

An in-depth investigation of experiences of sexual assault and factors that determine non-adherence to Post Exposure Prophylaxis (PEP) after sexual assault in a sample of raped women survivors attending a public health clinic in the Eastern Cape

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DECLARATION

I hereby declare that this thesis is my own work and effort, and that it has not been submitted anywhere for an award or degree. Where other sources of information have been used, they have been acknowledged.

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Signature..... Date.....

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ABSTRACT

Prevention of HIV following sexual assault is an important aspect of rape care. This includes taking Post Exposure Prophylaxis for 28 days. The present study aimed to provide an in-depth understanding of social and environmental factors that predisposed, promoted and also served as barriers to adherence to post exposure prophylaxis to prevent HIV infection after sexual assault in women in the Eastern Cape Province. The study involved a purposive sample of women who were offered Post Exposure Prophylaxis (PEP) after a sexual assault. Sixteen women were accessed at the Sinawe Referral Centre and participated in the study. Their ages ranged from 16 to 73 years. An interview guide was developed to assist the researcher, and semi-structured, in-depth interviews were used to collect data. These women were interviewed at the end of 28 days of taking the prophylactic medication. The data were analyzed inductively using grounded theory. Only three women completed the 28 days of PEP treatment. Participants gave different explanations for why they did not complete the treatment with only four participants returning to the centre for their medication. Some reported having no money for transport; others mentioned deciding to discontinue the medication because of its side-effects. Poor support systems, both within the community and the health services, including the provision of conflicting information also played a role. The study showed that few women were able to complete their PEP medication and knowledge about the service and access to it were the main factors that lead to non-adherence. There is an urgent need for the improvement of PEP services particular in the support to the women during the period of taking the PEP treatment to ensure protection from HIV after a sexual assault.

Keywords: *rape, sexual assault, HIV/AIDS, post exposure prophylaxis, adherence, prevention, South Africa, SAPS, and Department of Health.*

List of abbreviations

SAPS	South African Police Services
DoH	Department of Health
PEP	Post Exposure Prophylaxis
ARV	Antiretroviral
3TC	Lamivudine
AZT	Zidovudine
AIDS	Acquired Immune Deficiency Syndrome
HIV	Human Immunodeficiency Virus
WHO	World Health Organization
POWA	People Opposing Women Abuse
NGO	Non-governmental organization
STI	Sexually Transmitted Infections
UNAIDS	Joint United Nations Programme on HIV/AIDS
SSA	Statistics South Africa
PTSD	Post Traumatic Stress Disorder
RTS	Rape Trauma Syndrome

Table of Contents

Declaration
Acknowledgements
Abstract
List of Abbreviations

Chapter 1: Introduction and motivation for conducting the research

1.1 Definition of terms

Chapter 2: Literature review

Introduction

2.1 Rape in South Africa

2.1.1 Magnitude of rape in South Africa

2.1.2 Factors increasing women's vulnerability to rape

2.1.3 Factors influencing non-reporting of sexual assault incidents

2.2 Sexual Offences legislation

2.3 Human rights and medical care for survivors of rape

2.4 The health consequences of rape for women

2.4.1 Post Traumatic Stress Disorder

2.4.2 Rape trauma syndrome

2.4.3 HIV infection

2.5 Antiretroviral therapy in South Africa

2.6. Post Exposure Prophylaxis (PEP)

2.6.1 Adherence to Post Exposure Prophylaxis

2.7 Rape services in South Africa

2.7.1 Management guidelines for sexual assault clients

2.7.2 The role of the police

2.7.3 Counselling and information

2.8 Follow-up care

2.9 Theoretical framework

2.10 Aims of the research

2.11 Specific objectives

Chapter 3: Research methodology

- 3.1 Research design
- 3.2 Study population
- 3.3 Research site
- 3.4 Sampling technique
 - 3.4.1 Sample size
- 3.5 Recruitment procedures
- 3.6 Exclusion criteria
- 3.7 Data collection
- 3.8 Ethical considerations
- 3.9 Data analysis
- 3.10 Trustworthiness

Chapter 4: Results

- 4.1 The Rape
 - 4.1.1 The Sample
 - 4.1.2 The rape incident
- 4.2 Encounters with the police
- 4.3 Talking about the perpetrators
- 4.4 What happened at Sinawe Referral Centre
 - 4.4.1 Provision of information
- 4.5 Talking about PEP
 - 4.5.1 Experiences of side-effects
- 4.6 Adherence to Post Exposure Prophylaxis
- 4.7 Health concerns
- 4.8 Community responses
 - 4.8.1 Being blamed
 - 4.8.2 Reporting to the headman
 - 4.8.3 Families and friends
 - 4.8.4 Spouse's response to rape perpetration

Chapter 5: Discussion

- 5.1 Adherence to PEP
- 5.2 PEP services
 - 5.2.1 Police
 - 5.2.2 Health
- 5.3 Psycho-social affects
- 5.4 Socio-economic factors
- 5.5 Lack of knowledge
- 5.6 Reflexivity
- 5.7 Conclusion
- 5.8 Recommendations

References

List of Tables

Page

Table 1: PEP medication

Table 2: Grounded theory approach

Table 3: Themes that emerged from the collected data

Table 4: Sample description

Appendices

APPENDIX	A	Information sheet
APPENDIX	B	Consent form
APPENDIX	C	Interview guide
APPENDIX	D	Interview

Chapter 1

Introduction and motivation for conducting the research

Sexual assault and HIV are two of the most serious public health problems in South Africa. Numerous studies have shown that the health consequences of rape are extensive and includes physical, psychological and mental health problems (World Health Organization report, 2000 & UNAIDS, 2002). Of greatest concern is the possible transmission of HIV after a rape incident (Kim, 2003) given the rapidly escalating HIV/AIDS epidemic in South Africa (UNAIDS 2006).

Rape is a traumatic event that could render the person powerless in the same way as other traumatic events such as the loss of a loved one or being disabled in a car accident (Hansson, 1992). The psychological consequences following traumatic events have been well documented as Post Traumatic Stress Disorder (PTSD) (Faravelli, *et al.*, 2004 & Felitti, *et al.* 1998) and include symptoms such as fear, insomnia, lack of appetite, difficulty in concentrating, apathy, depression, impotence, low feeling of self worth, suicidal tendencies, and alcohol and drug abuse. Rape survivors experience similar psychological symptoms and this has been identified as Rape Trauma Syndrome (RTS) (Faravelli, *et al.*, 2004).

South Africa Police (SAPS) crime statistics for the period April 2005 to March 2006 showed that some 54 900 rapes were reported to the police (Crime Information Management, 2006). Of the rapes reported, the Eastern Cape Province had the third highest total reported rapes of all the nine provinces with 7 405 reported rapes. This is the tip of the iceberg since most survivors of rape prefer not to report the rape or they prefer not to attend health services. Research has found huge differences between the number of sexual violence cases reported to the police and the number reported in research studies. Jewkes and Abrahams (2003) reported a nine-fold difference in 2002, while, a national crime survey conducted by Statistics South Africa (SSA) found that one out of two rape survivors reported the matter to the police (SSA, 2000). Many survivors of rape are therefore not able to access services to assist them in the process of healing or to prevent transmission of HIV after a rape.

There has been growing interest regarding the provision of Post Exposure Prophylaxis (PEP) to reduce the risk of HIV transmission following sexual assault internationally and locally. This interest has evolved in the light of scientific evidence that such drugs can be both safe and effective. This has been proven to be effective following occupational exposure such as needle stick injuries to health care workers (Kim, 2003). In the light of the available evidence, in April 2002, the South Africa government announced the rolling out of Post Exposure Prophylaxis (PEP) treatment for survivors of sexual assault (Human Rights Watch, 2004). A few services in both the private and public health services had been providing PEP as part of their sexual assault services but this was dependent on available resources. The Western Cape province and Gauteng province have progressed the most in providing PEP in many of their health services and this is mainly because non-governmental organizations (NGOs) in these provinces were very supportive in the establishment of such services (Kistner, 2003). In 2005 the Department of Health finalized a sexual assault policy and this was to ensure comprehensive sexual assault care of which provision of PEP to prevent HIV prevention is one aspect of post-rape care (National Management Guidelines for Sexual Assault Care, 2004).

However, there have been many accounts of poor compliance to PEP (Christofides, *et al.*, 2004; Meel, 2005; Vetten & Haffejee, 2004) and in the Western Cape two separate studies reported that only 15% of patients completed their PEP (Mugabo 2005; Christofides, *et al.*, 2006). A study conducted in 2004/2005 by the Study of Violence and Reconciliation on adherence for PEP after sexual assault found that patients defaulted due to various reasons including: experiences of side-effects of the PEP drugs; forgetting the medication and not taking PEP in a right way. They also discovered that some health workers were not sufficiently trained on PEP and did not spend sufficient time on providing information to patients (Vetten & Haffejee, 2004). However, these results cannot be generalized because the research was done in specific settings.

Even lower rates of adherence have been reported in the Eastern Cape. At the Sinawe Referral Centre in Mthatha, Meel reported adherence as low as 3% (Meel, 2005). This centre is one of a few services in the Eastern Cape. It serves a large, rural area in the

Mthatha region and patients travel long distances to access the service. It is thus critical to explore the problem of adherence to PEP in the Eastern Cape. The Gender and Health Unit of the Medical Research Council was funded by the Department of Health (DoH) to conduct research on stigma of rape and HIV in the Western Cape Province. The aim of this broader study is to understand stigma of HIV and rape, and how that influences adherence to PEP. Given the low rate of compliance at the Sinawe Centre in the Eastern Cape, it was decided to extend the study to this region and to conduct a similar study exploring the factors that determine adherence amongst a sample of women who attend the Sinawe Referral Centre.

The findings from the study will be communicated to the sexual assault services at the Sinawe Centre, participants of the study and the Department of Health in the Eastern Cape. It is hoped that the research findings will assist in the development of health promotion strategies to improve adherence to PEP after sexual assault.

1.2 Definition of terms

Sexual assault: Sexual assault encompasses a range of acts involving unlawful or unconsented sexual penetration or attempts at penetration. This includes circumstances in which there is sexual penetration to any extent whatsoever, by any object or part of the body of one person into the genital organs, anus or mouth of another person (Sexual Assault Policy, 2004). This is also referred to as rape. This study will only focus on women who were sexually assaulted by men, where the penetration of penis to the vagina was performed without consent. The terms rape and sexual assault are used interchangeably in this thesis.

Post Exposure Prophylaxis (PEP): is an aspect of the comprehensive management of sexual assault survivors. The medical role of PEP is to reduce the risk of HIV infection after forced sexual contact by means of administering Antiretroviral (ARV) drugs after the rape incidence. The ARVs for PEP are only effective if given within 72 hours of the incident and taken for 28 days. In addition to the medical aspect, provision of PEP should include counseling on:

- Immediate and long-term effects of the trauma.
- Sexual transmitted infections.

- Unplanned and unwanted pregnancies (Antiretroviral Guidelines, 2004).

Trauma: trauma can be defined as an event that overwhelms the individual's coping skills. Traumatic situations are those situations in which the person is powerless and is in danger and includes events involving death and injury or the possibility of death or injury. It also includes both catastrophes and man-made violence (Matsakis, 1992). In this research the term trauma is used to describe the victim's experiences following sexual assault.

Rape Trauma Syndrome: This syndrome is not a type of mental disorder but rather a series of stages many (but not all) rape survivors experience. It is a cluster of emotional responses to extreme stress experienced by the survivor after the sexual assault and can occur in two phases, i.e. acute (initial) and the reorganization phases (Hansson, 1992).

Forensic examination: This is an examination conducted by authorized medical practitioner with the main purpose of collecting evidence from the rape survivor, which can be used to investigate the crime of rape and to provide evidence in the court process.

Chapter 2

Literature review

Introduction

This chapter will present and discuss the existing literature on the context and the magnitude of rape in South Africa including factors increasing women's vulnerability, factors influencing non-reporting of rape and the consequences of rape for women. Furthermore, the HIV/AIDS epidemic will be discussed and the role of antiretrovirals, and Post Exposure Prophylaxis (PEP).

PEP following sexual assault is a comprehensive intervention that requires commitment from government departments. In South Africa different models of rape services exist but the Department of Health is the leader (National Management Guidelines for Sexual Assault Care (2004) and works closely with the South African Police Services and the Department of Justice. The Thuthuzela Centres are one of the models of care and these are one-stop service centres for sexual assault victims that have been initiated by the Department of Justice. Currently more than six Thuthuzela Centres operate in the country but this thesis will not elaborate on these centres and will mainly concentrate on the two government departments, the Department of Health and South African Police Services with a bigger focus on the policies, norms and practices of handling sexual assault survivors by the Department of Health. This thesis will also discuss some aspects of the law in relation to PEP following sexual assault where it is relevant including the sexual offence legislation and the medical care of rape survivors in terms of a human rights approach. Finally, I will discuss the theoretical paradigm in which I have located my research study.

2.1 Rape in South Africa

2.1.1 Magnitude of rape in South Africa

Sexual assault in women and in girls is a problem of epidemic proportions in South Africa. Although men can also be raped, the majority of cases are women and girls who are most vulnerable to be raped by male perpetrators. According to SAPS crime

statistics for the period April 2005 to March 2006, some 54 900 rapes were reported to the police (Information management 2006). Of the rapes reported, the Eastern Cape Province had the third highest total reported rapes of all the nine provinces with 7 405 reported rapes.

However, this is only a proportion of the real number of rapes. Household surveys have presented another method of obtaining information on the extent of sexual violence and have found huge differences between the number of sexual violence cases reported to the police and the number reported in research studies. There have been three major surveys of violence against women conducted in different provinces of South Africa that have asked about the experiences of rape. The Three Province study of violence against women by the Medical Research Council of South Africa which included the following provinces, Mpumalanga, Eastern Cape and Limpopo, found that one in nine victims reported the rape (Jewkes, Penn-Kekana, Ratsaka & Schreiber, 2001). The South African Demographic & Health Survey (Department of Health 1998) found a national prevalence figure for rape of 7% with a range of 3-12% between the provinces, while the National Victims of Crime Survey found that one out of two rape survivors reported the rape to the police (Statistics South Africa, 2000). The researchers suggest that reported cases are the tip of the iceberg of sexual assaults in the country (Jewkes, *et al.*, 2002).

Rape statistics can also be gathered from other studies in the Eastern Cape. A study conducted at Mthatha and surrounding districts among a total sample of 1429 young men and women aged 16 to 25 years found that sexual violence was highly prevalent. The community randomized trial that tested a gender-based violence prevention intervention for HIV found one in twenty of the women reported having been raped by a man who was not her boyfriend and one in five had experienced attempted rape. (Jewkes, *et al.*, 2006).

It is also further estimated in South Africa that about one in six women who have been raped will attend health services (Jewkes & Abrahams, 2003). This gap is concerning as women who have been raped have specific needs such as psychological support, prevention of sexual transmitted infections including HIV and management of injuries (WHO, 2003).

2.1.2 Factors increasing women's vulnerability to rape

Certain groups of women have been identified as being more vulnerable to rape than others and their vulnerability increases if more factors are present (National Sexual Assault Policy 2004). These factors include:

- Being young.
- Using alcohol or drugs.
- Having mental health problems.
- Being in an intimate relationship, especially one characterized by physical and emotional violence.
- Poverty, particularly influencing lack of access to private vehicles, less-secure housing, the need to collect water and firewood, and vulnerability to risk taking when looking for employment.
- Having previously been raped or sexually abused and not having had an opportunity to deal with the vulnerability factors underlying that assault (UNAIDS 2000).

2.1.3 Factors influencing non-reporting of sexual assault incidents

According to Jewkes, *et al.*, (2002) barriers to reporting the rape cases include not being believed, difficulties with physical access, fear of the examination, fear of being blamed, fear of retaliation by the perpetrator, and fear of the legal processes, including experiencing rudeness and poor treatment from health workers. In addition, many women do not go to the police as they believe that police do not perform their function and, in many cases, the perpetrators will be not be punished at all. In a study based in Johannesburg it was found that there is only a one in 13 chance of seeing a rapist jailed (CIAC, 1997).

Survivor-related factors (Jewkes, Sen & Garcia-Mereno, 2002)

- Narrating the traumatic experience repeatedly to different people.
- Fear of not being believed.
- Fear of being blamed.
- Fear of stigmatization.

- Fear of the physical examination.
- Fear of the HIV test.
- Mental and socio-economic status of the victim.

Service-related factors (Jewkes, Sen & Garcia-Mereno, 2002)

- Inaccessibility of police and health services.
- Unpleasant attitude of the service providers.
- Lengthy legal processes.
- Fear of humiliation and ill treatment during court proceedings.

Perpetrator-related factors (Jewkes, Sen & Garcia-Mereno, 2002)

- Dependency for care on the perpetrator.
- Social reputation of the perpetrator.
- Mental status of the perpetrator.
- Date or marital relations.
- Fear of retaliation by the perpetrator.

Community or family-related factors (Jewkes, Sen & Garcia-Mereno, 2002)

- Lack of empowerment about personal rights, options and service availability.
- Fear of family disorganization.
- Fear of stigmatization.

2.2. Sexual Offences Legislation

Historically, sexual crimes in South Africa were prosecuted under the common law which is based on Roman-Dutch principles. The sexual crimes prosecuted under common law included rape, sodomy, bestiality, incest, public indecency and indecent assault. For perpetrators to be prosecuted, the South African courts rely heavily on medico-legal evidence. The South African Police Services and the Criminal Justice system recognize the importance of medico-legal evidence. More recently, to improve the collection of evidence, a new sexual assault kit was introduced and all evidence undergoes DNA analysis (National Management guidelines for Sexual Assault Care, 2004).

