


**DELAYED DISCLOSURE OF SEXUAL  
VIOLENCE INCIDENTS AMONG VICTIMS  
IN NEWCASTLE, KWAZULU-NATAL**

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A mini-thesis submitted in partial fulfillment of the requirements for the  
degree of Master in Public Health at the School of Public Health,  
University of the Western Cape  
WESTERN CAPE

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**KEYWORDS**

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Delayed disclosure

Rape

Victims

Sexual assault services

Gender-based violence

Health problem

Sexual rights

Sexual assault

KwaZulu-Natal



## ABSTRACT

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Sexual violence has many negative consequences, making it critical for victims to report promptly for treatment: this would help prevent HIV infection, unwanted pregnancy, and sexually transmitted infections. Prompt notification will also assist the victim in obtaining the necessary psychological support to deal with mental and emotional trauma associated with sexual violence. Sexual violence incidents have always been poorly reported by victims in South Africa. Consequently, to improve the health system response to sexual violence and strengthen sexual assault services in the country, there is need to identify the factors responsible for delay disclosure among sexual violence victims.

The aim of this study was to identify factors associated with reporting incidents of sexual violence after seventy-two hours at the sexual assault service centre in Newcastle, KwaZulu-Natal. This descriptive study was based on retrospective analysis of 534 medical records of victims of sexual violence at the Newcastle hospital between 2005 and 2009. A data collection sheet was designed to extract information from three sources namely: the victims' hospital files, J88 forms and specific hospital forms that were completed for sexual assault victims. The collected data were entered into and processed for analysis using EPI INFO statistical package. Frequencies, means and standard deviations were calculated for the data set. Test of significance was also done using the Chi-square test and presented using odds ratios with 95% CI and p-value of <0.05.

The victims' age range was 2-81years (mean= 18.84,  $\sigma$ =13.25). Approximately 87%

were female and 59.4% of the victims were aged 0-17 years. One in five victims (19.7%) was HIV positive, and most (74.4%) reported rape with vaginal penetration. Fifty-nine percent reported within 72 hours of being assaulted. The most common reason for delayed reporting (21.5%) was fear of the perpetrator. Most of the sexual assaults were committed by male (96%) and single perpetrator (90%). Nearly a third (32.4%) of the sexual violence occurred within intimate relationships and more than two-thirds (68%) knew the perpetrators. In all, 35% sustained injuries during the assault and a third (34.5%) reported the use of weapons during the assault. Nearly half of the victims (48.7%) were referred to hospital by their relatives who also accompanied them to the facility (42.1%). Of the 198 victims that were offered post-exposure prophylaxis (PEP), 87% collected the full 28-day course.

In conclusion, more than 40% of the sexual violence victims in Newcastle reported late at the hospital for medical assistance. Demographic factors associated with this delay were age, race, marital status and religion of the victim. Sexual and Reproductive health risk factors include the form of sexual violence, fear of the perpetrator, history of sexual violence and relationship between the victim and perpetrator. Further attention needs to be focused on educating potential victims on the importance of reporting sexual violence promptly. There is also a need for further research into service related factors that could influence the decision of victims to seek medical care after sexual assault.

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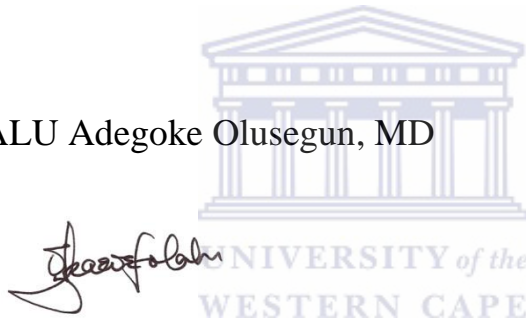
# DECLARATION

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I declare that *Delayed disclosure of sexual violence incidents among victims in Newcastle KwaZulu-Natal* is my own work, that it has not been submitted for any degree or examination in any other university, and that all the sources I have used or quoted have been indicated and acknowledged by complete references.

ADEFOLALU Adegoke Olusegun, MD

September 2010



Signature.....

## ACKNOWLEDGEMENTS

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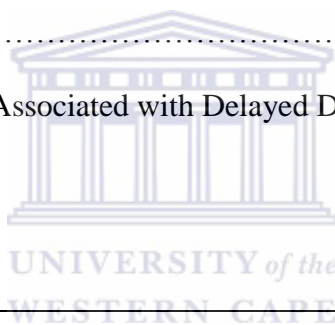
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## LIST OF ABBREVIATIONS

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AIDS - Acquired Immunodeficiency Syndrome  
ARV – Antiretroviral  
ART – Antiretroviral Therapy  
CIAC – Crime Information Analysis Centre  
CIET - *Centro de Investigacion de Enfermedades Tropicales* (Tropical disease research centre)  
DNA – Deoxyribonucleic Acid  
HIV – Human Immunodeficiency Virus  
J88 – Justice Department form number 88  
KZN – Kwazulu-Natal  
KZNDOH – KwaZulu-Natal Department of Health  
NDOH – National Department of Health  
NGOS- Non-Governmental Organizations  
NPH – Newcastle Provincial Hospital  
OCP – Oral Contraceptives  
OR – Odds Ratio  
PATH- Program for Appropriate Technology in Health  
PEP- Post Exposure Prophylaxis  
PTSD- Post Traumatic Stress Disorder  
SADHS - South African Demographic and Health Survey  
SAG – South African Government  
SAPS- South African Police Service  
STATSA- Statistics South Africa  
STIs- Sexually Transmitted Infections  
SOCA - Sexual Offences and Community Affairs Unit  
UK- United Kingdom  
UNHCR – United Nations High Commission for Refugees  
USA- United States of America  
WHO- World Health Organization

## TERMS AND DEFINITIONS

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### **Sexual Violence**

Sexual violence is defined as “any sexual act, attempt to obtain sexual act, unwanted sexual comments or advances or acts to traffic or otherwise directed against a person’s sexuality using coercion, by any person regardless of their relationship to the victim in any setting, including but not limited to home and work” (WHO, 2002:149).

### **Coercion in Sexual Violence**

The coercion used by perpetrator of sexual violence may include physical force, blackmail, psychological intimidation and use of threats in form of physical harm or other unjust punishment. In addition to the definition above, any sexual act obtained from a person who cannot give informed consent is regarded as sexual violence; examples of this are when the victim is drunk, drugged, asleep or mentally incompetent to comprehend the prevailing circumstance (Jewkes, Sen & Garcia-Moreno, 2002).

### **Sexual Assault**

The act of sexual violence is regarded as sexual assault and may take several forms. The “*World Report of Violence and Health*” by the World Health Organization described the following forms of sexual assault: rape within marriage or dating relationships, rape by strangers and systematic rape during armed conflict; unwanted sexual advances or sexual harassment including demanding sex in return for favors;

sexual abuse of mentally or physically disabled people; sexual abuse of children; forced marriage or cohabitation, including the marriage of children; denial of the right to use contraception or to adopt other measures to protect against sexually transmitted diseases; forced abortion; violent acts against the sexual integrity of women including female genital mutilation and obligatory inspections for virginity, and forced prostitution and trafficking of people for the purpose of sexual exploitation (Jewkes, Sen & Garcia-Moreno, 2002).

### **Rape**

This is obviously the most common form of sexual assault; rape is said to have been committed when there is penetration to any extent the genital organs of a person or any object into or beyond the anus or genital organs of another person without the consent of the person being sexually penetrated irrespective of gender. Based on this definition a male can be raped by either a male or female, and a female can be raped by either a male or another female.

### **Victim**

Victim in this study refers to an individual of any age or gender who has suffered an act of sexual violence and who has reported such incidents; it also includes persons whose relatives, guardians or friends reported the sexual violence committed against them on their behalf.

### **Delayed Disclosure**

Delayed disclosure of sexual violence in this study refers to incidents of sexual violence that were reported by the victims, their relatives, friends, police officers or prison officials or any other persons after seventy-two hours of the act being committed against the victim.

### **Sexual Assault Service Centre**

These are facilities specifically designed to serve victims of sexual violence. The services at these centres range from treatment of injuries, provision of prophylaxis against HIV infection, contraceptives for rape victims to prevent unwanted pregnancy, treatment of sexually transmitted infections (STIs), and provision of psycho-social support to the victims to address the psychological and emotional trauma associated with sexual violence. The centres also make provision for the collection of forensic evidence to be used in court for the prosecution of the alleged perpetrator of the sexual violence.

# CHAPTER 1

## INTRODUCTION

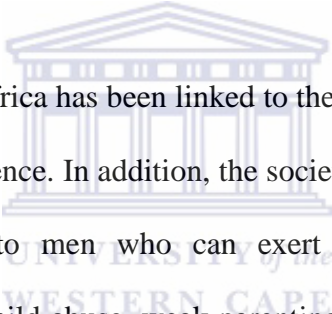
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### 1.1 Background

Sexual violence occurs globally and has been reported across various cultures and among all demographic and socio-economic groups. Although the two sexes are both affected, women are usually the victims and men the perpetrators; in some parts of the world almost one in every five women has suffered at least one incident of sexual violence (WHO, 2003). According to global estimates, approximately 13% of women and 3% of men will report at least one incident of sexual assault in their lifetime (Mein et al, 2003). This degrading act that predominantly affects females has been described as both global human right and public health problem which poses great threat to the health of the victims (WHO, 2003).

Sexual violence includes a range of acts that can take place in various setting and under different circumstances. These acts include, but are not limited to forced sex by intimate partners, sexual rape by strangers or family member, systematic rape during war, sexual abuse of children, child marriage, forced sexual trafficking or prostitution, sexual harassment (including demands for sexual favour in return for assistance), denied right to use contraceptives or to adopt other measures to protect against STI, forced abortion and certain acts directed against female sexual integrity like virginity testing and female genital mutilation (Jewkes, Sikweyiya, Morrell & Dunkle, 2009; Jewkes et al, 2002; WHO, 2002).

Victims of sexual violence develop physical and mental health problems that could manifest immediately or long after the incident. Some of the immediate consequences include physical body injuries and genital injuries (Moszynski, 2004; Slaughter, Brown, Crowley, & Peck, 1997); death as a result of suicide or murder by the perpetrator; or contracting infectious diseases like HIV, STI and hepatitis B (WHO, 2002). Long-term problems include erosion of self-esteem, post-traumatic stress disorder (PTSD), stigmatization and isolation of the victim by the society and family members, which may affect the social well-being of the victim for a very long time (Omaar & de Waal, 1994; WHO, 2002; Moszynski, 2004).



Sexual violence in South Africa has been linked to the long history of oppression and the resulting culture of violence. In addition, the society is patriarchal, where females are regarded as inferior to men who can exert control over their sexuality. Furthermore, exposure to child abuse, weak parenting and weak mechanisms of law enforcement all contribute to the social dynamics that favour the high level of violence in South Africa (Seedat, van Niekerk, Jewkes, Suffla & Ratele, 2009; Jewkes, Penn-Kekana & Rose-Junius, 2005; Armstrong, 1994). The long years of apartheid with state-sponsored violence and armed resistance further supported by unequal gender relations have made certain forms of violence acceptable as a way of life. The constant political persecution of non-white racial groups by apartheid forces led to the development of violent responses by the male gender. In post struggle South Africa with high level of poverty, widespread alcohol abuse, access to firearms, inequality and unemployment, this endemic violence has being sexualized

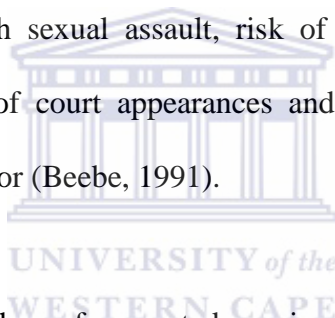
and females and children are now the obvious soft targets (Seedat et al, 2009; Armstrong, 1994).

Sexual violence includes a range of acts as earlier stated above. In South Africa rape with forced vaginal penetration is the most common form of sexual violence reported to the police with more than 50,000 cases reported to the police every year (Statistics South Africa, 2000). Police records show that 54,926 rape cases were reported nationally in 2006, with Gauteng showing the highest number of reported cases at 11,562 (21%), and Northern Cape with the least number of cases at 1,405 (3%) and KwaZulu-Natal with 9,731 (18%) (SAPS, 2007).

Rape in South Africa is estimated at 231 per 100 000 (CIAC, 2006), based on the number of cases reported to the police, but a community-based survey by Jewkes & Abraham (2002) put the rate at 1300 per 100000 women per year. The reason for this sharp difference may be attributed to under reporting of incidents of sexual violence as less than half of the victims of sexual violence are believed to report to the police (Statistics South Africa, 2000). Although police records are ready sources of information on sexual violence, it grossly underestimates sexual violence (Kim, 2000). Available data further reveals that females are five times more likely to be sexually assaulted than their male counterparts (Anderson & Ho-Foster, 2008) and these victims are usually young women aged between 16-25 years (Statistics South Africa, 2000).



Sexual violence has been described as a neglected public health issue which is poorly reported by 10-50% of victims (Malhotra, 2000). Whilst it is generally acknowledged that South African women experience high level of sexual violence, the extent of this crime is grossly underestimated due to non-disclosure (WHO, 2002), and which in turn is often attributed to the fear of not being protected adequately after reporting incidents of sexual violence as the victims fear possible reprisal from their attackers (Baumer, Felson & Messner, 2003). This poor reporting has also been attributed to a number of other reasons, which include social stigma, being considered promiscuous and being blamed for the assault, shame and humiliation associated with sexual assault, risk of losing the respect of society, perceived embarrassment of court appearances and cross-examination during the prosecution of the perpetrator (Beebe, 1991).



Service-related factors such as fragmented service delivery which results in the victim having multiple interactions with service providers, causes delay in accessing services. Negative attitudes of service providers, lack of privacy, and substandard provision of clinical care and trauma counseling are other service-related factors that influence victims' decision in disclosing sexual assault incidents (Kim et al, 2009). These are also the factors that constitute barriers to the utilization of services which could have a link with the poor reporting of incidents.

In a retrospective study in the United State of America with large sample size [n=3220] that was representative of all racial groups, the authors calculated the

length of time taken to disclose a rape incident by victims younger than 18 years at the time of the assault. The study showed that 47% never disclosed up to five years after being sexually assaulted, and 28% of child rape victims among the participants never reported until being interviewed as an adult (Smith, Letourneau, Saunders, Kilpatrick, Resnick & Best, 2000). This result indicates the huge extent of delayed disclosure and non-disclosure among females in the USA; therefore delayed disclosure is not limited to South Africa.

Disclosure of sexual violence can be described as the act of reporting the violence to family members, friends, criminal justice personnel or health professionals. Although there is no standard definition of the length of time that constitutes delayed disclosure in sexual assault, some authors attempted a 3-level categorizations as follows: (a) short-delay disclosers who disclosed within hours of abuse; (b) moderate-delay disclosers who disclosed within days, weeks, or months of abuse and (c) long-delay disclosers who waited one or more years to disclose or never disclosed (Foyne, Freyd & DePrince, 2009).

Delayed disclosure or non-disclosure of sexual violence can have major impact on the victim; a primary concern in South African with high prevalence of HIV is the risk of contracting HIV by the victim that suffered penetrative anal or vagina rape as a result of tearing which further increase the chances of HIV infection. Post-exposure prophylaxis (PEP given to victims within 72 hours of being sexually assaulted is a 28-day course of antiretroviral to prevent HIV transmission. The victim will benefit

maximally if given earlier after the rape. The scientific basis of the PEP is hinged on the fact that shortly after exposure to HIV, the viral load in the body is small enough to be controlled by the immune system. Therefore, antiretroviral drugs used at this stage will terminate the replication of the virus thereby reducing the virus to a manageable target to be handled by the body's immune system (Merchant & Keshavarz, 2001).

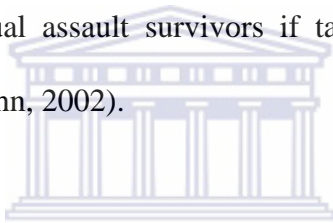
The long-term effects of sexual violence are better addressed as early as possible, this is done in form of psychosocial support, counselling and emotional support. When victims of sexual violence keep the incidents to themselves they are prone to developing mental and psychological problems which could impact negatively on their lives. Research has shown that young people especially males who were victims of sexual violence and were not adequately catered for at the time of the incident often grow up to become perpetrators of sexual violence (Jewkes & Abrahams, 2002; Watkins & Bentovim, 1992).

In light of the aftermath of non-disclosure or delayed disclosure of sexual violence incidents, further studies are needed to determine the time taken by victims to report sexual violence in a different setting and to understand the factors associated with such delays.

## **1.2 Statement of the Research Problem**

The specific problem experienced is the apparent delay among victims of sexual

violence in reporting to the sexual assault service centre in Newcastle. This is not limited to Newcastle; a study in Malawi revealed delayed reporting in 63% of the victims of sexual violence (Chesshyre & Molyneux, 2009). Another study in Durban also reported delays among one third (32%) of the victims of sexual violence who could not be offered PEP because they presented 72 hours after the assault (Collings, Bugwandeen & Wiles, 2008). Time taken to report sexual assault is of essence because there is need to provide certain treatment to the victims in order to prevent infections and unwanted pregnancy. Prophylaxis against HIV and presumptive treatment of STI has been shown to reduce the chances of contracting these infectious diseases in sexual assault survivors if taken shortly after the incident (Delsol, Perez, Rolon & Cahn, 2002).



Delay of disclosure in this study is described as any incident reported more than 72 hours after the act. If the victim presents seventy-two hours after the assault, PEP against HIV infection, the presumptive treatment for STIs and contraceptive against unwanted pregnancy are less effective (KZNDOH, 2009; Merchant, Keshavarz, & Louw, 2004; WHO, 2003). In addition, forensic evidence that could be used in pursuing criminal charges against the perpetrator is best taken from the victims as early as possible, preferably before victims wash or bath themselves (Martin, 2002; Wilken & Welch, 2003). The collection of this forensic evidence within 72 hours assists the police in pursuing criminal charges against the alleged perpetrator (Kucuker, 2008; Martin, 2002).

Despite the health system's efforts to establish sexual assault services in the country and to create ongoing advocacy to educate people on the need to urgently report incidents of sexual assault, many victims still delay or do not report sexual violence incidents in Newcastle area of KwaZulu-Natal province. Anecdotal evidence suggests that approximately 50% of the victims seen at the sexual assault service centre came within 72 hours from the time of assault; this means that the remaining proportion will either delay or not get assistance in the form of prophylaxis, presumptive STIs treatment, psychological support and legal assistance in form of forensic evidence collection.

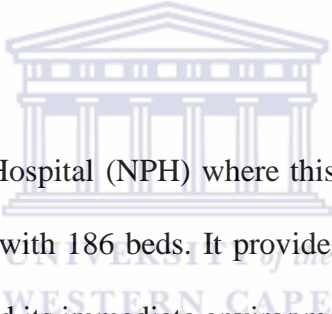
Based on the introduction, the background information given and the description of the problem stated above, the following research questions need to be answered with specific reference to the situation in Newcastle:

1. What is the socio-demographic profile of sexual violence victims seen at the Newcastle sexual assault service centre?
2. What is the profile of the perpetrators of the sexual violence incidents reported to the Newcastle sexual assault service centre?
3. What are the forms of sexual violence reported at the Newcastle sexual assault service centre by the victims and what kind of treatment are given to victims?
4. What proportion of the sexual violence victims presented after 72 hours of being assaulted to the Newcastle sexual assault service centre?

5. What are the factors associated with delay of reporting incidents of sexual violence among victims reporting to the Newcastle sexual assault service centre?

Answers to the above questions are important in establishing the reasons for delayed reporting and disclosure by victims in the Newcastle area, and may inform further research and advocacy. In addition, it will also proffer solutions to identified problems and aid in the development of interventions to improve early disclosure by the victims.

