJS. Interestingly, almost half of the service providers shared positive views about working in a multidisciplinary team, compared to more than half referring to challenges in working with other stakeholders in rendering post-rape care effectively to adult female rape survivors within the CJS.

For the purpose of this chapter, the researcher will (1) outline the aim and objectives achieved, (2) highlight the key findings of the research, (3) showcase new information that surfaced from the research, and (4) indicate the limitations

of the study, (5) propose recommendations for further research, and (6) explicate the value of the research (inclusive of a proposed post-rape prototype service delivery model).

The next section of the chapter will discuss the achievements of the aims and objectives of the study.

8.2. AIM AND OBJECTIVES OF THE STUDY

The researcher is of the opinion that the aim of the study was achieved since the research documented the perceived lived experiences of adult female rape survivors and service providers in accessing and providing post-rape services in South Africa. The aim of the study was achieved through the development and operationalisation of the following objectives:

8.2.1. Objective 1: *To conceptualise and describe a global view on the quality of service delivery to adult female rape survivors in the CJS.*

The objective was achieved through a literature review with the aid of relevant books, scholarly articles, and internet sources to explore the development and recent trends in the service rendering of post-rape services both local and globally. Chapter 2 highlighted the changing aspects of rape as a social phenomenon comprising the culture of rape, types of rape, communal responses to the crime of rape, and challenges for the rape survivors in reporting the crime of rape. Chapter 3 focused on policies, guidelines, norms, and standards in rendering medical, medico-legal, psychosocial, and legal post-rape services to adult women within the CJS, both locally and internationally. The research found that although certain domains of post-rape service rendering where satisfactory, several challenges emerged in providing a comprehensive and effective service to rape survivors within the Thuthuzela Care Centre model. The objective was therefore achieved.

8.2.2. Objective 2: *To contextualise and ascertain the roles and duties of the various service providers in terms of the quality of service delivery to adult female rape survivors within the CJS.*

In Chapter 3, it was established that major strides were made in South Africa regarding the modification of legislation, the introduction of numerous policies, directives, and the Victim Support Services Bill, which outlines the roles and duties of various stakeholders (medical, medico-legal, psychosocial, and legal modes of service rendering to adult female rape survivors within the CJS. Chapter 3 (modes of service rendering) and Chapter 7 (empirical findings of post-rape service providers) indicated that although most of the service providers were cognisant of their roles and duties within the CJS, challenges still remained pertaining to the implementation of policies, directives and legislation. The objective was thus reached.

8.2.3. Objective 3: *To explore and describe the various protocols, processes, and legislation that the different service providers within the CJS apply in relation to the quality of service rendering to adult female rape survivors within the CJS.*

Chapter 3 explored the specific roles, processes, and legislation within the CJS. In Chapter 7, the research results were indicative that although South Africa had comprehensive policies and legislation in place, the feasibility and standardised mode of service rendering seemed to be hindered by the unequal distribution of resources (shortage of staff, vehicles, challenges for survivors in accessing post-rape services), as shared by service providers, when compared to the available literature on post-rape services within the CJS. The objective was thus achieved.

8.2.4. Objective 4: *To identify the needs in terms service delivery of adult female rape survivors within the CJS.*

Both adult female rape survivors and service providers were probed regarding the quality of post-rape services rendered and received. In light of the literature study (Chapters 2 and 3) and the theoretical framework in Chapter 4, the researcher identified the needs of adult female rape survivors within the CJS, aligned with the empirical findings of Chapter 6 of the thesis. A discussion in relation to the medical, medico-legal, psychosocial, and legal needs of adult

female rape survivors will be outlined later in the chapter. The objective was thus reached.

8.2.5. Objective 5: To examine and explore the achievements and challenges in rendering services to adult female rape survivors from the point of entry to exit within the CJS.

The objective was attained in Chapter 3 (modes of post-rape service rendering) and Chapter 7 (empirical findings of service providers in rendering post-rape services), which highlighted the achievements and challenges in rendering post-rape services to adult female rape survivors from a medical, medico-legal, psychosocial, and legal sphere of service rendering. This objective will be elaborated upon later in this chapter.

8.2.6 Objective 6: Emanating from the research findings propose important key components that can form part of a holistic post-rape service delivery prototype model pertaining to the quality of service rendering to adult female rape survivors within the CJS (to be inclusive in legislation and policies).

The objective was accomplished since the researcher was guided by the needs, challenges and recommendations emerging from the responses of the adult female rape survivors and service providers in proposing the key components of a prototype model of post-rape services, being medical, medico-legal, psychosocial, and legal. The proposed components of the prototype model will be outlined later in the chapter.

The next section of the chapter will focus on the key findings in rendering medical, medico-legal, psychosocial, and legal spheres of post-rape services to adult female rape survivors within the CJS.

8.3. KEY FINDINGS OF THE RESEARCH

Given the depth of the research data, the researcher will highlight the key findings regarding the perceived quality of care rendered and received, advancements and challenges in relation to medical, medico-legal, psychosocial, and legal domains of post-rape services rendered to adult female rape survivors within the CJS. The following key findings can be highlighted as follows:

8.3.1. MEDICAL SPHERE OF POST-RAPE SERVICES

The outcome of the research confirmed that most adult female rape survivors reported the crime of rape for the purpose of accessing medical services. More specifically, termination of pregnancy, treatment for HIV and STIs and other genital injuries prompted the rape survivor to seek medical care. Three sub-themes will be discussed under this main theme.

- ***Perceived quality of post-rape medical services***

Regarding the perceived quality of medical post-rape services received by adult female rape survivors, most of the adult female rape survivors shared a positive experience when they accessed post-rape medical services.

- ***Advancements in post-rape medical services***

In the medical sphere of post-rape services, medical service providers cited an improved PEP regimen, which is perceived to reduce the side-effects of medication experienced when compared to the older versions of PEP.

- ***Challenges in rendering post-rape medical services to adult female rape survivors***

Medical practitioners highlighted challenges in post-rape care, which comprised defaulting in follow-up visits; a need for a designated facility for the termination of pregnancy; reluctance of the patient to undergo HIV testing; shortage of medical staff; refusal by the patient to take PEP; the unwillingness of a female rape survivor to be examined by a male clinician; and patient comprehension with regards to medication and adherence to follow-up appointments. Pertaining to the medium-long term effects of rape, medical service providers shared that secrecy in not disclosing their HIV-seropositive status; side-effects of medication; pathways of referral for specialist post-rape care; and clinical and psychosocial monitoring of the patient for 6 months as being reasons of concern in rendering post-rape service to adult female rape survivors within the CJS.

8.3.2. MEDICO-LEGAL SPHERE OF POST-RAPE SERVICES

The medico-legal component of post-rape services comprised of the collection of evidence from the body of the survivor, which they experienced as being made comfortable to an extend for the procedure to ensue, with others having had a negative experience during the medico-legal examination. Several sub-themes will be discussed in this regard.

- ***Perceived quality of post-rape medico-legal services***

Almost half of the rape survivors had a positive experience during the medico-legal examination (being informed of procedures and made to feel comfortable), while only a few survivors shared that they experienced the medico-legal examination as being negative (being painful, invasive, and traumatic).

- ***Advancements in post-rape medico-legal services***

Medical service providers cited improvement in the J88 form, re-establishment of specialised sexual offences courts, and the efficiency of the colposcope in detecting injuries during the medico-legal examination of the patient.

- ***Challenges in rendering post-rape medico-legal services to adult female rape survivors***

Regarding the challenges in rendering medico-legal care, medical service providers highlighted being examined by a male clinician; taking a bath prior to the medico-legal examination; refusal to undergo a medico-legal examination; and a shortage of female clinicians in the field of medico-legal medicine. In relation to the challenges in implementing protocols and processes, medical service providers indicated a reluctance by survivors to undergo medico-legal examination, absence of rape kits, facilitation of transport between facilities, and the quality of capturing the injuries sustained by the survivor in the newly revised J88 form. It is imperative to take note that the newly revised J88 is considered by the healthcare participants as being both an advancement and a challenge.

8.3.3. PSYCHOSOCIAL SPHERE OF POST-RAPE SERVICES

The provision and perceived quality of psychosocial services appeared to be varied across all three medico-legal research sites. In certain instances, psychosocial services were uniformly distributed, with RS 2 comprising a significant number of psychosocial services providers (a designated social worker and auxiliary social workers), while RS 1 and RS 3 had limited psychosocial services in relation to social workers. Sub-themes that will highlight this theme will be discussed.

- ***Perceived quality of post-rape psychosocial services***

None of the rape survivors had negative experiences regarding the perceived quality of psychosocial services, while their positive experiences can be attributed to a bond they formed with the service provider and the quality of follow-up services. The survivors also expressed generally positive attitudes towards the psychosocial services they received (i.e., being treated with dignity and being assisted).

- ***Advancements in post-rape psychosocial services***

Service providers cited continuous training, telephonic counselling, continuous engagement among service providers; helping the helper; buddy system in rendering post-rape counselling services; tracing correct information of the survivor, and pre-and-post HIV counselling by first responders as being key improvements in the domain of psychosocial post-rape services.