South Africa has finalized its Sexual Offences Bill. This bill affirms South Africa's obligations towards the eradication of violence against women and children in terms of several international legal conventions and covenants ratified by the country. It

emphasizes that the high incidence of sexual offences in the country has a particularly disadvantageous effect on vulnerable persons, and that women and children are vulnerable to sexual assault. The bill has come into effect soon and it recommends far-reaching changes to the definition of rape. It is thought that these changes will have an impact on services including the uptake of post exposure prophylaxis (Criminal Law Sexual Offences Bill, 2006).

2.3 Human rights and medical care for survivors of rape

According to the Clinical Management of Rape Survivors (2005) as it was mentioned earlier in the literature, rape forms part of sexual violence, which is a public health problem and a human rights violation. These guidelines state that government has a legal obligation to take all appropriate measures to prevent sexual violence and ensure that quality health services equipped to respond to sexual violence are available and accessible. Under these guidelines health workers are expected to respect the following human rights of the people who have been raped.

The right to health: Rape survivors (including survivors of other forms of sexual abuse) have the right to receive good quality health services such as reproductive health including pregnancy and STI care and to manage the psychological consequences of the abuse. However, the public health system in the country is designed in a way that survivors have to take responsibility for seeking medical help. In many cases, especially in rural settings, services like Post Exposure Prophylaxis after sexual assault are not known. Moreover, the survivors who seek medical care should not in anyway be 're-victimized' by the health workers.

The right to human dignity: In the context of health services, this means providing access to quality medical care, including privacy and confidentiality of medical records. It is emphasized that obtaining consent to use patient information should be obtained and for effective interaction, it is recommended that health service be delivered in the survivor's mother tongue.

The right to non-discrimination: This relates to the government policies and practices related to access to services. It is stated that the policies regarding access to health

care should not discriminate against a person who has been raped regardless of their race, colour, national or social origin.

The right to self-determination: For the survivors of rape to make informed decisions, it is essential that they receive adequate information about the service and health providers are expected to respect the choices made by the survivors. It is also recommended that providers should not force or pressure survivors to have examinations or treatment against their will. The decision about receiving health care and treatment is the survivor's choice as long as the health provider has given adequate information.

The right to information: The survivors of rape have the right to appropriate information. It is recommended that the information should be provided depending on the survivor's needs. i.e. when a woman of childbearing age is raped, the health care provider should discuss the available options legally available to her. Examples include abortion services, keeping the child and adoption services.

The right to privacy: Health providers should create conditions that ensure privacy for people who have been raped. It is further recommended that during the examination and medical treatment people who are involved in delivering the service should be present and the person who is accompanying the victim. No other person should be in the room during the process.

The right to confidentiality: the right to confidentiality includes several things. Firstly, the medical records of the survivors are to be kept in a safe place; secondly, the health status of the survivor is to be kept confidential even from family members. It is recommended that health workers may only disclose information about the survivor when necessary to people who are involved in the medical examination and treatment or with consent from the survivor.

2.4 The health consequences of rape for women

Studies have shown that the health consequences of rape are extensive and they include physical, psychological and social health problems (World Health Organization Report, 2000). These consequences vary from individual to individual and will not be experienced by all in the same way.

According to a WHO report (2000) these health consequences include physical injuries and sexual transmitted infections including HIV/AIDS, and mental health consequences that can include immediate as well as long-term consequences. Hannson, (1992) states that among the social and economical consequences identified are unwanted pregnancies, relationship problems, and stigma of the rape, social isolation and communication problems in the family.

Hannson, (1992) further argues that rape is a traumatic event that could render the person powerless in the same way as other traumatic events such as the loss of a loved one or being disabled in a car accident. The psychological consequences following traumatic events have been well documented as Post Traumatic Stress Disorder (PTSD) (Faravelli, *et al.*, 2004 & Felitti, *et al.*, 1998) and includes symptoms such as fear, insomnia, lack of appetite, difficulty in concentrating, apathy, depression, impotence, low feelings of self worth, suicidal tendencies and alcohol and drug abuse.

2.4.1 Post Traumatic Stress Disorder

Post Traumatic Stress Disorder (PTSD) is a diagnostic category used to describe symptoms arising from emotionally traumatic experiences. According to the *Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition or DSM-IV (American Psychiatric Association, 1996; cited By Hamber & Lewis 1997) the disorder presumes that the person has experienced a traumatic event involving actual or threatened death or injury to themselves or others, where they felt fear, helplessness or horror. Three main symptom clusters have been identified in PTSD. Firstly, the intrusive cluster that involves the following intrusions; unwanted and uncontrollable thoughts of trauma, nightmares and flashbacks. Secondly, the avoidance cluster, wherein a symptom consist of the person's attempt to reduce

exposure to people or places that may elicit memories of the event and involves social withdrawal, emotional numbing and a sense of loss of pleasure. The final cluster is called hyper arousal and it refers to physiological signs of increased arousal, such as hyper vigilance or increased startle response.

Baldwin (1996) argues that trauma symptoms evolved to assist the individual to recognise and avoid other dangerous situations although these reactions are disturbing to the victims, they are considered to be normal responses to abnormal events. Depending on the individual, some symptoms resolve within a few weeks of the traumatic experience. It is only when symptoms persist that a diagnosis of Post Traumatic Stress Disorder can be made. Multiple, chronic traumas experienced are likely to be more difficult to overcome than single instances (Baldwin, 1996).

The research that has evolved in people who have been exposed to traumatic events has revealed and highlighted different experiences and behaviours that might assist in understanding what to expect when working with such people. A study to test whether sexual traumatization is associated with poor health behaviour was conducted by Lang, *et al.*, in 2003 and they reported that a history of sexual assault was associated with increased substance use and risky sexual behaviours.

According to the literature, beliefs, expectations and assumptions about the world play a pivotal role in determining the effects of victimisation (McCann & Pearlman, 1990). Janoff-Bulman (1985) asserts that experiences of trauma shatter basic, healthy assumptions about the self and the world. These assumptions include the belief in personal vulnerability, the review of the self as positive, and the belief that the world is a meaningful and orderly place, and that events happen for a reason. After the rape incident the individual is left feeling vulnerable, helpless and out of control in a world that is no longer predictable.

2.4.2 Rape trauma syndrome

Burgess and Holmstrom (1977) first identified the syndrome in the 1970s. They conducted a study on experiences of rape survivors and found responses to rape often followed a sequence. They defined the rape trauma syndrome (RTS) as a process that

rape survivors go through in response to fear experienced during the sexual assault. RTS occurs in two phases (Burgess & Holmstrom, 1977).

The acute phase

During this phase, the survivor experiences a complete disruption of her life. In general, the survivor's initial response to the assault will be shock and disbelief. After this, they may experience a variety of emotions such as anger, fear, feeling lucky to be alive, humiliated, dirty, sad, confused, and vengeful and degraded (Burgess & Holmstrom, 1977). Physical concerns may arise during the acute phase as well. This phase may be described as the turning upside down phase as the survivor has lost the basic orientation of life. Furthermore survivors may notice disruption in their usual sleeping and eating patterns and some survivors will report soreness and aches throughout their bodies. This phase may last few a weeks depending on the survivor's coping skills (Smith & Kelly, 2001).

Reorganization phase

In this phase the survivor attempts to reorganize her life and recreate the world that she once knew. Burgess and Holmstrom (1994) assert that long-term reactions to sexual assault may include the inability to find peace and the inability to reorganise oneself. The latter may be influenced by personal factors such as coping mechanisms and support system from family and friends. Reactivation of the symptoms may occur depending on existing life problems such as alcohol and drug problems, and divorce. Even if the survivor had a life problem under control prior to the assault, this could re-surface as a result. In the study to evaluate psychopathology consequences after rape, 40 women who were victims of rape who reported psychiatric symptoms were compared with 32 women who underwent severe, nonsexual, life-threatening events such as car accidents, physical attacks or robberies. The findings of this study revealed a significantly greater prevalence of posttraumatic stress disorder, as well as sexual, eating and mood disorders among the rape victims (Faraveli, *et al.*, 2004).

The social consequences of being raped were also demonstrated in a 2001 study to examine social reactions to sexual assault victims (Filipas & Ullman 2001). Their analysis on both qualitative and quantitative data indicated that both positive and negative reactions are commonly received by victims disclosing their assault to

others, but that victims seeking help from formal support sources are more commonly faced with negative reactions of victim blame, stigmatizing responses and controlling reactions from others. These all contribute to the rape trauma syndrome.

The identification and recognition of the rape trauma syndrome has assisted in shifting the blame of the rape from the victim to focusing on the consequences of rape (POWA, 1997). According to Hanson (1992) the rape trauma syndrome has been introduced in court cases overseas to prove the victim's claim that she did not consent to having sex, to explain a rape survivor's poor memory about the rape, and to help the court to decide on a sentence. The Rape Trauma Syndrome has recently been introduced into the South African courts with similar results.

In the light of the above evidence, these may be important findings that might contribute to the administration of post exposure prophylaxis in sexual assault cases.

To conclude this section, I will now introduce literature on HIV in South Africa as it has been identified as another major health consequence for sexual assault survivors.

2.4.3 HIV infection

HIV can be transmitted in several ways (Sowardsky, 1999). This includes transmission through infected blood, sharing of needles, mother to child and sexually. Women are significantly more likely than men to contract HIV infection during sexually intercourse (UNAIDS, 2005, HIV/AIDS Surveillance Report, 2005). Sexually, rape is a significant risk factor for HIV in high-prevalence countries such as South Africa. The current literature on HIV transmission indicates that the risk of HIV seroconversion following rape is likely to be higher than from consensual sex given the increased physical trauma (Christofides, *et al.*, 2003). While Pope and Haase (2003) state that normally, white blood cells and antibodies attack and destroy foreign organisms that enter the body and this response is co-ordinated by CD4 lymphocytes (white blood cells) and they are also the main target of HIV, which attacks the cells and then enters its own genetic material into the lymphocytes and uses them to make copies of itself (WHO, 2003).

South Africa is currently experiencing one of the most severe HIV/AIDS epidemics in the world. An estimated 5.3 million people are living with HIV/AIDS in the country. It is further estimated that 1 800 people are infected with the HI virus daily (UNAIDS, 2006). According to Dorrington, (2000) the majority of people living with HIV/AIDS in South Africa are women and girls. This gendered pattern of the HIV epidemic has been shown in many countries in sub-Saharan Africa.

HIV/AIDS has been with us for more than 25 years and the only method to fight it so far is prevention (USAID 2003). Epidemiological and biological evidence suggests that the promotion of HIV/AIDS prevention programmes have the potential to reduce the risk of acquisition of HIV (WHO, 2003). In response to this evidence, in South Africa, the governmental departments, community-based organizations and non-governmental organizations have implemented different prevention programmes. Different research studies have been commissioned to produce scientific data for further decision making and to improve the HIV/ AIDS prevention programmes.

Communication campaigns have been the core of some major HIV prevention interventions including Love life, Khomanani and Soul City. Research has shown that these campaigns have become well known and recognized by the population (HIV & AIDS and Strategic Plan for South Africa, 2006-2011).

Furthermore, the South African government has been blamed by various organizations for their lack of political leadership and therefore for the continued increase in HIV prevalence. Debates have arisen as to whether the government response to this pandemic has been sufficient or not. These debates have arisen from various organizations and the main issue was the need for the provision of medication for people living with AIDS who require ARV medication.

The driving forces of the HIV epidemic are complex. Gender inequality has been shown to be an important factor with the result that higher numbers of women are infected with HIV. Gender inequality is a feature of violence against women as well and the intersection between the two has been shown. Due to the nature of sexual relationships women are prevented from being able to practice safe sex, making them vulnerable to infection (Collins & Rau 2000).

2. 5 Antiretroviral medication in South Africa

South Africa's response to HIV and AIDS has evolved rapidly over the last few years and the government is committed to providing a comprehensive package of care for People Living with AIDS (PLWA) and has taken steps to provide antiretroviral treatment (ART) to patients in the public health services. Antiretroviral drugs are used to slow the rate at which HIV replicates in the body. A combination of antiretroviral drugs called Highly Active Antiretroviral Therapy (HAART) is the standard treatment for HIV infection. This treatment approach offers the best chance of preventing HIV from multiplying and allowing the immune system to stay healthy (National Antiretroviral Treatment Guidelines, 2004). The World Health Organization recommends that ART must be commenced when an individual's CD4 count goes below 200 before since it is anticipated that at this stage AIDS-related infections are likely to be present.

According to the World Health Organization (2003), the primary goal of ART is to decrease HIV-related morbidity and mortality. People on ART take a longer time to develop AIDS and live longer than people who do not take antiretroviral drugs. Once ART is commenced, the patient's CD4 count should rise and remain above the baseline count (National Department of Health South Africa, 2004). Furthermore antiretroviral drugs are not limited for use by HIV-positive people. These drugs have been used as prophylaxis after occupational exposure to HIV to reduce the risk of HIV infection after accidental exposure to infected blood (Antiretroviral Treatment Guidelines, 2004). PEP has been used for occupational exposures since 1999 in South Africa.

The demonstrated efficacy and feasibility of post exposure prophylaxis for HIV after occupational exposure (Cardo, *et al.*, 1997) presents support for the use of antiretroviral drugs after rape and this has led to the inclusion of PEP in the comprehensive post-rape care package which includes PEP for HIV prevention (Kim, *et al.*, 2003). In April 2002, the government pledged to provide PEP to survivors of sexual violence and it was envisaged that it would be available in all public health clinics and hospitals.

2.6 Post Exposure Prophylaxis (PEP) after sexual assault

There are no definitive studies that have shown effectiveness of PEP after sexual assault; however, its effectiveness in occupational exposure has been shown. Since 1998, the data about the potential efficacy of PEP have accumulated from human, animal and laboratory studies. Clinicians and organizations have begun providing PEP to patients they believe might benefit. In the United States certain health departments have issued advisories or recommendations or otherwise supported the establishment of PEP treatment programmes in their jurisdictions.

The literature concerning PEP following occupational exposure, as well as the CDC's recommendations for PEP following occupational exposure, takes into account many details of the exposure. Specifically, the CDC recommendations consider the type of body fluid involved in the exposure as well as the route and severity of the exposure. The CDC recommendations also consider the source of the possible exposure and make different recommendations depending on whether the source patient is known to be HIV positive, HIV negative or of unknown serostatus. The CDC suggests that PEP decisions be individualized so as to account for various risk scenarios (Kistner, 2003).

PEP after rape to reduce the risk of HIV infection has been identified as a key health intervention to alleviate the impact of HIV on women and is based on the antiretroviral treatment as discussed earlier. According to Kim (2002) policies for PEP on sexual assault exposure exist internationally. As stated, in April 2002 the South African government committed itself to providing post-exposure prophylaxis for rape survivors. Under the national policy guidelines PEP should be offered to all male and female sexual violence survivors (including children) who present to a facility within 72 hours of the rape incident and who test negative for HIV. Survivors who refuse to be tested for HIV are usually not given PEP. The national guidelines also instruct that survivors should be counseled about the risks of HIV transmission after rape (National antiretroviral Treatment Guidelines, 2004). In South Africa, non-governmental organizations, private insurance companies, private hospitals and some provincial Departments of Health such as the Western Cape Province pioneered post exposure prophylaxis before the national Department of Health PEP policy was announced.

PEP treatment is part of a comprehensive package of care for sexual assault survivors. The other services provided to survivors include prevention of pregnancy, treatment of STIs, forensic examination for the treatment, the collection of evidence, and psychological support to the victim.

Depending on the resources at the health facility and depending on the mental health status of the client not all will have an HIV test done at the time of the initial visit. The management guidelines propose that if HIV test is not done the client is given a 'starter pack' which consists of three or five days supply of PEP medication. , within 72 hours the client is expected to return back to the health centre to be tested and examined and in-order to start the full PEP medication. However, if a HIV test is done and the result is negative the survivor will be given the full course of PEP. If the person tests positive, PEP is not provided. Contrary to the National Sexual Assault Policy, some health facilities do not provide PEP if the rape survivor declines to undergo an HIV test (Kistner, 2003). This is problematic, as it does not take into account the difficulties that the rape survivors might experience in giving their informed consent to HIV testing following rape.

In South Africa, the standard PEP combination as recommended by Department of Health consists of zidovodine for 28 days and 3TC. The dosage depends on age and weight. Alternatively, Combivir may be used, which is a single pill consisting of both AZT and 3TC. Combivir is prescribed as a twice-daily dosage for 28 days. Combivir is the preferred drug since it should allow a greater degree of adherence. Children under 12 years of age receive a combination of AZT and 3TC and all of these are available in a syrup format for children. (National Antiretroviral Treatment Guidelines, 2004).

2.6.1. Adherence to Post Exposure Prophylaxis after sexual assault

For HIV-positive patients on ARV not taking their medications as prescribed can mean that it becomes ineffective and may lead to an increase in viral load, a fall in CD4 cell count and greater risk of becoming ill and dying of HIV opportunistic infections. The main reason why adherence to ARV drugs is critical is because the

virus can quickly become resistant to the drugs used to treat it. Resistance to the drug means that they become ineffective in stopping the production of HIV viruses. Adherence is thus a critical aspect of ART management and doctors think it is wise to rather stop the treatment altogether than miss doses (Aids map, 2005).

