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RESEARCH REPORT

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# Client experience of rape victims accessing governmental post-rape services in South Africa



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## Reference and copyright

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# Summary

This study aims to better understand the experiences of rape victims accessing governmental post-rape services in South Africa. It was part of a larger intervention to develop an e-governance mobile phone ratings app for reporting user satisfaction with post-rape services, which aimed to improve accountability and responsiveness.

To understand rape victims' views about the quality of post-rape services, this cross-sectional study was conducted at one Thuthuzela Care Centre and three Rape Crisis Centres in Tshwane district. Three focus group discussions brought together adult female rape victims to discuss their experiences as service users.

Participants highlighted positive, negative and often mixed experiences in accessing post-rape services. Entry to centres was often delayed due to low levels of awareness, indirect referrals and delays at police stations. Positive experiences were characterised as welcoming, friendly, empathetic and non-judgemental. Negative experiences were characterised as threatening, blaming, physiologically taxing and lacking in empathy. Inadequate follow-up, delays in progress of cases, and poor communication and quality of information contributed to dissatisfaction with services.

While voicing their lived experiences of post-rape service delivery, participants highlighted gaps and proposed constructive recommendations. They also declared a strong willingness to participate in the e-governance rating app as a tool to improve services for future victims.

The findings of the study were used to inform the design and content of the app, as well as its technology platform and the content of marketing material. These contributed to its successful piloting and use at the four centres.

## Key themes in this paper

- Using mHealth interventions for reporting user views of service quality
- Drivers of satisfaction and dissatisfaction with post-rape service delivery
- Anonymity and e-governance service ratings apps

# Introduction

This research was conducted in an effort to better understand the experiences of rape victims accessing governmental post-rape services in South Africa. It was part of a larger intervention to inform the development and pilot of an e-governance 'client experience' survey application (app) using mobile phone technology. The aim of the client experience app is to give rape victims a voice to report back on the services they receive and hold service providers to account. Specifically, this research aimed to unpack the key drivers of victims' satisfaction and dissatisfaction with post-rape service delivery, as well as to understand the feasibility and acceptability of the proposed intervention from the victim's perspective. The research was intended to inform the client experience app's design, content and technology platform. This report explores the findings from focus group discussions on clients' experiences of services, while findings linked to the proposed technology and its feasibility and acceptability are explored in another research report (Mahlalela, Johnson and Mills 2017).

South Africa has a high rate of rape (South African Police Service 2015), a disproportionately low rate of rape reporting (Jewkes and Abrahams 2002) and an even lower rate of criminal conviction for rape (Vetten, Jewkes, Fuller, Christofides, Loots and Dunseith 2008). High-quality post-rape care can mitigate the immediate and long-term physical, mental, emotional and psychological health implications for victims (Jewkes, Christofides, Vetten, Jina, Sigsworth and Loots 2009). However, civil society watchdogs in South Africa consistently highlight substantial gaps in post-rape services, including deviation from guidelines, poor quality of care, and significant variations in practice between service providers (SANAC 2015). From an institutional perspective, weak legal and criminal justice systems, failure to prosecute perpetrators, and inadequate victim care are seen as contributing risk factors for gender-based violence (GBV) (Mpani and Nsibandé 2015). In South Africa, inadequate oversight and accountability of service providers, insufficient resource allocation to fund the GBV response, and inconsistent implementation of policies and guidelines contribute to the above-mentioned risk factors and, ultimately, a suboptimal national response and a continued high burden of GBV and rape.

The absence of feedback mechanisms through which rape victims can hold government accountable for the quality of post-rape service delivery informed the rationale for the intervention. The proposed mobile phone client experience app was conceptualised to record and report gaps in service delivery and / or areas of victim dissatisfaction. By giving the victims a platform to voice their individual client experiences, the app is designed as a tool to strengthen governance and accountability of post-rape service providers and drive improvement in overall quality of care. In line with the 2006 Kopanong Declaration, the app would support the government to improve standardised and coordinated services, provide effective support and implement monitoring and evaluation (M&E) mechanisms (UNICEF, Gender Links, National Department of Health, National Prosecuting Authority and Act Against Abuse 2006).

Based on research conducted in South Africa in 2015 using qualitative and quantitative methods with 21 people, this report offers insights in two key areas: entry pathways and barriers to victims accessing governmental post-rape services; and the lived experience of rape victims in accessing post-rape services at police stations and specialised care centres.

## A note on terminology

The authors acknowledge that there is significant debate about the use of the term 'rape *victim*' or 'rape *survivor*'. Many of the referenced articles and policy documents still use the terms interchangeably. This paper uses the term 'rape *victim*' rather than 'rape *survivor*' for the following reasons. Firstly, this research focuses on the experiences of participants at their first engagement with governmental post-rape service providers, often within days or hours of being raped. At that point in their individual journeys, the participants did not appear to have received adequate support and / or had enough time to feel empowered to self-classify as a *survivor*. Secondly, this research was undertaken primarily to explore the quality and sensitivities of service providers in providing services to individuals who had been raped. Use of the word *victim* draws attention to the harm and violence done to the individual and the

*By giving the victims a platform to voice their individual client experience, the app is designed as a tool to strengthen governance and accountability of post-rape service providers and drive improvement in overall quality of care.*

service providers' responsibility to mitigate further harm and victimisation (Maier 2014). That being stated, this research is dedicated to the brave and proud women who participated in it and used their

voice in a collective effort to help improve quality and accountability of future post-rape service delivery and thereby better facilitate other victims' journeys to becoming survivors.