- ***Challenges in rendering post-rape psychosocial services to adult female rape survivors***

Regarding the challenges in the implementation of protocols and processes, service providers cited confidentiality; distribution of human resources; receiving counselling by a male social worker; preferred demographics in accessing counselling services; adjustment of the Thuthuzela Care Centre model to cater for the survivor; engagement with service providers; vicarious trauma; and employment obligations of rape survivors as barriers in accessing post-rape counselling services.

8.3.4. LEGAL SPHERE OF POST-RAPE SERVICES

The legal sphere of post-rape services presented the most challenges in rendering post-rape care to adult female rape survivors (i.e., transport, staff capacity and attitude of service providers). Several sub-themes that will highlight this aspect will be discussed.

- ***Perceived quality of post-rape legal services***

A few survivors had a positive response when they engaged with legal service providers, while almost half the survivors had a negative experience with law enforcement agencies. The survivors voiced negative experiences with the legal service providers in terms of a lack of communication, cases being dismissed, secondary victimisation and lack of trust in the police.

- ***Advancements in post-rape legal services***

Service providers indicated that continuous updates both in terms of legislation and case progression, centre needs approach in rendering post-rape services, and testifying in camera at sexual offences courts had a positive influence on the management of cases within the CJS.

- ***Challenges in rendering post-rape legal services to adult female rape survivors***

Service providers shared numerous challenges within the domain of legal services, such as the provision of assistance to survivors in accessing legal services; treatment by the police; limited sexual offences courts; lost dockets; communication pertaining to case progression; delay in DNA results; burnout of police members; postponement of cases; quality of a completed J88 form; quality and readiness of the survivor to give a statement; the role of infrastructure in the investigation of cases; and the provision of false information by the victim.

8.4. NEW INFORMATION THAT EMERGED FROM THE CURRENT STUDY

During the course of the data analysis, the researcher conducted an electronic search (Ebscohost and Sabinet) for published research regarding findings to be new and documented these findings according to the medical, medico-legal,

psychosocial, and legal spheres of post-rape services within the CJS. It is of prime importance that this information should be regarded as being hypothetical in relation to post-rape services within the South African context. The following information can be regarded as new in this field of research and is discussed under the headings of medical, medico-legal, psychosocial and legal:

8.4.1. MEDICAL

- ***Financial support for patients accessing medical post-rape services***

Considering the need that was identified by certain service providers, namely to assist victims financially to access medical services, is a subject that was not highlighted by any other research and can therefore be seen as a subject that can add value to this research. The researcher could not find any supportive documentation that highlighted the importance of financial support to rape survivors.

8.4.2. MEDICO-LEGAL

- ***Reluctance to undergo medico-legal examination due to the presence of muti***

Certain service providers cited a reluctance by survivors to undergo a medico-legal examination due to the presence of *muti.* The fact that *muti* can hinder medico-legal services was not previously highlighted by any other research and can thus be viewed as new information that should be researched in future in more depth.

8.4.3. PSYCHOSOCIAL

- ***Age of the psychosocial service provider***

Considering the revelations made by certain service providers, namely that the age of a psychosocial service provider might influence the expectation of the survivor in relation to counselling services, the outcome of this research highlighted the issue that rape survivors prefer a psychosocial service provider to

be older or of similar age, for them to relate to the psychosocial service provider in terms of perceived life experience. The researcher could not find any empirical evidence to support this view and can thus be regarded as a first that can be explored in more detail by future researchers.

8.4.4. LEGAL

- ***Quality and readiness of a survivor to give a statement***

Certain survivors raised concerns pertaining to the quality and readiness of a survivor to give a statement. No other research outcomes could be traced by the researcher regarding the most appropriate time for a survivor to give a statement, primarily due to the notion that rape survivors respond differently to trauma. This is, without doubt, a theme that can be researched further as it can make such a difference in the effectiveness of the implementation of the legal process.

- ***The role of infrastructure in the investigation of rape cases***

Certain participants confirm the existence as well as the quality of infrastructure, specific in rural areas, as significant in rendering effective services to rape survivors.

This referred specifically to the lack of development thereof to trace offenders as there are often no roads to access areas or no addresses available.

The next section of the chapter will highlight the recommendations shared by adult female rape survivors and service providers in relation to post-rape services within the South African context.

8.5. RECOMMENDATIONS IN SERVICE RENDERING TO ADULT FEMALE RAPE SURVIVORS WITHIN THE CRIMINAL JUSTICE SYSTEM

The researcher will outline the recommendations shared by the participants, aligned with the challenges, with regard to the medical, medico-legal, psychosocial, and legal spheres of rendering post-rape within the CJS.

8.5.1. RECOMMENDATIONS WITHIN THE MEDICAL SPHERE OF POST-RAPE SERVICES

- ***Improvement of staff allocation***

The Department of Health must ascertain that all Thuthuzela Care Centres have either a forensic nurse or doctor available at all times. Furthermore, the Department of Health should endorse protocols for accessing post-rape services after hours (in relation to RS 3, which is only operational during the day). It is further recommended that PEP be made available earlier in the continuum of care; and that a full 28-day dosage is provided to rape survivors who have difficulty returning to the hospital (Thuthuzela Care Centres Compliance Audit and Gap Analysis, 2016:18).

- ***Financial support for patients accessing medical post-rape services***

There is a need for financial assistance for adult female rape survivors in accessing medical post-rape care, especially with regard to PEP compliance.

- ***Referral for specialist post-rape care***

There should be a protocol for referral mechanisms of services not provided at present health facilities. Additionally, the Thuthuzela Care Centre model needs to be linked with other existing rape crisis centres, inclusive of affording staff with an opportunity of self–referral for adult female rape survivors within the CJS (Thuthuzela Care Centres Compliance Audit and Gap Analysis, 2016:18).

8.5.2. RECOMMENDATIONS WITHIN THE MEDICO-LEGAL SPHERE OF POST-RAPE SERVICES

- ***Gender of the forensic clinician***

It must be considered that adult female rape survivors must be medically assisted by a female clinician.

- ***Readily availability of rape kits should be prioritised at all Thuthuzela Care Centres***

It is important that rape kits are readily available at Thuthuzela Care Centres, with the onus of providing these kits not solely being placed on the police.

- ***Quality of the completed J88 medical form***

The quality of the J88 form needs to be carefully reviewed and audited by medical and legal service providers (case managers).

- ***Use of the colposcope in detecting injuries***

Colposcopies (a technique used to closely examine the cervix, vagina and vulva) (Jina et al., 2008:4; Jina et al., 2015:2) need to be available at all Thuthuzela Care Centres.

- ***Facilitation of transport between facilities***

Transport for the survivor should be arranged by both the police and the Thuthuzela Care Centre, which implies the onus does not rest with a single service provider.

8.5.3. RECOMMENDATIONS WITHIN THE PSYCHOSOCIAL SPHERE OF POST-RAPE SERVICES

The recommendations regarding psychosocial services are mainly related to resources and staff allocation.

- ***A need for more social workers***

The Department of Social Development should take greater responsibility for providing short-term and long-term psychosocial support (Thuthuzela Care Centres Compliance Audit and Gap Analysis, 2016:18) to adult female rape survivors within the CJS by means of appointing more social workers.

- ***Gender of the social worker in rendering psychosocial services***

The gender of the psychosocial provider should be carefully considered in aiding the pathway to recovery for the adult female rape survivor since adult female rape survivors prefer to receive counselling from a female psychosocial service provider.

- ***Confidentiality***

Privacy and confidentiality are vital values in service delivery (Eogan et al., 2013:48; Kanan, 2018:11-12). Service providers should maintain records of their interventions; and be willing to make this information available to the recipients of these services, according to the prescripts of confidentiality (Global Fund to Fight AIDS, Tuberculosis & Malaria, 2015:10). Rape survivors want to feel continuously assured that their information will be kept confidential at all times within the CJS.

- ***Distribution of human resources***

An evaluation of services at Thuthuzela Care Centres by the Global Fund Gender-based Violence grant, comprising of a qualitative study involving NGOs, NPOs, the Department of Health and survivors of gender-based violence, found that survivors who had accessed services at Thuthuzela Care Centres were of the opinion that service providers executed their mandate in short-term psychosocial support services. Long-term psychosocial support was largely provided as intended; however, implementation was not consistent across all Thuthuzela Care Centres, with the implementation of psychosocial support mostly being affected by a number of contextual implementation issues (i.e., funding) (Process Evaluation of NGO Services at Thuthuzela Care Centres, 2018:4). It is thus envisioned that resources should be consistently allocated across all Thuthuzela Care Centres.

- ***Engagement with service providers***

It is recommended to strengthen current relations among all stakeholders in rendering post-rape services to adult female rape survivors within the CJS, with specific reference to their roles and duties, which may affect the quality of services rendered.

- ***Campaigns-awareness of Thuthuzela Care Centres***

Campaigns should be further prioritised as a way to prevent further victimisation and re-traumatisation. Thus, sustainable programmes need to be rolled out to the communities.

- ***A need for accessibility in post-rape counselling services***

Accessibility is closely linked with knowledgeability in accessing post-rape counselling services, which should be prioritised, inclusive of more training and research regarding challenges in accessing post-rape counselling services.