Adherence to PEP following sexual assault is therefore critical, mainly because its main outcome is to prevent HIV transmission. Therefore non-compliance in PEP following sexual assault is a matter of concern with many centres indicating that adherence levels are unacceptable. Prof. Meel who heads up the Sinawe Referral Centre in the Eastern Cape has indicated that most clients do not return for follow-up visits and therefore do not collect the rest of the drugs. The adherence level at the centre is as low as 3% (Prof. Meel, 2005). The exact reasons for their non-attendance are not known. It is therefore important to explore adherence to PEP after sexual assault. Such research will feed into interventions to improve adherence and ultimately also prevent HIV infection after sexual assault. Presently, the literature on PEP shows various barriers to adherence. PEP drugs are known to have side-effects. These include skin rash, diarrhoea and vomiting (Kistner, 2003). When the health worker offers or recommends PEP to a rape survivor; the provider should clearly explain the possible benefits and side-effects of taking the medications. When a survivor is unable to decide whether to initiate PEP, the provider should encourage the survivor to begin the medications immediately detailing the benefits of early treatment (National Management Guidelines for Sexual Assault Care, 2004).

The National Department of Health policy notes the potential side-effects of antiretroviral drugs which include nausea, diarrhea, vomiting, fatigue, flu-like symptoms, headaches and muscle pains. The policy recommends the management of these side-effects, which are usually most prominent at the start of the treatment and disappear after a while. Fortunately these effects are temporary and can be relieved with conventional medications (National Antiretroviral Treatment guidelines, 2004). The provision of a one-week supply of anti-emetics is given as part of the PEP treatment to deal with nausea, which is the most common side-effect.

Vetten (2004) did a study to investigate factors affecting adherence to Post Exposure Prophylaxis in the aftermath of sexual assault among rape survivors and health

workers in Johannesburg during 2004. Among the 105 interviews conducted with rape survivors, health workers and the observations at the seven health facilities, they found that patients defaulted due to the following: side-effects, forgetting to take their medication, and not taking their medication properly. They also found that some health workers are not sufficiently trained about the medication and provided patients with incorrect or insufficient information. Some health workers were adequately trained but did not spend sufficient time giving patients all the information required or checking that patients understood how to take the medication or asked about side-effects. These findings are not surprising given that most patients are in no condition to absorb much information at the time of the rape examination (Vetten & Haffejee, 2004).

According to Kim (2002), compliance patterns may vary according to whether PEP is administered following occupational or sexual exposure, consensual or non-consensual sex, same sex or heterosexual activity. Some of these patterns may be conditioned by self-perceived risk of HIV infection. Given adequate counselling and support, a woman who seeks treatment after being gang raped in South Africa may be much more inclined to complete treatment than a health care worker who has sustained a minor needle-stick injury while performing a routine clinical procedure in a low-prevalence country. Thus, it would seem likely that a client's perceived risk of HIV infection due to her/his exposure may play a key role in influencing treatment completion.

2. 7 Rape services in South Africa

Historically, in South Africa the district surgeons were employed by the state to implement sexual assault medical examinations. Generally, most practitioners were not trained in forensic examination. This resulted in the discrepancies in the service, with many complaints of dissatisfaction from the community and the sexual assault clients. Some of the complaints reported include judgemental attitudes, and insensitivity from the surgeons (Christofides, 2003).

The District surgeons system was phased out in 1996 to mitigate these problems and presently all the doctors in the public health system are providing sexual assault

medical examination including private practitioners in the private sector. In South Africa, most often a sexual violence survivor's first contact with the health system is with the casualty (accident and emergency) department at a hospital and in these settings the treating physicians and nurses are overworked, inexperienced and untrained to do clinical forensic exams or manage rape cases, (National Department of Health, 2002).

In 2000 the National Department of Health brought out a document entitled *The Primary Health Care Package for South Africa*. The package includes the health sector response to rape victims and acknowledges the need for interdepartmental and intersectorial collaboration in delivering rape services. The responsibilities are outlined in Box 2.1.

Box 2.1: Standards and norms for primary health care

- Every clinic should establish a working relationship with the nearest police office and social welfare office 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 staff are 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 diseases 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 abuse is taken and noted – with an indication that these are not full accounts. These notes are kept for 3 years.
- 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.
- Victims are not allowed to wash before being seen by an accredited health

practitioner.

- A female health worker attends to women who have been raped or abused and if this is not possible (e.g. a male district surgeon comes to the clinic) then another woman is present during the examination.
- The victim is given brief information about the legal process and the right to lay a charge.
- If the victim indicates a desire to lay charges the police are called to the clinic.
(www.gov.doh.ac.za)

How effective the implementation of these responsibilities is not known and it is not surprising that services have been different in different settings given that the Department of Health had not until 2006 finalized the policy guidelines for the implementation of the sexual assault services. The recent sexual assault policy recognized that the need for trained health workers to provide these services and the management guidelines developed with the new sexual assault policy replaces some of these standards and norms.

Early in 2003, the National Department of Health announced its decision to train forensic nurses throughout the health system to assume some of these responsibilities. This strategy was envisaged to reduce and improve services that would be accessible to the citizens of South Africa including providing PEP to rape victims. This training has been implemented in a very *ad hoc* manner and poor co-ordination meant that most trained nurses work in settings other than rape services (National Department of Health, 2004).

Furthermore, to facilitate the legal process and increase convictions of perpetrators of rape, One Stop Centres (Thuthuzela model) were established by the Department of Justice with initial five centres across the country. Most of the centres are situated within the public hospital premises. The Thuthuzela Model was also copied and implemented by the National Department of Health in other provinces. The centres function as a one-stop sexual assault service providing a comprehensive service using

a multidisciplinary approach to the management of sexual assault survivors. The multidisciplinary staffs include medical personnel, nursing staff, psychologists, social workers and police officers. This multidisciplinary team ensures that victims receive holistic care.

2. 7.1 The Management Guidelines for sexual assault clients

The National Management Guidelines for Sexual Assault Care (2004) provide details on the approach to the management of rape victims. It is stated that:

“Once sexual assault happens, the client must either report at the nearest SAPS police station where a statement will be taken and transport to the health facility will be provided or the client reports directly to a Health Care facility. At the Health Care facility the client is taken to the Sexual Assault Care room and emergency care is to be given including trauma counseling. Thereafter a medical history is taken and tests, including for pregnancy and HIV, are done. The medical officer who also completes J88 (a form with a report by authorized medical practitioner on the completion of a medico-legal examination) does a sexual examination. The clients who decline reporting the rape to police or to have a medical examination should have their decisions respected but clarifications of the implications should be explained.

A Sexual Assault Examination Kit (SAEK) which consists of specimen containers and a bar coded consent form to be completed by the health worker and signed by the patient, which are used during the examination for the collection of the evidence. This kit should be sealed and handed over immediately to the police who then sign to acknowledge receipt.

If clients reported the incident to the Health facility directly the police should be called to take the statement if the client wishes to lay a charge as well as to bring a Sexual Assault Examination Kit (SAEK) (if none are available at the hospital). Reporting the crime to police is obligatory for children, elderly and mentally incapacitated victims. Finally, follow-up arrangements should be made and police should provide transport home for the client.

The protocol also emphasizes that the sexual assault victims be informed about the significance of the tests and the examination to ensure informed consent procedures. It further indicates that an examination be done even if the survivor does not intend to report to the police to ensure that the evidence are collected when the patient changes their mind later.

The protocol further states that victims of sexual assault be referred to other client support services for further psycho-emotional management. However, such services are usually urban based while rural communities are poorly serviced and limited to the public health facilities.

The protocol further states that clients should not be chased away to other institutions when seeking medical help. Presently, in South Africa the services of the government departments are designed according to the geographical boundaries. People are serviced in their local service areas. This does not always happen and people often seek help outside of their service areas.

However, these National Management Guidelines are not always implemented as expected. The sexual assault services continue to be surrounded by discrepancies that are victim related, perpetrator related, community and family related and above all, the victims that had managed to be confident enough to report the case to the police or health facility are sometimes phased out of the service by unendurable conditions which involve unpleasant attitudes from the service providers and the relationships between the South African Police Services and the health facility.

2.7.2 The role of the police

The reasons for the low level of reporting rape to police were discussed earlier. It is expected that the police should work closely with the other government departments to ensure an effective service to rape victims.

It is stated in the National Management Guidelines for Sexual Assault Care (2004) that all sexual assault victims presenting at any SAPS facility should preferably be interviewed by a police officer of the same gender who has been trained to deal with

sexual assault cases. However, since the police force is dominated by men this does not happen often. In addition, few police officers have been trained in the handling of sexual assault cases. This is borne out by research that has shown that experiences of reporting a sexual assault to the police are not always optimal. Myths around rape and domestic violence influence how rape victims are treated and the service and attitude of the investigating officer is often determined by the degree of violence, the weapon used and the presence or absence of alcohol. In general the way victims are viewed were still dominated by the societal myths of rape which included the blaming of women for the rape and it meant that police did not consider it a serious crime (National Management Guidelines for Sexual Assault Care, 2004).

Secondly, on the presentation of the sexual assault case to the facility, they are to be interviewed in a private room and victims are not to be subjected to insulting, accusing statements by the SAPS members. This is not always the case, most of the police stations do not have enough space and it is also well documented in the literature that some police officer cannot write adequate statements. Previously, the police officers have used inappropriate crisis intervention techniques that avoided arrest and seek to reconcile (National Management Guidelines for Sexual Assault Care, 2004).

It is also expected of police officers to provide information to the survivors about the importance of preserving evidence until he/she has undergone forensic examination. Finally, the police officers are also expected to inform the survivors about investigation steps that will be followed as well as court procedures (Strategic Plan, 2007-2011).

2.8 Counseling and information

According to the *National Guidelines for Sexual Assault* (2004), counseling services should be provided for rape victims by professional, experienced counselors. Such counseling provides the opportunity for survivors to explore their feelings and express them in a safe place.

Kim (2000) reporting on the work done in the Mpumalanga Province that counseling is an important component in helping survivors to heal. However, this service is limited to the more resourceful and industrialized, urbanized provinces in South Africa and is often provided during follow-up visits usually by non-governmental organizations (NGO).

2.8.1 Follow-up care

Monitoring and follow-up visits have been identified as the key challenge in the effective management of Post Exposure Prophylaxis (Department of Health, 2004). This is due to the transport cost and long distances to travel to the health facility for further support and to collect the remaining medication. Therefore, adherence to medication and monitoring of side-effects has not been routinely followed as most of the clients do not return (Jewkes & Abrahams, 2002) and not much is known about what happens to survivors in the 28-day period of taking the PEP medication. This is a challenge as the National Management Guidelines emphasize that counseling during the initial visit to the health facility (acute phase) should be restricted to the explanation of the examination, specimen collection, and management of the risks of pregnancy and STIs. The follow-up visits are not given the same attention and are usually only related to psychological support and counseling, and very little attention is given to PEP management.

According to Kirsten (2003), the lack of psychological support results in some women finding it difficult to complete the course of medication as the taking of the drugs brings back memories of the rape experience. Contrary to this Vetten & Haffeejee 2004 argue that taking antiretroviral with comprehensive care after the rape incident should give the survivor control over her own health.

2.9 Theoretical framework

In attempting to understand factors that determine adherence to post exposure prophylaxis after sexual assault, this research study will attempt to ground its understanding of psycho-social processes that inform health behaviour in terms of the Health Belief Model and Theory of Reasoned Action (Rimer & Glanz, 2005) and

Green and Kreuter's (2005) Precede-Proceed Model. The Health Belief Model is a psychological model that attempts to explain and predict health behaviour by focusing on the attitudes and beliefs of individuals. It has been applied to a broad range of health behaviours and subject populations. Three broad areas can be identified: preventive health behaviour, which includes health promoting, health risk behaviours as well as vaccination and contraceptive practices (Conner & Norman, 1996). The Theory of Reasoned Action, examines the relationship between behaviour and beliefs, attitudes, subjective norms and behavioural intentions (Ajzen & Fishbein, 1980). Green and Kreuter's (2005) Precede-Proceed Model identifies, apart from psychosocial variables, potential contextual enabling factors that can promote and sustain particular behaviours.

The Health Belief Model is based on the understanding that a person will take a health-related action if that person feels that a negative health condition (i.e. HIV infection) can be avoided; has a positive expectation that by taking a recommended action she will avoid negative health consequences i.e. seeking post exposure prophylaxis will be effective at preventing HIV; and, believes that she can successfully take a recommended health action (she can use the treatment comfortably and with confidence).

Meanwhile, Ajzen and Fishbein (2003) in theory of reasoned action suggests that a person's behaviour is determined by their intention to perform the behaviour. According to this theory the best predictor of behaviour is intention. It is the cognitive representation of a person's readiness to perform a given behaviour and the intention is determined by attitude towards the specific behaviour, subjective norms and perceived behavioural control. The more favorable the attitude and the subjective norm and the greater the perceived control, the stronger the person's intention to perform the behavior should be.

These theories were located in this study to assist us to identify and understand the factors that might determine non-adherence to Post Exposure Prophylaxis after sexual assault. According to the health belief model, people who are not sick do not follow the prescribed treatment. The beliefs and attitudes influence the whole process of medication depending whether the beliefs are positive or negative and this is shaped

by information or knowledge about the condition and its consequences. In order to influence the beliefs and attitudes, the following strategies are to be implemented. Through counseling, it is important to define the population at risk and the level of risk involved. In the current study the population at risk were rape survivors, they were at risk of being infected by HIV depending on the perpetrator's status that is usually unknown. Rape survivors should also be informed about the risk involved when steps are not taken to reduce the chances of infection. The strategies involve include explanation of how and when to take action, and the positive result of taking action.

In the South African context, where the majority of women are exposed to multiple traumas, the way in which survivors make sense of rape may offer alternative understandings, which are not based on Western theories and Models. Applying these theories and models in addressing health prevention programmes in Africa is questionable.

The fact that the rape cases reported to the police are less than cases reported in research (Jewkes & Abrahams, 2002), indicates that the majority of sexual assault victims do not seek professional intervention that includes medical aspects, and some women only rely on their families and friends for support (Harvey, 1996 & Stefan, 1994). Research has found that the victims who seek medical and professional intervention are sometimes re-traumatized, as the current service delivery system in public facilities is often inadequate, poorly organized, with few trained health workers for handling the sexual assault cases (Vetten & Haffejee, 2004).

According to Airhihebuwa, (2000) the health belief model and other theories that are designed to address health prevention from an individual, rational perspective have proven effective in some Western societies for addressing certain diseases but have had a lesser impact in African societies. In African societies, families and community are more central to the construction of health. The construction of health of the communities also depends on the availability of resources in the country, political history and how informed people are in the community and the level of awareness among the people about the availability of the services.

Theories that are sensitive to the culture of marginalized developing countries/poor African communities may be more valuable. Airhihenbuwa (2000) also supports this suggestion that these theories are applied in the context for which they were not designed. Furthermore, Yuan, *et al.*, (2006a) urged that research with understudied communities such as racial and ethnic minorities and poor people is limited, possibly due to structured assessment tools lacking sensitivity to marginalized cultures. The need to establish theories that are sensitive to African settings that include culture, African perspective and economic status of some people living in Africa is needed. Airhihenbuwa (2000) also recommended this in his critical assessment of theories/models used in health communication for HIV/AIDS.

Therefore, given the low levels of adherence to PEP, the overall aim of the proposed study is to assist in the understanding of factors that influence adherence to post exposure prophylaxis (PEP) after sexual assault in the rural areas of the Eastern Cape. We are hoping that this research will contribute to the strengthening of the health system to ensure effective treatment and delivery of a comprehensive care and treatment services to all sexual assault survivors.

Aim:

The present study aims to provide an in-depth understanding of psychosocial and environmental factors that predispose, promote and also serve as barriers to adherence to post exposure prophylaxis after sexual assault in women. The findings gleaned from this study will be used to improve health promotion strategies among rape survivors with regard to adherence to PEP.

Specific objectives:

- To explore potential predisposing factors that affect adherence to PEP after sexual assault.
- To explore the potential reinforcing factors with regard to adherence to PEP after sexual assault.
- To explore perceived barriers with regard to adherence to PEP after sexual assault.

- To explore potential enabling factors that promote adherence to PEP.

Conclusion:

This research project forms part of a larger research project being done by the Gender and Health Research Unit of the Medical Research Council. The findings will be communicated to the sexual assault services at the Sinawe Referral Centre, participants of the study and the Department of Health in the Eastern Cape. It is hoped that the research findings will assist in the development of health promotion strategies to improve adherence to PEP after sexual assault.

Chapter 3

Research methodology

This chapter presents and discusses the methodological perspective of the current study and the logistics of carrying out the study. Included here is motivation or reason why the researcher opted for the methods, the research design, selection of participants, sample size, study population, research site, inclusion and exclusion criteria, data collection procedures, remuneration, analysis and ethical considerations.

This study forms part of a larger study entitled 'Exploring the impact of stigma on the uptake and adherence to antiretroviral treatment for HIV-positive individuals and post exposure prophylaxis for women following a sexual assault'. The researcher explored one aspect of the above problem that is, the factors that influence adherence to PEP among rape survivors who presented for treatment at the Mthatha research site. The researcher was solely responsible for the implementation of the study at the Mthatha site, which included the collection of data, the analysis of the data and the writing of the research report.

