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BEST PRACTICES IN COLLECTION AND DOCUMENTATION OF MEDICAL EVIDENCE AT THUTHUZELA CARE CENTRES IN GAUTENG PROVINCE, SOUTH AFRICA

by

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DECLARATION

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DEDICATION

This dissertation is dedicated to my dad for his unfailing love and motivation throughout the process, as well as my mother, who is with us in spirit. I know that she would be very proud of me. To my siblings for keeping me sane through the sleepless nights and fatigue, I sometimes experienced and reminding me that it will all be worth it in the end.

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This study would not have been possible without the consistent help from the following:

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ABSTRACT

Introduction: Sexual violence is defined as sexual acts committed against someone who does not or cannot give consent, and it is a global health problem. The victims of sexual violence face challenges when reporting cases; hence not many cases make it to court. In South Africa, a transdisciplinary team is part of the initial phase of collecting and documenting medical evidence to build a case that is fit to be presented in court.

Aim: This study aimed to document the practices in collecting and documenting medical evidence from records of sexual violence cases that were prepared for trial at Thuthuzela care centres in the Gauteng Province.

Methodology: A quantitative method was used in conducting this study. A record review method was used to collect data. A record review method is used where the collected data in an outcome happening in the current time is connected retrospectively to the determinants that happened in the past.

Results: The study showed that there two types of J88 forms in use, one developed in 1995 and a revised one in 2017. Around eighty four percent (83.84%) on the section of practitioner's details were incomplete. However, the section on patients' information was 100% complete on both types of J88 forms. The section on survivors' medical history was incomplete with 75.07%. History of relevance to a sexual offence was 50.35% incomplete. It was also alarming to find that 33.50% of a general examination was incomplete. The section on clinical findings was only 1.03% incomplete, however the downfall was that 18.11% of specific examinations was incomplete and 30.25% of the specimens collected for further investigations were

incomplete. Interestingly, 80% had the SAEK seal/ sticker attached meaning that more of the survivors arrived at the centre in less than 72 hours of the ordeal.

Abstract

Implications: This study revealed the reality of both J88 form and their shortfalls, showing that many cases of sexual violence against women are lost due to incomplete medical evidence. Therefore, there is a need for training health care practitioners on the importance of filling in the medical evidence for the trial of sexual violence in the J88 form/s. In-service training should also be provided on how to complete the J88 form.

Conclusion: Sexual violence cases rely heavily on the J88 form. It has been recognised that many healthcare practitioners find it complicated to complete, therefore leading to incomplete forms and subsequently delayed prosecutions. It was therefore recommended that there be more effective training of healthcare practitioners on the completion of the J88 form.

KEY TERMS /CONCEPTS: J88 form, medical evidence, practices, Sexual violence, Thuthuzela care centres.

TABLE OF CONTENTS

Table of contents

Table of contents

LIST OF REFERENCES

FIGURES

TABLES

TABLE

LIST OF ANNEXURES	
ANNEXURE	**ITEM**
Annexure A	Ethics Approval: University of Pretoria
Annexure B	Details of practitioner and facility
Annexure C	Request for Permission to do Research
Annexure D	Request for Permission to do Research
Annexure E	Letter of Clearance
Annexure F	Confirmation of Editing

Table of contents

CHAPTER ONE: OVERVIEW OF THE STUDY

1.1 INTRODUCTION AND BACKGROUND

Sexual violence is defined as sexual acts committed against someone who does not or cannot give consent and is a global health problem (Armstrong et al., 2018). Rape is defined as an unlawful and intentional oral, anal, or vaginal penetration without consent according to The South African Criminal law (Sexual Offences and Related Matters) Amendment Act 2007 (Abrahams et al., 2020). Sexual violence is a growing global crisis in which most victims are women. Sexual violence is a violation of one's human rights, although the true extent of the problem is unknown.

The World Health Organisation estimates that in 2006 "35.6% of women have experienced either partner physical or sexual violence or non-partner sexual violence with estimates for the African region (36.6%) being among the highest. "Global prevalence of sexual violence, including rape and other forced sexual acts by non-partners, is estimated at 7.2%, with the prevalence in Southern Africa estimated at 17.4%" (Jane et al., 2019, p 2). "Estimates of rape prevalence in South Africa vary widely within and across provinces, with rape by a partner ranging from 1.5% to 18.8% and non-partner rape ranging from 2.1% to 12.2%" (Jane et al.,

2019, p 2). The “South African Police Services’ annual crime report (2015/2016)” states that between 1 April 2015 and 31 March 2016, 41 503 cases of rape were reported — an estimated 114 rape incidents per day.

The SAPS states that the number of rape incidences reduced by 3.9% from the previous year, following a year-on-year reduction since 2012/2013” (Fouché et al., 2018). The “National

institute for Crime prevention and Rehabilitation says that only 1 in 20 cases of rape are reported to the South African Police Services' and that the numbers do not mirror the reality of what is actually occurring in public. Although, it has been noticed that the lack of faith in the criminal justice system and medical services is one of the biggest barriers to reporting and successfully prosecuting the perpetrators" (Fouché et al., 2018:8). It has been shown that 12– 25% of women report ever experiencing rape. Under-reporting of rape to the police is a well established global issue. The 41 583 rapes that were reported to South African Police Services in the year 2018–2019 only reflect on a small proportion of all rapes actually occurring (Abrahams et al., 2020). It has been reported that in low resource environments, forensic science and well-trained practitioners are usually difficult to obtain, Thus sexual gender-based violence is known for being underreported and positive outcome cases are rare (Smith et al., 2019). "In Kenya, an estimated 40 000 cases of sexual violence happened between the 2007/2008 elections but only 900 cases were reported, and no successful prosecutions having been achieved to date" (Smith et al., 2019:112).

More attention needs to be given to these cases and the healing of the victim psychologically in the long term by avoiding dragged-out cases. It has been identified that positive outcomes of these cases may also be attributed to whether the victim remembers the events of that day or not. With sexual assault and rape endemic in South Africa, the South African justice system depends on medico-legal evidence to substantiate what the survivor remembers of the assault.

Healthcare providers must be skilled in collecting evidence and documenting proper medicolegal findings relating to rape and sexual assault (Fouché et al., 2018). It is important for medical notes to be precise, especially in forensic and clinical medico-legal cases. Medical records of any type can be presented in court. In South Africa, the J88 form, owned by the "Department of Justice and Constitutional Development (DOJ&CD)," is used for this purpose. The current J88 form has been used for about 17 years, but healthcare providers and members of the criminal justice system have noticed that it has faults over time. Research that has been done on rape cases in South Africa has also revealed that there is an unsatisfactory completion of the form, with many inaccuracies (Jina & Kotzé, 2016). There are multiple potential reasons for this, including untrained healthcare providers, the attitude of providers to clinical medicolegal cases, a limited time frame to finish filling in the form accordingly, and poor design and language of the form (Jina & Kotzé, 2016).

Healthcare providers, mainly nurses and doctors, are required by criminal law (forensic procedures) to collect and document medical evidence from survivors of sexual assault for use in court. As such, they have a significant role in the criminal justice system in cases of sexual violence. There is a scarcity of research studies in the documentation and collection of medical evidence in sexual violence cases in South Africa. Most studies on sexual violence in South Africa focus on violence against children, even with little to no attention to collecting medical evidence (Ward et al., 2018; Fillis et al., 2019). This study aims to document the practices in collecting and documenting medical evidence from records of sexual violence that were prepared and completed for court fitness at Thuthuzela care centres in Gauteng Province. Identifying the practices in collecting and documenting medical evidence provide valuable data which can be used to inform the capacity building of expert witnesses (Nurses/Doctors). Consequently, this may enable the successful prosecution of sexual violence crimes in court.

1.2 PROBLEM STATEMENT

Globally, freedom from violence against women and children is central most to discussions on social transformation (Spröte, 2010). The United Nations' Sustainable Development Goal number 16 is the guiding principle for the "promotion of peaceful and inclusive societies for sustainable development, provide access to justice for all and build effective, accountable and inclusive institutions at all levels (Spröte, 2010).

However, eradicating violence against women and successfully prosecuting the perpetrators, particularly sexual violence, is a longstanding challenge in most African countries, including South Africa (Okewu et al., 2019: 143-155). Sexual violence continues to be a persistent problem worldwide; however, the incidence is high in Sub-Saharan Africa (Beyene et al., 2019:2) Globally an estimated one in three women experience rape and other forms of sexual violence (Beyene *et al.*, 2019:2)

In South Africa, 138 in 100 000 women are raped, resulting in the country having the highest rape incidents in the world (Crime Statistics Series Volume V Crime against Women in South Africa, 2018: 8). While much debate has been dedicated to defining the standards of care

essential when providing services to survivors of sexual violence, less attention has been given to procedures for evidence collection and documentation to allow the successful prosecution of perpetrators (Mukoma et al., 2011:162). The J88 is a detailed form that should be completed in duplicate by the healthcare worker who examines a survivor reporting rape or sexual assault. In a study to investigate the medico-legal documentation of forensic evidence from victims of sexual assault, 22.9% of healthcare workers had no prior knowledge of the J88 form (Fouché, Bezuidenhout, Liebenberg & Adefuye, 2018:10). At the same time, 54.3% of the health care practitioners reported experiencing difficulties in completing the form (Fouché et al., 2018:11-12). In a similar study conducted in Kenya, healthcare workers expressed problems in collecting specimens from survivors, as well as a lack of appropriate and sufficient equipment, little knowledge of the correct use of a speculum and a lack of proper facilities to examine samples at the district health facility level (Mukoma et al., 2011:165).

Studies have shown that the quality of the survivor's physical and verbal evidence collected by healthcare workers determines the success of the court case (Naimer et al., 2019:26512654.). As such, the persistently poor and insufficient collection, documentation and preservation of forensic evidence results in a negative outcome in court, where the perpetrators are not convicted.

Therefore, this study aimed to document practices in collecting and documenting medical evidence for sexual violence cases against women that are fit and ready for trial at Thuthuzela care centres in Gauteng Province, South Africa.

1.3 RESEARCH QUESTION(S), AIM AND OBJECTIVES

1.3.1 Research Question

The research question for this study was:

What practices are used in collecting and documenting medical evidence for sexual violence cases against women that are fit and ready for trial at Thuthuzela Care Centres in Gauteng province, South Africa?

1.3.2 Research Aim

The overall aim of the study was:

This study aimed to document the practices in collecting and documenting medical evidence from records of sexual violence that were prepared for trial at Thuthuzela care centres in the Gauteng Province

1.3.3 Research Objective

The overall aim was achieved through the following objective:

To document the current practices in collecting and documenting medical evidence for sexual violence cases against women that are fit and ready for trial at Thuthuzela Care Centres in Gauteng province, South Africa.

1.4 DEFINITION OF KEY TERMS / CONCEPTS

1.4.1 Sexual Violence

Sexual violence is defined as “any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic, or otherwise directed, against a person’s sexuality using coercion, by any person regardless of their relationship to the victim, in any setting, including but not limited to home and work.” As defined by the World health organisation

(WHO) (Bows 2016:149). In this study, sexual violence implies any sexual act/ penetration done without the victim's consent.

1.4.2 Medical Evidence

Medical evidence is a form of expert evidence. Medical evidence can take many forms. It can include a doctor's/ nurse's clinical notes or records and the forms a medical practitioner completes when a sexual violence/ rape case is opened and the victim presents at a crisis centre (Is et al., 2020:1). In this study medical evidence is the information collected and documented by a nurse/doctor from the victim at a Thuthuzela Care Center.

1.4.3 Best Practices

"Best practice in health care broadly refers to a systematic process involving the identification, collection, evaluation, dissemination and implementation of information, and the monitoring of outcomes of health care interventions for population groups and defined indications or conditions" Perleth, et al (2001:1). In this study best practices are the best methods used in collecting and documenting medical evidence using the J88 form as seen in the units of analysis from the Thuthuzela Care centres.

1.4.4 J88 Form

The J88 form is a legal form of the Department of Justice which is used in most clinical forensic examinations in South Africa. It is a form for medico-legal documentation and is currently the only format used in South African courts. (Kotze, et al., 2014:20)

1.5 PARADIGMS AND ASSUMPTIONS

1.5.1 Paradigms

A basic set of beliefs that give guidance for a reason or guide the interaction between a set of actions when conducting research. (Luis, F., and Moncayo, G., 2019) They can also be seen as a way that the world views or sees the general complexities of the world (Polit and Beck, 2012:12). In this study, the researcher chose positivism as the paradigm of choice as a positivist paradigm uses the traditional nursing scientific approach to research and has been suggested that quantitative research is a “modified positivist position” Polit and Beck, 2012:12 cited in Luis, F., and Moncayo, G., 2019. Positivists base their research on facts and aim to be as objective and neutral as possible (Alvesson, 2009:15-51). In this study, the positivist paradigm guided the methods and strategies of collecting data using the tool to analyse/ audit the facts given on the J88 forms in the medical records.