- ***Financial assistance to access psychosocial services at Thuthuzela Care Centres***

It is recommended that financial assistance be provided to adult female rape survivors from the point of entry to exit pertaining to counselling services.

- ***Group therapy***

A need for support groups to relieve the long-term consequences of rape by assisting the survivor to cope and facilitating socialisation (Willoughby, 2018:4).

- ***Assistance with transport designated for outreach initiatives***

Assistance with transportation for outreach initiatives by service providers is recommended to improve public awareness of the services provided at Thuthuzela Care Centres.

- ***A need for continuous training in rendering post-rape counselling services***

Policy and case-law training must include social context issues. This will facilitate a better understanding of the psychosocial impact of sexual offences; and how the consequences thereof interconnect with legal systems and requirements. Training should not be limited to legal experts only. Medical and psychosocial service providers should also be part of training programmes. Continuous skills attainment and advancement should be supported (Waterhouse et al., 2013: 23-25).

- ***A need for protocols in rendering counselling services to be revised***

A need for protocols in rendering counselling services to be revisited since the current research found discrepancies in relation to which service provider is deemed as being most qualified in rendering psychosocial services to the adult female rape survivor within the CJS.

8.5.4. RECOMMENDATIONS WITHIN THE LEGAL SPHERE OF POST-RAPE SERVICES

- ***Attitude of legal service providers in rendering post-rape services***

It is imperative for legal services to be adequately staffed in rendering post-rape legal services. In an analysis of court case files, Heath et al. (2018:9) found that although service providers rendering post-rape care within the CJS received social sensitisation training, they still experienced difficulty in applying sensitisation techniques attained during training in practice. The substantial caseloads and a shortage of prosecutors, intermediaries, court preparation officers and courtrooms were key challenges for all role players within the CJS. Emanating from hefty workloads, prosecutors are of the opinion that they do not have enough time to conduct in-depth consultations with rape survivors (Heath et al., 2018:11).

- ***Accessibility regarding legal representivity***

Accessing legal services should be improved by making the general public more aware of where to obtain legal representivity within the CJS.

- ***Sexual offences courts***

Notwithstanding the historical attainments of the sexual offences courts, the challenges surrounding the quality of facilities and services need intervention to promote its effective functioning. The sexual offences courts model should be regarded as an optimistic expansion in regulating the standard of facility and service at dedicated sexual offences courts. Some of the prerequisites highlighted a necessity to ensure training to service providers involved in sexual offence trials, comprised of an in-depth list of specifications for facilities, devices and equipment; as well as a list of services pertaining to court preparation, designated social workers, socio-psychological support services, judicial trauma debriefing, psychologists and psychiatrists, interpreters and court intermediaries; all premeditated to safeguard the mental and emotional well-being of survivors and witnesses of sexual offences (Sexual Offences Courts National Strategic Draft Plan 2016-2020:20).

- ***Communication pertaining to case progression***

It is recommended that directives/instructions for prosecutors contain the provisions that the survivor should be informed of the reasons for withdrawing a case in a timeous manner. Furthermore, the plaintiff should also be informed that she may speak to the prosecution about the reasons for the withdrawal of the case (Waterhouse et al., 2013: 27).

- ***Timeous processing of DNA***

The SAPS forensics division is experiencing delays in processing DNA in a timeous manner. By April 2021, the backlog surpassed 210,000 cases (SA's DNA backlog won't be cleared before 2023, at the current processing rate, 2021). It is further suggested that the state prioritise, upgrade and resource laboratories of SAPS in processing DNA more speedily (Gouws, 2022).

- ***The role of infrastructure in the investigation of cases***

Certain areas are inaccessible for the police to conduct investigations (i.e., no roads, addresses, or lights at night). Infrastructure development needs to be prioritised in ensuring and facilitating public safety.

- ***Allocation of more NPA staff***

Sufficient NPA staff must be provided. The NPA highlighted challenges pertaining to vacant posts combined with increased costs bearing salary increases. The NPA plan forthrightly shows the strain on the compensation budget, which will not improve soon. Improving the prosecution of sexual offences entails a passable budget for human resources. Failure to guarantee sufficient staffing will propagate a situation of gross injustice experienced by numerous survivors of rape within the CJS (Waterhouse et al., 2013:12-13).

- ***Centre-needs-approach in rending post-rape services***

A centre-based-needs approach should be of prime importance since the demographics of rape perpetration are not the same in all settings, with certain Thuthuzela Care Centres requiring more resources than others.

- ***Refresher courses***

The NPA interdepartmental training materials should be reviewed and presented by an accredited institution that can be linked to Continuous Professional Development (CPD) points (Thuthuzela Care Centres Compliance Audit and Gap Analysis, 2016:18).

- ***Testifying in camera at sexual offences courts***

Being in the courtroom should not subject an adult female rape survivor to any form of secondary victimisation or additional trauma. The recommendation is to make available the use of closed-circuit television or video conference technology, to permit survivors to testify during legal proceedings outside the physical presence of the alleged rapist(s) (National Crime Victim Law Institute, 2011:1).

- ***Prioritising court preparation for survivors***

Court preparation for rape survivors must receive high priority. Court preparation programmes pursue to support the rape survivor in understanding the court processes, services, and benefits. Its intention is to empower the rape survivor to be an effective witness during legal proceedings. On the date of the trial, it is envisioned that the rape survivor will be welcomed and assisted by the court preparation officer of the Thuthuzela Care Centre (Mkhwanazi, 2016; Skhukumisa, 2012:66).

- ***Monitoring of legal services***

In consultation with other pertinent state and civil society stakeholders, the Department of Justice and Constitutional Development, NPA and SAPS must come to a mutual agreement on the performance indicators to be utilised and the statistics to be monitored. This encompasses beyond statistics on prevalence and reporting rates, investigations outcomes, recommendations for prosecution and prosecution outcomes; and should preferably also be inclusive of the disaggregation by age, gender, rural/urban areas, cases presented in sexual offences courts vs those heard in normal courts, and cases originating from Thuthuzela Care Centres. It is vital that this data must be made publicly available

for monitoring purposes. It thus remains challenging to determine the allocations for prosecutions of sexual offences. The main question regarding this is to verify if the allocation for sexual offences is matched with the proportion of sexual offences entering the CJS (Waterhouse et al., 2013:12).

- ***Training of police officials***

Some police officials do not have the ability to accurately and proficiently take a statement, and in some cases of concern, police officials are unable to read and write English competently to take a statement or efficiently perform their duties (A Dialogue Between Government and Civil Society, 2013:10). Research conducted by Machisa et al., comprising of a quantitative sample involving 292 Family Violence, Child Protection and Sexual Offences officials nationally, found that the majority of investigating officers (45%) were constables and almost half (54%) had completed only their secondary education, while most of their participants (80%) had completed the Family Violence, Child Protection and Sexual Offences training course. Adult Basic Education and Training has been introduced as an interim intervention strategy. There exists a need to strengthen a whole set of skills, including tracking offences and keeping improved records. It has been documented that most police stations do not have copies of documents of acts relating to sexual violence, have no service directives, and lack information on sexual offences. It is not plausible to view all police officials in the same way negatively. There are numerous examples of police officials who execute their duties with professionalism and go well beyond the call of duty. On the other hand, it is infrequent to hear these narratives of success and resilience. This might be reflective of a need to display the good work of some of these officials within SAPS itself and the public. A lack of professionalism and a desire for better technology (i.e., better forensics) are key areas of improvement in the Family Violence, Child Protection and Sexual Offences of the SAPS (A Dialogue Between Government and Civil Society, 2013:10, 12).

- ***Safety of service providers in providing evidence in court***

Service providers reported concerns when they had to testify in court, which necessitated safety measures in the courtroom for service providers.

- ***Resources in terms of legal services***

There exist challenges pertaining to the funding of Thuthuzela Care Centres, and a need has been identified for a continuous, stable, and reliable mode of funding to ensure that all Thuthuzela Care Centres render standardised and uniform services, inclusive of legal services. A lack of funding within the Thuthuzela Care Centre model also creates a sense of mistrust between service providers and the recipients thereof (Thuthuzela Care Centres Compliance Audit and Gap Analysis, 2016:17).

- ***Stakeholder engagement***

Opposing interests and reducing conflict is an issues of concern within Thuthuzela Care Centres. The possibility that community-based organisations such as NGOs and NPOs be integrated into a single entity to act as a mechanism of self-regulation, with setting forth standardised modes of service rendering with needs-based post-rape services per setting (Vetten, 2015:44) is recommended.

- ***Roles and duties of service providers***

Better engagement between service providers should be facilitated to ensure commitment from all the respective stakeholders. It is recommended that stakeholders meet bi-annually to debate strategic operations as well as challenges within the Thuthuzela Care Centres model. It is further recommended and envisioned that a new and comprehensive set of directives be developed for the management of rape in South Africa (Thuthuzela Care Centres Compliance Audit and Gap Analysis, 2016: 17).

