

**Where The Streets Have No Names:
Factors Predicting the Provision of Counselling and Social Work
Services for Child Rape Survivors in KwaZulu Natal, South Africa**

By

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DECLARATION

Submitted in partial fulfilment of the requirements for the degree Master of Social Science in the Graduate Programme in Health Promotion Psychology, University of KwaZulu Natal, Durban, South Africa.

I declare that this dissertation is my own work. All citations, references, and borrowed ideas have been duly acknowledged. It is being submitted for the Degree of Master of Social Science in the Faculty of Humanities, Development and Social Science, University of KwaZulu Natal, Durban, South Africa. None of the present work has been submitted previously for any degree or examination in any other University.

Kerisha Naidoo

November 2009

DEDICATION

This work is dedicated to the many children who, in addition to being raped, have been further violated by the system meant to protect them; with this further violation resulting from the secondary victimisation suffered because of not being provided with the necessary services.

May this dissertation be their voice.

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ABSTRACT

Despite high prevalence rates for rape in South Africa, little focus has been placed on the rape of children, and even less on the secondary victimization of child rape survivors. Such secondary victimization may manifest in two forms, namely, negative attitudes and behaviours and the non-provision of essential services. This study aimed to explore secondary victimization in child rape as a result of the non-provision of counselling and social work services, to a sample of 200 child rape survivors, who presented for medico-legal assessment at a state hospital in the North Durban area (KwaZulu Natal, South Africa). Data analysis revealed that only 48.5% of the sample did in fact receive such services. In the majority of cases (20%), services were only provided between 2-7 days after the child had presented for medical evaluation. In addition, the study found that in most cases, service provision was limited to a single intake interview. Service provision was found to be less likely in cases where respondents resided in homesteads (informal or 'traditional' housing) that had no street address, or where the child presented at the study hospital outside of normal working hours. These findings are discussed in terms of their implications for secondary victimization and secondary prevention programming.

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CHAPTER ONE

INTRODUCTION AND BACKGROUND

1.1 Introduction

This introductory chapter provides an overview of the research field, outlines the research study, and provides a summary of future chapters in the dissertation.

1.2 Background to the study

South Africa's political status has evolved over time from a state of racial segregation to the achievement of democracy. Despite this evolution, the culture of violence experienced in South Africa, has not altered significantly. Moletsane (2000, p. 59) notes that South Africa as a country, is defined by "racial violence, xenophobia, robberies, crime, drug abuse, sexual and other forms of violence against women and children, police corruption and brutality". Crime and violence constitute two of the most pertinent social problems facing South Africa.

Sexual abuse is just one of a multitude of social evils facing South Africa. In terms of sexual abuse, South Africa can be termed a world leader. Meier (2002, p. 1), comments that "according to a report by BBC news, a female born in South Africa has a greater chance of being raped in her lifetime than learning how to read". In addition, Petersen, Bhana and McKay (2005), as well as Corbella and Collings (2007) reveal that South Africa has one of the highest rates of sexual violence in the world; while Hirschowitz, Worku, and Orkin (2000) confirm that South Africa's rape statistics are the highest among INTERPOL (International Police Agency) members.

South Africa has been faced with an increasing awareness of child abuse and neglect as a phenomenon that is serious and escalating (Pierce & Bozalek, 2004). The increase in child rape, is perceived to have been contributed to by the myth that sex with a virgin serves as a cure for AIDS, (Meier, 2002; Pierce & Bozalek, 2004). In consideration of the AIDS pandemic being experienced in South Africa, the reasoning for escalating rates of child sexual abuse is understandable; although it remains inexcusable. In light of such understanding, it is evident that various social and cultural aspects must be considered when attempting an explanation of child sexual abuse, especially in South Africa, a country that boasts a diverse and rich cultural heritage.

The political history of South Africa assists in broadening the understanding of acts of sexual assault, resulting in the evolution of the definition of rape, and a greater understanding of what constitutes rape. The statistics revealed in studies of rape and child rape, are indicative of the extensive nature of the public health issue posed by rape; and serve as an indicator that attitudes and behaviours toward sexual assault, and child rape in particular, are suggestive of what may be referred to as a social tolerance of such criminal acts. As a result, these acts continue despite the extensive consequences they have on the victim and on society at large. The attitudes and behaviours that enable the continuation of acts of sexual violence are collectively termed secondary victimisation. Secondary victimisation, however, also includes the non-provision of essential service that aid the victim's recovery. In enduring an event as traumatic as rape, various service providers are called on for assistance. Unfortunately, however, these service providers are not always properly equipped to deal with the magnitude of the trauma endured by the individual, and in cases where assistance is provided, such assistance might or might not be effective in addressing the needs of the rape victim. Ineffectively addressing the needs of the victim often results in the trauma of the rape being exacerbated, thereby resulting in secondary victimisation. It is this secondary victimisation that can result in the equivalent of, or more trauma, than the actual violation endured by a child (Underwager & Wakefield, 1990).

As a result of such secondary victimisation, the effects of rape are magnified. In an attempt to address secondary victimisation, it is advised that a multidisciplinary approach to addressing rape is adopted, and that the various service providers involved in the treatment of rape victims work together to minimise and ultimately prevent secondary victimisation.

1.3 Definitions of key terms

Available literature reveals the difficulties in attempting to conceptualise and define the constructs relevant to the present study; with numerous attempts having been made to provide a conceptual understanding of these constructs, and to highlight actions which these constructs describe.

1.3.1 Child sexual abuse

The difficulties involved in defining child sexual abuse is in itself indicative of the complexities of the phenomenon. The fact that child sexual abuse is difficult to define, and that no universal definition appears to exist, is acknowledged by the American Psychological Association (2001) and by the American Academy of Paediatrics (2000). Notwithstanding the difficulties of conceptualising child sexual abuse, various attempts at defining child sexual abuse exist, wherein the essential aspects of the age of the victim, the sexual nature of the act endured, and the abusive nature of the act endured, are highlighted.

The term child, refers to any individual who is younger than 18 years of age (*Constitution of the Republic of South Africa, Act 108, 1996*). In addition, the *Constitution of the Republic of South Africa, Act 108 (1996)* indicates that statutory rape and statutory sexual assault is deemed as having occurred in the event of the child being older than 12 years of age but younger than 16 years of age.

The sexual aspects of child sexual abuse, can manifest itself in ways that may be classified as contact and non-contact sexual abuse. Aspects included within the realm of contact sexual abuse include fondling or stimulation, oral contact, penetration or intercourse, exposing a child to sexual contact, genital contact, the use of objects in the vagina and/or anus, prostituting the child, and masturbation (American Academy of Paediatrics, 2000; American Psychological Association, 2001). Contact with a child's anus and/or breasts is considered as amounting to child sexual abuse by Prevent Child Abuse America (2005). Also, Hirschowitz et al. (2000) found kissing and the American Psychological Association (2001) identified bestial acts as a relevant characteristic in its definition of child sexual abuse. Non-contact forms of abuse that were identified by the American Academy of Paediatrics (2000) and the American Psychological Association (2001) include the making and/or showing of pornography. These findings confirm the assertion made by Latif (2008), that child sexual victimisation exists on a continuum from the 'most severe act' (which includes forced sexual intercourse or rape) to the 'less serious acts' (attempted sexual activity, or violations that do not involve physical contact, for example, voyeurism).

In exploring the abusive nature of the sexual act, Denov (2003) and Hirschowitz et al. (2000) indicated in their definitions that in order for the sexual act to be considered abusive, the child must be unable to comprehend the act, and be unable to give informed consent. In addition, Denov (2003) and Pierce and Bozalek (2004) indicate that child sexual abuse occurs when sexual taboos of family roles and cultural taboos are violated. The American Psychological Association (2001) highlights the dominant position of the adult in its definition of child sexual abuse. Other characteristics of child sexual abuse include that the perpetrator is an adult or older child (American Academy of Pediatrics, 2000), and that the sexual abuse is conducted on a dependant and/or developmentally immature child or adolescent (Denov, 2003); as well as that the intention of the sexual stimulation is primarily for the pleasure of the perpetrator (Hirschowitz et al., 2000; Finkelhor, 1994 as cited in Dawes, Borel-Saladin & Parker, 2004).

1.3.2 Child rape

It is evident that child rape falls within the spectrum of child sexual abuse. The *Criminal Law (Sexual Offences and Related Matters) Amendment Act* (2007) does not indicate explicitly what constitutes child rape. It does, however indicate that “rape does not only consist of the vaginal penetration of a female without her consent, but of the vaginal, oral or anal penetration of any person with any object without her/his consent” (South African Police Services, 2009, p. 3-4). It would then stand to reason, that a comprehensive definition of child rape would be, the sexual and non-consensual penetration, by any object, of the vagina, anus or mouth, of any individual aged less than 18 years. The *Criminal Law (Sexual Offences and Related Matters) Amendment Act* (2007)(15)(1) does however state that in the event of having received consent, sexual penetration of an individual below the age of 16, constitutes statutory rape.

Furthermore, Crosson-Tower (2005) indicates that child rape differs from other forms of sexual abuse in that it is motivated by anger and the need for control. In instances where the rape is motivated by anger, the child is used as a weapon with which to hurt others. In such cases, the rape is not premeditated. Crosson-Tower (2005) also explores power and sadism as motivators for child rape, wherein she finds that in instances where the perpetrator has been overcome by adult victims, he/she attempts raping children, as they are weak and cannot

resist; whereas when the intention is sadistic, such rapes are often premeditated, and the perpetrator is sexually stimulated by hurting the child.

For the purpose of clarification and consistency, in this dissertation, the definition of child rape that will be used, will include the non-consensual sexual penetration of the vagina, anus or mouth, of a male or female child, by any object, as provided by the *Criminal Law (Sexual Offences and Related Matters Amendment Act (2007)*. In addition, only in cases where the victim is younger than 18 years old will it be considered child rape; such rape may have been perpetrated by a male or female individual who may be known or unknown to the victim, and who may or may not be a parent, guardian, family member, extended family member, or acquaintance.

