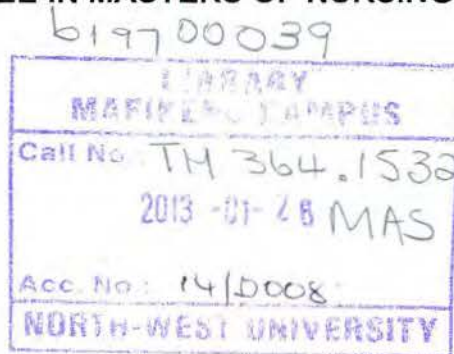


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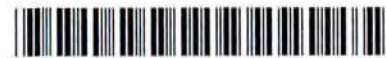
S M MASEMOLA

NOVEMBER 2013

**DISSERTATION SUBMITTED IN PARTIAL FULFILMENT OF THE REQUIREMENTS
FOR THE DEGREE IN MASTERS OF NURSING ADMINISTRATION**



**AN ASSESMENT OF POLICY IMPLEMENTATION ON SEXUAL ASSAULT AND
RAPE IN THE NGAKA MODIRI MOLEMA DISTRICT OF THE
NORTH-WEST PROVINCE**



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NOVEMBER 2013

DECLARATION

I, Salome Madithapo Masemola author of dissertation: *"An Assessment of Policy Implementation on Sexual assault and Rape in the Ngaka Modiri Molema district of the North West Province"* solemnly declare that this is an original work done and that all the sources that I have used or cited have been indicated and acknowledged by means of complete references.

Signature:

Date:

DEDICATION

“In loving memory of my late father”

Who, from a very young age, instilled in all his children the courage and determination to achieve whatever we set our minds on? Dad you are not here to rejoice with me, but spiritually you're a big part of my achievements.

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ABSTRACT

Rape and sexual assault is a global problem with far reaching and devastating social and health implications for victims of such crimes. South Africa has one of the highest rates of rape and sexual assault cases reported to the police compared to other countries globally. In an attempt to forge intervention, various programmes aimed at addressing sexual assault have been developed by relevant government entities. Since the development of these programmes, research on implementation and effectiveness of sexual assault services in South Africa has been minimal. The absence of research on these interventions prevents an opportunity for programme improvement and resource mobilization that would ensure that these programmes are efficient, effective and to ensure that it meet the needs of beneficiaries.

A quantitative and descriptive research design was used to assess the implementation of the national sexual assault policy by health professionals at referral and designated health facilities. The study was conducted in Ngaka Modiri Molema district in the North-West province, targeting nurses, doctors, unit managers and social workers rendering sexual assault services within the district. Self-administered questionnaires and checklist were used to collect data.

Findings indicated that there was no significant difference with regard to the implementation of the sexual assault policy. There was no hundred percent adherence to policy prescribed by health facilities, while resources were not equitably allocated to health facilities as rural health facilities still lacked basic resources like colposcopy. While most health professionals indicated to be knowledgeable about the service they deliver, the findings indicated that less than 45% of health professionals allocated to render sexual assault services are not trained nor frequently getting ongoing training in the management of sexual assault. Sexual assault services within the district were provided by untrained health professionals as in the whole population only one (1) health professional had forensic nursing training.

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ACRONYMS

AIDS	Acquired Immunodeficiency Syndrome
BBC	British Broadcasting Cooperation
CPD	Continuous Professional development
FBI	Federal Bureau of Investigation
HIV	Human Immunodeficiency Virus
HRW	Human Rights Watch
IPV	Intimate Partner Violence
M&E	Monitoring and Evaluation
NDOH	National Department of Health
NGO	Non-Governmental Organization
NPA	National Prosecuting Authority
NWP	North-West Province
NWU	North-West University
PEP	Post Exposure Prophylaxis
PHCC	Health Care Centre
SANC	South African Nursing Council
SAPA	South African Press Association
SAPS	South African Police Services
SOC	Sexual Offences Courts
SOCA	Sexual Offences and Community Affairs Unit

SPSS	Statistical Package for Social Science
STI	Sexually Transmitted Infections
TCC's	Thuthuzela Care Centre's
TLAC	Tshwaranang Legal Advocacy Centre
UK	United Kingdom
UN	United Nations
UNICEF	United Nations Children's Fund
WHO	World Health Organization

CHAPTER ONE

OVERVIEW

1.1. INTRODUCTION

This study intends to evaluate the implementation of sexual assault policies in order to improve service delivery. The Sexual Assault and Rape Act (32 of 2007) defines rape as an intentional act of sexual penetration without the person consent. It further defines sexual assault as the unlawful and intentional act of sexual contact with another person without that person's consent. The definition of rape varies in different parts of the world and in different times in history. The United Nations (UN) (2000) defines it as "sexual intercourse without valid consent" and the World Health Organization (WHO) (2002) defines it as "physically forced or otherwise coerced penetration – even if slight – of the vulva or anus using a penis, other body parts or objects. The WHO (2012) indicated that the Federal Bureau of Investigation (FBI) changed their definition from "The carnal knowledge of a female forcibly against her will ..." to "the penetration no matter how slight of the vagina or anus with any body part or object, or oral penetration by a sex organ of a person without the consent of the victim".

South Africa has the highest incidence of child and baby rape in the world with more than 67 000 cases of rape and sexual assault against children reported in 2000, with welfare groups believing that unreported incidences could be up to ten (10) times higher according to Perry (in Time.com 11 November 2007). The BBC News (19 January 1999) reported that one in three of the 4000 women interviewed by the Community of Information, Empowerment and Transparency indicated that they had been raped in 1998. The 2009/2010 South African Police Services (SAPS) crime report indicated a ratio decrease of 4.4 % from 144.8 sexual offences per 100 000 of South African population in 2008/2009 to 138.5% per 100 000 sexual offences in 2009/2010. (See *table 1.1.*) Services rendered should be evaluated to check if all institutions are providing care as according to the national guidelines

Table: 1.1. Ratios of all sexual offences from the highest decrease to the highest increase between 1 April 2009 and 31 March 2010

Province	2008/2009	2009/2010	Increase/Decrease
RSA	144.8	138.5	-4.4%
Gauteng	174.0	148.6	-14,6%
North west	146.6	137.9	-5.9%
Northern Cape	170.3	160.8	-5.6%
Eastern Cape	143.7	136.1	5,3%
KwaZulu-Natal	131.4	127.0	-3,3%
Mpumalanga	130.8	127.6	-2,4%
Free State	157.2	157.8	0,4%
Limpopo	88.6	93.8	5,9%
Western Cape	166.7	180.07	8,4%

Source: (SAPS 2009/2010)

It is important to note that the numbers reflected above is only of those cases reported to the police. Sexual assault and rape in particular are considered the most under reported violent crime (American Medical Association, 1995). This highlights major barriers to reporting rape and sexual assault to the police. Some of the barriers include fear of further trauma, especially lack of confidentiality, stigmatization and not being believed, fear of retaliation by the perpetrator and a perception that such reporting would be unlikely to result in punishment of the perpetrator (Christofides, Webster, Jewkes, Pen-Kekana, Martin, Abraham & Kim, 2003: 1).

Sexual assault can profoundly affect the physical, emotional, mental and social wellbeing of survivors of sexual assault irrespective of their gender, age or background (Christofides et al, 2003: 1). Whilst physical trauma to the genitals may be visible after sexual assault, in other instances it is the emotional trauma that present in different ways in the lives of the survivors of sexual assault. The risk of contracting sexually transmitted diseases is very high as perpetrators do not use protection during the

assault. In a study done in Tanzania, Rwanda and South Africa it was found that women who experienced Intimate Partner Violence (IPV) were at risk of acquiring HIV infections due to the fact that men who perpetrate in partner violence are more likely than other men to engage in HIV risk behaviors as a result are more likely to be HIV positive (WHO, 2004: 1). There is also pregnancy associated problems.

In cases where a country is faced by challenges of rape and sexual assault it is important to ensure that services for these clients are up to standard to cater for their needs. It is also important to make sure that professionals that are rendering these services are well equipped with the knowledge and skills needed to be able to render quality services. It is important that those professionals undergo training in order to be asserted with the correct skills.

The study of Christofides et al (2003: 38-39) indicates a problem nationally on how rape and sexual assault services are being rendered. The study developed recommendations that necessitated the National Department of Health (NDOH) to come up with National Management Guidelines for Sexual Assault Care to guide rendering of services to survivors of rape. These guidelines provide protocols for management of the survivors of rape and sexual assault and also provide a framework for the mobilization of optimal health resources required in the management of sexual assault survivors by health professionals. The public service then designated specific health institutions to treat survivors of sexual assault guided by these guidelines.

In 2009, the National Prosecuting Authority (NPA), in trying to respond to the scourge of rape in the country, launched the Thuthuzela Care Centres (TCCs). These centres are located in one public hospital in each province designated to render services of sexual assault and are ideally equipped with all physical and human resources that are needed to cater services for survivors of rape. While there are designated hospitals in all districts, it is important to note that sometimes due to the geographic locations and distances between designated hospitals and communities in deep rural areas, district hospitals in casualty departments still treat the survivors of rape and sexual assault. Clinics as referral centres to the hospitals also provide services by virtue of being first contacts points for patients. Based on all these dynamics, health professionals based at

all entry points of care need, to be skilled and knowledgeable about identifying and treating survivors of rape.

The only way to ensure that survivors get through their ordeal is by provision of quality services that in their holistic approach are seeking to heal those affected. These will need well knowledgeable and skilled professionals who are acquainted with the provisions of the National Sexual Assault Policy and the National Management Guidelines for Sexual Assault Care. Provision of resources at designated health facilities and clinics is paramount to quality services. What this means is that if knowledgeable and skilled health professionals should have the required resources to deliver quality sexual assault services.

1.2 PROBLEM STATEMENT

The 2009/2010 SAPS (2010: 6) annual report released indicated a 10,1% increase in sexual assault offences reported to the police nationally in SA. Rape in the country is a challenge as it is increasing at an alarming rate. To respond to the crisis South Africa developed various preventative programmes together with care, treatment and recourse policy guidelines in the form of National Management Guidelines for Sexual Assault Care (2004). The implementation of these guidelines has not been scrutinized by in-depth research. The absence of this information prevented an opportunity for programme improvement, resource mobilization and ensuring that the programme is efficient, effective and meets the needs of its users. In 2003 a survey was done to evaluate sexual assault services in the country and it highlighted several pitfalls in the implementation of the policy (Christofides et al: 2003).

The health system has also seen various changes since the time with the aim of making accessible, affordable, effective and efficient services available to the community at large (RSA 2003). Amongst the changes introduced was the abolishment of the district surgeon system in 1999. This system was responsible for amongst other things, the examination of sexual assault survivors. According to Christofides et al (2003:3) the main aim of abolishing the district surgeon system was to devise a strategy to improve

services and to move towards an integrated care approach. There was a shift from managing sexual assault survivors from district surgeons to emergency units. Public hospitals in provinces were designated as centres to house the rape and sexual assault unit to render services to rape survivors. The TCCs, working hand in hand with hospitals, were launched by the Minister in 2009. Based on the sexual assault prevention programmes that exist, policy adjustments and the high rate of sexual assaults in the country it became important to assess the implementation of the sexual assault policy.

1.3 RESEARCH QUESTION

Brink (2006:80) states that the research question is similar to the research problem, except that the research question is in a question form. This study intends to answer the following questions:

- To what extent is the Sexual Assault policy implemented in the designated health institutions?
- How well resourced are health care institutions to enable the health care and support of sexually assaulted/raped survivors effectively?
- What level of knowledge and attitude do health professionals have in order to deal with survivors of sexual assault?

1.4 AIM OF THE STUDY

The overall aim of this study is to assess the implementation of the Sexual Assault and Rape Policy across the designated health facilities and referral clinics within the Ngaka Modiri Molema district in the North-West Province (NWP).

The specific objectives of this study include:

- To assess the extent of implementation of the sexual assault and rape policy in the designated health facilities and referral clinics;

- To assess the availability of resources needed for the implementation of the policy in designated health facilities; and
- To describe the health professionals knowledge and attitudes towards survivors with regards to the implementation of the sexual assault and rape policy.

1.5 SIGNIFICANCE OF THE STUDY

The study is of importance because, if the findings of the assessment are known, it may assist service providers to develop strategies to remedy possible gaps in policy implementation and suggest best practices. It is also argued that potential findings of the study may assist policy makers and programme planners to assess if there is a need to amend or update the policy and management guidelines.

1.6 DEFINITION OF TERMS

Designated Health Facilities is defined as health facilities that had been pronounced by the Department of Health to be Centres for provision of sexual assault services within a demarcated district.

Health Facility in this study will mean hospitals and clinics within the Ngaka Modiri Molema district irrespective of their level.

Health Professionals in this study shall mean doctors, nurses, social workers, unit managers and counselors working in the unit where survivors of sexual assault are being treated.

Referral clinics in this study will mean clinics within the district referring patients to the designated health facilities rendering sexual assault services.

Resources in this study will mean physical and human resources needed to render service to the survivors of sexual assault. This may extend outside the health facility as sexual assault requires a multidisciplinary approach.

Rape/ Sexual assault is defined as unlawful and intentional act of sexual contact with another person without that persons consent (Sexual Offences and Related Matters Act 32 of 2007 as amended). In this study these concepts will be used interchangeably.