8.6. CHALLENGES EXPERIENCED DURING THE RESEARCH

The following challenges were experienced by the researcher during the study:

- Data collection took place during the COVID-19 pandemic, and as a result, NPA staff were rotating. This made it difficult for the researcher to access the survivors when the site coordinator of a Thuthuzela Care Centre was not available.

- Due to COVID-19, the researcher initiated the data collection with service providers via telephonic interviews, which were later suspended due to a low response rate.

8.7. LIMITATIONS OF THE STUDY

- The researcher only included a sample of adult female rape survivors of African descent due to the location of Thuthuzela Care Centres (Cf discussion pertaining to the demographic and biographic information of adult female rape survivors).
- The research findings cannot be generalised since the study only focusses on three medico-legal sites within the Gauteng province.
- A limited number of legal service providers participated in the study, with the majority of service providers being from the medical and psychosocial spheres of post-rape care.
- Only one of the adult rape survivors received court preparation.
- The COVID-9 pandemic made it difficult for the researcher to complete the study according to the proposed time frame.

8.8. RECOMMENDATIONS FOR FURTHER RESEARCH

The following recommendations can be formulated regarding further research:

- It would be of interest to expand the current study to other provinces for a more accurate analysis of the advancements, challenges, and recommendations in rendering post-rape services at Thuthuzela Care Centres.
- Research focusing on the role of infrastructure in investigating rape cases should be considered urgent since it plays a significant role in case progression.

- To do a study on an effective programme regarding the way to prepare rape survivors for a court appearance, including effective training of officers to implement such a programme within the CJS.

The next section of the chapter will explore the value of the research.

8.9. VALUE OF THIS RESEARCH

The following can be regarded as the most important factors that confirm the value of this study:

- The research highlighted advances, challenges, recommendations, and innovations in rendering post-rape medical, medico-legal, psychosocial, and legal modes of services to adult female rape survivors within the CJS. Regarding the ***medical sphere*** of post-rape services, the research found that the newer version of PEP significantly reduced the side-effects experienced by rape survivors, although there is a need for financial assistance in accessing medical care and a referral mechanism for specialist medical services (i.e., termination of pregnancy). Within the ***medico-legal sphere*** of post-rape services, service providers cited a need for the employment of more female medico-legal medical practitioners. The use of the colposcopy also indicated the accuracy at which the genito-anal injuries can be detected by the forensic examiner. The study also found that a survivor might be reluctant to be examined due to the presence of *muti*. Within the ***psychosocial sphere*** of service rendering, helping the helper and the buddy system seemed to have improved psychosocial services, with the ability of psychosocial service providers to also trace the contact details of the adult female rape survivor. The research found that the age of the psychosocial service provider should be linked closely with the age of the survivor since adult female survivors prefer to be counselled by a female psychosocial service provider. The ***legal sphere*** of rendering post-rape service highlighted a positive response towards protective factors such as victim empowerment programmes and the victim impact statement within the CJS. New

advances within the legal domain also emphasised the importance of an audit system across all Thuthuzela Care Centres, pertaining to the quality of the completion of the J88 medical form. The research also found that consensus needs to be reached with regard to the roles and duties of the various stakeholders in rendering post-rape services to adult female rape survivors within the CJS.

- Internationally, there exits discrepancies pertaining to the nature and extent of structures and post-rape service provision in terms of protocols and legislation of a certain country. Certain countries have a single model of post-rape services, while other countries have several post-rape service delivery models which are considered less structured in terms of post-rape service rendering to adult female rape survivors within the CJS. The perceived quality of post-rape care according to the recipients thereof is predominantly influenced by the directives set forth within the country they reside, but also detailed geographic settings (urban vs rural areas), and as in the case of the USA, discrepancies in state legislation, which can also have considerable outcomes on post-rape service provision (Kanan, 2018:9). Integrated post-rape mode of service rendering to adult female rape survivors within the CJS (as in case of South Africa with the Thuthuzela Care Centre model being dominant in rendering post-rape services), are combined within other pertinent services (i.e., as sexual health or violence against women). Whereas structured models have components of integration in that they provide multidisciplinary services, similarly, to cater for the needs of women who have experienced rape, like the Thuthuzela Care Centre model, integrated service models are also provided for by other entities such as NGOs and NPOs (Comparing Sexual Assault Interventions across Europe, 2013:16; Kanan, 2018:10). It is also important to take note, that although globally and locally post-rape services are being advanced in the form of model development, the implementation thereof remains a challenge in South Africa (Johnson et al., 2017:5). In South Africa, insufficient oversight and accountability of post-rape service providers, inadequate resource allocation of post-rape

services, and unreliable implementation of policies and guidelines contributes to the burden of rape as a form of gender-based violence (Johnson et al., 2017:5). Originating from the research findings, the researcher proposes two key main components among many others of a post-rape prototype model, being (1) a proper scientific theoretical framework that must form the basis for the development of post-rape services to adult female rape survivors within the CJS; and (2) to follow a holistic approach in rendering post-rape medical, medico-legal, psychosocial, and legal services to adult female rape within the CJS. This can be further highlighted as follows:

- **Holistic nature of a model for the post-rape mode of medical, medico-legal, psychosocial, and legal services to adult female rape within the CJS**

Service providers within the CJS are obliged to perform a needs assessment of all the different needs of the adult female rape survivor (Lorenz & Ullman, 2017:3), according to a holistic approach, as a way to understand the holistic functioning of the survivor, meaning their developmental needs (with an emphasis on developmental relationships, in which service providers and adult female rape survivors paths the way for developmental advancement) as well as the post-rape spheres of service rendering being medical, medico-legal, psychosocial, and legal of nature. The service providers that are responsible for the rendering of these different services can, therefore, not provide these services without interaction between them. Such a model needs to have a certain protocol to guide the service provider in delivering a holistic service. This can also prevent fragmented service delivering.

- **Scientific theoretical framework for the development of integrated post-rape services to adult female rape survivors within the CJS**

To accomplish the need to deliver an integrated service to the rape survivor, such a model needs to be scientific in nature. In this regard, the ecosystem approach as a scientific framework is deemed to be applicable to the field of service rendering to the female rape survivor, as it provides a platform to deliver an

integrated service to these survivors. The ecosystem approach consists of different systems such as the ***mesosystem*** (community resource), the ***ecosystem*** (formal systems such as law enforcement [police officers] in the community) and the ***microsystem*** (personal assistance, deemed to be more personal of nature [counsellor services] according to the needs of the survivor). It can be accepted that a model based on a scientific framework will produce the best possible results regarding service rendering to adult female rape survivors.

8.10. CONCLUSION

South Africa has enhanced its approach to rendering post-rape care to adult female rape survivors within the CJS, although certain modes of services (medical, medico-legal, psychosocial, and legal) remain fragmented. Pertaining to the medical sphere of post-rape services, the majority of the adult female rape survivors cited a positive experience when they accessed medical assistance, with an emphasis being on HIV and STI prevention, treatment of injuries sustained and termination of pregnancy, if so desired. Regarding the perceived quality of medico-legal services, approximately half of the rape survivors cited a positive experience during the medico-legal examination, with only a few having stated that they found the medico-legal examination to be invasive and painful. The psychosocial component of post-rape care found that the distribution and perceived quality of psychosocial services seemed to be diverse across all three medico-legal research sites. At certain medico-legal sites, psychosocial services were unequally distributed, with RS 2 being over-resourced (being a designated social worker and auxiliary social workers), while RS 1 and RS 3 had a shortage of psychosocial services regarding the adequate allocation of social workers. The legal domain of post-rape services revealed the most challenges in rendering post-rape care to adult female rape survivors, with transport, treatment by the police, being informed of case progression, the attitude of legal service providers and the timeous processing of DNA being key issues of concern within the CJS.

The research stressed the advancements, challenges, and recommendations, in rendering post-rape medical, medico-legal, psychosocial, and legal modes of

services to adult female rape survivors within the CJS. Concerning the medical domain of post-rape services, the research found that the newer version of PEP reduced the side-effects experienced by rape survivors, while there is a need for financial assistance in accessing medical care. With reference to the medico-legal component of post-rape services, service providers shared a need for the service of more female medico-legal medical practitioners. The use of colposcopy came across as being effective in detecting genito-anal injuries. The research also found that a survivor may refuse to be examined if *muti was* present. Within the psychosocial compass of service rendering, helping the helper and the buddy system was indicative of improving psychosocial services, with the capability of psychosocial service providers to also trace the contact details of the adult female rape survivor. The study also highlighted the need for the age of the psychosocial service provider to be closely linked with the age of the survivor and a desire to receive counselling services from a female psychosocial service provider. The legal domain of post-rape services projected a positive response towards protective factors such as victim empowerment programmes and the victim impact statement within the CJS. New developments within the legal sphere of post-rape services also indicated the relevance of an audit system across all Thuthuzela Care Centres pertaining to the quality of the J88 completion. The study emphasised the need for consensus to be reached in relation to the roles and duties of the various post-rape service providers within the CJS. After considering the advancements, challenges, and recommendations of the participants, the researcher proposed two key components based upon a scientific and holistic approach to the post-rape service delivery prototype model, envisioned to facilitate and improve the current mode of medical, medico-legal, psychosocial, and legal modes of service rendering to adult female rape survivors within the CJS. The scientific approach highlighted the significance of the various five levels of engagement of interaction between the rape survivor, service providers and the broader community as being the *mesosystem, ecosystem, microsystem, macrosystem level and chronosystem,* while the holistic approach of post-rape care outlined the key components for consideration is rendering all-inclusive post-rape services to adult female rape within the CJS. In conclusion, it

is envisioned that the empirical findings have the prospects of influencing policies, directives and legislation in rendering post-rape care to adult female rape survivors within the CJS.