1.5.2 Assumptions

Assumptions are concepts that may be viewed as real but without proof (Macnee and McCabe, 2008:254). There are three types of assumptions, namely ontological, epistemological and methodological assumptions.

1.5.2.1 Ontological Assumptions

The researcher assumes that the records that will be reviewed during data collection will have sufficient data to help answer the research question.

The researcher further assumes that the collected data will represent what is entailed in the actual Thuthuzela care centre records and are unbiased.

1.6 RESEARCH DESIGN AND METHOD

1.6.1 Research design

A research design is a general plan for putting together data in a research study (Brink et al., 2015:217).

A record review design was used in this study. A record review approach is used in a study where the collected data in an outcome happening in the present time is connected retrospectively to the determinants that happened in the past. The researcher begins with the effect and works backwards to determine what was associated with this effect in the past (Brink et al., 2015:102).

Therefore in this study, we looked at records that were ready for the court (effect) and worked backwords by auditing the documentation and medical evidence to see how it affected or contributed to the readiness of been used as evidence for prosecution of sexual violence against women. The use of the collected data in an outcome happening in the present time is connected retrospectively to the determinants that happened in the past (Brink et al. 2015:102). Thus, the researcher began with the effect and worked backwards to determine what was associated with this effect in the past.

1.6.2 Study Setting

The study was conducted in Thuthuzela care centres in the Gauteng Province, South Africa. “Thuthuzela Care Centres are all-in-one facilities introduced in 2006 as an important part of South Africa’s anti-rape plan, aiming to decrease secondary victimisation, improve conviction rates and decrease the duration leading to the finalisation of cases. Refer to Chapter 3 on the Study setting

1.6.3 Unit of Analysis

The units of analysis were the files/ medical records that were audited at the centres as part of the data collection process.

1.6.4 Sampling Method and Size

A two-stage sampling method was used in selecting a representative sample for this study. Stage one was the stratified proportional random sampling method. The stratified proportional random sampling method breaks down the population into subgroups and helps create an appropriate number of individuals for each subgroup based on population proportions. This study consisted of five subgroups, as indicated in chapter three.

Simple random sampling without replacement (SRSWOR) was used as the second stage of sampling.

1.7 MEASUREMENT TOOLS

The study was guided by a record review design to meet the objectives and achieve the aim of the study. This method was used because it involved looking at the medical records retrospectively and using the designed auditing tool to audit the medical records.

1.7.1 Measurement Method

The researcher used the developed tool to audit medical records from the chosen years. She started by identifying the medical records that meet the inclusion criteria and put them aside. She then assigned an identification number to the record and the tool that goes with it and then went through each file accordingly and made relevant notes on the tools that would assist later during the data analysis process.

1.7.2 Reliability

In this study, reliability was ensured by pre-testing 20 tools in the form of a pilot study to see if the tool would serve its purpose and, if needed, adjust it accordingly to meet the study's objective.

1.7.3 Validity

Validity refers to the ability of the measuring tool to quantify the behaviour or quality it is meant to measure and is a gage of how well the tool carries out its duty.

1.8 PILOT OF THE DATA COLLECTION INSTRUMENT

A pilot study was conducted before collecting the actual data, and the results obtained from this pilot study were not used in the actual study. Data analysis was done by having the researcher write out all the results on a spreadsheet provided by the statistician and then send it back to the statistician to be coded and analysed. A detailed methodology is found in chapter three.

1.9 QUALITY CONTROL

To ensure rigour, which is a way to create trust or confidence in the outcomes of a research study, the researcher applied validity and reliability appropriately with good reasoning, as described in chapter three.

1.10 DATA MANAGEMENT AND DATA ANALYSIS

1.10.1 Data Management

The data was captured into Microsoft Excel and sent to the statistician. The statistician imported the data into STATA version 13 for analysis. During data analysis the data was cleaned and coded. Coding refers to the placement of unrefined data into a format that may be recognised by a machine (De Vos et al., 2011:252.

1.10.2 Data Analysis

The process of gathering Information to create an image of all the information collected is referred to as data analyses (Macnee and McCabe, 200:25). The Chi-square tests (χ^2) for independence in a two-way contingency table were performed in order to determine the association between the demographics, socio-biographical characteristics, date of assault and date of medical evidence.

1.11 ETHICAL CONSIDERATIONS

Ethical permission for the study was sought from the Faculty of Health Science Ethics Committee, the University of Pretoria and Gauteng Department of Health, and the Gauteng NPA. The researcher also asked for permission from the selected Thuthuzela care centres see Annexure D. Though the study involved only records, the researcher kept the confidentiality of the information accessed from the records during data collection.

All the completed data collection tools were kept safe under lock and key for the confidentiality of the obtained data. All the completed tools were assigned numbers. Only the researcher, supervisory team, and statistician had access to the completed tool.

1.12 CHAPTER OUTLINE

CHAPTER 1: Overview of the study

This chapter introduces the dissertation to the reader. Included were the aim, objective, the setting of the study, definition of key concepts and the assumptions of the study.

CHAPTER 2: Literature review

Chapter One: Overview of the study

This chapter reviews the literature used within the study as guidance, which added substance and support to the information gathered within the process.

CHAPTER 3: Methodology

This chapter discussed the details of how the study was carried out. It included sampling, sampling size, inclusion and exclusion criteria, data collection, data analysis, quality control, and ethical considerations.

CHAPTER 4: Presentation, discussion and interpretation of the research results

Within this chapter, you will find the summary of the data collected, quality control and the study results illustrated in the form of pie charts, bar graphs and tables discussed in detail.

CHAPTER 5: Summary, Implications, Limitations, recommendations and conclusion

This chapter provides a summary of the results and concludes the findings. Feedback on the study is then provided through the overall implications, recommendations and conclusion.

1.13 SUMMARY OF THE CHAPTER

The Chapter described the overview of the study by discussing: the overview on the introduction, the problem statement, the aims and objectives of the study, and a brief synopsis of the research method and design.

The following chapter will discuss the reviewed literature of the study including the review process, electronic databases, literature search as well as the literature findings.

CHAPTER TWO: LITERATURE REVIEW

2.1 INTRODUCTION

The previous chapter discussed the overview of the study. The overview was on the introduction, the problem statement, the aims and objectives of the study, and a brief synopsis of the research method and design. This chapter will discuss the reviewed literature of the study.

2.2 THE OBJECTIVE OF THIS LITERATURE REVIEW

To explore the available scientific knowledge on collecting and documenting medical evidence of sexual violence cases.

2.3 LITERATURE REVIEW PROCESS

A literature review, also known as a critical review essay, summarizes and assesses a body of writings about a certain subject. It mainly has two important points, firstly, to briefly summarise the results from previous research efforts and secondly, to conclude the accuracy and completion of the knowledge found (Knopf, 2006: 127-132). It is important because it gives the researcher an overview of research work they are unfamiliar with. It opens the researcher up to what has already been done to prevent time wastage and repetition in the research world. It may give the researcher fresh ideas on how to conduct their own research.

It helps in revealing flaws that may be in the study (Knopf, 2006: 127-132).

In order to achieve the said objective, the researcher followed the following steps for this review: identification of the question for the review, establishment of a search strategy, selection of relevant studies, extraction of data, analysis and synthesise of the data and formulation of the concluding statements. The steps will be discussed below:

Step 1: Identification and formulation of a review question

When conducting a literature review, it is important to have a question to guide the researcher, keep the literature focused and specific to the study, and not lose track of its purpose. This is to assist in alleviating unnecessary information that is not necessary for the literature review.

This question guided the researcher in conducting this review was :

How is medical evidence collected and documented in sexual violence cases?

Step 2: Generation of a search strategy

A search strategy is a “map” created by the researcher directing the process of searching for literature. It specifies the type of literature needed, where to find the literature and how to know if the literature found is relevant to the literature review at hand. A search strategy is important because it minimises the time spent looking for literature, specifies what is needed from the literature and directs where the most relevant literature is most likely to be found. The search terms below were used in the search for literature because they were the most relevant to the study, and the results yielded from them were specific and directly linked to the review question. The following search terms were used for this review:

- Best practices
- Practices
- Medical evidence
- J88 form
- Collection and documentation
- Sexual violence
- Thuthuzela crisis centre

Inclusion and exclusion criteria

The purpose of the inclusion and exclusion criteria was to assist in identifying the most relevant literature that included the search words or was related to the study itself.

Inclusion criteria were:

- The text should Include search word/s
- To be in English
- To be a complete article
- To be as recent as possible (2016-2021)
- To discuss collection and documentation of medical evidence

Exclusion criteria were:

- Not in English
- Does not include search word/s
- Is not relevant to the studies topic

Step 3: Execution of the search and selection of the relevant studies

In order to obtain relevant literature on the collection and documentation of medical evidence, the researcher explored multiple sources of data, such as electronic data bases reference lists for authors of studies that discussed a similar topic.

Electronic data bases

The researcher searched for articles using the following databases: PubMed, Scopus and Google scholar. Criminal justice abstracts were also used as a database, including bibliographic records covering important areas related to criminal justice and criminology. Subject areas that are covered include criminal investigations, forensic science and investigations. These were the only databases used to search for articles for this review . Scopus was used as it is the largest abstract and citation database of peer-reviewed literature and has a comprehensive overview of the world's research output in the fields of science and medicine. Pubmed was chosen as it has more than 2.5 million citations from online books and life science journals. Google scholar is a freely accessible web search engine that indexes full

text or metadata of scholarly literature across various publishing formats and disciplines hence why it was chosen.

The search words were broad and most of them could be generalised into any topic, Hence different words were used for different databases and therefore the most relevant and accurate results determined which database would be used for which words.

Step 4: Extracting data

After searching for an article and before choosing it, the full article had to be fully available and in a format that may be downloaded. Once this was established, the researcher would read the abstract as well as the results and conclusion to see that the general part of the articles applied to this study and had information that would be of use to this study. Once that was established, the article was downloaded and placed in a platform called “Mendeley”, which would assist in the later process of citing and referencing that particular article. The information found in the article would then be applied to the study as needed, and the process would continue.

Step 5: Analysing and synthesizing

The search yielded a total of (N=253 302) articles from Pubmed, (N= 890688) from Scopus and (N= 10 590 503) from google scholar. All these articles were reviewed for their relevancy to the study. A total of fifty eight (N=58) met the criteria. After further scrutiny and further reading forty eight more articles were excluded because they did not have enough information to support the topic leaving (N=10) full articles that were used in the review. The full articles were then used in the foundation of this literature review.

