MASTERS RESEARCH

TItle: Exploring the perceptions of service providers on the availability and effectiveness of sexual violence interventions, services and programmes in De Aar

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Faculty of the Humanities

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Abstract

The aim of this study was to explore the perceptions of service providers on the availability and effectiveness of sexual violence interventions, services and programmes in De Aar. Participants were selected based on the nature of service they rendered to survivors of sexual violence. A qualitative study was conducted, using non-probability purposive sampling and snowball sampling. Data was gathered through a semi-structured interview.

The study found protection services, medical and psychological interventions to be easily accessible to all survivors of sexual violence. Additional services were also found to be available to survivors of sexual violence, depending on their needs. Participants were all of the opinion that the needs of survivors were being met in De Aar.

The data found the perceptions of service providers on the effectiveness of their interventions to be influenced by their adherence to regulations and training received through their organisations, in addition to personal steps taken to develop professional skills. The attitude of service providers and the co-operation of service users were found to hinder the effectiveness and consistency of prescribed interventions.

Gaps found to be inherent in all organisations were lack of human and physical resources such as vehicles. Stakeholders were found to be ineffective in their communication and co-operation between stakeholders was inadequate. Challenges found to hinder help-seeking were the perceptions of the community of the South African Police Service and sexual violence in general. The survivors themselves were also identified as a barrier to intervention, as they might accept, reject or discontinue intervention without warning.

Considering the aim and objective of this study, it can be concluded that there are services in place for survivors of sexual violence in De Aar. Immediate services, such as post-rape medical and legal services, are easily accessible. Follow-up and aftercare service are determined by a social worker and most organisations are effective in the services they render, despite organisational challenges and limitations.

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through this painfully growth journey. “I was born to make manifest the glory of God within me”; let me not dim my light, my God.

Chapter One

1. Introduction

Abuse, such as sexual violence, often results in physical injury and mental health problems for the survivor (Artz, Burton, Leoschut, Ward and Lloyd, 2016). Trauma theory asserts that trauma refers to the traumatic aftermath of an incident rather than the traumatic incident itself, which results in multiple symptoms of post-traumatic stress disorder (PTSD) (Visser, 2011). The impact of sexual violence on the individual thus varies and therefore requires different interventions that should be made available to provide effective and individualised interventions (Tavkar and Hansen, 2011).

People in rural areas of South Africa are not exempt from interpersonal violence, as abuse is prevalent across gender, location and setting, with some differences between boys and girls and younger and older persons (Meinck, Cluver, Boyes and Loening-Voysey, 2016), who are assumed to experience similar negative consequences of trauma that require appropriate intervention, which this research seeks to identify and describe. When working with survivors of abuse, interventions should specifically address the effects of trauma and facilitate healing (Substance abuse and mental health service administration [SAMHSA], 2018). It is unclear what trauma interventions are available to survivors of sexual violence in rural areas, or how effective the interventions are rendered by identified stakeholders. This research was intended to examine a range of sexual violence interventions rendered by various government and non-governmental departments in the community of De Aar.

1.1 Statement of the problem

According to Bougard and Booyens (2015), South Africa is the rape capital of the world, with high rates of sexual offences reported to the South African Police Service (SAPS) annually. The daily average of reported rape cases is 109.1, of which the majority involve adult females (Fact Sheet, 2018). Between 18,000 and 20,000 cases of sexual abuse reported annually involve children (Artz et al.,2016). Boys and girls were found to be at equal risk of sexual violence (Artz et al.,2016). Rape occurs at home, near the home in the community, at schools and in other physical

environments (Artz et al., 2016). Meinck et al. (2016) found no difference between urban and rural locations in terms of sexual harassment and rape victimisation. Sexual violence is thus not limited to an age group, gender or demographic location, meaning that people in rural areas are just as likely to be sexually violated as those in urban areas, therefore they require appropriate intervention measures too.

The consequences of rape include physical injury, the development of mental health problems and functional challenges such as missing school/work and/or being unable to complete tasks (Artz et al., 2016), thus directly influencing daily functioning negatively. Where the effects of sexual violence are severe, longer term challenges may include substance misuse and dependence, along with suicide ideation and attempts (Tillman, 2011) resulting in other psychosocial problems for the survivor, which add to distress caused by the incident. The immediate effects of rape on the survivor often manifest in emotions of anger, shame and guilt that contribute to increased levels of distress, obstructing disclosure and help-seeking from support structures (Tillman, 2011).

The prevalence of reported sexual offences is reflected in current statistics yet underreporting is well noted in literature. The true number of sexual violence cases is indicated by the estimate that only one in 13 cases is reported (Artz et al., 2016). Some factors contributing to underreporting include restrictions that exist in the community pertaining to sexual violence against women, fear that the police may discriminate against the survivor and secondary victimisation by role players in the criminal justice system (Bougard and Booyens, 2015).

The consumption of alcohol prior to rape has been found to influence observers' interpretations of the sexual occurrence and judgement of the survivor. Intoxication of the survivor is associated with greater survivor responsibility for the rape and less favourable views of the survivor (Goodman-Delahunty and Graham, 2011). Police perceptions of survivors' credibility and/or ability to consent to sexual activity were found to be influenced by contextual factors such as the level of intoxication of the survivor, victim characteristics (e.g. appearance), and questionable behaviour, such as walking alone at night, or going to bars by themselves (Goodman-Delahunty and Graham, 2011). Goodman-Delahunty and Graham (2011) found that the more intoxicated survivors were perceived to be, the more negatively the person was

viewed, and the less accountable the perpetrator was perceived to be by the police. Perceptions of society with regard to the relationship between alcohol use and rape are uninformed and presumptuous, as Linden (2011) highlights that alcohol is often used as a means to incapacitate the survivor.

Where child survivors are concerned, only one in four children is found to disclose rape, because of non-supportive reactions such as disbelief or blaming the child (Meinck, Cluver, Loening-Voysey, Bray, Doubt, Casale and Sherr, 2017). The way in which support structures are perceived by service users tends to hinder disclosure and help-seeking by survivors. Such perceptions of support structures may therefore influence the utilisation of services before any actual services are commenced and result in services not being utilised despite their availability.

Disclosure and help-seeking are steps taken by the survivor to heal and recover after being victimised (Tillman, 2011). Stakeholders should then ensure that survivors receive the help they seek by reporting the rape to stakeholders. Reporting to the police is the first, and potentially most important, step in the legal processing of sexual assault cases (Goodman-Delahunty and Graham, 2011). Collings (2009, cited in Meinck et al., 2017), however, found that children in informal settings or those seeking help after hours were less likely to receive any counselling or social services after disclosure. Meinck et al. (2017) found 49% of reported child sexual abuse cases to have received counselling and social work services that commenced between two days and six months after the incident. Approximately half of reported child sexual abuse cases did not receive any help from support structures, which confirms that disclosure of rape does not reflect help received (Meinck et al., 2017). Saywitz, Mannarino, Berliner and Cohen (2000, cited in Tavkar and Hansen, 2011) advise the commencement of intervention not to be delayed for too long to prevent worsened symptoms, or symptoms becoming chronic and resistant to treatment.

Literature shows that disclosure does not always result in help received and that a demographic location, along with the time help is being sought, influences the availability and consistency of services survivors receive (Meinck et al., 2017). What happens in one instance of seeking support has implications for further help-seeking and distress (Tillman, 2011). Therefore, when and how support structures respond to survivors' needs can harm and/or discourage survivors from seeking alternative

help, especially in areas where services to survivors are limited and/or unclear. Negative or hurtful disclosure experiences can be worse for the survivor than receiving no support at all (Basile and Smith, 2011).

Survivors' experiences of sexual assault are not universal; they have varied reactions to the incident and are likely to respond in diverse ways (Tillman, 2011). According to Aydin, Akbas, Turla and Dundar (2016), support structures should be a protective factor against the development of psychiatric disorders in survivors of trauma. Literature, however, describes support structures as hindering healing, and as a result contributing to underreporting, inconsistent service delivery and non-delivery of service. These consequences may result in secondary traumatisation of survivors or resistance to treatment owing to delays in intervention, which eventually contradict the intended effectivity of services to survivors and roles of support structures as a protective factor against further harm(Aydin et al., 2016).

1.2 Rationale and significance of the study

Rape is the most devastating personal trauma (Naidoo, 2013), which results in increased risk of developing PTSD (30%), major depression (30%) and contemplation of suicide (33%), of which 13% attempt suicide (Linden, 2011). In children, the risk of developing mental health symptoms are twice as likely and the immediate consequences of rape include missing school, being injured and needing medical attention (Artz et al., 2016). Rape thus has an impact on the psychological, physical and social well-being of the survivor. Linden (2011) explains sexual assault as a complex issue that presents no set, normal reaction to sexual violence. Support structures therefore have to be empathetic and competent in their response to survivors (Jina, Jewkes, Munjanja, Mariscal, Dartnall and Gebrehiwot, 2010).

The attitude of service providers to rape runs through the criminal justice system and if negative, can result in a negative work-based culture among support structures (Van der Bijl and Rumney, 2009). Ward (1995 cited in Van der Bijl and Rumney, 2009) warns against inaccurate, prejudicial and stereotypical perceptions of society about sexual violence. Van der Bijl and Rumney (2009) explain negative attitudes and myths to be found in every stage of the criminal justice process and state that rape stereotypes affect the judgement of individuals responding to survivors of rape. Literature describes the general beliefs of service providers as influencing individual

professional judgment and the entire justice system as support structure, resulting in a negative work culture that is not responsive to survivors' needs. This research seeks to explore the effectivity of services rendered, considering service providers' own and/or organisational beliefs about what influences the quality of services negatively.

Survivors of sexual violence have extensive post-assault needs (Tillman, 2011). For services to promote healing, interventions should be rendered by appropriately trained staff able to respond to immediate post-rape needs, which entail medical treatment and emotional support (Jina et al., 2010). It is recommended that a social worker or rape crisis counsellor evaluate the immediate and future emotional and safety needs of each survivor before such a person is discharged from a health care facility (Linden, 2011). Literature makes the assumption that all service providers are aware of the immediate and longer term needs of survivors and that all organisations rendering services to survivors are equipped to respond appropriately to survivors' needs. This research seeks to shed light on the reality of services available to survivors as explained by all appropriate stakeholders.

Table 1.1 below provides an overview of sexual offences as reported to the SAPS De Aar in 2018 (Crime Stats, 2018).

Table 1.1: Sexual offences 2018 statistics for De Aar

Rape	Sexual assault	Attempted sexual offences	Contact sexual offences	Total sexual offences
18%	0%	1%	2%	21%

From the above one can see that sexual offences constitute 21% of all reported crimes in De Aar. Of these reported sexual offences, 18% are incidents of rape, which highlights the need for appropriate intervention relating to survivors of sexual violence to address the nature and degree of harm caused by the offence.

This research seeks to explore service providers' perceptions of their own role and responsibility in the multi-sectoral approach to rape and how each department contributes to survivors' immediate needs and long-term well-being directly or indirectly.

1.3 Formulated research topic

The prevalence and the effects of sexual violence on the survivor (Artz et al., 2016; Linden, 2011; Bougard and Booyens, 2015; Africa check, 2018; Tillman, 2011) are well noted in literature and multiple support structures have guidelines (Naidoo, 2013; Jina et al., 2010; Department of Social Development, 2018) to promote evidence-based interventions that prioritise survivors' while preventing further harm caused by ineffective services. Literature lists how support structures can influence intervention with survivors negatively through, among others, non-supportive responses, failed or delayed responses to survivors and the negative social attitude of service providers to rape subsequently influencing the perceptions survivors have of support structures (Meinck et al., 2017; Bougard and Booyens, 2015; Van der Bijl and Rumney, 2009).

Tillman (2011) explains one instance of help-seeking to have implications for further help-seeking. Literature notes factors that influence help-seeking by survivors and effective service delivery by support structures, which in the end influence each other. This led the researcher to the question of, what happens to survivors in rural areas, where services are often limited and scattered . The researcher herself, was unaware of services available to survivors and could therefore not attest to the quality of services rendered by support structures. The researcher assumed that people rendering services would be able to identify other stakeholders who aid in the healing process and would be better able to shed light on the realities and effectiveness of services for survivors of sexual violence.

The topic is thus: Exploring the perceptions of service providers on the availability and effectiveness of sexual violence intervention services and programmes in De Aar.

1.4 Research questions

The main research questions to be answered by this study are:

1.4.1 What sexual violence interventions, services, programmes and support structures are available in De Aar to survivors of sexual assault?

1.4.2 What are the perceptions of service providers on the effectiveness of sexual violence intervention, services and programmes in De Aar?

1.4.3 Are there any gaps, issues and/or barriers in services, and if so, how can these be overcome?

1.5 Research objectives

The research objectives are derived from the research questions and read as follows:

1.5.1 To determine available sexual violence interventions, services, programmes and support structures in De Aar to survivors of sexual assault.

1.5.2 To explore the perceptions of service providers on the effectiveness of sexual violence intervention, services and programmes in De Aar.

1.5.3 To explore gaps, issues and/or barriers in services, and if so, how these can be overcome.

1.6 Main assumptions

The main assumption the researcher made was that services were available to survivors of sexual violence in De Aar. This assumption was based on the reality that most district departments were better resourced and were based in De Aar. De Aar was thus the best resourced town in the district, with services that were not limited to only one organisation (facility).

Another assumption was that service providers co-operated well with one another in rendering services, and there were few to no challenges in the handing over of cases (referral). Different departments had different mandates but they were also aware of their role when working with other departments. In cases such as sexual violence, departments were assumed to focus on their role in the entire structure and if each department participated effectively, there should be no hindrance in co-operation.

The last assumption was that professionals and the community at large in De Aar were not aware of the scope of services rendered to survivors of sexual violence. This assumption was based on the researcher's observation of professionals during inter-departmental and multi-disciplinary training programmes.

1.7 Clarification of terms

To ensure that the reader understands the research in the intended context; terms used throughout the paper will be defined in this section.

Rape

Rape is defined in the Criminal Law (Sexual Offences and Related Matters) Amendment Act, Act 32 of 2007 [Sexual Offences Act -SOA] as an activity where "Any person ('A')… unlawfully and intentionally commits an act of sexual penetration with a complainant ('B'), without the consent of B". For the purpose of this research rape will be referred to as defined by the SOA.

Trauma

The Diagnostic and Statistical Manual of Mental Disorders (DSM 5) definition of trauma requires " actual or threatened death, serious injury, or sexual violence". In this study trauma refers to the survivor's response(s) to a sexual violent occurance.

Service providers

The Public Service Act, Act of 1994 describes a public/civil servant as a person appointed on professional merit to operate in the public sector mandated by a government department or agency. Public servents are often service providers to survivors of sexual violence. In this study service providers refer to the diverse organisations and departments survivours of sexual violence come into contact with in the event of sexual violence.

Perceptions

Perception is described as the utelisation of sensory and cognative processes to view the world around us and understanding phenomenas through interpreting sensory information based on experience (Mc Donald, 2012). In this study perceptions refer to distinctive service provider's view on the availability and effectiveness of sexual violence interventions, services and programmes.

Sexual assault

The Criminal Law (Sexual Offences and Related Matters) Amendment Act, Act 32 of 2007 [SOA] defines sexual assault as "(1) A person ('A')… unlawfully and intentionally sexually violates a complainant ('B'), without the consent of B."

Sexual violence

This research will refer to sexual violence but use the definition of sexual acts defined in the SOA. A sexual act means an act of sexual penetration or an act of sexual violation (SOA) (RSA, 2007).

Survivor(s)

The United Nations (1985:303) describes survivors to mean persons who, individually or collectively, have suffered harm, including physical or mental injury, emotional suffering, economic loss or substantial impairment of their fundamental rights, through acts or omissions that are in violation of criminal laws operative within a state. The term 'survivors' will refer to person(s) directly harmed through sexual penetration.

Intervention/services

Intervention is defined as involvement and interaction with members of a specific social system to address specific social problems (Rebach, 2001). In this study intervention and services refer to actions taken by service providers to provide service or support directly to individuals, who in this study are survivors of sexual abuse. Interventions include activities such as counselling and programmes.

1.8 Main ethical considerations

All ethical considerations will be briefly discussed and their revevance to this study will be explained. Ethics considerations include harm to respondents, voluntary participation, informed consent, deception of respondents, and violation of confidentiality, denial of treatment, compensation, and debriefing of participants, the actions and competence of the researcher, co-operation with contributors and sponsors and publication of the findings.

1.8.1 Harm to respondents

Strydom (2011:115) explains that research may be physically and/or emotionally harming to participants and that it is the ethical responsibility of the researcher to protect participants, within reasonable limits, from emotional harm and physical discomfort (Strydom, 2011). In this research participants were verbally informed about possible harm to them and informed in writing, on the consent form, about

where help could be sought if this research should result in any harm to them. The information given before the research commenced gave participants the opportunity to withdraw from the study, if they chose to do so (Strydom, 2011: 116).

1.8.2 Voluntary participation

Participation should at all times be voluntary and never forced; participants should be aware that they are not obliged to participate (Strydom 2011: 116-117). In this study relevant stakeholders were requested telephonically to participate in the research and this was followed up in writing once they agreed to participate. Those who chose not to participate were asked to identify other possible stakeholders for this study.

1.8.3 Informed consent

Informed consent suggests that adequate information on the goal, duration of participants' involvement, procedures of the investigations, possible harm and the credibility of the researcher has been communicated to participants (Royse, 2004, cited in Strydom, 2011 ; Strydom, 2011). In this study participants who agreed to participate in the research received a consent form with all the relevant information pertaining to participation and this research. Participants were also informed of the degree of confidentiality with regard to the research.

1.8.4 Deception of respondents

Deception is described as the misleading and deliberate misrepresentation of facts or withholding information from participants (Strydom, 2011: 118). Participants in this research were given the option of going through the semi-structured interview schedule before the actual interview to allow them to ask questions of clarification or to withdraw from this research. Some participants received the interview schedule, on request, before speaking to the researcher and two participants withdrew from the research after they had received the interview schedule.

1.8.5 Violation of confidentiality

Confidentiality refers to safeguarding the privacy and identity of the participant (Strydom 2011: 119). Individuals who take part in research have the right to privacy and the right to decide when, where, to whom and to what extent his or her attitude, beliefs and behaviour will be revealed (Strydom, 2011: 119). The researcher

informed participants that there would not be full anonymity in this research, as some particulars, such as their job title and organisation, would be mentioned in the research findings. Anonymity might be even less for some participants because of being the only person at an organisation rendering services to survivors of sexual violence. Specific identifying information, such as names, however will remain confidential.

1.8.6 Denial of treatment

Denial of treatment refers to research done with groups where one group receives service and the other is denied service for the purpose of research (Strydom, 2011). The ethics of caring professions mandates access to some sort of service (Strydom, 2011:121). The researcher arranged for participants to see the social workers of the Department of Health (DOH) in the event of harm/re-traumatisation occurring from taking part in the research.

1.8.7 Compensation

Compensation refers to reimbursing participants (Strydom, 2011:121). Participants in this research did not receive any incentive for participating. The researcher made participation convenient for participants by allowing them to set a date, time and venue for the interview.

1.8.8 Debriefing of participants

Debriefing occurs after the research where participants get the opportunity to work through their experiences and have questions answered and misconceptions removed (Strydom, 2011). Debriefing in this research was done by the researcher where participants needed debreifing.

1.8.9 Actions and competence of researcher

To undertake the proposed investigation, researchers are tasked with the responsibility of ensuring they are competent, honest and adequately skilled (Strydom, 2011: 123). The researcher has done research during her under-graduate and post-graduate (Honours) courses. She is also under the research supervision of a study supervisor provided by the University of Cape Town to ensure all ethical obligations are met.

1.8.10 Co-operation with contributors and sponsors

Contributors are often colleagues and students who participate in the research process through, for instance, data gathering, whereas sponsors are often organisations that contribute to the research financially (Strydom, 2011: 124). No contributors or sponsors were involved in this research, as the researcher undertook the research process by herself with no financial help to complete the actual research.

1.8.11 Publication of findings

For the work of the researcher to be viewed as research, the findings of the study must be introduced to the public in writing and to the participants as a form of recognising and maintaining a future good relationship with the community concerned (Strydom, 2011: 126). Findings of this research will not be made available to the public at large, but to students of the University of Cape Town. Participants will each receive a copy of the research to aid in overcoming some of their challenges.

1.9 Outline of the chapters

The structure of the dissertation will be as follows:

Chapter 1: The chapter introduces the topic of interest to the reader. In this section the problem is stated and the significance of this research is motivated.

Chapter 2: This section delves into literature on the said topic. It also presents the theoretical, policy and legislative framework relevant to the research.

Chapter 3: The methodology stating how the research was conducted is set out.

Chapter 4: The findings are presented and discussed in relation to the research questions and objectives.

Chapter 5: The main findings of the research are discussed and conclusions are reached. Recommendations for service providers are made in the final chapter.

1.10 Summary

Sexual violence can result in multiple degrees of physical and psychological distress and harm to the survivor that has a direct impact on their daily functioning and overall longer term well-being. Relevant service providers (support structure) are tasked with the responsibility to respond effectively to the harm cause by sexual violence from the moment survivors disclose the occurrence of rape until all their

physical and psychological needs have been met, in attempt to rectify harm. How service providers respond to survivors in distress is explained to influence the continuation of the help-seeking process, countering the phenomenon of survivors failing to use services despite their availability and accessibility. Guiding principles for prescribed services to aid survivors will be discussed in the section that follows.

Chapter two: Literature review

2. Introduction

This section provides an overview of the national and international legislative framework and policies that relate to work done with survivors of sexual offences in South Africa. The theoretical framework used in this study aims to explain interpersonal (sexual) violence, while the rest of the section aims to illustrate types of services that need to be in place, or can be used, irrespective of the geographic setting, for effective intervention when working with survivors of sexual violence.

2.1 Policy and legislative framework

United Nations Convention on the Rights of the Child (United Nations General Assembly, 1989)

The convention outlines the human rights of children, such as the right to survival, protection against abuse and exploitation, and protection from harm (UN General Assembly, 1989). Article 39 of the Convention on the Rights of the Child (CRC) makes special provision for the rehabilitation of child survivors; it states that "children who have been neglected, abused or exploited should receive special help to physically and psychologically recover and reintegrate into society" (UN General Assembly, 1989). Service providers are thus mandated to provide "special help" to child survivors of sexual violence to ensure their safety and recovery.

The convention is based on four guiding principles, namely non-discrimination, best interest of the child, right to life and respect for the views of the child (Department of Social Development, 2018). The guiding principles of the convention set forth how children should be managed as survivors of abuse, despite their age or who the offender is, as it has been found by Artz et al. (2016) that 30% of children are sexually abused by a relative, whether staying inside or outside the home of the child. Support structures are therefore called upon to advocate the well-being (best interest) of children first, and the way in which they manage child sexual abuse cases determines whether or not service providers protect children or fail them.

Child survivors are recognised as a vulnerable group who require special protection appropriate to their age, level of maturity and individual special needs (United Nations, 1985:314). Service providers are charged to apply child-appropriate interventions when working with child survivors, who are different from adults in term

of maturity. This research seeks to explore how services are offered to child survivors through distinct enquiries relating to interventions and procedures when working with children and adult survivors where appropriate. This research was thus informed by the knowledge that intervention in the case of children should be appropriate to the child's age, maturity and individual special needs.