### **1.3 Study Setting**



The Newcastle Provincial Hospital (NPH) where this study was based is a regional hospital in KwaZulu-Natal with 186 beds. It provides sexual assault services to the community of Newcastle and its immediate environment (Newcastle Hospital, 2009). KwaZulu-Natal is on the east coast of South Africa, bordering Mozambique and Swaziland in the north, Mpumalanga and Free State in the west, Eastern Cape in the south and Lesotho in the south west. The province encloses 92 100 km<sup>2</sup>, constituting 7.6% of the total land area of the country, and has an average population density of 100 persons per square kilometre (Statistics South Africa, 2003). During the 1996 Census, 57% of people in KwaZulu-Natal lived in non-urban areas. According to the 2000 estimates, 9 211 922 people lived in KwaZulu-Natal, constituting 20.4% of South Africa's total population (Statistics South Africa, 2003).

The province accommodates slightly more women (52%) than men (48%). Nearly 35% of the population is younger than 15 years, and 61% are in their economically active years (15-64), while 6% are aged 60 years or older (Bradshaw *et al.*, 2004). The province has eleven districts including Amajuba where Newcastle is located.

Newcastle is one of the urban centres in the province and one of three local municipalities that make up Amajuba district. Within the district, Newcastle has a population of approximately 332 978 (71%), followed by Dannhauser with 102 786 (22%) and Utrecht with a population of 32, 276 (7%) (Statistics South Africa, 2003). Consistent growth over the decade has seen Newcastle transform from a rural town to thriving low income industrial and commercial town with a strong agricultural base (Newcastle Hospital, 2009). The Zulu people are the predominant racial group in Newcastle and the culture of patriarchy and polygamy is still practiced in the area. Newcastle hospital was selected for this study because of easy access to the records of victims of sexual violence where this researcher has worked and observed a number of victims who delayed disclosure of sexual violence incidents.

#### **1.4 Purpose of the Study**

The overall aim of this research is to identify the factors associated with delayed reporting of sexual violence incidents among victims seen at the Newcastle Provincial Hospital. The study results will assist in identifying gaps in the sexual assault service at the hospital, and the outcome of the study will be used to develop intervention and further research to improve sexual assault service at the Newcastle

Provincial Hospital.

## **1.5 Chapters outline**

This report is presented in six chapters and outlined as follows:

- Chapter 1 provides the introduction and background to the study, the statement of the research problem, the research questions guiding the study and the objectives. The study setting and the purpose of the study are also discussed in this chapter.
- Chapter 2 includes the literature review on epidemiology of sexual violence globally and in South Africa, the theories of sexual aggression, factors associated with delayed disclosure, the risk factors associated with sexual violence, consequences of sexual violence, state of sexual assault services, and policies and intervention on sexual violence in South Africa. The chapter concludes by highlighting some limitations of previous studies done on sexual violence.
- Chapter 3 covers the methodological approach including aims and objectives of the study, research design, sampling and study population, data collection technique, data management, procedure for data analysis and ethical consideration for the study.
- Chapter 4 describes the results of the study and chapter 5 discusses the results.
- Chapter 6 includes the conclusion of the study and gives recommendation and future directions for research.



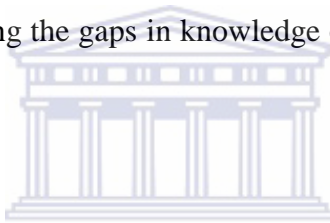
## **CHAPTER 2**

### **LITERATURE REVIEW**

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#### **2.1 Introduction and Purpose of the Literature Review**

Literature reviews provide the foundation on which new knowledge can be based and also provides the reader with background information necessary to understand the topic under discussion. This research followed a quantitative research approach; therefore it has to be done within the context of prior knowledge (Polit, Beck & Hungler 2004). An in-depth review of literature further underscores the importance of a new study by identifying the gaps in knowledge on the topic on which the study is based.

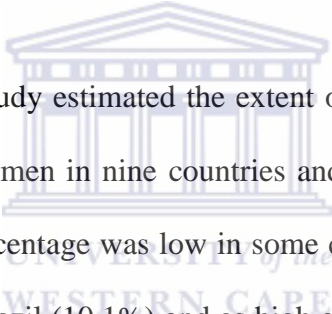


A literature review of relevant journals, books, articles, research reports, policy documents and other information sources was done to establish and to identify available knowledge on sexual violence. The following areas are covered in the literature review: epidemiology of sexual violence, theories explaining causes of sexual aggression, factors associated with delayed disclosure of sexual violence, consequences of sexual violence, risk factors associated with sexual violence, policy and programs of intervention on sexual violence in South Africa and some of the limitation of previous studies done on sexual violence.

#### **2.2 Epidemiology of Sexual Violence**

Prevalence of sexual violence varies among women from place to place.

Retrospective studies in the United States of America estimated a prevalence of 18% while in Canada the prevalence was 39% (Bachman & Saltzman, 1993). A cross-sectional survey conducted among women in the Nordic countries (including Finland, Denmark, Iceland, Sweden, and Norway) reported a prevalence ranging from 17 to 33% (Wijma et al, 2003). The difficulties associated with reporting, disclosing and measuring sexual violence make sexual violence prevalence vary across countries and studies. This was the reason why the World Health Organization conducted a cross-sectional survey in nine countries using one standardized instrument to offer comparisons among the countries (WHO, 2005).



The WHO multi-country study estimated the extent of physical and sexual intimate partner violence against women in nine countries and revealed different prevalence of sexual violence. The percentage was low in some countries, Japan (6.2%), Serbia and Montenegro (6.3%), Brazil (10.1%) and as high as 30.7% in Tanzania, 46.7% in Peru, 49.7% in Bangladesh and 58.6% in Ethiopia (WHO, 2005).

It is difficult to estimate the prevalence of sexual violence in South Africa, but the South African Demographic and Health Survey (SADHS) reported a national prevalence of 7%, with a range of 2% to 12% among provinces (NDOH, 1999). These estimates have been described as gross underestimation by various authors due to underreporting of sexual violence in the country (Jewkes & Abrahams, 2002; Kim et al, 2000). A cross-sectional study using multistage sampling by Jewkes, Penn-Kekana, Levin, Ratsaka & Schriber (1999) among females aged 18-49 years

established the prevalence of rape against women in three provinces in South Africa at 4.5% in the Eastern Cape, 7.2% in Mpumalanga and 4.8% in the Limpopo Province. The authors argue that sexual, emotional and physical abuse are common among these women who were in relationships, and the resultant reproductive morbidity and physical injuries sustained by these women will put extra strain on the already overburdened health resources in South Africa.

It has been estimated that 15% to 30% of females' first sexual intercourse were forced on them (Jewkes, Vundule, Maforah & Joordan, 2001; Jejeebhoy & Bott, 2003; Woods, Maforah & Jewkes, 1998). The situation is not different in South Africa where only 55% of women surveyed in a study reported to have willingly consented to their first sexual intercourse (Hallman, 2004); the remaining 45% were either forced or coerced into having their coitus debut.

Jewkes & Wood (1997) reported in a study among young African women that 60% of the women in the study had engaged in sexual relations against their wishes, and in another study conducted among 400 females in South Africa 17% of them claimed they had experienced at least one incident of rape (Peltzer & Pengpid, 2008). Sexual assault particularly rape is so common in South Africa that advocacy groups have claimed that an incident of rape occurs every 26 seconds (Stuijt, 2009) although no scientific data is available to substantiate this assertion.

In a survey done among 415 men and 127 women in Cape Town, 16% of the men

and 40% of the women indicated they have been victims of sexual violence in the past. In addition, 30% of the women reported they had been forced to have sex by their partners, with 13% having suffered multiple sexual assault incidents (Kalichman et al, 2005).

Sexual violence cuts across all age groups in South Africa (Vetten et al, 2008). An infant could be a victim of rape as the myth of cure for HIV/AIDS by raping a baby is also found among South Africans (Meel, 2003; Meier, 2002; Jewkes, Martin & Penn-Kekana, 2002; Richter, 2003). A female as old as 80 years could also be sexually assaulted. Police report revealed that women older than 17years are usually victims of rape (60.2%), followed by girls aged 12-17years (25.2%) (Statistics South Africa, 2000).



Sexual violence in South Africa is not without physical violence. Police records showed that women are raped with the threat of physical injury often with the use of knives (68.0%) or at gun point (16.5%). Most rape cases reported occurred on Saturdays (23.7%) and almost half of all rapes (47.3%) occurred inside the homes of the victims (Statistics South Africa, 2000). Most of the rapes were committed by people known to the victims (75%) and the rest (24.4%) by strangers.

The fact that these attackers are known may be the reason for non-disclosure of sexual violence. Some communities frequently shield perpetrators from prosecution because of their beliefs about sexual offences as something abominable that should

not be made public (Jewkes et al, 2005). In addition to the cultural beliefs about sexual offences among the people of South Africa, weak laws and policies related to sexual violence, lack of institutional support from police and judicial system often make it possible for the perpetrators to continue with these violent acts without being caught (WHO, 2002).

A recent cross-sectional study describing the prevalence of rape perpetration among men in South Africa revealed that men involved in sexual violence are twice likely to be HIV-positive. Twenty-eight percent of men in this study claimed they had raped a woman or girl before, 23.2% had raped two to three women and 7.7% had raped more than 10 women in their life time. In all, about 10% of the men in the study claimed they were less than 10 years old when they first forced a woman or girl into sex (Jewkes et al, 2009a). In another South African study, 23% of the men revealed they had sexually assaulted women in the past (Kalichman et al, 2005). With 30% of rape cases carried out by multiple perpetrators, the implication is the increased chance of the victim contracting HIV as these men are likely to be HIV positive (Jewkes et al, 2009a).

There are no statistics on sexual assault profiles of victims in Newcastle. In December 2008, the province of KwaZulu-Natal recorded a high incidence of child rape; of the total 437 rape cases reported, an alarming 59% involved children (KZNDOH, 2009). Another survey revealed that 3.8% of school pupils in the province had reported sexual assault incidents in 2008 (Newman, 2008). A study in

South Africa to understand the extent of sexual violence among school children reported that 6 sexual assault cases per 1000 people per year occurred among school boys aged 10-16 years in KwaZulu-Natal. In this study, 7.7% of the male youth respondents claimed they had been forced to have sex at least once in the past year (Anderson, & Ho-Foster, 2008).

This shows the vulnerability of children as they are not spared from this indecent act, and they often fail to disclose sexual assault against them (Smith et al, 2000; London, Bruck, Wright & Ceci, 2007; Paine & Hansen, 2002). The reason for non-disclosure among child victims has been explained by the child sexual abuse accommodation syndrome theory where sexually abused children develop coping mechanisms like secrecy, helplessness, entrapment and accommodation, delayed unconvincing disclosure and retraction (Summit, 1983).

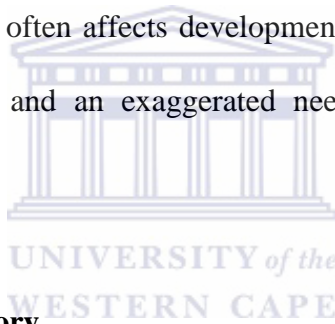
### **2.3 Theories Explaining Causes of Sexual Aggression**

According to Greco & Dawgert (2007:2) “Sexual violence is perpetuated by a rape culture - a system of attitudes, beliefs, messages, inequities, and acts that support sexual aggression and violence.” Theories from different disciplines will be explored to provide a better understanding of the rape culture that supports sexual aggression in humans. Some of these theories are quite relevant in the South African context and are briefly described; factors that are specific to the context of sexual violence in South Africa are also expounded upon.

### **2.3.1 Psychoanalytical theory**

According to Sigmund Freud's (1856-1939) writings that have been described as the foundation of psychoanalytical theory, an abnormal sexual behaviour is as a result of a character disorder that starts as infantile sexual desires and that eventually continues in adulthood. This Freudian theory assumes a predetermined relationship between sex and human behaviour (Lanyon, 1991).

Studies have shown that adverse childhood experience (especially sexual abuse) may result in sexual violence (Malamuth, Linz, Heavy, Barnes & Acker, 1985). For instance, childhood trauma often affects developmental processes which may result in feelings of inadequacy and an exaggerated need to control women sexually (Malamuth et al, 1985).



### **2.3.2 Social Learning Theory**

Social learning theory regards sexual violence as a learned aggressive behaviour towards women. The theory further states that people that strongly subscribe to traditional sex role are likely to behave violently against women. This theory has its origin in the assertion that repeated exposure to any stimulus will lead to positive feelings towards it. Thus men who are exposed to acts of violence towards women soon get used to it and the individual becomes less sensitive to the pain and humiliation that sexual assault inflict on the victims (Abraham & Jewkes, 2005; Ellis, 1989).

Social learning theory states that people model behaviour that they have been exposed to as children, through socialization with parents, relatives or friends either directly or indirectly. This behaviour is then reinforced in adulthood as a stress coping mechanism or in resolving conflict (Bandura, 1973 in Mihalic & Elliot, 1997).

According to Jewkes & Abrahams (2005), approximately 27% of the male respondents in a study who violently assaulted their intimate-relationship partners did so because they had witnessed violence against their mothers in childhood. This buttresses the argument of social cognitive theorists that some of the aggressive behaviour exhibited by certain individuals is learned over a period of time.

### **2.3.3 Attribution Theory**

Attribution theory provides a perspective on how the average person interprets an event based on his motives to find a cause for the event and his knowledge of his environment (Frieze, 1979). The theory is based on the premise that before a person can make a causal judgment he has to perceive the event first, which is followed by a cognitive process of categorizing the perceived information, and then he proceeds to judge and evaluate the event (Frieze, 1979).

Attributions made concerning the cause of rape for example have implication on how other people respond to the victims (Thornton, 1984). The attribution often made by some people that “women are raped because they are women” (Finchilescu,



1991:224) underscores the fact that attribution theory can explain the relentless continuation of sexual assault on women in a society like South Africa. The term rape has become a ‘normal’ and recurrent event that has been accepted as part of life and this may also explain why incidents are poorly reported.

#### **2.3.4 Feminist Theory**

This theory emphasizes the imbalance of power in the society in relation to gender differences as the major cause of sexual violence (Armstrong, 1994). An author proposes that sexual violence against women in South Africa is deeply rooted in the power inequalities related to hierarchical gender relations (Jewkes, 2002).

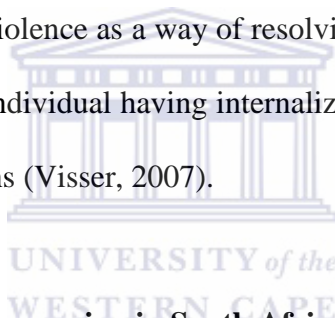
An American author, Mackinnon (1989) argues that we live in a hierarchical society that is based on male power which has been institutionalized by the state and its law; she described the state criminal justice system and its agents (police) as patriarchal. She further states that women’s lives and sexuality are determined by male interest and that male domination and violation of women have been sexualized by men. Feminists argue that sexual violence is a strategy used in asserting dominance and control over women (Armstrong, 1994). They assert that physical and sexual violence are used to manufacture and perpetuate gender hierarchy.

#### **2.3.5 Ecological Theory**

Ecological theory implies that a person’s behaviour can be understood in the context in which it occurs, which may be as a result of interaction between the person and his

environment. In other words, the setting (context) influences the individual, and context could include the immediate context like school, peer, family and workplace as well as the physical, cultural, social, economic and political environment around the individual (Dalton, Elias & Wandersman, 2007).

Research has shown that social relationship with peers, family and intimate partners may increase the chances of a person committing sexual violence. For example a person is likely to engage in negative sexual behaviour if such activity is encouraged and approved by his peers (WHO, 2002). At the community level, societal factors such as norms supporting violence as a way of resolving conflicts may lead to sexual violence on the part of an individual having internalize the concept of using violence means to deal with situations (Visser, 2007).



### **2.3.6 Theories of Sexual Aggression in South Africa Context**

The above theories are quite relevant to the South African context. The social learning theory may explain why violent behaviour has been entrenched in the South African society where the level of violent crime is unprecedented and people are exposed to this violence each day, which may affect them psychologically (Seedat et al, 2009).

The unique historical past of the country has resulted in various social vices that the populace has to live with; studies have linked the horrendous past with the high level of violent crimes including sexual violence. Poverty, unemployment, inequality and

weakness in the criminal justice system are some of the social dynamics fueling violence in South Africa that were described by some authors recently. These are as a result of the injustice of the almost 50 years of apartheid in South Africa (Seedat et al, 2009). The South African culture in which men believe that they are sexually entitled to women stemmed from massive gender inequalities that exist in the country, according to a reporter quoting the words of Prof. Rachel Jewkes in a BBC report of April 2002: “society with less gender inequalities do not witness rape at the rate at which they happen in South Africa” (Dempster, 2002).

The ecological theory of sexual violence aggression can be used to best describe the situation in some part of the country where gang rape is used as part of initiation by men (Mokwena, 1991). The gang rape is a group activity and since it is a behaviour that is seen as a norm and encouraged by the members, the men may not see anything wrong with this kind of behaviour.

The study by Woods & Jewkes (1998) in rural South Africa may also correlate well with the feminist theory of sexual aggression where it was revealed that young men often take pride in having forceful sexual relations with women, which according to them serves as a proof of their masculinity. In other instances, rape is used by men to ‘punish and correct’ lesbians and an infant might be raped just to punish the child’s mother. Sexual violence like rape is also used to punish women for infidelity or any behaviour that is regarded to be disrespectful to men in South Africa (Seedat et al, 2009).

Victim blaming is very common in South Africa. Victims are frequently blamed for causing the incidents and the criminal justice system is often slow in convicting the perpetrators, which may cause the perpetrators to see sexual violence as a non-serious crime. Thus, according to the social learning theory, perpetrators may believe that sexual violence is a petty crime that the society does not regard seriously and they will continue to perpetrate the crime as long as they wish until they are apprehended.

## **2.4 Risk Factors Associated With Sexual Violence**

Some factors have been identified which can predict the chances of sexual violence taking place. These are factors that (a) increase the risk of an individual being coerced into sex; (b) increase the risk of someone forcing sexual relations on another person; and (c) exist within the social environment and influence the likelihood of sexual violence. These factors have additive effects, and the chances of sexual violence are higher if the factors are overwhelmingly present at any given period (WHO, 2002).

### **2.4.1 Involvement in Intimate Relationship**

Being married or having a partner is a potential risk factor for sexual violence (Henttonen, Watts, Roberts, Kaducu & Borchert, 2008; Abrahams, Jewkes, Hoffman & Laubsher, 2004; WHO, 2002; Jewkes et al, 1999). Having multiple sexual partners can also increase the risk of sexual violence since the individual is exposed to many potential perpetrators (WHO, 2002). The assertion that intimate partner relationship

is a potential risk factor for sexual violence among women may not be without reason as various surveys to determine extent of sexual violence among women in relationships showed that 20-25% women had experienced sexual violence in United State of America (Testa, VanZile & Livingston, 2007; Tjaden & Thoennes, 2001), and about 15% women in England had had similar experiences (Coid *et al.*, 2003). The WHO multi-country study also revealed that intimate partners who have highly controlling behaviours are likely to be sexually violent (WHO, 2005).

In a survey among South African young females in relationships, 28% reported they were forced to have sex by their male partners against their will while in intimate relationships (Ritcher, 1996 in Wood, Maforah & Jewkes, 1996). Sexual violence in intimate partner relationship is often interpreted as overwhelming affection by women in South Africa and some women continue to endure such violence without regarding it as a form of abuse (Jewkes et al, 2006). This reflects the societal norms supportive of the long entrenched gender inequalities where males are perceived across most cultural settings as superior and can control females in all areas of their life including their sexuality (Anderson et al, 2004).

#### **2.4.2 History of Previous Sexual Abuse**

A history of sexual abuse has been linked with sexual victimization in adulthood. Young boys who were victims of sexual abuse are at increased risk of becoming perpetrators of sexual violence in adulthood (Watkins & Bentovim, 1992). In the USA, a study found that females who were raped before the age of 18 years were

twice likely to be raped as adults compared to those who never experienced rape (Tjaden & Thoennes, 2000). There is also likelihood of reoccurrence of sexual assault in women who have been victims previously; 24% of participants in a London study claimed to have been victims of sexual violence on more than one occasions (Coid *et al.*, 2003).