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APPENDICES

APPENDIX 1: APPROVAL OF REQUEST TO CONDUCT INTERVIEWS

Administration

NATIONAL PROSECUTING AUTHORITY
South Africa

Enquiry: Mr Marius Bester
Email: mjbester@npa.co.za
Phone: 0128456274
Date: 03/12/2019

Tel: +27 12 845 6000

Victoria & Griffiths
Mxenge Building
123 Westlake Avenue
Weavind Park
Pretoria

P/Bag X752
Pretoria
0001

Mr N.B.Bougard
Department of Criminology and Security Science
337 Veal Street
0-145
School of Criminal Justice
College of Law
Brooklyn

RE: APPROVAL OF REQUEST TO CONDUCT INTERVIEWS WITH SOCA SERVICE PROVIDERS AND RAPE SURVIVORS, AS WELL AS TO OBTAIN COPIES OF SPECIFIC SOCA POLICY AND PROTOCOL DOCUMENTS

Corporate Service Centres:

- Finance & Procurement
- Human Resources Development & Management
- Information Management
- Research & Policy Information
- Risk & Security

Dear Mr. Bougard

Thank you for showing interest in conducting research in the NPA. The purpose of this memorandum is to inform you that your request to conduct research with TCC Service Providers and Rape Survivors at TCCs at Masakhane, Laudium and Lenasia has been approved.

The NPA appreciates that the topic has been approved by the University of Pretoria (Ethics clearance reference no: GP-201901-025). Please consider and/or adhere to (whichever is applicable) the below-mentioned in support of your research:

1. Your request is supported by the Acting Head of the Strategy Management Office as well as the Senior Deputy Director of Public Prosecutions: SOCA.

2. Permission for your research has been granted by the NPA's Acting Head of Administration and OWP.

3. The research request focuses on gathering information from TCC Service Providers and Rape Survivors at TCCs Masakhane, Laudium and Lenasia.

4. Permission to conduct research is limited to interviewing the above persons only and is subject to their availability and personal willingness to contribute to your research.

5. Permission is specifically subject to the stated research questions as stated in your research proposal:

   "What are the experiences of adult female rape survivors and service providers regarding the quality of service delivery within the CJS?"

6. Upon completion of the research project, it is suggested that a copy of the report be sent to the NPA for perusal and approval. This is specifically to prevent the inappropriate interpretation and publication.

7. It is also suggested that in the event of the author publishing an article on research which contains NPA information, it be approved by the NPA.

8. It is noted that you have also submitted a request for access to records of a Public Body, Section 18(1) of the Promotion of Access to Information Act, 2000 (FORM A). Please note that the cost of making copies of the relevant documentation needs to be paid by you and it is strongly suggested that you liaise with the relevant SOCA officials before said copies are made, as in certain cases the documentation can be voluminous and therefor expensive to provide.

Kindly keep the NPA informed about further developments on this research and please direct all correspondence and communication directly to the Acting Director of Research Management on the following;

RE: APPROVAL OF A REQUEST TO CONDUCT RESEARCH: MR. N.B. BOUGARD

Name: Mr. Thomas Tshilowa
Telephone number: 012 845 6273
E-mail address: TTshilowa@npa.gov.za

Yours sincerely

Ms. Karen van Rensburg
Acting Head: Administration and OWP
Date: 3/12/2019

RE: APPROVAL OF A REQUEST TO CONDUCT RESEARCH: MR. N.B. BOUGARD

APPENDIX 2: RESEARCH ETHICS COMMITTEE APPROVAL 27 JANUARY 2020

UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA

Faculty of Humanities
Research Ethics Committee

27 January 2020

Dear Mr Bougard

Project:	**Service delivery within the criminal justice system: The experiences of adult female rape survivors and service providers**
Researcher:	**N Bougard**
Supervisors:	**Prof G Spies and Dr K Booyens**
Department:	**Social Work and Criminology**
Reference number:	**04348281 (GW20180844HS)**

Thank you for tyour response to the Committee's correspondence.

The resubmitted application was **approved** by the **Research Ethics Committee** on 27 January 2020. 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 Innocent Pikirayi
Deputy Dean: Postgraduate and Research Ethics
Faculty of Humanities
UNIVERSITY OF PRETORIA
e-mail: PGHumanities@up.ac.za

Fakulteit Geesteswetenskappe
Lefapha la Bomotho

Research Ethics Committee Members: Prof MI Pikirayi (Deputy Dean); Prof KL Harris; Mr A Bizos; Dr L Blokland; Dr A-M de Beer; Ms A dos Santos; Dr P Gatura; Ms KT Govinder Andrew; Dr E Johnson; Mr A Mohamed; Dr I Noorne; Dr C Puttergill; Dr D Reyburn; Prof M Soer; Prof E Taljard; Prof V Thebe; Ms B Tsebe; Ms D Mokalapa

APPENDIX 3: PERMISSION TO CONDUCT RESEARCH IN THE SOUTH AFRICAN POLICE SERVICE

South African Police Service — Suid-Afrikaanse Polisiediens

Privaatsak Private Bag X94	Pretoria 0001	Faks No. Fax No.	(012) 393 2128

Your reference/U verwysing:

My reference/My verwysing: **3/34/2**

THE HEAD: RESEARCH
SOUTH AFRICAN POLICE SERVICE
PRETORIA
0001

Enquiries/Navrae: **Lt Col (Dr) Smit**
AC Thenga
Tel: **(012) 393 3444**
Email: **LindieSmit@saps.gov.za**

APPROVED

NB Bougard
UNIVERSITY OF PRETORIA

RE: PERMISSION TO CONDUCT RESEARCH IN THE SOUTH AFRICAN POLICE SERVICE: UNIVERSITY OF PRETORIA: DOCTORATE DEGREE: SERVICE DELIVERY WITHIN THE CRIMINAL JUSTICE SYSTEM: THE EXPERIENCE OF ADULT FEMALE RAPE SURVIVORS AND SERVICE PROVIDERS: RESEARCHER: NB BOUGARD

1. The above subject matter refers.

2. You are hereby granted approval for your research study on the above-mentioned topic in terms of National Instruction 1 of 2006.

3. Further arrangements regarding the research study may be made with the following office:

4. The Provincial Commissioner: Gauteng:

- **Contact Person:** Lt Col Ruthnam
- **Contact Details:** (011) 547 9131
- **Email Address:** RuthnamKeith@saps.gov.za

- **Contact Person:** SAC Mphatse
- **Contact Details:** (011) 547 9131
- **Email Address:** MphatseB@saps.gov.za

5. Kindly adhere to paragraph six (6) of our attached letter signed on **2021-11-23** with the above reference number.

MAJOR GENERAL
THE HEAD: RESEARCH
DR PR VUMA

DATE: 2022-02-03

1

SAPS 21

SUID-AFRIKAANSE POLISIEDIENS

SOUTH AFRICAN POLICE SERVICE

Private Bag / Privaatsak X 57, BRAAMFONTEIN, 2017

Reference Verwysing	3/34/2(202200010)
Enquiries Navrae	Capt Nevumbani SAC Mphatse
Telephone Telefoon	(011) 547-9131
Fax number Faksnommer	(011) 547- 9189

THE PROVINCIAL COMMISSIONER

GAUTENG

A. The Provincial Head
S A Police Service
Legal and Policy Services
GAUTENG

B. The Deputy Provincial Commissioner
S A Police Service
Crime Detection
GAUTENG

C. The Provincial Commissioner
S A Police Service
GAUTENG

RESEARCH: PERMISSION TO CONDUCT RESEARCH IN SAPS: SERVICE DELIVERY WITHIN THE CRIMINAL JUSTICE SYSTEM: THE EXPERIENCES OF ADULT FEMALE RAPE SURVIVORS AND SERVICE PROVIDERS: UNIVERSITY OF PRETORIA: DOCTORATE DEGREE: RESEARCHER: NB BOUGARD

A-B: For your recommendation
C: For approval

1. Attached herewith is an application of NB Bougard to conduct research on the above mentioned topic, within the South African Police Service.

2. The application has been evaluated by Provincial Strategic Management (Research) as per attached Annexure and found to be in compliance with National Instruction 1 of 2006: Research.

3. In the opinion of Strategic Management (Research), the research study will be beneficial to the Service as it aims to explore and describe the experiences of adult female rape survivors (being the recipients of services) and stakeholders (being the providers of service delivery within the CJS).

4. The researcher will conduct the study without disrupting the duties of members of the Service. Prior arrangements will be made with the commander of the applicable business unit.