United Nations' Declaration of Basic Principle of Justice for Survivors of Crime and Abuse of Power (General Assembly Resolution 40/34, 1985)

The United Nations' Declaration of Basic Principle of Justice for Survivors of Crime and Abuse of Power (1985) is an international declaration that recognises the needs and rights of survivors of crime and violence, based on the belief that survivors should be identified and treated with respect and dignity (Department of Social Development, 2008).The declaration maintains that survivors are entitled to have access to justice and fair treatment to rectify harm and loss suffered as a result of violence (United Nations, 1985). Multi-sectoral service providers are therefore expected to ensure justice for the harm caused and to support and encourage survivors' healing.

The United Nations Declaration of Basic Principles of Justice for Survivors of Crime and Abuse of Power stipulates that service to survivors should be accessible, resulting in restitution for harm suffered, through appropriate training of professionals (United Nations, 1985). The United Nations (1985) recommends adequate training and education of professionals working with survivors to promote effective intervention that is sensitive in nature and protective of survivors. The direction of enquiry of this research was informed by the declaration on the effectivity of intervention, which specifically looked at training service providers receive to equip them with the skills to render the prescribed service. The research also explored the accessibility of appropriate services to survivors, as explained by service providers.

Constitution of the Republic of South Africa, Act 108 of 1996

The Constitution is the foundation of South African legislation in which government is mandated to protect every citizen equally by law. Chapter 2 of the Constitution of the Republic of South Africa (1996) is the Bill of Rights, which proclaims human dignity, equality and freedom that the state must respect, protect and promote as stipulated.

Service providers, such as the state, should uphold the Constitution through the Public Service Act under which government employees are employed. How service providers respond to disclosure of sexual violence illustrates whether or not the human dignity, equality and freedom of survivors are upheld and promoted by support structures in place for them.

Government is tasked to take appropriate steps to ensure that peoples's human rights are respected (Department of Social Development, 2018). Service providers such as SAPS and Department of Social Development (DSD) should therefore be proactive in preventing the occurrence of sexual violations (crime). Section 27(3) of the Constitution also mandates statutory interventions by medical personnel to provide emergency rape care to survivors of sexual violence (Naidoo, 2013). In this research, preventative measures employed by stakeholders to protect people and prevent future occurrence of rape are explored through probing into organisations' own evaluation of the services they render to survivors as a means of improving the effectiveness of their existing interventions.

Children's Act, Act 38 of 2005

The Children's Act (38 of 2005) describes the rights of children as outlined in the Constitution. The Act sets out principles relating to care and protection of children, defines parental responsibilities and rights, and makes provision for children's courts (CA)(RSA, 2005). Section 150 (1)(i) makes provision for children being maltreated, abused and neglected by a caregiver to be removed from the environment or that the alleged offender be removed from the child's environment, according to section 152.

For support structures to respond effectively to child survivors' needs, they require knowledge and understanding of legislation on the management of children who are abused to ensure safety and promote holistic well-being. With regard to sexual violence, the Children's Act (38 of 2005) outlines the responsibilities and rights parents have to aid service providers in satisfying the child's needs. The Children's Act (38 of 2005) illustrates that the impact of child rape influences not only the child, but also the non-offending parent as a secondary victim. In this research the Children's Act informs enquiry on intervention involving non-offending family who are

described to be the child's primary support structure in their environment and the management of child survivors in areas less resourced with services.

Child Justice Act, Act 75 of 2008

The Child Justice Act (75 of 2008) (CJA) makes provision for restorative justice (RJ) to occur through family group conferencing (FGC) and victim-offender-mediation (VOM). FGC entails bringing together a person who is alleged to have committed an offence, and the victim, supported by both families and other appropriate persons (CJA, section 61) (RSA, 2008). VOM is defined in the same way in the CJA, but with less emphasis on family presence during mediation (CJA, section 61) (RSA, 2008).

The CJA (section 2 (a-e)) aims to protect the interest of survivors and the community by holding offending youth accountable for their actions through applying RJ approaches that seek to reinforce respect for human rights (Steyn, 2010). RJ practices are mandated by court as a diversion option (section 61) or sentence option for youth offenders (section 61 and 73) (CJA, section 61)(RSA, 2008), often prescribed for the offender and not the survivor. The CJA, however, seeks to protect the long-term well-being of both the youth offender and survivor through discussion of offence/s, eventually compensating for harm caused by the crime (Steyn, 2010). In this research the CJA informs the exploration of the practical application of RJ practices and how these are applied to meet the survivor's needs, especially by the DSD, which provides probation services.

Criminal Law (Sexual Offences and Related Matters) Amendment Act, Act 32 of 2007 OR Sexual Offences Act

The Criminal Law (Sexual Offences and Related Matters) Amendment Act (CLAA) (32 of 2007) abolishes the common law offence of rape and replaces it with a new expanded statutory offence of rape, applicable to all forms of sexual penetration without consent, irrespective of gender (CLAA) (RSA, 2007). It creates new statutory offences that criminalise all forms of sexual abuse and gives adequate recognition to the needs of survivors of sexual offences (Artz, 2017).

Chapter 1(e)(ii) of the CLAA (32 of 2007) refers to service delivery in the criminal justice system responding to sexual offences by prescribing proper recognition of the

needs of survivors through timeous, effective and non-discriminatory investigation and prosecution. Chapter 5 of the CLAA prescribes services for survivors of sexual violence to ensure medical needs are met (CLAA) (RSA, 2007) and to prevent future medical conditions such as human immunodeficiency virus (HIV) infection. In this research the CLAA informed the semi-structured interview schedule by going beyond seeking the availability of interventions to survivors and noting the manner in which services are rendered and the time service providers take to respond to survivors' needs; these are prescribed to be non-discriminative towards the survivor.

2.2 Theoretical Framework

Trauma theory

The definition of trauma of the Diagnostic and Statistical Manual of Mental Disorders (DSM 5) includes actual or threatened death, serious injury, or sexual violence (American Psychiatric Association, 2013). Changes made in the DSM 5 to include sexual violence in the core premises of trauma thus reflect how rape would evoke significant symptoms of distress in almost everyone (Visser, 2011). Trauma thus refers to the traumatic aftermath (post-traumatic stage) of a traumatic occurrence that suggests the repetition of the stressor event through cognitive processes such as memory, dreams, narrative and/or various symptoms known under the definition of PTSD which provides a framework for understanding trauma (Visser, 2011). Trauma theory aims to create a language and method for understanding the long-term psychological effects caused by exposure to traumatic experiences (Tseris, 2013), experiences that stay with the individual in the form of a narrative after the incident has occurred.

Herman (1992, cited in Tseris, 2013) explains that exposure to a traumatic event can result in significant psychological harm causing a number of mental health symptoms, such as difficulty in controlling emotions, difficulty in relating to others and alterations in self-perception. Trauma can have lifelong implications for children and affect their adaptive and interpersonal functioning, negatively influence cognition and ability to regulate emotions, and reduce immune functioning (Khan, 2016). Other implications of trauma in children include disturbance in mood, behaviour, attention, attachment and impulse control, which can mimic other psychiatric disorders such as attention deficit hyperactivity disorder and bipolar disorder (Khan, 2016).

A traumatic event can disrupt attachment between oneself and others by challenging fundamental assumptions about moral laws and social relationships (Balaeav, 2008). Kirmayer (1996, cited in Balaeav, 2008) adds that social violation of a traumatic experience results in different types of trauma, producing different responses. The psychological impact of trauma on children can also be displayed in anti-social behaviour such as engaging in risk behaviour, poor school performance that leads to school drop-out, substance abuse and promiscuity (Khan, 2016), which in itself may result in multiple long-term challenges. The nature of the problem calls for intervention that is effective in responding to survivors' multiple needs.

Recovery from sexual violence is lengthy because of the impact, complexities and degree of homogeneity of the sexual experience (Tavkar and Hansen, 2011). Trauma theory describes survivors' response to sexual violence as unpredictable and unalike, calling for different approaches in responding to survivors' immediate and long-term needs. In this research, trauma theory informs the direction of enquiry on effective intervention through probing of stakeholders' response to survivors in a state of shock. Meinck et al. (2017) state that non-supportive reactions such as disbelief cause psychological harm to survivors. The research questions will seek stakeholders' understanding of the rape problem by asking questions on stakeholders' role(s) in rectifying harm caused by the offence and their opinion on how intervention can be improved when dealing with survivors, based on their past interaction with survivors.

Systems (ecological) theory

Systems theory conceptualises violence as a result of multiple, interacting levels of influence on the individual, relationship (family), community, and societal level (DeGue, Holt, Massetti, Matjasko, Tharp and Valle, 2012). General systems theory is a theoretical framework in which various micro-level approaches are known as systems, seeking to explain the behaviour of complex systems (Whitchurch and Constantine, 2009), such as rendering services to survivors of sexual violence. According to Balaev (2008), individual trauma can be passed on to others who did not experience the actual occurrence, but because they share social or biological similarities, the traumatic experience of the survivor influences the group with similarities. Women, for example, are more afraid for their own safety and of being

assaulted; they are fearful of doing things they used to do, and feel a greater sense of loss of security when survivors disclose that they had been raped (Banyard, Moynihan, Walsh, Cohn and Ward, 2010).

This shows that the impact of trauma is not limited to the survivor, but can also be transmitted to others, based on shared social characteristics (Balaeav, 2008) and the interconnection and relationships between people and their environment (Jack, 2012). Secondary traumatisation of non-victims may thus occur as a result of interacting with a victim as primary or micro-level service user. Service providers who work with traumatised clients may experience compassion fatigue caused by exposure to secondary trauma that can potentially affect the physical and mental well-being of the service provider (Jina, Jewkes, Christofides and Loots, 2013). System theory offers a way of looking at the world as interrelated (Whitchurch and Constantine, 2009), much as the impact of sexual violence on the survivor's holistic being; instead the impact of the trauma can have a ripple effect on all spheres in terms of effective protection of survivors and restoring harm caused by an occurrence of sexual violence.

Systems theory allows for a holistic framework in which different elements of a person's life can be located and connected between the different systems (Jack, 2012). This means systems theory can provide a framework where the needs of survivors are prioritised by connecting different stakeholders, as mezzo-level support structure, to dissimilar needs survivors may have in response to prescribed legislation and policies in place on macro-level to ensure restoration and prevention of future harm. Practically applied to this research, systems theory was used to explore the dynamics of services and service providers in their response to survivors. It also allowed the researcher to view sexual violence as an overall social problem in which related needs and services can be observed and explored in the framework of responding to sexual violence.

2.3 Themes (literature) linked

South Africa is reported to be a country with one of the highest rape rates in the world (Naidoo, 2013). In the year 2017/18, the majority of sexual offences recorded by the SAPD were rapes, followed by sexual assaults. Africa check (2018) reports a total of 50 108 sexual offences recorded by the SAPD in the year 2017/18, an

average of 110 rapes per day. The reports included all sexual assaults, irrespective of gender or age. Children were therefore included.

Sexual violence is one of the most intrusive forms of interpersonal violence, which can have negative, lasting effects on the well-being of the individual. Naidoo (2013) explains that rape invades the psychological and physical privacy of the survivor, resulting in shattered lives and sometimes loss of life. The psychosocial difficulties that stem from traumatic events are known as trauma symptoms (Tseris, 2013) or post-traumatic stress symptoms.

Trauma symptoms are explained by Naidoo (2013) to include feelings of shock, disbelief, numbness, fear, anger, guilt, self-blame, sadness and behavioural changes such as withdrawal, sleep disturbances, hypervigilance, mood swings and poor concentration, resulting in lifestyle changes and avoidance of others. Survivors of rape are at 30% risk of developing PTSD and/or major depression, and 33% risk of suicide ideation, of which 13% attempt suicide (Linden, 2011). Sexual violence is thus a complex problem with no set reaction that can be expected from all survivors (Linden, 2011).

Robertson (2011, cited in Naidoo, 2013) described trauma symptoms as emotional scars that take months and sometimes years to heal. This is especially true of children, because child survivors are twice as likely to develop mental health symptoms (Artz et al, 2016), predicting a need for psychological intervention. Trauma can have a significant impact on the individual's physical and cognitive development. Cohen, Mannarino, and Deblinger (2006:14, cited in Tseris, 2013) found children who had a history of sexual abuse, physical abuse, or exposure to domestic violence to have a smaller brain size, lower IQ, poorer grades and smaller corpus collosi (the part of the brain that connects the right and left hemispheres) than children who did not have such trauma histories. Trauma can therefore result in cognitive barriers that have lasting effects on children's cognitive abilities, which may affect their quality of life.

Lengthy recovery from sexual violence is influenced by the degree of complex and homogeneous impact sexual violence has on the survivor (Tavkar and Hansen, 2011).The impact the occurrence has on the survivor consequently determines the

service needs of each survivor. In the section that follows literature identifies possible service providers for the different needs survivors may have.

2.3.1 Service providers for survivors of sexual violence

Frequent incidents of rape led to the emergence of services for survivors of rape in the 1980s in South Africa, but the implementation of these was considered insufficient (Bougard and Booyens, 2015). The South African government instigated an anti-rape strategy in 2002 that aimed to respond to the problem, prevent rape and support survivors of rape through support of stakeholders who form part of a multi-disciplinary team referred to as an inter-departmental management team (Bougard and Booyens, 2015).

The complex nature of sexual violence calls for a multi-sectoral approach to ensure security and positive health outcomes for survivors (Jina et al., 2010). Service providers consequently come from different professional bodies contributing to protection and/or restitution for harm caused to the survivor. Sexual violence entails medical, psychological and legal intervention to address the complexities of rape (Linden, 2011).

Bougard and Booyens (2015) identified and described the task of role players as including the activities of legal practitioners in non-profit agencies (such as Legal Aid) to render support and prosecute the case; medical health care professionals from the DOH, who conduct the medico-legal examination; an investigating officer from the SAPS, responsible for administrative and investigative tasks; and the DSD, which primarily offers support services for survivors of rape and sexual assault. The multi-sectoral approach is an indication of survivors' multiple needs after victimisation and also indicates who the primary service providers are to meet survivors' basic needs post-assault.

The South African government has recognised the increasing problem of sexual violence, and in an attempt to protect society and repair harm, initiatives such as rape crisis centres have been established across the country (Bougard and Booyens, 2015). Thuthuzela Care Centres (TCC) are a known initiative of government and non-profit agencies across South Africa that operates as a one-stop facility, specifically for sexual violence (National Prosecuting Authority, 2015). The

ideal of responding to sexual violence is that all survivors' immediate needs are met at one facility to prevent of additional challenges, such as paranoia about new aggressors (National Prosecuting Authority, 2015). According to observation, De Aar as a community is resourced with all the organisations identified as necessary, operating in their designated fields. Stakeholders identified in literature allowed the researcher to ensure that each relevant organisation and professional body could be included in this research for more accurate findings. The section below will describe prescribed immediate procedures that apply to disclosure of rape to the SAPS or a health care facility.

2.3.2 Immediate services in responding to survivors

Sexual violence is a pervasive issue with many negative health outcomes that can result in acute and long-term physical and mental health complications (Munro-Kramer, Dulin and Gaither, 2017). Rape as a violent crime must be regarded as a medical emergency, since survivors are often physically assaulted snd sustain head injuries, fractures, drug intoxication and penetrating organ injuries (Naidoo, 2013). This means that all survivors of sexual violence are to be managed as emergencies, with particular procedures that apply during the medico-legal intervention.

A person who seeks care at a health care facility after sexual assault should firstly be evaluated for acute traumatic physical injuries by the emergency medical officer, followed by the administration of prophylaxis for sexually transmitted infections and pregnancy, and toxicological testing if it is indicated that a substance has been used to incapacitate the person (Linden, 2011). Because of the nature of sexual violence, the medical evaluation and treatment of survivors is time-intensive, as some interventions are linked to time passed, such as survivors receiving post-exposure prophylaxis within 72 hours after sexual assault, especially where the perpetrator is not known or is suspected to be HIV-positive (Linden, 2011). Anti-retroviral medication is provided to prevent HIV transmission as part of comprehensive post-sexual assault care (Abrahams, Jewkes, Lombard, Mathews, Campbell and Meel, 2010) that aims to meet survivors' immediate post-rape needs and is suggested to prevent future physical health challenges. Once the medical aspects of the survivor have been addressed, the survivor's statement of the incident is taken by the SAPS (National Prosecuting Authority, 2015).

A social worker or rape crisis counsellor is described as someone who has expertise in acute reaction to rape and can explain procedures in hospital (Linden, 2011). Emotional support by a rape crisis counsellor or social worker follows the medical interventions with a safe plan for discharge, including planned follow-up for medical care and psychological support (Linden, 2011). Naidoo (2013) suggests that emotional support should be available at least on a referral basis where support cannot be offered to the survivor at the time of the medical intervention. Alternatively, crisis counselling could also be offered enroute to a health facility by trained volunteers or police officers (National Prosecuting Authority, 2015). In first world countries, crisis services are rendered not only on contact with a service provider, but also through a telephone hotline service that allow access to crisis services at any time (Macy, Giattina, Montijo and Ermentrout, 2010). Survivors are then able to access information and referral, and may even receive brief crisis intervention in a state of crisis, eventually making a vital difference in the survivor's life (Macy et al., 2010). Crisis intervention with non-offending parents also enables parents to facilitate recovery after abuse (Tavkar and Hansen, 2011).

The National Prosecuting Authority (2015) describes a social worker as being responsible for the long-term counselling of the survivor, either personally or by referral, and to ensure that other psychosocial aspects are addressed. Linden (2011) adds that emotional support should also be provided to family and friends of the survivor on contact with a counsellor where the need arises. Mathews, Abrahams and Jewkes (2013) agree that emotional support should be provided to the survivor and family, but strongly advocate support immediately after disclosure of the survivor to enable the family to support the survivor's recovery and resilience, despite possible impairments in the family function caused by distress, anxiety and negative emotional reactions experienced as a result of the offence. Literature provides alternatives to emotional counselling to highlight the importance of meeting the survivor's emotional needs in a state of crisis. Concerns arise regarding the quality of the emotional support survivors receive if many alternative stakeholders are able to provide the same service, with no clear indication of an intervention process for emotional support. Moreover, specific organisations are not identified for each need survivors may have to prevent survivors from having contact with multiple

stakeholders, receiving the same service. The section that follows will discuss programmes and services that follow the medical examination of the survivor.

2.3.3 Broad services to survivors of sexual assault

When working with survivors of sexual assault, interventions should specifically address the effects of trauma and facilitate healing (SAMHSA, 2018). Muraya and Fry (2016) characterise interventions with survivors of sexual violence as intense person-centred services aimed at restoring physical and mental health, while building resilience in the survivor. People who have been sexually exploited benefit from access to high- quality, evidence-informed and effective programmes offered by health care and allied (additional) service providers, directly involved in an organisation itself or through community partners (Moynihan, Pitcher and Saewyc, 2018).

Lanktree (1994, cited in Tavkar and Hansen, 2011) urges a psychological evaluation to follow disclosure of sexual assault so that background information on the survivor can be gathered, the presenting problem can be assessed, the family history can be obtained and information can be gathered about the sexual abuse, from which an individual treatment plan may be formulated. Moynihan et al. (2018) explain that services that foster healing may vary in the delivery of their interventions (Moynihan et al., 2018), offering service providers several approaches to intervention.

Interventions that foster healing are promoted through intensive case management interventions that refer to services and programmes that provide comprehensive service that minimally address survivor's physical, mental, and psychosocial needs through multiple strategies such as crisis intervention, educational and vocational support, mental health services, and/or housing assistance (Moynihan et al., 2018). Intensive case management interventions use multiple approaches to address the immediate and longer term needs of each survivor holistically.

It is advised that psychosocial care be initiated as soon as the needs assessment is complete, following an individual treatment plan that includes the inputs of the survivor (Muraya and Frey, 2016). Wölte and Tautz (2007, cited in Muraya and Frey, 2016) argue that the goal of psychosocial care is to create a secure, respectful environment where the survivor is empowered and can heal psychologically.

Psychosocial care and counselling are terms interchangeably used in literature to refer to interventions that are not medically related, but psychosocially, and include services such as individual counselling, group counselling sessions, creative therapies, psychotherapy, psychiatric care (mental counselling) and peer counselling (support group) (Macy and Johns, 2011).

Counselling consists of mental health counselling, delivered by a mental health professional, and supportive counselling, that does not have a mental health focus and may be delivered by staff without mental health expertise (Macy et al., 2010). Counselling is described to promote insight into the impact of violence on survivors' lives and to promote significant, positive changes (Macy et al., 2010). Tavkar and Hansen (2011) draw attention to additional therapeutic sessions that are often required for survivors' post-crisis counselling. The onset of services (counselling) is recommended by Saywitz et al. (2000, cited in Tavkar and Hansen, 2011) to be unhindered, thus decreasing the risk of exacerbating symptoms, or symptoms becoming chronic and resistant to treatment. Individual counselling also allows for the assessment of survivors to be linked to a support group for additional support, as stated by Dienenman et al. (2002, cited in Macy et al., 2010) who believe that counselling and support services are central to helping survivors of domestic and sexual violence.

When working with children, they should not be seen as miniature adults and should be approached from a developmental perspective, because their natural means of communication comprise play and activity (Landreth, 2002). Developmentally children are unable to engage in abstract thinking or reasoning until they are 11 years old (Piaget, 1962 cited in Landreth, 2002). Play enables the child to conceptualise, structure and express experiences and feelings (Landreth, 2002). Landreth (2002) summarises the significance of play as the opportunity given to a child to act out situations that are disturbing, conflicting and confusing to the child. Play therapy is described as useful as the main method of intervention or as an aid when working with child survivors.

Psychoeducational therapy groups, as support group programmes for survivors, use varied therapeutic goals to promote the health and well-being of the sexually exploited and those at risk of sexual exploitation (Moynihan et al., 2018). These

programmes are facilitated by clinical and non-clinical stakeholders and include goals such as fostering healthier relationships (Countryman-Roswurm, 2014, cited in Moynihan et al., 2018), reducing shame and stigma (Hickle and Roe-Sepowitz, 2014, cited in Moynihan et al., 2018), and reducing PTSD, depression and behavioural problems while simultaneously increasing prosocial behaviour (Moynihan et al., 2018). Cohen and Mannarino (2008), however, believe that interventions based on trauma-focused cognitive behaviour therapy (TF-CBT) are superior in improving post-traumatic stress symptoms. Tavkar and Hansen (2011) assess TF-CBT as most effective in addressing PTSD symptoms while providing support and skills to non-offending parents to respond effectively to their child and cope with their own emotional distress (Tavkar and Hansen, 2011).

Many service providers use group interventions when working with preadolescent and adolescent survivors to target feelings of isolation and social stigmatisation, and to reduce the desire for secrecy (Tavkar and Hansen, 2011). Group interventions are cost-effective and efficient in treatment, although many have few resources available. These are, often utilised with survivors of child sexual abuse, as well as with non-offending family members to provide them with their own support network (Tavkar and Hansen, 2011). Group therapy, however, should occur later in treatment and not with children demonstrating severe acting-out behaviour (Tavkar and Hansen, 2011). Premature placement in therapeutic groups may hinder the individual recovery process.