3.1 Research design

The methodology adopted for this study is informed by the qualitative paradigm. Dahlgren, *et al.*, (2004) refers to qualitative research as a "type of inquiry in which the qualities, the characteristics or the properties of a phenomenon are examined for better understanding" (p.12). Qualitative research shares the theoretical assumptions of the interpretative paradigm, which is based on the notion that social reality is created and sustained through the subjective experience of people involved in communication and the fact that predictions cannot be made. The strengths of the qualitative paradigm are outlined below.

Box 3. 1: Advantages of qualitative paradigm

- Obtaining a more realistic feel of the world that cannot be experienced in the numerical data and statistical analysis used in quantitative research.
- Flexible ways to perform data collection, subsequent analysis, and interpretation of collected information.
- Provide a holistic view of the phenomena under investigation (Bogdan & Taylor, 1975; Patton, 1980).
- Ability to interact with the research subjects in their own language and on their own terms (Kirk & Miller, 1986).
- Descriptive capability based on primary and unstructured data. (Morgan, 1980).

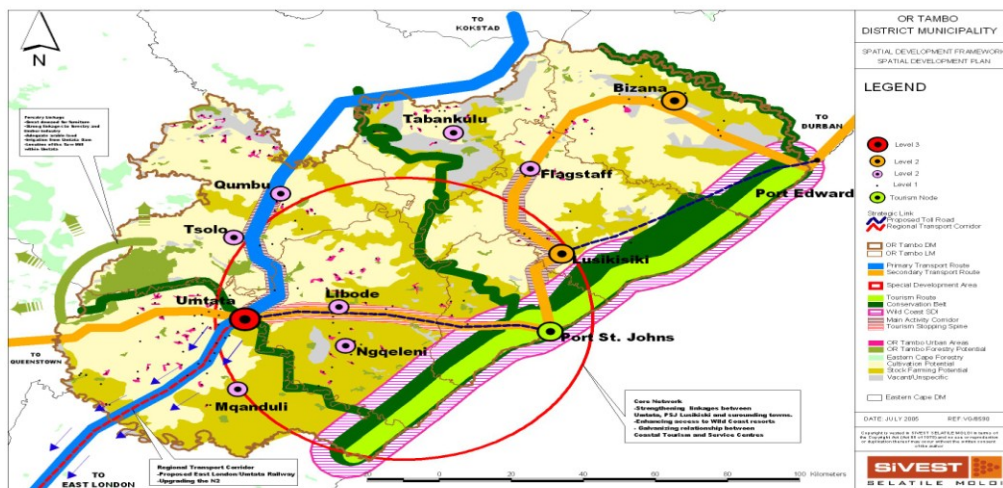
Furthermore, qualitative researchers are concerned in their research studies with attempting to accurately decode and interpret the meanings of phenomena occurring in their normal social context (Fryer, 1991). Mouton (2006) further states that qualitative researchers are concerned with how people make sense of the world and how they experience certain events. Some researchers such as Denzin (1971), Lincoln and Guba (1985) and Marshall & Rossman, (1989) have also highlighted the importance of conducting research in a natural setting, meaning that topics for the study focus on everyday activities (Matveev, 2002).

This method was thus suitable to meet the objectives of this research study in terms of exploring in depth the experiences of rape survivors with regard to Post Exposure Prophylaxis after sexual assault. This method provides the following strengths: more realistic feeling of the world that cannot be experienced in the numerical and statistical analysis used in quantitative research; flexible ways to conduct data collection; and, the interpretation of collected information and a holistic view of phenomena under investigation (Matveev, 2002). Finally Kirk & Miller, (1986) also support the above strengths of qualitative research and further add that the other advantage of qualitative methods include the ability to interact with the research participants in their own language and on their own terms.

3.2 Study population

This research study was conducted at Sinawe Referral Centre in Mthatha, in the Eastern Cape Province. The population of the region is African Black and mostly Xhosa. The community is characterized by low literacy rate with high levels of poverty. Physically, the centre is situated in the O.R. Tambo District Municipality. O.R. Tambo district is situated on the Eastern side of the province along the Indian Ocean coastline.

Figure 3.1: Map of the OR Tambo district Municipality: IDP(2007)



3.3 Research site

Access to the centre was sought via the relevant authorities including the Provincial Department of Health. The Sinawe Referral Centre functions as a one-stop sexual assault centre providing a comprehensive service using a multidisciplinary approach to the management of sexual assault survivors. The centre is part of the Mthatha Hospital Complex and is managed by the Walter Sisulu University (WSU), Department of Forensic Medicine. The multidisciplinary staff at the centre includes medical personnel, nursing staff, psychologists, social workers and police officers. This multidisciplinary team ensures that victims receive holistic care. Patients are referred from a wide area including Mthatha and the surrounding districts such as Tsolo, Mqanduli, Qumbu, Ngqeleni, Port St. Johns, Mount Frere and Butterworth. Patients arrive at the centre when referred by the South African Police or they are

referred from the Hospital Outpatient Department (OPD). Sometimes survivors arrive at the centre without a referral.

The medications, including the PEP medications that are offered to survivors of rape at the Sinawe Referral Centre at the time of the study are presented in Table 1. The combination drug Combivir that contains both AZT and 3TC is the preferred drug but it is often not available. If this is not available the survivors are given Zidovudine and Lamivudine as separate drugs commonly known AZT and 3TC. Stemetil and Prochlorperazine for nausea are also given depending on availability.

Table 3.1: Medication provided to rape survivors at Sinawe Referral Centre

PEP medication	Other medication
Lamivudine (3TC) Dosage depends on age and weight Taken twice a day for 28 days AND Zidovudine: (AZT) Dosage depends on age and weight Taken twice a day for 28 days	Treatment of infection Ciprobay: stat dose immediately Flagyl: taken for seven days. Doxycycline: taken for seven days.
Lamzid Combivir Combination of 3TC + AZT: Taken twice a day for 28 days	To prevent pregnancy Ovril 28: two tablets stat dose and another two tabs after 12 hours.
	To prevent nausea and vomiting Stemetil or Prochlorperazine.

3.4 Sampling technique

Sampling in qualitative research is purposive, meaning that participants are chosen because they share a certain characteristics relevant to the research topic (Dahlgren, *et al.*, 2004). When we select a subject we have a purpose, we want to answer our research objectives. In Glaser, (1978) purposive sampling is termed theoretical sampling, which Mouton (2005) further posits that the theoretical sampling is deemed

appropriate to collect data for the generation of theory. Researchers select, collect and analyze data in order to develop theory. Therefore, in the current study, women who had been offered PEP after a sexual assault were targeted.

3.5 Sample size

The sample size in qualitative research differs depending on the method used and research questions to be answered. Qualitative researchers do not have hard rules regarding sample size. It mainly depends on the research question to be addressed, what will be useful and what will be credible. What is important is to reach the point of redundancy or saturation, meaning no more relevant emerging data. (Dahlgren, *et al.*, 2004). This study adopted a purpose-sampling procedure and 16 women were interviewed. The recruitment process took place over a period of five months (July to November 2006).

3.6 Recruitment procedure

Immediately after the study was approved and the authorities granted the access to the centre, a meeting was arranged by the researcher to introduce the study to the staff at Sinawe Referral Centre.

The nurses and the researcher worked out the best possible ways of recruiting the rape victims. From this meeting with staff, an arrangement was made for the researcher to be present at the centre during the busiest periods. The nurses also agreed to call the researcher if new clients arrived and sometimes the researcher called the centre to find out if the new clients are available during the day (the MRC office is 2 km away from the centre). In addition, the researcher recruited women who returned to the centre to collect their second week of PEP treatment

The study was explained to the eligible participants and they were given an information sheet with written information about the study (see information sheet, Appendix A). They were requested to participate only after they had understood the study and the participants who were interested were also requested to give written

consent by signing the informed form (See Consent forms, Appendix B). Participants were selected on the basis of their willingness to take part in the study. The researcher is fluent in Xhosa and all the participants were Xhosa speakers. In order to schedule time and place for interviews the researcher collected contact numbers and physical addresses. The interviews were done after 28 days, which was after they were expected to have completed the medication and have attended all the psychological sessions including counseling sessions.

3.7 Exclusion criteria

Survivors of rape differ in terms of gender, age, and health status including HIV and mental health status. The current study did not include male survivors. Furthermore, participants with mental disability were excluded and finally, all the HIV-positive participants were also excluded, as they did not qualify to receive PEP. If a woman declined to take PEP she was also excluded. The radius for the study was 100 kilometers and people who lived further than this were excluded. This was done because of the financial constraints of the study as the kilometers would be too costly.

3.8 Data collection

The most common methods used to collect data in qualitative research include in-depth interviews, focus groups and participant observation. Depending on the research question and the researchers, some researchers combine the methods. Dahlgren (2003) gave different reasons for using multiple methods; firstly, to increase trustworthiness through triangulation and, most importantly since this is a sensitive issue, the in-depth interview serves the purposes of the study best to ensure survivors are given a private space to discuss their experiences.

3.8.1 Observations

Initially, the researcher did observational visits at Sinawe Centre. This initial process allowed her to develop a working relationship with the centre staff and become familiar with the services of the centre. This initial observational period also allowed recruitment of potential participants for the study.

3. 8.2 Semi-structured in-depth interviews:

Semi-structured, in-depth interviews were conducted by the researcher with the survivors at the end of the 28 days of taking PEP medication. This method allowed for some structure in conducting the interviews while creating spaces for flexibility in participant's responses. In-depth interviews entail a high level of participation on behalf of the participants. The fact that questions are open ended, follow-up questions provide a chance to clarify and expand on what has been said and they also indicate to the participant that the researcher is listening (Dahlgren, 2004). An interview guide was developed for the interviews, which allowed for probing and assisted the researcher in directing the interviews (see Appendix C). According to Mouton (2006) a qualitative interview is an interaction between an interviewer and a participant in which the interviewer has a general plan of inquiry but not a specific set of questions that must be asked in particular words and in a particular order.

Interviews were done after the completion of the PEP medication preferably within a week of the completion of PEP to ensure that the participants do not have a problem in recalling the experiences of taking PEP. Depending on the circumstances, some interviews were conducted at the participant's home or, alternatively, some participants were invited to come to the MRC office in Mthatha.

The sixteen interviews each lasted between 40 and 50 minutes. During the interviews a MP3 was used to record the whole discussion. The recording of the interview is a well-known method of collecting data and allows the interviewer to converse freely without having to make full notes during the interview, which may interrupt the conversation. Consent for the use of the MP3 was sought before it was used. All the interviews were transcribed then translated into English in preparation for the analysis.

3.9 Data analysis

In qualitative research there are many different ways to analyze data, however, all forms of analysis involve organizing the data according to specific criteria, reducing it

to a manageable form and interpreting it (Strauss & Corbin, 1998). This analysis of the data is based on Strauss and Corbin's (1998) method of grounded theory.

Grounded theory

The founders of the grounded theory approach, Strauss and Corbin (1998) define it as a qualitative method that uses a systematic set of procedures to develop an inductively derived grounded theory upon a phenomenon. While Lincoln and Guba (1985) state that the grounded theory has a naturalistic perspective with the sense that its point of departure is empirically grounded in data.

The origin of grounded theory was rooted in rigorous and systematic guidelines for analyzing data, and initially written in a language familiar to quantitative scientists. Since then, the process has become more pragmatic and less focused on techniques that ultimately lend themselves to forcing preconceived categories onto emergent data (Charmaz, 2000). It is positioned within the broader qualitative paradigm and like other qualitative research technique, it serves to portray moments in time based on the argument that the social world is constantly changing so that people's lives shift and change as circumstances and they themselves change (Charmaz, 2000). The grounded theorists tell a story that reflects both the researcher and researched since both parties frame the interaction and attribute meaning to it.

“The grounded theory approach is a qualitative research method that uses a systematic set of procedures to develop an inductively derived grounded theory about a phenomenon” (Charmaz, 2000). The primary objective of grounded theory, then, is to expand upon an explanation of a phenomenon by identifying the key elements of that phenomenon, and then categorizing the relationships of those elements to the context and process of the experiment. In other words, the goal is to go from the general to the specific without losing sight of what makes the subject of a study unique (Strauss & Corbin, 1998).

Furthermore, grounded theory contains many unique characteristics that are designed to maintain the 'roundedness' of the approach. Data collection and analysis are

consciously combined, and initial data analysis is used to shape continuing data collection. This is supposed to provide the researcher with opportunities to increase the 'density' and 'saturation' of recurring categories, as well as to assist in providing follow-up procedures with regard to unanticipated results. Interlacing data collection and analysis in this manner is also designed to increase insights and clarify the parameters of the emerging theory. At the same time, the method supports the actions of initial data collection and preliminary analyses before attempting to incorporate previous research literature. This is supposed to guarantee that the analysis is based in the data and that pre-existing constructs do not influence the analysis and/or the subsequent formation of the theory. If existing theoretical constructs are utilized, they must be justified in the data (Strauss & Corbin, 1998).

Grounded theory provides detailed and systematic procedures for data collection, analysis and theorizing, but it is also concerned with the quality of emergent theory. Strauss & Corbin state that there are four primary requirements for judging a good grounded theory: 1) It should fit the phenomenon, provided it has been carefully derived from diverse data and is adherent to the common reality of the area. 2) It should provide understanding, and be understandable; because the data are comprehensive. 3) It should provide generality, in that the theory includes extensive variation and is abstract enough to be applicable to a wide variety of contexts. 4) It should provide control, in the sense of stating the conditions under which the theory applies and describes a reasonable basis for action.

This research study used grounded theory based on the four elements that the theory emerges from (is grounded in). The researcher seeks to understand social processes, each piece of data is constantly compared to every other piece of data, data collection procedures are modified as the study advances and the researcher analyzes data as it is collected (Strauss & Corbin, 1998).

Employing a grounded theory approach, the researcher collected data and analyzed it simultaneously in an attempt to discover something new that is the dominating process within a particular problem area. In this study, this was achieved through transcription of the audio-recorded interviews and notes that were taken from the field to text and analysis.

Furthermore, Dahlgren (2004) posits that the grounded theory approach also offers a systematic way of transforming collected data into a more abstract form of information. In transforming the collected data, Dahlgren suggested six distinct steps which the current study has honoured.

Table3.2: Grounded Theory steps implemented

Steps	Comments
Data collection	Thematic interviews using tape recorder and note taking.
Documentation	Transcripts from tapes organized manually.
Open coding	Running through the transcripts finding codes.
Axial coding	Organize the codes links them to discover key analytic categories.
Selective coding	Examine previous codes to identify and select data that will support the conceptual coding categories that were developed.
Integration	Attempting to link findings with existing theories.

Positioning of the researcher

To some degree, all methodologies are shaped by interests and the position of the researchers who deploy them (Taylor, 1998) and the 'voice' heard by the reader cannot be only the interviewee (Parker, 2005). As the result of this, according to Parker (2005) the positioning of the researcher within the research is an invaluable and essential part of the research, since it informs how some things in the research came to be explored and how other avenues may have been closed down. The process of transforming the private account of women's lives into the public sphere (text), by analyzing and focusing on certain data, necessarily means that some aspects will be lost while focusing on others. The researchers argue that compensating for the loss is

by documenting the paths, detours and shortcuts that are chosen at each stage of research in order to allow the reader a more complete picture of the participant's version (Mouton, 2005). To ensure validity, the researcher has used direct quotations from my interviews to provide 'true' description of a given reality.

The researcher's power in the process of selecting, organizing and presenting data cannot be denied, regardless of the approach taken (Robinson & Edwards, 1998). In light of the above, the fact that I was already working with rape survivors sparked an interest in researching adherence issues and informed the research question, the selection of the research participants and research design. While doing the research, I thought about the issues of sameness and difference between myself and the study participants in terms of my understanding of rape, the importance of adherence, and my identity as a female master's student. As the researcher, I acknowledge that I have influenced the ways in which I understood and reported on what transpired during the interviews. More information about being reflexive and my role in this research study will be further explored in Chapter Five where I present a summary of the main findings and reflect on how my findings relate to my identity as a black, female researcher.

Triangulation

In order to minimize the threat of trustworthiness of the data, the researcher utilized the triangulation methods to ensure that multiple perspectives were reflected in the findings (Creswell, 1998; Merriam, 2001). Trustworthiness is a critical issue in qualitative research. In order to account for this, the researcher performed a verbatim transcription of all interviews and also checked transcripts with study participants to seek points of clarification in relation to issues arising from previous interviews. The researcher also performed an audit trail which means, assessment of the whole research process to see how records were kept and whether the reasons behind the emergent design were meaningful and conclusions were being grounded in the data. Finally, the identified themes were validated by other researchers, which include the supervisors of the study.

3.9 Ethical considerations

The planned empirical study has observed and honoured the WHO's ethical and safety recommendations for Domestic Violence (Ellsberg, *et al.*, 2002). According to Mouton (2005) the scientist has a right to research for truth but the rights of the people are to be respected. The following ethical issues were also considered.

Risk and benefits to patients: For social and emotional support the women were referred back to Sinawe Centre to meet the social workers and psychologists.

Remuneration: All 16 participants were compensated with R20 after the interview. This money was for lunch and transport.

Informed consent: When participants agreed to participate they were asked to give written informed consent to participate in the study. Only women aged 16 years and older were included in the study and possible risks were discussed with them.

Confidentiality: Participants were ensured that all information acquired from them would be strictly confidential and also all the interviews were conducted in a private place preferably in the participant's house.

Anonymity: Tapes were not labeled with the participants' real names. If required, pseudonyms were used.