RESEARCH: PERMISSION TO CONDUCT RESEARCH IN SAPS: SERVICE DELIVERY WITHIN THE CRIMINAL JUSTICE SYSTEM: THE EXPERIENCES OF ADULT FEMALE RAPE SURVIVORS AND SERVICE PROVIDERS: UNIVERSITY OF PRETORIA: DOCTORATE DEGREE: RESEARCHER: NB BOUGARD

5. The research study will be conducted at the researcher's exclusive cost.

6. In line with National Instruction 1 of 2006, you are afforded the opportunity to comment on the relevance and feasibility of the proposed research within your area of responsibility. Any objections against the research will be noted and you will be requested to clarify and motivate those with the Provincial Head: Organisational Development & Strategic Management.

7. In order to ensure the effective and efficient finalisation of this application you are requested to submit your comments to the Strategic Management office within the allocated time frame.

8. Your cooperation and assistance is appreciated.

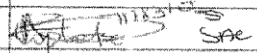
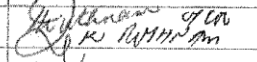
Regards

COLONEL
ACTING PROVINCIAL HEAD: ORGANISATIONAL DEVELOPMENT & STRATEGIC MANAGEMENT: GAUTENG
SC BASSON
Date: 2022-01-19

ANNEXURE A

RESEARCH: PERMISSION TO CONDUCT RESEARCH IN SAPS: SERVICE DELIVERY WITHIN THE CRIMINAL JUSTICE SYSTEM: THE EXPERIENCES OF ADULT FEMALE RAPE SURVIVORS AND SERVICE PROVIDERS: UNIVERSITY OF PRETORIA: DOCTORATE DEGREE: RESEARCHER: NB BOUGARD

COMMENTS & RECOMMENDATION: PROVINCIAL STRATEGIC MANAGEMENT: RESEARCH

I	OFFICIAL FILE NO:	3/34/2(202200010)			
	FILE COMPUTER REFERENCE NO:	8303584			
ii	MOTIVATION FOR RESEARCH:	To conceptualise and describe national and international all-inclusive mechanisms of the quality of service delivery to adult female rape survivors within the CJS and to contextualise and ascertain the roles and duties of the various stakeholders in terms of the quality of service delivery to adult female rape survivors within the CJS.			
	APPLICATION FOUND TO BE COMPLETE:	~~YES~~		NO	
	INDEMNITY / UNDERTAKING SIGNED	~~YES~~		NO	
Iii	APPLICATION PERUSED BY:	SAC Mphatse			
	CONTACT NO:	011 547 9131			
	SIGNATURE:				
	DATE:	2022-01-17			
Iv	APPLICATION VERIFIED BY:	UT COL K Rikhotso			
	APPLICATION RECOMMENDED:	YES ✗		NO	
	CONTACT NO:	011 547 9149			
	SIGNATURE:				
	DATE:	2022.01.18			

RESEARCH: PERMISSION TO CONDUCT RESEARCH IN SAPS: SERVICE DELIVERY WITHIN THE CRIMINAL JUSTICE SYSTEM: THE EXPERIENCES OF ADULT FEMALE RAPE SURVIVORS AND SERVICE PROVIDERS: UNIVERSITY OF PRETORIA: DOCTORATE DEGREE: RESEARCHER: NB BOUGARD

A. RECOMMENDATION BY PROVINCIAL HEAD: LEGAL AND POLICY SERVICES

TIME ALLOCATED: 3 days

COMMENTS WITH REGARDS TO ANY LEGAL OBJECTIONS AGAINST THE RESEARCH WITH ANY ADDITIONAL LIMITATIONS TO RESEARCHER:				
APPLICATION RECOMMENDED:	YES	X	NO	
SIGNATURE:	DATE: 2022-01-21			

B. RECOMMENDATION BY THE DEPUTY PROVINCIAL COMMISSIONER: CRIME DETECTION

TIME ALLOCATED: 3 days

COMMENTS WITH REGARDS TO THE RELEVANCE AND FEASIBILITY OF THE RESEARCH WITHIN YOUR ENVIRONMENT				
APPLICATION RECOMMENDED:	YES	✓	NO	
SIGNATURE: Maj General M.M. Khumalo	DATE: 2022-01-28			

PERMISSION TO CONDUCT RESEARCH IN THE SAPS

RESEARCH: PERMISSION TO CONDUCT RESEARCH IN SAPS: SERVICE DELIVERY WITHIN THE CRIMINAL JUSTICE SYSTEM: THE EXPERIENCES OF ADULT FEMALE RAPE SURVIVORS AND SERVICE PROVIDERS: UNIVERSITY OF PRETORIA: DOCTORATE DEGREE: RESEARCHER: NB BOUGARD

RESEARCHER: NB BOUGARD

Permission is hereby granted to the researcher above to conduct research in the SAPS based on the conditions of National Instruction 1 of 2006 (as handed to the researcher) and within the limitations as set out below and in the approved research proposal.

This permission must be accompanied with the signed Indemnity, Undertaking & Declaration and presented to the commander present when the researcher is conducting research.

This permission is valid for a period of Thirty Six (36) months after signing.

Any enquiries with regard to this permission must be directed to Lt Col. Ruthnam or SAC Mphatse at RuthnamKeith@saps.gov.za/MphatseB@saps.gov.za

RESEARCH LIMITATIONS / BOUNDARIES:

Research Instruments: Interview

Target audience/subjects: 10 members

Geographical target:

Provincial Component	***Station***
None	Pretoria Central SAPS Tembisa SAPS

Access to official document: No

LIEUTENANT GENERAL
PROVINCIAL COMMISSIONER: GAUTENG
E MAWELA (SOEG)

Date: 2022/01/31

SUID-AFRIKAANSE POLISIEDIENS **SOUTH AFRICAN POLICE SERVICE**

Privaatsak/Private Bag X 94

Verwysing/Reference:	3/34/2
Navrae/Enquiries:	Lt Col Joubert AC Thenga
Telefoon/Telephone:	(012) 393 3118
Email Address:	JoubertG@saps.gov.za

THE HEAD: RESEARCH
SOUTH AFRICAN POLICE SERVICE
PRETORIA
0001

The Provincial Commissioner
GAUTENG

PERMISSION TO CONDUCT RESEARCH IN SAPS: SERVICES DELIVERY WITHIN THE CRIMINAL JUSTICE SYSTEM: THE EXPERIENCES OF ADULT FEMALE RAPE SURVIVORS AND SERVICE PROVIDERS: UNIVERSITY OF PRETORIA: DOCTORATE DEGREE: RESEARCHER: NB BOUGARD

1. The above subject matter refers.

2. The researcher, NB Boudard, is conducting a study titled: Services delivery within the Criminal Justice System: The experiences of adult female rape survivors and service providers, with the aim ***to explore and describe the experiences of adult female rape survivors (being the recipients of services) and stakeholders (being the providers of service delivery within the CJS.***

3. The researcher is requesting permission to interview ten (10) police officials at Pretoria Central and Tembisa police stations.

4. The proposal was perused according to National Instruction 1 of 2006. This office recommends that permission be granted for the research study, subject to the final approval and further arrangements by the office of the Provincial Commissioner: Gauteng.

5. We hereby request the final approval by your office if you concur with our recommendation. Your office is also at liberty to set terms and conditions to the researcher to ensure that compliance standards are adhered to during the research process and that research has impact to the organisation.

6. If approval is granted by your office, this office will obtain a signed undertaking from researcher prior to the commencement of the research which will include your terms and conditions if there are any and the following:

6.1. The research will be conducted at his/her exclusive cost.

PERMISSION TO CONDUCT RESEARCH IN SAPS: SERVICES DELIVERY WITHIN THE CRIMINAL JUSTICE SYSTEM: THE EXPERIENCES OF ADULT FEMALE RAPE SURVIVORS AND SERVICE PROVIDERS: UNIVERSITY OF PRETORIA: DOCTORATE DEGREE: RESEARCHER: NB BOUGARD

6.2 The researcher will conduct the research without the disruption of the duties of members of the Service and where it is necessary for the research goals, research procedures or research instruments to disrupt the duties of a member, prior arrangements must be made with the commander of such member.

6.3 The researcher should bear in mind that participation in the interviews must be on a voluntary basis.

6.4 The information will at all times be treated as strictly confidential.

6.5 The researcher will provide an annotated copy of the research work to the Service.

6.6 The researcher will ensure that research report / publication complies with all conditions for the approval of research.

7. If approval is granted by your office, for smooth coordination of research process between your office and the researcher, the following information is kindly requested to be forwarded to our office:

- **Contact person**: Rank, Initials and Surname.
- **Contact details**: Office telephone number and email address.

8. A copy of the approval (if granted) and signed undertaking as per paragraph 6 supra to be provided to this office within 21 days after receipt of this letter.

9. Your cooperation will be highly appreciated.

MAJOR GENERAL
THE HEAD: RESEARCH
DR PR VUMA

DATE: 2021-11-23

APPENDIX 4: EKHURULENI HEALTH DISTRICT RESEARCH PERMISSION

City of Ekurhuleni

GAUTENG PROVINCE
HEALTH
REPUBLIC OF SOUTH AFRICA

EKURHULENI HEALTH DISTRICT RESEARCH PERMISSION

Research Project Title: Service delivery within the criminal justice system: the experiences of adult female rape survivors and service providers.