In literature, first world countries are reported to operate live-in facilities for people at risk of sexual exploitation and/or actually experiencing it, which are referred to as residential programmes. Residential programmes offer survivors a range of health, psychosocial, and vocational support (Moynihan et al., 2018). South Africa, as a developing country, operates shelters and/or crisis centres for survivors of interpersonal violence. However, most of these exist only in major urban centres (Heise, 2018), catering to the needs of women and children. Shelters provide safety and security, protecting the survivor from further harm, media and the community, without confining the survivor (Simeunovic-Patic and Copic, 2010, cited in Muraya and Fry, 2016).

The National Violence against Women Survey found that 62% of perpetrators of rape against adult women were intimate partners (Basile and Smith, 2011). Persons in violent domestic relationships frequently experience partner violence and sexual assault, at times as part of the same victimising occurrence and at other times over the course of their lives (Macy et al., 2010). People in violent domestic relationships are therefore at continuous risk of being sexually violated by their partners, should they stay in that relationship. To respond effectively to survivors in violent domestic relationships, service providers should provide survivors with help relating to violence, safety, emotional support, support in recovering from trauma, access to legal and health care services and emergency shelter (Macy et al., 2010). Services respond to all the basic needs of survivors who are sexually abused in their existing violent domestic relationships.

To diminish interpersonal violence, practices such as RJ are used and have been found to reduce crime more effectively where crimes are severe and where there is a personal survivor (Mc Glynn, Westmarland and Godden, 2012), as in the general case of rape. RJ practices make provision for a person who is alleged to have committed an offence, the victim, supported by both families and other appropriate persons (CJA, section 61) (RSA, 2008) to rectify harm caused by the offence through dialogue. The role of RJ in cases of sexual violence is to meet some of the survivors' needs and expectations by giving them a voice to tell their story of harm holistically, by granting a measure of control over the treatment of their complaint, by helping ensure their experience is honoured, treated seriously and with respect, and by providing an opportunity to secure a form of justice for survivors who wish to pursue RJ as an intervention option (Mc Glynn, Westmarland and Godden, 2012).

RJ affords survivors control and decision-making regarding contact with their offender and may encourage admission of offending, offering validation and, in focussing on the offender, may reduce victim blaming (Mc Glynn et al., 2012). Ptacek (2010, cited in Mc Glynn et al., 2012) warns against RJ resulting in the belittling of violence against women, re-victimising the vulnerable and endangering the safety of the survivor. RJ in cases of sexual violence demands greater scrutiny and expertise, preparation and risk assessment, and therefore more resources. However, excluding survivors from the opportunity to address their offender, tell of their harm and see some form of justice, for those who request it, cannot be justified

(Mc Glynn, Westmarland and Godden, 2012). Implementing RJ with survivors of sexual violence provides the survivor, and other appropriate persons, with the opportunity to confront the offender in a supportive environment with the goal of healing and justice for the survivor, but only on request and/or with the agreement of the survivor.

Banyard et al. (2010) found that the majority (70%) of survivors of sexual violence disclosed what happened to a friend rather than the authorities. Once sexual assault is reported to family members, they may experience secondary trauma due to having been confronted with the traumatic impact the occurrence has had on their loved one (Smith, Bryant-Davis, Tillman and Marks, 2010). Including family in RJ practices is therefore not only in support of the survivor, but also an opportunity for the family to express their experience. The intensity of the trauma the family experiences can in some cases be similar to that experienced by the primary survivor (Smith et al., 2010). Mathews et al. (2013) sensibly urge emotional support to occur immediately after disclosure, while Tavkar and Hansen (2011) advocate the family's own support network in the form of a support group.

Mathews et al. (2013) stress the importance of family support in recovery, which can be hindered by the family's emotional unavailability, family dysfunction, blaming the survivor or simply lack of support. Social support is not a programme or service as such, but substantially contributes to positive adaption of survivors to their environment and operates as a protective factor against the development of depression and PTSD symptoms in survivors (Bryant-Davis, Ullman, Tsong and Gobin, 2011). Informal helpers, such as friends, can be conducive to preventing risky situations from escalating into sexual assault and provide a solid safety net for survivors after an assault (Banyard et al., 2010). Social support entails positive reinforcement from society at large, which is described as being reluctant to accept that sexual consent can be denied, thus normalising sexual coercion in especially intimate relationships (Goodman-Delahunty and Graham, 2011) and deterring survivors of date rape from reporting it, especially where corroborating physical evidence such as bruising and torn clothing is lacking (Goodman-Delahunty and Graham, 2011). The family and social support survivors have in their environment also require intervention to provide survivors with appropriate support.

Aftercare services include home visitation programmes that take resources to families in their home to inform, support and provide additional services to improve family functioning (Runyan, Wattam, Ikeda, Hassan and Ramiro, 2002) and the functioning of the survivor. Aftercare services are explained to consist of many elements that will allow the survivor to maintain healthy functioning in society after rape, and often after release from a facility, such as a shelter. Aftercare services include life skills such as financial management, safety planning, life planning, decision-making, conflict resolution, problem-solving, emotional management and communication (Macy and Johns, 2011). Vocational training, education enrolment, CV writing and job-searching skills are also after-care interventions identified to help survivors, in their different circumstances, to achieve economic independence and stability (Macy and Johns, 2011). Home visits, evidence-based parenting programmes and multi-component interventions have been shown to be effective in preventing abuse (Meinck et al., 2016).

According to Gavey and Schmidt (2011), many old myths, such as denying the injurious nature of rape and/or blaming survivors for their victimisation, are found to continue their influence on shaping ordinary understanding of rape. Gavey and Schmidt (2011) further explain old-fashioned ideas of “victim provocation” to contribute to survivors being held accountable for their own rape and receiving negative responses from wider community services (Gavey and Schmidt, 2011). Community approaches to prevention of sexual violence, with the main focus on the individual, have demonstrated limited or short-lived effects (DeGue et al., 2012). It is therefore urged that strategies should include the wider community so that the norms and behaviour of society can be changed (De Gue et al., 2012) and result in prosocial change. Community-based prevention and educational campaigns are interventions based on the belief that awareness and understanding of a phenomenon among the general population will result in lower levels of abuse and increase recognition and reporting of abuse by survivors or third parties (Runyan et al., 2002). Community-level components of effective prevention of sexual violence include schoolwide poster campaigns and providing training for school staff and community service providers (De Gue et al., 2012).

2.4 Summary

The South African government has recognised the increasing needs survivors of sexual violence have after the occurrence of sexual assault. To respond effectively to survivors' multiple needs, legislation mandates intervention from public servants to be timeous, effective and non-discriminative, resulting in the equal protection of all survivors. Service providers are expected to understand the impact of rape on the survivors' overall well-being and urged to undergo the necessary training to enable them to provide intervention that will promote healing. Literature calls for the use of multiple approaches to provide adequate intervention with all survivors, maintaining their best interest. Accessibility and availability of services to survivors of sexual violence nevertheless do not guarantee the service received. Challenges from survivors and service providers are identified in literature that hinder disclosure and as a result help-seeking. In the section that follows procedures used to identify and select, process and analyse information on the research topic will be discussed.

Chapter Three: Methodology

3. Introduction

The following chapter focuses on the research design and the methods used to sample the population and approach them, the collection and recording of data, as well as the analysis of the data. This chapter of the research will also focus on the validity of the study, ethical considerations and the inherent limitations of the study.

3.1 Research design

The research design utilised in this research was qualitative because of the explorative nature of the study. Exploratory research will allow the researcher to understand the accessibility and effectiveness of interventions with survivors as an introduction to the actual field of work that follows formal education of the researcher. Exploratory research further aligns with qualitative research, as this research will only consider the perceptions of a small group (Babbie and Mouton, 2010) of stakeholders who offer direct services to survivors in a specific geographic location. Qualitative social research seeks to explore and understand it's subject matter or people from the perspective of those under study and from where they are currently located (Carey, 2012). Additionally it seeks to advance theory by providing new information about a braod pattern that holds across many cases at end advancing theoretical ideas or by analysing the commonalities that exist across cases (Carey, 2012).

Qualitative research entails the purposeful investigation, searches or processes that collect and evaluate information in order to gain knowledge and understanding (Carey, 2012). A qualitative research design uses systematic observation and focuses on the meaning people give to their social actions (Thomas and Hickey, 2002). Simplified, a qualitative study aims to explore people's behaviour, feelings and perceptions along with the meaning they give to these (Babbie and Mouton, 2010). This research is explorative and evaluative because it attempts to answer the question of "what" services to survivors are available, and seeks to determine the quality of services rendered to survivors from the perspective of the insider (Babbie and Mouton, 2010), who in this case is the service provider.

In qualitative research, only a specific group of participants is suitable for specific research (De Vos, Strydom, Fouché and Delport, 2011). In this study, people who have direct contact with survivors of sexual violence as a result of the offence are regarded as the service providers and are therefore included as service providers based on the nature of contact with the service user (survivor). The focus of this study is on the service and perceptions of service providers on the quality of work they do with survivors. People who have contact with survivors because of the multiple services they render are therefore included in this study as service providers. Fouché and Schurink (2011) explain quantitative design to allow for the objective study of an external reality and know things as they really are. This study aims to explore what services are offered to survivors of sexual violence and to determine the quality of service and if the service meets the immediate and long-term needs of the survivor.

3.2 Population and sampling

Babbie and Mouton (2010) describe the sample as representing the population of the study of interest. The population can be described as a large collection of individuals or objects known to have similar characteristics used to focus a scientific query (Carey, 2012). The sample is therefore the subset of the population. The sample is also refered to as participants. Participants refer to people who provide information that allows the researcher to construct a synthesised picture of the group of participants it represents (Babbie and Mouton, 2010). Babbie and Mouton (2010) state that participants are members of the sample group who can talk directly about the group.

Due to time and monetary contraints the researcher could not include the whole population and therefore a sample was drawn. In this research, the sample consists of participants who are employed to render services to survivors after rape and are assumed to know what to offer and how to render appropriate help to survivors based on their job titles. If service providers perceive their work as ineffective, survivors are likely to believe the same and vice versa. Literature prescribes how services should look, but does not indicate whether or not service providers adhere to set service interventions. Service providers can therefore give inputs on the quality

of the work done, as they are the link between government rendering the service and the people who receive the service.

This qualitative research utilised non-probability purposive sampling and snowball sampling. Purposive sampling allows the researcher to determine the sample based on the researcher's perception of which service providers are relevant to this study. Babbie and Mouton (2010) explain purposive (judgemental) sampling as samples selected based on the researcher's knowledge [subjective judgement] of the nature of the research, rather than random selection. The sample in this research cannot be random, as the study is focussed on the perceptions of service providers on the effectivity of interventions with survivors of sexual violence as a special group with specific service needs.

The selection of this sample was based on stakeholders identified in literature as significant in their work with survivors. Participants also identified other current stakeholders in De Aar, which led to snowball sampling. Snowball sampling refers to the process of accumulation where existing subjects (participants) suggest other subjects (Babbie and Mouton, 2010), allowing the researcher to identify and approach other, current, stakeholders who were unknown to the researcher.

Because of the research design of this study and the researcher's desire to collect relevant data, permission had to be obtained from the relevant people and organisations. The process of obtaining permission is referred to as gatekeeping in literature. Gatekeepers are defined by Fouché and Schurink (2011:325) as individuals with formal or informal authority to provide approval for access to participants. Each participant was contacted by the researcher to enquire about his or her willingness to participate in this research. Participants could agree to or deny the request, making participation voluntary. By signing the cover letter (see Appendix B), participants agreed to be interviewed by the researcher.

The researcher consulted 20 multi-disciplinary professionals who rendered direct service to survivors of sexual violence in De Aar. The multi-disciplinary sample included medical staff who rendered immediate and long-term medical services on different levels: social workers from the DOH, DSD and a non-governmental organisation (NGO) that offers primary services to survivors of sexual violence, SAPS members who operate in different branches and units within the SAPS and a

state prosecutor who ensures that the safety and justice needs of survivors are met, independent psychologists who were consulted for the psychological needs, and community workers and community volunteers trained by NGOs to offer additional support to survivors.

The researcher met face to face with all 20 participants, who were selected based on their identification in literature as an organisational actor and/or professional rendering services to survivors, and according to the criteria of the study "service providers who render services to survivors of sexual violence" to include professionals not listed in literature. Other sample characteristics include professionals who are currently employed to render services specifically to survivors of abuse and/or persons with the skills currently providing service, but not specifically employed to work with survivors of abuse.

3.3 Data collection

Flick (2017) describes qualitative data collection as the evidence of a real phenomena and process of which inferences can be made about the phenomena, which then can be tested againt additional data. De Vos et al. (2011) explain data collection as the gathering of information relevant to a study. The researcher used interviewing as an information collection method instead of observation, questionnaires and surveys, because interviews allow one to obtain data from the existing limited sample, who render service to survivors, and permits probing to determine underlying factors that may not have been made clear in responding to the questions (De Vos et al., 2011). Interviewing additionally permitted the researcher to explore intervention of different professional bodies that form part of the research population. The explorative nature of this research that sought the perceptions of service providers thus determined the method employed in this research as interviewing.

Flick (2017) explains that interview questions are what you ask participants in order to gain understanding of the phenomena your research question seeks to understand. Interviewing allowed the researcher to obtain information through direct interaction with participants who were expected to possess knowledge the researcher sought (De Vos et al., 2011). Interviewing as a data collection approach has been used in similar studies done by Abrahams et al. (2010), Aydin, Akbas,

Turla and Dundar (2016) and Macy, Giattina, Montijo and Ermentrout (2010) to obtain relevant data from a sample group. Individual interviews conducted in this research captured the diversity of perspectives among the different professional bodies as service providers.

The data collection instrument the researcher used was semi-structured interviews (see attached in Appendix A). De Vos et al. (2011) explain semi-structured interviews as an aid to the researcher in obtaining a detailed picture of the participants perceptions on a particular topic. Greeff (2002, cited in De Vos et al., 2011) explains that the interview schedule engages respondents and allows them to relate their experiences. A semi-structured interview allowed participants to add information not asked by the researcher and allowed the researcher to ask questions for clarification. Questions in this interview were open-ended.

Open-ended questions allow participants freedom to respond to questions in whichever way they deem fit. The interview was therefore flexible and receptive of new information (Babbie and Mouton, 2010). The researcher used open-ended questions to promote a conversation between participants and the researcher. Data recording devices the researcher used were a video camera, a cell phone audio recorder and field notes that were taken during interviews.

Questions asked in the semi-structured interview were informed by the research objectives. To determine available interventions, participants were asked about their role in their organisation, the services their organisation renders, the training they had to undergo to enable them to render these services, how first contact with survivors was made and whether or not survivors were linked to other organisations to meet additional needs they might have, which the organisation of contact might not offer. The questions sought to determine whether organisations did render services to survivors, and if so, what the services were, how accessible the services were and if the service providers were adequately skilled and trained to respond to the needs the organisation was said to satisfy. Adequate training and education of professionals working with survivors are necessary to promote effective intervention that is sensitive in nature and protective of survivors (United Nations, 1985). The questions also explored the relationship between organisations and the handing over of cases to have immediate and long-term needs met. The questions focused on the

knowledge and skills service providers utilise to respond to, or guide, survivors' multiple needs.

To explore the perceptions of service providers on the effectiveness of their intervention with survivors, participants were asked if their (own and other organisations') interventions with survivors were effective, and if so, what informed their perceptions of this effectiveness. Work done by Artz et al.(2016), Linden (2011), Bougard and Booyens (2015) and Tillman (2011) has shown the prevalence and effects of sexual violence on the survivor. In response to the effects of trauma, multiple support structures have formulated guidelines (Naidoo, 2013; Jina et al., 2010; Department of Social Development, 2018) to promote evidence-based interventions that prioritise survivors while preventing further harm caused by ineffective services. Policies and legislation set forth how and when intervention with survivors should occur to promote healing, based on survivors' extensive post-assault needs (Tillman, 2011). Policy and legislation thus inform all interventions with survivors of sexual violence, irrespective of their gender or age. The questions focus on how interventions are rendered and what informs service providers' interventions so that they may deem these effective.

The final research objective was to explore any gaps, issues and/or barriers to interventions by asking about internal and external organisational challenges that might hinder effective interventions with survivors in a service provider's organisation itself and that of other stakeholders. The questions also sought to determine if service providers perceived interventions in place to be adequate in meeting survivors' multiple needs and lastly, how current interventions with survivors could improve. Moynihan et al. (2018) state that survivors of sexual exploitation benefit from access to high-quality, evidence-informed and effective programmes through own service delivery or by referral to stakeholders. The questions focus on challenges faced by stakeholders that hinder effective, evidence-based intervention with survivors and how stakeholders respond to barriers rendering services.

3.4 Data analysis

De Vos et al. (2011) describe data analysis as the reduction of raw information through sifting and identification of outstanding patterns in order to construct a framework that reveals the essence of what the data divulges.

To analyse the data, the researcher transcribed interviews from the video camera and phone function audio into Microsoft Word. Permission to use a video camera or phone audio function was verbally obtained from participants when an appointment was made to conduct the interview and in writing before the actual interview commenced. The information was then dissected according to the eight-step analysis of Tesch (1990, cited in O' Brien: 2016). Data analysis occurred as follows:

Table 2.1: Data analysis

Tesch's analysis	Analysis of this research
1. Reading through all the transcripts.	1. Each transcript was read individually. Field notes were made on impressions of each interview and contradiction of verbal and non-verbal cues was noted.
2. Individually - Understanding the meaning of what respondent was saying in relation to the research objective.	2. Transcripts were read twice as a whole. This was done to pick up any words, sentences and activities that were repeated.
3. Jotting down notes on margins alongside the text that explain, describe, raise questions for the researcher.	3. Repeated patterns were coded. The researcher coded similar actions (experiences).
4. Use colour markers to begin labelling notes, using similar colours for labels that appear to be linked.	4. Comments/ codes were then grouped according to the main research questions. Questions asked in the interview were often inadequately answered and participants would later respond adequately to research questions in full. Responses were therefore moved to the sections of the research questions that responded to the main questions.
5. Repeat process with all transcriptions. Re-label, if necessary, keeping in mind the objective.	5. Codes were re-labelled within their groupings to identify significant findings according to participants' responses.
6. Once labelling has been carefully considered, begin to group under a main theme and categories. Themes must reflect issues linked to one's objective.	6. Codes were categorised by bringing two or more codes together and discarding others.
7. Rework themes so that they are mutually exclusive. Develop a schema- that sets out main themes with categories of those themes.	7. Categories and subthemes were created based on the relevance to the research objectives.
	8. Themes and categories were re-organised until

8. Refine the schema so that it flows logically, is coherent and mutually exclusive.	a logical image emerged.

The steps above allowed the researcher to interpret the data more accurately, enhancing the quality of the data. Once the findings of the research were clear, the researcher was able to discuss findings.

3.5 Inherent limitations of this study

Participants may be biased towards their organisation when asked about the quality of services rendered. To increase the quality of the responses, participants were asked to motivate their responses, as the manipulation of responses influences the outcomes of the research.

The sample consisted of 20 people employed in government, NGOs and community volunteers who rendered partial services to survivors. A few participants in this study had contact with survivors, but did not render any significant service to the victim. Also, some participants were in the same line of work, but at different geographic locations. They were included because the researcher noticed the use of different procedures at different stations of the same organisation.

Another challenge the researcher encountered was obtaining permission from the SAPS to speak to some members. The process of obtaining permission was very slow and challenging, as people with authority were unclear about procedures and were unwilling to co-operate, resulting in certain prospective participants, such as a forensic social worker, not participating in this research.

A further barrier was the language used in distinct professions; it was often not understood by the researcher, again influencing the research findings. Participants were willing and able to clarify their statements when the researcher did not understand.

3.6 Data verification

Data verification is the process whereby information is checked for 'truth value' (accuracy). Credibility aims to demonstrate that the research was conducted in such a manner as to ensure that the subject has been accurately identified and described

(De Vos et al., 2011: 420). Through the literature review services were identified and described to compare them to the findings of this research later.

Transferability concerns findings being transferred from one situation to another (De Vos et al. (2011) The findings of this research may not be generalised to the broader population, but findings may be used in areas with similar characteristics as De Aar.

Dependability looks at whether the research process is well documented and logical (Babbie and Mouton, 2010). The researcher maintained the authenticity of the data through video/audio-recording interviews, making notes during interviews and transcribing according to Tesch's analysis guide, mentioned above.

Conformability refers to whether the findings of the study could be confirmed by another researcher (De Vos et al, 2011:421). Should there be a need to confirm the research findings, the researcher has kept a record of all the information gathered. Should another party wish to confirm the findings, the data is available.

3.7 Ethical considerations

Ethics refer to rules of good moral conduct, and functions as reminder of sensitive themes for the researcher (Carey, 2012). Ethical considerations are put in place to protect participants (Babbie and Mouton, 2010), as research can be physically and/or emotionally harming to participants Strydom (2011). In this research participants were informed in writing and verbally about possible harm to them, and where help could be sought if this research should result in any harm to them. By doing so this research promoted the welfare, well-being and safety of research particiapnts (Carey, 2012).

Informed consent suggests that adequate information on the goal, duration of participants' involvement, procedures of the investigations, possible harm and the credibility of the researcher is communicated to participants (Strydom, 2011). Strydom (2011) counsels that information on the research should be given to participants before the research commences so that participants have the opportunity to withdraw from the study, should they choose to (Strydom, 2011). Participation was therefore voluntary, informed and not forced, as participants were aware that they were not obliged to participate, nor were they going to be compensated for their participation in this research (Strydom 2011). Participation in

this study occurred through telephonic agreement, followed up in writing before interviews commenced. People who refused to participate were asked to identify other possible stakeholders for this study and those who agreed to participate received the semi-structured interview schedule on request, to prevent deception. Deception of respondents entails misleading and deliberate misrepresentation of facts or withholding information from participants (Strydom, 2011: 118).

Anonyminty in a research project refers to when neither the researcher nor the reader of the findings can identify a given response with a given respondent (Babbie, 2007). Because of the nature of the study, it was explained to participants that they might not enjoy full anonymity, as organisations and professional bodies that operated in the field of service to survivors would be named. Confidentiality refers to safe-guarding the privacy and identity of the participant (Strydom 2011), which was only partially possible in this research due to the degree of anonymity. Confidentiality is the respectful handeling of information disclosed within a relationship of trust (Lowrance, 2012) between participants and the researcher. Anonymity and confidentiality is partial due to some particiapnts being the only professional and/or department working with survivors of sexual violence in De Aar decreasing their anonyminty and confidentiality. Participants were informed of the decreased anonymity however agreed to participate in this research.

Walliman (2006, cited in Strydom, 2011) defines the responsibility of researchers in terms of ensuring that they are competent, honest and adequately skilled to undertake the proposed investigation. The researcher informed participants that she was under the research supervision of a study supervisor provided by the University of Cape Town to ensure all ethical obligations were met. Publications of the findings of this research will not be made available to the public at large, only to students at the University of Cape Town.