1.3.3 Secondary victimisation

Primary victimisation refers to actions which occur during the actual assault of the victim, whilst secondary victimisation refers to the assault by the criminal justice system and the media (Tandon, 2007). Secondary victimisation includes a myriad of actions or non-actions that can result in intensifying the trauma experienced by the victim.

In attempting to provide an understanding of secondary victimisation, Campbell (2005) explored the relationship between a rape victim, and the system with whom he or she interacts. In considering this interaction, an important aspect that was noted, was the dynamic between the individual and the community. In doing so, Campbell (2005) highlighted two forms of secondary victimisation, namely a focus on what services the community provides for the rape victim, and the manner in which the rape survivor is treated.

Furthermore, Campbell and Raja (1999) employed the organizational theoretical framework of Martin and Powell (1994, as cited in Campbell & Raja, 1999), to differentiate between what they perceived as being responsive and unresponsive processing of rape cases. They identified the responsive processing of rape cases as being a prioritization of the needs of the rape survivor, and addressing those needs; whilst unresponsive processing of rape cases was a focus on the needs of the specific organization from which the rape survivor had sought services, examples of which are police and medical services.

Adopting an unresponsive approach to addressing the needs of the rape survivor, may have devastating consequences on the survivor's recovery and ultimate well-being. These negative consequences of unresponsive reactions to the needs of rape survivors is what Williams (1984, as cited in Campbell & Raja, 1999) terms secondary victimisation. And it is this definition as amended by Campbell and Raja (1999) that guided the present research study. The amended definition provided by Campbell and Raja (1999, p. 262) states that secondary victimisation is the

prolonged and compounded consequences of certain crimes; it results from negative, judgemental attitudes and behaviours directed toward the victim, which results in a lack of support, perhaps even condemnation and/or alienation of the victim.

These authors go on to state that secondary victimisation results from the poor response offered by social system personnel to the rape victims, resulting in additional trauma to the victim. In addition, these authors indicate that secondary victimisation stems from three sources. Firstly, it stems from myths associated with rape (e.g. the child is lying); secondly, it results from the non-provision of services (e.g. not providing information on HIV/AIDS); and thirdly, secondary victimisation arises from the extent to which services actually are beneficial to the rape victim (e.g. the further trauma of medical examinations and court proceedings).

In the definition of secondary victimisation provided by Campbell (2005), she focuses on an aspect of secondary victimisation that was not explored by other authors; namely that secondary victimisation occurs not only by the actions levied against the victim, but also by the services that are not provided to the victim; or that which she refers to as "service delivery".

Therefore, for the purpose of clarification, in this dissertation, secondary victimisation will refer to the attitudes and behaviours directed to the victim, which serves to exacerbate the trauma of the actual assault (Campbell, 2005; Campbell & Raja, 1999; Tandon, 2007), as well as failure to provide the victim with necessary services required after having been raped (Campbell, 2005; Campbell & Raja, 1999).

1.4 The need for a multi-disciplinary approach

In considering the numerous service providers involved in attending to the needs of rape victims, and the extensively specialised care needed when the victim of rape is a child, as well as the steps that need to be taken to reduce the long-term consequences of an experience as traumatic and violating as rape, it is suggested that a multidisciplinary approach be adopted by rape service providers. Furthermore, a “multidisciplinary approach requires the redefinition of violence as a problem that is not solely the responsibility of the criminal justice system” (Butchart & Emmet, 2000, p. 19). In order to achieve this, a team of appropriately trained and experienced service providers should be made available to all rape survivors (Shilumani, 2004). Christofides et al. (2003) further advise that collaboration between the police, medical service providers, social workers and Non Government Organizations (NGOs) is essential for dealing with the trauma and effects of rape. In adopting a multidisciplinary approach, it is anticipated that the effects of child rape will be dealt with timeously and effectively (van Zyl & Sinclair, 2006). A further advantage of the employment of a multidisciplinary approach to addressing rape and child rape, may be that the service delivery and secondary victimisation challenges noted in numerous studies consulted, may be addressed and to some degree resolved.

1.5 Rationale, purpose, objectives and aim of the present research

Despite extensive research conducted on sexual abuse, little focus is placed on child rape specifically, and even less focus on the secondary victimisation of child rape victims. Such limited availability of knowledge in itself amounts to secondary victimisation, as not enough information and research is available on the topic, thus hindering the provision of assistance to victims of child rape. In addition, it must be noted that with the mention of the words ‘secondary victimisation’, the synonyms that come to mind are stigma, attitudes etc. The victimising effects of the non-provision of services is not often explored or paid attention to.

A multidisciplinary approach to child rape is postulated in some studies (Christofides et al., 2003; Shilumani, 2004; van Zyl & Sinclair, 2006). The failure to adopt such an approach to addressing child rape, in itself perpetuates secondary victimisation by the non-provision of services, as there is inadequate control over what services are made available to victims of rape and child rape in particular.

With regard to settings in which studies on rape, are conducted, it is saddening to note that despite KwaMashu, Inanda, and Umlazi (which are located in Kwazulu Natal, South Africa) recently being identified as recording the three highest incidence of reports of rape in South Africa (South African Police Services, 2008), no previous studies have focused on this province (KwaZulu Natal) in particular.

The present research will thus focus specifically on *child rape* victims. In addition, the researcher acknowledges the victimising effects of not providing child rape victims with the necessary services. In exploring secondary victimisation, the specific form of secondary victimisation examined in the study will include the non-provision, or inadequate provision, of services to victims; with the study focussing specifically on the *non-provision of counselling and social work services* to child rape survivors. Furthermore, the adoption of a multidisciplinary approach to child rape will be advocated for; and the province of *KwaZulu Natal*, which boasts a high incidence of rapes, will be used as the setting for this research study.

1.6 Chapter outline

This research dissertation has been structured according to the following format:

- Chapter 1: The background and introduction; rationale; purpose and objectives; and aim of the present research.
- Chapter 2: A review of the literature is presented.
- Chapter 3: The present study is introduced; the research methodology (sampling technique, data collection method, and data analysis) is described; and ethical considerations are explored.
- Chapter 4: The findings of the research study are presented.
- Chapter 5: The research findings are integrated and compared with the aims of the research, and the literature reviewed. Lastly, recommendations made, and the limitations of the study conclude this chapter.

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

This chapter provides a review of literature pertaining to aspects of child rape and the secondary victimisation of child rape survivors. The review will highlight aspects of both child rape and secondary victimisation.

2.2 The incidence and prevalence of child rape

South Africa has been identified as a world leader in terms of the sexual crimes. Despite the fact that a large number of such crimes are reported, a significantly greater number are not reported. According to the Human Rights Watch (1995, as cited in Jewkes & Abrahams, 2002) only 1 in 35 rapes are reported. As a result, it is evident that statistics are not entirely reflective of the incidence and prevalence of child rape. Also, despite disclosing that he or she has been raped, no effort may be made to formalise the reporting of the act of rape; therefore resulting in there being no record of it, and the act not being included in annually calculated statistics (van Niekerk, 2004). In light of the various controversies surrounding the reliability and validity of statistics, van Niekerk (2004, p. 264) concludes that “it is therefore clear that official statistics may reflect a considerable understatement of the problem of sexual assaults on children”. Notwithstanding this however, various studies on rape and child sexual abuse have been conducted, and the statistics revealed by these studies have served to broaden knowledge and understanding of the incidence and prevalence of child rape internationally and in South Africa.

2.2.1 International reported statistics

In exploring the differences between male and female sexual abuse victims, Faller (1989) indicated that males are more likely to be abused by females; and that in the event of the victim being female, the perpetrator is more likely male, however when the victim is male, perpetrators may be male and/or female. In addition, Changwa and Pather (2008) indicate that, internationally, approximately 3% of men and 13% of women, report sexual assault in their lifetime. A study conducted by Huston, Prihoda, Parra, and Foulds (1997), which aimed to explore the factors associated with reports of penetration in cases of sexual abuse,

revealed interesting findings; which indicate that in 77% of the cases, the perpetrator was known to the victim. Also, children who reported penetration were significantly older than those who did not report penetration (10.8 and 6.2 respectively). Boys were more likely than girls to experience penetration, and in the event of the sexual victimisation being perpetrated by a stranger, or if the sexual abuse had persisted for a period exceeding 6 months, the likelihood of penetration was significantly higher. In considering the type of penetration experienced, it was found that in 42% of all cases involving a female victim, vaginal penetration was indicated, and in 9% rectal penetration was noted. Of all the cases in which the victim was a male, 56% experienced rectal penetration. In light of the results achieved, Huston et al. (1997) concluded that gender served as a determinant of rectal penetration, as well as of contact between the child's mouth and the perpetrator's genitals.

2.2.2 South African reported statistics

According to Shilumani (2004), the highest risk group for rape is females aged 10 – 17 years; whilst Collings, Bugwandeen, and Wiles (2008) note that 40% of reported cases of rape and attempted rape involve victims who are younger than 18 years of age; and Hirschowitz et al. (2000) indicated that of all rapes reported to the police in 1998, 40.3% of the victims were 17 years old or younger. However, the most recently reported crime statistics indicate that the group of children against whom the majority of sexual offences are conducted, are those aged 15-17 years (39.5%), and those aged 0-10 years (29.4%) (South African Police Services, 2009). In making the comparison, however, it must be noted that with the passing of the *Criminal Law (Sexual Offences and Related Matters) Amendment Act* (2007), the ambit which the term 'sexual offences' now incorporates includes crimes that were previously considered to be 'indecent assault' (South African Police Services, 2009).

Furthermore, Corbella and Collings (2007), indicated that the rape ratio for children between the ages of 12 and 17, is 471 per 100 000 female population; whilst Pierce and Bozalek (2004) found that the Child Protection Unit revealed statistics indicating that in the year 1994, 23 664 and in the year 1996, 35 838 cases of child abuse had been opened, whilst Shilumani (2004) noted that 20 000 cases of the rape and attempted rape of children are reported to the police annually. In addition, the Institute of Race Relations reported that more than 52 000 rapes were reported in 2000, of which 40% of victims were under 18 years of age (Meier, 2002). With regard to the most recent statistics pertaining to sexual offences

committed against children, as reported by the South African Police Services (2009), it was found that 20 141 cases had been reported. The figure is however non-comparable to the statistics reported since 2003, as in previous years the reports made by individuals under 19 years of age (18 years plus 364 days) were included in compiling statistics for crimes against children, when in fact only reports made by victims under 18 years (17 years and 364 days) should have been included under this category, as would be in keeping with the definition of a child (South African Police Services, 2009).