NHRD No: GP_202002_037

Research Project Number: 15/12/2020-03

Name of Researcher(s): Mr Nigel Bradely Bougard

Division/Institution/Company: University of Pretoria

Date of review by the EHDRC: 14 December 2020

DECISION TAKEN BY THE EKURHULENI HEALTH DISTRICT RESEARCH COMMITTEE (EHDRC)

- This document certifies that the above research project has been reviewed by the EHDRC and permission is granted for the researcher(s) to commence with the intended research project.
- Facilities approved for the research: Tembisa Hospital and Masakhane TCC.
- Participants' rights and confidentiality must be maintained throughout the study period and when disseminating the findings.
- No resources (financial, material and human resources) from the health facilities will be used for the study. Neither the district nor the health facilities will incur any additional cost for the study.
- The study will comply with Publicly Financed Research and Development Act 2008 (Act 51 of 2008) and its related regulations.

Title: Service delivery within the criminal justice system: the experiences of adult female rape survivors and service providers.

- The EHDRC must be informed in writing before publication or presentation of research findings and a copy of the report/publications/presentation must be submitted to the EHDRC
- The district must be acknowledged in all the reports/publications generated from the research.
- The researcher will be expected to provide the EHDRC with
  - Six monthly progress updates including any adverse events
  - The final study report in electronic format
  - Present the final research findings at the annual Ekurhuleni research conference if possible.
- The EDHRC reserves the right to withdraw the approval, if any of the conditions mentioned above have being breached
- The research committee wishes the researcher(s) the best of success.

Ms. Thembani Masina

DEPUTY CHAIRPERSON: CITY OF EKURHULENI

Dated: 25/01/2021.

Dr. R. Ilellaraman

CHAIRPERSON: GAUTENG DEPARTMENT OF HEALTH (EKURHULENI HEALTH DISTRICT)

Dated: 21/01/2021

APPENDIX 5: PERMISSION TO CONDUCT RESEARCH AT TEMBISA PROVINCIAL TERTIARY HOSPITAL RESEARCH COMMITTEE

GAUTENG PROVINCE
HEALTH
REPUBLIC OF SOUTH AFRICA

TEMBISA PROVINCIAL TERTIARY HOSPITAL
PR NO: 5602793
Cnr Flint Mazibuko Dr & Rev Namane, Olifantsfontien, 1665
Private Bag X 07, Olifantsfontein, 1665
Tel: 011 923 2320
Enquiries: Dr A. Mthunzi
E-mail: Vusi.Mthunzi@gauteng.gov.za

To : **Mr Nigel Bradely Bougard**

Subject : Permission to Conduct Research at Tembisa Provincial Tertiary Hospital Research Committee

From : Dr A Mthunzi, Chief Executive Officer, Tembisa Provincial Tertiary Hospital

Date : 27 September 2021

Mr Nigel Bradely Bougard

This is to notify you that you have been granted permission to conduct research in our institution for the following study:

Study Title: ***"Service Delivery within the criminal justice system: the experience of adult female rape survivors and service providers."***

NHRD Reference Number: GP_202002_037

Permission with the following restrictions:

- The study should not interfere with service provision.

Permission to conduct research as per study protocol

Please note the institution requires for all data collection and interaction with staff; patients or records to be as outlined in the study protocol and within the constraints of ethics approval obtained for this study. Should any of these parameters or professional conduct be violated at any stage then the Tembisa Research Committee reserves the right to review and change the decision to allow the researcher to conduct research at the institution.

Please report to the undersigned chair of the Research Committee with all your documents on the first day at the institution for further instructions and introductions.

Recommended by:
Dr M. Sethuntsa
Acting Clinical Support and Therapeutic Services Manager
Signature: _____
Date: 27.09.2021

Approved by:
Dr A. Mthunzi
CEO, Tembisa Provincial Tertiary Hospital
Signature: _____
Date: 29/09/2021

APPENDIX 6: INTERVIEW SCHEDULE FOR GROUP 2

THE EXPERIENCES OF ADULT FEMALE RAPE SURVIVORS REGARDING SERVICE DELIVERY WITHIN THE CRIMINAL JUSTICE SYSTEM

1. SECTION A: BIOGRAPHIC INFORMATION

1.1 Age _____

1.2 Race_____

1.3 Home language_____

1.4 Citisenship_____

1.5 Highest level of education_____

1.6 Marital status_____

1.7 Current living arrangements_____

1.8 Area of residence_____

1.9 Type of residence_____

1.10. Thuthuzela Care Centre where services were provided_____

2. SECTION B: DETERMINANTS FOR ADULT FEMALE RAPE SURVIVORS TO REPORT RAPE

2.1 What were the ***main reasons*** for you to report the rape?

2.2 What were the ***challenges*** that you experienced when you reported the rape?

2.3 Explain the manner in which your ***rights*** were explained to you when you reported the rape.

3. SECTION C: PROTECTIVE FACTORS IN PROVIDING ASSISTANCE TO ADULT FEMALE RAPE SURVIVORS

3.1 In what way do you think the following ***can assist*** women in the criminal justice system?

3.1.1 Victim empowerment programmes (VEP) (are activities undertaken within the criminal justice system to assist the rape survivor); and

3.1.2 Victim impact statement (VIS) (is an opportunity in which the victim is provided with an opportunity to express to the court, the manner in which the rape impacted their lives)

4. SECTION D: MEDICAL ASPECTS OF SERVICE RENDERING TO ADULT FEMALE RAPE SURVIVORS

4.1 Explain the way you experienced the ***medical care*** you received at the Thuthuzela Care Centre after you reported the rape.

4.2 What would you like to ***recommend*** regarding the way ***medical services*** are rendered to female rape survivors?

5. SECTION E: MEDICO-LEGAL ASPECTS OF SERVICE RENDERING TO ADULT FEMALE RAPE SURVIVORS

5.1 Explain the way you experienced the process ***to collect evidence from your body.***

5.2 What would you like to ***recommend*** with regard to the process by which evidence was collected from your body?

6. SECTION F: PSYCHOSOCIAL ASPECTS OF SERVICE RENDERING TO ADULT FEMALE RAPE SURVIVORS

6.1 Explain the way you experienced the counselling services you received at the Thuthuzela Care Centre.

6.2 What would you like to ***recommend*** with regard to the rendering of counselling services at the Thuthuzela Care Centre?

7. SECTION G: LEGAL ASPECTS OF SERVICE RENDERING TO ADULT FEMALE RAPE SURVIVORS

7.1 Explain the way you experienced the legal services you received at the Thuthuzela Care Centre.

7.2 Describe the ***court preparation*** services you received at the Thuthuzela Care Centre.

7.2 What would you like to ***recommend*** with regard to the rendering of legal services at the Thuthuzela Care Centre?

APPENDIX 7: INTERVIEW SCHEDULE FOR GROUP 1

THE EXPERIENCES OF SERVICE PROVIDERS IN RENDERING SERVICES TO ADULT FEMALE RAPE SURVIVORS

1. SECTION A: BIOGRAPHIC INFORMATION (ALL RESEARCH PARTICIPANTS)

1.1 Gender_____

1.2 Professional status within the criminal justice system_____

1.3 Years of experience_____

1.4 Thuthuzela Care Centre with which participant is affiliated _____

2. SECTION B: DETERMINANTS FOR ADULT FEMALE RAPE SURVIVORS TO REPORT RAPE (ALL RESEARCH PARTICIPANTS)

2.1 From your experience, what are the ***main reasons*** for adult female survivors to ***report*** the crime of rape?

2.2 From your experience, what are the ***challenges*** adult female rape survivors experience in reporting the crime of rape?

2.3 From your experience, what do you think are the ***challenges the role players within the criminal justice system experience*** in motivating adult female rape survivors to report the crime of rape? Please clarify your answer.

2.4 From your experience, what measures are in place to ***inform*** adult female rape survivors ***about*** their rights within the criminal justice system? Please clarify your answer.

8. SECTION C: FACTORS CONTRIBUTING TO THE RISK OF RAPE (ALL PARTICIPANTS)

8.1 From your experience, which ***risk factors*** may contribute to women being subjected to the crime of rape?

9. SECTION D: PROTECTIVE FACTORS IN PROVIDING ASSISTANCE TO ADULT FEMALE RAPE SURVIVORS WITHIN THE CRIMINAL JUSTICE SYSTEM (ALL PARTICIPANTS)

4.1 According to your knowledge, what role can the following play in ***assisting*** women within the criminal justice system?

- Victim empowerment programmes
- Victim impact statement.

10. SECTION E: MEDICAL ASPECTS OF SERVICE RENDERING TO ADULT FEMALE RAPE SURVIVORS (FORENSIC DISTRICT SURGEONS AND FORENSIC NURSES ONLY)

5.1 From your experience, what are the ***challenges*** in rendering medical ***care*** to adult female rape survivors? Please clarify your answer.

5.2 From your experience, to what extend are the role players within the criminal justice system, effective in managing the ***medium-to long-term medical effects*** of rape? Please clarify your answer.