3.8 Summary

In this section the researcher outlined the blueprint of how the research process proceeded, highlighting the design and methods used. A qualitative research design was utilised in this research owing to the explorative nature of the research. Non-probability purposive sampling and snowball sampling were implemented in the selection of 20 professionals as participants. Data collection occurred through open-

ended semi-structured interviews recorded on a video camera, a cell phone audio function and field notes during the interview. Data was later dissected according to Tesch's (1990) eight- step analysis. The chapter also explains aspects of data verification, ethical considerations and limitations of the study as these apply to the research. The next chapter will discuss and present the findings from the data analysis.

Chapter 4: Presentation and discussion of findings

4.1 Introduction

Chapter four presents the findings of the interviews conducted with the research participants. The main aim of the study was to explore the perceptions of service providers on the availability and effectiveness of trauma interventions, services and programmes in De Aar. Interviews were conducted with professionals who rendered different “help” services to survivors of sexual violence in De Aar at the time.

A profile of the participants is provided to give insight into the participants’ professional work context and the nature of the service(s) they rendered. The framework for the discussion of findings informed and guided this chapter through the use of themes and sub-themes concluded from the study objective and in the end these were discussed. accordingly. The chapter is concluded with a summary.

4.2 Profile of participants

This research involved 20 adult participants who all had direct contact with survivors of sexual violence through the particular services their organisations rendered. The table below provides a brief profile of the participants, including their age and gender, current place of employment, their individual highest qualification obtained, current occupation (role), length of work experience, and average case load in their organisation.

Table 3.1: Profile of participants

Identifying information	Gender	Age	Current place of employment	Current occupation (role)	Highest qualification obtained	Length of work experience with survivors	Average case load per month in organisati-on
Participant 1	Female	49	DSD – De Aar	Probation officer	Master's degree in social work	10 years	20 clients
Participant 2	Female	47	Ethembeni Community and Trauma Centre	Social worker	Bachelor's degree in social work	17 years	20 clients
Participant 3	Female	30	DSD- De Aar	Assistant Probation Officer	Certificate in social auxiliary work	3 years	N/A Deter-mined by probation officer
Participant 4	Male	43	TCC	Site manager	Bachelor's degree in human resource management	8 years	15 clients
Participant 5	Female	27	Own private practice	Clinical psychologist	Master's degree in clinical psychology	6 years	80 clients
Participant 6	Female	61	DOH- De Aar Central Karoo Hospital	Social worker	BA in health and welfare social work management	37 years	125 clients
Participant 7	Female	39	SAPS -Family Violence, Child Protection and Sexual Offences Unit	Investigating officer	Senior certificate (Grade 12)	20 years	8 clients
Participant 8	Female	46	DOH- De Aar Central Karoo Hospital	Forensic pathologist	Post-graduate training in forensic pathology	12 years	20 clients
Participant 9	Female	23	Ethembeni Community and Trauma Centre standby at TCC	Auxiliary social worker [first responder]	Certificate in social auxiliary work	2 years	15 clients
Participant 10	Male	63	Department of Education volunteering as a clinical psychologist	School principal	Master's degree in clinical psychology	7 years	200 clients
Participant 11	Male	45	National prosecuting authority	Regional court prosecutor	Bachelor of Law (LLB)	26 years	60 clients
Participant 12	Female	44	DSD- De Aar	Social worker	Bachelor's degree in social work	10 years	120 clients
Participant 13	Male	24	DOH- De Aar Central Karoo Hospital	Professional nurse	National diploma in nursing	8 months	100 clients

Participant 14	Female	35	SAPS	Sergeant – social crime coordinator De Aar	Senior certificate (Grade 12)	15 years	100 clients
Participant 15	Female	32	SAPS	Constable – Social crime coordinator Sunrise	Senior certificate (Grade 12)	10 years	50 clients
Participant 16	Male	63	Community Policing Forum	Chairperson	Diploma in Education	3 years	N/A
Participant 17	Male	50	SAPS	Acting visible policing commander	Grade 12	26 years	Undetermined
Participant 18	Female	49	DOH- De Aar Day Hospital	Professional nurse	Diploma in health science management	23 years	400
Participant 19	Male	40	SAPS	Sergeant	Grade 12	14 years	100
Participant 20	Female	40	DOH- De Aar Montana Clinic	Professional nurse	Diploma in nursing	17 years	600 clients

4.3.1 Gender and age

There were 20 participants in this research, of whom seven were male and 13 female. The age of participants ranged from 23 to 63, with a mean age of 42.5 (850/20= 42.5). The mean age of participants can be considered an indication of life experience and higher maturity levels service providers may have, while the gender of participants shows female domination in service provision to often female survivors of sexual violence. In this research, gender may suggest that services are sensitive towards survivors' needs, because women are the majority stakeholders, and age may indicate the professional experience of stakeholders to respond effectively to survivors. Older stakeholders may, on the other hand, contribute to outdated practices and even, because of old beliefs, stigmatising of survivors. Selection of participants was based on their current roles at their different organisations and how those roles led to contact with survivors through the service they rendered in their particular fields, irrespective of the service provider's age or gender. The gender and age, however, contribute to the accessibility and effectivity of stakeholders' interventions with survivors.

4.3.2 Current place of employment

The majority of participants are from government institutions and stakeholders range from the Department of Justice Department, Health and Social Development and the SAPS to NGOs and community members as volunteers. In this research,

government organisations are found to be the leading service provider; government has created special units within existing departments to respond specifically to the impact of crime and in partnership with NGOs, government has established services that focus solely on service to survivors of sexual violence in De Aar. The government thus takes tha main responsibility for the healing, safety and justice needs of survivors, with the provision and support of additional “special” services of non-governmental stakeholders, and therefore determines the availability and accessibility of services. The place of employment influences every stakeholder’s scope of practice, and whether a government department or NGO, stakeholders’ different organisational challenges, procedures and protocols have a direct influence on the effectiveness and consistency of services. The general perception of service users of organisations may further encourage or discourage help-seeking at specific organisations.

4.3.3 Highest qualification obtained

All participants had a minimum qualification of a senior certificate (Grade 12). Some jobs required additional formal training at a tertiary institute, such as that of a social worker, and other even post-graduate studies, such as the psychologist and probation officer. Persons without formal training were required to be trained and had undergone in-service training and/or short courses presented in workshop form. Academic qualifications often indicate higher knowledge, which is accompanied by specific skills to enable a person to render service. People with lower levels of education in this research render services that require fewer skills in working with survivors and vice versa. The organisations where service providers work and the role in which they are employed thus compel service providers to seek higher education to provide the prescribed services. Minimal specialist training of stakeholders may indicate inconsistent and/or decreased effectivity of interventions by inadequately trained staff and lower levels of empathy among stakeholders towards survivors.

4.3.4 Current occupation

Participants in this study are all, except for one, professionals trained to have contact with survivors of sexual violence, because of either the nature of the service the participants render or the core function of the organisation in which participants are

employed. The research found social workers to be the leading professionals operating at different government departments to meet survivors' multiple needs in the context of their organisations' mandate. Participant 10 is employed as a school principal, but renders a psychological service to survivors because of his qualification, skills and knowledge and also because of a history of lack of psychological service providers. Participant 16 is a pensioner who offers a support service to the community at large through his role as chairperson of the community policing forum. The majority of participants in this research operate in fields in which they have been formally trained as professionals, while the non-professionals who work with survivors operate under different titles, such as counsellors, first responders and volunteers. Occupations in the field of service to survivors require formally and informally trained people whose skills and knowledge range from legal services to medical, social and support services, to respond to survivors. This requires the researcher to have broad knowledge of how each professional body operates and contributes to the overall well-being of the survivor.

4.3.5 Length of work experience

The period of work experience includes all work with survivors of sexual violence through the current position held and previous positions at the same or different organisation(s). Work experience refers to the nature of the participant's primary role at an organisation. The minority of participants' work is limited to survivors of sexual violence. Those served include other groups in need, such as children and survivors of domestic violence. participants' work experience ranges from eight months to 37 years, with a mean of 13.3 years (267/20). The average period of work experience can be considered an indication of broader practical skills that service providers have acquired through work experience, but may also indicate the inconsistent use of evidence-based interventions and/or the use of outdated practices. The length of work experience may suggest growth that may have occurred among stakeholders and within services, through the establishment of services specific to survivors, which would influence participants' perceptions of the effectiveness of the current service.

4.3.6 Average case load per month

The average case load per month per participant includes not only work done with survivors of sexual violence, but also other roles participants fill at their organisation. The difference in the number of people seen by the different stakeholders is due to the nature of their service, the demographic area in which the services are rendered, the physical location of the organisation and where the help process through contact with survivors occurs. Caseloads range from eight clients per month to 200 clients per month in the different fields of service. The case load of participants cannot be generalised, as the quantity of work done does not reflect the quality of the work, but may show that services are rendered to survivors irrespective of how many survivors participants encounter. Higher case loads may reflect overworked stakeholders who may be insensitive towards survivors' emotional needs and reflect a decrease in intervention responsiveness to survivors' post-rape needs.

4.4 Framework for discussion of findings

Table 4.1 below provides a framework for the structure of presentation of findings of the research involving service providers to survivors of sexual violence in De Aar. Three main themes, informed by the research objectives, are sub-themed and categorised from what emerged from the data analysis and will be identified in the table below and discussed in the section that follows:

Table 4.1: Framework for discussion of findings

	Themes	Subthemes	Categories
4.4.1	Access to services for survivors of sexual violence	Immediacy of services on request	• Services are easily accessible • Services are inconsistently rendered and practices are outdated
		Services available to survivors and non-offending family	• Primary service is mainly rendered by social workers who then determine the need for mental health services • Psychiatric intervention occurs in extreme cases through referral of a psychologist and social worker • Primary health care services continue as a separate service from psychosocial interventions
		Continuum of care for survivors of sexual violence	• Support services are carried out poorly • RJ practices are applied incorrectly

		Difference in the application of intervention with child and adult survivors	• There are impediments to intervention with adult survivors • Child-friendly interventions are utilised with child survivors
4.4.2	Effectivity of services responding to survivors needs	Services are informed by organisational policies and legislation	• Adherence to organisational policy is inconsistent in responding to survivors • Legislation is used to coerce stakeholders to render service
		Organisational provision of training and supervision	• Formal training of service providers is scattered • Supervision strengthens effective service delivery
		Organisational measures of the impact of the service	• Organisations lack consistent and structured feedback from service users • There is significant reliance on service providers' professional observation to measure the impact of services rendered
		Linkage of service providers	• Establishment and maintenance of a victim empowerment forum • Poor linkage of organisations is evident in awareness and prevention initiatives
4.4.3	Barriers that hinder effective service	The attitude of service providers and service users hinders effective service	• The attitude of stakeholders to their role and responsibilities is unsatisfactory • Co-operation among service providers is ineffective • Co-operation from service users is poor
		Presence of community psychosocial barriers	• Stigma and mistrust in the SAPS hinder help-seeking • Domestic violence in relation to sexual violence normalises abuse
		Inadequate and ineffective use of resources	• Inadequate human and physical resources result in poor service • Funding hinders consistent and effective service • Poor communication results in service users getting lost in the system

4.4.1 Access to available services for survivors of sexual violence

All participants interviewed were of the opinion that interventions, services, programmes and/or support structures were available and accessible to survivors of sexual violence in De Aar. Sub-themes that stemmed from accessibility of available interventions included the immediacy of services on request, the availability of

services to survivors and non-offending family, the current continuum of care for survivors of sexual violence, and differences in the application of intervention to child and adult survivors of sexual violence.

4.4.1.1 Immediacy of services on request

Section 27(3) of the Constitution of the Republic of South Africa (1996) mandates statutory interventions by medical personnel to provide emergency rape care to survivors of sexual violence. In De Aar research found that emergency services only commence once disclosure (reporting) of sexual violation had been made to formally and informally trained professionals who are able to aid and/or are aware of, or are able to contact appropriate help. Appropriate help refers to stakeholders identified in literature as people who provide medical, psychological, social and legal intervention to address the complexities of rape (Linden, 2011; Tseris, 2013; The National Prosecuting Authority, 2015). Categories drawn from this sub-theme are that services are easily accessible to survivors and that services are inconsistently rendered and practices are outdated.

4.4.1.1.1 Easily accessible services

The Criminal Law (Sexual offence and related matters) Amendment Act (CLAA) (32 of 2007) Chapter 5 prescribes services for survivors of sexual violence to ensure medical needs are met and to prevent future medical conditions such as HIV. Medical services may be the first or second actual intervention to occur with the survivor after disclosure; it is often the SAPS that ensures contact with a medical officer. Participants were asked how first contact with them or the organisation occurred and what their role had been in helping a survivor of sexual violence. The responses explained accessibility to services as follows:

If it is a victim of rape, some they do come (to the police station), some don't. They call the police and we [Social Crime Unit] are also contacted. We go to the scene ... You take the victim away to a safe place … if it is a rape victim you take the victim to the trauma room and from there to the hospital. (P14)

… They come to the CSC (Community Service Centre) or they call and we will contact FCS (Family Violence, Child Protection and Sexual Offences Unit) and they

will take the victim to the hospital where the doctor will do the examination to see if rape did occur … (P15)

… I'm an investigator officer so I basically investigate crime of a sexual nature. Interviewing the victim, obtaining statements from the victim, getting the victim to a medical doctor, arrange for counselling… (P7)

Access to shelter and emotional support were described thus:

… Besides the shelter that we run, which is primarily for victims of domestic violence, we take in victims of sexual offences too … We also run the local TCC where all the victims of rape get services. Our role in that is that we have first responders. We have four first responders, which mean that if a case is reported at the police, the first responder is contacted and goes with the client to the hospital. The first responder is responsible for calming the client down and assist with the taking down of the statement and the doctor with the medical examination ... (P2)

… We (DSD) have social workers on standby for children so if it happens over the weekend that social worker is supposed to do the debriefing … (P 12)

Access to medical intervention is available at the TTC, which is described in literature as a one-stop facility for survivors of rape.

My role is to ensure that whoever comes (to the primary health care facility - clinic) that has encountered sexual violence, let's say over the weekend, the first priority is that patient must be seen by a doctor… (P 20)

Organising the doctor to come to the centre (TTC) for the samples (medical examination) and ensure the survivor has PEP (post exposure prophylaxis) to prevent HIV or prevent any other medical condition as a result of the rape. A case will be opened because the police will be there. If they are not there, we call the police to come in… (P4)

According to the above statements, services to survivors are easily accessible, as there are a few places where survivors can seek help by going to the distinct organisations/service points themselves or calling for SAPS intervention that will then ensure that prescribed services to survivors are rendered. Disclosure and help-seeking are the first steps taken by the survivor to heal and recover (Tillman, 2011).

Literature explains that reporting to the police is an important step in the legal processing of sexual assault cases (Goodman-Delahunty and Graham, 2011), as the SAPS ensures the completion of the medico-legal aspects that relate to the survivor (Bougard and Booyens, 2015), so that an offender may be successfully brought to justice.

This research found police stations (SAPS), in most cases, to be the first point of contact where survivors seek help after sexual assault has occurred. People who do not seek SAPS intervention report to the TTC or a primary health care facility (clinic), where the stakeholders than contact the SAPS so that the legal proceedings can occur as prescribed. Jina et al. (2010) describes medical treatment and emotional support as the intervention services that promote healing in response to immediate post-rape needs. In De Aar survivors' immediate needs are met in terms of safety, access to medical intervention and provision of emotional support offered by trained professionals and volunteers, as prescribed by the United Nations Declaration of Basic Principles of Justice for Survivors of Crime and Abuse of Power (1985). This declaration stipulates the services to be accessible to survivors to rectify harm. Access to services is therefore ensured through a collective approach adopted by stakeholders to meet survivors' immediate needs by providing access to personal and physical resources, such as a private room or a vehicle.

Stakeholders thus work together to meet survivors' multiple needs. However, legislation is the biggest driver of stakeholders to share responsibility and respond to survivors' immediate needs with respect and dignity. Legislation directly influences organisational policies by prescribing organisational responsibilities to survivors, which determines the degree and nature of intervention of stakeholders.

4.4.1.1.2 Inconsistently rendered services and outdated practices

The CLAA (32 of 2007) Chapter 1(e)(ii) addresses service delivery in the criminal justice system, responding to sexual offences by prescribing appropriate recognition of the needs of survivors through timeous, effective and non-discriminatory investigation and prosecution. Accessibility to services has been established in the previous section; however, literature reports that services to survivors are often inconsistent, despite their availability. Participants were questioned about their

referral process in handing survivors over to other stake holders. The consistency of services was described by participants from different organisations.

On disclosure at different SAPS stations, the following happens:

… For instance if there is a case reported, I am working in social crime … I come first at the scene. So if there was a rape case or a family violence case, you check first what sort of offence it is; if its family related or a stranger ... You take the victim away to a safe place. At the police station we have a trauma room; you make sure the person is safe there … You remove the victim from wherever the incident happened. You put the child in a safe place and contact the social workers … (P 14)

I don't have a role because we have a FCS unit that is working with all that cases. So when a complaint comes here regarding that, the standby officer is contacted of the sexual offence unit and they take it further. (P17)

… firstly you take the person to the safe room, it's at the back, like a trauma room. You interview that person but not heavily just the basics to obtain information on what happened … When the victim comes in our part is to secure the victim, to make sure the victim is safe, if there is a need to assist, we assist with whatever their needs are … Then you call FCS and they will come and take over (P 19)

We (FCS) are usually contacted by the Police stations where victims normally report first about a sexual offence ... Most of the time we receive the case docket after it was registered with the victim statement where the victim was already at the hospital for the medical examination and we take the investigation from there … the police at the police station are supposed to assist us with that; taking the statement, especially when it is an adult and getting the victim to hospital ... (P7)

… The challenge we have as the forum, from last year and this year, is the police; some of the victims have reported cases to the police but it's like the case is lost. The intervention of the police is not ongoing. Victims are not informed even about their case numbers. Victims are not informed on what is happening to the case. Everything is backlog. Everytime they go there, they are not treated well… (P1)

Emotional support is supposed to be rendered on disclosure.

… We have four first responders which mean that if a case is reported at the police, the first responder is contacted and goes with the client to the hospital. The first responder is responsible for calming the client down and assist with the taking down of the statement and the doctor with the medical examination. Not to do anything but just be there for emotional support. (P 2)

The debriefing is supposed to be done by the social worker on standby [from DSD]. We have social workers on standby for children so if it happens over the weekend that social worker is supposed to do the debriefing… (P12)

The social worker [from Ethembeni Community and Trauma Centre] also joins those (SAPS) at the hospital, she does the counselling… (P12)

… we do utilise the social workers at the hospital for counselling. We utilise them for walk in's, then refer to DSD. (P 4)

The Department of Health offers counselling and debriefing to survivors and also in the case where there is children, that the children are taken care of where the mother has to be hospitalised … (P 6)

…I (auxiliary social worker) am supposed to explain to the survivor what will happen at the TCC … I must make the survivor feel calm and protected…So I must have empathy and make sure that every procedure is done … (P 9)

Some services relate to medical intervention.
On weekends when the victim comes here after 4 pm … I always put out treatment prophylaxis and for pregnancy when possible, sometimes in OPD it is not possible to give the medication because the sister in OPD does not have the treatment … (P 8)

… let's say there is a victim that comes here at 1 am, you would find the people in OPD don't have the contraception or the PEP. In that case the pharmacist should be called but sometimes they aren't here and you have to wait for the next morning … they should leave the tablets there in OPD, sometimes it doesn't happen sometimes it does. (P 9)

Practices used at the TCC/ hospital when responding to survivors' immediate needs should be clear.

… We use to have challenges at the hospital where there was resistance of new people coming in to provide extra services, where doctors can't speak the language of the people, the nurses still taking people outside of the TCC to weigh them and take their blood pressure … (P 2)

… before the patient comes in here [TCC] with me, male or female, they have to go to OPD (out patient department- casualties) and in OPD the sister (professional nurse) sees the victim … (P8)

… once they enter the hospital with the counsellor and police. The first thing I do is take the blood pressure, pulse and everything else to obtain the observations. I have to check on the physical well-being. I then refer to the Doctor that deals with sexual abuse or doctor on call … by calling the doctor to inform of the victim in OPD ... (P 13)

From the above it can be seen that services are not consistently rendered at departments that offer immediate services to survivors. The United Nations' Declaration of Basic Principle of Justice for Survivors of Crime and Abuse of Power (1985) maintains that survivors are entitled to have access to justice and fair treatment to rectify harm and loss suffered as a result of violence. Responses show SAPS members to understand the need for a continuum of care for survivors of rape beyond reporting for justice purposes.

What is of concern is that community service centres (stations) do not all follow the same procedures when rendering service to survivors; one station would actively aid the victim and support the FCS unit and the other two stations would not touch the case and refer it straight to the FCS for service, such as taking the survivor's statement and ensuring medical intervention at the hospital, which the station should be able to do, as said by Participant 7. The presence of the FSC unit in the SAPS consequently extends the waiting period for intervention at some stations and contributes to inconsistent service delivery from the SAPS. Immediate service for survivors thus depends on the station where a survivor discloses sexual assault.

Immediate emotional support is described in literature as so important that it can be given enroute to a health care facility or after the medical intervention by a rape crisis counsellor or social worker and trained volunteers or police officers (Linden,

2011; National Prosecuting Authority, 2015). The researcher found that multiple service providers offerd emotional support, but there was no clear procedure or protocol that called for the involvement of a specific stakeholder. The lack of clarity and uncertainty among stakeholders on when immediate emotional support was to be offeref and who should offer it thus resulted in either abundant emotional support or no emotional support. Respondents explained that multiple organisations had people available to render immediate emotional support to especially child survivors, irrespective of the time or day of the week. Respondents, however, were not in agreement as to when which stakeholder should offer immediate emotional support, nor were the relevant participants aware of emotional support rendered by other stakeholders, such as social workers from the DSD or DOH. When immediate emotional support was given, it met the prescriptions of literature.

Literature prescribes that all survivors should be offered post-exposure prophylaxis at a health care facility within 72 hours after sexual assault occurred (Linden, 2011). To strengthen prescribed medical interventions the government provides anti-retroviral medication to all survivors as part of comprehensive post-sexual assault care to prevent HIV transmission (Abrahams et al. 2010) and other related medical challenges that may arise as a result of rape. In De Aar it was found that prescribed medication is available to survivors, but not always accessible at the time the survivor receives medical intervention. According to the findings, the administration of post-exposure prophylaxis occurs in respect of all survivors of rape within 72 hours from the time when the incident is reported. This means that a survivor who discloses rape right after the occurrence, is more likely to receive prescribed medication in the said time, but if the rape is reported a day or two later over the weekend, the survivor would be less likely to receive the prophylaxis within the prescribed time frame. The period between the time when a survivor discloses the rape and when access to prophylaxis is granted thus determines whether or not medical interventions will be adequate to prevent future harm and meet the survivor’s holistic immediate medical needs as prescribed in literature.