2.3 Profiling the victim and perpetrator

In terms of gender, females are deemed as being at a higher risk for being raped (Corbella & Collings, 2007; Shilumani, 2004); whilst, with regard to the race of victims, the South African Demographic Health Survey (as discussed in Hirschowitz et al., 2000) found that 66% of its sample was black African. This finding is in contradiction to the findings of the Victims of Crime Survey (as discussed in Hirschowitz et al., 2000), which claims that in its sample, the highest proportion of rape victims was made up by equal amounts of Indian and Coloured females. In addition, Hirschowitz et al. (2000) found that children younger than 17 years old, were at a high risk of being raped, whilst Shilumani (2004) identified the highest risk group as being between the ages of 10 and 17 years old.

In many cases of rape, children are unaware that the acts being performed are malicious, because the individual with whom these acts are being performed is a known and trusted individual. As a result, in many case of child rape, the perpetrator is in fact known to the victim. In an international context, Huston et al. (1997), found that 77% of their sample knew the perpetrator, and in a more local setting, Pierce and Bozalek (2004) found that of all the child abuse cases opened in 1994 (23664) and 1996 (35838), in 84% of these cases, the perpetrator was known to the victim. In some cases of child rape, the trauma endured is exacerbated not by the violent nature of the assault, but by the close relationship between the victim and offender. Russell (1995, p.62) notes that incestuous abuse does indeed take place in South Africa, and that “there are many reasons to believe it is extremely high”, however such incestuous abuse has previously been denied the attention it deserves, because of a focus on racial justice and other issues.

2.4 Etiological factors

In addition to the limited research conducted on child sexual abuse and relating specifically to South Africa, Gunston (1993, as cited in Pierce & Bozalek, 2004) states that even in the minimal cases that are reported accurately, statistics are not kept, and there is difficulty in offering a standardized definition and tools for measuring strategies. Therefore, Pierce and Bozalek (1993) cite the lack of resources made available to professionals, the political and economic difficulties facing individuals and communities, combined with the minimal research, budget constraints, and the increased workload of police and social services personnel, as barriers in reducing the incidence of child sexual abuse.

One may question what it is that places an individual at risk of sexual violence, with various studies having explored the risk factors involved. In light of these explorations, Petersen et al. (2005) conclude that there are multiple levels of risk involved in the phenomenon of rape. The levels highlighted by Petersen et al. (2005) include the distal or socio-cultural context within which lies traditional perceptions of masculinity; rape myths; the use of sexual violence to control the independence and assertiveness of females; raping the child when the mother does not conform to the demands of her partner; the commodification of sex, whereby sex is exchanged for food or money; and not having the material capacity to win the affection of a woman, thus taking sex forcefully. Within the proximal situation context, are factors of social norms, a reduction in the protective nature of brothers in light of their need to achieve a sense of belonging with peers, deeming it unnecessary to respect a female in light of her being beaten at home, poor parenting skills and role models, as well as the community serving as a weak protective shield. Intrapersonal factors are identified as being abuse within the family; females lacking assertive and refusal skills; and poor heterosexual communication skills, especially on the part of boys; as well as limited recreational activities, poverty, the culture of sexual entitlement, and the use of sexual violence to punish infidelity.

Similarly, Jewkes and Abrahams (2002) note the perpetuating factor of gender inequality and pressure for a male to have sexual intercourse as proof of his masculinity, as well as the use of forced sex to control the commencement and conclusion of the sexual relationship. Another perpetuating factor is the belief that having paid *Labola* (bridewealth), a man is entitled to have sex as and when he pleases (Jewkes & Abrahams, 2002; Posel, 2005). Also, in the event of the perpetrator being a current or past intimate partner; namely a husband or

boyfriend, the women tends to not label forced sexual intercourse as rape, and as a result does not report it (Hirschowitz et al., 2000).

2.5 The effects of rape

The effects of rape are associated with various immediate and long-term consequences. Not all of the scars of rape appear on the surface, and much of the trauma of such an experience lingers for many years and significantly shapes the rest of the victim's life. Such trauma and suffering can only be magnified when considering cases where the victim is a child, who barely comprehends the brutality of the violation endured. Richter and Higson-Smith (2004) indicate that the effects of abuse on a child varies in relation to various factors, including, among others, the duration of the abuse, the age of the child, and the effect of the abuse on the whole family.

In considering the effects of sexual abuse involving penetration, Huston et al. (1997) state that such abuse is most harmful to the victim. In addition, most often physical and visible signs of violation are evaded, so as to allow the perpetuation of the sexual abuse (Prevent Child Abuse America, 2005), as visible physical signs of abuse could possibly result in the abuse being detected. This differed from cases of child rape, wherein physical injury is present and often visible (Prevent Child Abuse America, 2005).

In addition to the physical trauma the child endures, various other consequences follow child sexual abuse. One such consequence is the behavioural changes that take place after the onset of sexual abuse. Some of these include changes in behaviour, sleeping patterns, fear of the dark, regression to infantile behaviour, personality changes including multiple personality disorder, delinquent behaviour, nightmares, poor concentration, hypervigilance, depression, lethargy, and being withdrawn (Prevent Child Abuse America, 2005). In addition to the consequences of sexual abuse already noted; the American Psychological Association (2001) highlights potential consequences related to fear and anxiety of the opposite sex, a display of inappropriate behaviour, depression, and self-destructive behaviour.

Long-term consequences of child rape include chronic self-perception of helplessness, hopelessness, depression, impaired trust, self-blame, self-destructive behaviour, low self-esteem, an increased likelihood of teen pregnancy, increased likelihood of homelessness, and an increased risk of drug and alcohol abuse (Prevent Child Abuse America, 2005). Jewkes, Penn-Kekana, and Rose-Junius, (2005, p. 1810) note that the long-term consequences of child rape include a heightened risk of “sexual and reproductive health problems, mental health problems, increased health risk behaviours such as smoking and alcohol abuse, and behavioural problems”. Russell (1995) focused on all effects noted above, and also drew attention to attempted or successful suicide, as well as suicidal feelings, being an underachiever, and experiencing difficulty trusting. The likelihood of an individual being susceptible to re-victimisation, also serves as an effect of sexual violence (Dunkle et al., 2004; Russell, 1995). Also, according to Killian and Brakarsh (2004) sexually abused children either present with the signs and symptoms of Post Traumatic Stress Disorder (PTSD), or alternatively exhibit increased sexual behaviour.

2.6 Secondary victimisation of rape survivors

In light of the horrendous effects of sexual assault, which is sometimes exacerbated by the age and gender of the victim, statistics surrounding rape and child rape, reveal a shocking social tolerance of such crimes (Jewkes & Abrahams, 2002). Such tolerance, is reflected in (Jewkes & Abrahams, 2002, p. 1240)

the trivial way in which complaints are treated by the police, particularly if they involve date rape; the lenient sentences handed down by judges and magistrates in the small proportion of cases that ever get to court; the hostile attitude of district surgeons towards rape survivors and careless way in which examinations are performed; the small price for which a docket can be ‘lost’; and the efforts of friends and relatives of rape survivors who often discourage women from laying charges, and suggest instead that the rape just be accepted.

These actions, or lack thereof, amounts to secondary victimisation.

2.6.1 Secondary victimisation through the attitudes and behaviours that exacerbate the trauma of rape

Negative attitudes and behaviours of service providers toward victims of any sort of crime may prove to be traumatic. However, in the event that the victim is a child, such trauma can only be exacerbated; a reality which is emphasised by Tandon's (2007, p. 120) assertion that "children are also most vulnerable to [secondary] victimisation...because of their innocence and inability of dealing with stressful and difficult situations".

With specific reference to rape, these negative attitudes and behaviours tend to stem from the victim-blaming attitude adopted by others. In fact, the reality is that the victim is often blamed for the rape to the point that it is understood that rape is a crime that results from the uncontrollable sexual urges of males; and in order to avoid being raped, females should refrain from arousing them (males) (Lea, 2007). A female often bears the responsibility for having been raped based on her dress, physical attractiveness, previous sexual history, level of intoxication, level of resistance during the attack, and her relationship to the perpetrator, among other factors. The study conducted by Lea (2007) identified that perpetrators and service providers differed in their exploration of the issue of physical attractiveness in that perpetrators focused on the general attractiveness of the victim (e.g. she was pretty), whilst service providers focused on how the victim *made* herself attractive (e.g. she dressed provocatively), thereby putting herself at risk. In emphasising the physical attributes of the victim, "she becomes partially responsible and, crucially the crime revolves around sex and not issues of power and control" (Lea, 2007, p. 505). Furthermore, highlighting a female victim, emphasises the perception that males cannot be raped.

2.6.1.1 International findings

Secondary victimisation behaviours of medical and legal service providers was one aspect that Campbell (2005) focussed on in her American study. Results of this study indicated that there was a 73%, 83%, and 79% agreement between victims and legal service providers, nurses, and doctors (respectively) pertaining to the manner in which rape survivors were treated. In terms of the secondary victimisation behaviour of legal service providers, 69% were discouraged from filing a report, 47% were told that their case was not serious enough to pursue, and 84% were asked if they had resisted the perpetrator (thereby feeding the myth that rape only occurs because the victim wanted it). With regard to the secondary

victimisation behaviours of medical service providers, results indicated that 30% of doctors refused to conduct a medical exam, 33% of doctors and nurses questioned the way the victim had dressed, and 100% and 85% of doctors and nurses (respectively) questioned whether the victim had resisted the perpetrator.