Right to withdraw: Participants were ensured that they were free to withdraw at any point in the study. They were also ensured that their withdrawal would not result in any form of prejudice or penalty.

Remaining tablets: The researcher did a pill count when she came across participants who did not complete the treatment. The researcher returned the outstanding pills to Sinawe Centre.

Reporting: A copy of the results of the research will be made available to the Sinawe Referral Centre, the Department of Health Eastern Cape, Walter Sisulu University (Forensic department) and the research participants.

Chapter 4

Results

The following results are based on the interviews with 16 rape survivors on their experiences of being on Post Exposure Prophylaxis. The themes that emerged from the data are presented in Table 3

Table 4.1: Themes that emerged from the collected data

Categories	Themes
1. The rape	The rape incidents
2. Police	The role of police
3. Perpetrators	What is known about the perpetrators
4. Health	Experiences with the health workers Medication prescribed Information received Side-effects experienced Taking tablets HIV, pregnancy and other infections
5. Community response to rape perpetrators	Blamed for reporting to the police The role of the headman Families and friends Partner/ boyfriend response to rape Perpetrators

4.1 The Rape

4.1.1 The sample

Table 4 presents an overview of the sample. The mean age of the participants was 34 years and their ages ranged from 16 to 73 years with three women over the age of 60 years. The majority of the women were single and most of them knew their perpetrators. The rape often happened at the survivor's home. All the incidences involved a single perpetrator and, in most cases, a weapon was not used. Overall, only four women adhered to their PEP drugs and completed the 28 days of treatment.

Table4.2: Description of the sample

Study ID	Age	Marital status	Perpetrator K/ U	Weapon Used	Where raped occurred	Adherence To PEP
1	23	S	K	Gun	P. Home	Yes
2	20	S	U	No	P. Home	Yes
3	16	S	K	No	River	Yes
4	44	D	K	No	P. Home	No
5	33	M	K	No	Field	Yes
6	22	S	K	No	Field	No
7	16	S	K	No	Hotel	No
8	18	S	K	No	P: Room	No
9*	60+	M	K	No	Field	No
10	73	M	K	Knife	P. Home	No
11	29	S	K	No	Sheeben	No
12	23	S	U	Gun	Field	No
13	18	S	K	No	F. Home	No
14	49	S	K	No	P.Home	No
15*	60+	S	K	No	Field	No
16	20	S	K	No	N	No

* Women could not give definite age but said they were definitely over 60 years old.

S= Single, M = married, U= perpetrator unknown, K= perpetrator known P.

Home = participant's home, F. home = friend's home, N= neighbour

4.1.2 The rape incident

The majority (seven rapes) occurred at the victim's homes or other homes, there was only one participant who reported that it happened at a hotel. Many of the rape incidences happened at night. One victim reported how it happened,

"I was sleeping in my room and two guys came and knocked acting as if they were my brothers." (P8).

She unknowingly opened the door and one of them raped her.

Another 18-year-old woman described how it happened.

“... I went to visit a friend at Norwood, we were drinking alcohol as we had a party and we went to sleep in the sitting room as we used to. When I woke up around 12 o'clock in the middle of the night the boy was on top of me, he was raping me, I pushed him and he pretended as if he was asleep...”(P13)

The rest of the rapes occurred in public places such as bushes, next to the river or on the train tracks. The opportunistic nature of rape was demonstrated when a woman went back to search for a wallet which she had lost while walking with the group on the way *“from end of mourning ceremony for my sister's husband, who passed away last year...”* (P5). One of the men in the group followed her and raped her in the field when other group members were no longer around. The ceremony they attended was a cleansing ceremony to connect with the ancestors and it is a ritual done to mark the end of mourning. In most Xhosa or African communities, people from the village and relatives come together to celebrate the occasion.

Some of the rape incidences were associated with robberies. These robberies involved the taking of cell phones or money. In one incident, perpetrators known to the community and who were neighbours of the survivor robbed a homestead because they knew that a funeral was taking place and money would be available. They stole the groceries such as sugar, milk and bread that were bought by the family in preparation for the funeral. They also demanded money. Fortunately, they could not get the money as the family had already used it for funeral preparations.

Although not all cases were associated with violence, some of the women reported being *“dragged, strangled, beaten”* and use of weapons such as guns and knives to threaten them. A woman who was raped together with her sister explained,

“... I was sleeping on the mattress, when I was trying to respond to what they were asking but I noticed that a gun was pointing at me, and they instructed me to cover myself and I did that. The man with a gun instructed us to hand over our phones to him and others were also pointing guns following this man. I immediately switched off my phone and hid it under the mattress. They started from the person that was sleeping next to the door, to the second person, both of them told these men that they did not have phones, they also approached me and I also told them that I did not have a phone, then, they threatened to kill us.” (P1).

Another older woman who was also threatened with a knife explained how she was injured, she said,

“From the kitchen he came straight to me and shouted ‘money, money’, he also searched me... He kicked the bucket full of water and water spilled on the floor, I slipped and fell on the wet floor and the pain on my joints got worse, I told him, ‘I don’t have these things you want’ then he said I am lying. I told him that when we receive our pension, we do not keep it with us because of muggers, he said, I must take him to the place I have hidden my things, I told him that I had sustained a terrible injury from falling and beside that I am wet. He pushed me down and placed the knife on my neck.”(P10).

4.2 Encounters with the police

The majority of the participants (14) reported the rape incident to the police and only two women were self-referrals to Sinawe Referral Centre. Mostly, cases were reported by the women at their nearest police station. The police would take the statements, provide transport to Sinawe Referral Centre, and return the women home after they had completed the process at Sinawe Referral Centre. However, the women who were self-referrals to the Sinawe Referral Centre could not be transported home. The Sinawe staff does not provide this service as the centre does not have vehicles. None of the women taken by the police to Sinawe knew about the centre before the incident. One of the women explained how she ended up at Sinawe,

“...We went to the police station. The police took us to Ntlaza (a rape centre based in Libode but we were not helped, then the police took us to Sinawe” (P6).

The two women that arrived at Sinawe Referral Centre without police escort indicated that they knew about the centre from someone within the family or friends who had visited the centre before. One explained,

“I heard about Sinawe from my sister whose child was once raped...” (P5).

Participants reported different experiences with police. While reporting the rape incident, and also on the way from their police stations to Sinawe Referral Centre, some participants reported having experienced re-victimization. A 22-year-old woman from Libode area explained how police responded when she reported her case. The Libode area has its rape service centre (Thuthuzela) but many problems have been reported regarding accessibility. They were short of police staff and were not keen to transport her to the Sinawe Referral Centre, which was about 30 km away from the police station where she reported the case. She talks about being “hurt” by their comments and said,

“We were with the police (woman), what hurt me most was, when we were at Ntlaza, the policewoman told the staff that she was bringing a victim and we couldn't be helped, the policewoman shouted saying she does not have time to go to Mthatha, her child have not been raped, she does not have victims, its government's victims” (P6).

She further explains how this continued when they arrived at Sinawe.

“Again at Sinawe there were comments from the staff, for instance, that, I was supposed to be helped at Ntlaza not at Sinawe, and that they did not ask that I must be raped...”

Not all the participants had negative experiences with police, some had positive experiences. One woman reported that,

“At police station I mentioned everything then the police told me that, it means he was raping me. I told them that especially on our first encounter, he also warned me not to tell anyone about it and they also asked if he had stopped or if it’s still happening to give them the last date. The police arrested him and took me to Sinawe” (P4).

A participant’s mother also explained her daughter’s experience, she said,

“The first visit was with the police, I was not at home when I was called, then I went to the police station where I found her with my brother and I was told by the police that they are going to take xxx to Sinawe and there was no need for me to go with her” (P3).

According to xxx’s mother, it would have been important to accompany her 16-year-old daughter.

4.3 Talking about the perpetrators

The ages of the perpetrators were not always known but appear to range from young men of about 17 years to men as old as 55 years. Only two of the 16 participants said they did not know the perpetrators. In almost all the cases, the perpetrators were from the same village as the participants or have family that lives nearby. In a few cases the perpetrators were even related to the victims. One woman spoke about how she was repeatedly raped by her uncle over a long period.

“... From 1997 up until now my uncle has been forcing me to have sex with him. It was very difficult to talk about it and I tried to tell his wife but instead of supporting me she fought with me.” (P4).

Another old woman was very disappointed by the fact that her sister’s child raped her. She said,

“I have been hurt because the perpetrator is my sister’s child” (P4).

Few perpetrators had been arrested and were either out on bail or released on request by the woman, as she feared victimization and retaliation. A 44-year old woman who was raped by her uncle explained her decision,

“...Because he is my blood ... it was my conscience, I could not let him stay in jail for so long, so, I decided to request the police to release him”. (P4).

The participants whose perpetrators were never arrested reported various reasons. A woman described why the perpetrators were not arrested,

“...They ran away, but there were rumours that they were around Qumbu but we never saw them” (P1).

The same participant further explained how they assisted the police.

“We were told that the one that raped xxx was around Qumbu and we tried to contact the police ...” (P 1).

The police had asked them for assistance and requested they contact them when they see the perpetrators.

On the other hand, a married woman who was scared of her abusive husband could not allow the police to arrest the perpetrator, she reported why,

” I wanted to tell my husband first before they arrest him...” (P5).

This woman further reported other experiences of abuse inflicted by her husband.

Information about the perpetrators from the police was not always available. The participants often heard about perpetrators being arrested and within a short time saw

the perpetrators back in the village. This resulted in anxiety amongst the participants. The mother of the participants explained what happened, she said,

“...since they took the perpetrator that day, the perpetrator stayed at the police station on Saturday to Tuesday then we saw him back in the village. We were not told how he came back and the police never explained what to do next ” (P3).

Another participant also reported her experience, she said,

” My employer went again to find out about the progress of the case. They told him that the case was still being investigated although the perpetrator was arrested; he is now out on bail” (P16).

4.4 What happened at Sinawe Referral Centre?

The participants reported what happened at Sinawe Referral Centre and the majority talked about the examination where ‘everything was checked’, that there were ‘things’ taken from their genitals, pubic hair was cut and some reported that their underwear (*panties*) were taken, The mother of the victim explained how her daughter was examined at the centre, she said,

“...they wanted to check her HIV status; her pubic hair was cut, her underwear was taken (panty) and her genital fluids were also taken...” (P3)

Another survivor said,

“I was tested and the specimens were taken ...” (P12).

4.4.1 Provision of information

Nurses were mainly responsible for giving information to the participants. This includes a wide range of topics such as termination of pregnancy, HIV/AIDS, contraception, STIs, emergency pills for women of childbearing age and ARVs.

The majority of the participants knew that they were taking the medication to reduce the risk of HIV infection, to “*clean the dirt left*” by the perpetrators, and to prevent pregnancy. Even those that did not return for their second and third doses of PEP reported this. One of the women said,

“I was informed about things that might happen after I had been raped, like pregnancy, HIV and the nurse also reassured me that they were going to try to reduce the risks of HIV” (P 1).

Another woman also said,

“... These pills are given to people that do not have HIV, to prevent it, so that even if the rapist is positive, taking these tablets can prevent it” (P 6).

However, a few survivors could not recall why they were taking ARVs. One of them said,

“ I cannot recall if she said they were to block the virus from expanding if I had the virus, she gave me ARV drugs and the other big tablet that I took while I was there” (P16).

Another woman said, “... *the other tablets I was supposed to skip a week, then take two and others that I take after that week, in that order*” (P14).

Only one of them reported that she was never told about tablets. She further explained,

“...They did not explain why the tablets but they only explained why blood” (P4).

The nurses and the participants also discussed condom use in sexually active groups and abstinence in older, married women during the PEP medication. The participants mentioned that during the counseling session they were advised to use condoms while on PEP. One of the women further explained what she eventually did with her partner.

“... We never slept since the rape”.

Whereas an older, married woman was advised to abstain from sex. She said,

“... I was told that meanwhile I was taking tablets we must not have sex.”

Participants were further asked if they received any written information about the medication that they received at Sinawe. According to some participants, they were only counseled and the only information that was written was on the containers or envelopes in which the medication was provided. They elaborate on what happened. One of them said,

“... No, beside that, the pills were written when to take them” (P1).

Another one said,

“... on the container of the tables there were instructions on how to take them then I took the tablets as per instructions until I completed” (P4).

Few participants reported that the nurse gave them written information on how to use the medication. One explained

“...Yes, I have a paper...” (P15).

Another woman asked the nurses to write down instructions, she said,

“I asked her to write down because I feared I would be confused and take them anytime. She did write on the paper” (P14).

This written instruction was shown during the interview

After the examination, a doctor will prescribe the medication including ARVs for the women. A nurse will provide information on how to use the medication and the return date for the collection of medication and blood results.

Contrary to this, some women did not understand what they were told by the nurses. Women understood prevention but not what was prevented. This was evident from how women spoke in the interviews. For instance, one woman talks about “*if there is something*” later she talks about six week’s treatment instead of four weeks.

4.5 Taking about PEP

When asked about taking tablets, most of the women reported that they took tablets in the morning and evening before meals. Some mentioned that they did not have stipulated time as to when to take the tablets. A 24-year old woman who, was raped at the same time with her sister by different perpetrators said,

“We did not take medication on the same time everyday...” (P1).

Misinformation on when tablets should be taken was reported by some of the participants. They were told by the nurse to take the medication in the morning and evening but on their initial visit they were told to take the tablets during the day while they were at Sinawe. This created confusion and a woman described how she took her tablets.

“The first day I took them during the day and I did not feel right such that I could not do anything so I decided to take them in the morning let them work then take them again late”(P 5).

Another woman said,

“The nurse said in the morning but initially she took five tablets telling me to take them. I took them on that day and on the next days I took them in the morning, mid day and evenings...”(P 16).

There were only two women out of 16, who reported that they were told by the nurses to schedule time for taking tablets. One of the women explained how she took her medication. She said,

“I took the ARVS at 06H30 and other treatment later” (P1).

Another woman said,

“...the nurse told me if I take them at 8 o'clock in the morning I must take the second ones at 8 o'clock at night” (P16).

Some family members assisted the victims in taking tablets and giving information about ARVs, including how and when to take the tablets. A victim's mother explained how her sister helped her.

“I noticed that the tablets were ARVs and I was very worried that my child had HIV. I immediately phoned my sister who is working as a nurse in Port Elizabeth and she told me that maybe the ARVs were for preventing HIV and she also encouraged us that she must continue with the medication”(P3).

Another survivor who could not take her tablets when she was supposed to take the dose reported how her aunt advised her. She said,

“When I was about to double the tablets my aunt advised me against it” (P1). Her aunt educated her further about ARVs.

Meanwhile, another survivor reported that her boyfriend supported her in taking the tablets. She mentioned that her boyfriend used to call her and remind her about the tablets and this woman also said that,

“...I think maybe if I did not know that they were for HIV maybe I would have taken the tablets with more enthusiasm.”

Despite the assistance from the boyfriend this participant further reported how she decided to change the dosage to cope with the side-effects.

“...I decided to take my tablets in the evening only but still I would be nauseous but I took them up until they were completed. These tablets were for one week but I completed them in two weeks time. When I went back to Sinawe they told me that I was not supposed to default more than 4 days...” (P12).

Some rape victims mentioned that they did not take all the tablets. One of the victims said,

“There are some tablets that I finished, the ones for prevention, but I think there are some left even if they are few” (P14).

Another rape victim also admitted that there were times that she forgot to take the tablets, this woman said,

“...there were times that I forgot to take my tablets” she further reported that, “I doubled the tablets” (P 8).

Different experiences with PEP medication were reported by some of the participants. One of the participants summarizes some of the experiences that were reported. She said,

“...You know when you taking tablets there is no difference between short time and life. It’s like, I m going to live like this, to take the tablets and feel nauseous, and you think, oh my god, if I am HIV positive I will vomit up until I die and becoming sick every day, the reality of taking the tablets is different from theory... It is easy to say it is just for now I will get over it. I promise you the time you take the tablets it’s difficult to take them even to swallow and you feel like not being up to it...” (P 12)

4.5.1 Experiences of side-effects

Both those who completed and those who did not complete the 28-day cycle of Post Exposure Prophylaxis reported different side-effects. The most common side-effect

was nausea. Out of 16 participants, two participants could not continue with the medication because of side-effects. They elaborate why they could not continue with their medication, one of them said,

“ ...I tried to take the tablets several times but I vomited and I decided to stop taking them, I did not go back to Sinawe because I did not want to cheat” (P 6). Another woman said, *“ ...I did not go back on my scheduled date because I did not even take the tablets. I took the tablets once, I felt cramps and I even vomited them and then I decided to stop taking the tables” (P 7).*

Some women further mentioned other side-effects such as headache, dizziness, ringworms and heavy flow of blood during menstruation. These women explained their experiences. One of them said,

“After I had taken the tablets from Sinawe I experienced the following problems, headache, and also I became dizzy” (P 4).

Another woman said, *“I noticed that while using the medication, I developed ringworms (izitshanguba) but they later disappeared” (P 1).*

Out of 16 participants, two participants reported changes in their menstrual cycle and one of them could not complete the PEP. One of the women who did not complete her PEP said,

“When I was taking the medication I notice a heavy flow of blood during my menstruating period” (P16).

This menstrual cycle change is most likely due to the emergency pregnancy drug that is also part of the medication given to prevent pregnancy. It would seem that none of the women were told to expect a menstrual period whilst on pregnancy prevention medication.