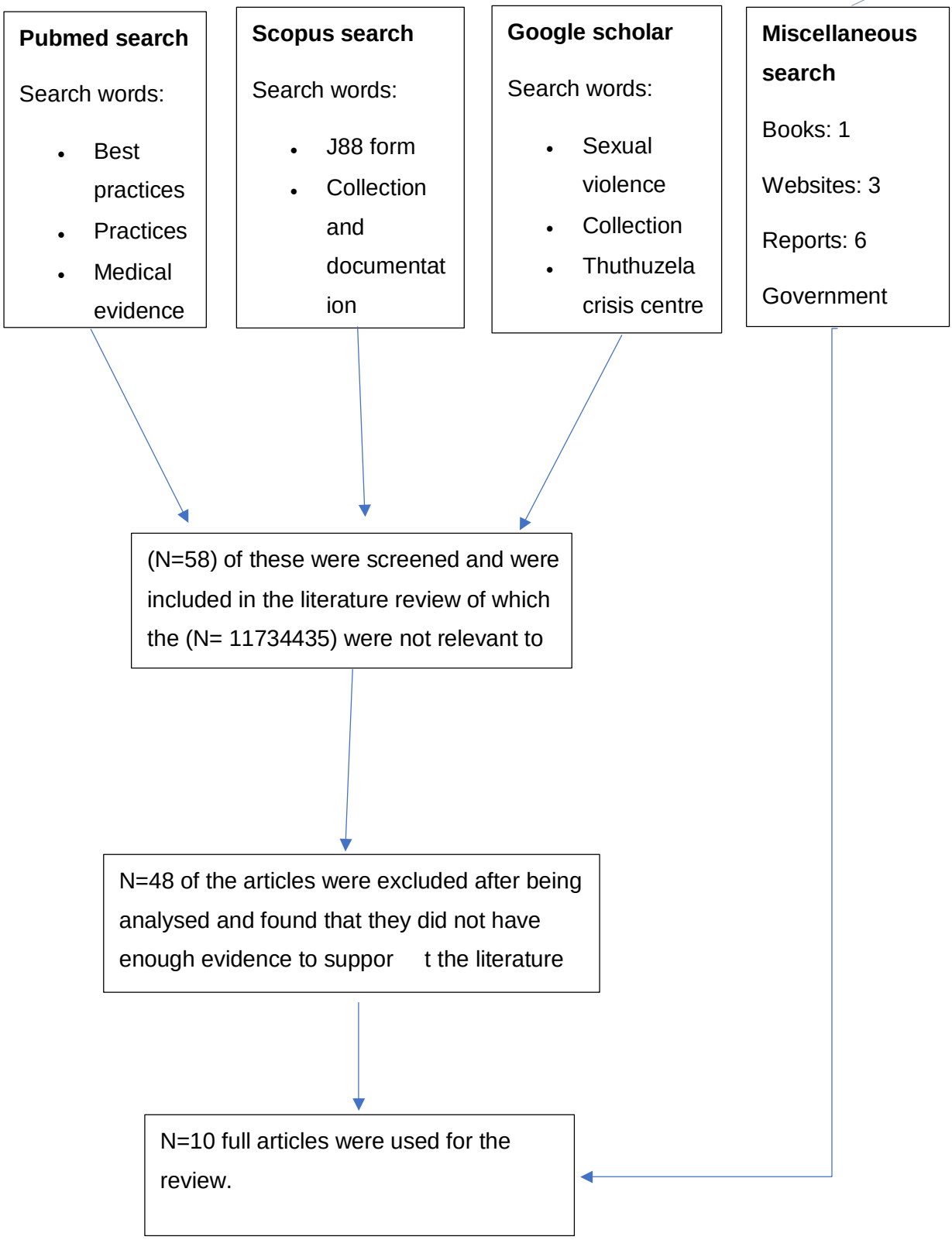

Figure 2.1: Literature search

Step 6: Formulating the concluding statements

This second chapter shows how the researcher looked for articles using databases online. Pubmed, Scopus, and google scholar were the databases used to search for articles that looked at the collection and documentation of sexual violence cases, as well as the j88 form as they have a large number of peer-reviewed articles/ literature both locally and internationally and have a wide variety of topics that they have information on that have been cited on multiple occasions. Three themes, namely: the collection of medical evidence, the victim as walking and talking evidence and documentation of medical evidence, were then identified and further elaborated.

Table 2.1: Description of reviewed articles

YEAR AND AUTHOR/S	COUNTRY	TITLE	AIM OF ARTICLE	DESIGN
Black et al., 2011	Atlanta, USA	The national intimate partner and sexual violence survey (NISVS): 2010 summary report	To identify women are/ have been sexually violated within their intimate relationships	Quantitative
Kotzé and Brits, 2017	South Africa	The emergency management of a rape case in a nutshell: Adolescent and adult cases	To address the reluctance to get involved in medico-legal cases and emphasises the holistic management of survivors of rape.	Qualitative
Campbell et al., 2014, p. 620	United States of America	The impact of sexual assault nurse examiner (SANE) programs on criminal justice case outcomes: A multi-site replication study	To examine how the police justified their investigatory decisions to identify potential leverage points for change. The	Quantitative
Smith, Flowe and Kanja, 2019	Nairobi, Kenya	Achieving more with less: A critical review of protocols for forensic investigation of sexual violence in lowresource environments	To focus on the need for innovation and development of training protocols for gathering testimonial and forensic evidence in SGBV cases, particularly in lowresource environments, such as developing countries, displaced communities, and conflict and post-conflict societies.	Qualitative
Muldoon et al., 2018	Ottawa, Canada	Achieving just outcomes: Forensic evidence collection in emergency department sexual assault cases	To determine the prevalence and correlates of Sexual Assault Evidence Kit (SAEK) completion and release to police among sexual assault cases presented to the ED	Quantitative

Fouché et al., 2018 p 10	South Africa	Medico-legal documentation of rape or sexual assault: Are community-service	To investigate undergraduate clinical forensic medicine training	Quantitative retrospective cohort

		doctors equipped for the task?	based on the experiences and opinions of community-service doctors.	
(Naimer, Volpellier and Mukwege, 2019).	South Kavumu, DRC (Democratic Republic of Congo.)	The case of Kavumu: a model of medicolegal collaboration	• To cultivate networks of col-laboration among these professionals so they can work together to strengthen accountability for perpetrators and better support survivors. • To design and implement a series of training programmes to enhance forensic medical competencies and increase multi-sectoral collaboration.	Qualitative
Rowe et al., 2013	South Africa	Justice through the J88: The doctor's role in the criminal justice system	To identify the role of medical doctors in the criminal justice system.	Quantitative
Jina and Kotzé, 2016	South Africa	Improving the recording of clinical medicolegal findings in South Africa	To describe the process that was undertaken to revise the current J88 form.	Unspecified
Kotzé, Brits and Botes, 2015	South Africa	Part 3: Medico-legal documentation practical completion of pages 2 and 3 of the J88 form	To highlight the value of the relevant aspects while raising awareness of an unscientific interpretation of clinical examination.	Qualitative

Discussion of the findings from the literature review

The literature in this review discuss three main issues: collection of medical evidence and the victim as walking and talking evidence and documentation of medical evidence. These three aspects will be discussed below.

2.4 COLLECTION OF MEDICAL EVIDENCE

The review indicates that there are various methods used to collect the medical evidence, such as conducting interviews or recording the victim to avoid them appearing in court and reliving the trauma (Muldoon et al., 2018:751). Additionally, the use of evidence kits, i.e. SAEKs, which will fall more in the forensic evidence collection, commonly done by the police officers (Muldoon et al., 2018:747). However, Patterson et al., (2012) have identified the widespread problem of untested sexual assault evidence kits (SAEKs). It has been estimated that between 41% and 62% of SAEKs collected at the hospital and submitted to police are not submitted for DNA testing.

In a Canadian study conducted at the emergency department pointed out that even though the victims have access to specialised forensic evidence collection, a lot of them do not go ahead with the completion of the SAEK. It was also said that of the 202 (77.1%) cases that were eligible for a SAEK, only 129 (63.9%) of the cases completed a SAEK and 60 (29.7%) released the SAEK to police for investigation (Muldoon *et al.*, 2018:748). In South Africa few evidence collection kits are kept at the applicable centres with the authorisation of the South African Police Services. The aim i to reduce the delay of examinations of patients that walk into the centres. Of importance these are kept for those and victims who are undecided on opening a case immediately after the incident of rape/ sexual assault.

Furthermore it was noted that the delay of medical and medico- legal assessments can be avoided in sexual violence cases. This will reduce the loss of evidence and better manage of the health needs of victims, including post-exposure prophylaxis (Kotzé and Brits, 2017:230-

236). A study that was conducted In Congo recommended strict procedures for the collection of forensic evidence and medical examinations (Naimer et al., 2019: 2651-2654).

Such measures are needed to ensure that the international best practices are to be followed especially with cases involving children where re-traumatisation might happen time and again (Naimer et al., 2019: 2651-2654).

2.5 THE VICTIM AS WALKING AND TALKING EVIDENCE

From the literature review it is noticed that some prosecutors do not encourage the inclusion of the history of the incident as measure to avoid differences between the formal statements and the j88 form(Kotze et al., 2017:232). In the review a detailed history is part of the assessment of all patients and should not be removed from the part of prosecution (Kotzé et al., 2015:16-22). The reason is that the victim forms an important part of evidence collection as the formation of the evidence is determined by the information given by them. This relate to the emphasis of victims reporting the case within 72 hours where the medical evidence is still there. The 72 hours reporting is also about a sharp recollection of the incident even though some information may be remembered at a later stage (Strom *et al.*, 2019:6-9).

Additionally, from the review it is reported that the South African courts depend highly on medico-legal evidence to support victims' accounts of assault (Fouché *et al.*, 2018: 21-25). Hence, the court sees the victim's mindset is an important factor in factual information (Kotzé and Brits, 2017:230-236) The need to examine the victim's mental status is important in these cases. As there is a perception that mental health may be a sign of whether or not the victim could have given consent, is unable mentally to do so or may be intellectually challenged (Kotzé and Brits, 2017:230-236).

Hence it is recommended that an extra mental capacity assessment may be recommended for the victim if the examining medical practitioner is unsure of the patient's mental capacity (Kotzé and Brits, 2017:230-236) during the examination and evidence collection as well as during prosecution As all emotions, controlled or expressed, after a traumatic episode are considered normal. It is real that in the initial phase following an emotional trauma resulting from violence, the victim might not be able to remember the events of the incident correctly,

and any inconsistencies may have an impact during the court hearing. (Kotzé, Brits and Botes, 2015)

The review reported that during medical history the stance of the victim whether or not they are intoxicated (drugs/ alcohol) may also affect the information (Krebs *et al.*, 2007:1-28) Therefore, before collecting medical evidence, these factors need to be assessed as they may affect the quality and amount of information that may be obtained from the victim ((Krebs et al., 2007:1-28). The stance of intoxication might impact the case , therefore, not be presented in court should it be determined that the victim who claimed to have been sexually assaulted had been drinking (Fouché *et al.*, 2018:21-28) . The reliability of the evidence given by such a victim will be seen as questionable in court (Fouché *et al.*, 2018:21-28). Even though soberness can only be assessed at the time of the examination, stating conclusions as to the soberness of the patient at an earlier time is deemed unscientific((Krebs *et al.*, 2007:1-28) as intoxication may be part of the crime. Therefore, the examination should not be postponed to give the victim time to become sober (Kotzé and Brits, 2017:230-236).

2.6 DOCUMENTATION OF MEDICAL EVIDENCE

It is reported that documentation of medical evidence includes the completion of the J88 form, which is standard in South Africa. J88 form is found in the D1 Sexual Assault Evidence Collection kit for adults and in the D7 Evidence Collection kit for children younger than 12 years (Kotzé and Brits, 2017). On the form there are various questions that need to be answered by the victim but is asked by the healthcare practitioner. These questions are asked in an interview style and filled in by the healthcare practitioner and not the victims themselves (Smith et al., 2019:108-113). The J88 form is an official form created by the department of justice and is an important part of medico-legal evidence for victims that would like to open a case (Kotze, J.M., Brits, H., Botes, B.A., 2014:20) Unfortunately, the awareness of the importance of the timely, thorough and accurate completion of the form to doctors is not clear. (Rowe, k., Botha, H., Mahomed, H., Schlemmer, A., 2013). There is a clear problem pertaining to the protocol for obtaining, finishing and continued management of the J88 form.

The review points out that There seems to be confusion in the role of the specific parties involved in the process, which sometimes leads to the victim closing the case before its

completion (Rowe, k., Botha, H., Mahomed, H., Schlemmer, A., 2013). From the review it is recommended that photos may also be included as part of the documentation process and the clear description of the injuries incurred by the victim during the violation (k.Mcclure, 2006:1-14) . The current J88 form has been used for about 17 years, but over the 17 years the healthcare providers and members of the criminal justice system noticed that it has faults (Jina et al., 2016:872-873). The review reports that research on sexual violence cases has revealed that there is an inadequate completion of the form, with many inaccuracies (Isacc et al., 2001:1-6) . There are numerous likely reasons for this, including untrained healthcare providers, the attitude of providers to clinical medico legal cases, a limited timeframe to finish the form accordingly, and poor design and language of the form (Jina and Kotzé, 2016).

Few study in the review indicated the need for training of health practitioners for better completion of the form itself as the primary practice (Rowe *et al.*, 2013; Jina and Kotzé, 2016.) Additional from the review some studies recommend the practice to be part of the formal training (Fouché *et al.* 2018). That said and of importance, from the review was that the reason for the incompleteness of the J88 form might be due to the design of the form itself. This was due to the flaws on the form such as poor design and language of the form Rowe *et al.*, (2013:437) and Jina et al.,(2016:872-873) are of the opinion that more training is needed to increase the correct and complete filling in of the said form.