The study conducted by Campbell, Wasco, Ahrens and Barnes (2001) aimed to determine what services were or were not provided to rape victims, and whether the services that were provided were in fact of any benefit to the rape victim. In analysing the responses of 112 women, the study found that only 49% of the sample received information on pregnancy, with 43% being provided with emergency contraception. In addition, it was found that 39% received information on Sexually Transmitted Diseases (STDs), and 32% were provided with information on Human Immunodeficiency Virus (HIV). Furthermore, Campbell et al. (2001) found that of those who sought legal assistance, 52% found the experience to be 'hurtful'; whilst of those who sought medical assistance and the assistance of a mental health professional, 47% and 70% (respectively) found the experience to be 'healing'.

In addition, Denov (2003) in her exploration of disclosure to professionals, as experienced by individuals who had been sexually abused by female perpetrators, found that aspects which intensified the trauma of victims included the minimizing of the sexually abusive act by the professional, as well as the reaction of shock when the perpetrator's gender was revealed, and disbelief of the victim's allegations.

2.6.1.2 South African findings

The study conducted by van Zyl and Sinclair (2006) on the effectiveness of the police in dealing with child rape cases, highlights many actions of the police that resulted in the secondary victimisation of children who had been raped. Some aspects that proved to be traumatic for child rape victims included the unsympathetic responses by some police officials, and the lack of co-operation shown by the district surgeon. From the sample of participants used in the study, many indicated that they either were not aware of their rights, or were too traumatized to challenge the behaviours and attitudes of the police officials. In addition, the disregard for a child's privacy shown by police officials also proved to intensify the trauma already experienced, and influenced the victim's ability to discuss sensitive issues (van Zyl & Sinclair, 2006). In this respect, Christofides et al., (2003) indicate that in the

Limpopo province, only 20.9% of medical care facilities, included in their sample, had private examination rooms; with a significantly lower result being yielded in Gauteng and Northern Cape (15% and 5.7% respectively) and a significantly higher result in Western Cape and KwaZulu Natal (93.2% and 96% respectively).

The opinion that rape did not warrant preferential waiting treatments, is evident in the long waits endured by rape victims as they anticipated medical attention and the services of various service providers; and was identified as a contributor to secondary victimisation (Christofides et al., 2003; Changwa & Pather, 2008; van Zyl & Sinclair, 2006). Within a South African context it was found that waiting periods for victims ranged from 30 minutes to more than 150 minutes (Christofides et al., 2003). These authors found that the extensive waiting periods were, in some cases, accounted for by the limited availability of medical personnel, awaiting the arrival of sexual assault evidence kits from the police, or service providers not being of the opinion that the rape was severe enough to warrant preferential treatment. This is evident in a comment made by a medical service provider that if a rape victim is “not bleeding heavily then she can wait like others in the queue” (Christofides et al., 2003, p. 23), and by the comment that “a gunshot wound to the chest was more urgent than the less serious injuries of a rape victim” (Changwa & Pather, 2008, p. 45c).

The extent to which a rape victim is encouraged to report the act of rape, may depend on the extent to which he/she is believed, and the attitudes toward the victim. With regard to encouragement to report the sexual assault, Christofides et al. (2003) found that in contrast to international findings, across South Africa 94.8% of medical service providers advised (and in some cases insisted) that the victim report the rape to the police.

2.6.2 Secondary victimisation through the non-provision of services

Highlighting the shocking number of rape cases that go unreported often results in a call for an increase in the reporting of rape. However, Russell, (1995) eloquently states that there is no point in calling for an increase in reporting, when the necessary services required for dealing with such reports, are not available. Although the trauma, and violation of the act of rape can never be completely erased, the consequences and long-term effects of rape and other forms of sexual abuse can, in some cases, be prevented by taking precautionary measures as soon as possible after the assault has occurred. Some of the long-term effects

that may be avoided include contracting of STDs, avoiding HIV and Acquired Immune Deficiency Syndrome (AIDS), as well as avoiding pregnancy. Therefore services to rape survivors should include a HIV test, pregnancy test, the provision of emergency contraception and post exposure prophylaxis (PEP), as well as tests for and treatment of STDs. In addition, services to address physical injuries, provide emotional support, and prepare the victim for psychosocial consequences of being raped, should be provided (Changwa & Pather, 2008). However, it is a sad reality that often education on, and precautions against, these and other aspects are not provided to victims of rape, and there is no consistency in the needs of children, and those of the system that is meant to protect them (van Zyl & Sinclair, 2006). A further reality is that “very often the psychological support much needed by the victim is neglected” (Changwa & Pather, 2008, p. 45a). The lack of provision of such necessary services results in secondary victimisation.

The benefits of making available counselling services after a sexual assault, were highlighted by the recent study conducted by the Medical Research Council of South Africa (MRC), which aimed to develop and evaluate an intervention to improve adherence to Post Exposure Prophylaxis (PEP) after a sexual assault (Abrahams, Jewkes, Lombard, & Meel, 2008). The objective of the study was to provide telephonic psycho-social support, and thereby support adherence to taking the prescribed medication. Although there were difficulties with regard to the particular form of counselling service provision administered in the study, “researchers found that...those who received the counselling appreciated it” (Abrahams et al., 2008, p. 3). The number of calls made, and the duration of counselling services provided, was dependant on the individual’s emotional state and required support. Findings of the study indicate emphatically that counselling services are a crucial aspect in the care of rape survivors, and that the provision of counselling services had a positive impact on adherence to PEP. Ultimately, Abrahams et al. (2008, p.18) concluded that “if someone had knowledge of health, HIV transmission and the psychological reactions to rape, then their understanding of what was happening to them was much easier”.

2.6.2.1 International findings

It is indeed a reality that often rape survivors do not receive the necessary services; and when such services are in fact provided, the value of these services are negated by the insensitive treatment of service providers. The study, conducted by Campbell (2005), focussed on the extent to which there was agreement between victims and service providers pertaining to the services that were provided. Results of the study revealed that for medical service providers there was a 70% agreement between victims and service providers on the services that were and were not made available to the victims, and for legal service providers, there was 81% agreement relating to the services that were provided. In terms of the services that were provided to the victims by medical personnel, results indicated that forensic evidence collection kits were consistently provided; however only 63% received information related to pregnancy, 53% received information on STDs, and 35% received information on AIDS specifically. Also, oral contraceptives were given to 28% and HIV prophylaxis was provided to 17% of the sample. Follow-up medical services for treating the physical and psychological effects of rape were only made available to 10% of the sample. Furthermore only in 9% of the cases referrals were made, and in 18% of cases an investigation was conducted (Campbell, 2005).

2.6.2.2 South African findings

According to van Zyl and Sinclair (2006), participants revealed that when the police officials did not explain procedures or did not adhere to the specified procedures, they (the participants) were left feeling as though the criminal justice system was not sufficiently equipped to deal with cases of child rape. In addition, participants revealed that despite their extensive efforts, they were unable to obtain information pertaining to their case e.g. court dates, whether the perpetrator had been arrested, etcetera. In their defence, police officials indicated that a barrier to providing such information and updates lay in the fact that some victims could not be traced. Amongst the participants of the study, there was consensus that no information had been provided on the perpetrator or the case, and that no referrals to support services were made.

The inadequacy of the criminal justice system was also highlighted by Petersen et al. (2005). These authors noted that the inefficiency of police officers, and the time delay between the reporting of the rape and any attempt at arresting the perpetrator, was sufficient to allow the perpetrator to go into hiding.

In addition, Christofides et al. (2003) found that in the North West Province, 0% of medical care facilities sampled provided HIV tests, contraception, PEP, or paid attention to STDs; and only 18.2% provided pregnancy tests. In Gauteng, 15% provided HIV tests, 37.5% pregnancy tests, 30% contraception, 15% PEP and 15% treatment of STIs; whilst in KwaZulu Natal, 70% provided HIV tests, 100% pregnancy tests, 82% contraception, 0% PEP, and 78% provided treatment of STIs. Further results by Christofides et al. (2003) indicated that referrals for social services were not always made; therefore, further assistance was not always available to the victim. In the North West province, referrals for social services were only made in 63.6% of cases, whilst in the Eastern Cape referrals were only made in 13.9% of cases. Not referring the victim to individuals or institutions who would be able to provide follow-up social services, was attributed to medical service providers not having links with such individuals or organizations, or not being aware of any such service providers that they could refer the patient to. In addition, it was revealed by these authors that in some cases, where there was knowledge of or links with relevant service providers, the relationship between these service providers and medical service providers were not always good. A non-existent relationship with the police was only noted in the Eastern Cape, and was indicated by 8.6% of the participants in that province. With regard to the relationship between medical service providers and social workers, Christofides et al. (2003) noted that a non-existent relationship was revealed by 43.1% of participants in the Eastern Cape and 8% in Limpopo, whilst a non-existent relationship with NGOs was noted in all provinces of South Africa, with the highest being 91.8% in the North West province, and the lowest 46.4% in the Western Cape.

2.7 The effects of secondary victimisation

Regardless of whether secondary victimisation occurs in the form of a non-provision of services, or the victim-blaming attitudes and behaviours of service providers, its effects may have a devastating and lasting effect on the emotional and social well being of the victim (van Zyl & Sinclair, 2006). A child who discloses rape is traumatized extensively not only by the act of rape, but also by disclosing the violation. Being further traumatized by the reactions to such disclosure may result in the child experiencing a myriad of emotions, which may even result in the child doubting whether the violation had indeed occurred. Denov (2003) revealed that in addition to exacerbating the negative effects of the sexual abuse, secondary victimisation results in the victim not trusting professionals, intensifying their anger, and questioning or denying whether the sexual abuse had occurred.

A lack of awareness of service providers relating to the effects of their actions on the victim, is highlighted in Campbell's (2005) focus on secondary victimisation, in which she explored how the victim felt after interaction with medical and legal service providers. There was a 58% agreement between victims and both legal and medical service providers relating to the emotions felt by the victim. This result emphasizes that service providers are often unaware of a victim's feelings. With regard to interaction with legal service providers, 91% of participants felt disappointed, 87% felt bad about themselves, and 73% felt guilty. In addition, due to their interaction with medical service providers, 94% felt violated, 74% felt distrustful of others and guilty. After their interactions with both legal and medical service providers 80% of all participants indicated that they were reluctant to seek further help.