In a study done in Soweto, South Africa, approximately 22% of women reported multiple incidents of sexual violence against them in the past. The authors also revealed that there is increased risk of sexual violence among women who had been victims previously (Dunkle, Jewkes, Brown, McIntyre, Gray & Harlow, 2003).

### **2.4.3 Age of an individual**

Age may be a risk factor in sexual violence as young women are found to be at higher risk than older women. Sexual violence takes place in schools and trafficking of women for sexual exploitation are mostly seen in young women (WHO, 2002), although financial problems may be a reason for this activity in some cases. The myth that sexual intercourse with young virgins or infants will rid one of infectious diseases like HIV and STIs may have contributed to the surge in child sexual assault cases in South Africa (Meel, 2003; Meier, 2002; Richter, 2003). The assumption that young females are likely to be free of HIV infection could be another reason for them becoming targets of sexual assault perpetrators in South Africa where 40% of rape and attempted rape survivors in 2000 were said to be under the age of 18 years (CIAC, 2000).

#### **2.4.4 Alcohol Consumption or Illicit Drugs Use**

Settings where illicit drugs are used may be potentially dangerous for victims of sexual violence. It is both a risk factor for perpetrating and being victim of sexual violence (Jewkes & Abrahams, 2002). Alcohol consumption has also been found to be a risk factor for sexual violence in non-intimate perpetrators; this means that perpetrators who are not well acquainted with the victims are more likely to use intoxication tactics than intimate partners (Testa, VanZile & Livingston, 2007). In a study conducted by Jewkes et al (2006) among young men in rural South Africa, the authors found that gang rape was associated with heavy alcohol consumption and illicit drug use.



#### **2.4.5 Socio-Economic Status**

Sexual violence occurs across all socio-economic levels but higher levels have been reported among women with little or no education and among the unemployed (Weiss, Patel, West, Peeling, Kirkwood & Mabey, 2008; Greco & Dawgert, 2007). Poverty and unemployment are factors that make women and young girls vulnerable to sexual violence through exploitation, trafficking and engaging in commercial sex work (WHO, 2003). Poverty could also influence reporting of sexual violence because victims who are dependent on the perpetrator for economic survival are less likely to report, and simultaneously unable to control their sexual safety (Greco & Dawgert, 2007). The socio-economic status of an individual could therefore be a predictor of being a victim of sexual violence especially the vulnerable people in the society.

#### **2.4.6 Societal Norms Supportive of Sexual Violence**

Societal norms supportive of male superiority and sexual entitlement, weak laws and policies related to sexual violence and, gender equality, and high levels of crime and other forms of violence are societal factors that increase men's chances of committing sexual violence (WHO, 2002). In addition, general tolerance of sexual assault within the community; weak community sanctions against perpetrators of sexual violence; individual associations with sexually aggressive and delinquent peers; family environment characterized by physical violence; strongly patriarchal and emotionally unsupportive family environments are all societal factors that may perpetuate sexual violence within the community (WHO, 2002).

#### **2.5 Consequences of Sexual Violence**

Consequences of sexual violence include immediate physical injuries which are genital trauma (Lessing, 2005; Wiebe, Comay, McGregor & Ducceschi, 2000), depression, substance abuse, alcoholism and PTSD, low self esteem, interpersonal difficulties such as aggression, lack of trust and excessive sexual activity (WHO, 2002; Schafran, 1996; Lončar, Medved, Jovanović & Hotujac, 2006). These consequences impact negatively on both physical and mental health of the victims resulting in inability to cope with daily activities and failure to maintain stable relationships long after the incident (WHO, 2002).

Some of these psychological impacts are further aggravated for survivors of rape during war. These manifest as feelings of inferiority, loss of dignity, social isolation



and stigma (Mukamana & Brysiewicz, 2008; Moszynski, 2004; Jewkes, 2007; Wakabi, 2008).

In a survey of 1240 Sudanese refugees in Uganda, 8.4% developed PTSD due to sexual assault, while 33.4% developed PTSD by just witnessing people being sexually assaulted (Karunakara et al, 2004). A rape-related pregnancy rate of 5% has been reported (Holmes, Resnick, Kilpatrick & Best, 1996); this percentage may increase in war situation as in the case of the Rwandan war where approximately 5000 children were reportedly born as a result of rape (UNHCR, 1997). Research has shown that the country is finding it difficult to integrate these children into the Rwandan society (Wakabi, 2008).

As sexually violent men are twice as likely to be HIV-positive, the risk of HIV acquisition by the victims of sexual violence is further increased (Jewkes et al, 2009). Intimate partner violence also increases the risk of HIV acquisition through forced sex because the ability of the woman to negotiate safer sexual practice like condom use is often limited in such a relationship (Kaye, 2004). A cross-sectional study in KwaZulu-Natal and Botswana examining the effect of gender on the ability of women to negotiate safe sex revealed that men who have multiple sexual partners are more likely to refuse condoms (Langen, 2005) thereby putting their partners at risk of contracting STIs and HIV infection.

## **2.6 Factors Associated With Disclosure in Sexual Violence**

Victims of sexual violence often fail to disclose the incidents promptly and some may never disclose. The reasons for this depend on certain circumstances and may not be generalized to the entire population. Some factors have been identified as predictors for late disclosure by researchers, and this includes younger women who experience sexual violence, close relationship with the perpetrators, and being a victim of repeated sexual assault (Smith et al, 2000). Reports in South Africa also reveal that in certain cases of unreported incidents of sexual violence the perpetrators were known to the victims which may be the reason for the non-disclosure of the incidents (Statistics South Africa, 2000).

Sexual violence is less likely to be reported if the perpetrator is an intimate partner, as some victims believe any act of sexual violence like forced vaginal sex against them by their partners cannot be described as rape, and instead, this is often referred to as forced sex and the term rape is reserved for sexual violence by strangers or former partners (Bugu, Amoko & Ncayiyana, 1996; Woods, Maforah & Jewkes, 1998).

Barriers to reporting incidents of sexual violence identified in various studies includes poor access to the police by the victims, fear of retaliation from the perpetrator, fear of not being believed, fear of ruined reputation if the incident is known, fear that confidentiality will not be respected by the health workers at health facilities, poor treatment by the personnel in the criminal justice system, and anticipation that the reporting will not result in conviction of the perpetrators

(Christofides et al, 2003; Artz, 1999 in Kim, 2000; CIET, 1998; Kim, 2000).

Furthermore, the uncaring and unsympathetic attitude of the health personnel, lack of privacy at the service centres and the fragmented service delivery resulting in victims having to revisit the centre several times are part of the reasons that might inform the decision of victims to disclose (Kim et al, 2009). Others victims may not wish to acknowledge the unwanted sexual encounter as sexual assault and therefore prefer to keep it to themselves (Moscarello, 1990).

Reasons for delay appear to be different for men. The stigma associated with one's sexual orientation appear to be the primary reason for men in the UK failing to report incidents of sexual violence as many fear being labeled as homosexual (Kaufman, Divasto & Jackson, 1980). Another reason may be the fear of not fulfilling the society's concept of a 'real man' if a male comes forward to report sexual violence in a male domineering society (Geist, 1988).

In South Africa, available data supports the fact that reporting a perpetrator to the police will often not lead to the perpetrator being prosecuted or punished. This is evidenced in the low conviction rate of sexual offender and the slow pace of prosecution (Jewkes, Christofides, Vetten, Jina, Sigsworth & Loots, 2009; Walker & Louw, 2005). Police records show that of the 45% reported cases of sexual violence taken to courts in 2000, only 16.5% of prosecutions resulted in guilty verdict. This translates to 1 in 13 chances of getting conviction from reported cases of sexual

assault (CIAC, 2001 in Christofides et al, 2003). In Gauteng, only 4.1% of rape cases reported to the police resulted in convictions (Vetten et al, 2008). Poor record keeping by the police, inappropriate conclusions by health professionals who examine the victims and lack of consultation with victims during the investigation process are some of the factors associated with low conviction rates (Vetten et al, 2008).

## **2.7 The State of Sexual Assault Services in South Africa**

As stated above, sexual violence has significant consequences on the total well being of victims; therefore support for the victims must comprehensively address all the negative impacts of the incident. The criminal justice system in South Africa plays a critical role in response to sexual violence in the country. According to Jewkes & Abrahams (2002) the performance of this sector in responding to sexual violence may be used as a yardstick to determine the seriousness of this inhuman act. Various studies have found the support given to victims of sexual violence by the criminal justice system in South Africa as inadequate (CIET, 1998; Vetten et al, 2008; Kim, 2000; Christofides et al, 2003). Therefore, attempts have been made to find an ideal model that will serve the victims efficiently in the peculiar situation in South Africa (Kim et al, 2009; Christofides, Muirhead, Jewkes, Penn-Kekana & Conco, 2005).

Convictions in sexual violence often revolve around the forensic evidence collected from the victims. District surgeons were previously used to gather medical evidence but poor attitude, sub-standard services and poor evidence collection led to the

abolition of the use of district surgeons (Jewkes & Abrahams, 2002). Medical officers within health facilities are currently used but the lack of expertise on the part of most of these doctors usually lead to poor evidence collection and inappropriate conclusions which subsequently affect court proceedings and conviction of perpetrators (Martin, 2002; Vetten et al, 2008; Jewkes et al, 2009b).

Christofides et al (2003) report gross inadequacies in the provision of sexual assault services in all the provinces in South Africa. Some of the shortcomings include long waiting time, no standardized protocols for use, poor attitude of health care workers and lack of adequate training for the responsible health professionals. The study recommended correcting all the above and advocate for proper supervision of sexual assault services to ensure consistency and to help the managers to identify gaps and how to address them. In addition, the need for intersectoral collaboration with the police and non-governmental organizations (NGOs) to ensure smooth delivery of sexual assault services in South Africa was highlighted (Christofides et al, 2003).

A survey describing the experiences of women and their preferences for services after sexual assault in rural and urban settings in South Africa showed that availability of PEP against HIV, and having sympathetic and caring service providers are factors that influenced the decision of sexual assault victims to seek medical assistance (Christofides et al, 2005). The study revealed that victims are prepared to travel to distant clinics to access sexual assault services provided there is PEP and the health providers are sympathetic. The importance of this finding is that

factors that are associated with delayed disclosure of sexual violence are not limited to the known ones like fear, guilt, lack of faith in criminal justice and the issue of cultural beliefs. The type of services offered at the sexual assault centres and the attitude of the staff may predict their use and subsequently early disclosure by victims.

## **2.8 South Africa Sexual Assault Policy**

The sexual violence policy in South Africa has evolved over the years and was informed by the need to provide holistic care to victims of sexual violence. The policy particularly aims to prevent HIV transmission in a country with a high prevalence of HIV (11%) (Shisana et al, 2009), considering that most sexual assault perpetrators especially those that commit rape with vagina penetration are likely to be men who are HIV positive (Jewkes et al, 2009a).

In 2000, the South African government (SAG) established an interdepartmental management team to work on rape, and this resulted in the introduction of the sexual assault evidence collection kit, a marked improvement in the J88 form on which medical examination findings are recorded, the introduction of DNA testing and the authority for forensic nurses to collect forensic evidence and serve as witnesses in court (Seedat et al, 2009).

By 2005, the National Sexual Assault Policy and Clinical Management Guidelines were released. These changed the model of sexual assault services to one that is rendered by trained service providers in health facilities (NDOH, 2004; Seedat et al,

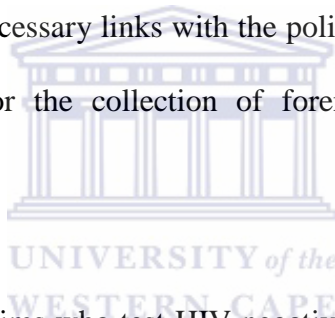
2009). These national guidelines are in line with international protocols such as the WHO guidelines and address the needs of victims in a holistic manner (WHO, 2003). They are currently implemented in the country including KwaZulu-Natal province.

There have been recent improvements in the policy relating to sexual violence in South Africa with the Sexual Offences and Related Matters Act that was promulgated in 2007 (South African Government, 2007). The amendment to the definition of rape in this law provides a broader definition which includes all forms of sexual penetration with any object, of vagina, oral or anal orifices without consent, and applies to all irrespective of gender, and further regards all forms of sexual violence without consent as sexual assault. Based on this law a male can be raped by either a male or female, and a female can be raped by a male or another female (South African Government, 2007; Lawrence & Van Rensburg, 2006). In addition, the new definition emphasizes the sexual nature of rape as well as the violent aspect which was not adequately defined in the previous legislation (Ross, 1993; South African Government, 2007).

Since 2002 the policy for the provision of PEP against HIV to sexual assault victims as approved by the government has been used in all facilities that provide sexual assault services (Jewkes & Abrahams, 2002; Collings et al, 2008; Killian, Suliman, Fakier & Seedat, 2007). The Sexual Offences Act of 2007 also made provision for the victim to be offered PEP and the alleged perpetrator to be tested for HIV, in cases

where there is resistance from the perpetrator; a court order is issued to make the perpetrator comply to have an HIV test (South African Government, 2007).

In accordance with the guidelines, all victims are to be counseled, treated for any injury, offered prophylaxis against HIV, given contraception and treated for STI especially in cases of vaginal and anal penetration (NDOH, 2004). Victims no longer have to report at the police station before being offered PEP as previously required. The new Sexual Act makes provision for victims to report at sexual assault centres where the healthcare personnel will attend to their needs holistically and also has the responsibility of making necessary links with the police to obtain statement from the victim and provide kit for the collection of forensic evidence (South African Government, 2007).



Following counselling, victims who test HIV negative and reported within 72 hours are offered dual therapy ARV prophylaxis consisting of zidovudine and lamivudine. A third drug may be added to this regimen if the victim's risk of contracting HIV is considered very high (NDOH, 2004). The medication is a 28-day course that is required to be completed for maximum benefit. Studies have shown poor adherence to PEP in South Africa among victims of sexual violence (Abrahams & Jewkes, 2010; Kim et al, 2009; Collings et al, 2008; Carries et al, 2007; Killian et al, 2007). Some of the reasons given for the poor adherence include lack of psychosocial support and stigma (Abrahams & Jewkes, 2010).



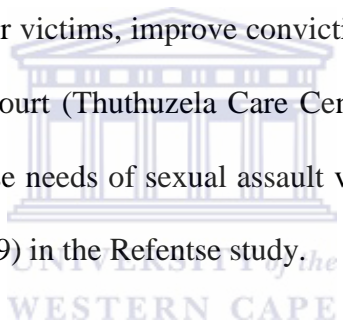
History of the incident is taken from the victim or relatives, and a physical examination is done with special attention given to the genitalia, anus, mouth, neck, breasts, inner thighs, buttocks and shoulder blades to assess the patient for physical injuries and to collect evidence for forensic evaluation and possible legal proceedings. Findings are documented in the J88 form and a rape kit guides the clinician through the collection of forensic evidence. The evidence is given to the police who preserved it to be used in the prosecution of the perpetrator (NDOH, 2004; KZNDOH, 2009).

The guidelines also make provision for the service provider to give follow-up appointments to the victim for ongoing counselling, psychosocial support, review of blood test, repeat of HIV test for those who were given ARV prophylaxis in 6 week, 3 months and at 6 month to ensure that the victim did not seroconvert within the period, and to ensure that the victim is further linked with the criminal justice personnel in prosecution of the perpetrator (NDOH, 2004).

Despite having a national guidelines for management of sexual violence, the Refentse study by Kim et al (2009), discovered that there are lack of standardized protocols for management of sexual violence victims at service centres, inadequate training of service providers, poor collection of forensic evidence, lack of counselling about drug treatment and unsympathetic attitude of the service providers. These problems the authors assert, constitute the greatest barriers to the provision of timely services to the victims of sexual violence. The study concludes by proposing a

model for the management of sexual violence victims. This consists of a one-stop multidisciplinary approach that includes police, forensic, social, psychological and legal support services (Kim et al, 2009).

The establishment of the Thuthuzela Care Centres by the National Prosecution Authority's Sexual Offences and Community Affairs Unit is an attempt to improve the response of the criminal justice system to sexual violence. Thuthuzela is a Xhosa word that means comfort; the centres are one-stop facilities that provide services to victims in one location rather than shuttle victims around. This strategy aims to reduce secondary trauma for victims, improve conviction rates and decrease the time taken to finalize cases in court (Thuthuzela Care Centre, 2010). This innovation is expected to meet the diverse needs of sexual assault victims as it follows the model proposed by Kim et al (2009) in the Refentse study.



## **2.9 Limitation of previous studies**

Sexual violence is a very sensitive topic for research; therefore most of the data used in sexual violence are derived from information from police records, medico-legal clinics, NGOS and surveys (WHO, 2002). The information available from these sources tends to show the serious forms of sexual violence as most subtle incidents are not reported. Therefore, the reported cases only represent a small fraction of the actual number as most victims do not report for various reasons ranging from fear, shame and stigma to ignorance (Henttonen et al, 2008; WHO, 2002).

The fact that most cases of sexual violence are not reported has resulted in sampling

bias in most of the studies on this topic due to the fact that only cases with severe physical and psychological consequences are reported. Most studies are conducted in clinical settings (Onoge, et al, 2005; Coid et al, 2003; Meel, 2005; Christofides et al, 2005; Kucuker, 2008), which exclude victims who do not report at health facilities. The conclusions reached in most of these studies support existing evidence on the extent of sexual violence globally, but are limited to people who sought medical treatment or who reported at the police station. For reasons that have been described earlier, victims of sexual violence may not seek medical attention or report to police; therefore such people are usually systematically excluded from most of these studies.

One of the few studies on sexual violence among men is a retrospective record study done in the United Kingdom where the authors tried to reduce the effect of sampling bias through the inclusion of victims from several settings (Hillman, O'Mara, Taylor-Robinson & Harris, 1990). The weakness of the methodology is that the reviewed records contained information volunteered by the victims and documented by counsellors. This kind of data is subject to information bias and could result in over reporting of incidents by some victims in certain instances.

Most of the research papers are limited to sexual violence against women, and the research manual published by WHO and PATH is intended for researching violence against women, (Ellsberg & Heise, 2005). There is need to increase research in sexual violence involving men, the bias towards women in researching sexual violence stems from the fact that most victims of sexual violence are women, but in

reality, men are also affected as approximately 3% of men will report incident of sexual assault in their lifetime (Mein *et al.*, 2003). The current study includes both sexes.

Finally, studies have been conducted in South Africa investigating reasons for victims' failure to report sexual violence incidents to the police and at health facilities (CIET, 1998; Chritofides et al, 2003; Walker & Louw, 2005; Artz, 1999 in Kim, 2000). Some of the reasons have been described earlier in this write-up. The research done by Chritofides et al (2005) and the interventional study conducted by Kim et al (2009) revealed that some factors that have to do with the services rendered at sexual assault centres might be predictors of utilization of sexual assault service centres in South Africa and could have a link to disclosure and reporting of sexual violence in the country. This revelation indicates that there is need for more research on determinants of sexual assault services utilization among victims of sexual violence, which may help in better understanding of reasons for late disclosure among victims of sexual violence in South Africa and how to develop intervention to improve early reporting.

## **CHAPTER 3**

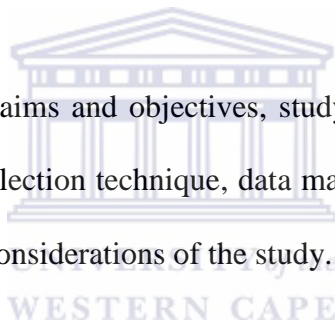
### **RESEARCH DESIGN AND METHODOLOGY**

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#### **3.1 Introduction**

The previous chapter dealt with the literature review of sexual violence and the delayed disclosure among sexual violence victims. This chapter presents the methodology used for the study. According to Burns & Grove (1995), the methodology used in a study influences the research process and defines its strategy from the beginning to data collection and data analysis.