Survivor of Rape in this study will mean any individuals women, men or children that have been sexually assaulted.

Unit manager will mean any person charged with the responsibility of managing the unit where sexual assault services are rendered.

1.7 OUTLINE OF THE STUDY

This dissertation on evaluating the implementation of sexual assault and rape policy in Ngaka Modiri Molema district is divided as follows:

Chapter One is an overview of the whole study outlining the background, aims and objectives of the study.

Chapter Two provides a literature review.

Chapter Three outlines the research design and method.

Chapter Four presents the study findings and results.

Chapter Five contains the discussions of the study findings, conclusions, limitations and recommendations of the study.

1.8 SUMMARY

In this chapter, the study was introduced and a brief background of the extent of sexual assault and rape globally were sketched, aims and objectives of what the study intends to achieve and the significance of the study were also indicated. The chapter also gave

an outline of the study. The next chapter will provide a detailed discussion of the literature applicable to this study.

CHAPTER TWO

LITERATURE REVIEW

2.1 INTRODUCTION

The previous chapter provided an overview of the study. In this chapter a literature review will focus on the following areas:

- Magnitude of the problem;
- health consequences;
- theoretical Framework; and
- the South Africa response to rendering sexual assault services- the milestones achieved.

2.2 MAGNITUDE OF THE PROBLEM

Sexual assault is a global problem; the World Bank estimates that one in three American women will be sexually assaulted in their life time (World Bank, 2005). About 87 000 of them were survivors of complete rape and 70 000 were survivors of attempted rape (World Bank, 2005). A report from the UN (2001-2002) indicated that more than 250,000 cases of rape or attempted rape were recorded by the police annually. The United Nations Development Fund for Women (UNDFW) (World Bank, 2005: 209) indicates that 90% of girls in South America and Peru, between the ages of 12 and 16 giving birth were pregnant from rape and often incest.

Internationally, the incidence of rapes recorded by the police during 2008 varied between 0.1 in Egypt per 100 000 people and 91.6 per 100 000 in Lesotho with 4.9 per 100 000 in Lithuania as the median (UN, 2010). This report by the UN (2010) showed that there was a tendency of rape occurring more in developing countries. In a national survey conducted in the United State of America; it was found that 14.8% of women over 17 years of age

reported having been raped in their lifetime (with an additional 2.8% having experienced attempted rape) and 0.3% of the sample studied being raped in the previous year (WHO, 2002).

In Cambodia, rape is estimated by local and international Non-Governmental Organizations (NGO) to be common (Cambodian Government, 2009). Only a very small minority of these assaults are ever reported to the authorities, due to the social stigma associated to being the victim of sexual crime, in particular, to losing virginity before marriage. It is reported that the police in Cambodia recorded 468 cases of rape, attempted rape and sexual harassment between the periods of 2008 and 2009 which was a 2.4% increase from the previous year (Ipsenews.net 10 July 2010).

The British Broadcasting Corporation (BBC) in 2007 reported that there were 85,000 women in the United Kingdom (UK) raped during 2006. The British Crime Survey Report 2006-2007 indicated that 1 in every 200 women were raped during that period (BBC News 9 July 2008: 8) while in Norway one in 10 women was reported to be raped (in The New York Times 15 November 2011:12).

According to McCrummen (in Washington Post 15 November 2007:16) reports that the prevalence and intensity of rape and other sexual violence in Eastern Congo as the worst in the world with about 200 000 survivors of rape estimated to be living in the Democratic Republic of Congo (DRC) yearly. The commentator of The Independent (12 May 2011) reports that rape in the DRC was used as a "weapon of war".

In South Africa it is estimated that a woman born has a greater chance of being raped than learning how to read and reported to be having the highest incidence of child and baby rape in the world (BBC News 9 April 2002). It was also reported that a 9-month old baby was raped by six men, aged between 24 and 66, after the infant was left unattended by her teenage mother. The infant injuries were so extensive that she needed reconstructive surgery to be performed on her. Since the HIV and AIDS epidemic in South Africa, there has been this myth that if a person who is HIV positive has sex with a virgin it will cure a man of AIDS (The Daily Telegraph, 2001). While this has not been scientifically proven, some men in countries like Zambia, Zimbabwe and Nigeria still believe in the myth as a lot

of cases of child rape are continuously reported in these countries (BBC News 9 July 2008).

The disturbing fact is that there were 27 417 cases of sexual assault cases reported against children (SAPS, 2009-2010) and 60% of those were committed to children below the age of 15 years. A more worrying factor is that 29.4% of these sexual offences involved children aged 0-10 years. This confirms the study done by Govender (in BBC News 9 April 2002) where a total of 89.4% of rape committed was involving children. The greatest challenge with sexual assault and rape is that survivors prefer to remain quiet about their experiences due to fear of victimization or societal and cultural pressures (Jina, Jewkes, Munjanja, Mariscal, Dartnall & Grehiwot, 2010: 134), leading to many cases going unreported. This becomes a problem as international and national statistics only reflect a fraction of what is really happening on the ground as statistics only cover cases reported to the police and information shared in research studies.

Figure 2.1 shows the ratios of sexual assault cases reported to the police in South Africa between the years 2008-2011. The highest incidence of all reported sexual offences was recorded in the Western Cape, followed by the Northern Cape and Free State, while Limpopo featured at the bottom of the list. Six of the nine provinces recorded a decrease in sexual offences while three experienced increases. Only one of the six provinces which experienced decreases also met the reduction target, namely Gauteng, with a very significant decrease of -14, 6%. The increase of sexual offences of 8,4% in the Western Cape is cause for concern.

In the 2010/2011 SAPS sexual assaults statistics, the overall ratio reduction was 4.4%, and even though it was the same as in 2009/2010, there was a concern that Free State, Northern Cape and North-West sexual assault cases reported, increased significantly as compared to 2009/2010 where there was only an increase noted in two provinces. Gauteng still remained the province that decreased with a significant percentage.

The rates also indicate the increase on the need for health services that should be rendered to the survivors of rape.

Trends of Sexual Offences from 2009-2011 per province

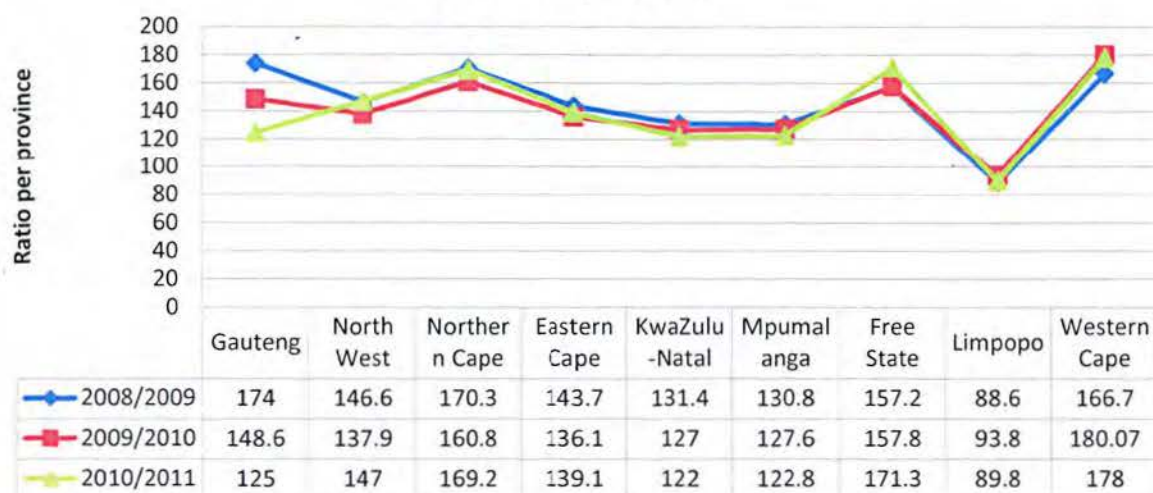


Figure 2.1: Trends of Sexual Assault ratios of cases reported to the police

2008-2011.

Source: Researchers summary of SAPS statistics 2008/2009 and 2009/2010.

The WHO compares the challenges in reporting cases of sexual assault and rape to an iceberg floating in water. This brought about the “tip of the iceberg theory” used by the WHO to present sexual assault and rape challenges globally and what is actually reported to the police (WHO, 2002). See figure 2.2.

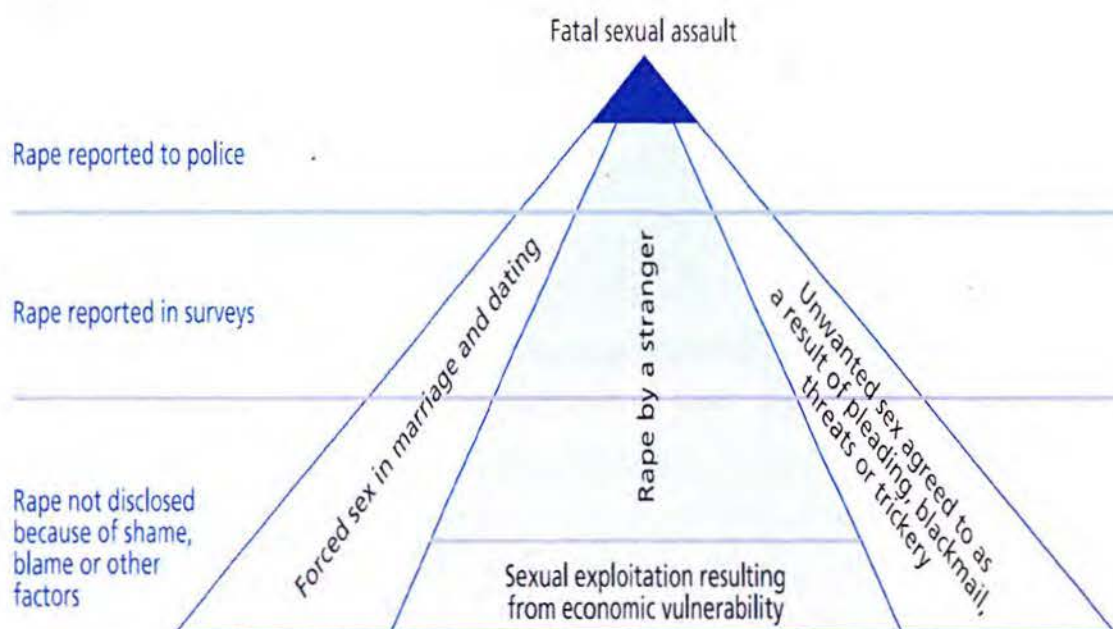


Figure: 2.2. The Magnitude of the problem (Tip of an Iceberg theory)

Source: (WHO, 2002).

The small visible tip represents cases reported to the police and a larger section revealed through surveys, research and work done by NGOs. However, beneath the surface remains a substantial although unqualified component of the problem. This shows that there are a great number of sexual assault and rape cases that go unreported as indicated on figure 2.2.

In a study conducted among the African Americans, it was found that secondary victimization with legal, medical, and social service systems where systemic barriers, women experienced the following forms of sexual assault (Tillman, Bryant-Davis, Smith & Marks, 2010:63). Racism and stereotypical images of African American women's sexuality were also cited in the study as a hindrance to reporting on disclosing sexual assault.

What this means is that the true magnitude of the problem remains unknown as there are a lot of factors playing a role in survivors not reporting rape. The true magnitude of the problem in South Africa remains unknown and there are great disparities with respect to reported cases of sexual violence. For example, Statistics South Africa found

that one in two rape survivors reported it to the police, while at the Medical Research Council a study by Jewkes and Abrahams (2002:55) found that only 1 in 9 women reported their experience of rape to the police. Both studies pointed to gross under-reporting of cases (Mullick, Teffo-Menziwa, Williams & Jina, 2010: 50).

According to the cultural practices of Bapedi from GaSekhukhune: women are socialized to believe that if a man has paid lobola for you, as the head of the family he has control over your body. What this means is that a married woman may not refuse her husband sex, and if it happens that the husband forces himself to her for sex, that would not be viewed as rape. This is supported by the UN (2000) report in which UNICEF indicates that sexual abuse and rape by an intimate partner is not considered a crime in most of the countries and women in many societies do not consider forced sex as rape if they are married to or cohabiting with, the perpetrator. This is further supported by the WHO report in 2002 that indicates that there are significant differences across cultures in the willingness to disclose sexual violence.

Thus, the theory indicates that even though survivors of sexual assault and rape are willing to share their experiences in research due to the protection and secrecy it gives them, they remain unwilling to come out publicly. There is also less willingness to report to the police as cases takes weeks and months in the courts with the rape survivors trying to prove beyond reasonable doubt that rape did take place. The worse scenario is that more often than once these perpetrators get off without being punished. Poor reporting lead to underutilization of sexual assault services, thus leading to survivor's health deteriorating. This leads to overexerting the health services at a later stage due to complications that could have been averted if dealt with at an early stage.

Some African cultures still hold the notion that men are unable to control their sexual urges and sometimes the way women dress provoke those desires leading to rape. This notion finds expression in the incidences of rape or sexual harassment of women in South Africa based on the clothes they are wearing. An example of such an incident happened at a taxi rank in Johannesburg where a woman was sexually abused by taxi drivers just because she was wearing a miniskirt (in Sowetan 20 February 2012). This led to the much publicized march by hundreds of woman led by the premier of Gauteng,

Nonvula Mokonyane, wearing a miniskirt to make a statement and to show the plight of women in South Africa. In other countries it is reported that women that are raped are forced to marry their perpetrators (UN, 2000) to avoid bringing shame to the family.

