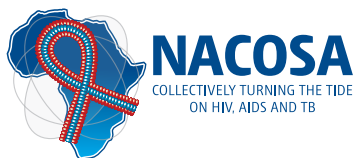


GUIDELINES & STANDARDS FOR THE PROVISION OF
SUPPORT TO RAPE SURVIVORS
IN THE ACUTE STAGE OF TRAUMA



supported by



COLLECTIVELY DEVELOPING STANDARDS OF CARE

In 2013 NACOSA, with support from the Global Fund to Fight AIDS, Tuberculosis & Malaria, began working with civil society organisations providing services at Thuthuzela Care Centres (TCCs) – one stop facilities for survivors of sexual violence led by the National Prosecuting Authority – and Designated Rape Centres at hospitals in areas not covered by a TCC. This integrated and multi-sectoral response has been recognised in South Africa and internationally as a successful model for supporting survivors of sexual assault to reduce secondary trauma, prevent HIV and STI infection and unwanted pregnancies and increase prosecution and conviction rates. There are 56 Thuthuzela Care Centres across the country and approximately 256 Designated Rape Centres. NACOSA works with 28 organisations at 41 TCCs and seven Designated Rape Centres.

Non-profit organisations provide a 24-hour ‘first response’ service to support survivors through the initial trauma process of forensic examination, HIV counselling and testing, provision of post-exposure prophylaxis (PEP), giving a statement and linking with other services and the justice system. This booklet is the product of the collective learning and knowledge developed by the organisations and people who provide these services to survivors; 24 hours a day, every day of the year.

GUIDELINES & RECOMMENDED STANDARDS FOR THE PROVISION OF SUPPORT TO RAPE SURVIVORS IN THE ACUTE STAGE OF TRAUMA

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“You should feel a great deal of pride for the work that has been accomplished and the contribution the work makes to such an important area of care for survivors.”

Sheila Young Steinbrenner, PhD, RN,
Indiana University School of Nursing

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Childline Free State	Mosaic Training, Service & Healing Centre
Ekupholeni Mental Health & Trauma Centre	Nisaa Institute for Women’s Development
Ethembeni Community Centre	People Opposing Woman Abuse (POWA)
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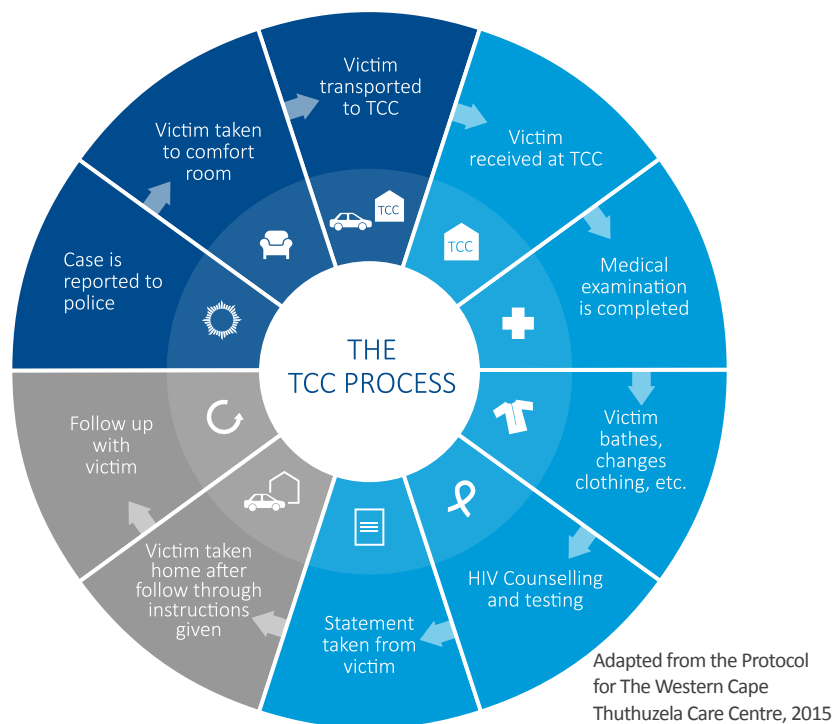
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Most importantly, we thank the dedicated brave and compassionate people working with survivors around the clock, across the country. They are our heroes.