Government, in partnership with non-profit agencies, have introduced TCC as a one-stop facility across South Africa specifically for survivors of sexual violence (National Prosecuting Authority, 2015). Literature describes the ideal of the TCC to have all survivors’ immediate needs met at one facility without having to move the survivor

from one place to the other, in the process worsening PTSD symptoms such as paranoia. According to the findings, the TCC is always the next point of service on disclosure of sexual assault. The TCC in De Aar still uses outdated practices of having survivors move in and out of the TCC for observation in the actual hospital thus exposing the survivor to worsened symptoms of PTSD. Having a survivor move through the hospital as an emergency case may also attract unwanted attention to the client from the public at large. The TCC in De Aar therefore contradicts its purpose by utilising practices deemed harmful to survivors in the relevant literature.

4.4.1.2 Types of services available to survivors and non-offending family

According to literature, the complex nature of sexual violence calls for a multi-sectoral approach to ensure security and positive health outcomes for survivors (Jina et al., 2010) and non-offending family. To address the complexities of rape, interventions consist of medical, psychological and legal services (Linden, 2011) that include a range of services to meet survivors and non-offending families' immediate and long-term needs. Categories that arise from the sub-theme include the fact that primary services are mainly rendered by social workers, who then determine the need for mental health services. Psychiatric intervention occurs in extreme cases through referral of a psychologist or social worker, and primary health care services continue as a separate service from psychosocial interventions.

4.4.1.2.1 Primary service mainly rendered by social workers who then determine the need for mental health services

In literature counselling said to stem primarily from mental health counselling or supportive counselling (Macy et al., 2010), which can be implemented through multiple professional approaches (Moynihan et al, 2018; Landreth, 2002). In the case of De Aar, when questions were asked on the role of service providers in dealing with survivors and the referral process used to meet the multiple needs of survivors, the following answers were elicited:

My role as a probation officer … My work includes therapeutic counselling, therapeutic group sessions of healing which takes about 16 sessions, referral to a psychologist if there is a need for that … (P1)

I am a social worker … I do counselling … for normalisation to stabilise the client. To initiate coping skills and mechanisms to go on with life … Sometime when I do the initial assessment with the client and I discover that the trauma is deeper (more severe) then I refer to the psychologist for counselling. They do in-depth counselling … I continue my services irrespective of the services with the psychologist. (P2)

… in the beginning I rendered counselling services, I made sure that the survivors are comfortable … I am only called now, when the Ethembeni social worker is unavailable. (P6)

… It is usually from a social worker who phones from outside to make an appointment to see the psychologist … My role is to see them for the initial sessions when they are still traumatised just to reassure them it is not their fault. Just to stabilise them and comfort them … It is important that the person sees a psychologist or a counsellor (social worker by profession) within three days after the incident…Such a person [survivor] needs the help they require and that must happen as soon as possible because the longer you wait the more harm occurs. (P10)

… What normally happened is that the court preparation officer will also mediate after a victim testified to refer the victim to a specific social worker for psychological counselling… (P11)

Additional services by social workers to meet survivors' immediate and long-term needs include:

I do referral to Ethembeni trauma centre where they work specifically with the victims;… I supervise the volunteers who offer support and information to victims of sexual offences; … As the sessions go on … some of them now become ready to face the offenders in terms of the victim-offender mediator services, family group conferences they are now ready and empowered to face the offender, challenge the offender and speak to the offender and family to what the crime has done to them … (P1)

I am a social worker. Besides the shelter that we run which is primarily for victims of domestic violence, we take in victims of sexual offences too. We take victims from … the whole district … We also run the local TCC where all the victims of rape get services … (P2)

…I made sure that the survivors … take the necessary steps like SAPS, in cases of a child, the protection of SAPS. If she wants to have a protection order then I will refer her to the Department of Justice … (P6)

… I would include the family as well … The goal of the family sessions is primarily to make the parent aware of what the child is going through. The child is the primary victim and the family the secondary victim. So I need to make the secondary victim understand what the primary victim is going through. (P12)

You remove the victim from wherever the incident happened. You put the child in a safe place and contact the social worker … I had to refer the case to the social worker at Ethembeni … they gave her a place to sleep, food, clothing, everything. I left her there. The next day I called the social worker where she explained she will take the matter over as there were signs of abuse in the girl's life. After three days I called again to check on progress where they reported they took the girl back home and handed the matter over to the social workers at her home …(P14)

Mental health intervention is something necessary with survivors and non-offending family.

… In the state setting unfortunately there is not enough time to provide proper family intervention. This year, in my practice I had a case where I saw the client and her whole family. It was quite nice to work with the whole family… I saw the client individually and the family as a group. (P5)

When I see the person is still in need of support or where the person is at risk of suicide, or has suicidal thoughts then I would join in the family and see them too … an eco-systemic way where the family plays a great part … I work over three sessions … Where it's not (sufficient) I make another appointment to see the person with the family in two weeks. But if therapy is still needed it can go on for as long it is needed. (P10)

From the above it can be seen that social workers are placed in multiple-disciplinary organisations to render relief services to people in distress. Literature explains the importance of crisis counselling after disclosure to contribute notably to the healing of the primary survivor and those who experience secondary victimisation (Linden, 2011; Mathews et al., 2013). Where crisis counselling can not occur immediately

after disclosure, literature advocates long-term counselling by a social worker to address psychosocial aspects hindered by the sexual offence (The National Prosecuting Authority, 2015). The research found emotional and support services, referred to as counselling, to be the primary form of immediate and long-term intervention when dealing with survivors of sexual violence. Counselling services are found to be predominantly rendered by social workers employed at DSD and Ethembeni, but are not limited to these organisations. Social workers from the DOH render short-term medically related in-patient services that include counselling; however, survivors in De Aar are referred to the DSD and Ethembeni for long-term out-patient intervention. In the least, survivors obtain information to resolve their intial fears and anxieties that most survivors of rape experience and is helped to avaoid the development of many other long-term problems associated with rape (Ledray, 2015)

Tavkar and Hansen (2011) prescribe the porpose of crisis intervention with non-offending parents as enabling parents to facilitate recovery post-abuse. The research shows that interventions by social workers more often than not exclude the family from the healing process, except for implementing FGC and VOM as prescribed by the CJA (75 of 2008). Little to no attention is given to the family of the survivor, unless it is a child survivor; only then is service to the family offered, but the focus remains on the child survivor. Although one individual may directly experience a violent or traumatic incident, family memebers may be affected by the event, resulting in secondary trauma (Bryant-Davis, 2011).

Mathews et al. (2013) advocate counselling for non-offending family members to address distress, anxiety and negative emotional reactions experienced as a result of the offence. The research found psychologists to include non-offending family in the intervention process, but social workers, only include the family to support the survivor's healing and not to address their own issues that manifest as a result of the rape. Family systemic traumatic stress results in sudden demands imposed on each member of the family system and results in change in the relationship patterns (Bryant-Davis, 2011). Including the family in interventions, as a secondary survivor, is therefore in the best interest of the family as a system and the survivors self.

In De Aar psychological services are available to families who have the financial means to pay for psychological intervention themselves. Balaeav (2008) explains that a traumatic event can disrupt attachment between the self and others by challenging fundamental assumptions about moral laws and social relationships. Because of the possibility of survivors' detachment from their family, non-offending family should be included in interventions, not only to enable them to respond appropriately to the survivor's needs, but also to address their own emotions and fears as a protective and/or supportive figure in the survivor's lives.

Literature suggests the completion of a needs assessment to establish individual treatment plans for survivors (Muraya and Frey, 2016), as different types and degrees of trauma can produce different responses (Balaeav, 2008) and therefore call for different interventions. Social workers in De Aar determine survivors' needs by assessing each survivor in the context of his or her environment and connecting survivors with appropriate intervention to meet the needs unmet by social worker intervention, such as mental health services. Social workers therefore determine which survivors will receive mental health services in addition to or instead of intervention by a social worker. Should survivors not receive intervention from a social worker in De Aar, they are less likely to receive intervention by a psychologist to meet severe mental health needs.

Literaturte states that survivors often require therapeutic sessions after crisis counselling (Tavkar and Hansen, 2011). Therapeutic sessions are found to occur without a clear time frame through interventions by a social worker or on referral to a psychologist. The social worker employed at Ethembeni Community and Trauma Centre renders all primary short- and long-term services to survivors as suggested by the National Prosecuting Authority (2015). Crisis counselling right after disclosure may not occur; however, a form of counselling is undertaken with all survivors who formally disclose sexual assault.

The findings indicate a great reliance on social workers to provide emotional and support services to survivors who disclose rape throughout their healing process. The social workers of De Aar, in their distinct organisations, all contribute to alleviating and/or solving problems related to immediate and long-term safety and physical and emotional needs, using their organisational means or through referral.

Social workers in De Aar can thus be regarded as the invaluable driving force behind interventions for survivors of sexual violence.

4.4.1.2.2 Psychiatric intervention in severe cases through referral of a psychologist or social worker

Sexual abuse is shown in literature often to result in mental health problems for the survivor that requires high-quality, evidence-informed, and effective programmes offered by health care and allied service providers (Artz et al, 2016; Moynihan et al, 2018). In literature the multi-sectoral approach is described to respond to all possible needs survivors may have beyond their immediate and physical needs. Service providers in De Aar were questioned on organisational referral processes and the availability of additional service options for survivors who display PTSD symptoms unmitigated by counselling and mental health services. Interventions beyond psychological counselling were explained as follows:

… Psychiatric services at the local hospital … If someone comes, and I detect that the person is suicidal or they are about to fall into major depression ... Either they get medication or they are admitted into hospital for 72 hours. (P2)

… We have a psychiatric nurse at De Aar who arranges that the clients see the psychiatrist when he comes. Even the psychologist makes assessment with regards to the extent of the trauma the client underwent and he makes a referral to the hospital to have the client admitted in order to stabilise the person … (P2)

… And where the person is complaining of insomnia, loss of appetite and when the person is still teary and depressed I refer to the GP [general practitioner] for medication because I do not have any … I do refer to the local hospital especially when a person is suicidal I refer for three days' observation; 72 hours psychiatric observation … (P10)

From the above it can be seen that service providers are aware of additional mental health services beyond counselling. Trauma theory asserts that trauma induces a temporal gap that divides or destroys identity and that exposure to a traumatic event can result in significant psychological harm, causing a number of mental health symptoms, such as PTSD, major depression and contemplation of/attempted suicide (Balaeav, 2008; Tseris, 2013; Linden, 2011). In De Aar service providers responding

to the counselling needs of the survivor ensure access to psychiatric services where survivors present with major depression and suicide ideation.

Daniels (2016) refer to rape and sexual violence as post-traumatic rape syndrome and explains it to be a normal emotional reaction to an abnormal situation. Different types of trauma, and the degree of the trauma, produce different responses, such as dissociative amnesia or intrusive recall (Balaeav, 2008), which calls for insensified interventions. Where counselling and mental health services are inadequate to stabilise the survivor, anti-depressant medication and/or admission to hospital for 72 hours' psychiatric observation are common practices utilised in De Aar. Psychiatric intervention, however, is explained to occur as a short-term relief service and/or until the survivor can be seen by a psychiatrist to meet possible long-term psychiatric needs. From the above it can be said that counselling and mental health service precede psychiatric intervention, since psychiatric intervention does not occur without referral from a social worker or psychologist. Should survivors not receive services to meet their emotional needs, they would be even less likely to receive psychiatric health services, which are often not rendered in time because of poor human resources.

4.4.1.2.3 Primary health care services continue as a separate service from psychosocial interventions

In literature, South Africa is described as providing comprehensive post-sexual assault care, which includes the availability of anti-retroviral medication to prevent HIV transmission among survivors of rape (Abrahams et al., 2010). The goal is to respond adaquately to the survivor's medical post-rape needs to prevent future physical health challenges. In the case of De Aar, services relating to the medical needs of survivors were explained according to the level of medical care. Service providers were asked about the available interventions and their organisational role in dealing with survivors. Primary health care services on a community level were explained to occur as follows:

… Usually we at the clinic we do the follow-up care which is continuing with the PrEP that is the post-exposure prophylaxis. We also treat for prevention of STIs, check pregnancies and provide counselling through the social worker… So when they come to the clinic I will be laying levels on what they have already gotten at hospital level... (P20)

… when a child is involved. The mother, grandmother, the care worker will come to the clinic to make sure, to see if the child was assaulted; if there is any bleeding or anything. They come to the service and we will take it from there. If it over the weekend they go straight to the hospital. (P18)

From the above it can be seen that primary health care facilities (known as clinics) respond to survivors' needs according to how the problem is presented at the facility. According to literature, a survivor who seeks care at a health care facility after sexual assault should first be evaluated for acute traumatic physical injuries; prophylaxis for sexually transmitted infections and pregnancy should then be administered (Linden, 2011). In De Aar the clinic and hospital can and will provide the same service to survivors depending on where in the help process the survivor is and the means of the facility in terms of human resources available at the clinic on disclosure. This means that should a medical doctor be available at the facility at the time of disclosure, the medical investigation can take place at the facility, with the support of relevant stakeholders such as the SAPS.

Responses additionally explain the clinic to be a possible first point of contact for help to child survivors of sexual violence where the care giver of the child suspects sexual violence to have occurred. In cases where possible sexual violation is suspected by the professional nurse, the SAPS will be called and the child, with the guardian, will be taken to the TCC where the whole justice, medical and psychological process will be initiated and the survivor will later return to the clinic for after-care medical intervention. The findings indicate that the clinics generally keep survivors on treatment initiated at the hospital after the medical examination has been completed, with minimal focus on additional needs. This means that medical after-care interventions on primary level continue from hospital interventions but operate as separate interventions, with the sole focus on the survivor's physical health.

4.4.1.3 Continuuum of care for survivors of sexual violence

Systems theory allows for a holistic framework in which different elements of a person's life can be located and connected between different systems (Jack, 2012). Applied to this research, systems theory provides a framework where the needs of survivors are prioritised by connecting different stakeholders to dissimilar needs

survivors may have in an attempt to restore and prevent future harm. The continuum of care refers to the services survivors receive in their environment. Categories that stem from this sub-theme are poor implementation of support services and incorrect use of RJ practices.

4.4.1.3.1 Poor implementation of support services

In literature, aftercare and support services are terms used interchangeably to refer to programmes that take resources to families in their homes to inform, support and provide additional services to improve family functioning (Runyan et al., 2002). Support services are described in literature as including among others the following: home visitation programmes, life skills [safety planning, decision-making, conflict resolution, problem solving], vocational training, education enrolment, CV writing and job searching skills (Macy and Johns, 2011), which are all interventions contributing to the survivor's holistic well-being. In the case of De Aar, when questioned on services that may benefit survivors, participants reported the continuum of care for survivors as follows:

… Our support service is on request of the probation officer … Assisting to transport victims to psychological services … During the home visits I would sit with the victim and enquire on their well-being, the services received after the incident … (P3)

… We follow up to ensure they have completed the PEP course and received counselling. (P4)

I go to the clients to hear how they are doing after the incident. If they want more counselling or if they needs someone to speak to, are they safe and if they received PEP are they adhering to it … we continue going there until the victim says 'No I am fine now'. (P9)

Various formal programmes are community-based:

… the support group ... It is settled by them so they(survivors) run the support group. The APO can just visit when they wish to. They are under the supervision of Ethembeni. It is something that comes out of them. They own the support group. (P1)

… in terms of the victim, they [assistant probation officers] do support services; they do home visits, they invite them for awareness programmes that they run. They offer

'NEW BEGINNING' that is focussed on victim of sexual offences. They also do referrals of those victims to other service providers. (P1)

From the above it can be seen that stakeholders' understanding of support services to survivors are lacking and in most cases not compliant with interventions identified in literature as essential. Stakeholders use the term support services to refer to administrative tasks, transporting and giving information to the survivor on programmes and progress on their criminal cases. The findings also receal that auxilliary social workers are tasked with the responsibility for after care/support services in the form of home visits.

Home visits are one of the interventions shown to be effective in preventing abuse (Meinck et al., 2016). In De Aar home-based services are designed to follow up on the work that has been done with the survivor and to identify possible additional needs after reporting the incident. Through following up on the services received, the probability of survivors not receiving service is reduced, thus avoiding having survivors deal with the trauma by themselves. The psychological impact of trauma can be displayed in anti-social behaviour such as engaging in risk behaviour, substance abuse and promiscuity (Khan, 2016). Related to non-service delivery, home visits that do not respond to survivors' needs in their environment then contribute to exacerbating symptoms, as auxilliary social workers are not alleviating some of the life challenges that hinder recovery and as a result may force the survivor to stay in circumstances that present future risk.

Additionally, DSD as a government department uses an accredited programme to strengthen the recovery of survivors and encourages shared responsibility for survivors' own healing. The support group is run by survivors themselves, allowing them to determine the degree of support from people who have experienced the same or similar events of interpersonal violence. Literature, however, prescribes group therapy to occur later in treatment (Tavkar and Hansen, 2011), as implemented with survivors. Support services in De Aar are thus not only poorly implemented, but also insufficient to respond to survivors' after-care needs.

4.4.1.3.2 Incorrect use of restortative justice practices

VOM and FGC are interventions the CJA (38 of 2004) makes available as a diversion or sentence option for juvenile offenders but can also be of value to the survivor's healing. In literature RJ practices are proven to reduce interpersonal crimes in especially severe cases such as rape (Mc Glynn et al., 2012). In De Aar RJ practices are implemented by DSD and when questioned were asked on the services the organisation offers survivors of rape, RJ intervention was explained as follows:

… some of them now become ready to face the offenders in terms of the victim-offender mediator services, family group conferences they are now ready and empowered to face the offender, challenge the offender and speak to the offender and family to what the crime has done to them … The FGC's and VOM's are initiated by the PO sometimes it's also a court referral. (P1)

… I asked if they wanted counselling and encouraged them to participate in VOM's because youth offenders come out of CYCC's/prison, they were sentenced there five years, they come out but the victims are not prepared to see the offender again … Probation officers, social workers should inform and prepare the victims for the offenders' release. (P3)

The findings reported by Participant 1 insinuate that FGC and VOMs occur after the survivor has undergone emotional intervention and is ready to have contact with the offender. Participant 2, however, reports the preparation of survivors to see or have contact with the offender to be fictional. The data suggests that survivors are often unsuspecting of contact with their offender because they do not receive preparatory services to observe the offender in the community. It can thus be said that emotional intervention does not include eventual contact with an offender, but only focusses on the sexual offence from which the survivor has to recover.

The CJA (section 2 (a-e)) aims to protect the interest of the survivors and community by holding offending youth accountable for their actions through the use of RJ approaches.these are intended to reinforce respect for human rights to protect the long-term well-being of both the youth offender and survivor through discussion of the offence/s (Steyn, 2010). If survivors are to meet the accused, formally and informally, they need to be prepared for the interaction, as failure to do so may result

in re-traumatisation. Preparation of the survivor to interact with the offender is done by the social worker or probation officer rendering service to the survivor, as explained by Participant 2.

The findings indicate that RJ practices could also be undertaken on recommendation of the court or suggestion of the probation officer. The survivor is therefore not the focus of the intervention, which is not survivor-centred, as implementation of RJ occurs through instruction. In literature RJ approaches are described as providing a platform where victims can express their experience and frustrations in a safe environment, with the physical support of their family (Steyn, 2010). RJ practices would be of especial value where survivors and offenders are known to each other and live in the same home/area, as the effects of inter-personal violence is not limited to the survivor and the offender, but extends to the family and larger community.

4.4.1.4 Difference in the application of intervention with child and adult survivors

Article 39 of the United Nations CRC makes provision for the rehabilitation of child survivors. It states that "children who have been neglected, abused or exploited should receive special help to physically and psychologically recover and reintegrate into society" (UN General Assembly, 1989).

In literature the impact of sexual violence on the individual is shown to vary and as such requires individualised interventions to address survivors' individual needs, taking into account the age and maturity of the child (Tavkar and Hansen, 2011; United Nations, 1985). Multiple stakeholders in the research mentioned differences in their intervention with child survivors compared to adult survivors. Categories that arise from the sub-theme are impediments to interventions with adult survivors and child-friendly interventions when dealing with child survivors.

4.4.1.4.1 Impediments to interventions with adult survivors

In responding to survivors of sexual assault, interventions should be person-centred aimed at addressing the effects of trauma while facilitating healing and ultimately restoring physical and mental health issues resulting from the rape (SAMHSA, 2018; Muraya and Fry, 2016). Literature calls for evidence-based practices that prioritise

survivors' needs for restoration and prevention of further harm (Jina et al., 2010; Department Social Development, 2018). Impediments to effective interventions with survivors named in literature include among others service users' perceptions of support structures and accessibility to services. In the case of De Aar, service providers were asked about external challanges that hinder effective intervention with survivors. Obstacles to intervention with adult survivors were explained as follows:

I would often suggest and encourage adults to still go for a medical just to go check on yourself … An adult has a right to choose. They can choose to go back to that man and no one can do anything. I can help with a protection order but that won't help if the woman lets the man back. (P5)

… The difference was that the adult can speak for herself and she can give you a detailed explanation of what happened … In cases of adults, the adult is under the influence of alcohol, where children are sober and this bad thing happened to them. So to me there is the big difference. Adults are more in control of themselves. (P6)

… With adults you can set up a sessions and go through your questions or whatever you would like to pose and you can get answers from them. They can voice it out to you, how they feel and their emotions … (P10)

When services coomence,

… the police at the police station are supposed to assist us with that; taking the statement, especially when it is an adult person and getting the victim to hospital… (P7)

From the above it can be seen that adult survivors are perceived to have the cognitive and verbal ability to express their thoughts and emotions in such a manner that intervention can progress with less effort, compared to children. In literature people in violent domestic relationships are described as experiencing partner violence and sexual assault as either one victimising occurrence or as part of a pattern over the course of their lives (Macy et al.,2010). The findings of this research confirm that survivors of sexual violence are often violated by their partners and that interventions are not inadequate per se to support the survivor, but rather that the survivor may choose to reject available interventions to aid her protection.

Literature explains issues relating to only adult survivors to include alcohol consumption. The consumption of alcohol prior to rape was found to influence

judgement of survivors, as intoxication is associated with greater survivor responsibility for the rape and less favourable views of the survivor (Goodman-Delahunty and Graham, 2011). Findings from this research confirm a degree of judgement from some stakeholders towards adult survivors when they are sexually violated while under the influence of alcohol. Alcohol is insinuated to contribute to sexual violation of adult females, resulting in reduced symphathy and empathy from stakeholders.

With regard to the commencement of services, the research found intervention with adults to occur effortlessly, as adults do not require additional support from a second party, such as a legal guardian, and can consent to medical interventions themselves. The Constitution contains the Bill of Rights, which proclaims human dignity, equality and freedom (RSA, 1996). The findings of this research explain adult survivors to have control over themselves and to have the ability to make their own choices. Adult survivors of sexual violence, therefore, influence if and when intervention will occur. Also, adult survivors can choose whether or not to report incidents of sexual violence.