Additionally, it is noted in the review that the cases that were reported to the police usually do not reach the point of prosecution as they fall through the cracks (Shaw, Campbell and Cain, 2016) due to the healthcare practitioners who do not know their roles in the completion of the form (Rowe *et al.*, 2013. This is happens as the healthcare practitioners provide inadequate and incomplete information Of importance from the review especially in South Africa accurate documentation in sexual violence cases is essential (Kotzé and Brits, 2017; Smith, Flowe and Kanja, 2019; Rowe *et al.*, 2013). Healthcare professional should be made aware of the importance of documentation in sexual assult /rape cases. This might improve quality of docementation. With improvements in documentation, high-quality forensic and medical evidence collection increased reporting rates and the support offered by the various crisis centres, this trend is hoped to be reversed. Accurate documentation is vital in forensic examinations for strong prosecutions, but information gathered at these examinations is also valuable for research (Smith, Flowe and Kanja, 2019).

2.7 SUMMARY OF THE CHAPTER

This chapter discussed the literature reviewed on the practices used in collecting and documenting evidence in rape/ assault cases.

The next chapter will discuss the research methodology and the various processes followed to collect data.

CHAPTER THREE: RESEARCH DESIGN AND METHOD

3.1 INTRODUCTION

The previous chapter discussed the literature review on available scientific knowledge on collecting and documenting medical evidence of sexual violence cases. This chapter will outline the study methodology, including the population size, sampling, inclusion and exclusion criteria, instrument used to collect data, data collection process, data organisation and data analyses. Rigour or quality control and ethical considerations are also included.

3.2 RESEARCH AIM AND OBJECTIVE

The overall aim of the study was to document the practices in collecting and documenting medical evidence from records of sexual violence that were prepared for trial at Thuthuzela care centres in the Gauteng Province

In order to achieve this aim, the following objective guided the study:

To document the practices in collecting and documenting medical evidence for sexual violence cases against women that are fit and ready for trial at Thuthuzela Care Centres in Gauteng Province, South Africa.

3.3 RESEARCH METHODOLOGY

Research methodology is how the researcher approaches the research to solve the research problem or respond to the research questions. According to Brink et .al (2015:199), the approach should be detailed enough to allow another researcher to “replicate” the research.

This study followed a quantitative research approach.

3.3.1 Quantitative Research Approach

A quantitative research approach was used in conducting this study. According to (Almeida et al., 2017: 369-387) and (Apuke, 2017: 40-47), “a quantitative study aims to find precise and reliable measurements that permit a statistical analysis and it also deals with quantifying and analyzing variables in order to heed results.” A quantitative research approach was used in conducting this study. According to Brink et al.: 2012:23, some of the characteristics of a quantitative research approach are unbiased and objective research, with a high number of respondents recruited for the study where numeric information is to be collected using formal instruments and the collected data is analysed through structured procedures. There are various quantitative research designs, such as descriptive surveys and record reviews (Source).

3.3.2 Research Design

A research design is a general plan for putting together data in a research study (Brink et al., 2015:217). The researcher opted to use the record review as the design of choice. A record review design is defined as a form of research design where existing patient records, “patient centred data”, are used to answer one or more research questions. The data used in these reviews exist in many forms: electronic databases, results from diagnostic tests, and notes from health service providers, to mention a few (Vassar and Matthew, 2013).

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3.4 STUDY SETTING

As indicated in Chapter one, the study was conducted at Thuthuzela centres in Gauteng Province. The Thuthuzela project is headed by the NPA's Sexual Offences and Community Affairs Unit (SOCA), together with multiple departments and donors, as a response to the urgent need for a combined strategy for prevention, response and support for rape victims. Since its establishment, the SOCA Unit has been working to develop practices and policies that seek to do away with the victimisation of women and children while improving prosecution, especially in the areas of sexual offences, maintenance, child justice and domestic violence. Thuthuzela Care Centers work best in public hospitals near communities that have a high incidence of rape. The centres are also connected to sexual offences courts, which are staffed by skilled prosecutors, social workers, magistrates, NGOs and police, which are located close by.

The centres are facilitated by a top-level inter-departmental management team comprised of the departments of Justice, Health, Education, Treasury, Correctional Services, Police, Social Development and designated civil society organisations. Upon arrival at the Thuthuzela Care Centre, the victim is shown to a quiet, private area and welcomed by the site coordinator. A doctor or a nurse trained in collecting medical evidence is immediately called to conduct a medical examination.

The victim is then given Information on the procedures to be performed. The victim (patient) signs a consent form for medical examination and blood specimens. If the medical examination happens within 72 hours of the rape, DNA and PEP are conducted, and after that, the victim is offered the opportunity to take a bath or shower and to change into clean clothes. After that, the investigating officer on call at the centre takes the victim's statement. The victim receives appropriate medication and is given a follow-up date for further medical treatment before being transported home." (Majokweni and Mafani, 2009). In Gauteng, there are currently seven such centres.

3.5 POPULATION / UNIT OF ANALYSIS

The unit of analysis for this study was all the completed medical records of victims of sexual violence that were prepared for the trial between 2015 to 2020 at Thuthuzela Care Centres in

Gauteng. Around 30-40 cases were seen monthly in one of the Thuthuzela Care Centres in Gauteng. Between 2014 and- 2019, the total number of reported sexual violence cases in Gauteng was around 39700, as indicated in Table 1 below (South African Police Service 2019).

Table 3.1: Gauteng annual rape Statistics (SAPS, 2018-2019 document)

2014/2015	2015/2016	2016/2017	2017/2018	2018/2019
7 916	7605	7700	8 062	8417

3.6 SAMPLING METHOD AND SAMPLE SIZE

A two-stage sampling method was used in selecting a representative sample for this study. The sampling method is used to choose “objects, persons or events” from which the information will be taken (Brink et al. 2015:130). The first stage was the stratified proportional random sampling method. The stratified proportional random sampling method divides the population into subgroups and assists in creating an appropriate number of individuals for each subgroup based on population proportions. This study consisted of five subgroups, as indicated in Table 3.1.

Simple random sampling without replacement (SRSWOR) was used as the second stage of sampling to select representative medical records from the target population. This SRSWOR process ensures that each record in the population of the Thuthuzela crisis centre has a known and equal probability of being selected and part of the survey (Rose et al., 2015). In order to avoid biases, simple random sampling was done for each subgroup since the subgroup population (Ni) are not equal in each subgroup, Table 1. The random number generation in Excel was used to randomly select the names of records that were used in the study. This process ensured that the record was not selected more than once. All selected records were used for this study.

3.6.1 Sample size

To determine a representative sample size, the study followed the Yamane (1967) formula for calculating sample size. The Yamane sample calculation formula is given by:

$$n = \frac{N}{1 + N(e)^2}$$

where “n” is the sample size, “N” is the population size, and “e” is the level of precision. According to Yamane (1967), at a 5% precision level, where the confidence level is 95%, and the degree of variability is 50% and applying the sample size formula, the appropriate sample size for the population of 39 700 assessed records in this study was 195 records. Furthermore, stratified proportional random sampling calculated a sample size proportional to each year’s records. Stratified proportional random sampling divides the population into subgroups (strata) and assists in creating an appropriate number of individuals for each subgroup based on population proportions. The Barreiro & Albandoz (2001) study was adopted in order to determine the sample size of each subgroup from Table 1 and was given by the following formula:

$$nn_{ii} = nn.\frac{NN_{ii}}{NN}$$

Where, ni = sample size for each

stratum n = required sample size

Ni = population size for each stratum

N= size of the population

The proportional sample size within each subgroup (records per year) to be used in this study is illustrated in the table below.

Table 3.2: The proportional sample size

Year	2014/2015	2015/2016	2016/2017	2017/2018	2018/2019	N	n
N_i	7 916	7605	7700	8 062	8417	39 700	195
n_i	79	76	77	80	84		

3.6.2 Sampling Criteria

Inclusion criteria

- Records of women who reported sexual violence between the ages 18-50
- Records prepared and completed for trial or tried before the court between 2015 and 2019 will be included in the study.

Exclusion criteria

- Records of victims of sexual violence that were incomplete or regarded by the care centres as unsuitable for use in court were excluded from the study.
- Records of victims of SV of 2014 and before were excluded from the study. This is because the researcher aimed to obtain data that was informed by current and recent practices in the collection and documentation of evidence for use in court.

3.6.3 Adoption of the Auditing Tool

A developed auditing form was used as an auditing tool to collect data from the records at the centres (see Annexure B). The tool has been developed based on the literature and the assistance of the statistician. This tool was designed with the purpose of auditing completed J88 forms. The completed J88 was reviewed for the following aspects: its completeness, its legibility, Was the information detailed? Is it being filled in appropriately to be presented in court? The tool was in English with twelve primary sections:

Section A: Details of the practitioner completing the form as well as the facitlity.

Section B: Patient information (not disclosing any identification details).

Section C: Medical history

Section D: History of relevance to a sexual offence (not to be completed if not applicable.)

Section E: General examination.

Section F: Clinical findings.

Section G: Specific examinations.

Section H: Specimens collected for investigation.

Section I: Technology used.

Section J: Additional pages used and attached.

Section K: Conclusions.

Section L: Transfer details

The tool was simple and direct, using ticks, Yes/No, and blank spaces to complete extracted from the records. It took the researcher 15-20 minutes to complete each tool. Each completed tool was assigned a number (identification number). No names from the files were part of the tool. A total of 195 (n=195.) J88 forms in old and new formats were reviewed.

3.6.4 Pilot Study

A pilot study was conducted at a Thuthuzela care centre in the City of Tshwane. The aim was to test the feasibility of the study. After receiving ethical clearance, a sample size of 20 units of analysis (n=20) that met the inclusion criteria was used in the pilot study. This process started on the 2nd of February 2022 to the 3rd of February 2022. The selected files were given an identification number, i.e. CAP1-20, “C” being the centre, “A” being the first centre used, “P” standing for pilot and 1-20 is the numerical number of units of analysis used. Data collection in this pre-test followed the same data collection processes. From the results of the pre-test, it was noted that most of the J88 forms were old. This implied that the auditing tool had several not applicable sections. With the supervisors and service providers at the pilot study centre, a joint decision was then taken to continue with the auditing tool and not to amend it despite the gaps in using the old J88 form. The reason was that there were those forms that were new. The decision was to put an identifier on top of each J88 form indicating if it is new or old.

But it would be specified at the top of the auditing tool that it was the “new or old” J88 form, therefore, confirming the reliability of the auditing tool. This was done before collecting the study's data and ensuring that it answered the research aim and question. Through the pilot study, the researcher was able to assess the feasibility of the auditing tool and determine whether the tool was able to collect the data that it was intended to collect. Data collected from

the pilot study was not used in the main study, which required a sample size of 195 units of analysis (n=195).

3.6.5 Data Collection

Permission was sought from the different managers of the Thuthuzela care centres where data was to be collected on-site.

The researcher requested research briefing meetings where the study and its purposes were introduced to the centre managers. Permission to access records for the study was sought by applying to the Gauteng Department of Health. Initially, the proposal was uploaded and taken through a process where the ethics committee reviewed the proposal and assessed whether it fell within the ethical boundaries of the research. Moreover, the Health Department wanted to verify if the data required could be collected at the centres that were being requested. After permission had been granted, the researcher arranged the logistics regarding the data collection times and days with the managers of the Thuthuzela care centre.

The researcher applied scientific methods explained in the sampling and sampling size section above to select records that were reviewed until a scientifically determined sample size per Thuthuzela care centre was reached according to the calculations done by the statistician. The process of collecting data took a month in January 2022. An auditing tool (annexure B) with 12 sections was used by the researcher to collect the data. Each question from the tool took about 2 minutes to be completed. The tool was completed in English. Because the tool was developed based on the new J88 form, when it came to auditing the old J88 form it was a little confusing because the J88 forms carry different formats and different questions in some sections. Nonetheless, the researcher was still able to audit both J88 forms using the same tool.

3.7 PREPARATION OF DATA FOR ANALYSIS

The data was captured into Microsoft Excel and sent to the statistician. The statistician imported the data into STATA version 13 for analysis. During data analysis the data was cleaned and coded. The statistician assisted with data analysis using relevant tests. Descriptive statistics were used to summarize the data in terms of frequency distributions, mean, median and standard deviations and demographic characteristics. The Chi-square tests (χ^2) for independence in a two-way contingency table were performed to determine the association between the demographics, socio-biographical characteristics, date of assault and date of medical evidence. Cramer's V tests (correlations) were also performed as a post-test to determine the strengths of association after the chi-square had determined significance. Tables, pie charts and bar graphs were used to organise and present data. Refer to Chapter 4 for Data Analysis. The hardcopies of completed auditing tools were scanned, placed in numerical order and stored in a protected, safe folder on the supervisor's computer. These copies will be stored for 15 years, as requested by the University of Pretoria Ethics committee.