RESPONDING TO SEXUAL VIOLENCE

A range of services are available to help survivors and their families cope with the aftermath of sexual violence. They may be based at police stations, courts, health facilities and non-profit organisations' premises and address survivors' health, social support and justice needs. But there are substantial gaps in these services and significant variations in practice, which means that all survivors do not receive the same range and quality of care. This booklet introduces a set of norms and standards guiding the provision of post-rape care to survivors in the acute stage of trauma to address this unevenness. The guidelines apply to the group of support workers employed by non-profit organisations to help survivors immediately after an incident of sexual violence at health facilities, including the Thuthuzela Care Centres (TCC), or police stations' victim-friendly rooms. We call these people 'first responders'. The guidance will also be helpful to health workers, police officers and any other frontline worker who engages with rape survivors immediately, or soon after, an experience of sexual violence.



While sexual violence takes many forms, ranging from unwanted touching through to rape homicide, these guidelines focus chiefly on rape as the form of violence reported most often to the South African Police Service (SAPS). Further, to acknowledge both the very real harm inflicted by rape, as well as the strengths and resilience demonstrated by individuals in coming to live well after rape, the terms 'victim' and 'survivor' are used interchangeably throughout this document.

Preventing secondary victimisation

Rape is a traumatising experience. In too many cases this initial trauma is *further* exacerbated by the disbelief and blame of others, as well as harmful or ill-informed treatment. This secondary victimisation, in combination with the stigma attached to rape, makes it much harder for survivors to come to terms with what has happened to them. To prevent secondary victimisation, post-rape services must be designed and implemented to uphold the rights contained in South Africa's Constitution, including those to equality, dignity, freedom and security, and the right to health care services. Where children are concerned, the Constitution also makes it clear that their best interests should be prioritised.

First responders and other frontline staff need to be familiar with the social and psychological consequences of rape, to ensure they create and maintain services that reduce the harm of rape, as well as take steps to prevent others causing further distress to rape survivors. They must provide support but also be the victim's advocate to prevent secondary victimisation. Rape survivors interact with a wide range of people on their journey through the health and justice systems so first responders must also network and collaborate closely with all the other service providers to ensure rape survivors and their families receive quality care.

RAPE IN SOUTH AFRICA

Violence is widespread in South Africa and has deep historical roots. Inequalities in gender, race, socio-economic conditions, geography, disability and nationality shape this violence and impact on the consequences of violence. Patriarchal models and systems, for example, have entrenched unequal power relations between men and women and privileged heterosexuality as a practice. This has profound implications for the forms of violence experienced by men and women, as well as responses to this violence. South Africa has the largest number of people living with HIV in the world (over 6 million people) which also impacts on both the causes and consequences of violence.

Sexual violence occurs frequently in South Africa and in 2013/14 a total of 62 649 different sexual offences was reported to the SAPS.¹ These figures do not capture the extent to which rape survivors remain silent about their experiences. Research undertaken in Gauteng found that almost one in 12 women (7.8%) had been raped in 2009, but that only one in 13 women raped by a non-partner reported the matter, while a scant one in 25 of the women raped by their partners went on to approach the SAPS.² National data estimated that only one in nine women who had been raped and also had physical force used against them reported the attack to the police.³ Overall, the Gauteng study suggested that one in four (25.3%) women interviewed had experienced sexual violence in their lifetimes, while 37.4% men admitted to having perpetrated such violence.⁴

 The extensive under-reporting captured in these surveys suggests that the majority of rape survivors never approach institutions for help.

The research and data do not show how different groups of women, as well as some men, are made vulnerable to rape. Both women and men may be targeted for attack because of their sexual identities, with a study based on a sample drawn from Botswana, Namibia, South Africa and Zimbabwe, finding 31.1% of women self-identified as lesbian to have experienced forced sex.⁵

Little information is available regarding the extent and experience of rape by women with disabilities. While one study of reported rape in Gauteng showed 1.9% of victims in the study to have some form of disability,⁶ these figures fell below the prevalence of disability in the female population of the province, suggesting that as with rape generally, the rape of women with disabilities is extensively under-reported.