## Service provision for rape victims in South Africa

Globally, between 3.3% and 21% of all women aged 15 years and over have been raped<sup>1</sup> by a non-partner. The highest rates of rape reported are in sub-Saharan Africa (Abrahams, Devries, Watts, Pallitto, Petzold, Shamu and García-Moreno 2014). Based on official statistics from the South African Police Service (SAPS), 46,253 rape cases were reported in 2013/2014 – that is, 87 reported rapes per 100,000 of the total population. This rate is considerably higher than the rates reported in Sweden (59), England and Wales (36) and Costa Rica (35), the highest ranking out of 79 countries as reported by the United Nations Office on Drugs and Crime (UNODC) (Wilkinson 2015). However, Jewkes and Abrahams (2002) estimated that the rate in South Africa is much higher – closer to 2,070 incidents of rape per 100,000 women per year; these estimates suggest that gross under-reporting to police masks an even higher rate of rape (Jewkes and Abrahams 2002). These estimations are corroborated by other South African research, including a community-based survey, which found that fewer than one in nine respondents who admitted being raped had actually reported it to the police (Jewkes, Penn-Kekana, Levin, Ratsaka and Schriber 2001).

Under-reporting of rape in South Africa is explained by numerous factors, including the poor quality of service provision at the level of the police, health workers and the criminal justice system, as well

as by individual and relationship aspects. Naidoo (2013) found that barriers to reporting included: fear of retaliation by the perpetrator; fear of secondary trauma at the hands of the police and health providers; fear of not being believed and / or of being blamed; fear of stigmatisation; lack of empowerment; and lack of faith in the criminal justice system such that reporting would lead to arrest of the perpetrator. These barriers are reinforced by widespread stigma and myths about rape in South Africa, which either blame or implicate the victim as culpable. These may further contribute to under-reporting, as the rape victim experiences feelings of guilt and / or fear of being blamed by their community or family (Rape Crisis Cape Town Trust 2017).

Even when incidents of sexual violence are reported, obtaining justice through the criminal justice system is extremely difficult given the complex, multi-stage process of prosecution. In a provincially representative sample of 2,068 reported and completed rape cases at 70 randomly selected police stations in Gauteng, Jewkes *et al.* (2009) documented that only 50.5% of reported cases ended in arrest, 43% of cases led to charges against the perpetrators, 17% of cases made it to trial, and 4.1% cases ended in convictions for rape. Of those convicted, 15.6% received less than the recommended minimum ten-year sentence; and only 8% of those eligible to receive a life sentence were

<sup>1</sup> This paper follows the definition of rape outlined in South Africa's Sexual Offences Act (2003), as an act of sexual penetration of a victim, without the individual's consent.

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given one. The case review highlighted significant gaps in policing and medical assistance, which contributed to leakages in the criminal justice system and cases being nollied<sup>2</sup> on the basis of paucity of evidence. Key gaps in the criminal justice system included: failure to identify the perpetrator (52%), delays in the investigating officer arresting the suspect following instructions to arrest (53%), and inability to trace the victim (34%) (Jewkes *et al.* 2009). Furthermore, there were low rates of sexual assault evidence collection kits (SAECKs) being completed and sent to the police forensic lab; and limited availability of DNA evidence from the victim or suspect (Vetten *et al.* 2008). The poor quality of some post-rape services inhibits many victims' access to justice and / or redress and contributes to many perpetrators of rape going unpunished.

Over the years, South Africa has put in place a number of interventions to try to reduce the incidence of rape, increase reporting of rape, and improve access to and uptake of post-rape services by rape victims. The Department of Health, SAPS and the National Prosecuting Authority (NPA) play interlinked roles in providing post-rape services. In line with the Criminal Law (Sexual Offences and Related Matters) Amendment Act 32 of 2007, the relevant government departments have each developed policy guidelines to set out the duties of health workers, police and prosecutors in relation to the Act. Broadly, the guidelines stipulate the package of services to be provided by each, and the manner of client engagement.

For the purpose of this report, the term 'post-rape services' encompasses any of the services provided by these three governmental departments, whether in health facilities, police stations or courts. Cross-cutting all three departments, the guidelines stipulate that the government service providers must: treat victims with dignity and in a sensitive manner; assume that the victim's allegation is true; give immediate attention in line with their respective scope of work; explain the procedures and the victim's rights; and avoid delays for medical examination and counselling

and access to medicines to prevent HIV, sexually transmitted infections (STIs) and pregnancy, as well as any other medical care necessary. The guidelines clearly stipulate that the medical examination takes priority over the police statement, and that the statement should only be made when the victim is in a psychological, emotional and physical state to make a statement (Women's Legal Centre 2010). Furthermore, South Africa's *National Management Guidelines for Sexual Assault* (National Maternal Child Women's Health and Nutrition Cluster 2003) state that health care and psychosocial support are not just important in offering care to victims, but they also play a role in encouraging people to report sexual assault to the police; they thus play an important role in promoting victims' engagement with the criminal justice system.

To respond to the specialised needs of rape victims and improve access to more sensitised service providers, over the past decade the South African government has scaled up clinical medical forensic centres (commonly known as rape crisis centres and often based in hospitals), sexual offences courts and access to specialised police services through the Family Violence, Child Protection and Sexual Offences Investigations units. In an effort to promote better coordination of post-rape services, the NPA's Sexual Offences and Community Affairs (SOCA) unit, in partnership with other government departments and donors, has gone a step further to create Thuthuzela care centres as a one-stop facility that brings together the medical, psychosocial, police and legal services in one place. These facilities are designed to be victim-centred and to facilitate victims' engagement with the criminal justice system while preventing secondary victimisation, reducing the time taken to pursue a prosecution, and increasing conviction rates for sexual offences. They are intended to be linked to courts staffed by skilled prosecutors, as well as to social workers, magistrates, non-governmental organisations (NGOs) and police located in close proximity to the centres (NPA 2009). Thuthuzela care centres and sexual offences courts are

<sup>2</sup> *nolle prosequi*. n. Latin for "we shall no longer prosecute," which is a declaration made to the judge by a prosecutor in a criminal case (or by a plaintiff in a civil lawsuit) either before or during trial, meaning the case against the defendant is being dropped. (<http://legal-dictionary.thefreedictionary.com/Nolle+prose>)

intended to be the gold standard of care for rape victims; however, nationally, to date, only 55 care centres and 43 sexual offences courts have been established. As a result, many rape victims who access post-rape services are likely to be served through the rape crisis centres, which are also likely to be situated at a hospital or community health centre, but do not have as direct a link to the NPA, court support services or other non-specialised service providers (e.g. clinics, hospital casualty rooms and general practitioners).