The magnitude of the problem signifies the importance of policy implementation to ensure service delivery but also the importance of policy assessment and evaluation to determine if the services rendered still meets desired goals and relevant to the context when it is provided. These will assist in planning health services that responds to patient's needs.

2.3 HEALTH CONSEQUENCES OF SEXUAL ASSAULT AND RAPE

Sexual assault and rape are traumatic experiences that may lead to physical and psychological health problems. The experience impact on the social wellbeing of survivors, if not responded to immediately. Several researches have been conducted related to the physical and psychological problems as a result of sexual assault and a brief discussion will be given.

2.3.1 Physical effects

Sexual assault and rape can happen in different settings under different circumstances. Campbell (2002: 1331) indicates that in some instances survivors may have visible injuries but most of women who are sexually assaulted and treated in health facilities do not have obvious injuries. Studies have shown that sexually assaulted survivors are at a greater risk for a whole host of physical health disorders that may be present many years after the abuse (Laserman, 2005:2). These effects, as according to Laserman (2005: 2), can manifest as poor health status, poor quality of life and high use of health services.

Sexual assault may lead to rape survivors experiencing reproductive health problems. In many instances the perpetrators do not use protection and these often lead to survivors falling pregnant if not using any mode of contraception. In a study of adolescence in Ethiopia, Mulungeta, Kassaye and Berhane (1998:7) found that 17%

victims became pregnant after the rape. This is nearly a similar figure 15-18% as reported by Rape Crisis Centre in Mexico (WHO, 2002:132).

Rape can also cause gynecological complications like vaginal bleeding (menorrhagia), pelvic infections, fibroids, decreased sexual desire, genital irritations, chronic pelvic pain and urinary tract infections (Campbell, 2002:132). This is supported by Laserman (2005:3) who found that rape can cause painful intercourse in some women. An analysis of 3 random surveys (2 regional and 1 national), Golding, Wilsnack and Learman (1998:1017) report that the number of gynecological complains for example, (dysmenorrhea, sexual dysfunction, heavy menstrual bleeding) were related to increased odds of having a history of being sexually assaulted. The WHO (2002:198) confirms these complications and report that they are consistently found to be related to forced sex.

Sexually transmitted diseases and HIV and AIDS are a common occurrence in rape survivors. Sexual assault, especially if it is violent, increase the risk of HIV (WHO, 2002:164) as in forced vaginal penetration, abrasions and cuts commonly occur, thus facilitating the entry of the virus-when it is present-through the vaginal mucosa. Research on women in the shelters (Wingood, DiClemente & Raj, 2000:273) has shown that women who experience both sexual and physical assault from intimate partners are significantly more likely to have had sexually transmitted diseases.

Sexually assaulted women can also experience abdominal pains and gastrointestinal disorders (Laserman, 2005:2). A random survey of a large primary care clinic found that women abused in childhood were more likely to report being bothered by stomach pains (33%), nausea (37%), pain in the lower belly (20%), and painful stools (26%) compared with non-abused women (13%, 24%, 8%, and 14%), respectively (Hulme, 2000:1479).

While sexual assault and rape may present with a multiple of physical disorders, it is important to take cognisance of the fact that sometimes these disorders may in turn become chronic disorders thus having an impact on health delivery as a whole. Proper diagnosis and empathetic care remains vital to ensure identification of problems are identified and be dealt with at an early stage.

2.3.2 Psychological effects

Whether the rape survivor decides to keep the secret of having being raped, or within the family, the chances of the experience manifesting into psychological problems are very high. Many studies show that sexual assault has been associated with a number of mental health and behavioural problems in adolescence and adulthood (Creamer, Burgess, Farlane, 2001:1239; Darves-Bornoz, 1997:62; Cheasty, Clare & Collins, 1998:199; Briggs & Joyce, 1997:136).

Most of the survivors of sexual assault are suffering from depression, anxiety and post-traumatic stress disorders (Campbell, 2002:1333). In a study conducted in Canada Ratner (1993:247) it was found that in addition to depression, abused women had significantly more anxiety, insomnia and social dysfunction than those not abused sexually. Campbell (2002:1334) found that 70% of emotional distress in Nicaragua was due to sexual assault. The WHO (2002:163) reports that there is a high prevalence of suicidal attempts in women who are sexually assaulted than other women. In Brazil sexual assault was the leading factor predicting several health risk behaviours, including suicidal thoughts and attempts (Bagley, 1997:364).

These issues highlight the need for careful attention to the mental health of patients who have been sexually assaulted. The National Sexual Assault Policy (RSA DoH, 2005: 22) advocates for the utilization of monitoring and evaluation as a tool to ensure quality sexual assault services. It is thus important that health professionals understand that failure to properly implement and monitor policy may lead to family units breaking down in the aftermath of sexual assault (RSA DoH, 2005:5).

The effects of sexual assault need a comprehensive and multidisciplinary approach with consideration of all driving factors of the ecological model that may influence how the rape survivors respond to rape. Failure to recognize that each rape survivor is an individual whose reaction is based on different circumstances, mental health of rape survivors will remain a challenge. Sexual assault can cause irreparable damage especially in cases where rape survivors did not have access to counseling and support. Disclosing sexual victimization to informal and formal support system alike and

experiencing positive reaction may give women access to emotional support (Tillman et al, 2010: 62).

The personal experience of the researcher working in the deep rural areas of Limpopo province, South Africa in a district hospital where there are no psychologists employed to counsel survivors is that most rape survivors come back for treatment with major psychological problems. This anecdotal experience is supported by the Venter and Jacobs (2005:2) study while at the Tshwaranang Legal Advocacy Centre (TLAC) study where they indicate that if sexual assault is ongoing over a period of time and the survivor(s) do not receive counseling it tends to have more complex psychological impact in the life of the survivor of rape.

It is thus imperative and important that the National Sexual Assault Policy (2005) and the National Management Guidelines for Sexual Assault Care (RSA DoH, 2003) be implemented to the core to ensure a holistic approach in treating survivors of rape. Table 2.2 gives a summary of the consequences of sexual assault. It is important to note that this list is not conclusive as each victim is unique.

Table 2.2: Health consequences of sexual assault

Fatal Outcome	Physical	Sexual and reproductive	Psychological and behavioural
➤ Femicide ➤ Suicide ➤ AIDS-related mortality ➤ Maternal mortality	➤ Fractures ➤ Chronic pain symptom ➤ Fibromyalgia ➤ Permanent disability ➤ Gastro-intestinal disorders	➤ Sexually transmitted infections, including HIV ➤ Urinary tract infections ➤ Unwanted pregnancies ➤ Pregnancy complications ➤ Vaginal bleeding ➤ Traumatic gynaecologic fistula ➤ Unsafe abortion ➤ Chronic pelvic pain	➤ Depression and anxiety ➤ Eating and sleeping disorders ➤ Drug and alcohol abuse ➤ Poor self-esteem ➤ Post-traumatic stress disorder ➤ Self-harm

2.4 Theoretical Framework

This study’s theoretical framework is based on the Ecological Model of the impact of sexual assault.

It is important, that when looking into psychological implications of sexual assault and rape, there is an understanding that individuals have differential patterns of experience given the different ecological settings (Campbell, Dworkin & Cabral, 2009: 225). The ecological model of recovery was used to evaluate how the legal, medical and mental health systems respond to survivors' needs and how those system experiences affect the survivors' psychological health outcomes.

Figure 2.3 indicates the Ecological Model of the impact of sexual assault on women's mental health. The individual level of analysis and the characteristics of the victim could certainly influence the recovery process (Campbell et al, 2009:228). This has to do with the individual's age, race/ethnicity, and social class as socio-demographic environment correlates with post assault psychological distress as all these characteristics will determine the drive of the victim to access support or how they will cope with rape.

Where and how the sexual assault took place remains important in the recovery process of the victim. Neville and Heppner (1999: 49) indicate that the severity of the sexual assault ordeal and threats made during the assault determine the severity of the post assault distress. Usually survivors that have been threatened by the perpetrator keep the secret due to fear and this may lead to psychological distress (Campbell et al, 2009:228).

The microsystem level of the model explores the impact of disclosure to informal sources of support like family members, friends and peers. Neville and Heppner (1999:51) indicate that the support structure as important as there is face to face interaction and interrelations between individuals and others in their immediate setting because the provision of (or denial of) social support occurs through direct interaction.

The meso/ecosystems deals with processes that contribute to linkages between systems and /or other individuals in the ecological environment to ecosystems which are formal systems with which individuals may or may not have contact. Campbell et al (2009:228) indicate that the analysis of extent literature on post assault sequelae suggests that empirically based distinction between these levels are not yet warranted thus being dealt with at the same level. What this means is that survivors may seek

assistance at a formal setting like a Rape Crisis Centre (RCC) and at the same time the RCC may establish connections with legal or medical systems to access more support i.e. mesosystem. While supporting survivors of rape by referral to meso/ecosystems, it is important to understand the rape victim at a macrolevel where behaviour can be influenced by the victim's cultural identity and its role in rape recovery.

Campbell et al (2009:228) also indicate that the chronosystem in the model reflects how a person's environment interaction is reciprocal and change over time, and examines the cumulative effects of multiple sequences of developmental transitions over the life course. See figure 2.3.

Ecological Model of risk factors

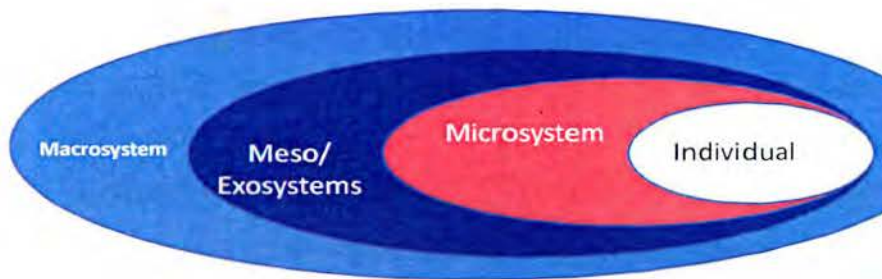


Figure 2.3: An Ecological model of the impact of Sexual Assault on Women's Mental Health.

Source: (Campbell et al 2009 ; Bott et al, 2005).

2.5 SOUTH AFRICA'S RESPONSE TO RENDERING SERVICES OF SEXUAL ASSAULT

Several changes took place within the NDOH over the years in response to the provision of sexual assault services to survivors of rape. In the 1990's the District Surgeon Model was used to provide services to sexual assault and rape survivors. District surgeons were doctors having their own private practices, employed by the state to provide sexual assault services to the survivors.

Most district surgeons in the rural areas were part-time combining their official duties with private practice (Human Rights Watch, 1997: 106). Based on the fact that district surgeons were also working at their private practices, it put a strain on the quality of sexual assault service they provided. This is supported by the Human Rights Watch (HRW) findings (1997:123) indicating that documentation was not completely filled to necessitate prosecution of perpetrators in some instances. The findings also indicated that district surgeons were accused of racism, misdiagnosis of rape, and reluctance to appear in court to provide evidence as it was clashing with their private practice work. This study also indicated that women living in the townships were the most likely (94%) to be satisfied with treatment they receive from the district surgeons than their counterparts in the rural areas (HRW, 1997: 164). This means that services were not equitably distributed and thus created a problem related to service delivery to survivors of rape.

All these challenges and many more prompted government to phase out the District Surgeon Model from 1996 and was totally abolished in 1999. Location of sexual assault services were offered at variety of settings nationally, including district, regional and tertiary hospitals as well as primary health care facilities. The services were provided by doctors employed in public health facilities. The TLAC (1997: 165) articulate that while the services were provided in casualty to ensure 24 hours coverage a range of reasons can be provided why these departments were most unsuited to deal with rape survivors as they were noisy, busy, chaotic, bloody and frightening (Venter & Jacobs, 2005: 3). Another challenge was that doctors and nurses were not well equipped to provide quality sexual assault services.

The published Primary Health Care Package for South Africa- a set of norms and standards outlined the responsibilities of service providers when dealing with survivors of sexual assault and rape (RSA DoH, 2000).

The responsibilities outlined in that document state that:

- Every clinic should establish working relationships with the nearest police officer and social welfare officer by having visits from them at least twice a year;
- a member of staff of every clinic must have received training in the identification and management of sexual, domestic and gender related violence. The training should include gender sensitivity and counseling;
- the clinic's staff is required to fast track in a confidential manner any rape victim to a private room for appropriate counseling and examination;
- all cases of sexually transmitted disease in children are managed as cases of sexual offence or abuse;
- when a person presenting at a clinic alleges to have been raped or sexually assaulted the allegation is assumed to be true and the victim is made to feel confident they are believed and are treated correctly and with dignity;
- a detailed medical history is recorded on the patient record card and a brief verbal history of the alleged incident is taken and noted - with an indication that these are not a full account. These notes are kept for 3 years;
- clinic staff should explain to a client that referral is necessary to an accredited health practitioner and arrangements are made expeditiously and while awaiting referral emergency, medical treatment is given with the consent of the victim: prophylactic treatment against STD and post-coital contraception;
- the victim is given information on the follow-up service and the possibilities of HIV infection and what to discuss with the accredited health practitioner at the hospital or health centre;
- survivors are not allowed to wash before being seen by an accredited health practitioner.