This chapter describes the aims and objectives, study design, study population and sampling methods, data collection technique, data management, data processing and analysis, rigor and ethical considerations of the study.



#### **3.2 Aim and Objectives**

The overall aim of the study was to identify factors contributing to delay in reporting sexual violence incidents by victims in Newcastle.

The objectives of the study were to:

Describe the socio-demographic characteristics of sexual violence victims and perpetrators from cases reported to the Newcastle Provincial Hospital.

Describe the forms of sexual violence incidents reported by victims to the Newcastle Provincial Hospital.

Identify factors associated with delay in reporting sexual violence to the Newcastle Provincial Hospital sexual assault service centre.

### **3.3 Study Design**

This was a descriptive study based on a retrospective record review of hospital records of sexual violence cases presented between 2005 and 2009 at the sexual assault service centre of the Newcastle Provincial Hospital. The study tested for any association between delayed reporting of sexual violence incidents and variables like age, sex, form of sexual assault, marital status, employment status, previous history of sexual violence and type of perpetrator.

### **3.4 Study Population and Sampling Method**

The sexual assault centre operates a 24-hour service, which is separate from the casualty unit, and has its own staff, although the medical officer at casualty unit is responsible for the centre and is required to examine victims and take forensic evidence. All victims seen at the Casualty ward and out-patient department are also referred to the sexual assault centre. The health personnel at the centre (apart from the medical officer) include two professional nurses who have undergone training in forensic medicine and two social workers. The treatment comprises PEP against HIV, contraception, antibiotics for STIs and psycho-social support. Due to staff shortages the only psychologist in the hospital does not work after hours and only consults clients between 8.00am and 4.00pm. Victims who come to the hospital at night are counselled by the nurses and subsequently referred to the psychologist the

following day.

Victims with extensive injury are usually admitted into the hospital wards for treatment. In child sexual abuse cases the social workers normally assess the household conditions of the child and determine whether it is safe for the child to return to the house where the alleged abuse took place.

Those that test HIV negative and report to the hospital within 72 hours after the assault are given a starter pack of ARVs that lasts for 3 days and asked to come back to collect the full 28-day course, the essence of this short appointment is to allow for adequate counseling of the victims. They are subsequently given 1, 2 and 3 week appointments for ongoing counselling and follow-up, and a repeat HIV test is done for them at 6 week, 3 month and at 6 month intervals according to the NDOH guidelines.

The study population included all the sexual assault victims that were seen at the hospital between years 2005 and 2009. A total of 568 people reported cases of sexual violence to the hospital during the 5 years under review, including those who reported more than one incident (Medical Records Department, Newcastle Hospital, 2010). The inclusion criteria for sample selection were all ages, gender and those with available records (either complete or partial). Thirty-four of the victims' records were completely missing and could not be accounted for although their names appeared on the hospital register as victims who reported cases of sexual violence at

the hospital. Five hundred and thirty-four records of victims were finally retained to be used as study sample.

### **3.5 Data Collection Method**

A data collection tool (Appendix I) was designed based on the objectives of the study as a quantitative instrument to abstract information from the victims' hospital records. This tool was earlier tested by using it to abstract information from twenty randomly sampled hospital records of victims at the sexual assault centre. It was subsequently adjusted, tested again and later finalized before the actual data collection started. The cases to be reviewed were identified from the hospital registers where names of victims that reported sexual violence incidents were recorded. Their medical records were then retrieved at the Medical Records section of the hospital and the data of interest abstracted into the data collection tool by the researcher. One data collection tool was used for each of the 534 victims whose medical records were retrieved.

Data was extracted from three sources for each victim, including (a) Newcastle Provincial Hospital crisis centre assessment tool sheets (Appendix II), which are specific hospital forms completed for only sexual assault victims by the forensic nurse, (b) the legal form *J88* (Appendix III) and (c) victims' outpatient files (Appendix IV) on which the medical officers document all their findings. All the three records contain socio-demographic information of the victims. The J88 forms deal extensively with victim's injuries and perpetrator characteristics. The outpatient



files document the history of the sexual violence, the time the assault was committed and the time it was reported at the hospital, the reason given for the delay in reporting at the hospital and the circumstances within which the sexual violence occurred, the type of treatment given to the victims, and the subsequent visits of the victims to the hospital for follow-up and counselling.

The researcher extracted data on variables like the socio-demographic data of the victims, relevant information on the sexual violence (time of assault and form of sexual assault, circumstances that led to the assault, mode of referral to crisis centre, time assault was reported in hospital), relevant information on perpetrator and victims, reason for delayed reporting, treatment given to the victims and the follow up visits done by the victim from the medical records. The items on the data collection tool were ticked against the responses from the victims' records by the researcher for each case.

### **3.6 Data Management**

Each of the data collection tools were checked twice by the researcher to ensure that they were entered correctly against the right person and that the data collection tool corresponded with the unique serial number that was allocated to each of the 534 victims. All the extracted data from the tools were entered into the Excel spreadsheet by the researcher using double entry method, checked for errors, cleaned and then exported into the EPI INFO programme for processing and analysis.

### 3.7 Rigour

All 534 medical records of the victims were used and formed the sample size of the study. Cross validation of the hospital medical records was done for each victim by comparing information in the Newcastle Provincial Hospital crisis centre assessment tool sheets (Appendix II), the legal forms *J88* (Appendix III) and victims' outpatient files (Appendix IV) to ensure validity of all the recorded variables. After data extraction, each data collection tool was scrutinized twice by the researcher before the data was eventually captured into Excel spreadsheet using double entry method. The data that differed during double entry were cross-checked against the three sources where the data were abstracted.

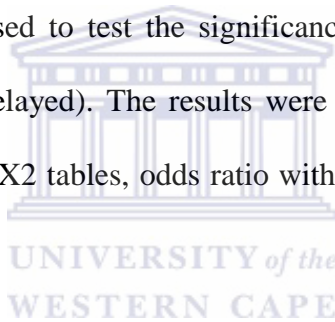
### 3.8 Data Analysis

EPI INFO programme was used to process the data for analysis. Delayed disclosure is the variable that the researcher believes would be influenced by changes in other variables; therefore it was depicted as the dependent variable, and the other variables referred to as independent variables.

Means and standard deviations of the age were determined. Frequencies were run for the **dependent variable** (Delayed) which means reporting to the hospital after 72 hours of sexual violence and **independent variables** (age group, sex, race, marital status, residential address, smoking, alcohol use, religion, employment status, interval between assault and time reported in hospital, forms of sexual assault, reasons for delay, type of injury sustained by victims, circumstances that led to

sexual assault, condition of victims clothing, previous history of sexual assault, number of victim's consensual partners, history of contraceptive use by victim, medical condition, psychological state of victims, mode of referral to hospital, people accompanying victims to hospital, HIV status of victim, modality of treatment given and proportion of victims that returned to collect full PEP, relationship between victim and perpetrator, sex of perpetrators, whether condom was used by perpetrators and whether victims was assaulted with the use of weapons and the number of perpetrators).

The chi-square test was used to test the significance of some of the independent variables with outcome (delayed). The results were presented as frequency tables, bar charts, pie charts and 2X2 tables, odds ratio with 95% confidence intervals (CI) and p-value of <0.05.



### **3.9 Ethical Considerations**

Strict confidentiality and anonymity was observed as the author personally captured the data and had sole access to the collected data. For privacy reasons, the records were kept under lock and key and were not taken outside the hospital throughout the duration of the study. Names of the victims were not mentioned in the study. Each victim was assigned a serial number for the data collection sheet and this number has no link with victim's name or hospital number. The study involved records review and the researcher did not have direct contact with the victims, therefore there was no harm to victims whose records were used for this study. The dissemination of the

research findings is limited to aggregated data and all the information collected would be locked in a secured location and not traceable to the victims.

It was envisaged that obtaining written consent from each of the victims before reviewing their records was impracticable because they were not readily available to provide consent or permission. Instead, approval in form of waiver was obtained from the management of Newcastle Provincial Hospital (Appendix V). Finally, ethical clearance was obtained from the Senate Research Committee of University of the Western Cape before commencement of the study.

### **3.10 Limitations of the Study**

The study was hospital based and limited to the Newcastle Provincial Hospital's sexual assault service centre records of victims that were seen in the hospital within a five year period. It is therefore possible that the results obtained from this study may not be generalized to victims of sexual violence in other hospitals or those who did not report their sexual assault to any hospital or authority. The researcher was also limited by the way the information was collected, for example the researcher could only classify the perpetrators into known, unknown or not sure. The limitation of the study design is the information bias which might occur due to the fact that the researcher had no control over the collection of victims' data recorded at the hospital. There is the possibility that some of the information that was reviewed might not have been recorded accurately, although the researcher made every effort to ensure the validity of the collected data.

## CHAPTER 4

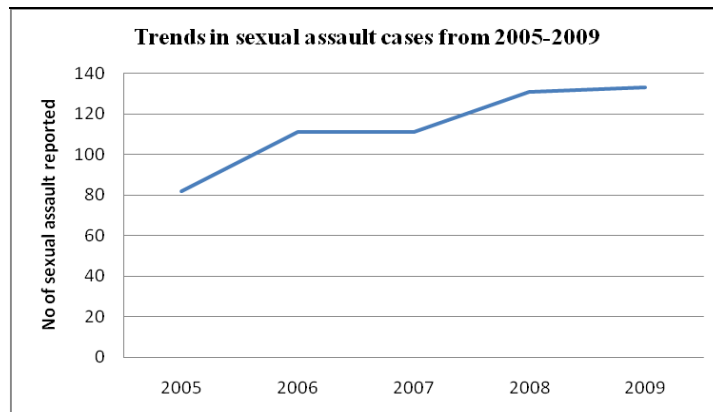
### RESULTS

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#### 4.1 Introduction

The previous chapter dealt with the research design and methodology, while this chapter presents the findings of the study. It contains both the descriptive and analytical statistics of the research.

During the five-year period between 1 January 2005 and 31 December 2009, there were 568 cases of sexual assault reported at the hospital. The average number of cases reported annually was 114 over the five-year period. Figure 1 shows the trend in sexual assault cases reported at Newcastle Provincial Hospital from 2005 to 2009. The graph shows a steady increase over the five years with not much difference in the last two years. There were 82 cases reported in 2005, 111 cases in both 2006 and 2007, increasing slightly to 131 cases in 2008 and rising to 133 cases in 2009. There was 38.3% increase in the number of reported cases over the five-year period.



**Figure 1: Trends in sexual assault cases reported from 2005-2009**

## 4.2 Descriptive Analysis of the Study Population

The socio-demographic description of the study population is presented in Table 1.

The age of the victims ranged from 2 to 81 years (mean 18.84; standard deviation of 13.25). The majority of victims were females 466 (87.3%) and 68 (12.7%) were male. The majority of the victims were children under 18 years with half (50.4%) aged 6-17 years and 9% below 6 years.

**Table 1: Socio-demographic description of the study population**

Characteristics	Frequency (N=534)	Percentage (95% CI)
<b>Age (mean + Standard deviation)</b>	18.9 + 13.25	
<b>Age group</b>		
0-5	48	9.0 (6.8-11.8)
6-17	269	50.4 (46.1-54.7)
18-24	102	19.1 (15.9-22.8)
25-34	54	10.1 (7.8-13.1)
35-44	30	5.6 (3.9-8.0)
45-54	16	3.0 (1.8-4.9)
≥ 55	15	2.8 (1.6-4.7)
<b>Sex</b>		
Male	68	12.7 (10.1-15.9)
Female	466	87.3 (84.1-89.9)
<b>Race</b>		
African	437	81.8 (78.2-85.0)
Colored	66	12.4 (9.7-15.5)
Indian	22	4.1 (2.7-6.3)
White	9	1.7 (0.8-3.3)
<b>Marital status</b>		
Single	477	89.3 (86.3-91.8)
Married	38	7.1 (5.1-9.7)
Widowed	10	1.9 (1.0-3.5)
Divorced	9	1.7 (0.8-3.3)
<b>Religion</b>		
Christian	477	89.3 (86.3-91.8)
Islam	37	6.9 (5.0-9.5)
Hindu	16	3.0 (1.8-4.9)
Traditional	4	0.7 (0.2-2.0)

<b>Employment status</b>		
Employed	109	20.4 (17.1-24.1)
Unemployed	125	23.4 (19.9-27.3)
Student	260	48.7 (44.4-53.0)
Preschooler	40	7.5 (5.5-10.1)
<b>Residential address</b>		
Newcastle-urban	265	49.6 (45.3-53.9)
Newcastle-rural	269	50.4 (46.1-54.7)

About one-fifth were aged 18-24 and just 11.4% were 35 years and above. Most of the victims (81.8%) belonged to the African race, were single (89.3%) and Christians (89.3%). Few were employed (20.4%), with nearly a half (48.7%) being students and (50.4%) lived in rural parts of Newcastle.

**Table 2: Description of health and sexual assault history of the study population**

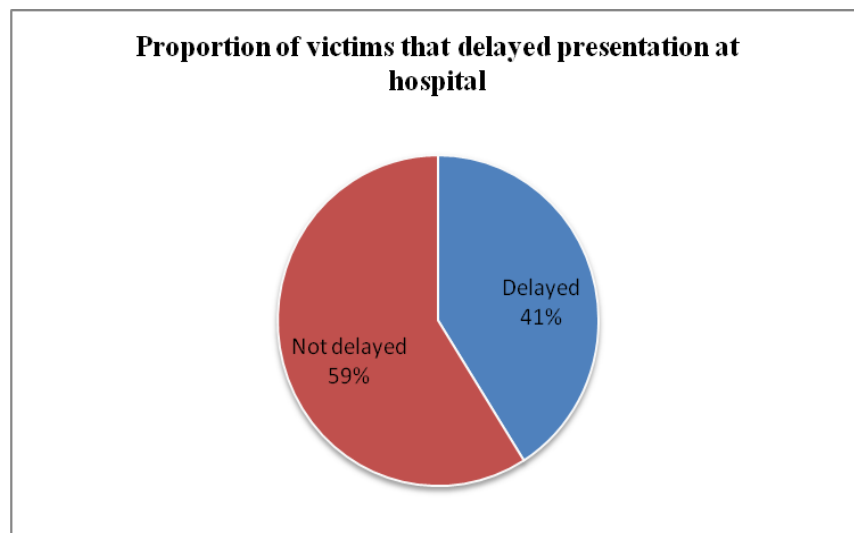
Characteristics	Frequency (N=534)	Percentage (95% CI)
<b>Social habits</b>		
Smoke tobacco	27	5.1 (3.4-7.4)
Use alcohol	100	18.7 (15.6-22.4)
Use illicit drugs	4	0.7 (0.2-2.0)
Use alcohol + tobacco	19	3.6 (2.2-5.6)
Use alcohol + illicit drugs	2	0.4 (0.1-1.5)
Smoke tobacco + illicit drugs	3	0.6 (0.1-1.8)
Use alcohol + tobacco + illicit drugs	3	0.6 (0.1-1.8)
None	403	75.5 (71.5-79.0)
<b>Previous sexual assault</b>		
Yes	115	21.5 (18.2-25.3)
No	419	78.5 (74.7-81.8)
<b>HIV status</b>		
HIV positive	105	19.7 (16.4-23.3)
HIV negative	424	79.4 (75.7-82.7)
Unknown	5	0.9 (0.3-2.3)
<b>Victim in intimate partner relationship</b>		
Yes	259	48.5 (44.2-52.8)
No	275	51.5 (47.2-55.8)
<b>History of medical condition</b>		
Yes	106	19.9 (16.6-23.5)
No	428	80.1 (76.5-83.4)

<b>Current Contraceptive use</b>		
Condom	140	26.2 (22.6-30.2)
OCP	18	3.4 (2.1-5.4)
Injectable	77	14.4 (11.6-17.8)
IUCD	3	0.6 (0.1-1.8)
None	296	55.4 (51.1-59.7)

One in five victims (21.5%) had experienced a previous sexual assault and 75.5% did not smoke tobacco, use alcohol or indulge in illicit drug use. The percentage of victims who were HIV positive at the time of presentation were 19.7%, while a further 19.9% had an existing medical condition and 55.4% of the victims were not using any form of contraceptives at the time of the assault.

#### **4.2.1 Interval between Sexual Assault and Time Reported at Hospital**

Only 37.6% of the victims visited the hospital within twenty-four hours of the assault and nearly half (41%) came to the hospital after seventy-two hours.



**Figure 2: Proportion of victims that delayed presentation**



#### 4.2.2 Forms of Sexual Assault Described By Victims

Table 3 shows the various forms of sexual assault reported by all the victims. Rape with vaginal penetration accounted for the highest number of reported sexual assaults (74.4%), followed by genital fondling (9.6%). Anal rape accounted for 5.1% and attempted anal rape was the least accounting for 0.4%. All the anal and attempted anal rape cases occurred to male victims.

**Table 3: Forms of sexual assault described by victims (n=534)**

<b>Forms of sexual assault</b>	<b>Freq</b>	<b>%</b>
Vaginal rape	397	74.4
Genital fondling	49	9.2
Attempted vaginal rape	40	7.5
Anal rape	27	5.1
Forced oral sex	19	3.6
Attempted anal rape	2	0.4
<b>Total</b>	<b>534</b>	<b>100</b>

#### 4.2.3 Reasons for Delayed Reporting At Hospital

Among the 219 victims that delayed their reporting, some (9.6%) did not provide any reason, but the fear of reprisal attack from the perpetrator if the incident was disclosed was the most common reason given by 37.4% of the victims. The second most common reason was recorded as being a minor (22.4%), which meant that the victim were children and could not have disclosed unless an adult suspected sexual violation of the child.

**Table 4: Reasons for delayed reporting at hospital (n- 219)**

<b>Reasons for delayed reporting at hospital</b>	<b>Freq</b>	<b>%</b>
Fear of perpetrator	82	37.4
Victim was a minor	49	22.4
Dejection and shameful	20	9.1
Scared of not being believed by relatives	14	6.4
Victim held captive by perpetrator	12	5.5
Victim was intoxicated	8	3.7
Victim mentally retarded	7	3.2
Sick or injured	3	1.4
Lack of faith in criminal justice system	2	0.9
Distance from sexual assault service centre	1	0.5
None	21	9.6
<b>Total</b>	<b>219</b>	<b>100</b>

Very few victims delayed disclosure due to fear that their relatives would not believe that they were sexually assaulted (6.4%), being intoxicated at the time of the assault (3.7%), distance from hospital (0.5%) and because they lacked faith in the criminal justice system (0.9%).

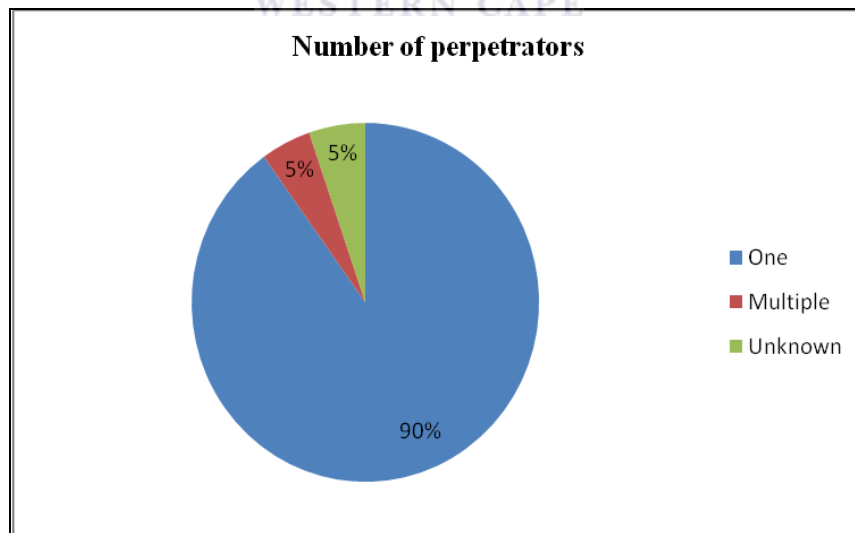
#### **4.2.4 Circumstances within Which Sexual Violence Occurred**

Table 5 shows the circumstances described by the victims that led to them being sexually assaulted by various perpetrators. In more than a third of the cases (37.6%), the victims reported sudden attacks without prior signs or warnings. About one-third (32.4%) of the sexual violence incidents were recorded as having happened while victims were in intimate partner relationships, and in another 21.5% the victims were sexually assaulted within their households by relatives or family members. A small proportion (4.7%) of the sexual violence reported occurred to victims who were

sexually assaulted as a result of their interaction with their religious leaders and in very few instances (2.8%) victims were sexually assaulted inside prison custody by their fellow inmates.