## Gaps in post-rape service provision

Numerous studies have explored client experiences of post-rape services. High-quality health and psychosocial support services have been shown to alleviate many of the victims' fears, provide for victims' basic health needs after experiencing sexual assault and assist them with information on how to progress their case through the criminal justice system (Jewkes *et al.* 2009). Campbell (2008) argued that although some rape victims have found services helpful, for many, post-rape services have contributed to secondary victimisation. According to Vetten (2001), secondary victimisation is characterised by: "blaming treatment of rape survivors by members of the criminal justice system and the victim's family, friends or community". Cited examples of secondary victimisation include: distrust and insensitive discouragement and management of victims reporting rape; government's failure to provide private space for victim management; and flaws in information collection and updating survivors on trial and case progression, as well as inappropriate and demeaning medical and legal management of reported cases. Such secondary victimisation not only compounds the initial rape trauma, but may also lead to individuals subsequently withdrawing charges (Vetten 2001). As noted above, perceptions and experiences of secondary victimisation can act as a barrier to accessing services (Naidoo 2013).

Despite significant investment to strengthen the national response to gender-based violence, numerous studies and reports still document endemic weaknesses in service provision. The 2013/2014 Shukumisa report identified unfriendliness, inefficiency and lack of

professionalism as key drivers of dissatisfaction among victims reporting rape to police. It also highlighted additional problems, including: poor availability of and / or low levels of knowledge of existence of key policy documents, guidelines and forms by reporting officers; inadequate access to specialised personnel such as those from Family Violence, Child Protection and Sexual Offences Investigations units (especially trained advocates and magistrates and / or trained volunteers); and general lack of rooms suitable to service victims of trauma (e.g. clean, private and / or well-equipped) (Shukumisa 2014). In one study, victims reported that law enforcement personnel actively discouraged them from reporting incidents of sexual violence, conducted humiliating and / or traumatising cross-examination, and threatened to charge the survivors themselves if the accuracy of their claims came into doubt (Campbell 2008). In another study, Christofides, Jewkes, Webster, Penn-Kekana, Abrahams and Martin (2005) highlighted low post-exposure prophylaxis (PEP) uptake (19.7%), lack of availability of protocols for care and management of rape victims (59.1% had no protocol), and low levels of training on how to care for rape victims (only 30.3% of clinical staff had been trained). Rape victims reported: having to wait a long time before getting care; that health needs beyond the medico-legal examination were not well met; and that the quality of facilities in which the examination took place was often poor. The same study reported that nearly one third of practitioners did not consider rape to be a serious medical condition (Christofides *et al.* 2005).

## Rationale for research

At the time of this research, there was no coordinated platform for rape victims to provide feedback on the quality of post-rape services received through South African government-supported Thuthuzela care centres and rape crisis centres. The research was conducted to address this knowledge gap and in an effort to inform the design of a client-centred, zero-cost, mobile phone application (app).<sup>3</sup> The purpose of the research was two-fold: (1) to better understand rape victims' perception of the quality of post-rape services and to identify key drivers of satisfaction and dissatisfaction; and (2) to determine if the proposed mobile phone app on an Unstructured Supplementary Service Data (USSD) platform

<sup>3</sup> Funding for this app was provided through the Making All Voices Count (MAVC) innovations grant, with a view to: (1) enhancing case management process to better oversee a rape victim's journey through the medical and justice process; and (2) establish a platform to hear the voices of rape victims in terms of their client experience. The research on which this report is based was conducted alongside the development and testing of the mobile phone app.



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would be an appropriate tool to record rape victims' client experience at these centres, with a view to informing improvements in service delivery. The research was intended to help define and develop an

e-governance 'client experience' survey application (app) that could easily and willingly be used by rape victims attending these centres to rate their satisfaction with and comment on service delivery.

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## Methodology

We conducted a cross-sectional study with rape victims from one Thuthuzela care centre and three rape crisis centres in Tshwane district, Gauteng province. Data were gathered through a mixed methods technique (Johnson and Onwuegbuzie 2004) that used a paper-based client experience survey, a paper-based survey of rape victims' mobile phone capacity, and follow-up focus group discussions. The study population consisted of rape victims who were attending follow-up visits at the centres during the study period (July – October 2015). The sampling frame for the focus group discussion participants was limited to individuals completing the paper-based surveys and meeting the following inclusion criteria: female; follow-up clients over the age of 18; conversant in English; with a minimum of two visits; and willing to provide consent to participate in the study. Participants were recruited from two study sites. Participation was voluntary and based on written, informed consent. All focus group discussions were facilitated by an independent specialist on sexual and gender-based violence contracted from Sonke Gender Justice, a leading organisation for advocacy and victim empowerment in South Africa.

We developed a guide for the focus group discussions to explore participants' experiences of services provided at the centres, including sources of satisfaction and dissatisfaction, and to assess participants' initial response to the proposed mobile phone app in terms of its feasibility and acceptability. The focus group discussion guide was designed around four domains that had been identified through expert consultation as being most important from a policy and service quality

perspective. These four domains aligned with the planned structure of the four-question satisfaction survey for the mobile phone client experience app: (1) the rooms and physical environment; (2) the service providers; (3) the package of services provided; and (4) the information and advice received. Focus group discussions were audio-recorded and transcribed verbatim. While the discussions were largely conducted in English, some participants gave their input in a local language, so these were translated into English as close to meaning as possible with the local language usage being documented in brackets.