Men experience rape too. A survey conducted in KwaZulu-Natal and the Eastern Cape found that about one in ten (9.6%) of the men interviewed had experienced sexual victimisation by other men in the course of their lifetimes.⁷

Small surveys of sex workers suggest that considerable violence is perpetrated against this group by both clients and police officers and that this, too, is rarely reported. In a survey of 1 136 sex workers more than half (54%) reported having experienced physical violence in the past year. The most common perpetrators were clients and police.⁸



THE MENTAL HEALTH CONSEQUENCES OF RAPE

The consequences of rape can be severe. Drawing on nationally-representative data, the South African Stress and Health study found rape to have the strongest association with post-traumatic stress disorder (PTSD) among women, affecting 6% of those who identified as having been raped.⁹ A Gauteng-based study found that 28.1% of women raped by non-partners were reported to have suffered from PTSD and 15.4% of women either sexually or physically abused by their partners suffered from PTSD.¹⁰ Other studies have found that women who experienced sexual assault, whether as children or adults, were also more likely to attempt or commit suicide.¹¹ In Gauteng, a quarter of women (25%) raped by non-partners reported attempting suicide while 19.1% of women either sexually or physically abused by their partners had attempted suicide.¹²

Other mental health difficulties associated with rape include mood disorders (such as depression) and anxiety disorders like PTSD; alcohol and substance abuse and dependence; eating disorders; and psychosis.

POST-TRAUMATIC STRESS AND RAPE

Rape survivors often experience the following cluster of reactions:

- Intrusive symptoms related to the event – distressing thoughts or mental images of the event, dreams or flashbacks.
- Persistent avoidance of things associated with the event – avoiding places, people, situations, activities or experiences that may be reminders of the event. This can include withdrawing from other people.
- Negative changes in understanding and mood – a host of negative thoughts and emotions may come to dominate survivors, such as fear and hopelessness, the loss of pleasure and feelings of mistrust and sadness.
- Changes in arousal and reactivity – physical changes that keep survivors on constant alert, leading to jumpiness, irritability, difficulties in concentration and sleep, and outbursts of anger.

National data detailing the psychological impact of child sexual abuse does not appear to exist in South Africa. However, a small study of 30 children aged between 8 to 17 and their care-givers provides some insight.¹³ At the first interview (conducted four weeks post-rape) 67.7% of children had symptoms indicative of full PTSD, while 29.3% exhibited partial symptoms. Anxiety of a clinically significant degree was identified in 45.2% of children, while high scores of depression were evident in 35.5% of children.¹⁴ The study did not attempt to measure caregivers' distress, but this appeared to be considerable. By the third interview, some caregivers' relationships with their children had become so troubled and difficult that initial support had been withdrawn from the child.¹⁵

An experience of childhood sexual coercion has other long-term consequences, including an increased risk of being subjected to physical and/or sexual violence at the hands of an intimate partner. Forced first intercourse was also associated with increased risk of physical and/or sexual partner violence.¹⁶ Teenage pregnancy is associated with sexual violence, with research conducted in the Western Cape finding that girls in the study whose first sexual experience was forced were 14 times more likely to be pregnant than their peers.¹⁷

Good support can lessen the effects of the immediate mental health consequences of rape, as well as prevent its medium and long-term effects (such as depression, or PTSD). The availability of support is also an important form of social redress. But mental health services generally, including those for rape survivors, are not widely available and there are too few psychologists and psychiatrists working in the public sector to meet the need.



In many communities, non-profit organisations are the only source of help to rape survivors.

The persistence and intensity of post-traumatic symptoms may lead victims to organise their lives around the trauma, altering their habits, activities and relationships in the attempt to avoid reminders of the attack. These reactions are generally at their worst in the first month following the assault and tend to decline in severity over time. When they persist for longer than four weeks this may result in a diagnosis of PTSD. But all victims are not affected in the same way. Some may experience only one or two reactions very intensely, while the onset of these reactions may be delayed for other survivors. Reactions may also subside – only to peak again at a later stage. Some victims' lives are marked by chronic and ongoing stressors which complicate their responses to the rape.



Not all survivors will be affected by rape in the same way.