- women who have been raped or abused are attended to by a female health worker and if this is not possible (e.g. a male district surgeon comes to the clinic) then another woman should be present during the examination;
- the victim is given brief information about the legal process and the right to lay a charge; and
- if the victim now indicates a desire to lay charges the police are called to the clinic.

Christofides et al (2003:3) assessed sexual assault services in South Africa and the study highlighted many challenges within the public service with regard to physical and human resources. This study also highlighted that the system was revised from visits to the district surgeon to hospital based visits without taking into account formal training of health providers or evidence of competence or proper allocation of resources. What it meant was that there was a need for health care professionals to be asserted with the necessary skills and knowledge needed to provide sexual assault services at the point of entry. The study then recommended that for the sexual assault services to meet the minimum standards outlined in the 2000 National Department of Health policy document entitled: "Primary Health Care Package for South Africa- a set of norms and standards". The following were recommended by the study:

- That the sexual assault management policy and clinical management guidelines as well as the finalization of provider training modules be prioritized and implemented as soon as possible;
- training should address psychosocial aspects and gender issues as well as the treatment and examination of patients after sexual assault. There should be a focus on attitudinal shifts as well as increased knowledge and skills;
- district managers as well as providers must be trained. Managers should be responsible for the supervision of service within the facilities;
- the hospital superintendent should explore where a private examination room can be set up in the hospital (if there is not one already). Thought should also be given to a system in place that will allow sexual assault patients to be moved to the front of the queue and their care prioritized;

- refresher courses or ongoing training on the management of STI and the provision of emergency contraception is recommended for all providers irrespective of whether they manage sexual assault;
- intersectional collaboration between health providers, police, social workers and NGOs should be facilitated at all levels; and
- NGOs that provide support and counseling for patients after sexual assault should build a relationship with service providers at local hospitals and encourage referrals (Christofides et al, 2003:39).

The study by Mullick et al (2010: 4) report that in the 2 608 cases of rape analyzed in Gauteng in 2003, only 17% of the reported cases made it to trial and almost one-quarter of these were withdrawn. To make it easier for health professionals in managing survivors of sexual assault and rape the Department of Health provided an annexure 2 in the National Management Guidelines for Sexual Assault Care, showing a step by step flow diagram on how to manage patients presenting within the first 72 hours after assault or after 72 hours.

Table 2.3: Flow diagram showing the management of patients presenting within the first 72 hours after assault or after 72 hours

Sexual Assault Flow Diagram	
Patients presents within 72 hours at the health facility	Patients presents after 72 hours at the health facility
1. Patient waits in designated room for sexual assault care provider 2. Emergency care given if needed 3. Trauma counselling 4. History taken 5. Examination conducted (unless patient chooses not to be examined) 6. HIV, STI, pregnancy counselling 7. HIV test and pre-test counselling (if consent is given) 8. Pregnancy test 9. Give post-exposure prophylaxis according to protocol - explain side-effects 10. Give STI treatment / prophylaxis 11. If pregnancy test is negative – give emergency contraception according to protocol and start regular contraception 12. If pregnancy test kit is not available give emergency contraception 13. Information on rape trauma syndrome given to patient 14. Collection of trace and biological evidence 15. Documentation of evidence such as injuries 16. Referral for counselling and NGO support group 17. Give information leaflet 18. Schedule clinical follow up	1. Patient waits in designated room for sexual assault care provider 2. History taken 3. Examination 4. HIV, STI, pregnancy counselling 5. HIV test (if requested) 6. Prescribe STI treatment 7. Pregnancy test 8. Insertion of IUD (+ antibiotic cover) or Abortion counselling if necessary 9. Can be provided with ECP if IUD contraindicated 10. Information on rape trauma syndrome given to patient if <5 days ago 11. Collection of forensic evidence 12. Documentation 13. Referral for counselling and NGO support group 14. Give information leaflet 15. Schedule clinical follow up

Source: (RSA DoH, 2003).

In view of the challenges still plaguing the health system regarding sexual assault service delivery the NDOH designated health facilities to provide services of sexual assault within districts as a way of trying to ensure quality effective care. The South African Justice System also responded to the high rate of sexual assault in the country by introducing anti-rape strategy aiming to reduce the secondary trauma to the survivors, improve conviction rates and reduce the cycle for finalizing cases. The TCCs was introduced by the National Prosecuting Authority's (NPA's) Sexual Offence and Community Unit (SOCA), in partnership with various donors as a response to the urgent need for an integral strategy for prevention, response and support for rape survivors (NPA , 2009). The TCCs model follows an integrated approach as all key professionals involved in the care of survivors located in one place to spare the survivors having to move from one point to another in the process of reporting and seeking health care. The TCCs are linked to Sexual Offences Courts (SOC) and provide the most effective services to survivors of sexual assault, but based on the demand out there, TCC's are insufficient to meet the need (NPA, 2011:104).

By 2011 already 37 TCCs had been established nationwide. TCCs are located in communities where there is a high recorded incidence of rape: 10 213 sexual offences were reported at TCCs across the country in the period 2009-2010. As there are about 50 000 to 55 000 reported cases of rape annually, this means that about one in five reported rape cases is being attended at these specialized facilities (NPA, 2011: 103-104). The report also indicate that the specialized courts perform well in relation to conviction rates, reaching an average of 70%, compared to the overall average of about 7% and SOC linked to TCC's perform even better. Advocate Majokweni in the NPA (2009:27) report indicates that at the heart of the success of the TCC's approach is the professional medical and legal interface, with a high degree of cooperation between survivors and service providers, by reporting and investigating the sexual crimes, leading to prosecution and conviction of the offender.

A multidisciplinary approach is paramount to the success of sexual assault service interventions as it ensures that rape survivor receives quality care and support. These

will enhance the trust that rape survivors will have towards formal systems mode of support thus leading to more rape survivors disclosing and utilizing services available. This is in line with what the ecological model of support advocates for in general.

2.5 SUMMARY

The literature review with regard work done on sexual assault was extensively searched and dealt with in the chapter looking at the magnitude of the sexual assault problem globally and in South Africa, the physical and psychological consequences of sexual assault, and how government responded over the years to improve services of sexual assault in South Africa. Policies and the ecological model of risk factors were also covered. The next chapter we analyse the methodology used in this study.

CHAPTER THREE

RESEARCH DESIGN AND METHODS

3.1. INTRODUCTION

This chapter presents the research design and method. The research method is a technique used to structure a study and to gather and analyze information in a systematic way (Polit & Beck, 2008: 765). Components presented in this chapter include the study setting, population, sample, pilot study, reliability and validity ethical considerations and data collection.

3.2 RESEARCH DESIGN

Burns and Grove (2009: 218) define a research design as the blueprint for conducting a study that maximizes control over factors that could interfere with the validity of the findings. The study design helps the researcher to plan the research in a way that it will assist the intended goal. LoBiondo-Wood and Haber (2010:159) indicate that a research design in quantitative research has multiple overlapping and yet unique purposes of which one is being a vehicle for testing research question and hypothesis. They further allude that the overall purpose of research design is twofold: to aid in the systematic solution of research question or hypothesis and to maintain control. The researcher in this study chose quantitative and descriptive methods as the study was assessing the implementation of the national sexual assault policy by the health professionals charged with the responsibility in the designated health facilities within the Ngaka Modiri Molema district in the NWP.

3.2.1 Quantitative

The quantitative design is the process of testing relationships, differences and cause, and the effect of interaction among variables (LoBiondo-Wood & Haber, 2010: 584). Burns and Grove (2009:22) define quantitative design as a formal objective, systematic process in which numerical data are used to obtain information about the world. It is believed that the currently predominantly used method of scientific investigation in nursing is quantitative research. As the objective of the study was to assess implementation of the policy, quantitative design thus is the relevant design to determine whether resources needed to implement the policy is in place in accordance with the stipulated guidelines.

3.2.2 Descriptive

A descriptive research provides an accurate portrayal or account of characteristics of a particular individual situation or group (Burns & Grove, 2009: 25). It offers the researcher a way of knowing what exists especially because in this study we wanted to understand the extent to which policy was implemented and also the attitude and knowledge of health professionals dealing with sexual assault survivors. Polit and Beck (2008:274) indicate that the purpose of descriptive research is to describe and document aspects of a situation as it naturally occurs. The implementation of sexual assault services in designated facilities was observed as professionals offered services where possible in order to serve as a starting point for hypothesis generation.

3.2.3 Observation

Observation is defined as the detailed examination of phenomena prior to analysis, diagnosis, or interpretation (Collins English Dictionary, 2003:637). The implementation of sexual assault services in designated facilities was observed as professionals offered services where possible in order to serve as a starting point for hypothesis generation.

3.3 STUDY SETTING

A research setting is defined as a place for conducting research – either field or laboratory setting (Brink & Wood, 2001:100). The study was carried out at designated health facilities rendering sexual assault services and referral clinics within Ngaka Modiri Molema district in the NWP, South Africa. The designated health facilities were rendering 24 hours services to survivors. Most of the designated health facilities were complexes under one management. Depending on management, both facilities under the complex were rendering sexual assault services or one facility was delegated to render services. In one of the health facilities there is a working relation with the NGO located within their premises where services are rendered at the NGO's site during the day and at the hospital casualty after hours.

3.4 TARGET POPULATION AND SAMPLING PLAN

A population is defined by Polit and Beck (2008: 761) as the entire set of individuals or objects having the same characteristics. In this study the population was made of health professionals working in the designated health facilities and referral clinics made up of doctors and nurses, unit managers, social workers and counselors. No categorization of nurses was provided as some clinics were only having staff nurses in charge due to staff shortages. It was also important that all nurses working in the units be knowledgeable about what to do when admitting a survivor of rape, irrespective of their nursing category. All these form part of a multidisciplinary team to rendering quality sexual assault services. Refer to annexure H for staffing and names of facilities.

3.4.1 Sampling method

Based on the low numbers of population in the designated health facilities, total sampling of health professional working in units providing services formed part of the population studied. In referral clinics purposive and convenient sampling were used. Purposive sampling is a nonprobability sampling method in which the researcher selects participants based on personal judgment about which ones will be most informative

(Polit & Beck, 2008: 761). The researcher, through the help of the local district health office, developed a list of clinics to form part of the study. Convenient sampling is defined by Burns and Grove (2009: 687) as non-probability sampling technique where participants are included in the study because they happen to be at the right place at the right time and entered into the study. In this study participation of referral clinic was also based on their geographical location and distance in relation to the Mafikeng Provincial Hospital where all hospitals/clinics were referring patients to for advanced care and therapy. This was to ensure that even remote referral clinics do form part of this study.

3.4.2 Sample size

Polit and Beck (2008:765) define a sample as a subset of a population selected to participate in a study. This was done through all the health professionals offering services regarding rape and they formed part of the sample. The total sample was 105 made up of health professionals from designated hospitals and referral clinics in the district.

3.5 INSTRUMENT

In this study questionnaires and an observation checklist were used.

3.5.1 Questionnaire

A questionnaire is defined as a document used to gather self-report data via self-administration of questions (Polit & Beck, 2008: 763) while Burns and Grove (2008:406) define a questionnaire as a self-report form designed to elicit information that can be obtained from a subject's written responses. The questionnaire was divided into two sections, A and B.

Section A: Demographic data

The section consisted of six (6) items namely age, gender, home language, population group, category of health professionals and names of health facility the respondents

were working.

Section B:

In this section the questionnaire consisted of sixteen (16) Likert-scale type questions and eight (8) dichotomous questions. The Likert-scale, according to Burns and Grove (2009:410), determines the opinion or attitude of a subject and contains a number of declarative statements with a scale after each statement. Dichotomous questions are defined as close ended questions that have only two values or categories (Polit & Beck, 2008:752). The Likert-scale gives five options to either strongly agree, agree, uncertain, disagree and strongly disagree. In this case, 1 was strongly agreeing and 5 strongly disagreeing. Questions 1-7 were testing respondents' knowledge about the National Sexual Assault Policy (RSA DoH: 2005) and 8-16 testing their attitudes when servicing the survivors of rape. Questions 17-24 were dichotomous requiring respondents to make a choice between the two response alternatives, yes or no. The questions were testing the procedural issues in serving survivors of rape as required by the National Management Guidelines on Sexual Assault Care (RSA DoH:2003).

3.5.2 Observation Checklist

A checklist is defined as a two dimensional arrangement in which a series of questions is listed along one dimension (usually vertical) and response alternatives are listed along the other (Polit & Beck, 2008:417).

The observation checklist consisted of 22 items adapted from the WHO (2003:22-23) Guidelines for medico-legal care for survivors of sexual violence and fundamental requirements. The researcher observed and highlighted resources available at designated health facilities as the checklist was used to determine the availability of resources at the point of service. Seven (7) questions were enquiring about the general resources pertaining to amenities while 8-22 dealt with resources that are supposed to be in the examination room where survivors of rape were treated.

3.5.3 Validity

According to Polit and Beck (2008: 196) validity is defined as the degree to which an instrument measures what it is intended to measure. In this study the validity of the instrument was ensured by:

Content validity

Content validity is defined as the assessment of how well the instrument represents all the components of the variable to be measured (Brink, 2006:160). The draft questionnaire and checklist were submitted to the supervisor and an independent biostatistician in order to evaluate the relevance of each item. The researcher distributed 10 self-administered questionnaires in the district for participants to comment on the clarity of the questions. There was a suggestion that some of the items in section B of the questionnaire be dichotomous. In the observation checklist there were suggestions that resources be divided into general amenities and those specifically to be in the examination room. All the recommendations were effected in order to improve clarity.