Analysis was led by the principal researcher and supported by two qualitative research experts to improve credibility of the data analysis; final analysis was overseen and supported by an expert in research on gender-based violence. Transcripts were analysed using a thematic analysis approach. They were coded for themes by using an immersion (reading or examining collected data in detail) and crystallisation process (identifying and articulating patterns or themes) and aggregated into categories for analysis (Malterud 2001). Immersion and crystallisation were achieved through repeated reading; common broad ideas that ran throughout the transcripts in line with our objectives were considered for primary themes. Once the primary themes were identified, the transcripts were transferred onto Microsoft Excel and all statements were cross-mapped into the primary themes, then, following a similar process of immersion and crystallisation, new sub-themes were identified. The statements were sorted by theme and sub-theme and organised into

matrices to compare and contrast client experience between service points and / or service providers. Comments were coded and sorted in terms of “positive”, “neutral” or “negative” experiences.<sup>4</sup> Quotes were used to illustrate and operationalise themes and provide examples of responses from unidentified participants. In July 2016, all focus group participants were invited to a data review and discussion meeting based on preliminary qualitative analysis in order to solicit feedback and check that we had correctly interpreted participants’ statements and intentions in our analysis frame. During analysis, we acknowledged a source of bias, which was that the focus groups only comprised perspectives of rape victims who had accessed post-rape services and had subsequently been retained for follow-up.

## Ethical considerations

The study protocol received ethics approval from the Foundation for Professional Development (FPD)’s research ethics committee and research approval from the Tshwane District Department of Health research committee. Focus group discussions were facilitated on the premises of the Thuthuzela centre or a rape crisis centre

in a closed room with no centre staff present. No personal identifiers were collected and all responses were anonymous. Participants were compensated for taking part and received a nominal incentive of shopping vouchers for a nearby grocery store.

## Stakeholder engagement

Dissemination of preliminary research findings was done with the Tshwane Department of Health clinical medico-legal unit, Tshwane district health management team, the NPA SOCA unit, and at all study sites in order to highlight recommendations and implications for the various stakeholders. Results were also shared with civil society organisations (CSOs) involved in the Increasing Services for Survivors of Sexual Assault in South Africa (ISSSASA) project, the FPD, Sonke Gender Justice, the Medical Research Council (MRC) and Soul City. The FPD reconvened participants from the focus groups to feed back on the analysis of the results and the progress of the pilot project the research had helped to form. This feedback session also updated participants on how the research and pilot project were shaping discussions with the NPA and Department of Health.

# Findings

Three focus group discussions were conducted at two sites, Mamelodi Thuthuzela Care Centre and Jubilee clinical medical forensic centre (a.k.a. Rape Crisis Centre), between September and October 2015, with a total of 21 participants (an average of seven per group). Emerging themes from these discussions included: (1) entry pathways into Thuthuzela care centre and rape crisis centre services; and (2) client experience of post-rape service delivery.

## Entry pathways into Thuthuzela care centre and rape crisis centre services

The focus group participants reported three entry pathways into the centre: via the police

station; from another health-care setting (e.g. clinic, hospital or emergency room); and directly. Based on participants’ stories, the police station appeared to be the most common entry point into post-rape care. The predominance of this entry point was largely due to victims being scared and not knowing where else to go, as well as a common misconception that they could not access medical care for rape without first opening a case. This misconception appeared to be shaped by community knowledge in the form of “*people told me*” (female focus group participant, Mamelodi), but was also reinforced by victims’ own experiences wherein police required them to first open a case at the police station before being referred on to the care centre or crisis centre. In one case, health-care workers at the hospital referred a participant

<sup>4</sup> Comments whereby the participant expressed satisfaction and / or happiness with service quality were classified as “positive”. Comments whereby the participant expressed dissatisfaction and / or unhappiness were classified as “negative”. Comments whereby the participant simply described a process and / or services received but did not express an opinion in terms of quality were classified as “neutral”. Comments with both positive and negative attributes were dual-coded.

directly to the police, as opposed to the centre, while also appearing to withhold medical care.

*At first it was bad because we first went to Stanza Bopape Hospital. They told us to go to the police station to open a case. I was beaten up, bleeding and in too much pain. It felt really bad to me because I needed them to assist me but all they could say to me is to tell me that I should open a case. One of the nurses recognised me and insisted that I should get help immediately. My concern was that, what if this nurse didn't recognise me? That simply means they shouldn't help me, if it wasn't for her. I felt that was very bad. Then they told us we should go to the TCC [Thuthuzela care centre]. When we arrived there they called the police to come to the TCC. I then opened a case without going to the police station. From there, everything went very well.* (Female focus group participant, Mamelodi)

Few participants reported any prior knowledge of the centres or how they operate. Only one participant reported visiting the centre immediately after the rape incident:

*Me, I did not go to the police station. I came straight to the centre and the police came to take the statement here. While I was waiting they caught the suspect out there. It was fast.* [Participant spoke in SeSotho] (Female focus group 1 participant, Jubilee)

Many participants expressed relief upon arriving at the centre. As participants told their stories about how they entered into care, the role of the frontline staff in determining their ease of entry became clear. Positive entry experiences were characterised by short waiting times, efficient progression through the numerous steps, and good coordination between the police and the centre. A number of participants made very positive reference to police escorts to the centre. While there were some positive entry experiences, the vast majority of participants' entry experiences were negative. These were characterised by: multi-step, indirect referral routes where you "need to go there and there" (female focus group participant, Mamelodi); waiting; frustration at the police interview process to open a case delaying access to medical care; frustration with it being "a long procedure" that "takes time" (female focus group 1 participant, Jubilee); a sense of discouragement about the process and thoughts to "let the whole thing go" (female focus group 1 participant, Jubilee); and the victim's general feeling of physical discomfort throughout the entire process, due to pain, fatigue, hunger, and the discomfort of having not bathed. Many participants also alluded

to the rape happening at night and waiting for the next day in order to initiate the process of accessing post-rape services.