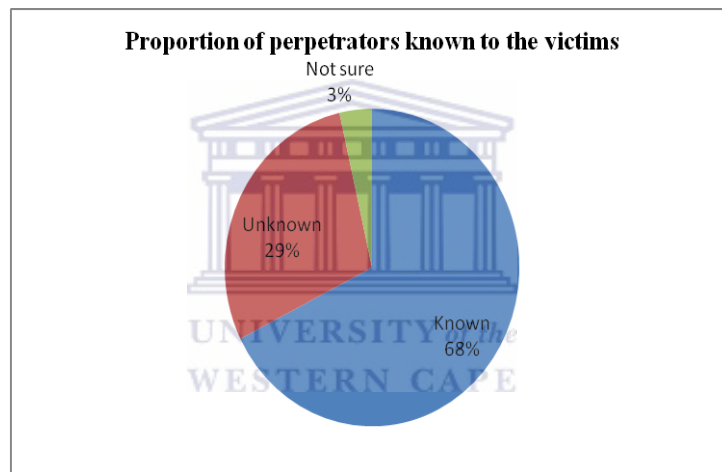
**Table 5: Circumstances within which sexual violence occurred (n=534)**

Circumstances that led to sexual violence	Freq	%
Sudden attack by perpetrator	201	37.6
Within intimate partner relationship	173	32.4
Within household with relatives	115	21.5
Religious leader/member interaction	25	4.7
Inside prison/police custody	15	2.8
Workplace sexual assault by colleague	4	0.7
Pupil/teacher interaction	1	0.2
<b>Total</b>	<b>534</b>	<b>100</b>

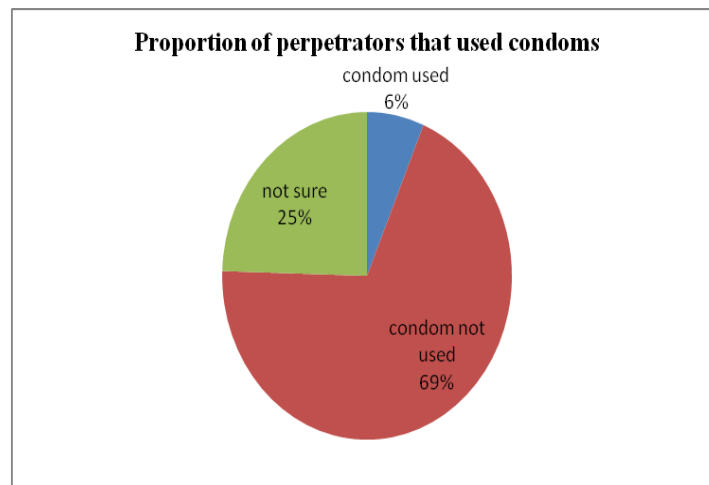


**Figure 3: Number of perpetrators involved in each incident of assault**

Amongst those that reported who their perpetrators were, almost all of them (96%) were male. The number of perpetrators involved in each incident of sexual assault are shown in Figure 3. Most victims (90%) reported that they were sexually assaulted by a single person, with only 5% of the reported sexual assaults involving multiple perpetrators. Figure 4 indicates the relationship between the victims and perpetrators. Most of the victims (67.6%) knew the person who sexually assaulted them, 29% did not know their attackers and very few (3.6%) were not sure whether they knew the perpetrator.

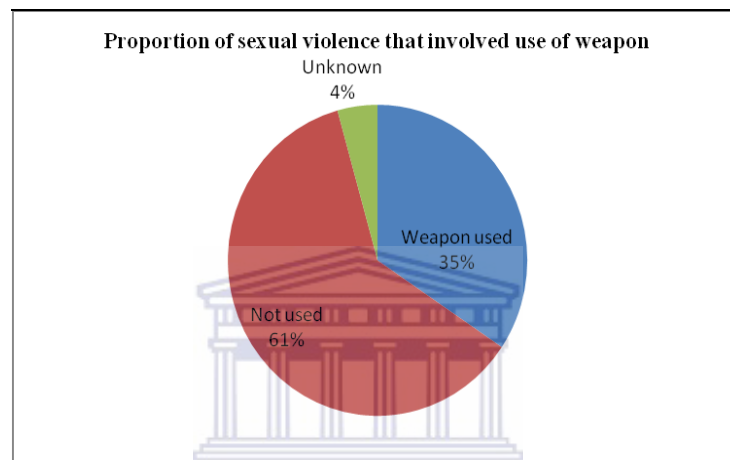


**Figure 4: Proportion of the perpetrators known to the victims**



**Figure 5: Proportion of perpetrators that used condoms**

In majority of the sexual assault cases (69.1%) the perpetrators did not use condoms (Figure 5). Figure 6 shows the proportion of sexual assault incidents that involved the use of weapons on the victims. Most of the sexual violence incidents reported at the hospital (61.2%) did not involve the use of weapons, and very few victims (4%) were not sure if any weapons were used on them during the sexual assault incidents.

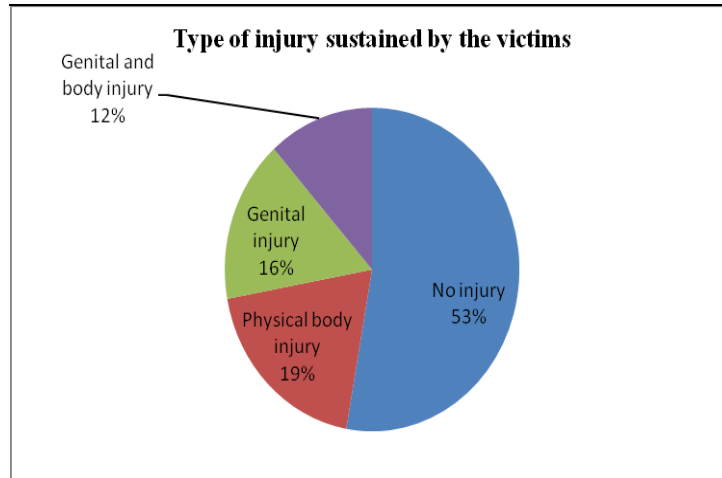


**Figure 6: Proportion of sexual violence that involved the use of weapon**

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#### **4.2.5 Types of Injury Sustained By the Victims**

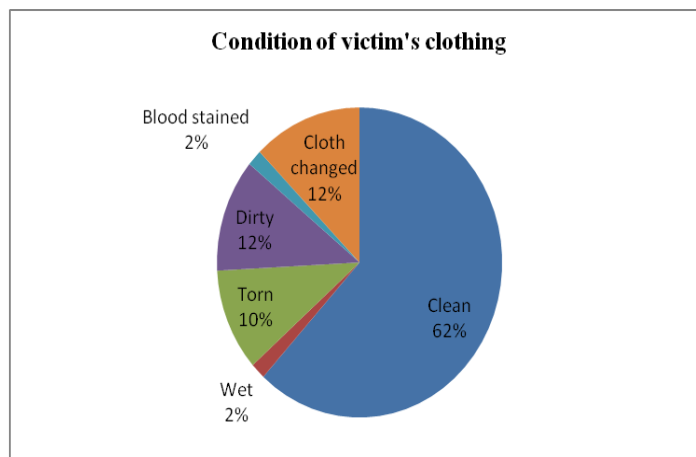
Figure 7 is a graphical representation of the types of injury sustained by the victims. Approximately half (53%) did not sustain any injury following the assault while 28% sustained injuries of which some involved both bodily and genital areas.



**Figure 7: Type of injury sustained by the victims**

#### 4.2.6 Condition of Victims' Clothing on Arrival at the Hospital

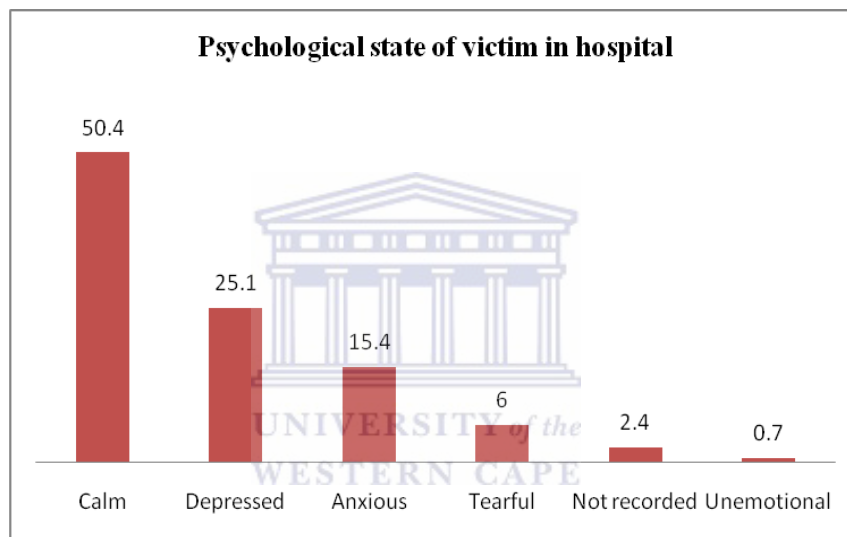
The state of the victims' clothes at the time of arrival in the hospital was recorded, this is depicted in Figure 8. Most (62%) of the victims had clean clothes at presentation in the hospital, while only 10% of the victims came with torn clothes and very few (2%) of them had blood stained and wet clothes on arrival at the hospital.



**Figure 8: Condition of victims' clothing on arrival in hospital**

#### 4.2.7 Psychological State of Victim in Hospital

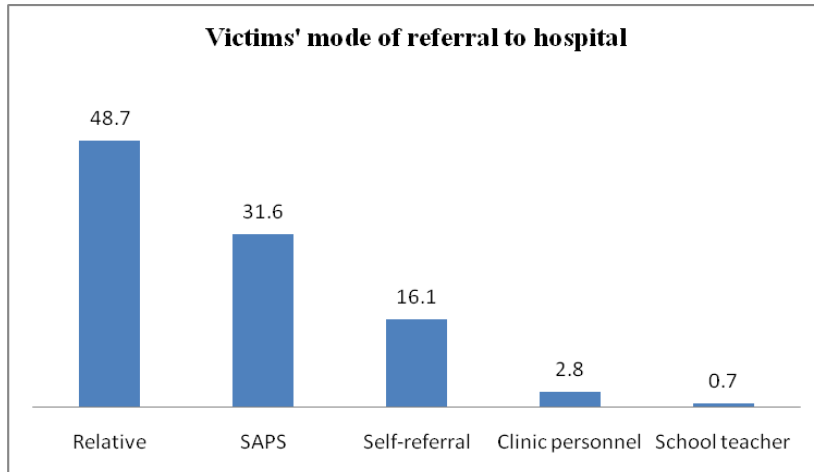
The psychological state of the victims is shown in Figure 9. According to the hospital records half (50.4%) of them were calm at presentation in the hospital, one-quarter (25.1%) were seen to be depressed and few (15.4%) were documented as being anxious while in hospital. In 2.4% of the cases of sexual assault reported the victims' state of mind was not documented.



**Figure 9: Psychological state of victims at presentation in hospital**

#### 4.2.8 Mode of Victim Referral to Hospital

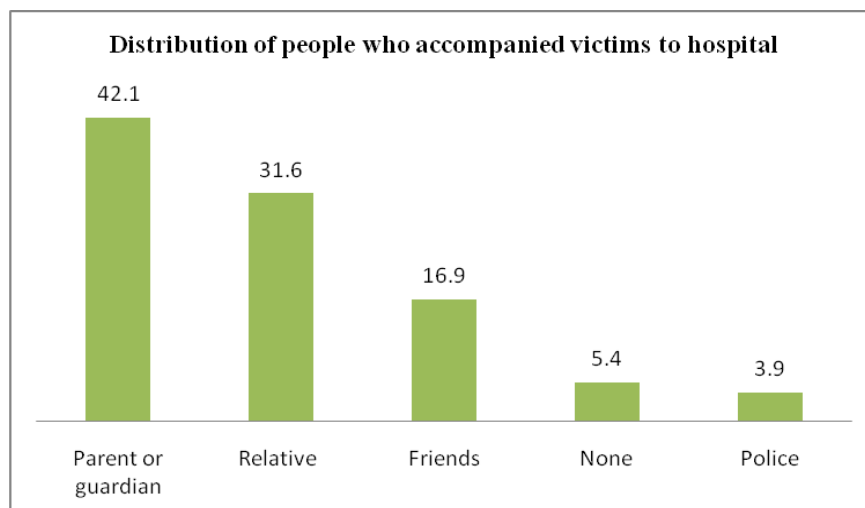
The mode of victim's referral to hospital is shown in Figure 10. Almost half (48.7%) of them were referred to the hospital by their relatives, about one-third (31.6%) were referred by the South African police personnel and 16.1% of the victims came to the hospital by self-referral.



**Figure 10: Victims' mode of referral to the hospital**

#### 4.2.9 Distribution of People Who Accompanied Victims to Hospital

Figure 11 is a graphical representation of the distribution of people that accompanied victims to the hospital to seek medical assistance; only one person was recorded per victim. In most of the cases (42.1%), the victim's parent or guardian accompanied them to the hospital. A small proportion (3.9%) was accompanied by the police and very few (5.4%) came alone to the hospital.



**Figure 11: Distribution of people who accompanied victims to hospital**

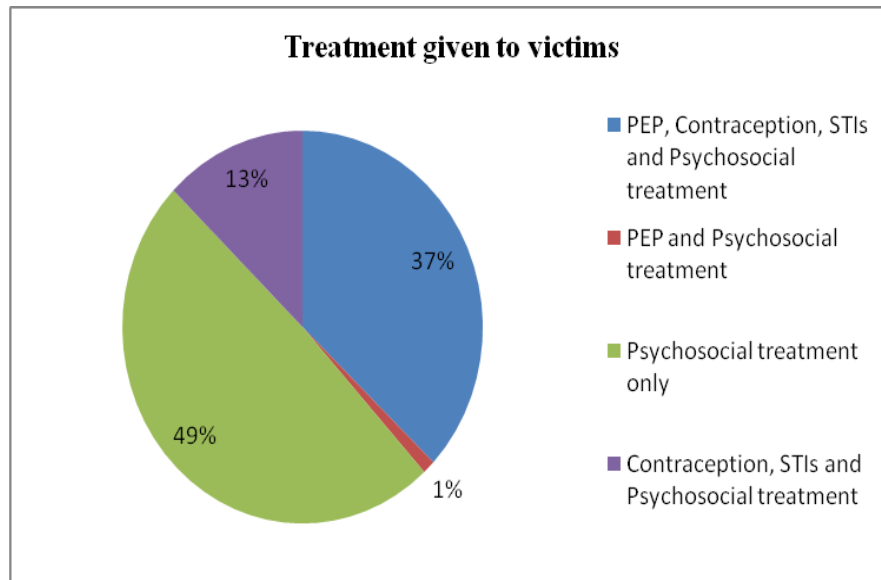


#### **4.2.10 Modalities of Treatment**

This section deals with modalities of treatment given to all the victims. These treatments include the following: post-exposure prophylaxis against HIV infection (PEP), contraceptive agents to prevent pregnancy in female victims, presumptive STI treatment and psychosocial support.

Figure 12 shows the treatment given to the victims. The full course of treatment was not given to all victims because some (41%) did not come within the 72 hours after being sexually assaulted. Just more than one-third (37.1%) of the victims were given full treatment package which includes PEP against HIV, contraceptive agents, STI treatment and psychosocial support. Half (49.1%) of the victims were offered only psychosocial support and 12.7% were given contraceptive agents to prevent pregnancy, STI treatment and psychosocial support. Only 1.1% of the victims were offered PEP and psychosocial support, most of the victims in this category were those who experienced forced oral sex.

Out of the victims that were offered PEP medication (n= 198), the majority (87%) returned to collect their follow-up medication.



**Figure 12: Modalities of treatment given to the victims**

#### 4.2.11 Differences in the Pattern of Sexual Assault (2005-2009)

Table 6 shows the differences in the proportion of sexual assault incidents reported by victims over the five years. The proportion of children that reported sexual assault incidents differed over the five years with year 2008 having majority (74.6%) of the victims under 18 years. The proportion of males reporting sexual assault remained within the range of 10-14% over the years with no significant increase over the five years.

Vaginal rape was the highest form of sexual assault reported over the 5 years accounting for over 80% of all the forms of sexual assault reported in 2005. Forced oral sex was very low in 2005 (1.3%) and has been increasing gradually over the years accounting for 5.4% of total cases of reported sexual assault in 2009. Attempted anal rape was only reported in 2006 (1%) and 2009 (0.8%) and represented the least form of sexual violence reported over the 5-year period.

The fear of perpetrators constituted the highest proportion of reasons for delayed reporting by victims from 2005-2006. It constituted one-third (33.3%) of all the reasons given in 2006 and almost half (43.5%) in year 2008 (43.5%). The distance from the hospital was given as a reason for delayed reporting only in 2006 and was the least frequent (1.9%) of reasons given for delayed reporting at the hospital.

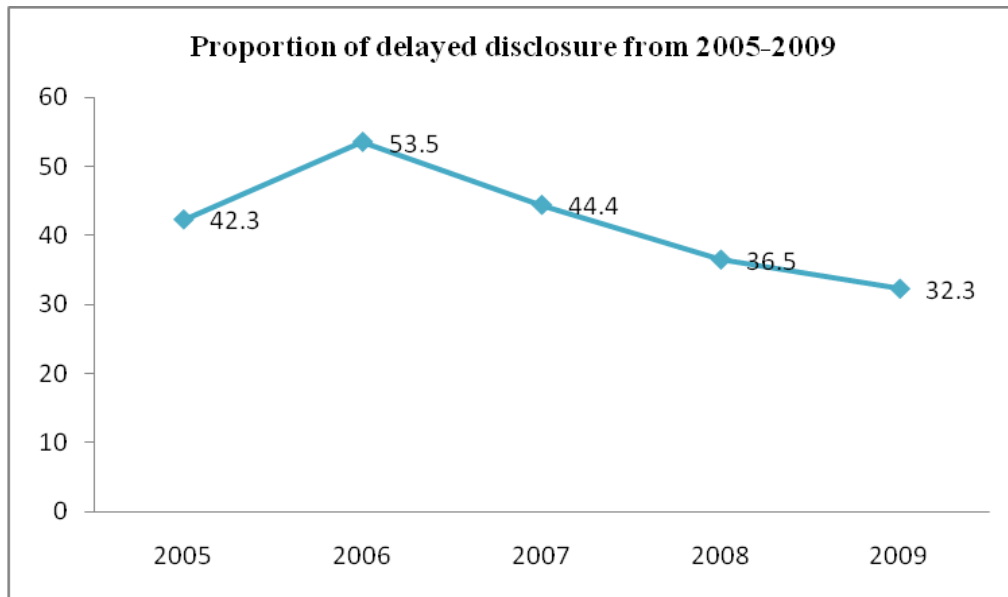
Sexual assault in which victims were suddenly attacked by the perpetrators was consistently high (34.1-42.3%) over the 5 years. This was closely followed by those which occurred within intimate partner relationships which was in the range of 28.6 - 42% from 2005-2009.