3.5.4 Reliability

Reliability is defined as the degree of consistency or dependability with which an instrument measures the attribute it is designed to measure (Polit & Beck, 2008: 764). Brink (2006, 164) defines reliability as the degree to which the instrument can be depended upon to yield consistent results if used repeatedly over time on the same person, or used by two researchers.

- **Internal consistency**

Internal consistency is the degree to which the subparts of an instrument are all measuring the same attribute or dimension, as a measure of the instrument reliability (Polit & Beck, 2008:756).

- **Observation checklist test**

In this study the Cronbach's Alpha was used to test the reliability of the observation checklist and the reliability score was 0.854 as indicated in table 3.1 (a) and (b).

Table: 3.1(a): Observation facility checklist Reliability Statistics

Cronbach's Alpha	Cronbach's Alpha Based on Standardized Items	N of Items
.854	.851	16

Table 3.1(b): Intraclass Correlation Coefficient

	Intraclass Correlatio n ^b	F Test with True Value 0			
		Value	df1	df2	Sig
Average Measures	.854 ^c	6.854	5	75	.000

- **Self-administered questionnaire test**

The self-administered questionnaires were also tested using the Cronbach's Alpha and gave the following reliability results.

Table 3.1(c): Implementation of the sexual assault policy reliability statistics

Cronbach's Alpha	Cronbach's Alpha Based on Standardized Items	N of Items
.835	.832	9

Table 3.1(d): Attitude reliability statistics

Cronbach's Alpha	Cronbach's Alpha Based on Standardized Items	N of Items
.433	.520	15

3.6 PILOT STUDY

A pilot study is a small scale version of the main study useful to test all the procedures and feasibility of the study (Comarck, 2000:311).

The pilot study was done in hospitals and clinics outside the study site and did not form part of the study. A total of 9 participants took part. The outcome of the pilot study offered valuable information on the study feasibility of the data collection process.

3.7 DATA COLLECTION PROCESS

The data collection process was done from 15 June to the end of September 2012. The researcher was personally responsible for distribution of questionnaires in the different health facilities within the district and these were collected the next day by the researcher for proper monitoring of the process. The process ensured that day and night staff had an opportunity to take part in the study.

3.8 DATA ANALYSIS

Data analysis means the systematic organization and synthesis of research data in quantitative studies (Polit & Beck, 2008:751). De Vos (2002:223) defines data analysis as categorizing, ordering, manipulating and summarizing the data to obtain answers to

research questions. The Statistical Package for Social Science Statistical Software (SPSS), version 18.0 was used to analyze the data. Descriptive statistics were used to describe and organize the data. Furthermore Cronbach's alpha was used to assess internal consistency.

The Mann-Whitney U test was also used to test the difference between categories of staff as based on ranked scores.

3.9 ETHICAL CONSIDERATIONS

Ethics is defined as moral values that are concerned with the degree to which research procedures adhere to the professional, legal and social obligations to the study participants (Polit & Beck, 2008: 753). In this study the three fundamental ethical principles of respect for persons, principle of beneficence and principle of justice as stipulated by Brink (2006:31-35), were ensured from the beginning to the end.

3.9.1 Principle of respect for persons

The principle of respect for persons was observed and ensured by the researcher in accordance with the following criteria:

- **Permission to conduct research**

Written approval was obtained from the research ethics committee of the North-West University (NWU), Mafikeng Campus (Reference Number NWU- 00031-11-A9 (See Appendix A). Presentation of the intended study was done at the North-West Provincial Department of Health and approval was granted in writing (See Appendix B). Permission was also requested from the Chief Director District Services, Director Hospital Services and the Local District Office to access and conduct research in their health facilities (See Appendix C (i), C (ii) & H) respectively.

- **Informed Consent**

Informed consent means that subjects have adequate information regarding the research, and are capable of comprehending the information and have the power to free choice, enabling them to voluntarily consent to participate in the research or decline (Polit & Hungler, 1999: 36).

- Participants were given an information sheet explaining the purpose of the study, objectives, procedure to be followed when conducting the study before data was collected (See Appendix D). The contact details of the researcher and study supervisor were given for any clarity seeking questions and queries.
- In order to avoid coercion, participants were informed of their right to participate or not to participate in the study. They were further informed that whatever decision they take there would not be any penalty or risk of punishment as they had the right to withdraw from the study at any time they wished to.
- Participants were given consent forms to sign as agreeing willingly to be part of the study (See Appendix E).

3.9.2 Principle of Beneficence

Polit and Beck (2008: 748) define beneficence as a fundamental ethical principle seeking to maximize benefits for the studying participants by avoiding harm. To ensure adherence to the principle, the participants were protected from physical, emotional or spiritual discomfort/harm. The participants were given opportunities to ask questions and only took part if they felt comfortable doing so.

3.9.3 Principle of Justice

Polit and Beck (2008: 173) define justice as the participant's right to fair treatment and their right to privacy.

- **The right to fairness and privacy**

The participants in this study were selected based on the fact that they provided services of sexual assault thus directly involved with the problem under study. All

information provided by participants were treated as private and not shared in the public domain. Brink (2006:35) defines confidentiality as the researcher's responsibility to prevent all data gathered during the study from being divulge or made available to any person. In this study participants were informed that information gathered will only be accessible to those involved in the research. All completed questionnaires and checklist were handled with the strictest confidence.

3.10 SUMMARY

Questionnaires and checklists were used to collect data at designated health facilities rendering sexual assault services in the Ngaka Modiri Molema district in the NWP. The study design was quantitative and descriptive in nature and the total population of the health professionals at the designated health facilities formed the study sample while purposive and convenience sampling was done in the referral clinics. The Statistical Package for Social Science Statistical Software (SPSS) version 18.0 was used to analyze the generated data. While conducting this study the three fundamental principles of respect of persons, beneficence, and justice were adhere throughout the study. The next chapter presents a report on the findings of the study.

CHAPTER FOUR

RESULTS

4.1 INTRODUCTION

This chapter presents the findings of the study. The chapter is structured in a way that contextualizes the results under the following objectives:

- To assess the extent of implementation of the sexual assault and rape policy in the designated health facilities and referral clinics;
- to assess the availability of resources needed for the implementation of the policy in designated health facilities;
- to describe the health professionals knowledge and attitudes towards survivors with regards to the implementation of the sexual assault and rape policy.

4.2 DEMOGRAPHIC AND PROFESSIONAL CHARACTERISTICS OF PARTICIPANTS

The total number of participants was n=105 participants. The population was composed of doctors n=12, nurses n=75, forensic nurses n=1, social workers n=2, unit managers n=13 and health counselors n=2. The majority 77% of health professionals that took part in the study were females. About 98.1% of the study population was represented by people of African origin and 89.5% of them spoke Setswana as their home language. (refer to table 4.1 for detailed information).

Table 4.1: Demographic and professional characteristics of respondents

	Frequency	Percentage
Age		
25-30	15	14.7
31-35	16	15.7
36-40	11	10.8
41-45	14	13.7
46-50	16	15.7
51-55	16	15.7
56-60	11	10.8
60+	3	2.9
Gender		
Male	24	22.9
Female	81	77.1
Home language		
Afrikaans	1	1.0
English	4	3.8
Setswana	94	89.5
Xhosa	1	1.0
Sotho	5	4.8
Population group		
African	103	98.1
Indian/Asian	2	1.9
category		
Doctor	12	11.4
Nurse	75	71.4
Forensic Nurse	1	1.0
Social Worker	2	1.9
Unit Manager	13	12.4
Other	2	1.9

Table 4.2 indicates the designated and referral health facilities that were included in the study. The population was evenly represented with the highest number from health facility A at 17.1%. From the referral clinics health facility J was the highest represented at 8.5% participants. See table 4.2 and also refer to appendix H (Names of health

facilities).

Table 4.2: Population distribution of participants per health facility.

	Frequency	Percentage
Facility A	18	17.0
Facility B	15	14.2
Facility C	10	9.4
Facility D	2	1.9
Facility E	12	11.3
Facility F	5	4.7
Facility G	7	6.6
Facility H	6	5.7
Facility I	5	4.7
Facility J	9	8.5
Facility K	4	3.8
Facility L	5	4.8
Facility M	2	1.9
Facility N	2	1.9
Facility O	4	3.8

4.3 ASSESMENT OF IMPLEMENTATION OF THE SEXUAL ASSAULT AND RAPE POLICY IN NGAKA MODIRI MOLEMA DISTRICT

Tables 4.4 and 4.5, report findings of the implementation of the sexual assault and rape policy. Items covered were 1-9 on the questionnaire. Responses to this questions were ranked on the 5 point Likert scale ranging from strongly agree (1), agree (2), uncertain (3) disagree (4) to strongly disagree (5). The Likert scale was further collapsed into three categories as follows: strongly agree and agree were represented as agree, strongly disagree and disagree were represented as disagree and uncertain as neither agreeing nor disagreeing for purposes of analysis.

Table 4.3 in 9 items responded to by the respondents the Mann- Whitney U test showed no significant difference with regard to implementation of the sexual assault policy

across categories of gender ($p=0.451$), age in years ($p=0.741$) and home language ($p=0.939$). Hence there was a significant difference between the implementation of the sexual assault policy across categories of population group ($p=0.020$).

Table 4.3: Implementation of Sexual Assault Policy Descriptive Statistics

	Min	Ma x	Mea n	SD
Health care professionals undergo training before being allocated in unit to manage survivors of sexual assault and rape	1.0 0	5.0 0	3.03	1.4 8
Staff receive refresher courses or ongoing training on the management of sexual assault and rape	1.0 0	5.0 0	3.18	1.4 2
Policies and guidelines on the management of sexual assault and rape are readily available	1.0 0	5.0 0	2.09	1.1 9
Female survivors of sexual assault and rape attended to by the health workers of the same sex (e.g. a male doctor only available) then another female health professional always present during the examination	1.0 0	5.0 0	3.10	1.5 3
Staff allocated in units rendering sexual assault services knowledgeable enough to provide quality care	1.0 0	5.0 0	2.69	1.3 151 6
Supplies for post exposure prophylaxis readily available	1.0 0	5.0 0	1.63	0.9 4
There is a good working relation between health providers, police, social workers and NGOs	1.0 0	5.0 0	2.18	1.1 7
The survivors of sexual assault treated as emergency without waiting in a queue	1.0 0	5.0 0	1.86	1.0 4
The health facility ongoing monitoring and evaluation of sexual assault and rape services	1.0 0	5.0 0	2.79	1.3 5
Implementation of the sexual assault policy (total score)	9.00	40.0	22.71	7.65
		0		

Table 4.4 indicates the level of sexual assault policy implementation by the health professionals. The results reveal that vast majority (73.3%) agree that policies and guidelines on management of sexual assault and rape are readily available and about

87% agreed that supplies for post exposure prophylaxis are readily available in their health facilities. Furthermore it was agreed by 53% of the participants that staff allocated in the units rendering sexual assault services are knowledgeable enough to provide quality care to the survivors of sexual assault and rape. About 72% reported that there is a good working relationship between the health providers, police, social workers and NGO's. Eighty one percent (81%) of the participants reported that the survivors of sexual assault were treated as emergencies without waiting in a queue and about 46% agreed that the health facility provided ongoing monitoring and evaluation of sexual assault and rape services.

Table 4.4: Frequency and percentages of measures of implementation of sexual assault policy

Sexual Assault Policy Implementation	1	2	3	4	5
Health care professionals undergo training before being allocated in unit to manage survivors of sexual assault and rape	24.2 (24)	17.2 (17)	11.1 (11)	26.3 (26)	21.2 (21)
Staff receives refresher courses or ongoing training on the management of sexual assault and rape	16.2 (16)	21.2 (21)	16.2 (16)	24.2 (24)	22.2 (22)
Policies and guidelines on the management of sexual assault and rape are readily available	36.4 (36)	37.4 (37)	12.1 (12)	6.1 (6)	8.1 (8)
Female survivors of sexual assault and rape attended to by the health workers of the same sex (e.g. a male doctor only available) then another female health professional always present during the examination	22.2 (22)	14.1 (14)	19.2 (19)	16.2 (16)	28.3 (28)
Staff allocated in units rendering sexual assault services knowledgeable enough to provide quality care	20.2 (20)	33.3 (33)	18.2 (18)	13.1 (13)	15.2 (15)
Supplies for post exposure prophylaxis readily available	56.6 (56)	31.3 (31)	6.1 (6)	3.0 (3)	3.0 (3)
There is a good working relation between health providers, police, social workers and NGOs	29.3 (29)	42.4 (42)	12.1 (12)	8.1 (8)	8.1 (8)
The survivors of sexual assault treated as emergency without waiting in a queue	45.5 (45)	36.4 (36)	8.1 (8)	6.1 (6)	4.0 (4)
The health facility ongoing monitoring and evaluation of sexual assault and rape services	20.2 (20)	25.3 (25)	20.2 (20)	20.2 (20)	14.1 (14)

Only about 50.5% scored above the mean in the implementation of the sexual assault and rape policy and there were no significant differences between those that implemented and those who did not implement

4.4 ASSESMENT OF AVAILABILITY OF RESOURCES NEEDED FOR IMPLEMENTATION OF THE SEXUAL ASSAULT POLICY

Table 4.6 indicates the findings on the 22 items adapted from the WHO (2003:21-27) Guidelines for medico-legal care for survivors of sexual violence. The items on the checklist were divided into resources that are to be available in a unit serving survivors of sexual assault and rape and resources that are to be specifically located inside the examination room for easy access during treatment. Items from 1-7 on the checklist representing general resource items in the sexual assault unit and items 8-22 representing resources expected to be in the examination room to ensure quality health care. The researcher used an observation checklist having yes and no values to record the findings. Yes representing availability/presence of the resource and No representing unavailability/absence of the resource.