There were some other women who could not eat certain foods or reported loss of appetite and perceived this to be because of PEP. One of them said,

*“The only thing I noticed was that I lost my appetite, so I tried to force myself”
(P 7).*

Another one said,

“When I took them I could not eat other things as they made me want to vomit but I would take the pills. I could not eat eggs and other foods” (P 5).

4. 6 Adherence to Post Exposure Prophylaxis

The major factors related to adherence to PEP include the need for women to return to Sinawe to collect the follow-up doses of the medication. They also have to return for the follow-up HIV tests, and for further psychosocial support. Depending on the distance of the women’s homes from Sinawe Referral Centre, some received medication that lasted for a week while others received medication for two weeks. Very seldom did they get medication for the full 28 days. This meant that most women had to return to the centre to collect the follow-up doses of PEP.

The mother of the victim who participated with her daughter in the interview reported the reason for collecting medication fortnightly, she said,

*“...So we went last week they gave us pills that were to last for two weeks...
the reason being that I was too far from Sinawe...”.(P3)*

The data indicate that 12 women out of the 16 could not complete the medication. They did not return for their appointments for further support and for the collection of PEP medication. Seven participants reported they did not have money for follow-up visits to collect the tablets. One woman said,

“I was supposed to go back to Sinawe on the 18th of the same month but I thought it’s the 8th of the following month. I did not even go back on the 8th because I did not have money for transport...”(P4).

Another woman also explained why she could not return to Sinawe, she said,

“... they told me that when the tablets are finished, I can even send my child to pick up other tablets but I did not do that because I did not have money...”(P9).

The reasons for not returning varied. A 73-year-old survivor reported why she could not complete the medication as she went to stay with her son in Port Elizabeth because of their concerns about her safety following the rape. When she was due for her second medication she went to the nearest hospital in PE but the health workers could not assist her and she did not get her second batch of PEP medication. She said,

“I went to Port Elizabeth; my children said that in PE the health workers will read what is on my card and they will also give me other tablets but in PE I was told that I should complete the medication then after 3 months go back for another blood test” (P9).

It is not entirely clear but it seems that continuation of care could not be provided by this hospital.

Confusion about the use of ARV drugs by HIV-negative victims was also reported. There was a woman who strongly believed that ARVs were only for HIV-positive people to boost them to stay healthier; she could not understand why she had to take ARV drugs because she was HIV negative. She said,

“...as I told you before that I was not positive, so I became bored of taking the tablets then I stopped...” (P7).

This participant was doing Grade 9 and she mentioned that at school she had been doing a school project on HIV and she had learned about HIV/AIDS and ARVs on television and radio.

Meanwhile the other survivor said, “... *I was stressed...*” and that she was “...*scared...*” of being infected by the HI virus. Miscommunication on when to go back to Sinawe was also reported. One woman reported her confusion because of what the nurse said and what was written on her card. The nurse had written her follow-up date as being in two weeks but her medication was given for one week, she explained how it happened.

“...In fact, I was to take tablets weekly, so I assumed that they gave me two weeks medication because they wrote that in my card...”(P 12).

Further, a 22-year-old woman who was working as a nanny, reported that she could not go to collect other tablets as she was looking after her employer’s child. She could not get time off. She explained,

“...on the 16th -day of November... but I did not go because I was looking after my employer’s baby while she was at work” (P 16).

4.7 Health concerns

Women were asked whether they have thought of health issues such as HIV, pregnancy and other sexually transmitted infections after the rape incident. Most of them were concerned about HIV and women of childbearing age were mostly concerned about HIV and pregnancy. A participant who was raped together with her sister said,

“...Our concern was HIV because they did not even want to use condoms” (P1).

For this participant a further concern about the potential infection of HIV was related to her sister's chances of being infected by the virus. She said,

"... the one that raped Zandile had a sexual relationship with an HIV-positive person and that was my brother's concern..."

The fear of HIV was clearly illustrated when a participant said,

"I prayed, in all what had happened, I must not be infected with HIV, It's better to be pregnant than being positive, because one can terminate a pregnancy" (P 12).

Out of 16 participants, two rape victims reported having contracted sexual transmitted infections during the rape incidents; one of the survivors reported her experience. This participant was repeatedly raped by her uncle over a number of years

She said,

"... I noticed that this pain was from him because if I've had sex with him it becomes better. When I skip a day without having sex with him it becomes painful..." (P4).

Another woman explained,

"...What I noticed was a discharge that was very smelly, I used to tell people about it. What puzzled me is that the discharge did not allow me to be in town for the whole day, I had to have a spare panty so that I can go to the toilet, wipe myself then put on fresh panties" (P14).

The data indicate that women's concerns were mainly based on experiences from their communities, the experiences of people living with AIDS and attitudes of people on HIV/AIDS matters. Almost every woman had seen or witnessed experiences of

people living with AIDS in their communities, and neighbourhoods. One of the women reported her experience of HIV/AIDS in her community. She said,

“My neighbour who was HIV positive gave birth to a negative child but she passed away leaving a child behind” (P 12).

Another woman also reported the experiences of her two cousins who were HIV positive. She said,

“... the first one died and was buried, the second one was buried 3 months back from now, when she became aware about her status, she came back from Johannesburg to stay with us, and it’s hard to watch someone dying in front of you”(P 13).

4.8 Community responses

The data showed that rape was viewed differently in the communities. Some women mentioned the support that the community had shown. The community members supported participants in different ways. Two participants explained how the community members supported them after the rape incidents. One of the women, said,

“... other people from the community were called and they came, some came with their and took us to the police station...” (P1).

Another woman who is working as a domestic worker said,

“...They came to see me because they heard that I was also beaten up...” and she further reported that, *“My employer would tell them what had happened” (P16).*

Other participants’ experiences after the rape incidents were not pleasant, they mentioned being chased away from the community, ‘gossip’ by community members, being laughed at by peers, being blamed for the rape and passing of judgmental comments. Community members who drink alcohol were particularly not trusted as one participant said *“...people who drink liquor”* discussed them. Another woman

mentioned that those who haven't experienced rape "*undermined the seriousness of rape*", by laughing and by judging the rape survivors.

4.8.1 Being blamed

Reporting the rape to police was often not acceptable in some of the communities. Participants reported that their communities blamed them for the rape. One describes her situation;

"... people in the village were blaming us for reporting it to the police..."

Another 44-year old woman who was repeatedly raped over nine years by her uncle was severely ostracized by her community when she eventually reported her uncle to the police. She explained,

"...Because I had reported the rape and my uncle was arrested two days after that, his neighbours became very angry about that. I ended up withdrawing pressing charges and my uncle was released in jail"(P4).

She continues reporting that withdrawing the charge was not enough and she was driven out of her community and said,

"Even though the case was dropped they wanted me out of the village, for me that meant I was poisonous". (P 4).

4.8.2 Reporting to the headman

Only four out of the 16 women reported the rape to their headmen. The data showed that not all four headmen were supportive to the rape victims. Only two headmen responded positively from the onset. One of the headmen supported the woman by writing a letter to the police station and another headman, with assistance from community elders, chased the perpetrator out of the village. The third headman initially took the perpetrator's side, however, he changed his mind after the husband

of the victim spoke to him and he accompanied them to the police station (the headman was related to the perpetrator). The response from the fourth headman was to isolate the woman from the rest of the community. The woman explained what happened,

“...The headman placed me here in this shack until I get my own place, with conditions. I was not allowed to visit anyone, which meant I was on my own and nobody had to visit here. I was also not allowed to visit my family...”

(P 4).

We interviewed this participant in a one-room shack and some of her children were around, as they were no longer attending school because of financial constraints.

4.8.3 Families and friends

Some families and friends were told about the rape. A trend was observed where younger victims preferred not to report the rape incidents to their parents but disclosed to their friends. Some family members were supportive and others were not. Those who were supportive contributed by providing money for transport to Sinawe Referral Centre for second visits up until the completion of 28 day's cycle of PEP. One woman said she would request money from her brother. Another woman reported how the decision was taken by her family to go and report the case to the police station. She said,

My husband told his younger brothers and they decided as a family that I should go to town (police station)”(P9).

A 44-year-old woman who was raped by her uncle repeatedly reported her incident to the perpetrator's wife. She illustrated her experience as follows,

“She questioned how I can say things like that and she even said I was disturbed mentally” (P4).

This woman also reported how the community members responded.

His neighbors took this matter seriously. I was chased away. They told me that they were tired of our fights...we used to fight with my uncle and make peace again ... but that time his neighbors wanted to beat me, telling me to search another place...the headman organized for me to live here I was also told that I am not allowed to go to my uncle's place and questioned them on that because I was wondering how shall I be assisted, when I had a problem because my uncle is family to me.

The family of the perpetrator also threatened another incident. The woman reported how the family reacted. She said,

“Even his brother used to threaten me and tell me that if I ever lay a charge against his younger brothers, he would beat me up and kill me but now we chat”. (P14)

However, not all the women reported the rape incident to their families. The main reason was that they feared being blamed for rape. One of the women explained why she could not tell her family (parents). She said,

” ...They will ask why I went out late, why did I even go there, and to tell the truth we did not have a reason why we did not go to school earlier...”

Another woman said,

“Even if I tell them they won't care so it's going to be the same...I have been raped before... by my brother... I realized that they don't care.” (P 13).

This participant further reported that her family took no steps when her biological brother raped her. Her mother acted as if nothing had occurred.

In some cases friends were reported to be supportive by assisting in reporting the cases and supporting the victims during the process of taking the medication. One woman reported how her friend helped her so that the perpetrator could be arrested.

“...When one of our friends called us, telling us to stand still as she saw xxx (perpetrator)” (P6).

They reported this information to her boyfriend who responded by assisting the police in arresting the perpetrator. The data revealed how people sometimes resolve the rape incidents in their communities if it is not reported to the police. In one case a mother of a 16-year old participant who also participated in the interview talked about how rape should have been dealt with by the families affected. She expected an ‘apology’ referring to the mother of the perpetrator. She said,

“If she had apologized, I would have forgiven her son” (P4).

4.8.4 Spouse response to rape perpetration

Most women were in intimate relationships. Twelve women had boyfriends, three were married and a 73-year-old woman did not have a partner. Almost all of them had informed their partners about the rape incident except one married woman who reported that she was unable to tell her husband,

” I am scared of telling him, I do not know whether he has heard about it. The reason is that he is cruel, jealous; he is going to look at the time it happened and not believe it. I am thinking if I go to him it will be better because if I phone him he is not going to understand. He does not ask about it when we talk on the phone so I assume he has not heard about it. I cannot tell him because you see here, I was stabbed by him” (P5).

The response from the partners differed in many ways but according to most of the participants, their partners were supportive and caring, while others were hurt by the incident. Some partners were keen to know about the HIV status of their girlfriends. One of the woman reported how her boyfriend responded,

“...we spent two days talking about what had happened... He would call me every time, when I was taking tablets, he used to remind me not to forget the tablets, and ask me how I was and also that I must not stop taking tablets.”(P12).

There were other two cases where partners played a major role in arresting perpetrators. One of the victims reported how the perpetrator was arrested,

“With the police officer we used my boyfriend’s vehicle to arrest him” (P6).

Co-operation from partners was also mentioned by most of the rape victims. An example given was the use of condoms while on Post Exposure Prophylaxis. Though some women were already using condoms there were those who had to introduce their use. Some partners chose to abstain from sex while on medication. One of the women said,

“...I requested that we stop having sex for a while, so he did not have a problem with that. We never had sex since the rape.”(P1).

Another woman also reported how other people treated her partner after her sexual assault,

“ My boyfriend told me that when he is with a group of people, people in the group would start a topic about me, things like xxx is in jail because of me”(P6).

Chapter 5

Discussion

5.1 Adherence to PEP

This study was conducted to explore the factors that impacted on adherence to PEP after sexual assault by rape survivors attending the Sinawe Referral Centre in Mthatha. Out of the 16 women interviewed, only four said they had completed the PEP treatment. A further two of those who had completed, also reported having missed taking the pills - one because she forgot and another one missed a dose because her friend used the handbag in which her medication was stored. The rest of the participants could not complete the 28 days treatment.

The women reported a number of factors that prevented them from completing the PEP medication. These included lack of money to return to the centre to collect the second dose of medication, life stressors, side-effects of the medication, service provider factors such as incorrect information, poor attitude from the service providers and a poor referral system. These factors will be discussed in detail below.

Generally, PEP drugs have been associated with different side-effects. Taking contraceptives and antibiotics in conjunction with the prescribed PEP drugs may compound the side-effects of PEP (Ulrike, 2003). The literature on PEP indicates that there have been many accounts of poor compliance to PEP due to side-effects (Vetten & Haffejee, 2004). In the current study, all the participants reported different side-effects, however, they were told to expect this by the nurses. Among these participants, there were two participants who identified the side-effects of the PEP drugs as the main reason why they stopped the PEP course. The most common side-effects were nausea, vomiting, followed by tiredness. The degree to which these side-effects incapacitated survivors varied, with four participants maintaining that it was constant throughout the 28 days and 12 participants maintaining that they experienced side-effects in the first week or two only. Women further tried to deal with the side-effects and some skipped either the morning or evening doses in order to reduce the severity of the side-effects.

It was also difficult for four of the women to return to the centre. All four were unemployed, one of them was still at high school, and the other two women's source of income was the government support grant (old age and child support grant). The women on grants reported that the grant collection date was not yet due and this meant they did not have money for transport to collect their PEP medication on time. These results are congruent with the existing literature on the economic status of the OR Tambo district municipality, as it is said to be the poorest district in the Eastern Cape with the highest poverty gap (R2,231 million) compared to the other districts (OR Tambo, ISD document, 2006).

Two women missed their return dates to the centre to collect their medication due to miscommunication from the staff. One of the women reported that a nurse wrote on her card that the medication was for two weeks instead of one week, eventually, she went back to Sinawe Referral Centre after two weeks and her PEP was stopped because she was considered a defaulter. Confusion was also common among the women. A woman confused her return dates. She thought her return date was the following month and when she returned a month later she was also removed from the PEP regime. In general the study has shown that women are not provided with any information to take home about the PEP treatment. It is known that due to the traumatic experiences people do not take in all the information given at the health centre and the information should be repeated or information provided in the form of pamphlets so that women can read at home when they are able to focus better (Vetten & Haffejee, 2005).

Health service factors were also found to play a role in adherence to the PEP. The need for a proper referral system for rape survivors throughout the province was highlighted in this study. This is particularly important because rape victim's lives are affected by the rape and many move to other places: 1) either to a place where they feel safer or; 2) because support for the person can be provided in the other settings. However, the health services do not easily accommodate these potential changes in people's lives. The results of the current study resemble the existing literature nationally and in other parts of Africa (Kim, 2003 & Speight, *et al.*, 2005). In Kenya similar reasons for poor adherence after sexual assault were reported, for instance, lack of transport cost to the hospital and side-effects (Speight, *et al.*, 2005). In an

attempt to address the quality of sexual assault care, minimum standards and norms were developed by the National Department of Health in a document entitled *The Primary Health Care Package for South Africa*. The document recognises the need for intersectoral and interdepartmental collaboration in the delivering of services (National Management Guidelines for Sexual Assault Care, 2004). How effective the implementation of these standards and norms has been is not known and it is not surprising that services has been different in different settings given that the Department of Health has only recently finalized the policy guidelines for implementation of sexual assault services (December 2007).

The poor levels of PEP adherence have also been reported by non-governmental organizations that are involved in implementing sexual assault services in South Africa. These NGOs include the Greater Nelspruit Rape Intervention Project (GRIP) and ACTS Clinic in Mpumalanga Province, Sikekelwe Crisis Centre in Johannesburg, and Thuthuzela Care Centre in Cape Town. In Gauteng the Provincial Department of Health commissioned research to find out the reasons behind low adherence and their results were similar to those found in the current study (Kachienga, 2004).

Some recommendations have been given on how to improve PEP adherence and the ACTS Clinic in Mpumalanga Province has switched from dual therapy to combivir, which they believed is easily administered (Kistner, 2003). In addition, they have started a home visitations programme to assist and support rape survivors in the period of the 28 days. To date they report an adherence level of 80% (Kim, 2005). No other interventions have been forthcoming from the Department of Health.

Furthermore, the improved information regarding risk and the HIV susceptibility is required first as the beliefs and attitudes influence the whole process of medication. (Green & Kreuter, 2005). The more favourable the attitude and the subjective norm are the stronger the person's intention to perform that behaviour should be.

5.2 PEP services

5.2.1 Police

In the current study the police knew and did their job reasonable well in terms of taking women to the centre but there were other aspects of police engagements with women that were not always positive. Some women reported having been requested by the police to assist with investigations, i.e. that they had to call the police, when they see the perpetrators. This might have influenced the recovery process of the survivors because they had to focus on assisting the police. Poor treatment by the police has been reported in community surveys and it has been suggested that this could be one of the main barriers to reporting rape to the police (National Management Guidelines for Sexual Assault Care, 2004). According to Jewkes & Abrahams (2002) barriers to reporting the cases include not being believed, difficulties with physical access, fear of the examination, fear of being blamed, fear of retaliation by the perpetrator, and fear of the legal processes, including experiencing rudeness and poor treatment. (All of these factors have been shown to affect levels of reporting). According to Green & Kreuter's (2005) precede-precede planning model the enabling factors that enable persons to act on their predispositions include available resources, supportive policies, assistance and services. Although, the policies regarding management guidelines for sexual assault care are available in South Africa, barriers in reporting rape to the police are still being reported. Some researchers have found that professional intervention may sometimes be re-traumatizing as current service delivery is often fragmented, poorly organized and not gender specific (Havery, 1996, Christofes, 2003).