**Table 6: Differences in the pattern of sexual assault reported from 2005-2009**

	2005	2006	2007	2008	2009
<b>Age (n-534)</b>	%	%	%	%	%
0-17 years	69.2	51.5	50.5	74.6	51.5
18-24 years	16.7	14.9	16.2	16.6	28.5
25-34 years	5.1	14.9	17.1	3.2	10.8
35-44 years	6.4	7.9	8.1	3.2	3.8
≥45 years	2.6	10.9	8.1	2.4	5.4
<b>Total</b>	<b>100</b>	<b>100</b>	<b>100</b>	<b>100</b>	<b>100</b>
<b>Sex of victims (n-534)</b>	%	%	%	%	%
Male	14.1	10	14.1	13.5	12.3
Female	85.9	90	85.9	86.5	87.7
<b>Total</b>	<b>100</b>	<b>100</b>	<b>100</b>	<b>100</b>	<b>100</b>
<b>Forms of sexual assault reported by victims (n-534)</b>					
Vagina rape	80.8	78.2	61.6	80	74.6
Anal rape	5.1	5.9	8.1	4.0	3.1
Attempted vaginal rape	5.1	4.0	12.1	6.3	9.2
Attempted anal rape	-	1.0	-	-	0.8
Genital fondling	7.7	7.9	16.2	7.9	6.9
Forced oral sex	1.3	3.0	2.0	4.8	5.4
<b>Total</b>	<b>100</b>	<b>100</b>	<b>100</b>	<b>100</b>	<b>100</b>

<b>Reasons for delayed disclosure (n-219)</b>					
	<b>%</b>	<b>%</b>	<b>%</b>	<b>%</b>	<b>%</b>
Fear of perpetrator	36.4	33.3	38.6	43.5	35.7
Dejection and shame	6.1	11.1	9.1	4.3	14.3
Lack of faith in criminal justice system	-	-	-	2.3	2.4
Distance from hospital	-	1.9	-	-	-
Victim is minor	27.3	25.9	18.2	17.4	23.8
Victim was held captive	9.1	3.7	9.1	2.3	4.8
Victim was intoxicated	6.0	1.9	4.5	6.5	-
Victim mentally retarded	-	3.7	4.5	6.5	-
Victim was sick or injured	-	3.7	2.3	-	-
Scared of not being believed by relatives	3.0	7.4	6.8	4.3	9.5
None	12.1	7.4	6.8	13.0	9.5
<b>Total</b>	<b>100</b>	<b>100</b>	<b>100</b>	<b>100</b>	<b>100</b>
<b>Circumstances within which sexual violence occurred (n-534)</b>					
Within intimate partner relationship	41	31.7	33.3	28.6	30.8
Sudden attack by perpetrators	39.7	34.7	37.4	34.1	42.3
Workplace sexual assault by colleague	-	-	2.0	1.6	-
Religious leader/member interaction	2.6	6.9	-	7.1	5.4
Within household by relatives	14.1	25.7	24.2	22.2	20
Inside prison/police custody	2.6	1	3	5.6	1.5
Teacher/pupil interaction	-	-	-	0.8	-
<b>Total</b>	<b>100</b>	<b>100</b>	<b>100</b>	<b>100</b>	<b>100</b>

The trend of delayed disclosure of sexual assault incidents over the five-year period is shown in Figure 14. Almost half (42.3%) of the victims that reported sexual assault incidents in 2005 came after 72 hours. This proportion rose to the highest level (53.4%) in 2006 and decreased steadily from 2006 to about one-third of the victims (32.3%) in 2009.



**Figure 13: Proportion of delayed disclosure of sexual assault from 2005-2009**

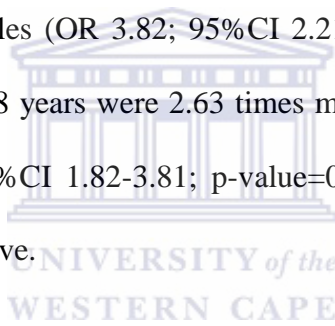


### **4.3 Risk Factor Analysis**

To determine the factors associated with delayed disclosure of sexual violence at Newcastle Provincial Hospital, Chi-square tests were done for selected variables to find out their association with outcome (delayed) with 95% confidence interval (CI) and p-value <0.05. The results are shown in the Tables 7 – 11 below.

#### **4.3.1 Risk Factors Associated with Delayed Disclosure of Sexual Violence in Newcastle**

Table 7 shows that males were 3.82 times more likely to delay reporting at the hospital compared to females (OR 3.82; 95%CI 2.21-6.61; p-value=0.000). Young victims below the age of 18 years were 2.63 times more likely to delay reporting at the hospital (OR 2.63; 95%CI 1.82-3.81; p-value=0.000) compared to those who were aged 18 years and above.



In reference to racial differences, an African victim was 1.7 times more likely to delay reporting at the hospital (OR 1.70; 95%CI 1.06-2.72; p-value=0.03), and students were 2.69 times more likely to delay (OR 2.69; 95%CI 1.89-3.85; p-value=0.000). Those who were single were also likely to delay disclosure (OR 4.86; 95%CI 2.25-10.48; p-value=0.000) and Christians were 2.31 times more likely to delay reporting (OR 2.31; 95%CI 1.23-4.435; p-value=0.01) compared to other religions. Victims living in rural parts of Newcastle were 1.85 times more likely to delay disclosure (OR 1.85; 95%CI 1.30-2.62; p-value=0.001) compared to those living in urban areas.

**Table 7: Unadjusted odds ratios of the association between selected victims characteristics and delayed disclosure of sexual assault incident (n= 534)**

<b>CHARACTERISTICS</b>	<b>N</b>	<b>OR</b>	<b>95% CI</b>	<b>P-value</b>
<b>Sex of victim</b>				
Female	466	Referent	Referent	
Male	68	3.82	2.21-6.61	<0.000
<b>Age group</b>				
18 years or more	217	Referent	Referent	
< 18 years	317	2.63	1.82-3.81	<0.000
<b>African Race</b>				
No	97	Referent	Referent	
Yes	437	1.70	1.06-2.72	0.03
<b>Single marital status</b>				
No	57	Referent	Referent	
Yes	477	4.86	2.25-10.48	<0.000
<b>Christian</b>				
No	57	Referent	Referent	
Yes	477	2.31	1.23-4.35	0.01
<b>Student</b>				
No	274	Referent	Referent	
Yes	260	2.69	1.89-3.85	<0.000
<b>First episode of sexual assault</b>				
Yes	115	Referent	Referent	
No	419	2.60	1.63-5.15	<0.000
<b>Existing medical condition</b>				
Yes	106	Referent	Referent	
No	428	2.53	1.56-4.09	<0.000
<b>Victim has consensual sexual partner</b>				
Yes	259	Referent	Referent	
No	275	2.98	2.08-4.28	<0.000
<b>HIV status</b>				
Negative	424	Referent	Referent	
Positive	105	0.82	0.53-1.27	0.37
<b>Contraceptive use</b>				
Yes	238	Referent	Referent	
No	296	3.09	2.14-4.47	<0.000
<b>Residential address</b>				
Urban Newcastle	265	Referent	Referent	
Rural Newcastle	269	1.85	1.30-2.62	<0.001

Victims without a previous history of sexual violence (OR 2.60; 95%CI 1.63-4.15; p-value=0.000); those who did not have any medical conditions (OR 2.53; 95%CI 1.56-4.09; p-value=0.000); those without consensual sexual partners (OR 2.98; 95%CI 2.08-4.28; p-value=0.000) and those who were not using any form of contraceptives (OR 3.09; 95%CI 2.14-4.47; p-value=0.000) were more likely to delay their presentation at the hospital. Positive HIV status was not associated with delayed disclosure of the assault (OR 0.82; 95%CI 0.53-1.27; p-value=0.37).

**Table 8: Unadjusted odds ratios of the association between forms of sexual assault and delayed disclosure of sexual assault incident (n= 534)**

<b>CHARACTERISTICS</b>	<b>N</b>	<b>OR</b>	<b>95% CI</b>	<b>P-value</b>
<b>Vaginal rape</b>				
No	137	Referent	Referent	
Yes	397	0.44	0.29-0.66	<0.000
<b>Anal rape</b>				
No	507	Referent	Referent	
Yes	27	3.65	1.57-8.96	0.0002
<b>Attempted vaginal rape</b>				
No	494	Referent	Referent	
Yes	40	0.52	0.25-1.07	0.07
<b>Genital fondling</b>				
No	485	Referent	Referent	
Yes	49	2.99	1.62-5.55	<0.000
<b>Forced oral sex</b>				
No	515	Referent	Referent	
Yes	19	3.25	1.22-8.68	0.013

Victims who experienced vaginal rape were 0.44 times as likely to delay reporting at the hospital while those who experienced anal rape (OR 3.65; 95%CI 1.57-8.96; p-value=0.002), forced oral sex (OR 3.25; 95%CI 1.22-8.69; p-value=0.013) and genital fondling (OR 2.99; 95%CI 1.62-5.55; p-value=0.000) were more likely to delay disclosure (see Table 8).



**Table 9: Unadjusted odds ratios of the association between causes of delay and delayed disclosure of sexual assault incident (n= 219)**

<b>CHARACTERISTICS</b>	<b>N</b>	<b>OR</b>	<b>95% CI</b>	<b>P-value</b>
<b>Fear of perpetrator</b>				
No	137	Referent	Referent	
Yes	82	5.11	3.25-8.04	<0.000
<b>Feeling dejected and ashamed</b>				
No	199	Referent	Referent	
Yes	20	1.48	0.78-2.83	0.24
<b>Victim mentally retarded</b>				
No	212	Referent	Referent	
Yes	7	2.57	0.74-8.88	0.11
<b>Victim was minor</b>				
No	170	Referent	Referent	
Yes	49	3.66	2.15-6.22	<0.000
<b>Victim was intoxicated</b>				
No	211	Referent	Referent	
Yes	8	0.59	0.25-1.37	0.22
<b>Victim was held captive by perpetrator</b>				
No	207	Referent	Referent	
Yes	12	2.99	1.10-8.08	0.02
<b>Scared of not being believed by relatives</b>				
No	205	Referent	Referent	
Yes	14	21.44	2.79-164.3	<0.000

As shown in Table 9, victims who feared reprisal attacks from the perpetrator were more likely to delay disclosure (OR 5.11; 95%CI 3.25-8.04; p-value=0.000). Victims who were minors at the time of the assault were also likely to delay disclosure (OR 3.66; 95%CI 2.15-6.22; p-value=0.000). Victims who were held captive by the perpetrators were three times more likely to delay disclosure compared to those who were not (OR 2.99; 95%CI 1.10-8.08; p-value=0.02), and those who were scared that their family members would not believe they were sexually assaulted (OR 21.4;

95%CI 2.79-164.3; p-value=0.000) were also likely to delay disclosure at the hospital.

**Table 10: Unadjusted odds ratios of the association between circumstances of the sexual violence and delayed disclosure of sexual assault incident (n= 534)**

<b>CHARACTERISTICS</b>	<b>N</b>	<b>OR</b>	<b>95% CI</b>	<b>P-value</b>
<b>Sexually assaulted within intimate relationship</b>				
No	361	Referent	Referent	
Yes	173	0.63	0.43-0.91	0.015
<b>Sexually assaulted within household by relatives</b>				
No	361	Referent	Referent	
Yes	115	3.25	2.11-4.99	<0.000
<b>Suddenly attacked by perpetrator</b>				
No	333	Referent	Referent	
Yes	201	0.32	0.22-0.47	<0.000

As shown in Table 10, victims who were sexually assaulted within their households by relatives or neighbors were more likely to delay their reporting at the hospital (OR 3.25; 95%CI 2.11-4.99; p-value=0.000) while victims who were suddenly attacked by perpetrators likely to be unknown to them were less likely to delay reporting at the hospital.

**Table 11: Unadjusted odds ratios of the association between selected characteristics of the sexual assault and delayed disclosure of sexual assault incident (n= 534)**

<b>CHARACTERISTICS</b>	<b>N</b>	<b>OR</b>	<b>95%CI</b>	<b>P-value</b>
<b>Genital or physical injury sustained</b>				
No	282	Referent	Referent	
Yes	252	0.26	0.18-0.38	<0.000
<b>Referred by relative to hospital</b>				
No	274	Referent	Referent	
Yes	260	1.83	1.29-2.59	0.001
<b>Relationship between victim and perpetrator</b>				
Unsure/Unknown to victim	173	Referent	Referent	
Known to victim	361	3.13	2.08-4.70	<0.000
<b>Condoms used during the assault</b>				
No	369	Referent	Referent	
Yes	34	0.42	0.19-0.95	0.03
<b>Assaulted with weapons</b>				
No	327	Referent	Referent	
Yes	184	0.33	0.22-0.49	<0.000
<b>Number of perpetrator(s)</b>				
One	481	Referent	Referent	
Multiple	25	1.14	0.51-2.55	0.76

According to the analysis presented in Table 11, victims who knew their assailants (OR 3.13; 95%CI 2.08-4.70; p-value=0.000) were more likely to delay presentation at the hospital. The mode of referral of a victim to the hospital also showed association with delayed disclosure. Victims who were referred by their relatives were twice as likely to delay their visit to the hospital for medical assistance (OR 1.83; 95%CI 1.29-2.59; p-value=0.001) compared to others.

## CHAPTER 5

### DISCUSSION

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#### **5.1 Introduction**

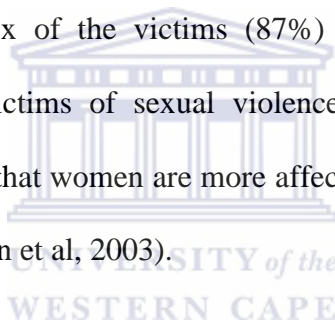
The number of sexual assault cases reported at the Newcastle Provincial Hospital increased steadily over the five years without significant difference in the last two years. The male to female ratio remained the same, and children aged 0-17 years constituted the highest age group that reported sexual assault in the five-year period. Vaginal rape remained the highest form of sexual assault reported by the victims while attempted anal rape was the least in the five years. The fear of reprisal attack from the perpetrator was the reason given by most of the victims who delayed disclosure at the hospital from 2005 to 2009. The proportion of victims that delayed reporting at the hospital peaked in year 2005 to 53.5% and decreased slightly over the years to 32.3% in 2009.

#### **5.2 Demographic Characteristics of the Victims**

The age of victims ranged from 2 to 81 years which indicates that sexual violence affects all age groups in Newcastle area. This finding is supported by the earlier study by Vetten *et al* (2008) that reported that sexual violence cuts across all age groups in South Africa. It is not uncommon in South Africa for children as young as one or two years old to be raped, and it has been suggested that the rape of children might be associated with the myth of HIV cleansing (Jewkes, Martin & Penn-Kekana, 2002; Science in Africa, 2002).

The mean age of 18.8 years and the fact that people within the age range of 0-24 years constitute 78.5% of all the victims indicate that young people were at the highest risk of being victims of sexual assault in Newcastle. This finding is in agreement with other studies where this age group has been reported as being the most vulnerable (Bello & Pather, 2008; Collings, 2005; Malhotra, 2000). Higher incidence of sexual assault among these young people could be due to their physical and mental immaturity and the lack of ability to physically defend themselves against the perpetrators.

Four hundred and sixty-six of the victims (87%) were females, indicating that women are usually the victims of sexual violence, this corresponds with most previous studies that show that women are more affected than men in terms of sexual violence (WHO, 2003; Mein et al, 2003).



Most of the victims (75.5%) were non-smokers, did not consume alcohol and never used illicit drugs. Only 5.1% of the victims reported they were intoxicated with alcohol at the time of the assault. This is in sharp contrast to the report of Killian et al (2007) where more than 25% of the victims in a Cape Town study had used alcohol at the time of being sexually assaulted. Research has shown that use of alcohol and illicit drugs create situations that increase the chances of sexual violence to occur among victims and among those perpetrating the violence (WHO, 2002).

Half (50.4%) of the victims lived in rural areas of Newcastle and the other (49.6%)

in the semi-urban part of the town. This distribution indicates that both rural and urban parts of the Newcastle community are equally affected by sexual violence and is further corroborated by an earlier statement that sexual violence occurs globally, cutting across races and cultures (WHO, 2003).

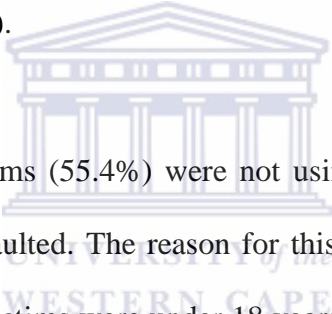
Christianity constitutes about 90% of the victims' religion; this reflects the religion pattern in South Africa (Statistics South Africa, 2003). Most of the victims were African (82%), in keeping with the distribution of the racial groups in South Africa, since according to Statistics South Africa (2009) Africans are the dominant ethnic group, constituting almost 80% of the total South African population.

The majority of the victims were students (48.7%). This may be as a result of approximately 60% of the victims falling within the age range of 0-17 years and it is assumed that most people of that age will be attending school. The percentage of unemployment among the victims was 23.4%, which is close to the unemployment rate in South Africa estimated at 24.3% (Statistics South Africa, 2009).

Most of the victims were single (89.3%) at the time of experiencing the sexual assault. This may also be due to the fact that most of them (78.5%) were less than 25 years at the time of the assault. This finding is almost the same as that of Bello & Pather (2008) conducted in Cape Town where most of the victims (91.2%) of sexual violence in their study were single.

### **5.3 Sexual History and Health Characteristics of the Victims**

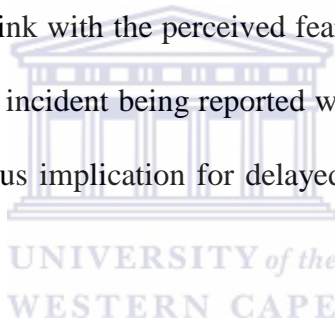
One out of five of the victims (21.5%) had been sexually assaulted before the reported incident. This agrees with previous findings that there is likelihood of reoccurrence of sexual assault in women who have been victims previously (Coid *et al.*, 2003; Dunkle, Jewkes, Brown, McIntyre, Gray & Harlow, 2003; Tjaden & Thoennes, 2000). The implication of this is the long-term effect of such incidents on the victims, because according to the psychoanalytic theory of sexual aggression, sexual abuse of a person may lead to the individual perpetrating or being victim of sexual related crimes in their later life (Cantwell, 1990 in Anderson & Ho-Foster, 2008; Malamuth *et al.*, 1985).



More than half of the victims (55.4%) were not using any form of contraceptives prior to being sexually assaulted. The reason for this is not known but considering the fact that 59.4% of the victims were under 18 years it could be assumed that most of them were not in intimate relationship at the time of the assault. This is further supported by the proportion who claimed to have no consensual partners (51.5%) at the time of their assault, which implies that they were not engaging in sexual relations at the time of the assault. The implication of not using any form of contraceptives by victims who were sexually active includes risk of unwanted pregnancy, STIs and HIV infection.

It is disturbing that 31.6% of the victims were referred by the police, indicating that the victims reported the assault to the police before they visited the hospital.

However, only 3.9% of the victims were accompanied by the police while the policy clearly states that the police should escort victims who reported sexual assault to hospital. This may be due to the manner in which the incident was reported or an incidental finding. In the researcher's experience, victims referred by South African Police Service often do not give details of sexual assault at the police station. The victims tend to focus on the physical assault and are therefore sent for medical examination at the hospital. It is only once at the hospital that some victims disclose sexual assault while being examined. Police have to then be re-summoned to take statement and to provide a forensic evidence collection kit. The reason for this is unknown, but may have a link with the perceived fear of the police by some victims who were not sure how the incident being reported would be received by the police. This is likely to have serious implication for delayed and non-reporting among the victims.



A large proportion of the victims (62%) came to the hospital with clean clothes, and 12.4% came to the hospital after changing their clothes. Only a few (22%) came with torn and dirty clothes as evidence of being sexually assaulted. The condition of the victims' cloths is often used in forensic investigations to prosecute perpetrators, which is the reason that victims of sexual assault are often told to preserve their clothes for forensic analysis (Martin, 2002; Jewkes et al, 2009b).