*I remember I went to the police station at around 7am and when I got there I waited until late and I came here (to the centre) at 2pm and that was the only time they were able to bring me here. So when I got here I waited and the only time I went home it was like 5pm and I have not eaten anything ever since and I have not rested.* (Female focus group 1 participant, Jubilee)

These findings highlight the need to raise public awareness about the availability and location of 24-hour post-rape services at Thuthuzela care centres and rape crisis centres in South Africa, as well as the importance of training and sensitising police and health-care workers on rape and post-rape referral protocols, with a focus on rapid referral and supportive escort of victims to these dedicated centres and care before case statement. Due to the sheer volume of potential entry points (police stations, hospitals, clinics) there is a need for significant investment to ensure saturation training and sensitisation of these frontline staff to triage and fast-track rape victim referral into centres. As our focus group discussion participants comprised rape victims who had successfully accessed and were subsequently retained in centre services, their stories of frustrations with and barriers to accessing care may help tell the untold stories of those many victims who have never accessed centre services and provide the context for the low reporting rates for rape in South Africa.

## Client experiences of post-rape service delivery

Many participants made reference to their overall satisfaction with the experience at the centres and credited the good rapport with staff, the quality of services and the information received with helping them to recover. The focus groups highlighted areas of satisfaction and dissatisfaction, and identified specific gaps in expected and / or desired service delivery. Entry pathway into care was closely aligned with level of satisfaction. Much of the reported dissatisfaction related to frontline service staff and entry at the police station.

## Rooms and physical environment

Satisfaction with the rooms and physical environment at the centre was perceived to be important but did not feature as a central sub-

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theme in the focus group discussions. When probed, many participants said they had initial concerns about privacy and being seen by others while accessing services at the centre, but these concerns were quickly allayed as the centres were widely perceived as private, confidential and safe.

*The building is private as you can see it and some of the things that I was scared of was what if I found people in here, how would they look at me, my situation? But then I did not find people in here and I just saw it was private, and they were professional and the information is kept confidential. (Female focus group 1 participant, Jubilee)*

The biggest concerns in relation to rooms and the physical environment at care centres and crisis centres related to: their distance from victims' homes and the transport costs incurred making visits; the lack of clear signage while within hospital premises; and its confusing name ("medico centre"), which made asking for directions within the hospital even more complicated. At the focus group data verification meeting, its name was further explored, with one participant reiterating (to general consensus) that the name "me-di-co" was both hard to hear and to say, and that its meaning was unclear and a source of unnecessary confusion. Its obscure name and the difficulty in finding the physical premises meant that participants needed to ask for assistance, which was problematic as it entailed them disclosing what type of service they were seeking and undermined their sense of privacy.

*We don't feel free to talk with someone and tell that I have been raped. (Female focus group 2 participant, Jubilee)*

### **Different experiences with the police and care centres: perceptions of service quality, service providers, and information and advice**

Most of the discussion in the focus groups revolved around participants sharing stories of their initial

engagement with the various types of service providers involved in providing post-rape services, namely medical professionals (doctors and nurses), psychosocial support providers (counsellors, social workers and psychologists) and police officers. Although participants made reference to and commented on the degree of satisfaction with specific services they received (e.g. medical examination, medical care, treatment to prevent disease, counselling services, opening a case), the quality of engagement with service providers was the dominant thread in the narrative. Most of the reported engagement occurred at the care centre; however, in the case of the police, some stories took place at the police station; this is important to note, as the tone of the narrative differed between service points.

In the discussions regarding victims' experiences of service providers, two very different narratives emerged. Overwhelmingly, experiences with care centre or crisis centre staff (e.g. health-care workers and psychosocial support staff) were positive. These service providers were characterised as welcoming, friendly, professional, patient, empathetic, non-judgemental and easy to talk to. Participants felt that these staff knew what they were doing and were "doing their job". Many participants expressed pleasant surprise at how well they were treated at the centres, with the underlying connotation that it was largely unexpected, which may in part be amplified by their contrasting experiences at the police station; their lived experience at the centres contradicted preconceived notions that they would be "judged" or "blamed" and that the health-care staff would be "rude":

*... so the staff – they [centre staff] were welcoming. I was afraid that they would judge me and stuff but it was not like that. They were just welcoming. It felt like they were in my shoes, they understood my situation ... and they just treat you like in a good manner and they make you realise that whatever happened to you, it was not your fault and that you can get proper help*

*and they do give you proper help.* (Female focus group 1 participant, Jubilee)

Accessing medical services at the centre was characterised by long waiting times, specifically for the doctor on-call, who often had to be called from home or elsewhere to come to the centre for the sole purpose of examining and providing medical care to the victim. Most participants reported waiting a minimum of two to three hours and even up to five hours at the centre. Waiting at the centre was often characterised by hunger and not always knowing why they were waiting; nonetheless, many participants expressed appreciation for the services and an understanding of the need to wait because the doctor was off-site.

*You will wait in this place, until you get hungry [speaking SeSotho]. [Participants laughing]* (Female focus group 2 participant, Jubilee)

*He was spending time with his family and he had to come to the centre especially for me. That made me feel really special. That made me feel good.* (Female focus group participant, Mamelodi)

Despite long waiting times, participants reported satisfaction with the quality of medical care and counselling services they received. In general, participants expressed satisfaction with: the manner of clinical examination; the time taken to conduct a thorough clinical examination, including the running commentary of the process; and the provision of medication to “prevent the diseases” (female focus group participant, Mamelodi). Staff were also praised for conducting telephone follow-up just to see how the participants were doing. When describing the medical and psychosocial services they had received, participants voiced appreciation for the quality of interpersonal engagement and the manner in which centre staff spoke to them, for how they felt heard without being judged, and how they were allowed to tell their story at their own pace. One consistent sub-theme across the focus groups was that participants did not feel blamed for the incident, which in some cases stands in sharp contrast to participants’ experiences with the police.