Percentages and frequencies were used to present the results for each item asked on the observation checklist. On items about availability of "private examination room", "toilet facilities", "examination couch", "examination disposable gloves", "sharps container" and "well identified waste bags" all health facilities scored 100%. Furthermore (83.3%) of the health facilities observed had a private room available for 24 hours, consent forms in the room, speculum, cupboard for storage of Post-Exposure Prophylaxis (PEP) treatment, swabs, sanitary pads and blood tubes available while only 50% of the health facilities had shower/bath facilities and hot water provided in the shower/bath facilities, a telephone in the examination room and patients gowns. More information can be found in table 4.5.

Table 4.5: Percentages and frequencies of resources in facilities

	Yes Percentage (frequency)	No Percentage (frequency)
Is there a private room for examination of survivors of rape?	100.0 (6)	
Is the private room available 24 hours?	83.3 (5)	16.7 (1)
Are there a shower /bath available to be used by the survivors of rape?	50.0 (3)	50.0 (3)
Is there a toilet facility close to the examination room?	100.0 (6)	
Is there hot water provided in the shower/bath facility?	50.0 (3)	50.0 (3)
Are protocols for handling survivors of rape in the room?	66.7 (4)	33.3 (2)
Are consent forms available in the room?	83.3 (5)	16.7 (1)
Is there an examination couch?	100.0 (6)	
Is there a working angle lamp?	66.7 (4)	33.3 (2)
Is there a colposcope?	33.3 (2)	66.7 (4)
Are there examination disposable gloves?	100.0 (6)	
Is there a speculum?	83.3 (5)	16.7 (1)
Is there a telephone?	50.0 (3)	50.0 (3)
Is there a lockable cupboard for storage of medico legal/forensic evidence?	33.3 (2)	66.7 (4)
Is there a drug cupboard for storage of pep treatment?	83.3 (5)	16.7 (1)
Are there emergency clothing for clients?	16.7 (1)	83.3 (5)
Is there sharps container?	100.0 (6)	
Are there swabs?	83.3 (5)	16.7 (1)
Are there patients' gowns?	50.0 (3)	50.0 (3)
Are there sanitary towels?	83.3 (5)	16.7 (1)
Are there well identified waste bag?	100.0 (6)	
Are there blood tubes?	83.3 (5)	16.7 (1)

**Numbers in brackets indicate frequency of institutions*

Table 4.6: The number of facilities complying with the checklist

Descriptive Statistics						
	N	Range	Min	Max	Mean	SD
Total facility score	6	11.00	24.00	35.00	28.1667	4.30891

Table 4.7 represents the observation scores per health facility. Facility C is a health complex made of two Health Care Centres (HCC), due to the distance between the two health facilities separate observation checklists were filled as both are offering the services and not only one delegated to do so. In the presentation of the results both facilities were reported separately but they are sharing the same code. The total possible facility observation score was 22. The facility that scored high was Facility A (20) with Facility B lowest scoring (9). The total general observation mean score was 5 (SD =.1.36) while the total examination room observation mean score was 10 (SD = 3.02). (See more information in table 4.9 as indicated.

Table 4.7: Observation scores per designated health facility

Facility	Total general observation score	Total examination room observation score	Total score per facility
Facility A	07	13	20
Facility B	03	06	9
Facility C	05	08	13
Facility E	6	13	19
Facility E	6	13	19
Facility F	5	10	15
Total possible facility observation score	07	15	22

Table 4.8: Total observation scores for all facilities

Descriptive Statistics					
	N	Min	Max	Mean	Std. Deviation
Total examination room	6	6.00	13.00	10.50	3.02
Total general	6	3.00	7.00	5.33	1.36

4.5 ASSESMENT OF HEALTH PROFESSIONALS KNOWLEDGE AND ATTITUDE TOWARDS THE REQUIREMENTS OF THE SEXUAL ASSAULT AND RAPE POLICY

Table 4.9 and 4.10 represent results on health professionals' attitudes when treating survivors of sexual assault and rape. The table reports on items 10-16 in the self-administered questionnaire. A 5 point Likert scale was used and results interpreted as in the assessment of the implementation of the sexual assault and rape policy point 4.3 above.

The results reveal that the vast majority (79%) disagreed with the statement that "sex workers cannot be raped with a mean score of 4 (SD = 1.29). Seventy one percent disagreed with the statement "a married woman cannot claim to be raped by her husband" scoring a mean of 3.77 (SD = 1.39). Furthermore, the mean for the statement "some women lie about rape to get attention was 3.03 (SD = 1.19) while the mean for the statement "a person rarely die from injuries of rape" was 2.59 (SD = 1.26) with 52% respondents agreeing to the statement. The total attitude mean score was 19.98 (SD = 4.59).

Table 4.9: Frequencies and percentages of health professional’s attitudes

Health professional's attitudes	1	2	3	4	5
A person rarely die from injuries of rape	21.7	31.1	17.9	17.9	8.5
Some women lie about rape to get attention	10.4	23.6	32.1	18.9	14.2
Rape can cause serious medical problems	52.4	36.2	5.7	1.0	4.8
If a person is drunk is impossible to say he/she didn't agree to sex	30.1	29.1	15.5	15.5	9.7
A married women cannot claim to be raped by her husband	14.3	4.8	10.5	30.5	40.0
Rape leaves obvious signs of injury	26.7	31.4	15.2	19.0	7.6
Sex workers cannot be raped	9.5	6.7	4.8	30.5	48.6

Table 4.10: Descriptive statistics of health professional’s attitudes

Descriptive Statistics						
	N	Range	Min	Max	Mean	SD
A person rarely die from injuries of rape	103	4.00	1.00	5.00	2.59	1.26
Some women lie about rape to get attention	105	4.00	1.00	5.00	3.03	1.19
Rape can cause serious medical problems	105	4.00	1.00	5.00	1.69	.98
If a person is drunk it is impossible to say he/she didn't agree to sex	103	4.00	1.00	5.00	2.46	1.33
A married women cannot claim to be raped by her husband	105	4.00	1.00	5.00	3.77	1.39
Rape leaves obvious signs of injury	105	4.00	1.00	5.00	2.49	1.28
Sex workers cannot be raped	105	4.00	1.00	5.00	4.02	1.29
Total attitude score	98	24.00	7	31	19.98	4.59

Table 4.10 indicates findings of items 17-24 in the self-administered questionnaire. The items were testing the level of knowledge of health professionals about procedural requirements pertaining to the implementation of the sexual assault policy. The values were yes and no and in presenting the findings yes will represent knowledgeable about what the policy advocate for and no will mean poor knowledge about what the policy advocates for.

The results revealed that an overwhelming majority of the respondents responded positively to seven (7) of the items reported in table 4.12 with a percentage score above 85% respectively. The item asking "if the rape survivor comes to the health facility, are they sent to the police station first before examination" had a score of yes (45.2%) and no (54.8%). More information embodied in table 4.11.

Table 4.11: Level of knowledge of health professionals pertaining to procedural requirements of the sexual assault and rape policy

Level of knowledge of health professionals	Yes	No
If the rape survivor come to the health care facility, are they send to the police station first before examination?	45.2	54.8
Are the police routinely called to come if the victim present at the health care facility first after rape?	88.5	11.5
Are survivors of rape routinely advised to test for HIV and AIDS?	95.2	4.8
Do you routinely recommend that a rape survivor have a full medico-legal examination to collect evidence whether they choose to report the rape to police or not?	89.1	10.9
Are the HIV/AIDS focused services provided to the survivors after rape?	87.3	12.7
Are pregnancy related services routinely offered to survivors after rape?	87.1	12.9
Are STI related services routinely offered to survivors of rape?	95.1	4.9
Are survivors of rape routinely referred for trauma/psychological counseling?	93.3	6.7

4.6 SUMMARY

The chapter assessed the level of sexual assault and rape policy implementation in the Ngaka Modiri Molema district in the NWP. The study revealed that there was no significant difference between those that implemented and those who did not implement the sexual assault and rape policy. A majority of the designated health facilities had the resources required to render sexual assault services. The findings further revealed that health professionals' attitudes mean scores were above average and that the majority of the health professionals were knowledgeable about the procedural requirements of the sexual assault policy to ensure a holistic care to survivors of sexual assault and rape.

CHAPTER FIVE

DISCUSSIONS, CONCLUSIONS, LIMITATIONS AND RECOMMENDATIONS

5.1 INTRODUCTION

This chapter will discuss the findings of the study and will make reference to relevant research studies to support the findings. The discussions will be aligned with the study objectives which are:

- To assess the extent of implementation of the sexual assault and rape policy in the designated health facilities;
- to assess the availability of resources needed for the implementation of the sexual assault policy in the designated health institution; and
- to describe health professionals knowledge and attitudes towards the requirements of the Sexual Assault and Rape Policy.

The base of the discussion will also take consideration of the ecological model of support which advocates for a multidisciplinary approach to ensure that the needs of rape survivors are dealt with holistically. The study design was quantitative and descriptive in order to quantify its variables and describe the level of implementation in the health facilities. Health professionals n=105 (nurses, doctors, social workers, unit managers and counselors) completed the questionnaires. The researcher completed an observation checklist for each designated health facility that was rendering sexual assault services. The SPSS version 18.0 was used to analyze the generated data. Recommendations were made to guide policy development, operations and further research.

5.2 DISCUSSIONS

5.2.1 Demographic and professional characteristics of respondents

The highest numbers of respondents were nurses at 71.4%, due to the fact that the South African (SA) health care system is dependent on nurses as like other African countries. Within the 71.4% of nurses that participated in the study only one nurse had forensic nursing training. This is a big gap especially in a highly specialized area like sexual assault care, taking into consideration the high rate of rape experienced in the country.

5.2.2 Implementation of the sexual assault policy

The study found that there was no significant difference with regard to the implementation of the sexual assault policy across health professional's categories.

About 73% of the health professionals agreed that the policies and guidelines on management of sexual assault and rape were readily available in their health facilities. This is a great improvement as compared to the findings by Christofides et al, (2003: 31) that indicated that one of the district managers reported that there were no protocols in the district and province. Also, health professionals reported that they couldn't use the guidelines as they were locked in the matrons office. It is important that the remaining 27% do make policies and guidelines readily available to ensure quality sexual assault services across the district. The study also revealed that 88% of health professionals indicated that supplies for PEP were readily available. This was important as survivors of rape are predisposed to HIV and AIDS according to Jina et al (2010: 2) as perpetrators rarely utilize condoms for protection. The national survey done by Christofides et al (2003: 15), indicate that NWP has the lowest proportion of facilities available for tests and treatments. Ngaka Modiri Molema district is centrally located and is where the departments provincial offices and referral hospital are located, whether that had an impact on the improvement within the district still need to be tested. PEP

remains an important component in the treatment of survivors of rape and it is important that 100% of all health facilities do have PEP in their units.

The WHO guidelines (2003:18) on Medico-legal care of survivors of sexual violence highlight that survivors of rape should be able to see a health care provider when they present at the health facility. The study results indicate that 82% of the health professionals treat survivors of sexual assault as emergencies when they arrive at the health facility. Though 46% of health professionals indicate that there is an ongoing monitoring and evaluation (M&E) of sexual assault services in their health facilities, more than 50% does not comply with the sexual assault policy (RSA DoH, 2005) that advocate for monitoring and evaluation as a tool to ensure quality of sexual assault services. The absence of M&E in health facilities may lead to standards and procedure like treating rape survivors as emergencies being compromised.

The Primary Health Care Package for South Africa- a set of norms and standards advocates in the document that health professionals allocated to render sexual assault services receive training in the identification and management of sexual, domestic and gender related violence. The study found that nearly half of the health professionals 41% as compared to 48%, who disagreed that health professionals undergo training before being allocated in the unit to treat survivors of sexual assault. This shows improvement as the findings of Christofides et al (2003: 31) where only 23.6% health providers were trained on management of sexual assault. The results also revealed that there is a correlation between training/ongoing training of health professionals as results indicated that only 37% compared to 46% say there is ongoing training for rape training in the facilities they work.

Training of personnel and continuous in-service training remain important to keep health professionals updated with developments in the field of expertise. The study indicates that only 41.4% of health professionals treating survivors of rape had undergone training while only 37.4% received ongoing training in the management of sexual

assault and rape. What this signifies is that health professional treating survivors of rape are not well prepared to deal with challenges they face on the ground. This is confirmed by the study showing only one nurse having qualifications in forensic nursing.

5.2.3 Availability of resources for implementation of the sexual assault policy

The study indicates that 100% of the health facilities have a private room and examination couch to examine survivors of rape. This shows an improvement compared to the finding by Christofides et al (2003:11) whose study indicated that only 81.8% facilities in NWP did have an examination room available 24 hours.