3.8 RIGOUR / QUALITY CONTROL

3.8.1 Reliability

Reliability refers to the stability of the measuring tool used and its ability to be consistent as time goes on. In other words, “Reliability is the ability to measure instruments to give similar results when applied at different times” (Sürücü, L. and Maslakçi, A., 2020:2694-2726). A test is perceived as being reliable when it can be used by various researchers under stable conditions, with consistent results, and the results do not vary. Reliability mirrors consistency and replicability over time. Therefore, reliability is seen as the degree to which a test is free from measurement errors (Bruin, 2011). Reliability was ensured by conducting a pre-testing of the tool. Pre-testing of 20 medical records/ units of analysis was conducted to determine whether the auditing tool could collect the data it intended to collect. Upon conducting the pilot study, it was found that the tool would be able to collect the data but a little easier to do so with the new J88 form rather than the old J88 form as the tool was developed based on the new J88 form, but it was still effective.

3.8.2 Validity

Validity refers to the ability of the measuring tool to be able to quantify the behaviour or quality it is meant to measure and is a gage of how well the tool carries out its duty. Validity is defined by the significant and appropriate interpretation of the data received from the measuring tool as a result of it being analysed. As well as the obtaining of data that is appropriate for the intended use of the measuring instruments (Sürücü, L. and Maslakçi, A. 2020:2694-2726).

The types of validity include:

- Construct validity

  Construct validity is related to the instrument's level of measurement of the concept, behaviour, idea or quality. There are two types of construct validity which are convergent and discriminant. (Sürücü and Maslakçi, 2020) This study compared the auditing tool to other similar tools during its construction phase.

- Content validity

  This type of validity is a qualitative form of validity that weighs if the terminologies found within the measuring instrument represent the idea that was meant to be measured. Furthermore, it can be said that a content validity of a measuring instrument is a validity study that shows the level to which each section in the measuring instrument serves the purpose. (Sürücü and Maslakçi, 2020). It looks at how the tool's content performs (Bruin, 2011). In this study, the two types of methods applied were seeking expert opinions, i.e. supervisors and statistical methods provided by the statistician. Qualified experts are important for the results to be consistent and unbiased.

- Face validity

  Face validity is built on a foundation of the researchers' feelings, thoughts and instincts, making it subjective in terms of the functioning of the measuring instrument. Researchers such as Kaplan and Saccuzzo (2017) and Whiston (2012) proposed that face validity should not be considered a marker of validity. Due to the belief by researchers that the outcomes of face validity are not supported by statistical data and may be believed to show validity, the measuring tool may not measure what it was meant to measure. Also, because face validity is considered to be subjective according to the researcher's thoughts and opinions, a measuring tool that uses this form of

validity may not necessarily be seen as convincing to other researchers. Therefore, face validity is generally viewed as a weak form of structural validity. Face validity is evaluated by an expert or academic staff on the structure of the measuring instrument and what it is trying to determine. Within the evaluation criteria, different criteria are included, such as (a) the point of every statement is suitable for the measuring instrument, (b) the statements in the scale are easily understood by the participants (researcher collecting data in this case) (c) the legibility of all statements in the measuring instrument, (d) the appeal of the measuring tool created, (e) the complexity of each item applicable for the level of the participants. (Sürücü and Maslakçi, 2020). In this study, face validity was ensured by the researcher and the supervisors by reviewing the tool before any data could be collected, ensuring that all the aspects mentioned above were applied.

- Internal validity

  Internal validity is the level at which the seen results represent the truth in the population being studied. To enhance internal validity, the researchers should make sure that the study is planned carefully and that there are enough quality control and implementation strategies, including recruitment strategies, data collection, data analysis, and sample size. (Patino and Ferreira, 2018). In this study, internal validity was ensured by assessing the crisis centre to ensure that there are enough medical records on-site to reach an adequate sample size according to the calculations done by the statistician.

- External validity

  External validity was ensured by asking if the study results relate to similar patients in different settings or not. External validity can be enhanced by using a wide inclusion criterion that ends in a study with a population closely resembling actual patients. (Patino and Ferreira, 2018). In this study, external validity was ensured by having a broad inclusion criterion, resulting in a population that is very close to real patients.

  Peer review of the data collection tool by the research supervisors ensured its validity. Expert consultation was done by involving a statistician in this study's tool development and data analysis.

Reliability and validity were ensured by collecting data using a pre-testing tool on 20 medical records/units of analysis to see if the tool would collect the data it intended to

collect. The supervisors peer-reviewed the tool to ensure validity, and the statistician was used as an expert consultation of the tool.

- Pilot study

  The pilot study was conducted at a Thuthuzela care centre in the city of Tshwane to test the study's feasibility. Twenty medical records were used as a sample size. They all met the inclusion criteria. The results collected from the pilot study were not used in the main study. The results showed that the tool would be able to collect the intended data but proved to serve the new J88 form more than the old one, as it was found that there was a small number of the new J88 forms that were used in the medical records.

3.9 ETHICAL CONSIDERATIONS

Ethical permission for the study was sought from the Faculty of Health Science Ethics Committee, the University of Pretoria and Gauteng Department of Health. The researcher also asked for permission from the selected Thuthuzela care centres see Annexure D. Though the study involved only records, the researcher kept the confidentiality of the information accessed from the records during data collection. All the completed data collection tools were kept safe under lock and key for the confidentiality of the obtained data. All the completed tools were assigned numbers. Only the researcher, supervisory team, and statistician had access to the completed tool.

3.9.1 Principle of Beneficence

This principle refers to acting to benefit the person involved in a way that will not inflict harm. This principle was applied to the study by having multiple review committees, the ethics committee, external and internal committees and supervisors look through the study to take note of any risks/ potential harm and make adjustments as recommended.

3.9.2 Principle of Respect

This principle refers to the ability to allow the participants involved to make their own decisions (autonomous). This was applied by providing informed consent to the manager of the crisis centres at the department of health and the centre managers on site to allow permission to use their medical records. The information obtained was then kept confidential, in a file, and locked away. For confidentiality, the patients' names and personal information were not included in the study, but instead, a special identification number was given to each auditing tool to not reveal any of the patient's private information, including names, surnames, and addresses.

3.9.3 Principle of Justice

This principle ensures that the information obtained is protected and only shared with parties that are relevant to the study. This was ensured in this study by only allowing the primary researcher to collect data, and having the supervisors involved was necessary as guidance throughout the collection process.

3.10 SUMMARY OF THE CHAPTER

In this chapter, we looked at the study's methodology, which included sampling and sample size, the data collection process, and the analysis thereof. Quality control/ rigour was also highlighted within the chapter, as well as ethical considerations that were also described, including the principles involved. The following chapter will look at the study's results, including the analysed data in the form of bar graphs and pie charts.

CHAPTER FOUR: PRESENTATION AND INTERPRETATION OF THE RESEARCH RESULTS

4.1 INTRODUCTION

The previous chapter discussed the study design, setting, population and sampling, and data collection. The current chapter will discuss the data analysis, presentation, and results interpretation.

4.2 AIM AND OBJECTIVES OF THE STUDY

Research Aim:

- This study aimed to determine the current practices in collecting and documenting medical evidence for sexual violence cases against women that are fit and ready for trial at Thuthuzela Care Centres in Gauteng province, South Africa.

Research Objective:

- To document the current practices in collecting and documenting medical evidence for sexual violence cases against women who are fit and ready for trial at Thuthuzela Care Centres in Gauteng province, South Africa.

4.3 SUMMARY OF DATA COLLECTION AND PREPARATION FOR ANALYSIS

At the start of the study, it was estimated by the statistician that the sample size would be 396 (n=396). Upon conducting the pilot study, it was realised that the sample size would be too high and would be difficult to reach within the timeframe set out. The statistician was consulted to reduce the sample size. She worked on the confidence level and the degree of variability of the sample size and reached a new total of 195 (n=195). The results were generated through the random number generation in Excel and were used to randomly select records used in the study. This process ensured that each record was not selected more than once. All selected records were used for this study. The data was captured into Microsoft Excel and sent to the statistician. The statistician imported the data into STATA version 13 for analysis. During data analysis the data was cleaned and coded. Descriptive statistics were used to summarize the data in terms of frequency distributions, mean, median and standard deviations and demographic characteristics. The Chi-square tests (χ^2) for independence in a two-way contingency table were performed to determine the association between the demographics, socio-biographical characteristics, date of assault and date of medical evidence (Holt, Scott and Ewings, 1984). Cramer's V tests (correlations) were also performed as a post-test to determine the strengths of association after chi-square had determined significance.

4.3.1 The summary of the auditing tool

The auditing tool (data collection instrument) that was utilised was adopted from J88 form used to record evidence for sexual violence in South Africa. The statistician and supervisory team approved the use of the instrument. The tool had 12 sections:

With a total of 42 questions, 3 of which were both open and closed-ended, and 1 was not applicable in both the old and new J88 form as it was regarding the examination of male genitalia (section G), which was part of the exclusion criteria. 28 questions were close ended and 10 were open ended questions.

The closed-ended questions could be answered with either a yes or a no, and the open-ended questions had room to elaborate briefly on the findings, including none, not specified, not sure, and not applicable. The tool was compiled with simple terminology, but some of the questions proved to be a little confusing upon the collection of data and where therefore rephrased for better understanding. One specific instruction was to not fill in/ audit sections that do not apply

to the old or new J88 form. The researcher printed the tool and filled it in by hand and in English.

4.4 RESEARCH RESULTS

Data was presented using different methods such as tables, graphs, pie and bar charts, as seen below.

The data were grouped in the following order:

Section A: Details of the Practitioner and Facility

Table 4.1 below shows that of 195 auditing tools, 167 (85.64%) did not have the practitioners' registration number filled out, and only 28 (14.36%) had it filled in. The practitioners' cellphone numbers section was 156 (80%) incomplete, and only 39 (20%) had filled in the practitioner's number. The practitioners' email address was completed in 5 (2.56%) of the forms, and 190 (97.44%) of the forms were incomplete. The practitioners' fax number was filled in, in 43 (22.05%) of the forms, and the rest, 151 (77.44%), of the forms were without a fax number.

Table 4.1: Details of practitioners and facility

Details of practitioner and facility		Frequency	Percentage	eX²-value	DF	Prob-value
Practioners_number	No	167	85,64	99,08	1	<.0001
	Yes	28	14,36			
Practioners_CellNo	No	156	80	70,20	1	<.0001
	Yes	39	20			
Practioners_Email	No	190	97,44	175,51	1	<.0001
	Yes	5	2,56			
Practioners_Fax	Na	1	0,51	184,25	1	<.0001
	No	151	77,44			
	Yes	43	22,05			

Section B: Patient information

Table 4.2 as shown below, indicates that 2 (1.03%) of the forms did not have the patients' names filled in, and 193 (98.97%) had them filled in. All of the 195 (100%) forms had the gender filled in. the date of birth was filled in in 194 (99.49%) of the forms and was not completed in 1 (0.51%) of the forms.

Table 4.2 Patient information

Patience information		Frequency	Percentage	eX²-value	DF	Prob-value
Patience_Name	No	2	1,03	187,08	1	<.0001
	Yes	193	98,97			
Patience_gender	Yes	195	100			
Patience_DOB	No	1	0,51	191,02	1	<.0001
	Yes	194	99,49			

Section C: Medical history

Table 4.3 below indicates that 182 (93.33%) of the patients seen did not have an intellectual disability, whereas 13 (6.67%) of the patients were noted to have an intellectual disability. One hundred and eighty-eight (96.41%) of the patients were said to not have other impairments or disabilities compared to the 7 (3.59%) that noted other impairments. One hundred and ninetytwo (98.46%) of the patients seen did not indicate the relevant medication being taken on their forms as opposed to the 3 (1.54%) that did. Of the forms, 169 (86.67%) noted that the patients did not have a relevant medical history, and 26 (13.33%) did. Of all the patients seen, 194 (99.49%) had a history of assault/ rape that was identified as opposed to the 1 (0.51%) that did not.