2.8 Avoiding the secondary victimisation of child rape survivors

Various measures may be taken to avoid secondary victimisation, especially in cases involving children. Underwager and Wakefield (1990) suggest that in an attempt to minimize and ultimately prevent secondary victimisation, factual data must be sought, and both the accused and the individual to whom the disclosure was made must be interviewed. Also, when possible, the perpetrator rather than the child must be removed from the home (Russell, 1995; Underwager & Wakefield, 1990). In addition, in situations of parental pressure, social services may need to meet with the child outside of the home. Regardless of such factors, police and social services personnel should refrain from meeting with the child at school, as it

can be both embarrassing and excessively traumatic for the child. Also, it should not be assumed that the child has been severely damaged by the sexually abusive act; and the provision of long-term therapy, although beneficial to some, may prove to intensify the trauma of the violation as the child is required to relive the abuse in each therapy session.

Campbell and Raja (1999) propose that mental health professionals can address secondary victimisation by advocating for change, and that therapists and community professionals should be appropriately educated and trained. The pertinent issue of appropriate training is also emphasized by the findings of Christofides et al. (2003), which show that across all provinces of South Africa less than 40% (except Northern Cape with 42%) of medical service providers had some training relating to rape. In addition, it is recommended that in addressing secondary victimisation, attitudes of rape support need to be modified (Christofides et al., 2003; Petersen et al., 2005; van Zyl & Sinclair, 2006). In consideration of the limited knowledge and difficulty in accepting that a woman may very likely be the perpetrator of sexual abuse and/or rape, it is advised that professional training initiatives include a specific focus on female sex offenders, as such training may assist in increasing the professional recognition of this problem (Denov, 2003). Lea (2007) further states that in order for rape myths to be addressed, specific training of those working with sex offenders should be considered.

In terms of secondary victimisation by police, van Zyl and Sinclair (2006) recommend that some actions which may minimize secondary victimisation include a child friendly interview room, video interviews for evidence, the use of female police officials for cases involving children, a system that allows for access to information on cases and for an efficient feedback system to be implemented. In terms of those providing support services, van Zyl and Sinclair (2006) state that family support should be provided to allow parents, guardians, and caregivers to understand the needs of the child after the sexual assault. Also, counselling should be offered to the parent/s and child, and mediation between the victim and perpetrator should be facilitated. In addition, van Zyl and Sinclair (2006) propose that there be a Family Violence Unit at every police station, and that bail not be granted to those accused of child rape.

CHAPTER THREE

RESEARCH METHODOLOGY

3.1 Introduction

Various research studies pertaining to rape in general or child abuse, have been conducted; however little research has been conducted on child rape specifically. More especially, little focus has been placed on the needs of child rape victims, and the extent to which these needs are met. Failure to provide child rape victims with the services that are crucial to their recovery, amounts to secondary victimisation. The present research study focused on just one of the many needs of a child rape victim; namely that of counselling and social work services. In this chapter, the present study is introduced; the methodology (sampling technique, data collection, data analysis) is described; and ethical considerations are addressed.

3.2 The present research

Secondary victimisation exists in the form of non-supportive attitudes and behaviours towards survivors of child rape, and in the form of the non-provision of services to these survivors (Campbell, 2005; Campbell & Raja, 1999; Tandon, 2007). The present study focussed specifically on secondary victimisation in the form of the non-provision of services, and aimed to determine factors predicting the provision of counselling and social work services for child rape survivors in KwaZulu Natal, South Africa. Aspects that were explored included determining the extent to which referrals were made for child rape survivors to be contacted by welfare organizations in their area, and barriers to the victim being contacted by welfare organizations. Therefore, greater understanding of a specific form of secondary victimization; namely, the non-provision of services, as experienced by victims of child rape, was facilitated. In light of the shocking statistics on rape in KwaZulu Natal (Hirschowitz et al., 2000; South African Police Services, 2008), the present study highlighted child rape in a small slice of the broader context of South Africa. The data are therefore specific to the context of South Africa, and reflects the extent to which secondary victimization, by means of non-provision of services is experienced particularly in the province of KwaZulu Natal.

The fundamental questions that the present research study aimed to address were:

1. To what extent do hospitals refer child rape survivors for counselling / social work services?
2. What is the latency and duration of services provided?
3. In the event that child rape survivors are not contacted by welfare organizations, what reasons are cited for this non-provision of services?

To achieve these aims a quantitative research design was deemed to be most suitable; therefore the research study was guided by quantitative research methods, and was conducted within a positivistic paradigm. A paradigm, encapsulates the assumptions and key issues that frame the research in its attempt to seek answers (Neuman, 2006). A positivistic paradigm combines “deductive logic with precise empirical observations of individual behaviour in order to discover and confirm a set of probabilistic causal laws that can be used to predict general patterns of human activity” (Neuman, 2006, p. 82). The author notes that positivistic research aims to give back control to people in relation to the aspect being researched, as well as to make accurate predictions on that specific phenomenon; however, despite this, positivists are criticized for reducing people to numbers. In addressing an issue as sensitive as secondary victimization of child rape victims, it is required that the researcher apply rational thinking which transcends any personal biases and values. Such rational thinking may be achieved by the researcher remaining objective, neutral and detached; which is in keeping with the requirements of a positivistic researcher (Neuman, 2006). In addition, in terms of the extent to which positivistic research may be generalised, Neuman (2006) highlights positivism’s assumptions of the stability of social reality, which does not change over time, but can be expected to persist in the future. The fact that the present study serves as an audit of the services provided to child rape victims, further warrants the use of a positivistic framework, and a quantitative approach to the research.

3.3 Conceptual framework

The conceptualisation of secondary victimisation developed by Campbell and Raja (1999) and Campbell (2005), as well as the distinction between primary and secondary victimisation indicated by Tandon (2007), informed the present research study. Campbell and Raja (1999) and Campbell (2005) indicate that secondary victimisation may assume the form of the negative attitudes and behaviours toward a rape victim, as well as the non-provision of services to a rape victim; and it is this definition that guided the research study.

3.4 The context

According to Mudaly and Goddard (2006 as cited in Latif, 2008), identifying the most suitable site for conducting a research study, requires that various criteria be taken into consideration. Some of the criteria that need to be met include that the researcher has easy access to the participants; where there is high probability of the subject matter of interest to the researcher being available, and that in using the identified site, the quality of the data, as well as the credibility of the research study will be assured. In light of such recommendations, a provincial hospital, which serves a large portion of residents of a specific part of KwaZulu Natal, and which frequently addresses cases of child rape, was found to meet the abovementioned criteria, and was thus identified as the ideal site for the research study to be conducted.

3.5 The sample

In obtaining a sample for the present study, the sampling methods of non-probability, and in particular purposive sampling (one of various forms of non-probability sampling) was employed. In employing non-probability sampling, the odds of any one individual being included in the study, is unknown (Strydom, 2002). In terms of purposive sampling, individuals to be included in the sample for the research study must meet specific criteria. For the purposes of this research study, in order to be included, individuals had to have been a child (less than 18 years old), a child rape victim (anal or vaginal penetration), who sought medical evaluation at the hospital at which the study was being conducted.

The sample comprised a consecutive sample of 200 child rape survivors, who sought medical evaluation at the study hospital during the period of October to December 2004.

3.6 Duration of data collection

Table 1

The Number of Participants Obtained per Month of Data Collection

Month	<i>n</i> (%)
October	69 (34.5)
November	83 (41.5)
December	48 (24.0)
Total	200 (100.0)

Data collection took place over the period of October to December 2004. Two hundred children who presented for medical evaluation during the given period were included in the study. For the months of October and November, all the children who presented at that hospital were included in the study; however, for the month of December, only the first 48 child rape survivors (the number required to reach the target of 200 participants), that presented at the hospital were included in the study.

3.7 Data collection technique

The procedure that was followed in collecting data for the research study involved various steps. Firstly, the resident social worker at the hospital at which the study was conducted, reported to the researcher whether the child rape victim who presented for medical evaluation, was provided with social work services or not. Based on the information provided by the hospital social worker, it was determined which child rape victims had been provided with social work services at the given hospital, and which had not received such services. In the event that the child was not seen by the social worker at the hospital, it was determined whether a referral had been made for the child to receive social work services in his or her area. Approximately six months after these children were seen at the hospital, an audit was conducted to measure the services that were provided to the child rape victims. An audit measure presented as a form to be filled by the social worker, as well as a covering letter explaining the nature of the research study and providing instructions for filling out the form, were sent to various social work organizations to which the hospital had referred child

rape survivors. The form included both open-ended and closed-ended questions. A hospital representative signed the covering letter, and indicated his contact details on both documents.

Based on the child welfare societies, to which referrals were made, a form was compiled for each such child welfare organization, listing the names, dates of referral, and address for each child that had been referred to that child welfare organization. In addition, the audit measure requested that the social worker indicate whether the referral had in fact been received, whether the child had been referred to another agency, and whether the child had been contacted, as well as whether services had been provided to the child. In addition, social workers were requested to complete the column marked “comments”, to provide motivation for, and details of the selections made. Social workers had to provide the required information for each child rape survivor that was referred to his/her organization as per the records of the social worker at the hospital.

3.8 Data analysis

In keeping with the advice of Kruger, de Vos, Fouché, and Venter (2002), data were prepared for analysis by being appropriately coded in accordance with the measurement level of the question (i.e. nominal, ordinal, ratio etc.). Thereafter, for the purposes of analysis, the data were entered into a standard statistical database; namely the Statistical Packages for the Social Sciences (SPSS, version 15.0).

Descriptive statistics indicating the mean, mode, median, range, and variance were calculated. These descriptive statistics, were fundamental in exploring demographic aspects of the child rape survivor; namely gender, race and place of residence. In addition, descriptive statistics indicated the ages of survivors and perpetrators; as well as allowed for the exploration of whether the rape had been intra familial (incest), or extra familial, and the different types of penetration that were experienced. These statistics also indicated the extent to which social work services were or were not provided; if the services were provided, how soon after the initial presentation at the hospital where they provided, and over what duration where they provided (i.e. how many times was the child seen by the social worker); as well as, in the event that services were not provided to the child, what reason was provided for the non-provision of services.