5.2.2 Health

The Department of Health as the leading department on HIV/AIDS is the major service provider of PEP services after rape. Recently, the Department has extended the services to be provided by any health personnel who have gone through forensic training to attend to medical needs of the rape survivors (Kim, 2003). At the Sinawe Centre, doctors remain mainly responsible for examination of the survivors and the nurse's roles include counseling, and provision of information and follow-up visits.

Women showed varying degrees of understanding of the PEP medication. Most of them knew why they were given ARVs. However, despite the information provided by the centre, two women believed that ARVs were only for HIV-positive people and did not complete the medication because of this perception. At Sinawe Referral Centre information about PEP is integrated with counseling and the survivors routinely received verbal information on the PEP medication. This study has shown that none of the 16 participants received written information about PEP and taking of the tablets. Only a few were given written instructions about the medication, usually written on the container and these were related to the dosage and time for taking the medication. According to the theory of reason action by Ajzen and Fisbein (2003) the most important determinant of a persons' behaviour is behavioural intent. They argue that the individual's intention to perform behaviour is a combination of attitude towards performing the behaviour and subjective norms. If a person perceives that the outcome of performing that behaviour is positive, that person will have a positive attitude towards performing that behaviour and, on the other hand, if a person has a negative attitude towards performing a given behaviour that person might not perform well because of the negative attitude (Ajzen & Fisbein, 2003). Meanwhile, according to the Health Belief Model, asymptomatic people may not follow prescribed medication, since the motivation has to be based on the acceptance that although they are not sick, they could be infected with HIV and the medication will help to prevent that. This is what part of the results has shown (Green & Kreuter 2005).

At one of the interviews we saw handwritten instructions that were given to the participant. This handwritten note included the date she must return and the name and telephone number of the nursing staff member who wrote it. This is evidence that the lack of available information is at times compensated by the nursing staff providing handwritten instructions which could be time consuming if done for all patients. There was also evidence of variability in the information received with only four having been told to take the medication at the same time every day while the rest of the participants were told to take tablets in the morning and evening. In addition, health system factors also played a role in promoting non-adherence with women receiving incorrect information about follow-ups and not collecting the medication on time.

The shortage of PEP information has been identified across the country (Christofides 2003 & The Greater Nelspruit Rape Intervention Projects, 2004). According to GRIP, information, education and communication materials that assist counsellors and health workers to inform rape survivors about the medication are not available. In response to the shortage, the GRIP has produced booklets detailing medication, side-effects, and information on HIV testing. Grip is the only NGO that has reported good follow-up and adherence rates.

5.3 Psychosocial effects and stigma

The psychosocial factors that affect rape survivors have been discussed earlier in the literature in the studies on violence against women. They include Post Traumatic Stress Disorder that involves Rape Trauma Syndrome. In the current study almost all the participants (15) reported that they were stressed after the rape incident. Some mentioned that they had sleeping disorders, headaches, flashbacks (images of what happened during the rape), intrusive thoughts and nightmares. While it is noted that the use of Western psychological models of trauma in non-Western contexts should be cautioned, (Yuan, *et al.*, 2004), the women's extracts illustrated subjective descriptions of symptoms that closely resemble those listed in the DSM-IV-T under Post Traumatic Stress Disorder. These findings are consistent with the existing literature that 95% of women met the symptom criteria for PTSD within two weeks of post assault (Hamber & Lewis, 1997). This may have influenced adherence and it is clear that the health services must address the psychosocial care of rape survivors.

Furthermore, the social consequences of rape cannot be undermined as they can affect the survivor's ability to recover after the rape. Six women from the current study reported that they were subjected to negative social reactions, such as stigma and discrimination. This included being blamed by the community for reporting the rape to the police, being laughed at by the peers at school, being discussed in the shebeen and the perpetrator joking about the survivor's vagina to other people in the community.

Similar stigma and discriminatory consequences have been described by People Opposing Women Abuse include and these could influence ongoing social relations (Faravelli, *et al.*, 2004).

One participant experienced particularly severe forms of discrimination when she was isolated from the community. The profound social consequences may result in family breakdown, as some families do not cope very well in the aftermath of sexual assault (Christofides, 2003). It is clear from the literature Hannson (1992) that the social consequences of rape can lead to heightened PTSD. There is limited information in the literature regarding the type of intervention to reduce the negative social consequences for rape survivors. The 16 interviews conducted with the rape survivors indicate that families, friends and the community at large can play a major role in preventing and supporting the recovery of the rape survivors. The data show that support from the families during PEP can act as an enabling factor to increasing adherence to PEP, as some women reported being supported by the family members during the 28 days of PEP. The results of the current study are congruent with the existing literature on social stigma attached to rape survivors, depending on each survivor's situation, some survivors reported the incidences to their families and others choose not to disclose on their family members because of various reasons. According to Jewkes, *et al.*, (2002) the barriers to reporting rape are one of the major stigma in our societies. People are fearful of being blamed and of retaliation. Jewkes *et al.*, (2002) further mention the different factors related to social stigma - victim related, service related, perpetrator related, and community related. It is therefore necessary to address these social factors in order to increase the level of adherence to PEP after sexual assault.

5.4 Socio-economic factors

The challenges surrounding PEP services are similar to other social programmes that have neglected the socio-economic factors in the initial programme-planning phase of health service delivery. The notion of social capital represents a way of thinking about the broader determinants of health and about how to influence them through community-based approaches to reduce inequalities (Gillies, 1998). Social capital refers to the macro level analysis of social systems thereby looking into mechanism of

co-operation and conflict between sectors. It assumes that co-operation between sectors generates a social capital, in other words, social capital refers to benefits generated by collaboration between established social organizations (Putman, 1990). The existing literature on social capital shows that social cohesion and social responsibility contribute to more cohesive communities (Hawe & Sheill, 2000). According to Kawachi and Kennedy (1997), in any society, where there is a large gap between the rich and the poor and high disparities in levels of education exist, people from low socio-economic groups who are also poorly educated tend to suffer the worst health that leads to higher mortality. The lack of access to economic support from community members to attend the hospital may be a reflection of low levels of community adhesion and therefore low social capital. However, since rape is such a sensitive and sometimes also a stigmatizing issue, it is possible that the participants did not request economic support because they fear stigma responses. Furthermore, the expectation of stigma following rape in itself could also be an indication of poor social capital, i.e. poor support from community members. The findings of the current study could be a reflection of how low social cohesion can negatively impact on treatment adherence to PEP. In the current study participants could not return to Sinawe for further support mainly due to their low socio-economic status. These participants could, therefore, not complete the 28 days of PEP.

5.5 Lack of knowledge

Health Promotion according to OTTAWA Charter (WHO 1986) is supposed to initiate and drive the process of social change aiming at the improvement of living and working conditions conducive to health. The lack of health promotion activities in the management of sexual assault including PEP has been shown in this study. The biggest gap is between the beneficiaries of the service and the service deliverers. Many of the women interviewed were not aware of the service. To ensure that PEP services are accessible and are known by the people, the development of contextual health promotion strategies is essential. The one critical aspect absent in this service is the availability of basic health information. If information is incorporated into service delivery, it could have a positive impact on the level of adherence to PEP in that the rape survivors are able to gain increased control over their health (Green and Kreuter,

1999, WHO, 1986, WHO1997). Unfortunately, the PEP services in the country are only concentrated on making sure that ARV drugs are available for rape survivors. None of the health promotion strategies are included in the PEP services. This gap has also been identified by different NGOs that are providing PEP in the country (Kim, 2003).

5.6 Reflexivity

During the data collection phase there were various points of commonality and differences between the researcher and the participants that may have influenced the research process and the findings. These commonalities and differences are further explored below:

Identity

Our understandings are influenced by our identities, which, in turn, influence our experiences of the world, including an experience of rape and experiences of taking PEP medication. Social identities and inequalities such as gender, race and class, are fluid while at the same time also enduring. Boundaries of the sameness and differences are constantly negotiated while broad structures of inequality remain consistent (Acher, 2004). For instance, in this current research, the researcher may have prioritized her identity as a female when interviewing the participants. Even though there may have been commonality in terms of race, there were other aspects of my identity that were different from the participants, for instance, in terms of differences in education and socio-economic status, knowledge of ARV drugs and the importance of adherence. All of us may have shared a similar understanding of feminist knowledge of rape to varying degrees but my educational status as a Masters student, for instance, made me different from almost all the participants. This difference is likely to have influenced both mine and participant's perceptions of power and status during the interviews.

Positioning of the researcher

According to Acker (2000), we constantly shift back and forth when addressing the position of the researcher and the researched between insider and outsider positions because of our multiple subjectivities. He suggested that we should retain the tension of these positions as part of our overall reflexivity about our work. Another distinction besides that of just insider and outsider is that of indigenous insider (versus indigenous outsider). This is someone from the community or organization who is perceived as a legitimate member of others, and who is promoting the well being of that community or organization through research (Acker, 2000).

During the process of this study, I found myself shifting between the positions of indigenous insider and indigenous outsider. On the one hand, my indigenous insider position resulted from my experience as a lay counselor and as a life skills sexuality and reproductive health trainer that afforded me some insight into the internal dynamics of survivors of rape. This is what appeared to have facilitated the process of the sharing of experiences of rape and experiences of taking Post Exposure Prophylaxis medication on the part of my study participants. On the other hand, the fact that I was not a rape survivor prevented me from fully understanding the subjective experiences of rape survivors, the indigenous outsider position.

Foregrounding the inherent tensions between these researcher subject positions allows me to engage with the boundaries of the phenomenon under study, that is my understanding of the experiences of rape survivors and their adherence to PEP. More specifically, my identity as an indigenous insider and indigenous outsider influenced how I related to the scientific aspects of the research study, such as, the phrasing of the study aim and research question, the study approach and how the data were analyzed and produced. My acknowledgment of the 'self as the instrument' which is central to qualitative research, means that the voice accorded to 'the other' (my participants) can only be described, as partial, in my presentation and discussion of the interview transcripts in this thesis. Notwithstanding the above comments, I have, during the process of this research always attempted to centralize the lives of my participants and was always aware that I may have been inadvertently re-traumatizing them through their participation in this study. In this regard, women who participated

in this study did so voluntarily; I made every effort to ensure that women who required additional counseling sessions after the interview duly received these on request. I also made myself available after the completion of this study to provide feedback regarding the study results and, in addition, provide life skills, sexuality and reproductive health training to women attending the Centre.

5.7 Conclusion

After careful consideration of all the experiences of rape survivors and the literature review there appears to be a number of factors affecting adherence to PEP. The research has revealed that the rape service is not well known by community members and, given the high levels of rape in South Africa, it is important that such services are made accessible to communities. In addition, attempts must be made to strengthen relations between SAPS and Department of Health to ensure access to services. Not many services exist for rape survivors in the Mthatha community and there is an urgent need to develop such services and to further strengthen the existing organizations that are providing domestic violence services to ensure that survivors get the support they need in order to heal from the rape ordeal.

5.8 Recommendations

The study has shown that, the factors affecting adherence to PEP after sexual assault include: socio-economic status, lack of health promotion activities, knowledge about PEP, side-effects, psycho-social factors and health systems factors. The following section presents recommendations aimed at improving adherence rates.

Increase knowledge on PEP

It is recommended that:

- Health promotion strategies must be implemented to raise awareness about PEP and ARV drugs.
- Rape survivors should be provided with written information to take home about PEP drugs. This written information should be accessible to

those who use the service and should include information on how to take the tablets and how to deal with side-effects.

Medication

To improve adherence to PEP it is recommended that:

- The government should use drug regimes for easier dosage and lesser side effects.
- The option of dispensing Combivir should be encouraged as research on PEP indicates that this drug has less complications and it is a single dose and has the potential of a better adherence rate.

Follow-up visits and support

As recommended by the National Assault Management Guidelines of 2004, follow-up visits are necessary as the initial visit is based on explanations of the examination and medication including ARVs. For further support such as counseling, monitoring and management of the medication, follow-up visits are essential part of recovery.

- For accessibility, PEP services should be provided by the local HIV/ AIDS clinics.
- The health services for the rape survivors should not only focus on provision of PEP. The psychological impact of trauma suffered should be acknowledged.
- For trauma counseling and support all the rape survivors should meet the social worker regardless of age as most of the participants did not meet the social worker.
- Families and friends to be incorporated for medication support when the rape survivors are at home.
- Relationships between rape services and NGO services should be strengthened to provide support to rape survivors.
- Referral system to be established to accommodate the survivors in cases where the survivor decides to relocate due to unforeseen circumstances.

Further research

Further research is required to develop interventions and test them to improve adherence and follow-up of rape survivors through the 28 days cycle of PEP to understand what will improve adherence.

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Appendix A

Information Sheet: (participants from sexual assault services)

Introduction

Hello, my name is..... and I am the researcher working for the Medical Research Council. I am doing research to get information on women's experiences following a rape to help us understand the problems women experience following a rape. In particular we want to know your attitudes and responses to taking anti-retroviral treatment for HIV positive individuals or post exposure prophylaxis since you have been raped. We think that getting your views is very important. We want to ask you to give us some of your time to talk about your experience because it is only by speaking to women like you that can help us understand the problem that you face.

Why We Have Chosen You?

The women we are talking to have all been to a health service after a rape. At the center they were asked to give permission to have their contact details passed on to a researcher. All of the women were given explanations that a researcher will make contact with them to further explain the study and to asked permission to participate in the research.

What you can expect

I would like to conduct an interview with you. I will not ask you many questions and there is no set format to the interview. I will prefer that it is a conversation in which you relate your experiences and your feelings that you encountered when you interacted with people after the rape. There is no right or wrong way of talking about your experience – everything you say is important to me. The interview will take about 1 hour.

Confidentiality

All information that you give us will be treated confidentially. Instead of using your name we will use a code when we are looking at the information that you give us. No one except me will know that it is you who talked to me. I will be interviewing many women and will combine all the information from the women and a report will be produce that will present the final findings. You will not be revealed in the report. We will also keep all the information such as this interview in a safe place where nobody can access it.

Privacy

The interview will be conducted in a place where nobody else will overhear us. You can also tell me where you prefer to have the interview done and I will make the necessary arrangements. If somebody enters the room while we are busy I will stop immediately. As I said the above information will be stored in a safe place.

Consent

It is OK if you do not want to participate in the study. We respect your decision. You could also remove yourself from the study once you agreed – this can happen at any time. If you agree to be part of the study I will ask you to sign a form that indicate that you have been given information about the study and that you fully understand what will happen and that you agree to participate in the study.

Compensation

We will give you R20.00 for the time that you spend with us when we interview you. We are aware that this is not a lot of money but it hopefully will compensate for the time and effort that you are prepared to give.

Thank you, your help is appreciated.

My Contact Details

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If you have any further questions now or after the research please contact us at:

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Appendix B

PARTICIPANT CONSENT FORM:

A study to explore the impact of stigma on the uptake and adherence to anti-retroviral treatment for HIV positive individuals and post exposure prophylaxis for women following a sexual assault.

I have read and understand the information sheet on the above study.

I understand that my participation is voluntary and that I could withdraw from the study at any time.

I agree to participate in the study:

..... (Signature)

I agree that a tape recorder can be used:

..... (Signature)

Date.....

Appendix C

Interview Schedule

1. Attending the health service

What made you decide to use the health service?

What did they worry most about when seeking care?

Were any of these concerns conform during the visit

What was the most stressful aspect of attending the health service?

If not stressful – what was most helpful?

What was it like to be dealing the issue of pregnancy, STI and HIV?

If tested - how did you partner feel about the HIV test?

Did you understand what was happening regarding the testing and the drugs?

What was it like to return to the clinic for the test result and for the drugs?

What was it like to take the drugs to prevent HIV infection?

Were you able to successfully complete the course of medication?

Did you speak to others about it?

2. Taking medication

What made you to come to Sinawe?

What did the sister told you about the drug?

Did you understand what the reasons for testing and for taking the drugs?

How did you take the drugs?

Is there a time schedule?

Do you have a person that reminds you to take the drugs?

Are you experiencing any problem with the drugs?

For how long does the treatment going to last?

Were you given a return date?

What was it like to return to the clinic for the test result and for the drugs?

How did you feel when taking drugs to prevent HIV infection?

Were you able to successfully complete the course of medication?

What has been your feelings about the possibility of HIV infection been?

Changes in others towards you

What have been people reactions after you tell them about you rape?
Does the partner know about the rape?
If so what was it like to tell him about the rape and what was his reaction.
Did this influence the relationship?
Were people's reactions the same when you told them?
If not how was it different among them (friends, family members, colleagues?)
Do you think that the rape has changed the way others look at you or view you?
Have you regretted telling some people and why?
Have peoples behaviour towards you changed since they heard
How do you feel if people are treating and behaving towards you differently?
What makes you think or how do you know that people are viewing you differently.
Have all people changed their behaviour towards you or only some – who are they
and why do you think only certain people changed
How do you deal/respond to the change in people's behaviour?
Have you found that people are avoiding you?
Have you lost any friendships?
Why do you think the friendships have changed? Is it the peoples or is because of
your own actions.
Did people refer to the health consequences such as pregnancy and HIV when they
speak about the rape?
What were there concerns if they raised it?
Do you think people are most concern about the possibility of HIV compared to other
consequences such as pregnancy?