#### **5.4 Forms of Sexual Violence Reported by Victims**

Rape with vaginal penetration accounted for the highest form of sexual assault



reported by the victims (74.4%). This is close to the findings of another study in KwaZulu-Natal where vaginal rape was as high as 92% (Collings et al, 2008). In a Malawian study, vaginal rape also accounted for the highest form of rape (81%) reported by victims (Chesshyre & Molyneux, 2009). This finding is further supported by the report published by StatSA that rape with forced vaginal penetration is the most common form of sexual violence in South Africa with more than 50,000 cases reported to the police every year (Statistics South Africa, 2000). This probably has a link to the fact that women are the usual victims of sexual assault.

Vaginal rape was followed by genital fondling (9.2%) commonly reported by very young male victims. This form of sexual violence may be underreported as young victims do not know what actually constitutes sexual assault. Attempted vaginal rape was next, at 7.5%. This form of sexual violence may also be under-reported because some victims may decide not to disclose since this often occurs in intimate partner relationship and the victim might just feel there is no case against the perpetrator and therefore not report the incident (Henttonen et al, 2008; Buga et al, 1996).

### **5.5 Delayed Disclosure among the Victims and Reasons Given by Victims**

More than 40% of the victims came to the hospital after 72 hours of being sexually assaulted for a number of reasons. This is almost the same as the findings of Collings (2005) where 34.1% of victims in another study were found to have reported more than 72 hours after the alleged sexual assault and thus victims could not benefit from

most of the treatment given to victims of sexual assault.

The time interval between incidents of sexual violence and the presentation at the hospital is crucial for adequate medical assistance (South African Government, 2007; Jewkes, 2009b; Martin, 2002; Collings et al, 2008; Wiebe et al, 2000). A study in Cape Town investigating the modalities of treatment given to rape victims by Bello & Pather (2008) reported that only 67% of victims who tested HIV negative were offered PEP. The rest did not benefit because they did not present at the hospital within 72 hours of the incident of violence.

Fear of reprisal attack by the perpetrator appeared to be the main reason for some victims not reporting the incidents early enough, with 21.5% of the victims claiming that they feared the perpetrators were going to harm them if they disclosed the incidents. Similar findings have been reported by other studies (Christofides et al, 2003; CIET, 1998). Some children may be too young to understand what was done to them and therefore failed to report. In 13.5% of the cases the victims who were minors failed to report early because of their age. These children were primed by the perpetrators into secrecy. This phenomenon is explained by the child sexual abuse accommodation syndrome theory where sexually abused children develop coping mechanisms to deal with sexual assault (Summit, 1983).

The assertion that some women may not report rape in South Africa because they lack faith in the criminal justice system (Kim, 2000) seems not to be reflected among

the victims in Newcastle as very few 2 (0.4%) gave this reason for their delayed appearance at the hospital. Victims have been reported to delay disclosure because they assumed nothing would be done if they reported to the law enforcement agents (WHO, 2003; Kim, 2000).

Access to the sexual assault service centre appeared not to be a major problem for the victims as only 4.1% of the victims said they could not come to the hospital immediately because of the distance from their home. It has been shown that factors such as availability of PEP and sympathetic health providers at sexual assault service centres are more important in victim's decision to utilize sexual assault services rather than the travel time required to access these services (Christofides et al, 2005). Moscarello (1990) stated that some victims do not want to disclose sexual assault for the fear of not being believed or even blamed for the assault. This is true of some victims (2.8%) in Newcastle who said they did not want to report that they were sexually assaulted because they thought their family or relatives would not believe them.

### **5.6 Circumstances within Which Sexual Violence Occurred**

According to WHO (2003), sexual violence occurs in settings like home, schools, place of worship and at the workplace. Although significant proportion of the victims (37.6%) in this study was suddenly attacked by the perpetrators, some victims (5%) were assaulted at the place of worship by their religious leaders and some by their colleagues at work (0.7%). Approximately, one-fifth (21.5%) of the

victims were assaulted inside their households by the people they know which confirms the WHO definition of settings where sexual violence may take place. In addition to the above, about one-third (32.4%) of all the sexual assault cases occurred among victims who were in intimate relationships, which supports the findings of earlier studies that an intimate relationship may be a potential risk factor for sexual assault (Jewkes et al, 2006; Testa et al, 2007; Tjaden & Thoennes, 2001; WHO, 2005).

### **5.7 Injury Sustained by Victims**

More than half (53%) of the victims did not sustain any injury according to their hospital records. The absence of physical injuries does not mean sexual assault did not happen because the perpetrator could have exercised power over the victim so that the latter offers little or no resistance. Some victims, especially women, do not resist their perpetrators for fear of serious bodily harm and death or because they are paralyzed by a psychological state called “frozen fright” (Schafran, 1996).

This study also found 19% victims with body injuries, about 16% with genital injuries and 12% with both genital and body injuries. This is close to the findings of Killian et al (2007) where 35% of the victims sustained genital injuries and 26% had other physical injuries. Physical body injuries and genital injuries have been documented as injuries that victims of sexual violence are prone to sustaining during sexual violence (Lessing, 2005; WHO, 2002; Slaughter et al, 1997) and documentation of these injuries is crucial in prosecution of perpetrators of sexual

assault (Jewkes et al, 2009b). Rapid healing injuries can be missed if the victim has delayed in coming to hospital. The limitations of medical examination immediately following sexual assault is the fact that bruises may not become apparent for at least 48 hours in certain instances.

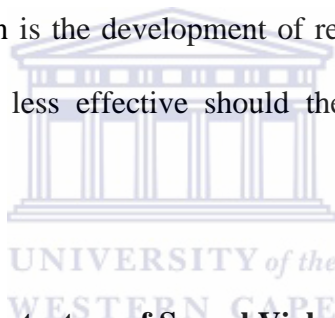
### **5.8 HIV Status and Post-Exposure Prophylaxis against HIV**

The HIV seroprevalence of the victims was 19.7% on presentation in hospital. This is higher than 10% reported by Collings (2005), 12.1% by Bello & Pather (2008), 13% by Killian et al (2007) and 13.7% by Meel (2005) but less than the 35.6% found in a study done in KwaZulu-Natal by Carries et al (2007). The seroprevalence found among victims in Newcastle was also higher than the 11% national prevalence (Shisana et al, 2009). Since KwaZulu-Natal has one of the highest HIV prevalence in South Africa, the possibility of HIV transmission during sexual assaults is also high among victims in this setting.

No record of victims who completed the PEP regimen was available, as this was not routinely kept, but 87% of the 198 victims offered initial 3-day PEP returned to collect the full 28-day dose. This is higher than a previous study in KwaZulu-Natal where 35.4% of victims offered initial 3-day PEP returned to collect the full 28-day course of PEP (Collings, Bugwandeen & Wiles, 2008). Completion of the 28-day drug regimen by victims is an issue for concern. In an interventional study done in rural South Africa the researchers were able to increase completion of PEP among victims of sexual assault from 20% to just 58% (Kim et al, 2009), which is still low

considering that the treatment primarily aims to prevent transmission of HIV infection. Another study in KwaZulu-Natal revealed that only 57% of victims who tested HIV negative and were offered PEP completed the 28-day course (Carries et al, 2007).

In a recent study in South Africa approximately 30% of the studied victims completed the 28-day PEP. Stigma and lack of psychological support for victims are some of the reasons given for non-adherence in this study (Abrahams & Jewkes, 2010). The implication for non-completion apart from reduced efficacy of the drugs in preventing HIV infection is the development of resistance to the virus which may render antiretroviral drugs less effective should the victims require them in the future.

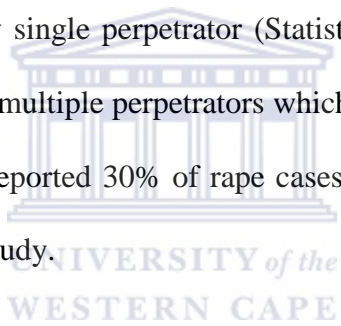


### **5.9 Characteristics of Perpetrators of Sexual Violence**

Many studies have reported that acts of sexual violence are usually committed by people known to the victims (Schafran 1996; Speight et al, 2006; Fimate & Devi, 1998). Previous studies have also reported that about 40-65% of victims knew the perpetrators (Chesshyre & Molyneux, 2009; Merchant et al, 2004; Wiebe et al, 2000). The percentage is even higher among young victims, according to Vetten et al (2008) who states that 84% of rapes in young people are carried out by known people, including relatives, neighbors or friends. The same can be said of Newcastle where 67.6% of the victims knew the perpetrators, although this percentage was higher than 35% reported by Statistics South Africa (2000). It has been reported that

being sexually assaulted by someone you know is more psychologically damaging than being assaulted by stranger, because the assault tends to destroy the ability of the victim to trust people (Schafran, 1993).

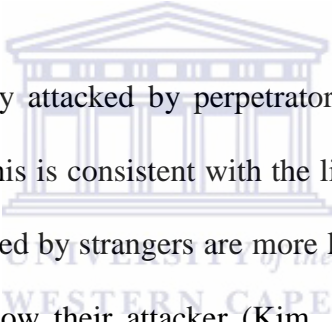
Nearly all the perpetrators were male 514 (96.2%), only 2 (0.4%) were identified as females. This is similar to findings in the literature that indicate that men are the usual perpetrators of sexual violence (WHO, 2003; Jewkes et al, 2009a). Most (90.1%) of the victims were assaulted by single perpetrator; this is similar to the report of Statistics South Africa that showed 88.1% of rape incidents reported to the police being carried out by single perpetrator (Statistics South Africa, 2000). Only 4.7% of the cases involved multiple perpetrators which are lower than the findings of Jewkes et al (2009a) that reported 30% of rape cases being carried out by multiple perpetrators in a different study.



Sexual violence in South Africa often involves the use of physical violence (Statistics South Africa, 2000), this is reflected in this study with 34.5% of the victims being physically threatened with weapons by the perpetrators. This is in keeping with police records which showed that women are frequently raped by threatening them with physical injury often with the use of knives (68.0%) or gun (16.5%) (Statistics South Africa, 2000).

### **5.10 Factors Associated with Delayed Disclosure of Sexual Assault**

The factors associated with delayed disclosure among victims of sexual assault in Newcastle are young age group (< 18 years) at the time of assault, being a minor and being assaulted within household. These are findings that support those of several studies (Smith et al, 2000; Summit, 1983; Wright & Ceci, 2007; Paine & Hansen, 2002). These authors state that young victims who are well known to the perpetrators do not disclose incidents because of fear. Furthermore, these young victims develop the coping mechanisms explained by the child sexual abuse accommodation syndrome which is used to deal with the abuse.



Victims who were suddenly attacked by perpetrators unknown to them were less likely to delay reporting. This is consistent with the literature as research has shown that victims who are assaulted by strangers are more likely to disclose sexual assault compared to those who know their attacker (Kim, 2000; Paine & Hansen, 2002; Wright & Ceci, 2007).

Fear of the perpetrator is another predictor of delayed disclosure in Newcastle. This findings concur with previous research findings that fear of reprisal from perpetrator may cause the victim not to disclose incident of sexual violence (Baumer et al, 2003; Artz, 1999 in Kim, 2000; CIET, 1998). In addition, when the perpetrator is known to the victim, chances of reporting the incident is very low. For example, some women in South Africa assume that rape by intimate partners is not a serious event that should be reported to the police or to any other authorities (Buga et al, 1996; Woods



et al, 1998). This also account for the under reporting of sexual assault in South Africa.

Kim (2000) reported that some victims do not report sexual assault because they are afraid of not being believed by their relatives. This is also true in Newcastle as one of the factors identified as the cause of delayed reporting of sexual assault at the hospital by the victims, where victims gave the same reasons for their delayed reporting at the hospital.

Other factors identified in the study that are associated with delayed disclosure of sexual assault at the hospital include anal rape, genital fondling and forced oral sex. No prior history of sexual violence; no prior contraceptives use; living in rural areas of Newcastle and absence of consensual sexual partners at the time of sexual assault are further contributing factors.

## CHAPTER 6

### CONCLUSION AND RECOMMENDATIONS

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The last chapter covered the discussion of the results derived from the analysis of the collected data from the medical records of sexual violence victims over a 5-year period. This chapter presents the conclusions reached from this research and concludes with the study recommendations.

#### 6.1 Conclusion

This study was conducted to find out the reasons why some victims report incidents of sexual violence at the Newcastle hospital after 72 hours. The research shows a steady decline in the proportion of victims that delayed their presentation at the hospital from about 42% in 2005 to 32% in 2009. This is a reflection of better awareness of the sexual assault service at the hospital and the accessibility to the service by the Newcastle community. The findings of this research support previous studies outcomes in terms of what causes delay in disclosure of sexual violence. The identified reasons for the delayed disclosure in this study are described below; they may be used improving the services in the hospital for the benefit of sexual violence victims.

1. **Age** - The young victims are most likely to delay disclosure of sexual violence incidents to the Newcastle provincial Hospital. Some of these young victims, especially those who are underage and minors may not be able to

recognize sexual violence when they are being sexually assaulted and will not report unless an adult becomes aware of the problem and eventually brings them to the hospital for treatment. Others may also delay the report if the perpetrator is known to them.

- 2. No prior history of sexual violence** - victims who have not experienced sexual violence previously may not actually know what kind of acts to be regarded as sexual violence, or appropriate actions to take after the assault. Findings from the research in South Africa indicate that forced vaginal intercourse by boyfriends or acquaintances is often referred to as “forced sex” and not rape, therefore the interpretation of sexual encounters by the victims is very important as a predictor of disclosure of sexual violence.
- 3. Forms of sexual assault** – forced anal intercourse, forced oral sex and genital fondling are forms of sexual violence that are likely to be delayed in being reported at the hospital. The reason for this may be related to how the victims who suffered from these forms of sexual assault interpret the act.
- 4. Setting where assault takes place** - This study identified that sexual violence that occurs within homes and perpetrated by either relatives or neighbors are poorly reported at the hospital. This may be due to the influence the perpetrators have on the victims. Research has showed that sexual assault against young children is usually perpetrated by those who are

very close to them which is why they do not disclose. This study also revealed that rural areas of Newcastle are settings where there may be delayed reporting of sexual assault incidents.

**5. Fear of perpetrator and relatives** - This has been discussed earlier as one of the causes of delayed disclosure among victims. The fear of reprisal attack from the perpetrator could prevent the victim from reporting, and the victim may also delay disclosure if the victim is financially dependent on the perpetrator. In other instances, victims may assume that their family members will not believe them if they report they have been sexually assaulted. This is very common among victims who are blamed for causing the assault.

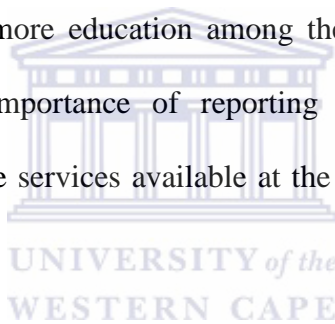
**6. Mode of referral to hospital** - Victims who were referred by their relatives were more likely to delay disclosure in Newcastle. The factor responsible for this may be connected with the cultural beliefs in South Africa where some communities often shield perpetrators from prosecution because of their beliefs about sexual offences as something abominable that should not be made public.

**7. Relationship of victim and perpetrator** – Victims who knew their perpetrators were more likely to delay presentation at the hospital. Again the reason for this includes fear of not being believed by the relatives of the victims, poverty, gender inequalities and the cultural belief system. Victim-

blaming is one of the reasons that victims with close relations with their perpetrators often fail to disclose acts of sexual aggression. A victim in an intimate relationship may assume that her family will not believe her if she claims she has been raped by a man who is known to her family. In addition, some women believe sexual assault like rape cannot occur in marriages, and therefore acts of sexual aggression against them are not regarded as sexual violence to be reported.

## **6.2 Recommendations**

1. There is need for more education among the people of Newcastle and its environs on the importance of reporting incidents of sexual violence promptly and on the services available at the hospitals for victims of sexual violence.
2. The component of sexual assault services addressing the needs of children should be strengthened as they constituted the highest proportion of age groups seen as victims of sexual violence at the hospital.
3. Considering the fact that some data were not available, for example no records of victims who completed PEP were available. In-service training should be conducted for all the healthcare personnel working at the Newcastle sexual assault service centre on a regular basis, and should focus on how to complete the medico-legal forms and document findings in



victims' files.

4. There is need to establish a system within the sexual assault service that will assist the victims in adhering to all the treatment, especially PEP offered them after sexual assault.
  
5. A qualitative research among the victims in Newcastle area is needed to improve understanding of factors that influence victims' decisions to seek medical care after experiencing sexual assault. Additionally, a population-based qualitative research would be appropriate in Newcastle.



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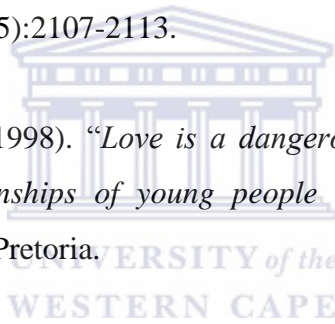
[http://www.who.int/violence\\_injury\\_prevention/violence/global\\_campaign/en/chap6.pdf](http://www.who.int/violence_injury_prevention/violence/global_campaign/en/chap6.pdf)

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**APPENDIX: I DATA COLLECTION TOOL**

**RESPONDENT NUMBER** \_\_\_\_\_

*The following were recorded in the victim medical record and J88 forms.*

**A. SOCIO-DEMOGRAPHIC DATA OF VICTIM**

**1. Date of birth** \_\_\_\_\_

**2. Sex**

1. Male 2. Female

**3. Race**

1. African 2. Colored 3. Indian 4. White 5. Others

**4. Marital status**

1. Single 2. Married 3. Widowed 4. Divorced

**5 Residential address**

1. Newcastle- semi-urban 2. Newcastle- rural

**6 Social Habits**

1. Smoking 2. Alcohol 3. Drugs 4. Others 5. None

**7 Religion**

1. Christianity 2. Islam 3. Hindu 4. Traditional 5. Others \_\_\_\_\_

**8 Employment status**

1. Employed 2. Unemployed 3. Student 4. Preschooler

**B. RELEVANT INFORMATION ON SEXUAL ASSAULT INCIDENT**

**9. Interval between incident and disclosure at hospital for medical assistance**

1. Less than 24 hours  
2. After 24 hours but less than 72 hours  
3. After 72 hours

**10. Reason(s) for delay**

1. None  
2. Fear of perpetrator  
3. Feeling dejected or ashamed after the assault  
4. Lack of faith in judicial system  
5. Distance from sexual assault service centre  
6. Victim is minor

7. Held captive by perpetrator
8. Intoxicated
9. Victim is mentally retarded
10. Sick or injured
11. Scared of not being believed by relatives

**11. Form of sexual assault**

1. Rape with vagina penetration
2. Forced anal intercourse
3. Attempted rape
4. Attempted anal intercourse
5. Male rape by female
6. Genital fondling
7. Forced oral sex

**12. Circumstances that led to sexual violence**

1. Forced co-habitation
2. Intimate partner relationship
3. Sudden attack by perpetrator
4. Workplace sexual assault
5. Religious leader/member interaction
6. Household with family member
7. Inside prison or police custody
8. Pupil/teacher interaction

**13. Type of injury sustained during incident**

1. None
2. Physical body injury
3. Genital injury
4. Both physical and genital injury

**14. Condition of clothes**

1. Clean
2. Wet
3. Torn



4. Dirty
5. Blood stained
6. Changed

### **C. VICTIM FACTORS**

#### **15. Previous history of sexual violence**

1. Yes
2. No
3. Unknown

#### **16. Number of consensual partner(s)**

1. One
2. Two
3. More than two
4. None

#### **17. History of contraceptive use**

1. Condom
2. Oral contraceptive
3. Injectable contraceptive
4. Intra uterine contraceptive device
5. None



#### **18. Presence of an existing medical condition**

1. Yes
2. No

#### **19. History of allergies**

1. Yes
2. No

#### **20. Psychological state after assault**

1. Calm
2. Anxious
3. Depressed
4. Tearful
5. Unemotional
6. Not recorded

#### **21. Referred to hospital by**

1. Self

2. Relative
3. Clinic personnel
4. SAPS/Prison officers
5. NGO
6. School Teacher

**22. HIV Status**

1. HIV positive
2. HIV negative
3. Unknown HIV status

**23. Accompanied to hospital by**

1. Parent/guardian
2. Relative
3. Friend
4. None
5. SAPS/Prison officer

**24. Treatment given**

1. PEP, Contraception, STI treatment and psychosocial support
2. PEP and psychosocial support
3. Psychosocial support only
4. Contraception, STI treatment and psychosocial support