Factors pertaining to the likelihood that a child rape survivor would receive social work services was explored using a Step-Wise Binary Logistic Regression Analysis. In conducting this statistical procedure, the criterion variable was identified as being the provision (versus non-provision) of social work services, whilst various predictor variables were considered, including survivor and perpetrator characteristics (age, race, gender, relationship); abuse characteristics (form of abuse, frequency, duration, degree of violence); time of presentation at the hospital; and area of residence (urban versus rural, formal versus informal, distance from hospital). The purpose of the analysis was to determine which of these factors most significantly predicted whether a child would receive social work services or not.

3.9 Ethical considerations

Prior to commencing with the project of which the present research study is a part, an application for ethical clearance was made to the Research Ethics Committee of the University of KwaZulu Natal; who granted permission for this study to be conducted.

Given the sensitive and personal nature of the particular area of research being explored, there was no direct contact between the researcher and the participants, as the data for the study had already been collected as part of a broader study. In addition, in collecting the data for this study, there was no direct contact between the child rape survivors and the researcher. All data collected were obtained from the social welfare organizations to which the child had been referred.

In preserving anonymity and confidentiality, the names of participants, their family members, and the hospital at which the participants were accessed, was not disclosed in the write-up of the research study. In addition, only the researcher and her research supervisor were granted access to the data; and the security of all research files were maintained throughout the research study. Upon completion of the research study, data will be kept in a locked cupboard for a period of five years, after which they will be destroyed.

3.10 Conclusion

This chapter has outlined the aspects that the present research study aimed to address; as well as the conceptual framework underpinning the understanding that was achieved, the context in which the study was conducted, and details of the data collection technique and methods by which the data were analysed. In addition, ethical considerations were explored, and methods by which ethical principles were adhered to, were addressed.

CHAPTER FOUR

RESULTS

4.1 Introduction

Data analysis revealed information pertaining to demographic aspects of the sample, including gender, race, area of residence, as well as the ages of survivors and perpetrators. In addition, aspects of service delivery were explored, and the latency and duration of service delivery, as well as aspects that predicted whether a child rape survivor was likely (or not) to receive social work services, were highlighted.

4.2 Sample demographics

Participants were predominantly female (96%), and black African (91%). Only a small portion of the sample included child rape survivors who resided in urban areas (8%), whilst the majority of participants (56%) hailed from semi-rural areas of residence. Data analysis also revealed that the average age of the child was 10.7 years (range: 1-17). Exploring the data in terms of the type of rape that was experienced revealed that one third of the sample experienced intra familial rape (the perpetrator was a family member), with such involving either vaginal (92%) or anal (8%) penetration. The average age of alleged perpetrators was 22.69 years (range: 15-72).

4.3 Service Delivery

4.3.1 Question 1: To what extent do hospitals refer child rape survivors for counselling / social work services?

4.3.1.1 Services provided

With reference to Table 2, it is evident that approximately half of all participants (48.5 %) were provided with social work services; with only six being seen by social workers at the referral agencies. The hospital social worker provided all other social work consultations. In light of the results, it is evident that in the event that a child did receive social work services, these services were most often (20%) provided between 2 – 7 days after the initial presentation at the hospital (see Table 2).

4.3.1.2 Services not provided

Services were not provided to 51.5% of the sample (see Table 2). The results revealed in Table 2 indicate that in the event that the child did not receive social work services, the most common (19%) reason for a child not receiving social work services, was that the referral agency was unable to contact the child. Other reasons cited for the non-provision of services, were that the referral was not made, or the social worker had not received the referral (see Table 2).

Table 2

Provision of Social work services for child rape survivors

Service Provision	Survivor seen by social worker	
	Yes n (%)	No n (%)
Latency of Service Provision		
At presentation	21 (10.5)	
2 days – 1 week	40 (20.0)	
1 week – 1 month	21 (10.5)	
1 month – 6 months	15 (7.5)	
Total	97 (48.5)	
Reason for non-provision of services		
No action taken by hospital social worker		30 (15.0)
Referral agency “did not receive referral”		35 (17.5)
Referral agency “could not contact survivor”		38 (19.0)
Total		103 (51.5)

4.3.2 Question 2: What is the latency and duration of services provided?

4.3.2.1 Latency of service delivery

As revealed in Table 2, the majority of cases (20%) services were provided between 2 – 7 days after presenting for medical evaluation; whilst equal proportions of the sample (10.5%) received services on presentation and between 1 week – 1 month after presenting for medical evaluation. In addition, analysis of the data revealed that with regard to the rape survivors who received social work services from external agencies, such services were only made available more than a month after the child had presented for medical evaluation.

4.3.2.2 Duration of service delivery

Social work services involved a single intake interview in all cases except one; where the child was seen 3 times by an external agency.

4.3.3 Question 3: What are the factors that predict whether a child will receive services?

Data were analysed to highlight the factors that had the most significant impact in determining whether a child would receive social work services or not. The analysis, as displayed in Table 3, revealed that the two factors which were most significant in determining service delivery, was whether or not the child was able to provide a street address, and whether or not the child presented at the hospital for evaluation after working hours.

Table 3

Factors Predicting the Provision of Social Work Services: Step-Wise Binary Logistic Regression Analysis (n=200)

Variable	Wald	df	Odds ratio	95% confidence interval	P
Not having a street address	5.381	1	.507	.285 – .900	.020
After – hours presentation	4.493	1	.625	.348 – 1.144	.044

Note: Specified levels for each variable were associated with a decreased likelihood of social work provision. Model fitting information: $\chi^2(2)=10.10$, $p=.006$, Cox & Snell $R^2=.049$.

4.4 Conclusion

This chapter presented the results of the analysis of data. Results pertaining to the demographic profile of child rape survivors, as well as the latency and duration of service delivery, and factors that predispose an individual to not being provided with social work services, were highlighted. An interpretation and discussion of these findings will be explored in the next chapter.

CHAPTER FIVE

DISCUSSION

5.1 Introduction

This chapter presents findings of the present research study, which will be discussed in the context of related literature. The implications of these findings will be explored, and limitations and recommendations will be indicated.

5.2 Question 1: To what extent are child rape survivors provided with counselling and social work services?

In exploring aspects of service delivery, the present study aimed to determine the extent to which counselling and social work services were provided at the study hospital. And in the event of these services not being provided at the hospital, to determine to what extent referrals were made to social welfare organizations. In addition, in the event that referrals were made to social welfare organisations, to determine to what extent these organisations contacted the child rape survivor, such that said services could be provided.

Child rape requires that counselling and social work services be made available in order that victims are provided with the necessary resources to enable them to deal with the trauma of the violation that they have endured. In most cases, these services are made available to a rape survivor upon presentation at a medical facility. However, for a range of reasons including that the rape survivor presented after hours, a social worker was not available to see to the child, as well as numerous other reasons, social work services may not be provided. In the event of such a scenario, the onus is on the social worker at the relevant hospital, to ensure that a social welfare organisation, in the child's area of residence, is contacted and informed of the rape, so that they (the external social welfare organisation) can take over and make available the necessary services to the child.

5.2.1 Services provided

In the present study, it was found that of the 48.5% of the sample, who did receive social work services, in most cases services were provided by the hospital social worker.

Furthermore, only 6 out of these 97 child rape survivors received services from an external welfare organisation.

Despite being provided with counselling and social work services, the extent to which the rape survivor benefitted from these services may be questioned; as in instances where services are provided, these services are not always provided by an appropriately trained individual, therefore the information that is disseminated is not always entirely correct. This assertion is made in light of South African research that was conducted, as Christofides et al. (2003) note that of all service providers included in their study, approximately 50% had any training on sexual assault, and in approximately half of such cases the training was obtained during undergraduate studies or whilst undergoing basic training. In addition, participants in the study conducted by van Zyl & Sinclair (2006) were unanimous in their opinion that when services were provided, it appeared as though service providers were not properly trained to be conducting these services, that procedures were not appropriately followed and that no referrals were made for support services.

It is therefore evident that despite service provision occurring, aspects of service provision may cause distress to the rape survivor, thereby resulting in secondary victimisation. An example of this is displayed by the international perspective given by Denov (2003), who in her exploration of experiences of disclosure, focused on experiences of counselling wherein the alleged offender was female; and found that 57% of the sample expressed having had a negative experience of disclosure. The impact of such negative experiences was that the individual's distrust of the professional was exacerbated, the rape victim's sense of anger was fuelled, and/or the rape victim began to question or deny the act of abuse. These findings emphasise the fact that even when services are provided to survivors of rape or sexual abuse, they sometimes do more harm than good. Furthermore, Campbell et al. (2001) indicated that 25% and 29% (respectively) of their sample of rape victims expressed that experiences with mental health and medical service providers, were 'hurtful'.

It may therefore be asserted that in the event that services are inappropriately provided, the value of these services is inevitably discounted. In some cases, it may even be concluded that incorrectly or inappropriately providing services, may bear a more detrimental effect than not providing services at all; because when an individual who has been raped seeks services, it requires enormous deliberation and courage, and in the event that the services are inappropriately provided, the trauma experienced by the rape victim is contributed to not only by the act of rape, but also by the act of inappropriate service provision; as was found by Denov (2003) and Campbell et al. (2001).

However, in the event that services are appropriately provided, these services may be crucial in allowing a rape victim to come to terms with the violation he/she has suffered. This assertion is emphasised by Abrahams et al. (2008) who, based on a study conducted in South Africa, concluded that a rape survivor's pain may be eased by knowledge and understanding of what he/she is experiencing, and will experience, after having been raped.

Furthermore, the study conducted by van Zyl & Sinclair (2006) indicates a discrepancy in the views held by social workers and rape victims (or their families). In the study, social workers who were consulted indicated that they had contacted all of the rape victims to whom they had been referred. This however was in contradiction to the perceptions of the rape victims, who indicated that they either sought social welfare services on their own, were offered these services at the hospital at which medical evaluation was sought, or did not receive any social work services.