The effects of rape are not confined to the victim alone. Dealing with the consequences of rape can also be traumatic. The distressing content of rape matters, in combination with high caseloads and the limited resources available to provide services makes counsellors and other frontline workers susceptible to trauma and burnout.

Because the psychological response to traumatic events changes over time, support needs to be flexible and adapted to the particular stage of trauma survivors are experiencing.

STAGES OF TRAUMA¹⁹



These guidelines and standards deal with the **acute stage** – that period of time following immediately and soon after the rape. During this stage, a victim's coping skills may be overwhelmed and their emotional and psychological reactions to the attack particularly intense. This makes them particularly vulnerable to others' ill-informed interventions or judgemental conduct. Good, supportive care is crucial during the acute stage to prevent any further harm to the victim. Supportive interventions soon after a rape can also help counteract victims' experience of others as dangerous and harmful, as well as make them aware that further help is available, including support around dealing with criminal justice system processes. The value of good help at this stage is made all the more important by the fact that, for many survivors, this will be the only time they receive mental health assistance.¹⁹

GUIDELINES AND RECOMMENDED STANDARDS

These guidelines and recommended standards for those supporting victims in the acute stage of trauma (first responders) aim to:

- Detail the **scope** and **content of services** to be provided to victims of rape in the immediate aftermath of the attack.
- Outline the **training** and **supervision needed** to support first responders
- Ensure a high and **consistent standard of care** to rape survivors
- Help prevent secondary victimisation

First responders should refer to their training manuals and any other guidelines or documents provided by their organisation to inform practice.

LAWS & POLICIES

These guidelines complement the following laws and policies that apply to sexual offences in South Africa:

- The Criminal Law (Sexual Offences and Related Matters) Amendment Act, 32 of 2007
- The Children's Act, 38 of 2005 (as amended)
- Older Person's Act, 13 of 2006
- National Directives and Instructions on Conducting a Forensic Examination on Survivors of Sexual Offence Cases in Terms of the Criminal Law (Sexual Offences and Related Matters) Amendment Act, 2007 (issued by the Department of Health)
- National Instruction 3/2008: Sexual offences (issued by the South African Police Service)
- Regulations on services for victims of sexual offences and compulsory HIV testing of alleged sex offenders (issued by the Department of Justice and Constitutional Development)
- National Instruction 2/2012: Victim Empowerment (issued by the SAPS)
- Regulation 33076: Consolidated Regulations Pertaining to the Children's Act, 2005 (issued by the Department of Social Development)
- The Victims' Charter.

GUIDING PRINCIPLES FOR SERVICES

Services should be developed in accordance with rape survivors' needs and, wherever possible, be informed by research. The following principles should guide services.

Dignity

Service providers must ensure that all procedures applied to rape survivors uphold their dignity and that rape survivors are treated with respect. All possible steps should be taken to prevent secondary victimisation.

Confidentiality

Rape survivors' personal details, as well as information related to the rape and associated criminal justice system processes, are to remain confidential. Organisations must ensure that counselling and examination environments offer privacy and that all documents relating to rape survivors are kept in a secure place.

Accountability & Transparency

Service providers should maintain records of their activities and be willing to make information about these available, within the bounds of maintaining survivors' confidentiality. They should also be willing to provide reasons for their decisions.

Safety & Security

All services must seek to create safe, helping environments for survivors and prevent further harm to survivors once they return home. Children should not be returned to environments that are neglectful and compromise their safety.

Self-determination & Participation

Services should seek to restore control to the survivor and secure their involvement in decision-making.

Non-judgemental & Non-discriminatory

Service providers must be equipped to deal with the diverse needs of rape survivors and make certain that they do not behave in ways that demonstrate prejudice or discrimination. Organisations must ensure their staff are trained accordingly. Services should also be equitable and the same standard of care provided to all service recipients regardless of their social identity and situation.

Rights-based & Responsive

Services must be rights-based and responsive to the unique needs of each survivor.

Best Interests of Children

Services must uphold the best interests of children.