3. Coping

Are you selective about who you tell about the assault?
How do you decide whom to tell?
Why did you only tell certain people and not others?
Have you told people everything or given selective information only?
Did you tell people about the taking of drugs? If not, why?
How have you coped with the changes in yourself?
How are you dealing with the way people have changed towards you
What have been the changes in you social life since the rape/knowledge of HIV
status?

Have the changes occur because of your own behaviour or because of others.

Appendix D

Interview

PEP STUDY

MPEP: 1

Date: 22/08/2006

Interviewers

N: Naeema

K: Khuzwayo

P: Participant

N: May be, xxx can start by telling us about how she ended up at Sinawe Centre.

P: From the beginning, how it started?

K: Yes, why did you ended up at Sinawe?

P: Okay, it was Friday the 8th around 1 am; there was bereavement in the family so there were other people that were around to support the family during this time. The funeral was to be on Sunday. We, girls and children had to sleep in the other house within the yard (exandeni) and the adults were sleeping at the kitchen . We were sleeping, when I heard my sister that was sleeping in the bed making noise. I realized that there were other people in the room but we did not hear them pushing the door, some of them used the window to get inside and opened the door for others. The door from the room was kicked thus when my sister cried.

I was sleeping on the matras, when I try to respond, but I notice that a gun was pointing at me, and they instructed me to cover myself and I did that. The man with a gun instructed us to hand over our phones to him and others were also pointing guns following this man. I immediately switch off my phone and hid it under the matras. They started from the person that was sleeping next to the door to the second person both of them told these men that they did not have phones, they also approached me and I also told them that I did not have a phone then they threatened to kill us

K: Okay)

P: Some gave up two v23100 and two 3310, one of the 3310 was owned by the lady who was sick and had two phones hiding another phone (1600) they took the other 3310 on the changer.

This man told us that they want phones and money. After they had found phones, there was this one that was pointing Zandile with a gun the same man that was instructing us to give them phones instructing her to go to the other room. He dragged and pushed her down in the other room where he tried to rape her. My sister managed to escape, and come back crying, asking me to rescue her, but I could not rescue her because they were with guns.

K: M m.

P: He chased her and drags her back again to that room and he raped her. Another man that was also with these men that was wearing a black hat, said I must stand up, but, because, I had a 3-year-old child, I asked him if I can bring my child but he refused then I delayed, and he too dragged me to the other room. On our way to the room, we passed the other man raping Zandile next to the door. He said I must sleep and I told him that I cant with out a condom. I requested him that we use a condom but he said that he does not have time for condom. I begged and begged, he finally agreed after I indicated that the condoms are available but I could not find them and we were told by my sister that they are in the other flat within the yard; this time he did not want to listen he slashed and pushes me down and took off my panty then raped me. After the rape he told me that they know me that I am Thanduxolo's sister they want money that was brought by funeral scheme (umbutho) for the funeral.

K: M m

P: I told them that the only thing that I know was that, the money was spent on making arrangements of the funeral that include buying of the ox and payment of the funeral services and I do not know any thing about the change because they were also asking about it. He also wanted to know where my phone was, because it was not there with other phones and told me that they are not going to leave with out it and I told him that I have given Thobani whom I do not even know where he was, where as, I knew where my phone was. I agreed when they told me that they will search for it and they are going to kill me if

they come across it. They dragged me back to the same room that I was sleeping in, with other people and the other man had also stopped raping Zandile, she was already back with others in the room. When I was in this room they instructed me to bend down on my knees next to the person that was sick.

K: Okay.

P: They searched my matras that I was sleeping on and they found the phone under the bed but this time they did not hit me. They also asked my brother's room. And I told them that my brother was no longer staying here. He was staying in his place. They wanted my brother's wardrobe and they said that there was no way that he cannot have it here. I told them that my brother does not have a wardrobe but they can search and take any thing they see, so they searched and used bags to pack our clothes.

They asked the adults 's room and I told them that they are in the kitchen and they told us that they have been there but nobody was there, only to find out that they went to the six corner not the rounder (rondavel), I said maybe they heard them and ran away taught I am fooling them and one of them kicked me.

K: Okay

P: They went back again to the rounder (ronta) and searched and found two phones and money from the people that were there for bereavement. With my mother they only found silver (money) and they went back again to our room (Exandeni) bringing candle from the kitchen because they had destroyed the lights (globes) and that was when I could see the one that was raping me. I did not know his name but when I was describing him, I was told that his name was Zukile from Matyhaneni location.

K: M m

P: They instructed us to give them pin codes and also they took the other things for funeral like Baked bread, sugar, and long life milk, because the sugar was heavy they left it next to the garden.

N: I am sorry to hear that Nomsa, it must have been difficult, very difficult.

P: Okay

K: And then

P: I requested them to at least not leave with our sim cards but they only gave us two sim cards and mine was not there with these that were left, then we used Babalwa's phone, the other phone that she had managed to hide and my other sim card.

K: There were two Babalwa in the house?

P: Yes, another Babalwa belongs to Dlwambu family

K: How many people were there in the house(exandeni)?

P: Nine

K: Nine girls

P: No, Two baby boys and seven girls

N: all raped

P: No, only two were raped

N: Okay

P: We phoned my brother and he immediately phoned the police, then police said he must check what the perpetrators were using.

K: Did the police send you brother to check on perpetrators?

P: Yes, but he refused, telling the police that it was dangerous and he cant exposed himself because he was going to be hate. The police took long to come and stopped on the near by road and they said, they want a person that wants to open a case and my brother went to them, there after, they went back to the police station.

K: Ok, Excuse me; did the police stopped there?

P: Yes and the perpetrators had gone already. Some men from the location arrived and the other people from the community were phoned, they arrived with their cars and then we were taken to the police station. On our arrival the

police on duty informed us, that we would be served by the next shift team (morning shift). The police from the morning shift went at Matyhaneni location to search for Zukile where they found our clothes.

K: Okay

P: The phones, bread and other things were not found and the police also took us to Sinawe.

K: When, not on the same day?

P: On the same day, the perpetrators came around 1 am and left around 3 am and then we went to the police station and we were taken to Sinawe in the morning.

K: Okay

P: It's where we were told that a doctor would check us.

K: O right

P: We met the doctor on our arrival and the blood was drawn from us every thing was checked.

K: And then

P: M, m, there were things that were taken on our genitals and the nurse said it's done to help us to track the rapist.

K: Okay

P: We were also given pills and we were told that they were for cleaning

K: Cleaning what?

P: To clean the dirtiness that was left by the perpetrators, like we were tested and the ARVs were given to us. We were informed that they were to protect us if the perpetrator had HIV.

K: Okay

P: We used the medication. Our first visit was on the 8th before the funeral and the second visit was on the 17th and I do not remember the other dates but I

have a card that is indicating when. We were also tested, but they did not give us the results.

K: O right.

N: Did you get any information about the pills?

P: We were told that the tablets were for our protection and if we did not use them properly they won't protect us. They also informed us about the side effects.

K: Like what

P: That we can be dizzy, develop rash things like that.

N: Did you take the treatment? All of it or do you have it somewhere?

P: Yes, we have completed it we never took it again.

K: How many times did you visit Sinawe?

P: Four times on the 8th, 17th, 20th and.....

K: What was the first visit all about?

P: I was informed about things that might happen after I had been raped, like pregnancy, HIV and she also reassured me that they were going to try and clean so as to reduce the risks.

K: What did they do to clean you?

P: I was already tested for HIV when the nurse calls a doctor. Before the test I was told that if I am positive it means I was positive before the rape and the ARVs were not going to work but I was given ARVs because I was negative to prevent HIV infection.

K: Okay

P: The doctor arrived and I was also tested for pregnancy and I was not pregnant before the rape. The nurses also informed me that next time they would check if he did not impregnate me.

K: Same day or the following day?

P: No, Not on the same day, on my next visit. The doctor told me to take off my clothes and he conducted the examination they also requested that I leave my underwear (Panty).

K: Okay

P: The doctor orders a nurse to gave me injection and white four pills then the nurse said I must drank two pills there at Sinawe and to drink the other two later.

K: Thus your first, can you please tell me about your second visit.

P: We went back for the second time and we were given ARVs. I am not sure if on the third visit we were also given another type of ARVs, on the fourth visit they did not gave us because the nurses said we have completed the medication, we will only be tested, this was the day we meet you at Sinawe. We were tested but did not get the results.

K: Naeema will be looking at your card while we are talking, if it's okay with you.

P: Okay

K: Now, I would like to know when you were using medication, how did it go, how did you take it, how was your medication?

P: Nothing wrong but I noticed that while using the medication I developed ringworms (izitshanguba) but they disappears?

K: How

P: I do not know, in fact I did not report this a Sinawe.

K: Ok.....O right

N: Can I ask, who wrote this for you, the nurse?

K: Nurse Niki

N: And this number? Its nurse Niki's number

P: The doctor wrote this part and then nurse niki only wrote this.....and then other part any nurse that is at Sinawe when I am there will also write.

K: Otherwise this is doctor's order and Niki only wrote a return date.

N: This is doctor's orders and the number?, the cell number?, is this Niki's number?

K: But this writing is the same one as the above, its doctor's number

N: Okay, so did you have to go back on the fourteen of last month and you went back?

P: Yes

N: Then when must you go back? On the fourteen you got more tablets?

P: mm

N: You had to go back again on the 20th?

P: Yes

N: You have been going back all the times

P: mm

N: Did you have any side effects any rash, vomiting?

P: There were times that I felt like scratching myself and we were provided with medication to use when I had nausea.

K: Otherwise have you ever felt like vomiting?

P: Yes

K: Any other side effects?

P: Yes, I did developed ringworms (izitshanguba)

N: How did you take the tablets, morning, evening?

P: (Laughter) There were tablets that were taken in the morning, midday and afternoon.

N: Did your sister take the tablets?

P: Yes
N: How did she take tablets?
P: Like me
K: At the same time
P: Yes
K: Did you have a schedule time?
P: No, we did not schedule time because we were told to drink the medication in the morning and afternoon.
K: Okay
P: We did not take medication on the same time every day?
K: Not like that?
P: We were never advised to schedule time
N: So you did not take every day at nine o'clock for example?
P: mm
N: Okay, did you sometimes forget to take them in the morning and then you remember in the evening.
P: I did not forget but there was this day that the girl that was accompanying you borrow my hand bag, I could not drink my medication because I did not know where she put my medication and it was for the morning doses.
K: What happened there after?
P: When I was about to double the tablets my aunt advise me against it
K: Okay
N: After 28 days did you finish your tablets?
P: Yes
N: Okay, can I just go back here, on Friday you went to Sinawe and you did a blood test?

P: Yes

N: Did they give you results?

P: No

N: No, you must go back for results, is it important to do that, do you see it as very important?

P: Are you asking if it is important to be tested or to take my medication?

N: Actually both may be you can talk about why was it important to take tablets and why was it important to be tested also.

P: It's important to take medication to avoid infection especially because I was negative and it's also important to know my status so that if I am infected I can be able to use medication.

N: Did you think about HIV during the time?

P: Yes, I was thinking about it.

N: What did you think about?

P: So many things

N: Its difficult question nee?

P: No, but there are many things about HIV

N: I know it's difficult for you to talk, its important information for us and we keep all this information confidential

P: Some times I think if I had HIV what will I be like but I also reconcile my self because I 've got friends that are HIV positive. They are not discriminated. I tell myself that I will also be fine.

K: Did you tell anyone about the tablets?

P: Yes, like my family and a friend that was there during that night

K: Did you experience any changes from them?

P: No, instead they are supportive.

N: Did the whole community know about the rape thing?

P: Yes

N: And how they are towards you, they are right?

P: Yes, they do not have a problem instead they are uncourageous?

N: Because some times people treat those that have been raped differently, have you come across that?

P: No

N: For example they treat people with HIV differently, is that right. In this area if your neighbor know some body has HIV they look that person differently.

P: No, in this area there are many people that are HIV positive. They are the same, they are not treated differently and we do not see any discrimination by other people for instance we have an HIV person in my family.

K: So, you were not blamed?

P: No

K: Tell me, about the support group, may be they have contributed on this response

P: About Dr Mgobozi?

K: Yes

P: Yes, there are support groups

K: May be thus the reason why the is no discrimination

P: I won't say, because those that they do not know their status do not normally attend these support groups, only positive people are catered. Every last Wednesday of the month people are encouraged to attend so as to know what the support groups are all about but people do not have interest.

K: Okay, otherwise, you have accepted, you do not have a problem.

P: Yes, we do not have a problem

N: Its good to hear because sometimes its not always like that, you know when the rape happen you phoned your brother, does most of the people worried about HIV?

P: Yes, our problem was HIV because they did not even want to use condoms and the one that raped Zandile had a sexual relationship with an HIV positive person and that was my brother's concern but he also mentioned that even if we can be infected he does not see any problem we will be okay, as long as we will be alive.

N: So your sister goes to the clinic at the same time with you also?

P: Yes

N: Okay, o right and she are doing okay, your sister?

P: Yes

N: So they are going to do blood test 6 weeks, three months and 6 months?

P: Yes, but so far we have done two tests.

N: So are you people more worried about your sister?

P: Yes and me too, because, I do not even know his situation and he is not from my location and also, I do not know his sexual life style.

N: What happened, did the police pick the perpetrators?

P: They were not found

N: But it's a neighbor!

P: They run away, but there are some rumors that are saying the perpetrators are around Qumbu but we never saw them. We were told that the one that raped Zandile was seen and we try to contact the police to inform them that he is not at Mthatha as they told us.

K: From the location or in town

P: Both, he was seen in the nearby road, riding a bicycle

N: And what did the police say?

P: To tell them when we come across him.

N: It's the same even in Cape town (laughter) in Cape town they also asked women to call them when they see a perpetrator. His mother lives here and the family?

P: His mother passed away. He was staying in his mother's home, he is from Matyhaneni location and I do not know if his father is still alive. He was chased away at Matyhaneni because of the same wrong things he does.

N: mm

P: Then he run away and stays here in his mother's home, thus when he repeated same things and he is not wanted here, but he comes during the night.

K: So he was chased away or what happened?

P: Yes, the decision was taken on the meeting but I do not know if he is aware about it?

K: By the Chief or Headman

P: By the headman

N: Is the chief very helpful to people that are raped?

P: I wont say, its like, we have our headman and their have their headman at Matyhaneni location the case was reported to the headman at Matyhaneni location and the decision was taken on that meeting, that they do not want to see him again in the area.

K: What about your headman?

P: He did not come to the meeting but in our meeting, we had the members of the community, like when the comforter that was stolen was found on the whole the adults (Ibandla) in the village were called, then police were also phoned, thus how we support each other in the location.

K: What is ibandla

P: It's a group of people, men and women from the location.

N: When you went for a test on Friday did they do testing and counseling? Did they talk with you about the test and that?

P: Not on Friday, they only tested us and we met a social worker.

N: Did you talk with the social worker?

P: Yes

N: And they just take the blood and not talk to you about the test?

P: Yes, but they told us that we must come back for the results and we can even come on December, when we will be due for another test. Firstly she asked if I would have chance to go back to Sinawe and I told her that I can come during month end but, she said in case, I do not get the money I could come on the 8th of December.

N: So it's a struggle for you to go there, how much- transport?

P: The return is R52 with out food (lunch).

N: So if you go with your sister, its R52 plus R52 and where did you get the money from?

P: From my mother or brother.

N: Are you a big family?

P: No, we are not that big, because my brother is no longer staying with us . He is staying in his place but when there is a shortage he assist us like he would buy groceries and my mother also contribute by her pension.

N: So, what are you going to do if you want to go back again?

P: I will request money from my brother

N: He is working,????????????????????

P: Yes

N: ??????????????????????Is that your child?

P: mm

N: Okay, how are you coping? Are you coping okay with the rape, do you think a lot about it, how are you otherwise coping?

P: Mm, but now I am fine, I do not have a problem, I am no like when the rape was still fresh like initially, I would have images of that day. Now I do not have any dreams related to the incident. But I am afraid when the dogs are barking.

N: The Sinawe people: Psychologists and social workers can help you a lot with your problem. Why did the dogs bark dogs worrying you?

P: Normally when the dogs are barking, they see something. We usually think that they are coming back when the dogs are barking.

N: Okay, Do you have a boyfriend?

P: Yes.

N: Okay, how was your boyfriend after the rape?

P: I told him, he was shocked but then he was okay with it and he reassured me by saying bad things do happen to people and I am going to be o right.

N: So you think he is okay about it, but he knows about the tablets that you taking everyday?

P: Yes

N: So, when you come back from the clinic, he asked about it?

P: Yes, he asked about my first test results and I told him and about the second test, I also told him that I did not get the results.

K: Do you remember that the nurse had mention condoms while on treatment?

P: Before we went to Sinawe.

K: No, while on treatment.

P: I requested that we stop having sex for a while, so he did not have a problem with that. We never slept since the rape.

N: How long do you think it's going to happen (laughter) your boyfriend won't get worried soon?

P: I told him that I am going to inform him when I am ready so he agreed, he was not funny and he did no change, thus when I realized that he does not have a problem.

K: So you did not talk about condoms at all?

P: No

K: Okay

N: When do you think you will be ready again?

P: I do not know (laughter)

N: So, I mean to be back with your boyfriend because you obviously been hurt a lot and you busy covering better and better, you lost your uncle and this happen, its going to take a while, you need to get better, are you fine?

P: Now, I am fine, it is not like the same as before, we can have sex but we will use condom.

N: Is that your son. I wonder if he understands what we have been saying (laughter), any thing you want to tell us, are you wondering why are we asking you these questions

P: I do not have questions because you have already explained why.

K: Thank you