5.2.2 Services not provided

Data were also analysed to determine to what extent counselling and social work services were not provided to child rape victims who presented at the study hospital for medical evaluation. With regard to the 51.5% of the sample who did not receive social work services, it was found that 15% of the sample did not receive services due to the fact that no action was taken by the hospital social worker (meaning that no referral to a social welfare organisation had been made). This occurred because these child rape survivors, presented at the hospital after working hours, and did not return to the hospital for follow-up appointments. There was no evidence in the hospital social worker's files to indicate that these children had been referred to an external agency for follow-up appointments. In addition, a further 19% of the

sample did not receive social work services because of the fact that the child could not be contacted.

International research conducted by Campbell (2005) found that participants were treated in an insensitive manner, and that essential services were not provided. Campbell (2005) also found that measures to treat the psychological effects of rape were only offered to 10% of participants; whilst in South Africa, Christofides et al. (2003) found that referrals for services were not always made, and that referrals for counselling services were the aspect given least attention, in managing a sexual assault. This is consistent with the findings of Changwa and Pather (2008) who note that the psychological services needed by a rape victim are often neglected. Christofides et al. (2005) further revealed that referrals are often not made because organisations offering such services cannot be identified, or that relationships, between the hospital and these organisation, are strained or non-existent.

In the event that a child, who has been raped, is not provided with any counselling and social work services, the fate of the child is that he/she will have to come to terms with the trauma of having been raped, without the assistance of trained professionals. Such coping and closure is not something that a child has the cognitive and emotional capacity to achieve alone, certainly not in the face of having been violated in such a violent and traumatising way. As a result of the inefficiencies of appropriate departments and persons, the future of these children is clouded by uncertainty. Who knows what the fate of these individuals would be if they were provided with appropriate services, and more importantly, who can fathom the future of these children in the event that they are not provided with the appropriate services. Yet despite knowing the trauma surrounding rape, the feelings of guilt and shame, and the absolute helplessness of a rape victim, the lives of these children are gambled with, and their souls are lost as a result of being failed by adults who could have done more.

5.3 Question 2: What is the latency and duration of services provided?

The purpose for analysing the latency and duration of service delivery was to determine the duration over which counselling and social work services were provided, and how long the child rape victims had to wait before receiving these services.

5.3.1 Latency of service delivery

The present study found that in the event that a child rape survivor was provided with social work services, only in 21% of cases were such services provided at initial presentation at the medical facility. In addition it was determined that in the majority of cases (20%), such services were only provided between 2-7 days after the initial presentation; and, in 7.5% of the cases, services were only provided between 1-6 months after the child had initially presented at the hospital.

The statistics revealed in the present study suggest that rape is not treated as seriously as it deserves. Although the latency of service provision was not addressed in previous research, it is understood that the psychological and emotional wounds caused by a rape heal over a long period of time, and it is essential that these wounds be treated as soon as possible, so as to minimise the effect it could potentially have on the rest of the child's life. A child is by nature naive and trusting, and having been violated in such a horrendous manner, the very nature of the act demands that the child be provided with the guidance of an individual who would be able to reassure him/her and assist him/her in making sense of what had occurred. Allowing a child to go for such extensive periods of time, without providing any form of services, may potentially result in the child concluding that the act of rape was insignificant, that he/she deserved to be treated in that manner, or that he/she is responsible for the fact that the rape had occurred. Such minimization, in addition to negatively affecting the development of the child's self-esteem and feelings of self-worth, may potentially contribute to the child's increased susceptibility to further sexual violations. In addition, such trivialization of the act of rape, serves to feed the victim-blaming attitudes held by many.

Also, during the counselling sessions, a child is in a safe environment wherein a sense of trust and reciprocity is facilitated. It is often in these settings that a child will disclose many details of the act of rape, which are essential in developing a criminal case against the alleged perpetrator, or even possibly identifying the alleged perpetrator. In the event that there are extensive lapses of time between the act of rape and the first encounter with the social worker, the child may forget important pieces of information. In addition, the lapse in time may be sufficient for the perpetrator to escape the area in which the rape had occurred, and go into hiding (Petersen et al., 2005).

The reality however, is that often, despite counselling and social work services being made available to child rape survivors, these services are not utilized immediately. Possible reasons for failing to utilize available services, include, but are not limited to, that the child is unaware of the availability of services, or the child does not attend appointments; in addition the lapse in time may be attributed to attempts to locate the child so that services may be provided.

5.3.2 Duration of service delivery

Social work services were found to involve a single intake interview in all cases except one; wherein the child was seen 3 times by an external social welfare agency. Although having been conducted on a separate continent, similar results were achieved by Campbell et al. (2001), who despite not quantifying the duration over which services were provided to rape victims, do differentiate between those who engaged in 'long-term' and 'short-term' therapy; with the study finding that the majority of the sample (65%) benefitted from short-term therapy.

Failing to engage in long-term therapy, when it is available, may be attributed to many factors, including the distance to be travelled, and the expense of such travel. In addition, the number of times that the victim is seen by the professional, could be affected by a fear of being stigmatised, as well as a belief that the services being provided are not useful, or that the rape survivor would not benefit from the continuation of such services.

Despite the obvious benefits of engaging in therapy, and the need for the child rape victim to be provided with extensive therapy such that the traumatic experience of rape can be appropriately dealt with and the child can live a fulfilling and happy life, Underwager and Wakefield (1990) suggest that extensive therapy in which the child is required to relive the act of rape and display hatred for the perpetrator, may in fact hinder the child's progress, and exacerbate the trauma that he/she has endured. Although the potential for a counselling session to exacerbate the trauma caused by the rape exists, it is essential that a child rape survivor be afforded sufficient therapy for him/her to fully understand the various facets of the violation he/she has suffered.

5.4 Question 3: What are the factors that predict whether a child will receive services?

In considering the extensive trauma that a rape survivor endures, and more especially the extent to which such trauma is exacerbated in the event that the rape survivor is a child, the need for counselling and social work services to be provided to the survivor becomes emphasised. However, despite the efforts made by many relevant parties, there are a range of factors (variables) that may play a significant part in determining whether a child receives these services or not. These variables include, but are not limited to, characteristics of the child rape survivor and the perpetrator, including age, race, gender, relationship; characteristics of the abuse, namely the form of abuse, and frequency of the abuse, duration over which the abuse was conducted, as well as the degree of violence. Additional variables included the time of presentation at the hospital; and aspects pertaining to the area of residence of the child, including whether he/she lived in an urban or rural area, formal or informal housing settlement, and the distance from the hospital.

The study by Logan, Evans, Stevenson and Jordan (2005), aimed to explore the barriers to providing services to rural and urban rape survivors. Data for the study were analysed according to barriers to the provision of health and mental health services, and barriers to criminal justice system services. Findings revealed that the major barriers to seeking health and mental health services after being raped included, amongst others, the affordability, availability, and accessibility of services; misperceptions of who the services were available to; staff incompetence; as well as issues of shame and blame, trust, confidentiality, and sensitivity (Logan et al., 2005).

Analyses of the data for the present study indicated that two variables accounted for a significant portion of the explained variance in service provision (Table 3); thereby most likely predicting the non-provision of social work and counselling services to children, post rape. These two variables pertained to whether a child rape survivor lived in an informal or formal housing settlement, and whether the child presented for medical evaluation after normal working hours.

5.4.1 Housing

The variable that accounted for the most variance was form of housing (informal versus formal), with children residing in informal housing (informal settlements or traditional homesteads) being less likely to be provided with counselling and social work services. Additional analysis of written responses provided by social workers at the social welfare organisations, to which child rape survivors had been referred, indicated that it was not the actual form of residence that influenced service provision. Instead, based on residing in an informal settlement or traditional homestead, no fixed street address could be provided by the child rape survivor. Therefore, in 37 out of 38 (97%) cases, the social worker to whom the child had been referred, was unable to provide services to the child because “no fixed street address” was provided. In all 37 of these cases, the child resided in an informal home. The extent to which a child rape survivor could be contacted, therefore proved to be fundamental in determining whether or not the child would receive counselling and social work services. This finding appears to be a South African phenomenon, as van Zyl and Sinclair (2006), indicated that in many cases, services and feedback could not be provided to rape victims and their families, because the individual could no longer be found at the address that was provided, or that incorrect contact details were provided. In light of this, it is essential for contact details of rape victims to be regularly updated, and measures should be put in place to ensure that the correct information has been provided.

It is evident that the journey of service delivery does not occur on a one-way street. In order that a child can be provided with the services that he/she requires after having been raped, it is essential that at the very least, he or she provide appropriate and correct contact details to facilitate service provision. It is also the responsibility of the rape victim and his/her parent or guardian, to ensure that the information is correct, and that the information is revised in the event of changes.

5.4.2 Time of initial presentation

Service provision was also significantly determined by the time at which the child rape survivor presented at the hospital for the initial medical evaluation. In the event that the child presented after normal working hours (at night or over weekends), the child was less likely to benefit from social work and counselling services.

A possible reason for the finding, noted above, is provided by Christofides et al. (2003), who indicate that in South Africa, professionals responsible for conducting the medical examination of rape victims, are sometimes not available on the hospital premises after hours (they are on call), and there are extensive delays in getting him or her to the hospital, in order that the medical evaluation can be conducted. In addition, many resources, including examination rooms, are not accessible after working hours (Christofides et al., 2003).

The very fact that rape victims endure difficulties in the event that they present for medical evaluation after working hours appears illogical, because Hirschowitz et al. (2000) discuss a study conducted by the Crime Information Analysis Centre, which indicates their finding that the majority of rapes (23.2%) took place on a Saturday, followed by 20.3% of rapes which occurred on a Sunday. In addition, the Rape Surveillance study discussed in Hirschowitz et al. (2000, p.32), found that most rapes occur over the weekend, as well as “after dark or after working hours”, and were found to peak between 18:00 and 22:00. The overall finding of these authors was that most rapes in, South Africa, occur between 19:00 and 01:00. In light of these findings, it stands to reason that facilities, at which rape victims would seek medical evaluation and services, should be operating at their optimum during these periods.