4.4.1.4.2 Child friendly interventions used when dealing with child survivors

In literature child survivors are described as a vulnerable group who require special protection appropriate to their age, level of maturity and individual special needs (United Nations, 1985). The United Nations CRC further highlights the importance of appropriate intervention as "special help" for child survivors (UN General Assembly, 1989). In De Aar service providers were questioned on their intervention with child survivors. Intervention with child survivors was described as follows:

… I have also experienced that there is more fear in children from the experience compared to an adult. Physically … their whole demeanour/attitude, they are in shock … in the case of children, the medical investigation is very traumatic for children, so there has to be someone that will comfort the child and take care of the child…Children are vulnerable and they don't understand when it comes to sex, you consider the age of the child, you need to give more attention and support to a child … (P6)

…When you work with children, they can't voice their feelings like adults … They cannot say and put it how they feel. You than need some skills to get that information

from them. You use therapeutic techniques for instance play therapy … when I'm working with young children. I make use of teddy bears, drawing, play ect … (P10)

…if I do sexual offences of children. Small children requires me to build rapport with that child first. Because in most of the cases you get children of six,seven, or eight years old, they are not willing to talk to you. First of all, in my instance, because I am a male and in most of the cases the culprit is a male, so I first have to establish a bond with that child so than it will differ from normal adult persons because than sometimes I see the children two- three times before we get to the trail stage. It is because the children have to trust me first then they will be open about their experiences. We then consult. Sometimes I have to do the trail readiness two- three times with children specifically before we go to court. (P11)

… With child victims, I am a social worker doing play therapy…we have a play room at Ethembeni Trauma Centre so when children of sexual abuse are referred to DSD I do play therapy with them in the play room at Ethembeni … my objective is for the child to work through the trauma and acknowledge that this is what happened to me and how we can move forwards. So assist the child in acknowledging and moving forward. (P12)

Legislation has an influence on intervention.

… children we prefer that the guardian of the child can open the case so the statement can be taken from the guardian and if trouble taking the statement from the child we usually do it ourselves. (P7)

… When there is a child involved the guardian or parent of the child must be involved … (P15)

From the above it can be seen that service providers understand the limitations regarding children's understanding and ability to express themselves. The Children's Act sets out principles relating to care and protection of children and define parental responsibilities and rights with regard to the child (RSA, 2005). The findings show that when working with children, parental responsibility and right are upheld by service providers; intervention with children does not commence without the consent and presence of the guardian of the child. By requiring guardians to report the

incident to authorities, guardians are further encouraged to take responsibility for their child's safety and well-being.

The United Nations CRC is based on four guiding principles, namely non-discrimination, the best interest of the child, the right to life and respect for the views of the child (Department of Social Development, 2018). The research found stakeholders to consider and respect the views of the child. Firstly, the child's statement is taken, in addition to that of the guardian, meaning that how the child experienced the offence is not discarded, as children are given the opportunity to share their story in their own words. Secondly, when a child is called as a witness in court, the prosecutor prepares the child and builds rapport prior to the court proceedings, allowing children to give their testimony as best as they can in circumstances that are less stressful owing to preparation.

The research further shows that "extra" attention is given to children because of their inability to process information as adults do and because of how notable their physical reaction to the trauma is. Children are found to be less able to deal with the impact of violence compared to adults. As Landreth (2002) states, when working with children they should not be seen as miniature adults and should be approached from an appropriate developmental perspective.

The findings additionally indicate that service to child survivors will occur irrespective of the children's inability to express their thoughts and emotions verbally. Service providers explain the use of child-friendly approaches, such as play therapy techniques, to enable the child to communicate in a manner that is comfortable and appropriate to the child. Children's natural means of communication are through play and activity (Landreth, 2002), which service providers understand and implement. Through adjusting the work method when working with children, stakeholders promote non-discrimination and the best interest of the child, as set out by the CRC.

4.4.2 Effectivity of services responding to survivors needs

All participants interviewed perceive sexual violence interventions, services and programmes to be effective in responding to the needs of survivors of sexual violence in De Aar. Sub-themes on the effectivity of services include services being informed by organisational policies and legislation, organisational provision of

training and supervision, organisational measures of the impact the service makes and linkage of service providers in responding to survivors.

4.4.2.1 Services informed by organisational policies and legislation

Service providers such as the government are tasked to take appropriate steps to ensure that the human rights of persons in South Africa are respected (Department of Social Development, 2018). With regard to services to survivors of sexual violence, policies and legislation are described in literature to inform respectful intervention with survivors to eventually rectify harm and ensure that safety needs are appropriately met. Categories from the sub-theme include inconsistent adherence to organisational policy in responding to survivors, and legislation being used to coerce stakeholders to render service to survivors.

4.4.2.1.1 Inconsistent adherence to organisational policy in responding to survivors

The United Nations' Declaration of Basic Principles of Justice for Survivors of Crime and Abuse of Power (1985) recognises the needs and rights of survivors of violent crimes and stipulates that survivors should be identified and treated with respect and dignity. In agreement with international policies, organisations use individualised organisational policies to respond to the needs of survivors. In De Aar service providers reported interventions with survivors to be informed by policies that refer to the core function of the organisation itself. Legislation is shown to inform intervention as follows:

Our department's policy and the services being rendered at the department is to see to the poor, vulnerable and those who are in distress, to see that their well-being is attended to … We have ethical policies that we all must adhere to. (P6)

…according to policy it is also considered an emergency; sexual offences fall on our red block of emergencies. They are therefore dealt with as an emergency. (P13)

One of the main things that come out of our meetings is the way the police treat our people ... Sometimes the community will be at the police station and call me and I would go and intervene … Our main problem here also is when you phone in, someone will be rude on the other side … (P16)

I think its standing orders in the Act that says you cannot take the statement of a person under the influence. You can listen to what the situation is; you can open a case docket regarding that as a police officer. When the person is sober the investigation can continues where she says she is going on (with the case) the facts are alright she was rape. The necessary test will be done. (P17)

From the above it can be seen that stakeholders cannot necessarily name the policies that inform their organisational response to survivors; however, awareness of policies is shown to inform procedures applied at organisations in responding to survivors under different circumstances. Prescribed policy thus informs how organisations render services in De Aar. According to literature, rape as a violent crime must be regarded as a medical emergency, since survivors often present with physical injuries (Naidoo, 2013). The service policy of the DOH makes special provision for survivors of sexual violence to be treated as an emergency at health care facilities. This research found survivors to enjoy immediate attention at the hospital and the 'first-come first-service' principle not to apply in cases of rape. In De Aar service providers regard service to survivors as urgent, ensuring that the immediate needs of the survivors are met.

Literature explains police perceptions of survivors' credibility to be influenced by contextual factors such as the level of intoxication of the survivor, victim characteristics (e.g. appearance) and questionable behaviour, such as walking alone at night or going to bars by themselves (Goodman-Delahunty and Graham, 2011). The operational policy of the SAPS, known as standing orders, prescribes that a statement of a person under the influence of alcohol and/or drugs cannot be taken. This policy does not prohibit services to survivors, but prescribes alternatives that require later follow-up with the survivor from the SAPS. Policies at the SAPS discourage contextual discrimination, which may result in non-service to survivors, but cannot encourage humility in service providers, which is also explained in literature to contribute to non-disclosure by survivors (Bougard and Booyens, 2015; Meinck et al., 2017). The attitude of the service provider to rape, if negative, can result in a negative work-based culture among support structures (Van der Bijl and Rumney, 2009), which is often found among SAPS officials rendering service at the community centres.

4.4.2.1.2 Use of legislation to coerce stakeholders to render service

Chapter 1(e)(ii) of the CLAA (32 of 2007) addresses service providers responding to sexual offences by prescribing proper recognition of the needs of survivors through timeous, effective and non-discriminatory investigation and prosecution. In the case of De Aar, service providers report organisational intervention to be informed by, among others, legislation. The practical implementation of legislation is described to occur as follows:

… we (DSD) are the custodians when it comes to children's rights and the Children's Act along with VEP. So everything is going smoothly because we have to adhere to certain legislation and policies. It goes smoothly because we are working according to that ... (P12)

… We fought the fight and won for the victims because there are acts and I just challenged people on the acts. If an Act says you must do that you must do it. I don't care how you feel. It's not about you, it's not about me it's about someone else who is in pain and traumatised. (P2)

… We must empower ourselves with the law because the law changes every year, every time. So we must get training to empower ourselves by going to a course or reading study guides. (P14)

From the above it can be seen that legislation prescribes and informs interventions along with the professionals rendering prescribed services. Sexual violence entails medical, psychological and legal intervention to address the complexities of rape (Linden, 2011). To guide service providers in their work with survivors, acts are put in place to mandate appropriate intervention. The data shows service providers to be fully aware of legislation that informs and prescribes their work and explains the perceived necessity to empower themselves with knowledge so as to render effective services. In addition, stakeholders report awareness of continuous amendments, encouraging individual steps to ensure updated and relevant changes to their role and responsibilities.

Literature explains the complex nature of sexual violence, which calls for a multi-sectoral approach to ensure security and positive health outcomes for survivors (Jina et al., 2010). In the case of De Aar, service providers describe legislation as a tool used to coerce stakeholders into co-operating to help survivors. Legislation is

therefore used to bring about the change needed in service delivery among stakeholders to ensure that survivors get the needed help, irrespective of personal opinions service providers may have. Legislation may not encourage a positive view of survivors, but it does ensure service to survivors.

4.4.2.2 Organisational provision of training and supervision

The United Nations Declaration of Basic Principles of Justice for Survivors of Crime and Abuse of Power determines that service to survivors should result in the rectification of harm suffered by appropriately trained professionals (United Nations, 1985). Training of service providers is explained in literature to be essential for effective services (Moynihan et al., 2018). Categories from the sub-theme include scattered formal training of service providers and supervision that strengthens effective service delivery.

4.4.2.2.1 Scattered formal training of service providers

The United Nations (1985) advises adequate training and education of professionals working with survivors to promote effective intervention that is sensitive in nature and protective of survivors. In De Aar, service providers were asked if their role in their organisation required additional training to provide service to survivors. Training of stakeholders responding to survivors was reported to occur as follows:

… as a social worker your first training [undergraduate studies] that is part of the module which I did … working with victims of sexual offences, trauma counselling … so that already gives you the basis of what to do … I had my qualification specialising in probation and correctional practice and one of the courses I did was conducting forensic interviews with victims of sexual offence … I did training with an NGO which addresses only working with victims of sexual offenders and how to render counselling … We have in-service training organised (DSD) by the department on how to work with victims of crime generally and not only with victims of sexually offence. (P1)

… They gave us basic training in calming survivors down and how to communicate with them in a state of shock. Victims respond in different ways to trauma, their response depends on the trauma they suffered. The training enabled us to handle the situation … It's not a once-off training, we do it every year. It's a multi-disciplinary approach … (P4)

To practice as a psychologist one needs a master's degree, so that is the first requirement. If you do any forensic work … I have to work under the supervision of an experienced psychologist who does forensic work … I had a bit of trauma counselling training. To make me feel more equip to deal with the work. This was part of my professional training. (P5)

... We get specific training to work with child victims, child witnesses in sexual offences. And then we get intensive training to do sexual offences…it is in-house training we receive from specialists ... (P11)

… I was given the opportunity to do the course in play therapy … We were seven social workers from our district but no body implemented it, like it usually is in organisations … I am the only one implementing it … I do my own research online. I got a manual for doing therapeutic group work with children … but still my biggest training was undergrad … (P12)

Yes we (SAPS) got the training on sexual offences. Every police officer is supposed to receive training on sexual offences and training on domestic violence. That is basically it. From there you build on your knowledge. For example if Social Development or TTC has training on something, they would invite you. (P15)

Needs were identified by external stakeholders

Training and sensitising the whole SAPS around VEP. Information sessions for example. Making sure they know how to treat victims because we preach it but don't practise it. We get a lot of complaints from victims that they were handled roughly or officials were rude to them … I think because they (SAPS) don't understand the psyche of people ... We have to be non-judgemental … So I think it's a lack of training or information on what people are all about. Under the influence of drugs or alcohol we need to treat people with dignity. I don't think their training includes that, or I don't know if it does, but they don't implement it … It is the general officials of SAPS that needs training on dealing with survivors of sexual violence … (P12)

From the findings above it can be seen that service providers undergo formal academic training and work-integrated training in their respective professions to enable effective interventions. The United Nations Declaration of the Basic Principle of Justice for Survivors of Crime and Abuse of Power promotes adequate training

and education of professionals working with survivors to protect and effectively work sensitively with survivors (United Nations, 1985). In the case of De Aar, the degree of training service providers requires is determined by the role of the person and the responsibility of the organisation for the community at large. Some stakeholders, such as the probation officer and clinical psychologists, are required by their professional bodies to undergo additional formal training at a tertiary institute to become a specialist in their respective professional fields. In addition, specialist service providers report continuous updating of their knowledge and new developments in their professional field by attending workshops and participating in in-service training.

Literature reports that 49% of reported child sexual abuse cases receive counselling and social work services commencing between two days and six months after the incident (Meinck et al., 2017). Literature therefore report that most child survivors do not receive any intervention from a social worker. In contradiction to literature, this research found social workers to determine and ensure that the needs of survivors are met, especially in cases that concern child survivors. Specialist service providers in De Aar responding to survivors of sexual violence are not only limited in number, but also scattered, resulting in high case-loads for service providers, which then contributes to lengthy recovery as a result of inconsistent and overstretched services.

The findings refect that training is prescribed and adhered to by all organisations in preparation for work with survivors throughout the help process of the particular organisation. Specific additional training is found to be given to certain stakeholders to enable them to work effectively with child survivors, in addition to the work they already do with adult survivors. The research found the availability of training not to contribute to the establishment of special services in organisations for child survivors, which also increases the case-load of service providers that implement their knowledge and skills to aid child survivors.

The findings also show that empowering service providers with knowledge does not necessarily contribute to improved service provision and that service users may still not seek help from stakeholders, for example the SAPS, which is alleged to respond inhumanely to survivors. The SAPS is often where survivors disclose violence and

seek help to heal and recover after being victimised (Tillman, 2011), and if they are responded to poorly, this may prevent the survivor from using other services.

4.4.2.2.2 Supervision strengthening effective service delivery

To promote effective intervention that is sensitive in nature and protective of survivors (United Nations, 1985), supervision in the work place can be described as a continuation of training formally received. Participants were asked if their role in working with survivors required them to have special training and/or a qualification. The responses to questions on the perceived effectiveness of service delivery were as follows:

If you do any forensic work, you have to, well I have to work under the supervision of an experienced psychologist who does forensic work. I do not have much experience in doing that work and prefer to work under supervision... (P5)

… Luckily I was already in an institution that allowed me to practise before I did the actual work. I practised a lot so in my practising I gained more experience and confidence to do it with an actual client … We also have a social worker as a supervisor, I would ask her help and we would come up with solutions together on how we can address those thing and we try to do it better. (P9)

Yes. Many officials are trained. Should there be a situation where one person is not trained another official will be able to stand in for the official that is untrained. (P15)

From the above it can be seen that supervision in the work-place provides a supportive environment that enables stakeholders to render service effectively. When working with survivors of sexual violence, interventions should specifically address the effects of trauma and facilitate healing (SAMHSA, 2018). In De Aar supervision assists with ensuring that correct procedures are applied and that legislative mandates are implemented.

The findings show that stakeholders also receive guidance and support from co-workers to enable untrained stakeholders in organisations to render service in the future and ensure that prescribed organisational responsibilities are complied with. Supervision in the work-place is therefore formal or informal. It can be said that supervision allows stakeholders to take shared responsibility for improving and maintaining the quality of work at their organisations.

The data also shows that stakeholders are more confident in their work where they are subjected to regular formal supervision. Supervision of stakeholders responding to survivors in their distinct organisations should be put in place to support service providers appropriately and ensure training needs are met adaquately and interventions implemented correctly. Lastly, supervision is found to create a platform for some stakeholders to acquaint themselves better with new information or expected skills. Supervision thus adds to formal training to strengthen skills and knowledge obtained in training.

4.4.2.3 Organisational measures of impact of service

In literature it is explained that because of frequent incidents of rape in South Africa the government instituted services to survivors of sexual violence in the 1980s which were later described to be insufficient in responding to survivors' needs (Bougard and Booyens, 2015). To enable service providers to give an accurate reflection of the quality and/or adequacy of the work they do with survivors, they are assumed to receive some form of feedback from service users, which influences their perceptions of intervention. Categories from the sub-theme include organisations' lack of structured feedback and significant reliance on professional observation to measure the impact of services rendered.

4.4.2.3.1 Organisations' lack of structured feedback from service users

Literature states that stakeholders in government are responsible for taking appropriate steps to ensure that the human rights of people are respected (Department of Social Development, 2018). To determine the degree of their effectiveness and to identify areas where services can be improved, organisations generally have service users evaluate their service. In De Aar participants were asked if and how they evaluated the effectiveness of their service. Evaluation of services was reported to occur as follows:

… We have an evaluation format whereby we also speak to the client, the receiving family, how do they perceive their reception of the services … Every session there is an evaluation where the client evaluates the service… (P1)

The DOH respresentatives reported:

… I also take from the comments made afterwards by the doctors and others, they were always pleased and thankful for how we are able to get to the level of the child and calm the child, to get the child out of crisis state. (P6)

… with our quarterly reports from the peer reviews, we get positive feedback. Our patient's side effects are less. Our statistics in most of our programmes has stepped up… (P20)

Representatives of the Department of Justice said:

…It is actually measured on conviction rates and monthly statistics, where the case is in the process … (P7)

… last year we averaged a conviction rate of 86% this court for sexual offences. We have been nominated by the National Directory in Pretoria as one of the top 10 courts two or three years ago in the whole country this court. So we tend to look at statistics to determine your success and the impact that you make. (P11)

If … the case was treated well, at times we will get those notes "thank you for the service, we appreciate" they always write it to the station commander and he will transfer the message to us. It is the same with complaints. (P14)

We do not have evaluation tools but we do have a box for complaints if you are dissatisfied with the service you have received. (P15)

The above indicates that the majority of stakeholders do not evaluate their service. Only Participant 1 formally evaluated the effectiveness of services rendered by the probation officer. Participants in this research who evaluated their interventions were found to form part of the highly effective stakeholders in their role and responsibility towards survivors, as they were also the people who offered a wider range of services or more intensive service to survivors.

The data reports the effectiveness of interventions to be observed in the numeric value obtained from the service rendered by stakeholders in the Department of Justice. This means Department of Justice stakeholders rely on statistics to reflect the effectiveness of the services they render. The findings indicate high conviction rates in the sexual offences court. This shows that, with the support of other

stakeholders such as DOH, Department of Justice stakeholders contribute notably to ensuring justice to survivors of sexual violence who have disclosed sexual assault. The numeric value, however, does not reflect the quality of the intervention.

Findings show that most stakeholders based their assumption of effective services on the verbal and written feedback received from service users or other stakeholders. The majority of stakeholders were found to rely strongly on complaint boxes in their different organisations, which according to particiapts were generally not used by service users. Feedback on the effectiveness of intervention would thus primarily be in the form of a complaint. The absence of a complaint may then be considered by stakeholders as a reflection of adequate service to survivors, which is not an accurate reflection of the quality of service rendered. This may also mean that organisations will always be reactive to complaints instead of taking a proactive, preventative approach to improve services.

4.4.2.3.2 Significant reliance on professional observation to measure impact of services rendered

Literature explains that stakeholder's perceptions of survivors are influenced by contextual factors such as victim characteristics (e.g. appearance) and questionable behaviour (Goodman-Delahunty and Graham, 2011). Stakeholders' perceptions are further said to influence the services rendered to survivors. In De Aar stakeholders were asked how they determined the effectiveness of their service with survivors. Evaluation of interventions was explained as follows:

… Every session there is an evaluation where the client evaluates the service and I also evaluate the client … how the client is able to cope … You can see that there is progress… they begin to go out to look for a job … [They] stopped drinking so that's where I would see the progress, the difference that the services do. (P1)

*I do not evaluate my services because I have not thought of that. I would often ask scaled questions. For example, when you first saw me on the 17th of April. You rate yourself out of 10. 1; I feel horrible, I'm going to commit suicide today. 10 being I am a 100% I don't need psychotherapy, I am well away. I would use questions like that. I would ask in each sessions how my clients are to note difference. So in some sense I do evaluate, just not formally where my clients have to write anything. (P*5)

The following question was posed by the researcher :

<u>"Do you evaluate your service? Or is it a matter of, if I don't see you, you are fine?"</u>

Something like that … In terms of client outside, professionals sometimes think the client still needs help but the client just stays away. So thus you can't evaluate your service. (P2)

You can see the body language … their behaviour during the session can show how the session affects the person. A person would also not come for a follow-up session if the first session were not good or if they were re-traumatised. (P10)

With children I don't let them write because many can't write. We have a play session on evaluation as well. I measure the impact that I make on the healing process of the client; there are certain sign post where the child is supposed to be if the child is within the healing process. (P12)

The above refelcts significant reliance on the professional opinion of stakeholders to determine the responsiveness of survivors to intervention. Literature describes society's perceptions of sexual violence as inaccurate, resulting in prejudice and stereotypes. This is found in every stage of the criminal justice process, subsequently negatively affecting the judgement of individuals responding to survivors of rape (Van der Bijl and Rumney, 2009). The judgement of stakeholders in De Aar responding to survivors is positively affected by their intervention with survivors: stakeholders are more sensitive and aware of the needs of survivors. It should be noted that the above responses are from stakeholders who play significant roles in satisfying survivors' emotional needs and have undergone notable training to respond to survivors. In contradiction to literature, the majority of stakeholders do not have negative, stereotypical views of survivors, but do have preconceived notions of how healing is expressed, which may not be a true reflection of the survivors' reality because survivors' responses to sexual violence are unpredictable and unalike, as explained by the trauma theory (Tavkar and Hansen, 2011; Balaeav, 2008).

Participant 5 explains at length the process used to conclude whether the services rendered to survivors are effective. Participant 12 describes prescribed evaluation methods when working with child survivors which, as explained, are highly dependent on the social worker's opinion of the child's behaviour. Professional

opinions of stakeholders can be effective in establishing changes in the survivors' well-being, but are not an accurate measure of the survivor's experience with the specific stakeholder, as interventions by other stakeholders, e.g. the SAPS removing the abuser from the home, resulting in a safer home for the survivor, could be the real reason for an improved emotional state. Evaluation based on just the stakeholders' professional opinion is thus inadequate to reflect the effectiveness of service received by specific stakeholders.

4.4.2.4 Linkage of service providers

The South African anti-rape strategy aims to respond to rape, to prevent it and support survivors of rape with the help of stakeholders who form part of a multi-disciplinary team referred to as an inter-departmental management team (Bougard and Booyens, 2015). Stakeholders from different departments thus have to work together in their distinct fields to support survivors' healing. Categories from the sub-theme include the establishment and maintenance of a victim empowerment forum, and poor linkage of organisations in an awareness and prevention initiative.