*... what made me to be satisfied is that when they ask you questions, they [centre staff] don't rush you to answer. They give you much time before you can reply. I even felt free to ask them questions and they were very supportive.* (Female focus group participant, Mamelodi)

*So like, she [the counsellor] was nice and I was expecting to be judged and say like, “you, young*

*people, what-what,” you know, but she was nice and gave us advice.* (Female focus group 1 participant, Jubilee)

*At least you are in a safe place [the centre] and you can be free to talk. Because when I came here I was very angry, but the minute I entered the centre and talked to someone I became relieved.* (Female focus group 2 participant, Jubilee)

Counselling services were praised but not universally or comprehensively accessed. In some cases, passive referral for counselling, limited follow-up, waiting for counsellor availability, distance to services and associated transport costs acted as barriers to uptake of counselling. Many participants expressed a desire for more counselling services, as well as the need for peer support networks within their own communities.

For some participants, the gap in service quality from centre staff related to information and advice, specifically about medication and side effects. Some participants complained about not receiving sufficient if any information and / or remaining confused about possible side effects of medication and next steps. Some acknowledged that their own personal state of mind was the source of confusion, as it “*was not stable at that moment*” (female focus group 2 participant, Jubilee), highlighting the need for repetition of information and advice at follow-up visits and / or via telephone, and ensuring an ongoing opportunity to ask questions.

In contrast, participants’ stories of their experiences with the police were largely but not exclusively negative. In the few positive experiences, the police were described as nice, friendly, conscientious in follow-up, and generally concerned about the victim’s wellbeing.

*The police who was in charge with my case was so much concerned he even told me that he will make sure that these boys will get arrested, and he managed to arrest two of them. I was raped by three boys; he arrested two, one of them fled, till today he is nowhere to be found. During the court dates he asked me if I will be able to face them or not, he even helped me to get counselling from the psychologist and social workers to support me during this case. He even made sure that these guys, they go to jail, and they were both charged 15 years in prison. He even used to come to my place to check if I was fine, he would even ask if I can talk, if not he can come back some other time. He was the best.* (Female focus group participant, Mamelodi)

However, most participants' experiences of police were very negative. The negative accounts characterised the police as either ambivalent or outright threatening, blaming, judgemental, lacking empathy, insensitive and, at times, actively discouraging the victim from opening a case. The contrast between the experiences of service providers (centre staff versus police) is most sharply highlighted through differences in interpersonal engagement with the victim, first in terms of the mode of questioning, and then in terms of follow-up. While it was perceived to be the police's "job" to ask questions to open the case, many participants reported high levels of dissatisfaction and discomfort with the manner of questioning, particularly given the victim's mental and physical state at the time of questioning. Participants expressed frustration at the aggressive style of questioning, the repetition of questioning, the insinuation and sometimes outright accusations that the victims were "lying", and the difficulty in answering questions in part due to the circumstances (e.g. darkness, or masked perpetrators) and / or due to the victim's state of mind brought on by the trauma of the assault: "You are not able to think at that moment" (Speaking SeSotho) (female focus group 2 participant, Jubilee). Many participants shared how difficult it was to talk to the police about being raped and how hard it was to make a statement.

*And it's not his job, how you feel, but his [police] job is it write down when you tell him what happened.* (Female focus group 2 participant, Jubilee)

*Like, even when you make the statement, they [police] tell you that you have to talk about every detail. It's like, I am going back to that situation again. I know they have to do that but just in a nicer way. They are just too serious and too difficult and you ended up feeling like you wanted this thing to happen and they do not trust you. The cases they do not take them too serious, like, if you do not make follow-ups, they do not even care that they catch the suspect or something.* (Female focus group 1 participant, Jubilee)

*But my concern is that some police members are very rude. They will ask you what were you doing at the street by that time, why were you not at home? Simply because they never experience what you went through.* (Female focus group participant, Mamelodi)

*Me, I find it weird, like, if it happened at night and they [police] ask you to give a description of the*

*suspect. How are you going to do that? And that time you are trying to fight that person and it's very difficult to recognise the person and get his image and even the voice, because by that time you are scared. You will just forget the voice of the person.* (Female focus group 1 participant, Jubilee)

*But then it's very weird how they [police] think we are lying, because how can you put yourself through such an experience of waiting and being taken from one place to another? Like, it doesn't happen because you want to destroy a person's life, you cannot do that.* [Another participant adds: *You cannot even fake the evidence that they find.*] *So, it is surprising how they think that we lying. Whereas, you know, I can imagine the experience that I went through on that day from the whole day ... and you know when the person comes to me and thinks that I am just making up a story, it touches me.* (Female focus group 1 participant, Jubilee 1)

*They [the police] were a bit harsh and seems like they do not trust me and seems they have doubts on what I was saying to them ... Is like, what I am telling them that makes them not to believe me, because they were not there when the incident happened.* [Participant spoke in Tswana] (Female focus group 1 participant, Jubilee)

Overall, the questioning by police contributed to many participants experiencing feelings of secondary trauma and victimisation, which they attributed to having to recount the precise details of the assault in an unsupportive environment. This stands in direct conflict with the national guidelines for client engagement (Women's Legal Centre 2010). Participants expressed an expectation that their questioning by the police should have been handled in a more sensitive manner. One participant even reported an explicit threat of violence on the part of the police officer opening the case.