Table 4.3: Medical history

Medical history		Frequency	Percentage	eX²-value	DF	Prob-value
Intellectual disability noted	No	182	93,33	146,47	1	<.0001
	Yes	13	6,67			
Other impairment/ Disabilities noted	No	188	96,41	168,01	1	<.0001
	Yes	7	3,59			
Relevant medication taken e.g. PrEP	No	192	98,46	183,18	1	<.0001
	Yes	3	1,54			
Relevant medical history to help with differential	No	169	86,67	104,87	1	<.0001
	Yes	26	13,33			
History of assault +/ rape noted	No	1	0,51	191,02	1	<.0001
	Yes	194	99,49			

Section D: History relevant to a sexual offence

Table 4.4 below shows that 193 (98.97%) of the forms noted that the DNA had been tampered with mainly by wiping the genitalia after urinating, and only 2 (1.03%) had not tampered with the DNA. Of the 194 records, it was noted that 182 (93,33%) the patients were not menstruating as opposed to the 13 (6.67%) that were said to be menstruating. It was noted that 107 (54.87%) of the forms indicated that a condom was not used during the rape/assault, 60 (30.77%) did not have it noted, 11 (5.64%) were not sure if a condom was used and 17 (8.72%) said a condom was used. 185 (94.87%) of the patients were not pregnant, 4 (2.05%) were not noted, and 6 (3.08%) women were pregnant at the time of the rape/assault.

A vaginal delivery did not apply to 67 (34.36%) of the forms as the patients had never been pregnant before, and 15 (7.69%) had never had a vaginal delivery due to having had either a c-section or a miscarriage that was not to term. 98 (50.26%) did not specify it, and 15 (7.69%) had had a vaginal delivery before.

Table 4.4: History of relevance to a sexual offence

History of relevance to a sexual offence		Frequency	Percentage	eX²-value	DF	Prob-value
tamper with DNA i.e wiped, bathed, defecated, rained	No	2	1,03	187,08	1	<.0001
	Yes	193	98,97			
Menstruating	No	182	93,33	146,47	1	<.0001
	Yes	13	6,67			
Was a condom/ lubricant used	No	107	54,87	122,11	3	<.0001
	Not noted	60	30,77			
	Not sure	11	5,64			
	Yes	17	8,72			
Currently pregnant	No	185	94,87	332,34	2	<.0001
	Not noted	4	2,05			
	Yes	6	3,08			
Ever had a vaginal delivery	Na	67	34,36	103,32	3	<.0001
	No	15	7,69			
	Not specified	98	50,26			
	Yes	15	7,69			

Section E: General examination

Table 4.5 The table below indicates that 3 (1.54%) of the forms did not note the patients' physical appearance, and 192 (98.46%) had it noted. While 9 (4.62%) of the forms did not mention or describe the clothing of the patient during the consultation, and 186 (95.38%) had noted or described the condition of the clothing worn by the patient during the consultation. 1 (0.51%) of the forms had clinical evidence of alcohol/drugs as not applicable, as opposed to 184 (94.36%) that noted no evidence of alcohol or drugs, and 10 (5.13%) had seen evidence of alcohol or drugs during the consult.

Table 4.5: General examination

General examination		Frequency	Percentage	eX²-value	DF	Prob-value
Physical appearance noted	Noted	Frequency	Percent	183,18	1	<.0001
	No	3	1,54			
	Yes	192	98,46			
	No	9	4,62	160,66	1	<.0001

Clothing mentioned/ described	Yes	186	95,38			
Clinical evidence of drugs/alcohol noted	Na	1	0,51	327,42	2	<.0001
	No	184	94,36			
	Yes	10	5,13			

Section F: Clinical findings

Table 4.6 below indicates that 2 (1.03%) of the forms did not note the clinical findings during the consultation and 193 (98.97%) of the forms had it noted. Although it could be done better, having the majority of the forms filled in strengthens the case, as this section required detailed descriptions of the ordeal and the physical injuries that could have been acquired on the scene.

Table 4.6: Clinical findings

Clinical findings	Frequency	Percentage	eX²-value	DF	Prob-value
No	2	1,03	187,08	1	<.0001
Yes	193	98,97			

Section G: Specific examinations

Table 4.13 below indicates the examinations that were done during the consultation. These examinations collect medical evidence in the form of DNA samples, such as semen, blood samples, hair, and skin. They are also done to see the extent of damage caused, if any, during the ordeal, which may strengthen the case. One hundred and eighty-one (92.82%) of the forms had the oral examination as not applicable as the old J88 form does not ask for an oral exam to be done, and in the new J88 form, 10 (5.13%) of the forms were incomplete. Only 4 (2.05%) forms indicated that an oral examination was done. An anal exam was done in 102 (52.31%) of the forms and not done in 93 (47.69%) of the forms. This may be due to the assumption that females are generally penetrated vaginally and not anally as is with males, leading to the examination not being conducted in most females. Male genitalia examination was not applicable in all the forms as males fall into the exclusion criteria. A gynaecological examination, which holds a large significance in collecting evidence of sexual violence cases

as it may provide key evidence, was not done in 3 (1.54%) of the forms and was done in the remaining 192 (98.46%) forms.

Table 4.7: Specific examinations

Specific examination		Frequency	Percentage	eX²-value	DF	Prob-value
Oral examination done	Na	181	92,82	310,80	2	<.0001
	No	10	5,13			
	Yes	4	2,05			
Anal examination done	No	93	47,69	0,4154	1	0,52
	Yes	102	52,31			
Male genitalia examination done	Na	194	99,49	191,02	1	<.0001
	Yes	1	0,51			
Gynaecological examination done	No	3	1,54	183,18	1	<.0001
	Yes	192	98,46			

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Section H: specimens collected for investigation

Table 4.8 below shows that 39 (20%) of the forms did not have SAEK seal number stickers. This could be because the patient arrived at the centre more than 72 hours after the incident had occurred, which means that there is no evidence left to collect related to the incident, and 156 (80%) of the forms did have a sticker. Of the 195 forms, 179 (91.79%) of them could not have an alcohol collection kit seal sticker as it was not applicable because there was no clinical evidence of alcohol found in the patient. Sixteen (8.21%) forms with evidence of alcohol did not have a collection sticker. A clothing kit seal number was not found on 166 (85.13%) of the forms as opposed to the 29 (14.87%) that had a clothing kit seal number, mainly for the underwear that was collected as evidence. Urine samples were not taken in 15 (7.69%) of the forms and were taken in the remaining 180 (92.31%) mainly to do a pregnancy test.

Table 4.8: Specimens collected for investigation

Specimens collected for investigation		Frequency	Percentage	X^2-value	DF	Prob-value
SAEK seal no#/ sticker	No	39	20	70,20	1	<.0001
	Yes	156	80			
Alcohol collection kit seal no#/sticker	Na	179	91,79	136,25	1	<.0001
	No	16	8,21			
Clothing kit seal no#/sticker	No	166	85,13	96,25	1	<.0001
	Yes	29	14,87			
Urine +/ samples	No	15	7,69	139,62	1	<.0001
	Yes	180	92,31			

Section I: Technology used

Table 4.8 below shows that in 181 (92.82%) of the forms, it was not applicable to have photographs taken as in the old J88 form it is not required to have them, whereas, in the 14 (7.18%) forms remaining which were the new J88 form, no photographs were taken. It was the same with the use of the colposcope/ toluidine blue.

Table 4.9: Technology used

Technology used		Frequency	Percentage	X^2-value	DF	Prob-value
Photographs taken	Na	181	92,82	143,02	1	<.0001
	No	14	7,18			
Colposcope/ toluidine blue used	Na	181	92,82	143,02	1	<.0001
	No	14	7,18			

Section J: Number of pages added

Table 4.10: Indicated that no extra pages were added to all the audited J88 forms, both old and new.

Number of page	Frequency	Percentage	eX²-value	DF	Prob-value
None	195	100	na	na	na

Section K: Conclusions

Table 4.11 below shows that a motivation for the conclusion was not made in 3 (1.54%) of the forms and was made in the remaining 192 (98.46%) of the forms at the end of a consultation which concludes whether or not the injuries or lack thereof, as well as all the examinations, are done, and whether they coincide with evidence of rape or sexual assault.

Motivation for conclusion	Frequency	Percentage	eX²-value	DF	Prob-value
No	3	1,54	183,18	1	<.0001
Yes	192	98,46			

Section L: Transfer details

Table 4.12 below shows that transfer details were not included in 31 (15.9%) of the forms. This could be because a patient chose not to open a case as of yet even though the evidence was collected or that they came to the centre after 72 hours of the incident happening, which means evidence could not be collected. Transfer details were included in 164 (84.1%) of the forms meaning that a case was opened and handed over to the police.

Table 4.12: Transfer details

Transfer details	Frequency	Percentage	eX²-value	DF	Prob-value
No	31	15,9	90,71	1	<.0001
Yes	164	84,1			

4.5 SUMMARY OF THE CHAPTER

This chapter discussed the study's results and the interpretation of the analysed data presented in the form of pie charts, bar graphs and tables.

The next chapter will discuss the results, implications and limitations of the study, as well as recommendations for further research.

CHAPTER 5: DISCUSSION OF THE RESULTS, IMPLICATIONS, LIMITATIONS, RECOMMENDATIONS, AND CONCLUSION

5.1 INTRODUCTION

The previous chapter discussed the analysis and interpretation of the research findings. Therefore, this chapter will discuss the results' implications, limitations, recommendations and conclusions drawn from the results.

5.2 AIM AND OBJECTIVE OF THE STUDY

The overall aim of the study was to document the practices in collecting and documenting medical evidence for sexual violence cases against women that are fit and ready for trial at Thuthuzela Care Centres in Gauteng province, South Africa. For the collection and documentation of medical evidence from records of sexual violence that were prepared for court fitness at Thuthuzela Care Centres in Gauteng Province.

5.3 SUMMARY OF THE RESEARCH RESULTS

To keep order, the synopsis of the results will remain in the same order as the previous chapter, chapter 3, from section A all the way through to section L, which is taken from the auditing tool design.

5.3.1 Section A (Details of the practitioner and facility)

This section required the practitioner to complete his or her information. The current results showed that a large number of audited J88 forms were incomplete with regard to different details of the practitioner. This is similar to the results of the study conducted in Gauteng, Johannesburg, which revealed that there are inaccuracies and poor completion of forms that document sexual violence evidence (Vetten, Jewkes, Sigsworth, Christofides, Loots, Dunseith 2008). Compared to the study that reviewed the first-contact medicolegal clinical notes of interpersonal violence in South Africa, the clinician's date, time and signature were highly recorded on the J88 form (Loots and Saayman, 2019).

The J88 form is regarded as a legal document by health practitioners (Fouché, Bezuidenhout, Liebenberg and Adefuye 2018). The (ibid) know that recording the factual findings assists in prosecuting the perpetrators. Therefore, all the required information from the examining person should be completed. According to Jina and Kotzé (2016), many reasons contribute to failure in completion of all the required information, which include untrained or inexpert healthcare providers, the attitude of providers towards clinical medicolegal cases, lack of time to complete the form properly, and poor design and language of the form. On the other side, the completion of the J88 form in section A may be considered confusing concerning the optional part in section A, such as the cellular phone number of the practitioner and providing the physical address of the facility or practice only if comfortable to do so Kotzé (2017). Although enough contact information should be given to ensure that the practitioner can be reached in the future if need be, there are no legal repercussions if it is not included on J88 forms (ibid). This explains why most of the cell phone number slots are left blank. The place of examination is where the examination was done, and therefore the physical address is important as this is where a subpoena can be served. An email address should be given as in these modern times, email addresses are most likely to stay current, unlike the physical address (Kotzé, Brits and Botes, 2015).

The other reason might have been attributed to the fact that most of the audited medical records had used the old J88 form, which has been explained to ask for fewer details than the new J88 form. Although, even with the new J88 form, some of the information was still not completed, including the cell phone number, email address, fax number, and registered qualifications, which include the qualifications and registration number at the relevant professional council. The researcher believes that the registration number is vital data for the professional expert witness because it not only confirms the qualification but also supports the expertise.

5.3.2 Section B (Patient information)

Patient information means individually identifiable, which includes a demographic profile and all other information or data relating to the patient history. According to Riplinger, PieraJiménez and Dooling (2020), identification is the process that assists in matching patients correctly to the intended interventions. In a J88 form, the section on patient information needs the completion of patient names, surname, gender, date of birth/age, companion to the facility, people present during examination and their capacity and patient signature.