In order to be prepared for the possibility that a child rape victim may present for medical evaluation and services, it is essential that service providers take into consideration various factors. Firstly, most parents work on weekends, and many children are therefore left to their own devices on these days, and the chances of them being raped is multiplied as a result of the possible lack of adult supervision. Also, a child is unlikely to make his/her own way to a hospital or other medical facility upon being raped. In further considering that the child may have working parent/s, it is understandable that the child would possibly wait for his/her parent to return home, explain what had occurred, and the parent would then seek the necessary resources. Also, the rape would be unlikely to occur while the child is at school, or at a public place, and most children are at school until the late afternoon, leaving just a few hours before ‘normal working hours’ are exceeded. In addition, rapists who intend preying on older victims (but who may legally be classified as a child), would do so when the child is out after dark, as this would minimise the chances of the rapist being seen. Furthermore, in the event that the child is employed, the act of rape would occur when the child is alone, which would possibly be after working hours. Although this does not insinuate that rapes do

not occur during 'normal working hours', it is evident that a rape is more likely to occur after working hours, and a rape survivor is more likely to seek services after working hours. As a result thereof, it may be concluded that the need for social workers, counsellors, and professionals responsible for conducting the medical evaluation of a rape victim to be available at the medical facility after normal hours of operation, is essential.

5.5 Implications

The present study highlighted the importance of providing social work and counselling services to child rape survivors, as well the extent to which such services are not provided, and the factors serving as barriers to the provision of these essential services. Furthermore, the research study paints a picture of the reality facing many child rape survivors in poverty stricken South Africa, who depend on the services provided by the government, and who suffer at the hands of inappropriate and ineffective service delivery. As a result of the failure to provide adequate (if any) social work and counselling services to a child who has been raped, the long-term result is that the child will have no alternative but to live with the doubts, questions, fear, and guilt that no other has clarified or dismissed for him/her.

In light of the findings of the present study, it is evident that numerous factors must be taken into consideration when addressing child rape. In addition, the findings of the research study serve as motivation for the need for a multidisciplinary approach to child rape, as the role of numerous stakeholders have been highlighted.

Although the present research study does not claim to represent a comprehensive study on the secondary victimisation of child rape survivors, the intention is that the findings of this study will serve to provide insight into child rape, the services required by child rape survivors, barriers to providing these services to child rape survivors in a South African context, as well as methods by which these barriers may be addressed and overcome. Taking into consideration the findings highlighted, may be the first step on the path of eliminating the secondary victimisation suffered by child rape survivors who bear the brunt of the wrong that was done to them.

5.6 Recommendations

Based on the results of the present research study, a number of pertinent issues were revealed. It is suggested that the issues outlined below be prioritized in the evaluation of current initiatives aimed at addressing child rape, and should be considered in the planning and evaluation of further initiatives and programmes.

At a time in South African history when groups are protesting in opposition to the changing of street names, many are being denied services because they cannot provide a street name. In the event that a child rape victim is unable to provide a clear physical address, measures should be taken to ensure that a detailed description surrounding the child's physical location is obtained. In addition, referring the child to a social welfare organisation in his/her area, will increase the likelihood that the child is provided with services, as professionals working in the area will be more familiar with the surroundings, and relevant landmarks, and as a result will possibly be more successful in accessing the child. In addition, an efficient and user-friendly system should be employed, to enable the rape victim to update his/her contact details regularly.

The very fact that many individuals are unable to access services because they reside at traditional homesteads or informal settlements, must be taken into consideration. Such informal residences are often very far from hospitals, child welfare organisations etcetera, thereby serving as an obstacle to the individual making an attempt to access these services. Also other factors that must be taken into consideration include the availability of transport to the medical facility, and the cost of that transport. As a result of the distance and expenses involved, an individual may be reluctant to seek the necessary services. In light of this, individuals living in rural areas, should be educated on the availability of services most accessible by them, and the procedures that need to be followed in order that a rape case is formalised and the victim's needs are addressed. Jewkes and Abrahams (2002) and Shilumani (2004) agree that measures need to be put in place by relevant government departments in South Africa, to ensure that poverty is not the reason for which an individual refrains from reporting a case of rape.

With regard to the fact that research has determined when the ‘peak’ rape periods are, it is advised that appropriate service providers perform at their optimum during those periods, to ensure that their services are available when it is most needed. The urgency in the need for such optimum performance outside of working hours in addressing the issue of child rape in comparison to other forms of rape, is that when an adult man or woman is raped, he/she is less dependent on others ensuring that he/she receives the services needed, because he/she is able to access the necessary services for him/her self. However, when the victim of rape is a child, he/she is more dependent on government departments, because should these departments fail the child, unless his/her parents or guardian takes ownership in ensuring that the needs of the child are met, the child is lost in the system.

Furthermore, as a result of the fact that a rape case involves so many service providers including social workers, psychologists, medical practitioners, police officers, lawyers etcetera, research conducted in South Africa, by Christofides et al. (2003), Shilumani (2004), and van Zyl and Sinclair (2006), suggests that a multidisciplinary approach be adopted in addressing various forms of rape, especially child rape. The multidisciplinary approach that is proposed, is one in which all relevant stakeholders have links between them, and rather than merely handing the child’s case from one to the other, all stakeholders are simultaneously involved in addressing the needs of the child. This may best be displayed by means of the graphic representation offered below.

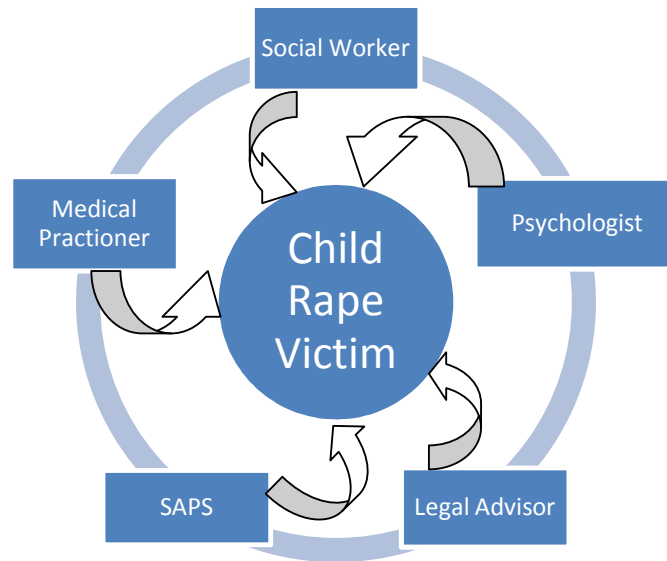
Not only does the graphic depiction indicate some of the service providers that will be involved in addressing the needs of the child that has been raped, it also indicates a feedback loop between service providers, by which they can track the progress being made in various other sectors of the case of rape. In addition, by means of a multidisciplinary approach, service providers can call on each other for additional support e.g. in the event of the child having to have to participate in an identity parade conducted by the South African Police Services (SAPS), the psychologist and social worker involved in a particular case may be called on to be present, to assist the child in the trauma of facing his/her alleged rapist, or to intervene in the event of incestuous abuse.

An additional benefit of such collaboration is that these individuals may speak with one voice in lobbying for policy changes, and other relevant issues. In addition, in identifying rape as a

public health problem, as is advised by Jewkes and Abrahams (2002), the call for “joint action” (WHO, 1986, p.2) emphasises the need for a multidisciplinary approach in addressing rape.

Figure 1

A multidisciplinary approach to child rape



5.7 Limitations

This study aimed to explore the extent to which child rape victims receive social welfare services and counselling services, in KwaZulu Natal, South Africa. The findings of the study, although reflecting a gross lack of services provided to participants, may not necessarily be reflective of the extent to which such services are provided in other parts of KwaZulu Natal, or other parts of South Africa.

Also, data for the present study was collected in 2004, and as a result, may not be reflective of the current situation in terms of the services provided to child rape victims. This is possible, based on recent initiatives that may have since been employed, to ensure the provision of essential services to child rape victims.

However, despite the limitations noted, the research study highlights important aspects pertaining to the services required by child rape survivors, and the value of ensuring that these services are provided.

5.8 Conclusion

This chapter provided a discussion and contextualization of the results found in the study; wherein the results of the study were examined in relation to that of other related studies. In addition, the implications of these findings were noted, and in light of such, recommendations were made. Also, factors which limited the study, were acknowledged.

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APPENDIX A

DEPARTMENT OF HEALTH PROVINCE OF KWAZULU-NATAL

The Social Work Supervisor
XX Welfare Agency
Private Bag XX
4000 NDWEDWE

22 February 2005

Dear Madam/Sir,

The Crisis Clinic at [REDACTED] is currently attempting to update its files regarding child rape cases which presented at the clinic in the period October to December 2004. According to our records the cases on the attached sheet were referred to your agency during this period for social work services, but our records do not provide any indication of the nature of the services provided by your agency.

In this context, it would be appreciated if you could provide us with an indication of the nature of the services provided by your agency for these cases. On the attached sheet there is place for you to indicate one of four possible outcomes, as well as a space for you to add any comments that you feel may be helpful. The four possible outcomes are:

- A. REFERRAL NOT RECEIVED BY OUR AGENCY:** (e.g., where the referral letter was given to the child's caretaker but the caretaker never made contact with the agency)
- B. NOT POSSIBLE TO MAKE CONTACT WITH THE CHILD:** (e.g., the child had moved from the address provided on the referral letter)
- C. CASE REFERRED TO A MORE APPROPRIATE AGENCY:** (e.g., an agency closer to where the child lives)
- D. CHILD CONTACTED AND APPROPRIATE SERVICES PROVIDED.**

It would be appreciated if you could place a cross in the appropriate box on the attached sheet (for each child) to indicate the nature of services provided. The completed form can be faxed to me at [REDACTED] or posted to us at the above postal address. If necessary I can be contacted on [REDACTED]

Many thanks for your assistance in this matter.

Yours faithfully

[REDACTED]