4.4.2.4.1 Establishment and maintenance of a victim empowerment forum

Literature explains that the complex nature of sexual violence calls for a multi-sectoral approach that ensures the security and positive health outcomes of survivors (Jina et al., 2010). Service providers are thus from different professional bodies and organisations contributing to protection against and/or rectification of harm caused to the survivor. In De Aar participants were asked about their role when working with other stakeholders and how roles are clarified between stakeholders in the assistance process. The effectiveness of intervention by the inter-departmental management team is explained to occur as follows:

Part of my services is to co-ordinate the victim forum, which consist of other service providers; the police, forensic social workers, hospital social workers, clinical social workers, community members, municipal members. We sit and discuss challenges in relation to victims of sexual offences and the service they receive. (P1)

… All the relevant stakeholders form part of the VEP forum. They discuss their roles and responsibility to victims … (P3)

… We also call a meeting with all the stakeholders where we discuss information to ensure themes are understood the same by everybody… (P4)

… the VEP of DSD has stakeholders meetings. Within those meetings role clarification is done and the flowing of the referral system is checked on a regular basis. Also the people working within this tunnel, if I can call it that, they are very committed. It is professionals. The people from SAPS for instance CPU [Child Protection Unit] they are trained in what they are doing, they are compassionate and they are open to inputs by other professionals within this. (P12)

Role clarification is thus done by stakeholders themseves in an attempt to ensure responsive services. System theory explains the world as interrelated (Whitchurch and Constantine, 2009) as the stakeholders respond to survivors of sexual violence. Including all relevant stakeholders in the victim empowerment forum (VEP) results in the handing over of cases presenting fewer challenges and clarity on the responsibility of each department increases effective service delivery through appropriate contact between stakeholders in each department. In De Aar the VEP forum is the platform stakeholders use to link services, to address challenges on a bigger scale, and to increase awareness between organisations on challenges and limitations in different departments.

Literature describes stakeholders as rendering medical, psychological and legal intervention to address the complexities of rape (Linden, 2011). Stakeholders comply with the stipulations of literature and further strengthen legislative commands by ensuring that information is understood in the same way by all stakeholders, reducing uncertainty or misunderstandings when rendering services. The research found that the VEP Forum contributes significantly to effective co-operation between organisations, but does not guarantee responsiveness by organisations as a whole where all stakeholders in an organisation are not actively part of the VEP forum.

4.4.2.4.2 Poor linkage of organisations in awareness and prevention initiative

Community-based prevention and educational campaigns are interventions based on the belief that awareness and understanding of a phenomenon among the general population will result in lower levels of abuse, increasing recognition and reporting of abuse by survivors or third parties (Runyan et al., 2002). In the case of De Aar some

stakeholders explain part of their responsibility to include awareness and prevention services. Prevention initiatives are explained to occur as follows:

In VEP we mostly do awareness programmes … I focus on programmes … holiday programmes with include sports but are preventative in nature. We also raise awareness with prevention programmes. (P3)

… we [Ethembeni] have the VEP volunteers who go out into the community to have information sessions, awareness programmess and campaigns … We also have a programme called, Girl child. The objective of that programme is to reach our girls at risk. Those who stay in houses where there is no guidance. So we are running with that where we have life coach's teaching them about life in general, how important education is and so forth … (P9)

… we were at a programme at Ethembeni where they launched the red dot. Where in each area they identified someone to put the red dot in their house window so if someone is a victim to sexual violence or domestic violence, and they do not have means to get help, the person in that house will help you call or bringing you to the police station. (P15)

Crime prevention by the SAPS is a constant endeavour

The police are trying. In women's month [August] they have campaigns against domestic abuse and sexual abuse … (P5)

… I know the police have regular campaigns, brochures are distributed to people to try and prevent these things [crime] such as rape … There are four, five campaigns that they do in a year. There are different complaints so they focus on different crimes such as rape; assault, there are many, they go out and make people aware of incidents that can occur. (P17)

I'm working with the community policing forum as well as women against crime. On a weekly basis we are doing projects with regards to sexual offences and domestic violence. Every day we sit to discuss the crimes that came in the previous day or on Monday, the weekend events. We then plan what we will do for the week with regards to the crimes that occurred. Apart from that we also have our yearly plan and we go from there. (P15)

From the above it is evident that organisations have separate prevention and awareness campaigns that adopt multiple approaches. The Constitution of the Republic of South Africa (Act 108 of 1996) mandates government to protect every citizen equally by law, which calls for service providers to be proactive in responding to the problem of sexual violence on a community scale. In De Aar the DSD and Ethembeni provide programmes that keep children off the streets and pro-socially occupied, especially during school holidays, in an attempt to prevent crime targeting children. The DSD and Ethembeni as the leading organisations responding to survivors of rape thus comply with legislation and literature by being proactive in preventing interpersonal violence.

The research found that prevention and awareness interventions by the SAPS are not limited to offences of a sexual nature, but include all types of crime. Campaigns hosted by the SAPS, for example those understaken in women's month, occur annually in support of prevention of specific offences such as domestic and sexual violence. It is explained that door-to-door campaigns can occur on a weekly basis with the support of community members who form part of the community policing forum. To some extent the SAPS is pro-active in increasing awareness to prevent crime from harming more people in the community; however, interventions of the SAPS are described as mostly reactive to crime, resulting in the SAPS operating in a state of crisis (emergency response).

Systems theory is explained to allow interconnection and relationships between people and their environment (Tracy and Brown, 2011, cited in Jack, 2012). The use of community members in the policing forum strengthens the relationship between service users and service providers while encouraging self-help in communities to ensure their own safety. Literature explains negative perceptions of society to be inaccurate, resulting in prejudice and stereotypes (Van der Bijl and Rumney, 2009). Similar to the SAPS, Ethembeni includes the community at large to form part of the assistance process through the “red dot” campaign that can be said to contribute to increased sensitivity and reduced stereotypes concerning rape, on a community level. Stakeholders therefore comply with literature by implementing strategies that include the wider community so that the norms and behaviour of society can be changed (De Gue et al., 2012). However, stakeholders may gain more from joining some organisational prevention and awareness interventions, especially where just

information is given through support professionals and volunteers, to alleviate the workload of stakeholders so that they may focus on pro-active preventative approaches. Moreover if all stakeholders provide similar interventions, the community at large may lose interest in stakeholders' initiatives because of excessive community campaigning and home visits.

4.4.3 Barriers that hinder effective service

All participants interviewed were of the opinion that services to survivors can be improved by stakeholders through addressing gaps, issues and barriers in services. Sub-themes that stem from this theme include the attitude of service providers and service users that hinders effective service, the presence of community psychosocial barriers and inadequate and ineffective use of resources.

4.4.3.1 Attitude of service providers and service users that hinders effective service

Literature explains the importance of stakeholders working together as an inter-departmental management team to ultimately respond to and, prevent rape and support survivors of rape (Bougard and Booyens, 2015). In De Aar service providers -operate mostly in governmental organisations to render specific services to the community at large. In rendering services to communities, stakeholders have identified internal and external organisational barriers that complicate effective intervention with survivors. Categories in the sub-theme are: the attitude of stakeholders to their roles and responsibilities, ineffective co-operation among service providers; and poor co-operation from service users.

4.4.3.1.1 Attitude of stakeholders to their role and responsibility

According to the literature, the attitude of stakeholders to rape in a work-based culture, if negative, would be refelcted in a negative work-based culture among service providers (Van der Bijl and Rumney, 2009). The work culture of stakeholders can therefore be noted in the way in which stakeholders respond to their role and responsibilities towards survivors. Stakeholders in De Aar were questioned on their own and other organisations' internal and external challenges that hinder effective and efficient service provided to survivors. Internal and external barriers to service were explained as follows:

… currently it may only be a human factor where you don't feel very good today when I come in and you have an attitude but then we go back and challenge that… (P2)

… the attitudes of how people want to do their jobs or what they think of their jobs … You do get victims with different attitudes but police officials are trained, they are supposed to know how to deal with it. (P7)

… The pharmacist on call are difficult to reach on weekends, if you do reach them, they don't pitch … They (survivors) are referred to the clinics depending on the time because PEP must be taken within 72 hours after the incident has occurred … we refer to Ethembeni. There an auxiliary worker would be tasked to go to the pharmacy in town to buy the treatment the victim needs. (P8)

One of the main things that come out of our meetings is the way the police treat our people … there are some of our police who don't care a damn. Sometimes the community will be at the police station and call me and I would go and intervene. If we can't get along I will call the Cornel or the captain and they will come in and discipline that member … problem here also is when you phone in, someone will be rude on the other side. (P16)

From the above it can be seen that stakeholders' attitude to their work is reflected in how they render service. Myths about rape allow people to feel safe by letting them believe that rape rarely happens, and when it does, it's due to women wanting to be raped because the world is just and safe (Ledray, 2015). Literature explains negative attitudes, myths and stereotypes to affect the judgement of individuals responding to survivors of rape (Van der Bijl and Rumney, 2009). In the case of De Aar, it is found that negative attitudes are due to stakeholders' general attitude to their work and are not a reflection of myths and stereotypes regarding survivors.

The findings further explain that the neglect of duties by one stakeholder, e.g. a pharmacist, results in another stakeholder having to take on additional responsibility to ensure that the required interventions occur. In such a case the DOH fails the survivor because of neglected duties by a pharmacist, which then forces Ethembeni Community Centre to provide intervention outside of it's scope of practice in an attempt to ensure the prescribed medical intervention with survivors.

Literature advises that interventions should be rendered by appropriately trained staff who are able to respond to immediate post-rape needs as survivor's experiences of sexual assault are not universal and are therefore expressed in varied reactions (Jina et al., 2010; Tillman, 2011). It is insinuated that in De Aar SAPS members at the station do not implement their knowledge and training when working with difficult service users. Because of a negative response to responsibilities, stakeholders are then negative towards survivors, ultimately contributing to difficult implementation of intervention, which increases the likelihood of service failure.

4.4.3.1.2 Ineffective co-operation among service providers

In literature the importance of an inter-departmental management team (Bougard and Booyens, 2015) has been explained to be essential in responding effectively to survivors of rape through joint efforts. In addressing survivors' needs, co-operation among stakeholders is required. In De Aar participants were asked how their organisation, and others, can improve services to survivors of sexual violence. Issues within the inter-departmental management team were described as follows:

… The challenge we have as the forum, from last year … is the police; some of the victims have reported cases to the police but it's like the case is lost … Every time they go there, they are not treated well. We tried to intervene by going to the brigadier and colonel to address those because the police officials on the ground level don't seem to understand or give their co-operation … we are trying to address the issues we have and make members commit. (P1)

… the challenge that we are facing here at the TCC with the rape victims is that the pharmacist on standby, let's say there is a victims that come here at 1 am, you would find the people in OPD don't have the contraception or the PEP. In that case the pharmacist should be called but sometimes they aren't here and you have to wait for the next morning … it is said(by DOH management) … that the pharmacist should leave the tablets there in OPD, sometimes it doesn't happen sometimes it does… (P9)

… When we go out, the police must go with us but they don't. That puts us as social workers at risk, especially when I have to remove the child. It is a battle for me and the child to be safe, to get us to a safe place like the trauma centre … (P12)

It is thus evident that stakeholders in different organisations often hinder the intervention organisations are compelled to render. Literature explains that what happens in one instance of seeking support has implications for further help-seeking and distress (Tillman, 2011). In De Aar intervention by stakeholders is found to be reliant on others to respond effectively to survivors' multiple needs. When some stakeholders co-operate poorly by not fulfilling their responsibilities, they contribute to the distress of survivors through unnecessarily extended intervention periods.

In literature the ideal of responding to survivors is that survivors' immediate needs should be met at one facility (National Prosecuting Authority, 2015). In De Aar the ideal of meeting survivors' immediate needs at the time of disclosure is hindered by some stakeholders's failure to co-operate. Findings explain core stakeholders to be proactive in their attempts to resolve their challenges, but they still fail to obtain consistent co-operation from wider stakeholders. In addition, the research found poor co-operation among stakeholders in attempt to increase the safety of survivors and stakeholders. These findings correspond with earlier findings referring to the attitude of service providers hindering effective service to survivors.

4.4.3.1.3 Poor co-operation from service users

Literature reports that approximately half of reported child sexual abuse cases do not receive any help from support structures and that disclosure of rape does not reflect help received (Meinck et al., 2017). It is explained in literature how stakeholders can contribute to poor service and non-service. In De Aar stakeholders highlighted how intervention is influenced by service users themselves. Service users' co-operation is explained as follows:

Yes all the victims of sexual offences I refer them. Especially those who seem to not be coping and those who accept to receive that service … some of the victims are not willing to come to the office … Remember like I said, the core of social welfare services, you cannot force … The individual sessions take six to eight sessions but it depends on the persons. Sometimes they terminate the service before the eight sessions. (P1)

…Some are victims of sexual violence but they don't want any intervention. They tell you specifically they just want to forget about it and go on with their lives… (P2)

Not showing up to appointments are quite a big thing. What I do is call the day before to remind the client of their appointment with me and send an sms on the day of the appointment. It's a horrible situation that you have to remind people so much but it has to be done ... Sometimes it's not the service provider that does not do their part; it is the victim or the family that does not do their part. A social worker/psychologist can provide a service, counselling or psychotherapy, but you have to pitch up for your appointment. I must stress the importance of a person's responsibility in their own well-being or getting better. That is sometimes just neglected… (P5)

From the above it is clear that survivors influence the intervention process through accepting or rejecting services available to them. Literature warns against stakeholders hindering survivors' healing and as a result contributing to inconsistent service delivery and non-service delivery that may result in secondary traumatisation of survivors or resistance to treatment due to delays in intervention (Meinck et al, 2017; Tavkar and Hansen,2011). In De Aar it is explained that (adult) survivors not only determine if intervention occurs, but also determine the duration of the intervention through self-termination of service. Survivors rejecting intervention in De Aar may cause and/or contribute to their own suffering. Service providers, the quality of service and access to service are therefore irrelevant where no services are rendered.

The findings show that stakeholders have to encourage survivors to participate in the healing process by reminding survivors of appointments made. In De Aar survivors are given the choice and are not forced into interventions, which can be said to foster co-responsibility for survivors' healing. Intervention with survivors not only requires co-operation from stakeholders to occur effectively, but also needs survivors' co-operation to render quality service.

4.4.3.2 Presence of community psychosocial barriers

Systems theory conceptualises violence as a result of multiple, interacting levels of influence on the individual, relationship (family), community, and societal level (De Gue et al., 2012). Similarly, survivors are constantly in interaction with the world around them (their community), directly and indirectly influencing each other. Categories from the sub-theme include stigma and mistrust in the SAPS that hinder

help-seeking, and domestic violence in relation to sexual violence that normalises abuse.

4.4.3.2.1 Stigma and mistrust in SAPS hinder help-seeking

Literature explains old-fashioned ideas of "victim provocation" to contribute to survivors being held accountable for their own rape and receiving negative responses from wider community services (Gavey and Schmidt, 2011). Literature further describes prejudiced perceptions of society of survivors as inaccurate (Ward, 1995, cited in Van der Bijl and Rumney, 2009). In De Aar participants explained external challenges that hinder effective intervention with survivors as follows:

… Another external challenge as we are discussing it is fear. Fear of the victim … the victim would say '… I didn't want to come because I am afraid to be seen, I'm afraid the perpetrators family will hurt me …' (P1)

If it is rape sometimes it is fearing the stigma or the person that raped you. The other thing is sometimes the person that got raped was drunk and with the drinking the guy assumed, because he is buying drinks, that he is entitled to whatever. So then that women feels half it's her doing that led to this (rape) … (P20)

Perceptions about the SAPS are often negative:

… There is always that mistrust between the community and the police; the community don't trust the police … Some community members believe some police members are involved in crime … they are afraid to come forth with certain information … it's safety first with the community … people get frustrated; you gave information but nothing happened. So maybe that police did not follow up on the lead that you gave, that is one aspect … if you phone in … you want a response immediately. Maybe you spoke to a police official but got no response, you won't trust that person again … (P16)

The above indicates that inaccurate perceptions of survivors and the community at large influence how service providers and survivors of rape are viewed and responded to. In literature old myths such as denying the injurious nature of rape and/or blaming survivors for their victimisation are explained to shape understanding of rape continuously (Gavey and Schmidt, 2011). In De Aar it has been shown that communities accept rape if there are "circumstances" related to the rape. Both

offender and survivor are explained to normalise behaviour of sexual assault based on general community perceptions of circumstances that are perceived to invite and result in sexual violence. It can be said that the non-supportive and stereotypical views of the community, which coerce survivors to hide, result in stigma and blame for being a survivor of rape.

The findings explain fear of re-traumatisation by the offender and/or family of the offender, which notably influences the steps survivors take in getting help. Literature describes support structures as a protective factor against the impact of rape (Aydin et al., 2016), which would include protection from an offender. In De Aar, however, it is explained that the general community belief that SAPS officials are involved in crime cause non-reporting of information on crime owing to fear of victimisation. Individual trauma can be passed on to others who did not experience the actual occurrence, but because they share social or biological similarities, the traumatic experience of the survivor influences the group with similarities (Balaev, 2008). Findings show that negative personal experiences with the SAPS are passed on to others in the community.

Lastly, communities expect a response from the SAPS when they call for assistance. It is reported that mistrust in communities stem from non-response from the SAPS when communities need assistance and note no SAPS intervention on reported matters, further discouraging future reporting of crime. The community's perception of the SAPS creates a barrier between the SAPS and the people.

4.4.3.2.2 Domestic violence in relation to sexual violence normalises abuse

Literature reports 62% of perpetrators of rape against adult women to be intimate partners (Basile and Smith, 2011). Sexual assault is common in intimate partner relationships. In De Aar stakeholders often referred to domestic violence as grouped with sexual violence. Survivors of rape in violent domestic relationships are explained to influence intervention as follows:

Within their domestic situation ... It's (rape) also a form of power. If you hit or abuse someone physically and that does not work than often the perpetrator would go to more extreme measures, such as rape, to get power over the other person. (P5)

…some people don't see it as rape or people just don't come and make a case against their perpetrator but it does happen in domestic situations that the women are raped by their partners. Some women don't see it as rape; they consider it to be part of their roles as a woman, to give sex to their partners ... (P6)

The findings show that people in a violent domestic relationship are often also sexually violated by their partners. Some types of rape, such as stanger, date and acquaintance rape are easier to identify whereas other forms of rape such as marital rape, ritualistic abuse and sexual harresment is more difficult to identify and address (Ledray, 2015). Literature explains that people in violent domestic relationships may experience sexual assault as part of one victimising occurrence or over the course of their lives (Macy et al., 2010). In De Aar rape is described as normalised by women in violent domestic relationships through the belief that part of their role as women is to have sexual intercourse on the demand of their partner. This adds to previous findings that sexual violence in communities is normalised when there are perceived accepting circumstances, like having to have sexual intercourse with one's partner.

Literature describes effective intervention with survivors in domestic violence relationships to include services relating to safety, emotional support, support in recovering from trauma, access to legal and health care services and emergency shelter (Macy et al., 2010). The nature and extent of the relationship and circumstances affecting a survivor's life in a domestic situation, can encourage or discourage intervention with the survivor. When survivors are in domestic relationships they require more basic resources to ultimately dissolve their domestic problems and prevent continual sexual violation. Stakeholders should thus be able to respond to survivors' domestic needs, which require multiple basic resources such as housing and employment, in addition to their needs stemming from being survivors of rape. Domestic violence thus increases negative personal beliefs of survivors, resulting in a sense of hopelessness which prolongs survivors suffering.

4.4.3.3 Inadequate and ineffective use of resources

In attempt to promote effective intervention with survivors of rape, literature promotes the adequate training and education of professionals working with survivors (United Nations, 1985). Skilled human resources are one part of the resources required to provide and maintain quality service to survivors. Categories from the sub-theme

include inadequate human and physical resources resulting in poor service, lack of funding that hinders consistent and effective service; and poor communication resulting in service users getting lost in the system.

4.4.3.3.1 Inadequate human and physical resources resulting in poor service

Literature stresses the importance of appropriate training to promote healing. Interventions should be rendered by appropriately trained staff able to respond to immediate post-rape needs, which entail medical treatment and emotional support (Jina et al., 2010). In De Aar stakeholders explain that knowledge and skills do not solely determine the effectivity and quality of work; they identify physical resources as the counterpart for responsive intervention. Participants explained organisational internal challenges that hinder effective and efficient services to survivors as follows:

As the department (DSD) we have a psychologist outsourced in Kimberley so we take our clients to them. We have two. One is a lecturer at the University of Bloemfontein and the other one has a private practice in Kimberley. The professor who is a lecturer comes down for the week or so he stays in De Aar for that period. The one in Kimberley, we have to arrange transport for them to be taken to Kimberley for the service… (P1)

… At the local TCC there is supposed to be a victim offender mediator, but they don't have that. They only have an office site co-ordinator. They are also supposed to have a case manager linked to each case of sexual violence … Currently there is no case manager, which means these cases don't get preference over other cases … (P2)

… There are people in places that try but the amount of human resources and the amount of victims make it difficult ... For me to provide effective therapy I need to see my clients at least once a week or once in two weeks but if you are in a district that is as big as Pixley you are never going to get to Carnarvon every week, it's impossible. So employment of more people to account for the geographic area… (P5)

The only thing we have a challenge with is vehicles. Sometime we have a lack of vehicles so we would take time to attend a complaint."(P14)

… refer to the clinical psychologist who is in Kimberley but at the moment we are making use of our social workers … I call to make an appointment and it takes up to weeks. There are only two Psychologists in Kimberley doing the whole region. (P18)

From the above it is evident that organisational physical resources contribute notably to the availability and rendering of services to survivors of rape. In De Aar stakeholders agree that human resources are the biggest challenge across most departments in responding to survivors. The lack of personnel in departments is explained to increase the workload for stakeholders rendering service, which then affects the efficiency of the services to survivors. Similarly, the research found inadequate physical resources to delay intervention from service providers.

Literature describes TCCs as facilities specifically for sexual violence where immediate post-rape needs of survivors can be met through co-operation from stakeholders (National Prosecuting Authority, 2015). Literature further prescribes a TCC to have basic personnel to render survivor-focused intervention. In De Aar the TCC does not have any of the prescribed professionals, causing the site coordinator, as the only employee, to render service out of his professional scope of practice. Intervention offered at the TCC can be described as superficial, as it does not address survivors' crisis needs.

The TCCs lack of basic staff causes inconsistency in services to survivors, which are determined by who and which resources are available to the survivor at the TCC. Stakeholders explain that they render service to a vast geographic area. Because stakeholders have to move up and down in the district, the service does not continue consecutively, even for survivors in De Aar. Stakeholders providing specialised help to survivors have the highest case-loads, automatically causing lengthy intervention periods because they have to serve a large geographic area. This again reduces the efficiency of service owing to survivors outnumbering stakeholders who can respond to their needs.

The onset of services is recommended not to be delayed for too long, to decrease the risk of exacerbating symptoms, or symptoms becoming chronic and resistant to treatment (Tavkar and Hansen, 2011). In De Aar the onset of services is determined by the kind of help survivors need and where the help is accessed. Symptoms of PTSD becoming resistant to treatment are a real possibility where survivors require

specialised help, which is only available out of town or once every few months. Daniels (2016) explains PTSD as an automatic response to being exposed to a traumatic experience which can be considered to be life threatening. In De Aar the lack of stakeholders contributes to outdated and unacceptable practices that add to delays in intervention and non-service at end reducing the quality of life for survivors.