The documentation of this information assists in reducing any confusion that might arise when addressing the victims' reported issues (Kotzé, Brits and Botes, 2015). It was of concern to notice that the required information was not completed in some of the audited J88. In a previous study conducted in South Africa, there were instances where documents or patients' information, such as age, was missing, incomplete or difficult to read (Jina, Machisa, Labuschagne, Vetten, Loots & Jewkes 2020). In South Africa, the situation might be worse because a completed J88 form is physically moved from one desk to another, whereby the contents might be tampered with (Mogale, Kushner & Richter 2015).

The current results are similar to other studies that looked into the documentation of patients' information, in which errors are identified and found to have implications when data is shared and affect patient care and safety (Mutshatshi, Mothiba, Mamogobo & Mbombi 2018; Riplinger et al. 2020). Bowman (2013) confirms that when a patient's information is incorrectly or not documented, it can be mismatched and mixed with another patient's record and jeopardize the database systems. In the case of sexual violence prosecutions, the mismatch is associated with non-arrests and prosecutors declining cases (Machisa, Jina, Labuschagne, Vetten, Loots & Jewkes 2022).

5.3.3 Section C (Medical history)

The J88 form forms part of medicolegal documentation and requires a detailed history in line with the incident. The accuracy and quality of clinical notes taken at the time of first contact

between the practitioner and victim may be paramount in facilitating the administration of justice (Loots & Saayman, 2019). Therefore, medical history is an important part of rape/ sexual violence as it could serve as a vehicle to facilitate the health care needs of the victim and account if the condition developed due to the sexual assault or was pre-existing.

It should be noted that all pre-existing conditions that may have an impact on the behaviour and vulnerability of the victim and interpretation of the evidence or which may have an effect on any part of the analysis of the clinical findings are recorded. This includes cognitive ability, disabilities, and recent surgeries, including genital surgery (Kotzé, Brits & Botes, 2015). The other reason for taking a medical history is because conditions such as diabetes, asthma, epilepsy, mental retardation, behavioural disorders, and psychoses could lead to non accidental injuries that cause or worsen bruising or that can be transmitted sexually (Kotzé & Brits, 2017).

The same authors also emphasise that it is important to include the history of medical conditions, disabilities, mental health, surgery and medication as they give a clinical picture for the patient to provide informed consent (Ward *et al.*, 2018). Our study results revealed that this section was completed well, and most of the patients seen did not have medical conditions prior to the sexual violence incident. In support of the results, the study conducted among community-service doctors in South Africa shows that many community-service doctors who had encounters with rape or sexual assault case/cases recorded detailed histories (Fouché et al., 2018). The results also show that a small percentage (1.54%) of patients' history of relevant medication was documented. This might have resulted from patients not having any relevant medical conditions.

Of relief was that almost all of the patients had seen the history of assault/ rape, which included the date, time, location, surface, number of perpetrators (s), relationship to the perpetrator(s), use of condoms or not, and all other required histories as per J88 were documented.
According to Kotzé & Brits (2017) all this information is necessary to assist in the prosecution.

5.3.4 Section D (History of relevance to a sexual offence)

It is well documented that the history of relevance to sexual violence should be obtained from the victim and accurately recorded (Mogale et al. 2015; Jina & Kotzé 2016; Jina et al. 2020). The relevancy includes if the evidence of sexual violence was tampered with through wiping, washing/bathing/showered after the occurrence, if menstruating during or immediately after the offence, or if a condom or lubricant was used. In summary, this section focused mainly on information that could affect the DNA, which could be used as evidence in court (Kotzé, Brits & Botes, 2015. They (ibid) argue that courts in South Africa depend largely on medicolegal evidence for a positive prosecution of physical assault and rape/sexual assault cases. The audited files showed that the section had been completed. However, almost all the forms (98.97%) documented that the evidence had been tampered with mainly by wiping the genitalia after urinating. This may affect the evidence the victim gives as it may be difficult to obtain the DNA of the offender(s).

5.3.5 Section E (General examination)

Documentation of the general appearance and condition of clothing is made regarding whether the clothing is blood/fluid stained or torn and whether the clothing has been changed or taken for a forensic. A general examination is important as it strengthens the medical evidence for court, especially in the first 72 hours of the incident. According to the results, most of the records analysed included the description of physical appearance. In the South African study that reviewed the medicolegal clinical notes for cases of interpersonal violence, only 11% of general body appearances were recorded (Loots & Saayman, 2019).

With regard to the examination, description and documentation of the clothes worn by the victim during the examination, the results show that almost all were sufficiently recorded. The examination of clothes is recommended as they may be a source of donor DNA and can confirm that there was a struggle during the offence (Kotzé & Brits 2017). Loots & Saayman (2019) argue that the clothing, including underwear, that the victim had on at the time of the incident should be checked thoroughly for damages, stains from blood, semen, sweat, saliva, and hair. Hence it was of concern that in their study only 20% recorded the clothing the victim

wore during the offence. These could be reasons for including a clothing description in the study that developed and validated a data quality index for forensic documentation of sexual and gender-based violence in Kenya (Olson, Macias-Konstantopoulos, Muchai, Johnson, Mishori & Nelson 2022).

A few of the records indicated that there was a use of drugs or alcohol prior to or after the incident. This included collecting blood or urine samples in the laboratory to confirm intoxication. Alcohol evidence collection kits were completed and identified with a record sample seal number. It is important to note that the use of substances alters a person's mental status, which could affect the information provided by the patient. However, there are concerns regarding using alcohol intoxication as evidence in cases of sexual assault. Some authors believe that in South Africa, most cases may be wrongly dismissed based on the biased decision informed by the perceptions about the victim's alcohol consumption (Smythe, 2015; Morabito, Pattavina, Williams. 2019).

5.3.6 Section F (Clinical findings)

Clinical findings note and describe the nature and extent of injuries, if any. Clinical findings are important as they add the facts to the verbal evidence given by the patient during the general examination (Fouché et al., 2018). A top-to-toe, back-to-front examination must be done systematically, as the victims may not be aware of certain injuries. There is a need for a detailed description of the clinical findings to confirm the patient's struggles and proper treatment (Kotzé, Brits and Botes, 2015).

The literature indicates that documentation of the clinical findings after sexual assault, which is high in quality, has been shown to increase the trial, prosecution and conviction rates of perpetrators (Tamamyan and Armas-Cardona, 2019; Kjærulff, Bonde and Astrup, 2019). In support, a study conducted in South Africa, analysing the association of sexual assault injuries such as nongenital or anogenital documentation and legal outcomes, reported that conviction was more likely when cases had documented injuries (Jewkes, Christofides, Vetten, Jina, Sigsworth, Loots 2009). It is, therefore, important to acknowledge that conviction is probable if injuries are documented (Olson et al., 2022). It is relieving to find that of all the records

audited. The clinical findings were recorded except for two files. Consistently to the literature, the most common injuries were noted on the patients' genitalia (Fouché et al. 2018; Jina, Jewkes, Vetten, Christofides, Sigsworth and Loots 2015).

Despite these results, there are reports of poor completion of the form, especially in the clinical findings (Jina and Kotzé 2016). In agreement, a study conducted among community service doctors proved that most healthcare professionals lack the competence to assess and document medicolegal findings related to rape/sexual assault (Fouché, Bezuidenhout and Adefuye, 2019). Hence, the participants from the same study suggested that their training should zoom into the history taking, examination, completing the documentation properly and the correct use of the specimen collection kits, as well as being more practical than theoretical, which has proven to be inadequate for imparting knowledge effectively. The reality is that in countries such as Kenya, doctors have, although limited, other data quality assessment tools other than the standerdized forensic evidence forms used in documenting findings for sexual assault cases such as the MediCapt app, which is a digital form platform. (Olson et al., 2022). In South Africa, there is only the J88 form, which sometimes is not even available in the trauma unit (Loots & Saayman 2019).

5.3.7 Section G (Specific examination)

The specific examination forms part of the medico-legal evidence. According to a J88 form, this examination includes oral, anal, male and gynaecological examinations and schematical drawings indications. These examinations are done to solidify the allegation of sexual assault/ rape (Jina *et al.*, 2015). A specific examination follows a thorough systematic checking of the extra and anogenital areas to able detailed outcomes such as injuries and extent of damages to conclude the evidence of assault (Kotzé & Brits 2017). The same authors advocate for the acronym “TEARS”, which stands for **T** Tears and tenderness, **E** Ecchymosis (bruises), **A** Abrasions, **R** Redness, and **S** Swelling. The size, shape, depth, and specific features such as wound margins, foreign material, tissue bridges and associated injuries should be carefully noted during the examination and appropriately described. The examination findings should be presented in both written words, photographs or drawings of injuries (Mogale et al. 2015). According to Kotzé and Brits (2017), a diagrammatic or drawing explanation gives a visual image of the extent of penetration or force that caused injuries.

The current study results showed that oral examination was not applicable, although it was a requirement. This might have been from the previous practice because the old J88 form did not have this section. Kotzé & Brits (2017) believe that oral examination is as important as anal and gynaecological because the mouth is a sexual organ, and penetration by genitals or objects resembling genitalia constitutes sexual assault. The gynaecological examination scored 98.46%, which is not surprising because the study included women only.

An anal examination is expected to be done in all cases (males and females) to assess for forceful penetrations, acute injuries, signs of healed or structural change, medical conditions that may need treatment and conditions that may mimic anal penetration, and the absence of positive findings does not rule out the possibility of anal penetration (Kotzé & Brits 2017). In this study, it was of concern to identify that just above half, or 52.31%, of patients, were examined anally. This implies that if women are penetrated anally, the evidence can be missed because of the stereotypes that women are only penetrated vaginally. It was still worrisome to realise that out of all the audited forms for women's sexual assaults.

There was still missing information for the gynaecological examination. This implies that the provided information for the prosecution in most cases is not complete and misleading. The participants in the study conducted in South Africa were critical of the condition of J88 forms presented as prima facie evidence. They felt that in most cases, the evidence provided on the J88 is not talking but silent since some important information is missing (Mogale et al. 2015). As for the male genitalia, examinations were not done in all the cases since the study focused on cases of women's sexual assaults. The victims and survivors of sexual assaults deserve high-quality forensic examination, evidence collection and documentation as part of their care (Olson et al., 2022).

5.3.8 Section H (specimens collected for investigation)

In cases of sexual assault, it is recommended that specimens are collected from any of the available evidence before they can be tampered with (Kotzé & Brits 2017). In South Africa, a set of accompanying evidence-collection kits is used for cases of sexual assaults. Each kit contains a user-friendly guide to assist the health worker in collecting evidence within 72 hours

post the incident without contamination (Republic of South Africa 2007; National Prosecuting Authority South Africa 2014). The Sexual Assault Evidence Collection Kit (SAECK) is completed by the health care provider and submitted to the Forensic Scientific Laboratory (FSL) by the police. The specimens are documented on the J88 form to maintain the chain of evidence (Kotzé, Brits & Botes, 2015). The collected specimen is matched against the DNA of the perpetrator(s) (Jina et al. 2015). In the current study of all the specimens collected, there were no alcohol collection kit stickers, and most of the results were not applicable as they are not a requirement on the old J88 form.

The SAEK seal sticker was found on most of the forms, and those that did not have the stickers were due to the case being older than 72 hours. Some forms seemed to have been photocopied, possibly the original having gone with the police officer or because a case had not been opened yet. A South African study that looked into the factors associated with rape case attrition found that forensic specimens were submitted to the FSL (Machisa et al., 2022). This resulted in the success of processing and arresting perpetrators or having them charged in court (Machisa et al., 2022). Therefore, healthcare providers must be trained and competent and have the skills required to collect evidence and correctly document medicolegal findings (Jina & Kotzé, 2016).

5.3.9 Section I (Technology used)

The J88 form requires the completion of technology used to examine sexual assault victims. The technology includes taking photographs and the photographer's name (Muldoon *et al.*, 2018), the use of Colposcope and Toluidine Blue or any other form of technology. The reviewed literature revealed that technology is a great tool for collecting sexual assault evidence (Kotzé, Brits and Botes, 2015).

Including the use of toluidine blue staining, which is used for staining tissues that contain DNA and RNA (Jina *et al.*, 2015). It is useful in identifying subtle injuries in the anogenital areas. It Has been proven to produce a higher rate of detecting genital injuries than using the naked eye alone (Piccinini *et al.*, 2019). In the current study, technology was not used in any cases.

5.3.10 Section J (Number of pages added)

When writing a sexual assault report, it is allowed to add extra pages for any other information that is found necessary to assist with the processing of the offence and attach it to the J88 form. None of the forms we audited had indicated any additional pages, although, in the majority of the files, there were blood results, referrals and clinical notes, which form part of the additional pages added (J.M., H. and B.A., 2014).