*The police in charge of my case was an older male police. He was OK but then he was asking me one question for too long [Participants laugh]. He was telling me that I am not telling the truth and I am lying, and I kept insisting that I am telling the truth. He told me that he wanted to give me a female police officer so that she can beat me so that I can tell the truth ... He told me that he wanted to give me a female police officer who beat people until they tell the truth at the police station [facilitator expressing shock]. But he was OK, just that he asked one question*

*for too long. He was scaring me.* [Participants laughing] (Female focus group 1 participant, Jubilee)

The reported experiences suggest that most participants engaged with police who were poorly trained and sensitised in dealing with rape cases. Although not always explicit, participants appeared to be more dissatisfied with their engagement with police at the station as opposed to with police who came to the care centre or crisis centre. In the South African context, this could highlight differences in the quality of client engagement based on training: police coming to the centre would more likely be from specialised units and / or have been trained and sensitised on investigating rape compared with their counterparts based at the local station. This observation about difference in quality of engagement with police depending on the location of engagement (e.g. centre versus police station) was explored and validated as correct through the session that was arranged to feed back results of the focus group discussion findings.

In addition to high levels of dissatisfaction with the process of opening the case, many participants also criticised the police for poor follow-up and lack of progress with the criminal justice process. Although some participants had empowering stories of accessing justice, this was the minority experience. Most participants in the group discussions expressed frustrations and delays in terms of progress of their case. Police were criticised for not taking the case “*too serious*” or not appearing to “*care if they catch the suspect*” (female focus group 1 participant, Jubilee), as well as not keeping commitments to the victim, for disappearing dockets, and for failing to follow up and / or keep the victim up to date with progress of the case and the onus resting on the victim to drive the process forward. Some participants complained that they were still waiting to open their case as the police had not come back or they were waiting for “*letters*” from the doctor.

*I was disappointed by the police service, because the day I arrive at the centre I spoke to one of the policemen, he even accompanied me to my*

*place, and he told me that he will pick me up the following day so that I can show him where these boys are staying. But he never came till today.* [Responding in SeSotho] *He said to me, “Tomorrow, this time I will come and pick you up to show me where these boys are staying.” But he never came.* [Responding in SeSotho] (Female focus group participant, Mamelodi)

*I remember two days after I had to show the person who is in charge of my case the crime scene and he was just very rude to me, telling me that I am going to drop charges, like he was just very discouraging.* (Female focus group 1 participant, Jubilee)

Most participants were either waiting to finish opening the case or simply waiting for their case to progress through the judicial system. One participant reported satisfaction with her judicial outcome and a bond with the magistrate. In general, participants expressed frustration with the lack of information and understanding about next steps and at how long the process takes. There were no direct references in the focus group discussions to experiences of court preparation activities; indeed, very few participants’ cases had progressed to court. Access to judicial support services and progress of the criminal trail appeared to be a significant gap in service quality for these participants.

*But sometime they refuse to give bail, like the case I was attending the lawyer asked for bail but the magistrate refused, the magistrate who was handling my case was once raped so she knows how it feels to be raped. She gave them 15 years in prison without hesitating.* [Smiling while sharing the story] (Female focus group participant, Mamelodi)

*I could not talk, I just broke down. I have been to court for so many times and I am pissed that they are delaying because by now my case will be finalised but they, like, just dragging me down. So this year I have never been to court at all, so I have been waiting for them to come.* (Female focus group 2 participant, Jubilee)

*The interpersonal relationship between the service provider and the victim was the main driver of satisfaction or dissatisfaction ... participants reported high levels of satisfaction with health workers, whereas they commonly reported extreme levels of dissatisfaction with police.*

## Conclusion

This research helped us better understand the experiences of rape victims accessing governmental post-rape services in Tshwane district, South Africa. The findings highlighted key drivers of satisfaction and dissatisfaction with post-rape service delivery and directly informed the structure and content of the proposed e-governance 'client experience' survey application (app). Focus group participants showed ability and willingness to report positive, negative and often mixed experiences, highlight gaps in services received and propose constructive recommendations to improve service quality. In general, the participants endorsed the importance of the e-governance app's four domains of satisfaction: (1) the rooms and physical environment; (2) the service providers; (3) the package of services provided; and (4) the information and advice received, in terms of driving their own satisfaction and dissatisfaction. However, the interpersonal relationship between the service provider and the victim was the main driver of satisfaction or dissatisfaction. In fact, it was often hard to differentiate satisfaction with the package of services from satisfaction with the service provider, with the latter being the stronger driver of satisfaction.

The focus group discussions also highlighted a significant divergence in terms of satisfaction depending on the service provider; participants reported high levels of satisfaction with health workers, whereas they commonly reported extreme levels of dissatisfaction with police. Conversely, there was very limited discussion and / or reported engagement with "court services", which may reflect limited actual engagement and / or a bias on the part of participants, which would require further investigation. To make the client experience app's feedback more meaningful, we modified its final structure to require the respondent to select the service provider (health staff, police, court

services or "general") prior to rating satisfaction with the four domains and allowing the respondent to participate multiple times to rate multiple service provider categories. We felt this modification would make the client experience rating a more precise metric of satisfaction and would afford a more targeted systems response to drive quality improvement initiatives based on client feedback. It is also important to note that power dynamics and assured anonymity play an important role in potential uptake and validity of client experience responses. Given that rape victims are largely dependent on service providers (police and health staff) to provide whatever services are available, we felt that the app had to safeguard respondent anonymity so that potential critical responses do not trigger increased risk of victimisation. In the interest of more sustainable, systemic responses to quality improvement, as well as increased uptake, we also opted to design the app to place site selection at district level, rather than facility level, in order to mask victim voice in the crowd.