4.4.3.3.2 Lack of funding affecting consistent and effective service

Stakeholders in De Aar report Ethembeni Community and Trauma Centre as the leading organisation to respond to the multiple needs of survivors of sexual violence and domestic violence. Ethembeni, however, is an NGO reliant on funding to sustain services. When questioned on internal and external challenges that hinder the effectivity and efficiency of service, stakeholders explained funding to influence intervention as follows:

… A budget for services to victims will also be of value. One could get those who need additional support in contact with experts such as clinical psychologists (P3)

… NGOs need funding and resources. Other departments can contribute to those NGOs with finance or clothing, toiletries and those … (P6)

I have to applaud Ethembeni because they are so on top of it. From DSD and government side I would say we need to support these organisations more financially. They give out care packs [underwear, sanitary products] it costs money, so the money we give the NGO is not nearly enough to see to the clients' basic needs … (P12)

It is evident that for some organisations funding is essential to respond to survivors' needs. In De Aar stakeholders explain finances to hinder the provision of services to address immediate and longer-term needs. Funding ensures that survivors have access to specialised help required and can meet their crisis needs. Stakeholders thus view funding as a means to an end to meet survivors' expected and unexpected needs.

The findings show that stakeholders are aware of financial limitations in other departments and strongly urge their own organisations to contribute to the services rendered at Ethembeni. Ethembeni, as an NGO, was found to be the leading organisation in working with survivors of sexual violence. Stakeholders should

therefore ensure that already limited resources at Ethebeni and other organisations are not wasted on interventions that can be offered by other organisations, such as prophylaxis. To maintain the services offered to survivors of sexual violence, not just from De Aar, the organisation will need continuous contributions to maintain some of the current services it renders, as no funding means no service to survivors.

4.4.3.3.3 Poor communication resulting in service users getting lost in the system

According to literature, the importance of effective co-operation among service providers encourages shared responsibility for the problem of sexual violence among support structures (Bougard and Booyens, 2015). Participants were asked how their organisation and other stakeholders could improve services to survivors. Barriers to effective service delivery were explained as follows:

… The intervention of the police is not ongoing. Victims are not informed even about their case numbers. Victims are not informed on what is happening to the case. Everything is backlog … (P1)

… the department's people fail to communicate. Without communication we cannot go very far but if the communication can be improved within all the departments, the TCC with the help of the stakeholders can be the best. (P4)

… proper referrals because I believe people slip through the cracks where they maybe did have contact with a sister or doctor in casualties. I believe there must be a protocol in line that stipulates that any form of sexual abuse must be referred to a psychologist or a social worker. (P5)

… The bigger problem is that the police sometimes know nothing about the case. I ask what happened and the police say they don't know anything. What the police don't understand is, it's not only about doing just the examination, the history is important too. If I know the history I work better ... (P8)

From the above it is clear that effective communication is a prerequisite for inter-departmental management of survivors. In De Aar the findings show poor communication among stakeholders, hindering access to and the availability of interventions with survivors. The first communication breakdown reported is that survivors are unaware of justice processes that concern them. The second is that service providers do not effectively communicate with each other. This may result in

delay of services rendered to survivors and/or over-concentration of services rendered to certain survivors, as they undergo similar interventions from multiple stakeholders.

The data also shows that information on the incident is required by the medical officer to render more effective service, but because of lack of communicated information, the effectivity of the medical officer's work is hindered. Stakeholders need to establish and maintain a communication platform that will allow service to continue uninterruptedly and with ease.

Literature explains that survivors should be granted a measure of control over the treatment of their complaint and help ensure survivors' experience is honoured, treated seriously and with respect, and should be given an opportunity to secure a form of justice for themselves (Mc Glynn et al., 2012). Because stakeholders do not communicate effectively with one another and with survivors, they deprive survivors of a sense of control and justice for harm done to them. Stakeholders in De Aar thus fail survivors at times owing to ineffective communication and lack of communication.

4.5 Summary of the section

In this section the researcher presented the findings according to how these emerged from the data analysis. Findings were presented in themes, sub-themes and categories.

The research found services that respond to survivors' physical, health and psychological needs to be easily accessible in De Aar. Interventions that occur are found to be based on the needs of the primary service user. Service may be extended to the secondary survivor, but only if it is in the best interest of the survivor. The continuum of care for survivors was found insufficient according to prescriptions in literature, pointing to ineffective aftercare service provided to survivors. Awareness and approaches to prevent of sexual violence were found to involve the community at large to reduce general stigma. Community perceptions, however, were found to contribute to negative prejudicial beliefs that encouraged non-disclosure and consequently non-service.

Organisational internal and external challenges were found to influence the effectivity and consistency of service to survivors, as the nature and intensity of intervention

were determined by the survivors needs, to which stakeholders in De Aar may not often be able to respond. Within means, service providers apply appropriate intervention to child and adult survivors of rape. The quality of service was found to be influenced notably by the service provider's attitude and resources for intervention with survivors. Survivors' circumstances and perceptions of stakeholders were explained to influence disclosure and help-seeking. Stakeholders operating in De Aar are influenced by multiple characteristics of the survivors and the organisational structure to determine and respond to needs. The following chapter will discuss the main conclusion of the study and provide recommendations based on the findings of this study.

Chapter five: Findings and recommendations

5.1 Introduction

The final chapter provides an overall conclusion on the findings, followed by recommendations. This study set out to explore the perceptions of service providers of the availability and effectiveness of sexual violence intervention, services and programmes in De Aar. Interviews were conducted with 20 stakeholders who are prescribed in literature to render services with survivors of sexual violence. Participants not identified in literature were consulted through referral from participants. Participants in this research rendered different services to survivors of sexual violence in De Aar. In this chapter, concluding remarks will be made according to the study's objectives and followed with recommendations. An overall conclusion will conclude the research.

5.2 Conclusions and recommendation relating to the study themes

5.2.1 To determine sexual violence interventions, services, programmes and support structures available to survivors of sexual assault in De Aar

It is evident from the finding that immediate services are easily accessible to survivors of sexual violence in De Aar. The findings show that three leading organisations are used by survivors to disclose sexual assault, namely the SAPS, TCC, and Ethembeni Community and Trauma Centre. These organisations make first contact with survivors in their distinct fields and form part of the stakeholders that provide immediate primary services. despite the availability of services to survivors, the research found inconsistent practices at SAPS stations in responding to survivors in distress. Practices of the TCC were found to be outdated, involving moving the survivor in and out of the TCC at the hospital.

In De Aar survivors have their emotional and mental health needs met by a social worker, psychologist and/or psychiatrist. Counselling services are primarily rendered by social workers in distinct organisations who offer additional services to survivors of rape. Social workers then determine survivors' needs and link survivors to other professionals and organisations. Survivors who have no contact with a social worker are less likely to receive service from a psychologist or psychiatrist in case of need. Psychiatric intervention by a psychologist occurs where interventions of the social

worker are inadequate to meet the survivors' emotional needs. In De Aar a psychologist is less accessible than a social worker and a psychiatrist even less accessible than a psychologist owwing to the low number of specialist professionals in the rural area. Psychological and psychiatric interventions are thus less accessible, resulting in lengthy recovery periods and longer suffering of survivors.

In addition, psychological interventions are not limited to the primary survivor, but includes work with non-offending family. Intervention with non-offending family in De Aar only occurs for the sake of a child survivor, so that the family can support the child's healing, whereas the family of an adult survivor is not included in the healing process at all. No intervention is thus available to family to address their own needs that stem from rape.

Survivors were found to receive continuous intervention from stakeholders after all their immediate needs had been met. Support services offered to survivors, however, were found lacking, leaving survivors in the same and/or a worse state. Similarly, RJ practices were not survivor-centred, but offender-centred, due to initiation by the court or the probation officer. Services preparing survivors to participate in RJ practices were also found to be inconsistent or even non-existent.

The way in which service is rendered to survivors in De Aar is found to be influenced by the age of the survivor. Adult survivors require fewer skills from stakeholders for intervention, because of their cognitive and verbal abilities. In addition, they are allowed more control over the interventions they receive as they can accept or reject services. Adult survivors, however, often experience multiple abuse due to their domestic relationships. Intervention of stakeholders is then dependent on how the survivor wishes to respond to the problem. Intervention may or may not occur, depending on the adult survivor's wishes. Unlike adult survivors, child survivors have no option for the services they receive. The choice regarding intervention with children is made by the guardian. Intervention approaches by stakeholders are child-friendly, appropriate to the child's age and maturity. Special attention is paid to child survivors by all stakeholders to ensure effective intervention by the organisation and the protection of the child from further harm.

5.2.1.1 Recommendations

Based on the findings mentioned above, it is respectfully recommended that:

The TCC should employ at least two professionals. One should be a forensic nurse to administer and ensure medication after a sexual offence has occurred, and to prevent outdated practices being followed, such as survivors having to be seen in the out-patient department at the hospital because of staffing challenges. The other employee is recommended to be a counsellor to do crisis counselling when the survivor is seen at the TTC. Having a counsellor at the TTC will contribute to efficient services for survivors and ensure that all survivors' post-rape needs are met in a manner that is responsive to the survivor.

SAPS stations have been found to be inconsistent in the services that they render to survivors; they apply different procedures when responding to survivors at the station. It is recommended that general officials be trained to respond effectively to survivors in a state of crisis and that protocols that relate to survivors of sexual violence be re-established to ensure service that takes into account all organisational means and resources, while still focussing on the interest of the survivor.

It is recommended that organisations rendering long-term psychological intervention, such as DSD and Ethembeni, shoul include the family or support structure of the survivor in their interventions to respond to the family's ultimate needs. Because of the limitations of stakeholders, alternatives to working with the family are recommended to be group work or a support group with non-offending family to enable them to respond effectively and support survivors, especially children. The DSD is also advised to use service providers, such as a psychologist, in De Aar to prevent lengthy intervention that prolongs survivors' suffering.

The DSD and Ethembeni are identified as organisations that respond to survivors' multiple needs. It is recommended that support services offered by these organisations move beyond transporting and giving survivors information. Support services should entail interventions that empower the survivor with skills to develop and nurture healthy functioning to resolve the harm caused permanently. Support services, at the minimum, should include life skills such as financial management, safety planning, life planning, decision-making, conflict resolution, problem-solving, emotional management and communication (Macy and Johns, 2011).

5.2.2 To explore the perceptions of service providers on the effectiveness of sexual violence intervention, services and programmes in De Aar

It is evident from the findings that a number of factors influence service providers' perceptions of their effectiveness in responding to survivors of sexual violence. The findings show organisational policies and national legislation to inform and mandate services with survivors. In De Aar, social workers use legislation as a tool to coerce stakeholders into co-operating in assisting survivors. Because they adhere to prescribed legislation, stakeholders in De Aar believe they are effective in their roles. It should, however, be noted that the research found that adherence to policy and legislation could ensure service to survivors, but could not change survivors' negative perceptions of SAPS officials.

The data found all stakeholders to have undergone training in the form of workshops. Some participants were required to undergo formal training at a tertiary institution as a requirement of their profession to become specialists. Specialist service providers were found to keep up with knowledge and developments in their professional field by participating in workshops, in-service training and making supervision available to all employees of an organisation to strengthen interventions. Stakeholders who have undergone extensive training in responding to survivors were found to be limited in number and scattered. The research additionally found stakeholders to have easy access to supervision and revealed that supervision is a positive reinforcement for effective intervention with survivors.

The data shows that the majority of stakeholders do not evaluate their service and rely strongly on complaint boxes. Stakeholders who evaluate their interventions form part of the highly effective organisations responding to survivors. stakeholders generally consider lack of complaints as a reflection of adequate service to survivors, which may result in continuous reactive practices to complaints instead of taking a proactive, preventative approach to improve services. Similarly, the research found great reliance on the professionals' observation of stakeholders to judge the effectiveness of services. It was found that stakeholders who have undergone intensive training were more sensitive to survivors' verbal and non-verbal cues, thus judging the impact of their intervention more effectively.

The findings show that role clarification is done by stakeholders themselves in their VEP meetings in an attempt to ensure responsive services by all relevant

stakeholders. Data found the VEP forum to encourage effective co-operation between organisations; however, participation in VEP does not guarantee responsiveness by an organisation as a whole. The data findings show stakeholders to run separate prevention and awareness campaigns that adopt multiple approaches. The DSD and Ethembeni were found to provide programmes that kept children off the streets. It was found that interventions by the SAPS were not limited to offences of a sexual nature, but included all types of crime. SAPS campaigns occur annually in support of prevention of specific offences such as domestic and sexual violence.

5.2.2.1 Recommendations

Based on the findings mentioned above, it is respectfully recommended that:

All SAPS officials should undergo continual refresher sessions at work on victim empowerment, which entail the treatment of survivors, encouragement of a positive work culture and a non-judgemental attitude to survivors. The community comes into contact with people on ground level and when they have attitude problems, the survivors are less likely to use the service, eventually not reporting sexual offences.

Organisations such as the DSD should provide training for people who are willing and able to render the service for which they are trained. Not using skills that organisations develop in their human resources is not only a waste of resources, but also increases the responsibilities of stakeholders implementing services. Training should thus be provided to people who express clear desire to undergo certain training.

Organisations, especially the SAPS, should offer formal supervision sessions to guide stakeholders to render service that is not harming to the survivor. In addition, supervision will assist SAPS officials to debrief and develop their confidence in responding to survivors.

Organisations put formal evaluation tools in place to prevent having to be reactive to problems and to be able to take a more proactive approach, consequently avoiding harm to service users and preparing stakeholders better to respond to needs. Formal evaluation will also reduce guessing by stakeholders and reflect actual satisfaction with service rendered by the organisation.

Organisations should consider combining some of their prevention and awareness campaigns. By combining similar interventions that require the same resources, organisations could reduce expenses. For example, when the SAPS raises awareness of sexual violence, the TCC and Ethembeni could participate in increasing awareness of sexual assault instead of having a different session. Fewer resources and less time would be used, allowing stakeholders to focus on evidence-based intervention.

5.2.3. To explore gaps, issues and/or barriers in services and how these can be overcome

It is evident that oraganisations can improve the services rendered to survivors. The findings show the attitude of some stakeholders to their role and responsibilities to hinder effective intervention with survivors and indicate that poor co-operation of stakeholders contribute to the distress of survivors through unnecessarily extended intervention periods. In addition, the findings show that service users influence the intervention process by accepting or rejecting services available to them. Accessibility of service is irrelevant when survivors do not even attempt to use services.

On community level the findings show stigma and mistrust of the SAPS to hinder help-seeking by survivors. The data shows the general perceptions of communities to be accepting of rape, if there are “circumstances” allowing the rape. These generalised beliefs then lead to stigmatisation of survivors. General mistrust in the SAPS in De Aar is described as a barrier to the community seeking SAPS intervention. Non-supportive and stereotypical views of the community force survivors into hiding, resulting in non-service to survivors. The findings show that people in violent domestic relationships are often sexually violated by their partners but believe that forced sex is not rape. This adds to community perceptions that sexual violence is normalised when there are perceived accepting circumstances.

A gap found in all organisations was the need for personal resources to enable stakeholders to improve current interventions. Understaffing in organisations was shown to result in increased workloads and delayed response from service providers. Lack of physical resources was also found to cause delayed services. The research found funding to be a significant contributing factor to the degree of

services rendered at Ethembeni. Ethembeni provides the widest range of service to survivors, which include a shelter and the running of the TCC. Poor funding of Ethembeni results directly in poorer service to survivors of sexual violence.

Challenges over which stakeholders have more control were found to be communication between service users and service providers. For stakeholders to respond effectively to survivors' needs, they should be able to communicate clearly between departments. Findings show that service providers do not communicate effectively with each other and that survivors are unaware of justice processes that concern them. Poor communication was found to delay services to survivors and/or over-concentration of services with certain survivors, as they underwent similar interventions with multiple stakeholders that were unaware of each others intervention.

5.2.3.1 Recommendations

Based on the findings mentioned above, it is respectfully recommended that:

Awareness programmes should address the perceptions of the community at large about sexual violence. In addition, preventative measures should promote the understanding of rights and personal responsibility in families and schools to avoid harm where possible. This research found the community to condone incidents of sexual violation where it assumed the existence of accepting circumstances. Being proactive in changing communities' perception of sexual violence can contribute to a decrease in incidents.

All departments collectively create a protocol in responding to survivors of sexual violence to avoid confusion and challenges in handing cases over. The protocol is recommended to include consequences for failure to adhere to procedures. Holding people accountable for their behaviour or lack of action should also reduce challenges related to the attitude of service providers to service users. This can be achieved in a well-staffed organisation with staff support, such as supervision and ongoing in-service training, to enable stakeholders to render services to the best of their ability for the benefit of the survivor.

5.3 Recommendations for future research

Limitations of this research include a wide range of stakeholders of which the proportions of professional bodies and organisational type, for example medical or aftercare services, are unequal. Widely unequal populations may reflect exaggerated perceptions of effective and ineffective interventions and/or challenges within organisations and among stakeholders. It is recommended that future studies should include a bigger and more balanced sample group to reflect the effectiveness of individual organisational services and professional bodies so that findings can be clear on where and what specifically should improve in specific professional bodies rendering service to survivors.

Another limitation would be that the sample size was very small and only focused on services in one town, which reflects only a fraction of the sexual violence problem in rural areas. Because of the sample size the findings cannot be generalised to all rural areas or even the Northern Cape Province. It is recommended that a bigger sample size be included in further studies so that findings can be generalised to atleast the province. A bigger sample size would also give a more accurate indication of the conditions under which survivors receive intervention.

The last limitation of this research is that survivors of sexual violence were not included in this research. The findings thus only reflect stakeholders' perceptions of the work they do and not survivors' satisfaction with the services they receive. It is recommended that survivors be included in further studies so that findings will not be one sided and will include the perceptions of those for whom the interventions are intended.

5.4 Conclusion of this study

The aim of this study was to explore the perceptions of service providers on the availability and effectiveness of sexual violence interventions, services and programmes in De Aar. Participants were selected based on the nature of the service they rendered to survivors of sexual violence. A qualitative study was conducted, using non-probability purposive sampling and snowball sampling. Data was gathered through a semi-structured interview.

The study found protection services, medical and psychological interventions to be easily accessible to all survivors of sexual violence. Additional services were also

found to be available to survivors of sexual violence, depending on their needs. Participants were all of the opinion that the needs of survivors were being met in De Aar.

The data found the perceptions of service providers on the effectiveness of their interventions to be influenced by their adherence to regulations and training received through their organisations, in addition to personal steps taken to develop professional skills. The attitude of service providers and the co-operation of service users were found to hinder the effectiveness and consistency of prescribed interventions.

Gaps found to be inherent in all organisations were lack of human and physical resources such as vehicles. Communication and co-operation between stakeholders were foun to be ineffective. Challenges found to hinder help-seeking were the perceptions of the community of the SAPS and sexual violence in general. The survivors themselves were also identified as a barrier to intervention, as they might accept, reject or discontinue intervention without warning.

Considering the aim and objective of this study, it can be concluded that there are services in place for survivors of sexual violence in De Aar. Immediate services, such as post-rape medical and legal services, are easily accessible. Follow-up and aftercare service are determined by a social worker and most organisations are effective in the services they render, despite organisational challenges and limitations.

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Appendix A: Semi-structured interview schedule

Interview schedule

By J.Alexander

Research objectives

Good day sir/madam. Thank you for your participation in this research. My name is Jacoline Alexander. I am a final-year Masters student at UCT in the Social Development Department. This research seeks to explore the perceptions of service providers on the availability and effectiveness of sexual violence interventions, services and programmes in De Aar for survivors of sexual violence.

The interview will be guided by semi-structured questions, approved by my research supervisor (Professor L. Holtzhausen). The interview seeks to determine your perceptions as a professional rendering service(s) to survivors of sexual violence on the available sexual violence interventions, services, programmes and support structures in De Aar and the quality of the said service(s); and to explore gaps/ issues/ barriers in services, and if there are any, how these can be overcome.

The research interview schedule will be as follows:

1)Demographic data

Please state your:

- Gender and age,
- Current place of employment,
- Highest qualification obtained,
- Current occupation,
- Length of work experience,
- Averaged caseload per month.

2) *To determine available sexual violence interventions, services, programmes and support structures in De Aar to survivors of sexual violence.*

1. What is your role in your organisation in working with survivors of sexual violence?
    a) How long have you been doing this work?
2. Which services does your organisation offer to survivors of sexual violence?

a) Why does it offer these services?

3. How does your organisation's first contact with survivors of sexual violence occur?
4. Does your role in working with survivors of sexual violence require you to have special training and/or a qualification? If yes, can you provide me with some examples of this?
5. In working with survivors, do you refer cases to other organisations or people for service? What are those services?

3) To explore the perceptions of service providers on the effectiveness of sexual violence intervention, services and programmes in De Aar.

6. In your professional opinion, how effective are the service providers in their role(s) in working with survivors of sexual assault? Motivate your answer in terms of:
    a) Your organisation's effectiveness
    b) Other stakeholders' effectiveness.
7. How do you evaluate the effectiveness of your service?
8. What is your professional opinion of the adequacy of services rendered to survivors of sexual assault in De Aar?

4) To explore gaps, issues and/or barriers in services, and if any are found, how these can be overcome.

9. Does your organisation have any internal challenges that hinder you from providing effective and efficient services to service users?
10. Does your organisation have any external challenges that hinder you from providing effective and efficient services to service users?
11. In your professional opinion, how can services to survivors of sexual violence be improved by your organisation?
    a) How can services to survivors of sexual violence be improved by other stakeholders?
12. Are there any other needs that survivors might benefit from having satisfied?

Appendix B: Consent to participate in the research

Cover letter

My name is Jacoline Alexander. I am a final-year Master's student at the University of Cape Town (UCT) in the Social Development Department, under the supervision of Professor L. Holtzhausen. Participants are invited to participate in the study on the availability and quality of services to survivors of sexual violence in De Aar.

What is this research about?

The researcher seeks to explore the perceptions of service providers on the availability and effectiveness of sexual violence interventions, services and programmes in De Aar for survivors of sexual violence.

Procedures and duration of the interview

Participants will be required to attend an interview in which the researcher will ask semi-structured questions. The primary recording tool will be a video camera that faces the researcher to keep the identity of the participant confidential. The researcher will use codes referring to participants (for example Participant 1 or Medical officer 1) when information is shared. The interview is estimated to take between 40 and 60 minutes.

Participation

Participants in this study are professionals who are assumed to render services, interventions and programmes to survivors of sexual violence. Participation in the research is voluntary and the participant has the choice to decline. During the interview, the participant may at any time stop or pause the interview. Please note that there will be no compensation for participants, financial or otherwise.

Are there any risks involved in participating?

There is no immediate risk to the participant. Should the participant feel that any emotional harm has occurred by participating in the interview, the participant will be referred for counselling by the social workers at Central Karoo Hospital.

For further information on the research contact the researcher, Ms. J.R.M Alexander, at missjrm7@gmail.com or the superviser, Professor L. Holtzhausen, at leon.holtzhausen@uct.ac.za .

Thank you for your participation. Your help is highly appreciated.

By signing, the participant agrees that the above information has been read, and that s/he agrees to participate in the research.

Signature	**Date of interview**
....	....