5.3.11 Section K (Motivation for the conclusion)

Once all the evidence is collected, a motivational conclusion is made from the evidence to confirm if the evidence correlates with signs of rape/sexual violence (Med and Cmsa, 2017). A motivation was made for the majority of the forms, and the 3 forms that did not have a motivation were either due to it being incomplete or the information inconclusive. The conclusion is built on the history and the clinical findings concerning differential diagnoses, age and body build, clothing, injuries, sobriety and mental and emotional picture (Kotzé, Brits and Botes, 2015). It is a well-known fact that the J88 form serves as evidence in court.

However, the missing details, along with illegibility, unrecognisable acronyms as well as the use of a language other than English, such as Afrikaans, which was commonly found during the collection of data, leads to there being a need for more practitioners to testify in court more frequently which could be avoided (Med and Cmsa, 2017; Jina and Kotzé, 2016). Due to an old and new J88 form, some details were not filled in on the old J88 form as it was not required. That said, even on the new J88 form where the information is required, some practitioners did not fill in the required information. Although it has been noted that the new J88 form requires more detail, it is still simple to fill in and was designed to reduce the time of completion as it has text boxes which may be ticked “yes” or “no” for a large number of the questions on the form (Med and Cmsa, 2017).

5.3.12 Section L (Transfer details)

This process is done once the J88 form is complete and is formally handed over along with the evidence to a police officer who will be handling the case as a continuation of the chain of evidence (Strom *et al.*, 2019). Most of the forms were handed over for further proceedings. Those not handed over were either incomplete, a case was not yet opened, or the information was inconclusive and could not be transferred for further investigation. This has further been made difficult because most of the sealed SAEK kits (provided by the investigating officer) arrived with the old J88 forms inside, which adds to the incompleteness of the forms. The investigating officer is accountable for transferring these forensic specimens to a forensic laboratory. (Kotzé, Brits and Botes, 2015).

5.4 IMPLICATIONS AND LIMITATIONS OF THE STUDY

5.4.1 Implications of the study

This study aimed to document the practices in collecting and documenting medical evidence from records of sexual violence that were prepared for trial to improve the current practices that are currently in place, leading to more rape/ sexual assault cases going to court and reaching the prosecution phase.

This study, therefore, revealed the need to phase out one of the J88 forms as intended and use one standardised form for all the cases to avoid confusion, which leads to incomplete forms, when filling in the required form. This study revealed the reality of the J88 form and its shortfalls, showing that many cases of sexual violence against women are lost due to incomplete medical evidence.

Therefore, more training needs to be given to the Health Care Prectitioners on the importance of the medical evidence for the trials of sexual violence cases. In-service training should also be provided on how to complete the J88 form.

5.4.2 Limitations of the study

Limitations occurred due to the research design, sample size, data collection method, data analysis, rigour.

Sample size was a limitation in this section as it did not represent the whole 'population' as such.

5.4.3 Recommendations

It would be recommended that for the auditing tool, only records with the new J88 forms be audited to have more diverse information. This would have lessened the confusion in the auditing form and allowed for the results to be better understood as they would have represented information from one form and not both. It would also be recommended that more institutions focus on the training of healthcare paractitioners on the J88 form as well as have in-service trainings for the healthcare practioners working in the centres. A larger sample size would also be recommended so as to get a more diverse spread of data.

5.5 CONCLUSION

This study sheds light on the importance of the accurate, detailed and complete collection and documentation of evidence of sexual violence cases by trained and experienced practitioners for the positive outcome of these cases. Sexual and gender-based violence is an urgent issue affecting thousands of people worldwide, no matter their gender, creed or colour. In South Africa, a J88 form is used as a standard to document sexual violence case evidence. It is, therefore, important that the form is complete and filled in accordingly. This is because the form acts as the "voice" of the victim and portrays a picture of the incident for the court, which may ultimately lead to a positive outcome.

South Africa has one of the highest numbers of sexual violence and rape, causing a high ratio of patients to that one practitioner. This may be motivated to train more health practitioners, including nurses, to examine patients and fill in the J88 form, as there has been evidence that there is a better completion of forms when done by nurses. However, with this being said, it

must be noted that the J88 form was designed before the official training of forensic nurses. With the introduction of the new, more detailed J88 form, there was much controversy among the practitioners as it was argued that they were not consulted in the development of the new form and that the new form was not in line with the training provided in medical schools. This may have contributed to the reluctance to use the form and ultimately complete it as required. However, the Health Professions Council of South Africa has developed a booklet titled “Guidelines for Good Practice in the Health Care Professions.” as a means to guide the attending practitioner.

Overall, this study proves there is a gap in the training of practitioners in the effective collection and documentation of sexual violence cases in preparation for court and, ultimately, the positive outcomes of these cases.

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ANNEXURE A

ETHICS APPROVAL:

UNIVERSITY OF PRETORIA

ANNEXURE A: ETHICAL APPROVAL LETTER

UNIVERSITEIT VAN PRETORIA
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26 March 2021

Faculty Ethics Committee

Faculty of Health Sciences

University of Pretoria

To whom it may concern,

Evaluation of a protocol for the following student:

Student Zondo NB - Department of Nursing Science (MNur); student number: 12114792

Title: Best practices in collection and documentation of medical evidence for sexual violence cases at thuthuzela and crisis care centres in Gauteng Province, South Africa

This letter serves to confirm that the above-mentioned protocol was discussed by the Postgraduate Committee of the School of Health Care Sciences during the Online meeting of 17 February 2021. The proposal was accepted with minor changes, and the corrections were effected. It is hereby referred to your committee for ethical clearance.

Sincerely yours,

JMothabeng.

Nontokozo Bhekiwe Zondo

2022

Annexures

Professor DJ Mothabeng

Chairperson: Research and postgraduate committee

ANNEXURE B

DETAILS OF PRACTITIONER AND FACILITY

Nontokozo Bhekiwe Zondo

ANNEXURE B: AUDITING TOOL

Section A: Details of practitioner and facility	
Identification number of file	
Name of health facility practice	
Address of centre	
Telephone number of the facility	
Qualification of practitioner	
Registration number of practitioner	YES/NO
Cellphone number of the practitioner	YES/NO
Email of practitioner	YES/NO
Practitioner and facility fax number	YES/NO
Facility/practitioner patient record no#	

Section B: Patient information	
Name and surname	YES/NO
Gender of patient	MALE/FEMALE
Date of birth/ age of patient	YES/NO
Patient accompanied by	

Who was present during examination	

Section C: Medical History

Intellectual disability noted	YES/NO
Other impairment/ Disabilities noted	YES/NO
Relevant medication taken e.g. PrEP	YES/NO
Relevant medical history to help with differential diagnosis noted e.g. HIV positive already?	YES/NO
History of assault +/ rape noted	YES/NO

Section D: History of relevance to a sexual offence (do not use if not applicable)

Since the offence, has the patient exposed their genitalia to anything that could tamper with DNA, i.e. wiped, bathed, defecated, rained on etc	YES/NO
Menstruating	YES/NO
Was a condom/ lubricant used	YES/NO
Currently pregnant	YES/NO
Ever had a vaginal delivery	YES/NO

Section E: General examination	
Physical appearance noted?	YES/NO
Clothing described?	YES/NO
Clinical evidence of drugs/alcohol noted?	YES/NO

Section F: Clinical findings	
Section filled in	YES/NO

Section G: Specific examinations	
Oral examination done?	YES/NO
Anal examination done?	YES/NO
Male genitalia examination done?	N/A
Gynaecological examination done?	YES/NO

Section H: Specimens collected for investigation	
SAEK seal no#/ sticker	
Alcohol collection kit seal no#/sticker	
Clothing kit seal no#/sticker	
Urine +/ samples	

Section I: Technology used	
Photographs taken	YES/NO
Colposcope/ toluidine blue used	YES/NO

Section J: Additional pages used and attached	
Number of pages added	

Section K: Conclusions	
Motivation for conclusion made	YES/NO

Section L: Transfer details	
Transfer details complete	YES/NO

*If there are sections that are not applicable, do not fill in/ audit.

ANNEXURE C

REQUEST FOR PERMISSION TO DO RESEARCH

ANNEXURE C: REQUEST FOR PERMISSION TO TO RESEARCH

UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA

Dear Sir/madam (CEO/Headquarters)

RE: REQUEST FOR PERMISSION TO DO RESEARCH IN THE THUTHUZELA CARE CENTRE

I hereby wish to apply for permission to conduct research in The Thuthuzela Care Centre. My research project will involve sexual violence files that are fit to be presented in court. My research topic is “Practices in collection and documentation of medical evidence for sexual violence cases against women that are fit and ready for trial at Thuthuzela care centres in Gauteng province, South Africa.”

Nontokozo Bhekiwe Zondo

This study will involve the selection of sexual violence case files that are fit to be presented in court from the archives of various Thuthuzela Care Centres in Gauteng, South Africa. A tool will then be used, of which the questions asked on the tool will be answered by the information obtained from the selected files. The tool is designed to be specific, simple and checklist-style. The information obtained will be treated with the strictest confidentiality and will be used solely for this research purpose.

Yours sincerely

N.B Zondo

ANNEXURE D

REQUEST FOR PERMISSION TO DO RESEARCH

ANNEXURE D: REQUEST FOR PERMISSION TO TO RESEARCH

UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA

Dear Sir/madam (Manager)

RE: REQUEST FOR PERMISSION TO DO RESEARCH IN THE THUTHUZELA/Crisis CARE CENTRE

I hereby wish to apply for permission to conduct research in The Thuthuzela Care Centre. My research project will involve sexual violence files that are fit to be presented in court. My research topic is “Practices in collection and documentation of medical evidence at Thuthuzela and Crisis care centres in Gauteng province, South Africa.”

This study will involve the selection of sexual violence case files that are fit to be presented in court from the archives of various Thuthuzela Care Centres in Gauteng, South Africa. A tool will then be used, of which the questions asked on the tool will be answered by the information obtained from the selected files. The tool is designed to be specific, simple and checklist-style. The information obtained will be treated with the strictest confidentiality and will be used solely for this research purpose.

Nontokozo Bhekiwe Zondo

Yours sincerely

N-B-Zondo

ANNEXURE E

LETTER OF CLEARANCE

ANNEXURE E: LETTER OF CLEARANCE

AGRICULTURAL RESEARCH COUNCIL

BIOMETRY

Nontokozo Bhekiwe Zondo

PO Box 8783, Pretoria, 0001, South Africa

ARC LNR E-mail.Phone: • NgwaneC@arc.agric.za(012) 427 9811 Fax: (012) • Web 427 site: 9743 www.arc.agric.za(Int: +27 21)

Exceiåv:ee in Research and Development

Letter of clearance

This letter confirms that Nontokozo Bhekiwe Zondo (student no. 12114792) studying at the University of Pretoria discussed the project titled Best practices in collection and documentation of medical evidence for sexual violence cases at Thuthuzela and Crisis care centres in Gauteng province, South Africa with Cynthia Boitumelo Ngwane (a statistician working for Biometry at Agricultural Research Council).

I hereby confirm that I assisted the student with determining the sample size, sampling method, data collection and data analysis methods. The student will also be assisted with data analysis and interpretation of the results. Chi-squared test for equal proportions and association will be used as a data analysis tool in order to achieve the study objectives. Crammers V test will also be used to determine the strength of the association between the demographics and practices in collecting and documenting medical evidence. All data will be analysed using

SAS statistical software package (9.2).

Name Cynthia Boitumelo Ngwane Date 01 September 2020

Signature 

AGRICULTURAL RESEARCH COUNCIL

P.O. BOX/POSBUS 8783
O I SEP 2020
PRETORIA • 0001

LANDBOUNAVORSiNGSRAAD

Nontokozo Bhekiwe Zondo

ANNEXURE F

CONFIRMATION OF EDITING

14 December 2022
Pretoria, South Africa

Nontokozo Bhekiwe Zondo

To whom it may concern,

I hereby confirm that I undertook the language editing for the MNur Thesis:

PRACTICES IN COLLECTION AND DOCUMENTATION OF MEDICAL EVIDENCE FOR SEXUAL VIOLENCE CASES AGAINST WOMEN THAT ARE FIT AND READY FOR TRIAL AT THUTHUZELA CARE CENTRES IN GAUTENG PROVINCE, SOUTH AFRICA

by Nontokozo Zondo

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