**25. Return for full PEP**

1. Yes
2. No
3. PEP not given

**D. SEXUAL PERPETRATOR FACTORS**

**25. Perpetrator known to victim**

1. Yes
2. No
3. unknown

**26. Number of perpetrators**

1. One
2. Multiple
3. unknown

**27. Sex**

1. Male
2. Female
3. unknown

**28. Condom used**

1. Yes
2. No
3. unknown

**30. Weapons used by perpetrator**

1. Yes
2. No
3. Unknown

APPENDIX II: NEWCASTLE CRISIS CENTRE ASSESSMENT TOOL

  
**NEWCASTLE HOSPITAL**

**CRISIS CENTRE – ASSESSMENT TOOL**

<b>Personal information</b>		<b>Habits:</b>	
Date:	Time:	Smoking:	Alcohol:      Drugs:
Name:	Surname:		
DOB:	Age:	File nr.	<b>Social History:</b>
			Single:      Married:      Widowed:      Divorced:
<b>Vital Signs:</b>			
BP:	Pulse:	Temp:	<b>Psychological state:</b>
Resp:	WT:	Ht:	Calm:      Anxious:      Tearful:      Depressed:
			Unemotional:
<b>Relevant information:</b>			
Preg test:	HIV test:	<b>Health History:</b>	
Menarche:	LNMP:	Medical:	
Days:	cycle:	Surgical	
		Gynecological:	
<b>Allergies:</b>			
Food:		<b>Religion:</b>	
Medication:		<b>Medical/Cultural preferences:</b>	
Other			
<b>Condition of clothes:</b>			
<b>Referral:</b>		Clean:	Changed:      Dirty:
PHC:	SAPS:	Wet:	Blood stained:      Torn:
PVT DR:	Walk in:		
Other depts.:	NGO'S	<b>Sexual History:</b>	
		Nr of consensual partners:	
<b>Mobility:</b>		Last Consensual intercourse:	
Walking:	stretcher:	Contraceptive/ condoms:	
Wheelchair:	Crutches:		
Stretcher:		<b>Perpetrator:</b>	
		Known:      unknown:	
<b>Accompanied by:</b>		Nr. of perpetrators	
Alone:	Parent/guardian:	Condom used:	
Relative:	Friend:		
Other:		<b>Current complaint:</b>	
<b>Nutritional state:</b>			
Well nourished:		Undernourished:	
Dehydrated:		Emaciated:	

**APPENDIX III: J88 FORM**

G.P.-S. 01/02

J 88 (81/805259)

**REPORT BY AUTHORISED MEDICAL PRACTITIONER ON THE  
COMPLETION OF A MEDICO-LEGAL EXAMINATION**

*To be completed in legible handwriting and signed on every page*

1

**A. DEMOGRAPHIC INFORMATION**

1. Police station:	2. CAS No.:	3. Investigating officer: Name and number:	4. Time : : : : : Day Month Year
5. Name of medical practitioner: 6. Registered qualifications: 7. Phone number: 8. Fax number: 9. Place of examination:			10. Physical practice address or stamp:
11. Full names of person examined:		12. Sex: M <input type="checkbox"/> F <input type="checkbox"/>	13. Date of birth/apparent age:

**B. GENERAL HISTORY**

1. Relevant medical history and medication:

**C. GENERAL EXAMINATION**

1. Condition of clothing:

2. Height (cm):    3. Mass:    4. General body build:

5. Clinical findings: In every case the nature, position and extent of the abrasion, wound or other injury must be described and noted together with its probable date and manner of causation. The position of all injuries and wounds must also be noted on the sketches.

6. Mental health and emotional status:

7. Clinical evidence of drugs or alcohol:

8. CONCLUSIONS

Signature of medical practitioner

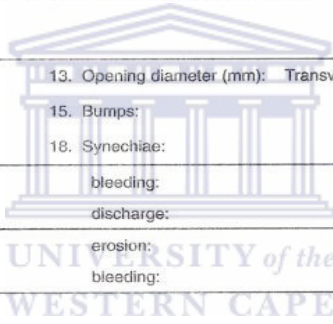
**D. HISTORY IN CASE OF ALLEGED SEXUAL OFFENCE**

**2**

1. Age of menarche <input type="text"/>		2. Number of pregnancies <input type="text"/>		3. Number of deliveries <input type="text"/>		4. Duration of pregnancy (if applicable) <input type="text"/> weeks	
5. Contraception (indicate with X): Yes <input type="checkbox"/> No <input type="checkbox"/>				7. First date of last menstruation:			
6. Method and last date of application/ingestion:				8. Duration of period <input type="text"/>		9. Duration of cycle <input type="text"/>	
10. Date and time of last intercourse with consent:				11. Number of consensual sexual partners during last 7 days:		12. Condoms: Yes <input type="checkbox"/> No <input type="checkbox"/>	
13. Since the alleged offence took place, has the person (indicate with X): bathed <input type="checkbox"/> washed <input type="checkbox"/> douched <input type="checkbox"/> showered <input type="checkbox"/> urinated <input type="checkbox"/> changed clothing <input type="checkbox"/>							

**E. GYNAECOLOGICAL EXAMINATION (State clinical findings)**

1. Breast development: Tanner stage 1-5 <input type="text"/>		2. Pubic hair: Tanner stage 1-5 <input type="text"/>		3. Mons pubis:	
4. Clitoris:			5. Frenulum of clitoris:		
6. Urethral orifice:			7. Para-urethral folds:		
8. Labia majora:			9. Labia minora:		
10. Posterior fourchette: scarring:			bleeding:		
tears:			increased friability:		
11. Fossa navicularis:					
12. Hymen: configuration:		13. Opening diameter (mm): Transverse <input type="text"/>		Vertical <input type="text"/>	
14. Swelling:		15. Bumps:		16. Clefts:	
17. Fresh tears (position):		18. Synechiae:		19. Bruising:	
20. Vagina: Number of fingers admitted:		bleeding:		tears:	
		discharge:			
21. Cervix:		erosion:		discharge:	
		bleeding:		other:	
22. Perineum:					



**F. SAMPLES TAKEN FOR INVESTIGATION**

1. Forensic specimens taken: Urine sample for pregnancy test:		Positive <input type="checkbox"/>	Negative <input type="checkbox"/>	Seal number of Evidence Collection Kit:
2. Specimens handed to:	Name:	Rank and Force number:		
	Signature:			

3. CONCLUSIONS

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Signature of medical practitioner



**G. ANAL EXAMINATION (State clinical findings)**

**3**

**SKIN SURROUNDING THE ORIFICE**

- |                     |                         |                        |
|---------------------|-------------------------|------------------------|
| 1. Hygiene:         | 4. Abrasions:           | 7. Redness/erythema:   |
| 2. Pigmentation:    | 5. Scars:               | 8. Bruising/haematoma: |
| 3. Fissures/cracks: | 6. Swelling/thickening: | 9. Tags:               |

**ORIFICE**

- |   |  |                          |
|---|--|--------------------------|
| 10. Tears/fissures:                         | 13. Reflex dilatation:                 | 16. Twitchiness/winking: |
| 11. Swelling/thickening of rim (tyre sign): | 14. Shortening/eversion of anal canal: | 17. Discharge:           |
| 12. Funnelling:                             | 15. Cupping:                           |                          |

**DIGITAL EXAMINATION**

- |  |                               |
|--|-------------------------------|
| 18. Presence of hard faeces in rectum: | 20. Thickening of anal verge: |
| 19. Laxity (pressure on anal orifice): | 21. Tone (sphincter grip):    |

**22. CONCLUSIONS**

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**H. MALE GENITALIA**

- |   |   |                           |
|---|---|---------------------------|
| 1. Genital development: Tanner stage 1-5 <input type="checkbox"/> | 6. Pubic hair: Tanner stage 1-5: <input type="checkbox"/> | 11. Prepuce and frenulum: |
| 2. Glans:   | 7. Shaft:   | 12. Scrotum:              |
| 3. Testes:  | 8. Epididymus:  | 13. Vas deferens:         |
| 4. Ulceration:  | 9. Penile discharge:                                      | 14. Smegma:               |
| 5. Presence of faeces:  | 10. Circumcision:   | 15. Urethral orifice:     |

**16. CONCLUSIONS**

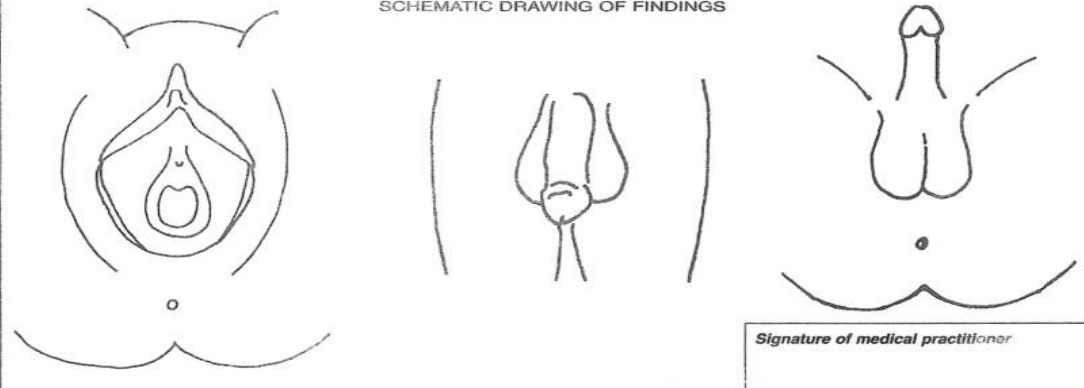
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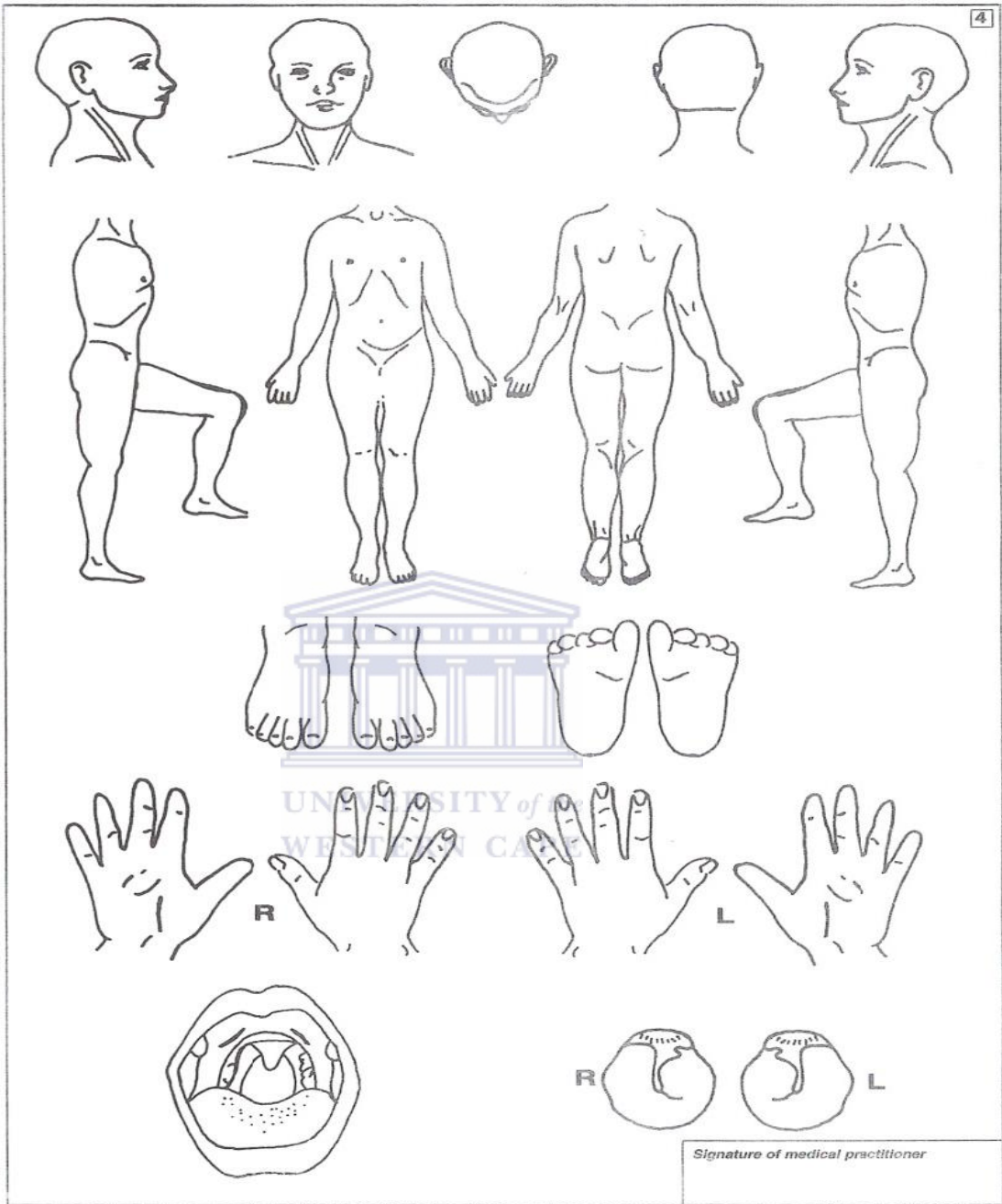
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**SCHEMATIC DRAWING OF FINDINGS**





Signature of medical practitioner

# APPENDIX IV: NEWCASTLE HOSPITAL OUTPATIENTS FILE

CAT. NO. 23-27608/A378058/08.09/NPP - Tel.: 033 345 0376

**PROVINCE OF KWAZULU-NATAL: DEPARTMENT OF HEALTH - OUT-PATIENT RECORD**  
**PROVINSIE KWAZULU-NATAL: DEPARTEMENT VAN GESONDHEID - BUITEPASIËNTEREKORD**

Patient No. Pasiënt Nr.	78 0531
----------------------------	---------

DEBTOR'S DETAILS • DEBITEÛRE SE BESONDERHEDE  
 HOSPITAL PATIENTS • HOSPITAALPASIËNTE

HOSPITAL • HOSPITAAL
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Type of case Tipe geval	PPP PPP	PHP PHP	PP PP	SP SP	FP FP
----------------------------	------------	------------	----------	----------	----------

Marital Status Huweliksstaat		Number of dependent children Aantal afhanklike kinders		
Gross Monthly income  Bruto maandelikse inkomste	Debtor: Debiteur:	R	R	R
	Spouse: Gade	R	R	R
	Other: Ander:	R	R	R
	<b>TOTAL TOTAAL</b>	<b>R</b>	<b>R</b>	<b>R</b>

PATIENT DETAILS • PASIËNTEBESONDERHEDE

Surname Van	[REDACTED]			IN-PATIENT PARTICULARS BINNEPASIËNTEBESONDERHEDE		
First names Voorname	[REDACTED]			I-P No. Ep Nr.	Date of Adm. Datum v. Opn.	Date of Dis. Datum v. Ont.
Address Adres						
	Postal Code • Poskode					
Sex Geslag	M	F	D.o.b.	78 0531		
	M	V	D.v.g.			

FULL-PAYING AND PRIVATE PATIENTS  
 VOLTAARIEF EN PRIVAAT PASIËNTE

Name of debtor Naam van debiteur	
Medical Aid Mediese Hulpskema	
Membership No. Lidmaatskap Nr.	
Employer or Department	
Werkgewer of Departement	
Address Adres	
Telephone No. Telefoon Nr.	
Patient's Occupation Pasiënt se beroep	
Labour / Service Number Arbeid / Diensnommer	
Identity Number Identiteitsnommer	

Group Groep						Other information: Ander inligting
Date Datum						
Signed Geteken						Debtors code • Debiteurs Nr.

I declare that the above information to the best of my knowledge and belief to be true and correct in all respects and acknowledge and understand that any false information supplied by me will make me liable for prosecution on a charge of fraud. Furthermore, permission is hereby granted for the disclosure of the nature of 'my/the patient's illness for accounting purposes. I further undertake to notify the hospital authorities of any change in financial and personal particulars that could effect my/the patient's classification as a patient.

Ek verklaar na die beste van my wete en oortuiging dat die informasie hierbo getoon waar en volledig is in alle opsigte en erken en verstaan dat enige onware informasie deur my gegee my aanspreeklik sal maak tot vervolging op 'n klag van bedrog. Verder verleen ek toestemming vir die openbaarmaking van die aard van 'my/die pasient se siekte vir rekeningdoelindes. Ek onderneem ook om die hospitaalowerhede in kennis te stel van enige finansiële en persoonlike besonderhede wat my/die pasient se klassifisering as 'n pasient mag verander.

Admitting Officer • Toelatingsbeampte

Date • Datum

(\*Delete which is not applicable)  
 (\*Deurskrap die wete van toepassing is nie)

Signature:

Handtekening:

Date:

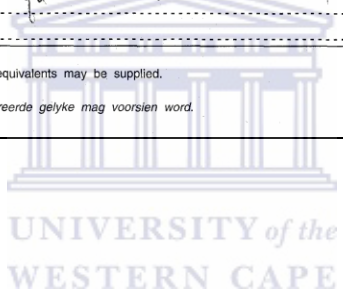
Datum:





MEDICAL DATA ■ MEDIESE BESONDERHEDE		PRESCRIPTION ■ VOORSKRIF				MASS ■ MASSA			
Date/Time Datum/Tyd	History, clinical findings, progress, treatment and signature of Medical Officer in full. Geskiedenis, kliniese bevindings, vordering, behandeling en handtekening van Mediese Beampte voluit.	DRUG SENSITIVITY MEKAMENTE SENSITIWITEIT	1 .....	2 .....	3 .....	4 .....	* Full Signature of Medical Officer * Volle handtekening van Mediese Beampte	Qty. supp. Hoëv. voors.	For Pharm. use only Net vir Aptk. gebrk.
23/12/07									

\* Prescribers are advised that registered generic equivalents may be supplied.  
FULL SIGNATURES ARE REQUIRED.  
Voorskrywers word in kennis gestel dat geregistreerde gelyke mag voorsien word.  
VOLLE HANDEKENING WORD BENODIG.



**APPENDIX V: LETTER OF APPROVAL FROM NEWCASTLE HOSPITAL**



**HEALTH**  
KwaZulu-Natal

**NEWCASTLE PROVINCIAL HOSPITAL**

4 Hospital Street, Newcastle, 2940  
Private Bag X 6653, Newcastle, 2940  
Tel: 034-3280026/34, Fax: 034-3124392/3280022  
Email: [vukilem@dohnc.kzntl.gov.za](mailto:vukilem@dohnc.kzntl.gov.za)  
[www.kznhealth.gov.za/newcastlehospital](http://www.kznhealth.gov.za/newcastlehospital)

**Date:** 22.07.2009  
**Enquiries:** Ms MV Mavundla  
**Reference:** Research

ATTENTION:

Dr Adefolalu

**RE- APPLICATION FOR APROVAL TO USE CLIENTS RECORDS**

This serves to inform you that Management looked at your request and gave permission to you to use the client's records. You will have to make arrangements with the department concerned with all relevant documents.

Wishing you success in your studies

**MISS M.V. MAVUNDLA**  
HOSPITAL CEO  
NEWCASTLE PROVINCIAL  
HOSPITAL  
**MS MV MAVUNDLA**  
CEO – NEWCASTLE HOSPITAL

UNIVERSITY of the  
WESTERN CAPE

uMnyango Wezempilo . Departement van Gesondheid

*Fighting Disease, Fighting Poverty, Giving Hope*