While the study indicated that 100% of the health facilities in the district had toilet facilities closer to the examination room to provide ablution services to the survivors of rape only 50% had a shower/bath and hot water to enable survivors of rape to wash after examination. The implication of not having bathing facilities for rape survivors is that it worsens the extend of trauma towards the patient. Rape is a violation of one's dignity as a women and remaining with the smell of the perpetrator is traumatic.

An angle lamp is critical in the examination of sexual assault survivors. The current study indicates that 66% of health facilities had a working angle lamp in their facilities. This was a decline compared to what was found by Christofides et al (2003:12) survey in the NWP where all health facilities had a working angle lamp. The majority of responses were from facility A, B and C, even though on inspection the angle lamp of facility C was reported to be out of order for some time. As most of the facilities were hospitals rather than PHCC and it raises questions of equity in allocation of resources in health facilities.

The study found that about 83.3% of the health facilities had examination speculums. From the 5 health facilities, facility A and B had speculums in the examination room while C, E and F shared with other units and indicated that there was a sterile speculum ready for use all the time.

It is a legal requirement to first obtain consent from a victim of rape before physical examination can be done. This is to ensure that survivors of rape have informed consent 83.3% of the health facilities had consent forms in their examination rooms with the exception of facility B where consent forms were at the nursing station and this is a regression as Christofides et al (2003:13) found that all NWP health facilities had consent forms in the examination rooms. This is important to ensure minimum movement by the health professional if everything needed for the care of the rape survivors is in the examination room. This will also prevent incidences where examination is done without consent.

The study further indicates that only 16.7% of the health facilities had emergency clothing in case the survivor's clothes are to be sent for forensic investigations. Facility A was the only facility that had emergency clothing, and they indicated that the clothes were donated. Lack of emergency clothing may be a possible barrier for not sending clothes for forensic investigation thus limiting the forensic expects adequate specimens to test.

All health facilities had disposable gloves, sharps containers and well identified waste bags in the examination room to ensure prevention of cross infection to the rape survivors and health professionals.

The study indicated that 83.3% of the health facilities had sanitary pads, swabs and a drug cupboard for storage of PEP treatment in the room.

5.2.4 Health professional's knowledge and attitudes towards the requirements of the Sexual Assault and Rape Policy

Being raped is a traumatic experience. When survivors of rape arrive at the health facility they have gone through a lot of trauma. It is important that health professionals are supportive and knowledgeable to provide quality care. In this section the health professional's knowledge and attitudes towards the requirements of the sexual assault policy was assessed.

The study demonstrated that an overwhelming majority of the health professionals (87%) indicated that rape can cause serious medical problems. This is supported by Christofides et al (2003:1) and Campbell (2002:1331).

A percentage of 32.1% were uncertain as to whether some women lie about rape to get attention. This was a concern as health professionals are not to be judgmental, but to take the survivors word. The implication of this is that one may find rape survivors that are not treated as emergency because health professionals feel that their testimonies may be false.

The majority of health professional (79%) disagree that sex workers cannot be raped. This is encouraging as usually sex workers are amongst the marginalized and vulnerable groups in society. If health professionals realise that they may fall victims to rape, then their right to health care can be assured. The mean score of 19.98 (SD: 4.59).

The study showed that health professionals were well knowledgeable about the procedural requirements of the policy as in 8 out of 9 items health professionals agreed with a percentage above 85%. This high percentage is disturbing as an earlier finding indicated a percentage less than 45% where there was no training at all before health professional were being allocated to work with survivors of rape nor any in-service training being offered at their particular health facilities.

In the section where health professionals were asked if they send survivors of rape to the police after reporting first at the health facility without being examined, 45.2% agreed and 54.8% disagreed. It is of concern if nearly half of the health facilities send the rape survivors first to the police because that's what the guidelines discourage. It is important that when clients enter health facilities that they are provided with care to reduce the trauma being sent from pillar to post. Systems must be in place to ensure that there is good liaison with other stakeholders in provision of care in this regard. A multidisciplinary approach to be adopted at all times to prevent secondary victimization (Tillman et al, 2010: 66). While this shows differences in the application of the policy, it is more on the compliance site.

A clear understanding of each victims ecological settings is important (Campbell et al, 209:225) as that will ensure that health professionals treat and manage sexual assault patients as unique based on their circumstances as advocated by the ecological model of the impact of sexual assault.

5.3 CONCLUSIONS

More than half of health professionals allocated in the sexual assault unit were not trained or updated as recommended by the norms and standards as only 48% comply. This is compromising the quality of services the health professionals are rendering as one needs to be well knowledgeable and skilled about the subject. In this study only one nurse had forensic training.

The policies and guidelines dealing with management of sexual assault were available (74%) to health professionals working in the sexual assault units whereas it is recommended that all health facilities should comply and ensure that health professionals know what is expected of them.

While the majority of health facilities (88%) reported to have PEP in their health facilities, it is important that 100% compliance is attained as PEP is very important in ensuring prevention of cross infection to the rape survivors.

The majority of health professionals (82%) were treating survivors of rape as emergencies when they are admitted in their facilities. This is encouraging as it means that rape is taken as a serious crime which may destroy the life of the victim if not attended to and given the support survivors need. It is also of the utmost importance that all health facilities should comply 100%.

There is good working relationships between police, social workers and NGO's (72%), thus ensuring that survivors of rape are treated holistically and that secondary trauma is prevented. This is very important as it may lead to more rape survivors disclosing and

accessing care (Tillman et al, 2010: 63). This is confirmed by the Ecological Model of the impact of sexual assault at the microsystem level where impact of disclosure at an informal level is encouraged and the meso/ecosystems processes contributing to linkages of different stakeholders. The working relations between stakeholders show that this model is of importance.

The attitudes of health professionals are generally very good as the mean score was 19.98 (SD: 4.59). Health professional attitudes are very important in delivering health care services as it can be a deterrent to health care access. Health professionals that empathize with their patients without being judgmental and providing support will encourage rape survivors to access care all the time as they will feel safe.

Physical examination is sometimes hampered by lack of instruments like colposcopy as these were only available at 33.3% of the health facilities. The implication of this is that health professionals have to improvise when rendering care, which might lead to omissions and commissions in their line of duty. Sometimes it may lead to contamination of the specimens. It is important that designated facilities are well equipped to be able to discharge their mandate without fail.

Forensic evidence sometimes compromised where clothes are also needed for investigation as only one facility had emergency clothing. This is a barrier as it limits the chance for prosecution of the perpetrator especially where variety of specimen is needed to exclude evidence.

Half of the health facilities did not have hot water (50%) in their units thus limiting the survivor of rape an opportunity to bath after examination. This increases the rate of infection to the rape survivors as there is usually abrasion that occurs during forced sex providing a good medium for cross infection and it also causes secondary trauma to the victim as they feel dirty after being raped.

5.4 LIMITATIONS OF THE STUDY

The study was limited to only one district in the NWP, thus the findings cannot be generalized.

5.5 RECOMMENDATIONS

Based on the results of the study the following recommendations are made:

5.5.1 Recommendations for professional development and nursing education

- Health facilities should ensure that pre-training is offered before health professionals are allocated in units rendering sexual assault services;
- Continuous training should be given on a regular basis to ensure that health professionals working in the sexual assault units have the skills and knowledge required to render services;
- Academic institutions in health sciences should integrate a curriculum on forensic health in their programmes to ensure that newly qualified health professionals have basic knowledge when they complete their programmes;
- Forensic medicine should be provided in at least one university in each province to ensure that the course is accessible to health professionals within the province to ensure adequate supply of qualified health professionals;
- Universities should introduce e-learning in order to make forensic medicine easily accessible to students in rural areas, and provision of preceptors should be provided to health professionals; and
- Continuous Professional Development (CPD) to be implemented to ascertain that health professionals are abreast in the field.

5.5.2 Recommendation for Nursing Management

- A multidisciplinary approach based on the ecological model of support should be followed when providing sexual assault services to encourage disclosure thus decreasing the number of cases lost in the system due to fear of secondary victimization;
- Inspections should be done by nurse managers and the South African Nursing Council (SANC) to ensure that designated health facilities comply with the requirements of the sexual assault policy;
- Newly qualified nurses should be allocated in sexual assault units in order to ascertain career path and continuity;
- One-Stop Centre's to be established to house sexual assault survivors that are from high risk settings like "children abused by their own family members" to ensure that they are in a protective environment while their cases are investigated. This is specifically for deep rural areas;
- Provision of emergency clothing should be made available to all designated health facilities to enable that survivors clothes are send for forensic investigations if the needed;
- Each designated health facility should be equipped with the basic necessary equipment in the examination room to ensure quality health care without compromising the forensic evidence;
- Provision of amenities such as telephones in the examination rooms where sexual assault cases are treated to avoid that survivors are being left alone, cannot be over-emphasized especially at facilities experiencing high staff shortages;
- Employment of counselors to work in units where sexual assault services are rendered to provide counseling and support is encouraged. This is important in rural areas where psychologists are not available; and
- Close collaboration with NGOs that fights for the rights of survivors is recommended.

5.5.3 Recommendations for further research

- This study should be conducted in a broader setting that includes all districts designated and referral clinics within the province. This will assess the level of implementation of the sexual assault policy.
- On-going research on sexual assault policy implementation will enable policy makers to update policy based on the changing needs in the field.
- Qualitative research should be done to get in-depth information on the experiences of health professionals providing sexual assault services.
- The psychological impact of sexual assault rates on health professional working in units providing sexual assault services should be researched. This will assess the health professionals' wellbeing dealing with large numbers of cases.

5.5.4 Recommendations for policy development

- SANC should develop training guidelines in forensic nursing to assist nursing education institutions that want to do training, and recognize forensic nursing;
- A policy should be developed that will ascertain the staffing ratios and level of education and skills required for one to work in the units providing sexual assault services to ensure that quality care is not compromised; and
- While the National Management Guidelines are clear about the required standards, there must be a policy that indicates to managers the basic health professionals' categories to be in place for effective care to take place.

5.6 SUMMARY

In this chapter the findings of the study were discussed. The objective of the study was to assess the implementation of the sexual assault policy, to assess the resources available in the health facilities and describe the health professional's knowledge and attitude with regard to rendering of sexual assault services. The study found that while

the implementation of the sexual assault was done, there were challenges of the services being provided by health professionals who were neither trained nor updated on regular basis in the field of forensic medicine. Recommendations were made which will address some of the challenges.

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NORTH WEST UNIVERSITY
YUNIBESITHI YA BOKONE-BOPHIRIMA
NOORDWES-UNIVERSITEIT
INSTITUTIONAL OFFICE

ETHICS APPROVAL OF PROJECT

This is to certify that the next project was approved by the NWU Ethics Committee:

Project title :

AN EVALUATION OF POLICY IMPLEMENTATION ON SEXUAL ASSAULT AND RAPE IN THE NGAKA
MODIRI MOLEMA DISTRICT

Student/Project leader: Prof.M Maselesele

Ethics number: NWU-00031-11-A9

Status: S = Submission; R = Re-Submission; P = Provisional Authorisation; A = Authorisation

Expiry date: 2016/05/30

The Ethics Committee would like to remain at your service as scientist and researcher, and wishes you well with your project.

Please do not hesitate to contact the Ethics Committee for any further enquiries or requests for assistance.

The formal ethics approval certificate will follow shortly.

Yours sincerely



health

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North West Province
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POLICY, PLANNING, RESEARCH, MONITORING AND EVALUATION

**To : Ms S.M Masemola
North West University**

From : Policy, Planning, Research, Monitoring & Evaluation

Subject: Research Approval on An Evaluation of Policy Implementation on Sexual Assault and Rape in the Ngaka Modiri Molema District.

The Subject matter above bears reference

Purpose

To inform your good selves that permission to undertake the above mentioned study has been granted by the North West Department of Health. The researcher is expected to issue this letter as prove that the Department has granted approval to the districts or health facilities that form part of the study.

Arrangements in advance with managers at district level or facilities shall be facilitated by the researcher and the department expects to receive the final research report upon completion.

Kindest regards

Director: Policy Planning, Research, Monitoring & Evaluation
Mr B Redlinghys

2/9/11

Date



Healthy Living for All



APPENDIX C (i): LETTER TO HEALTH CARE FACILITIES

P O BOX 1280

PRETORIA

0001

Dear Sir/Madam

REQUEST TO CONDUCT RESEARCH IN YOUR INSTITUTION

I hereby apply to conduct a research study for Masters in Nursing Administration at your institution. I am a student of University of North-West, Mafikeng Campus.

Research topic:

AN EVALUATION OF POLICY IMPLEMENTATION ON SEXUALASSAULT AND RAPE
IN THE NGAKA MODIRI MOLEMA DISTRICT

Aim of the study

The overall aim of this study is to assess policy implementation on sexual assault and rape across health facilities in the Ngaka Modiri Molema district.

Objectives

The specific objectives of the study are to:

- a. Assess the implementation of the sexual assault and rape policy in the designated health facilities;
- b. assess the availability of resources needed for the implementation of the sexual assault policy in the designated health institution; and to
- c. describe knowledge and attitude of health professionals towards the requirements of the Sexual Assault and Rape Policy.