5.3 From your experience, what are the ***challenges*** in implementing the ***protocols and processes*** with regard to rendering medical services to adult female rape survivors?

5.4 From your experience, are role players within the criminal justice system abreast with the latest ***technological advancements and practices*** with regard to ***medical post-rape care*** for adult female rape survivors? Please clarify your answer.

5.5 Do you have recommendations for improving the ***medical services*** for adult female rape survivors?

11. SECTION F: MEDICO-LEGAL ASPECTS OF SERVICE-RENDERING TO ADULT FEMALE RAPE SURVIVORS (FORENSIC DISTRICT SURGEONS, FORENSIC NURSES AND CASE MANAGERS ONLY)

6.1 From your experience, what are the ***challenges*** in rendering ***medico-legal*** care to adult female rape survivors?

6.2 From your experience, what are the ***challenges*** in implementing the protocols and processes with regard to rendering ***medico-legal*** services to adult female rape survivors? Please clarify your answer.

6.3 From your experience, are the role players within the criminal justice system abreast with the latest ***technological advancements and practices*** with regard to ***medico-legal*** post-rape care for adult female rape survivors? Please clarify your answer.

6.4 Do you have recommendations for improving the ***medico- legal services*** for adult female rape survivors?

12. SECTION G: PSYCHOSOCIAL ASPECTS OF SERVICE RENDERING TO ADULT FEMALE RAPE SURVIVORS (ALL PARTICIPANTS)

7.1 From your experience, what are the ***challenges*** in rendering counselling services to adult female rape survivors?

7.2 From your experience, what are the ***challenges*** in implementing the protocols and processes to render effective counselling services to adult female rape survivors? Please clarify your answer.

.

7.3 From your experience, are the role players within the criminal justice system abreast with the latest ***advances and practices*** with regard to counselling services for adult female rape survivors? Please clarify your answer.

7.4 Do you have recommendations for improving the ***psychosocial*** services for adult female rape survivors?

8 SECTION H: LEGAL ASPECTS OF SERVICE RENDERING TO ADULT FEMALE RAPE SURVIVORS

8.1 From your experience, what are the ***challenges*** to rendering effective ***legal*** services to adult female rape survivors within the criminal justice system? Please clarify your answer.

8.2 From your experience, what are the ***challenges*** to applying relevant ***legislation*** to assist adult female rape survivors when they report a rape? Please clarify your answer.

8.3 From your experience, are role players within the criminal justice system abreast with ***the latest advances*** and practices with regard to legal services for adult female rape survivors? Please clarify your answer

8.4 From your experience, are the role players within the criminal justice system aware of their duties and responsibilities with regard to working in a multi-disciplinary team in rendering ***legal*** services to adult female rape survivors? Please clarify your answer.

8.5 From your experience, to what extent are the current ***legal services*** beneficial with regard to the ***court preparation*** of adult female rape survivors? Please clarify your answer.

8.6 Do you have recommendations for improving the ***legal*** services for adult female rape survivors?

APPENDIX 8: TSHWANE RESEARCH COMMITTEE: CLEARANCE COMMITTEE

GAUTENG PROVINCE
HEALTH
REPUBLIC OF SOUTH AFRICA

Enquiries: Mpho Moshime-Shabagu
Tel: +27 12 451 9036
E-mail: Mpho.Moshime@gauteng.gov.za

TSHWANE RESEARCH COMMITTEE: CLEARANCE CERTIFICATE

DATE ISSUED: 24/04/2019
PROJECT NUMBER: 27/2019
NHRD REFERENCE NUMBER: GP_201901_025

TOPIC: Service delivery within the criminal justice system: The experiences of adult female rape survivors and service providers

Name of the Researcher:	Mr Nigel Bradely Bougard
Name of the Supervisor:	Prof GV Spies Dr K Booyens
Facility:	Laudium CHC
Name of the Department:	University of Pretoria

NB: THIS OFFICE REQUEST A FULL REPORT ON THE OUTCOME OF THE RESEARCH DONE AND

NOTE THAT RESUBMISSION OF THE PROTOCOL BY RESEARCHER(S) IS REQUIRED IF THERE IS DEPARTURE FROM THE PROTOCOL PROCEDURES AS APPROVED BY THE COMMITTEE.

DECISION OF THE COMMITTEE: **APPROVED**

.....
Mr. Peter Silwimba
Deputy Chairperson: Tshwane Research Committee

Date.....24/4/19..

.....
Mr. Mothomone Pitsi
Chief Director: Tshwane District Health

Date: 2019.04.25

Annexure 1

GAUTENG PROVINCE
HEALTH
REPUBLIC OF SOUTH AFRICA

DECLARATION OF INTENT FROM THE PHC MANAGER FOR TSHWANE PROVINCIAL CLINICS

I give preliminary permission to **Mr. Nigel Bradely** to do his or her research on **"Service delivery within the criminal justice system: The experiences of adult female rape survivors and service providers"** in
LAUDIUM CHC

I know that the final approval will be from the Tshwane Regional Research Ethics Committee and that this is only to indicate that the clinic/hospital is willing to assist.

Other comments or conditions prescribed by the PHC Manager to the Researcher are

The researcher to have an entry meeting with potential facilities before starting with the data collection.

DR. SL PHOSHOKO
ACTING PRIMARY HEALTH CARE: TSHWANE
Date:

APPENDIX 9: RESEARCH COMMITTEE OF JOHANNESBURG HEALTH

GAUTENG PROVINCE
REPUBLIC OF SOUTH AFRICA

Joburg
a world class African city

Research Committee of Johannesburg Health

Faculty of Health Sciences Student Research
Ethics Committee
University of Pretoria

Email: bougarb@unisa.ac.za

Enquiries: Ms. Busisiwe Sikhosana
Tel: 011 694 3909
Busisiwe.Sikhosana@gauteng.gov.za
Hillbrow CHC: Administration Building
Cr Smith Str. & Klein Street
Private Bag X21, Johannesburg
South Africa, 2017

Dear: Mr Nigel Bradely Bougard

TITLE: ***SERVICE DELIVERY WITHIN THE CRIMINAL JUSTICE SYSTEM: THE EXPERIENCES OF ADULT FEMALE RAPE SURVIVORS AND SERVICE PROVIDERS***

DRC Ref: 2020-02-004

NHRD Ref no: GP_202002_037

Your application for research approval refers.

The Johannesburg Health District Research Committee (DRC) has reviewed your application. This letter serves as approval to access the Districts Health facilities (mentioned below) for the above research.

The following conditions must be observed:

- The facilities in which the research will be conducted are:
  - LENASIA SOUTH CHC
- This facilities will be visited from 18/08/2020 to 18/08/2021
- Participants' rights and confidentiality will be maintained all the time.
- No resources (Financial, material and human resources) from the above facilities will be used for the study. Neither the District nor the facility will incur any additional cost for this study.
- The study will comply with Publicly Financed Research and Development Act, 2008 (Act 51 of 2008) and its related Regulations.
- You will submit a copy (electronic and hard copy) of your final report. In addition, you will submit an annual progress report to the District Research Committee.

- Your supervisor and the University of Pretoria will ensure that these reports are being submitted timeously to the District Research Committee.
- The District must be acknowledged in all the reports/publications generated from the research and a copy of these reports/publications must be submitted to the District Research Committee.
- You will liaise with the manager/s before initiating the study.

Contact	Sub District	Sub District Manager/ Area Manager	Contact No.	Cell phone
	ABCEF	Ms Matlala	011 440 1259	082 307 0267
	D	Ms Maria Mazibuko	011 674 1200	082 781 9919
X	G	Mr Peter Mathole	011 213 9603	072 483 6839
	CoJ A	Ms Nelly Shongwe	011 237 8010	082 467 9276
	CoJ B	Ms Zanozuko Mbane	011 718 9656	082 551 5804
	CoJ C	Mr Tebogo Motsepe	011 761 0200	084 655 5420
	CoJ D	Ms Busi Phiri	011 986 0164	082 467 9316
	CoJ E	Mr Vusi Mazibuko	011 582 1504	082 464 9547
	CoJ F	Mr M Monyamane	011 681 8130	082 467 9423
	CoJ G	Ms Olga Kruger	011 211 8936	083 286 0388

We reserve our right to withdraw our approval, if you breach any of the conditions mentioned above. Please feel free to contact us, if you have any further queries.

On behalf of the District Research Committee, we would like to thank you for choosing our District to conduct such an important study.

Regards,

Prof S. Moosa
Chairperson: District Research Committee
Johannesburg Health District
Date 21/08/2020

Mrs M.L Morewane
Chief Director
Johannesburg Health District
Date: 24/08/2020

APPENDIX 10: LETTER OF EDITING

30 January 2023
Pretoria, South Africa

To whom it may concern,

I hereby confirm that I undertook the editing for the dissertation:

Service delivery within the criminal justice system: The experiences of adult female rape survivors and service providers

by Nigel Bradely Bougard
Student no: 04348281

Cillié Swart BA (Harvard) MBA (Kuehne)
+27 (0)73 612 0278
pjcswart@transkaroo.net