Participants reported many barriers and delays in entry into the specialised Thuthuzela care centres and rape crisis centres. Their experiences may help explain the continued low rate of rape reporting in South Africa. Only one participant reported coming to the centre directly; the vast majority arrived by means of referral from police. Most participants described long waits, frustrations with the delayed process and feelings of extreme physical discomfort at their original entry points (police stations and hospitals). Due to high levels of entry to post-rape services via the police, most participants' first engagement with government service providers was with the police under the auspices of opening a case against the alleged perpetrator(s). The focus group discussions highlighted a common violation of police guidelines, which stipulate that the medical examination takes priority over the



*Power dynamics and assured anonymity play an important role in potential uptake and validity of client experience responses.*

police statement, and that the statement should only be made when the victim is in an appropriate psychological, emotional and physical state to do so (Women's Legal Centre 2010). However, for most participants, the process of opening the case preceded and delayed access to the much-wanted post-rape medical and psychosocial care.

Many participants reported that the process of opening the case was traumatic in and of itself. In general, experience with the police was negative, with many participants citing intimidation, accusations of lying, lack of trust, aggressive questioning tactics, lack of empathy, blaming and judging attitudes, and rudeness as main reasons for dissatisfaction. Furthermore, participants cited lack of follow-up and inadequate communication, lack of progress in the case and / or delays in processing and finalising rape cases as the main reasons for continued dissatisfaction with the police.

Police misconceptions and disregard for the sensitivities surrounding a sexual offences case are not only traumatic for the victim but are also detrimental to the justice process. A police statement is the foundation of any criminal case, yet our focus group participants' stories show engagement with police who, in general, were not sensitive to the fact that the victims may be suffering from trauma, including rape trauma syndrome, which affects a victim's ability to recollect the traumatic event and may impact her recollection over time. Without specialised training, police officers and prosecutors alike may perceive the victim's changing or evolving statement as lying. Recognising that loss of memory connected to a rape (known as psychogenic amnesia) is a symptom of rape trauma syndrome can have a significant impact on how they perceive victims' statements and testimony (Burgess 1983). Findings from this research highlight the urgency of mainstreaming systems to support victims' rapid and supportive referral into specialised post-rape centres like Thuthuzela care centres and rape crisis centres. Rapid referral could minimise secondary trauma and victimisation by limiting victims' exposure to poorly trained and poorly sensitised police, but it would also shift the burden of opening the case to specially trained police officers who support these specialised centres, which would

probably result in better statements and collection of evidence for improved judicial outcomes.

Participants reported high levels of satisfaction with service providers working at the rape crisis centres and Thuthuzela centres. They acknowledged many negative preconceptions about the quality of services to expect at the centres, including finding staff who were blaming, rude and judgmental; however, most participants reported very positive experiences with the health-care and psychosocial staff at the centres. They attributed these positive experiences to the staff who were described as welcoming, friendly, empathetic, caring, patient, non-judgmental and conscientious. Although the centres were difficult to find due to strange naming conventions and lack of signage, participants described the rooms as making them feel safe. Many participants credited the services and support that they received at the centres with assisting in their healing process. Due to the generalised entry via police stations, most participants engaged with poorly sensitised and probably untrained police at the police station before engaging with sensitised and better-trained staff at the centres. The high levels of dissatisfaction with the police at the station prior to arrival at the centre may also account for some of the expressed surprise at the good quality of service by centre staff.

The biggest gap in services and satisfaction at the centres related to: long waiting times and associated feelings of physical discomfort (hunger, dirtiness, exhaustion, pain); inadequate information, either received and / or remembered and retained; and insufficient ongoing counselling. In general, participants expressed a need for expanded access to counselling, either face-to-face and / or by telephone, at the centres and within their communities. Although they appreciated the counselling, medical care and medicines to prevent disease, it is unlikely that the average rape victims know her or his full rights and / or the full package of services and support to which she or he is entitled. This lack of knowledge may explain why the interpersonal relationship with the health staff appears to be the stronger driver of satisfaction. The client experience app pilot corroborated this finding and showed high rates of correlation in terms of level of satisfaction between service

*Reported client satisfaction provides important metrics of service quality, but other monitoring and quality assurance systems should also be implemented to ensure that rape victims receive the full package of services in line with their entitlements.*

provider and services, suggesting that it is difficult for most respondents to differentiate satisfaction between the two domains.

Reported client satisfaction provides important metrics of service quality, but other monitoring and quality assurance systems should also be implemented to ensure that rape victims receive the full package of services in line with their entitlements. A routine 'client experience' rating system may act as an early warning indicator to highlight service providers and service settings that may be deviating from guidelines and thus trigger a more intensive investigation. Based on this research, we believe that the proposed client experience app can serve as an important feedback mechanism to hold government accountable for quality of post-

rape service delivery. Routine tracking and use of the 'client experience' rating metrics may help record and report gaps in service delivery and / or highlight areas of victim dissatisfaction and allow for rapid intervention and responsiveness and / or motivate for additional resources.

Overall, this research and its parallel study (Mahlalela *et al.* 2017) affirmed the ability and willingness of rape victims to provide meaningful and targeted feedback to strengthen government post-rape service delivery and hold service providers to account for their performance. By giving the victims a platform to voice their individual client experience, the app can help drive improvements in overall quality of care, as well as help empower victims by signifying that their voice matters.

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## About Making All Voices Count

Making All Voices Count is a programme working towards a world in which open, effective and participatory governance is the norm and not the exception. It focuses global attention on creative and cutting-edge solutions to transform the relationship between citizens and their governments. The programme is inspired by and supports the goals of the Open Government Partnership.

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## Research, Evidence and Learning component

The programme's Research, Evidence and Learning component, managed by IDS, contributes to improving performance and practice, and builds an evidence base in the field of citizen voice, government responsiveness, transparency and accountability (T&A) and technology for T&A (Tech4T&A).

## About the Foundation for Professional Development

FPD is an indigenous South African organisation established in 1997 by the South African Medical Association and registered with the Department of Higher Education as a private institution of higher education. FPD's vision is to build a better society through education and development. In line with its mission to catalyse social change through developing people, strengthening systems and providing innovative solutions, FPD works across the development spectrum with a focus on HIV / TB, gender-based violence, health systems strengthening, literacy and adult education.

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