Procedure

The study will consist of a questionnaire that the respondent has to complete and an observation checklist to assess the resources available to deliver quality health care services to the survivors of sexual assault. The participants will be asked to fill a consent form after reading and understanding this information leaflet. The dignity of the research participants will be respected and protected by upholding the rights to confidentiality, anonymity, informed consent and their right to withdraw from the study. There will be no risks or benefits for the participants. The dignity of the study participants will be respected and protected in this study by upholding their rights to confidentiality, anonymity, informed consent and their autonomy with their right to withdraw from the study at any time.

The study has been approved by all the relevant committees it has been submitted to at the North-West University (Mafikeng Campus). The copy of the proposal is also attached. My supervisor is Professor Mashudu Davhana-Maselesele, North-West University (Mafikeng Campus).

In case you have more questions you may contact me on 0825516041 and thank you for your anticipated cooperation and support.

A handwritten signature in black ink, consisting of stylized initials 'SM' followed by a horizontal line, all enclosed within a circular loop.

Ms Madithapo Salome Masemola

APPENDIX C (ii): LETTER TO HEALTH CARE FACILITIES

P O BOX 1280
PRETORIA
0001

Policy planning, Research Monitoring and Evaluation
North West Provincial department of Health
Private Bag 2068
MMABATHO
2735

Dear Sir/Madam

REQUEST TO CONDUCT RESEARCH IN YOUR INSTITUTION

I hereby apply to conduct a research study for Masters in Nursing Administration at your institution. I am a student of University of North West, Mafikeng Campus.

Research topic:

AN EVALUATION OF POLICY IMPLEMENTATION ON SEXUAL ASSUALT AND
RAPE IN THE NGAKA MODIRI MOLEMA DISTRICT

Aim of the study

The overall aim of this study is to assess policy implementation on sexual assault and rape across health facilities in the Ngaka Modiri Molema district.

Objectives

The specific objectives of the study are:

- To assess the implementation of the sexual assault and rape policy in the designated health facilities;

- to assess the availability of resources needed for the implementation of the sexual assault policy in the designated health institution; and
- to describe the knowledge and attitude to health workers towards the requirements of the Sexual Assault and Rape Policy.

Procedure

The study will consist of a questionnaire that the respondent has to complete and an observation checklist to assess the resources available to deliver quality health care services to the survivors of sexual assault. The participants will be asked to fill a consent form after reading and understanding this information leaflet. The dignity of the research participants will be respected and protected by upholding the rights to confidentiality, anonymity, informed consent and their right to withdraw from the study. There will be no risks or benefits for the participants. The dignity of the study participants will be respected and protected in this study by upholding their rights to confidentiality, anonymity, informed consent and their autonomy with their right to withdraw from the study at any time.

The study has been approved by all the relevant committees it has been submitted to at the North-West University (Mafikeng Campus). The copy of the proposal is also attached. My supervisor is Professor Mashudu Davhana-Maselesele.

Should you have more questions you may contact me on 0825516041 and thank you for your anticipated cooperation and support.



Ms Madithapo Salome Masemola

APPENDIX D: INFORMATION SHEET

North-West University, Mafikeng Campus

AN EVALUATION OF POLICY IMPLEMENTATION ON SEXUAL ASSAULT AND RAPE IN THE NGAKA MODIRI MOLEMA DISTRICT

Introduction

I Madithapo Masemola a student at the North-West University, Mafikeng Campus is doing a Masters degree in Nursing Administration. I would like to conduct a research on the state of the Sexual Assault and Rape Policy implementation in the Ngaka Modiri Molema District in the North-West Province.

Aim of the study

The overall aim of this study is to assess policy implementation on sexual assault and rape across health facilities in the Ngaka Modiri Molema district.

Objectives

The specific objectives of the study are:

1. To assess the implementation of the sexual assault and rape policy in the designated health facilities;
2. to assess the availability of resources needed for the implementation of the sexual assault policy in the designated health institution; and
3. to describe knowledge and attitude of health professionals towards the requirements of the Sexual Assault and Rape Policy.

Procedure

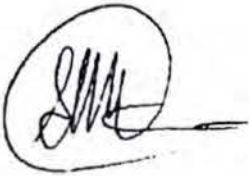
The study will consist of a questionnaire that the respondent has to complete and an observation checklist to assess the resources available to deliver quality health care services to the survivors of sexual assault. The participants will be asked to complete a consent form after reading and understanding this information leaflet. The dignity of the research participants will be respected and protected by upholding the rights to

confidentiality, anonymity, informed consent and their right to withdraw from the study. There will be no risks or benefits for the participants.

Right to withdraw

Your participation in this study is voluntary. If at any time you do not want to answer an interview question you can skip it. You have the right to withdraw from the study at any time.

Contact numbers: The study has received approval from the ethics committee of the North-West University, Mafikeng Campus. In case of any questions and clarity I can be contacted at 0825516041.

A handwritten signature in black ink, consisting of stylized initials 'SM' followed by a horizontal line, all enclosed within a circular loop.

Ms Madithapo Salome Masemola

APPENDIX E: CONSENT FORM

North-West University, Mafikeng Campus

AN EVALUATION OF POLICY IMPLEMENTATION ON SEXUAL ASSAULT AND RAPE IN THE NGAKA MODIRI MOLEMA DISTRICT

I confirm that I am participating willingly in this study. The purpose, procedure, risks, benefits of the study have been explained to me. I am aware that the results of the study including my personal details will be anonymously processed to research reports. I have had the time to ask questions and have no objection in participating in the study. I understand that should I wish to discontinue with the study, my withdrawal will not affect me in anyway.

Respondents Signature:

Date:

APPENDIX F: OBSERVATION FACILITY CHECKLIST

AN EVALUATION OF POLICY IMPLEMENTATION ON SEXUAL ASSAULT AND RAPE IN THE NGAKA MODIRI MOLEMA DISTRICT

GENERAL	COMPLIANCE	
	YES	NO
1. Is there a private room for examination of survivors of rape?		
2. Is the private room available 24 hours?		
3. Is there a shower/bath available to be used by the survivors of rape?		
4. Is there a toilet facility close to the examination room?		
5. Is there hot water provided in the shower/bath facility?		
6. Are protocols for handling survivors of rape in the room?		
7. Are consent forms available in the room?		
IN THE EXAMINATION ROOM		
8. Is there an examination couch?		
9. Is there a working angle lamp?		
10. Is there a colposcope?		
11. Are there examination disposable glove?		
12. Is there a speculum?		
13. Is there a telephone?		
14. Is there a lockable cupboard for storage of medico legal/forensic evidence?		
15. Is there a drug cupboard for storage of PEP treatment?		
16. Are there emergency clothing for clients?		
17. Is there sharps container?		
18. Are there swabs?		
19. Are there patients' gowns?		
20. Are there sanitary towels?		
21. Are there well identified waste bags?		
22. Are there blood tubes?		

APPENDIX G: QUESTIONNAIRES

This questionnaire has 5 pages

For office use:

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RESEARCHER : M S MASEMOLA

Dear Participant

I am Madithapo Salome Masemola, and a student of North-West University, Mafikeng Campus undertaking a Masters degree in Nursing Administration. I am in the process of data collection for the fulfillment of dissertation entitled, "AN EVALUATION OF POLICY IMPLEMENTATION ON SEXUAL ASSAULT AND RAPE IN THE NGAKA MODIRI MOLEMA DISTRICT". You have been identified as a potential participant in this study. The study will assist the Department of Health nursing to improve service delivery in the care of sexual assault survivors.

Your rights as a participant, is that your name/ identity will not be reflected anywhere. Anonymity and confidentiality regarding your responses will be maintained. It is also important to note that you are not obliged to participate in this study. It is voluntary.

INSTRUCTIONS

- Kindly mark your answer in the appropriate space with an X.
- Please answer each question as truthfully as possible. There is no right or wrong answers.
- All answers will be treated confidentially.
- This will take forty five minutes (45) to complete.

Thank you for your co-operation

EXAMPLE

How many years have you been working in the health facility?

1-5 years	
6-10 years	X
11-15 years	
16-20 years	

If you have been in the health facility for 7 years, then mark the line '6-10 years' with an X

SECTION A: BIOGRAPHICAL DATA OF RESPONDENT

1. AGE IN YEARS

OFFICE

.25-30	
.31-35	
36-40	
.41-45	
.46-50	
.51-55	
.56-60	
.61+	

USE

1	
2	
3	
4	
5	
6	
7	
8	

2. GENDER

1.Male	
2.Female	

1	
2	

3. HOME LANGUAGE

1.Afrikaans		1	
2.English		2	
3.Tswana		3	
4.Xhosa		4	
5.Other – Please Specify		5	

4. POPULATION GROUP

1.African		6	
2.Coloured		7	
3.Indian/Asian		8	
4.White		9	
5.Other- Please Specify		10	

5. CATEGORY

1.Doctor		11	
2. Nurse		12	
3. Forensic Nurse		13	
4. Gynecologist		14	
5. Psychologist		15	
6.Social Worker		16	
7. Unit Manager		17	
8. Other- Please Specify		18	

6. IN WHICH HEALTH FACILITY ARE YOU WORKING

1. Thuthuzela Care Centre/Mafikeng Hospital		19	
2. Lehurutse/Zeerust Hospital Complex		20	
3. Thusong/General De Larey Hospital Complex		21	

4. Delareyville Community Health Care Centre		22	
5. Ottosdal/Sannieshof Community Health Care Centre		23	
6. Ratlou Community Health Care Centre		24	

SECTION B

I am conducting a research **to assess the implementation of the sexual assault and rape policy**. No personal feedback will be given to any individual nor will any individual be discussed with your supervisor. Responses to items in this questionnaire relates to your evaluation of sexual assault services in the health facility. Please ensure that you keep this in mind when responding to the items.

Please judge how often each statement fits your answer. If you are unsure or do not know, leave the answer blank.

Please use the following rating scale:

1=Strongly Agree (SA) 2=Agree (A) 3=Uncertain(U) 4=Disagree
(D)5=Strongly Disagree (SD)

IMPLEMENTATION OF THE SEXUAL ASSAULT POLICY	SA	A	U	D	SD		
1. Health professionals undergo training before being allocated in unit to manage survivors of sexual assault and rape	1	2	3	4	5	25	
2. Staff receives refresher courses or ongoing training on the management of sexual assault and rape	1	2	3	4	5	26	

3. Policies and guidelines on management of sexual assault and rape readily available.	1	2	3	4	5	27	
4. Female survivors of sexual assault and rape attended to by health workers of the same sex(e.g. a male doctor only available) then another female health professional always present during the examination	1	2	3	4	5	28	
5. Staff allocated in units rendering sexual assault services knowledgeable enough to provide quality care	1	2	3	4	5	29	
6. Supplies for Post-exposure prophylaxis readily available	1	2	3	4	5	30	
7. There is a good working relation between health providers, police, social workers and NGOs.	1	2	3	4	5	31	
8. The survivors of sexual assault treated as emergency without waiting in the queue	1	2	3	4	5	32	
9. The health facility ongoing monitoring and evaluation of sexual assault and rape services	1	2	3	4	5	33	

ATTITUDE

10. A person rarely die from injuries of rape	1	2	3	4	5	34	
11. Some women lie about rape to get attention	1	2	3	4	5	35	
12. Rape can cause serious medical problems	1	2	3	4	5	36	
13. If a person is drunk is impossible to say he/she didn't agree to sex	1	2	3	4	5	37	

14. A married women cannot claim to be raped by her husband	1	2	3	4	5	38	
15. Rape leaves obvious signs of injury	1	2	3	4	5	39	
16. Sex workers cannot be raped	1	2	3	4	5	40	

	YES	NO	
17. If the rape survivor come to the health care facility, are they send to the police station first before examination?			41
18. Are the police routinely called to come if the victim present at the health facility first after rape?			42
19. Are survivors of rape routinely advised to test for HIV and AIDS?			43
20. Do you routinely recommend that a rape survivor have a full medico-legal examination to collect evidence whether they choose to report the rape to the police or not?			44
21. Are HIV/AIDS focused services provided to survivors after rape?			45
22. Are pregnancy related services routinely offered to survivors after rape?			46
23. Are STI related services routinely offered to survivors of rape?			47
24. Are survivors of rape routinely referred for trauma/psychological counselling?			48

APPENDIX H: CODE LIST FOR HEALTH FACILITIES

AN EVALUATION OF POLICY IMPLEMENTATION ON SEXUAL ASSAULT AND RAPE IN THE NGAKA MODIRI MOLEMA DISTRICT

The following codes were given to the health facilities for ethical reasons.

Health Facility Name	Code Name
Mafikeng Hospital/Thuthuzela Care Centre	Facility A
Lehurutse/Zeerust Hospital Complex	Facility B
Thusong/ General De Larey Hospital Complex	Facility C
Delareyville Community Health Care centre	Facility D
Ottosdal/Sannieshof Community Health Care Centre	Facility E
Ratlou Community Health Care Centre	Facility F
Montshioa Town clinic	Facility G
Magogoe clinic	Facility H
Dinokana clinic	Facility I
Montshioa Stadt clinic	Facility J
Setlopo clinic	Facility K
Lekubu clinic	Facility L
Tsetse clinic	Facility M
Mokgalo clinic	Facility N
Tshunyane clinic	Facility O

CERTIFICATE OF LANGUAGE EDITING

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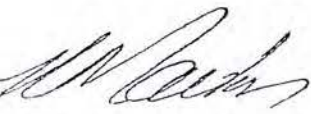
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