Accessibility

To be inclusive, services must be accessible to all groups of rape survivors; including:

- **Physical:** at its most basic this refers to the location of services and their distance relative to major public transport routes. This is particularly relevant to people living in rural areas and informal settlements. Times at which the service is offered also determine access. Access for people with a disability should include adapted washrooms, appropriately designed ramps, doorways and floor surfaces and lifts.
- **Procedural:** how flexible service providers are willing to be in adapting routine or regular procedures to accommodate the diverse needs of victims. The adaptability of procedures is particularly relevant to younger children, victims with young children to care for, and people with disabilities.
- **Communication:** the availability and accessibility of information in a variety of languages and mediums, as well as alternative formats such as Braille, audiotapes and other communication aids.
- **Attitudinal:** service providers' sensitivity to the multiple needs of rape survivors, as well as their ability to deal with the diversity of marginalised groups such as lesbian, gay, bisexual, transgender and intersex (LGBTI) people, sex workers and street children, without prejudice.
- **Financial:** affordability of services, including the costs to clients of using public transport to reach facilities.

Organisations should ensure that these principles are integrated into the various codes guiding the activities of the organisation and its employees.

PSYCHOLOGICAL FIRST AID

Psychological first aid is a supportive intervention designed to reduce the initial distress caused by traumatic events. Its use has been recommended by many international expert groups including the World Health Organisation (WHO), the Inter-Agency Standing Committee, the International Federation of the Red Cross and the War Trauma Foundation. Its goal is to encourage people's ability to cope and function in the short and medium-term.

The provision of psychological first aid is not limited to psychologists or other professionals but can be applied by a range of para-professionals such as counsellors, disaster workers, health workers and police. It does not necessarily involve asking people to go into a detailed discussion of events, or to place events in time or order. No pressure is placed on victims to describe their feelings and reactions to events, nor are they asked to analyse what happened to them. Psychological first aid is therefore not a therapeutic, long-term intervention.

Psychological first aid works to:

- Establish human connection in a non-intrusive, compassionate way
- Enhance immediate and ongoing safety
- Provide physical and emotional comfort
- Calm and orientate emotionally overwhelmed and distraught survivors
- Help survivors identify their immediate needs and concerns
- Offer practical assistance and information to help survivors address their immediate needs and concerns, including their safety.
- Connect survivors as soon as possible to social support networks like family and friends
- Support coping mechanisms and acknowledge coping efforts and strengths
- Provide information that may help survivors cope effectively with the psychological impact of rape.
- Prevent further victimisation by ensuring that survivors are attended to promptly and compassionately by service providers.
- Link survivors to ongoing support by referring them to further services.

The role of the first responder

First responders, or those counsellors who help rape survivors in the immediate aftermath of the attack, should focus on enabling and supporting the conditions needed to promote a natural process of recovery. The role of the first responder is a dual one: they act both as a victim's advocate and as their support worker.

First responders should not assume that rape will always result in severe mental health consequences for survivors. This is because survivors are not all affected in the same way, or to the same degree, by a rape. Interventions should be flexible and adapted to the needs and concerns of individual survivors, as well as the available time. Those steps not completed during the first contact can be continued in subsequent contacts (such as return visits to collect medications). First responders should also act as advocates for survivors by ensuring that they are well-treated at all times during the reporting and forensic examination processes. This includes making certain that they are not left unattended for lengthy periods of time.

WHAT DOES THE FIRST RESPONDER DO?

- Provides psychological first aid
- Explains the various procedures that have to be followed when a rape is reported and/or a forensic examination is conducted.
- Is present, at the survivor's request, during the taking of the survivor's statement by police, as well as during the forensic examination.
- Provides information about post-exposure prophylaxis (PEP) to prevent HIV infection and follows up on PEP adherence. Those victims found to be HIV-positive at the time of rape should be provided with information about living with a positive status and referred for further support and treatment.
- Maintains client records and other information
- Issues comfort packs (usually containing: toiletries, a snack, underwear, sanitary towels and a small gift or reading material).
- Liaises effectively with all role players to ensure that survivors are attended to promptly and compassionately and takes action when procedures are not followed. Where possible, first responders should try to limit the number of people a survivor is exposed to and ensure they do not have to retell their experience unnecessarily.
- Provides referrals to further help
- In those organisations which include programmes addressing HIV (like those supported by the Global Fund), first responders may also be trained to provide HIV counselling and testing (HCT).

The 10 steps of psychological first aid

1 Preparation

First responders must be knowledgeable about their field of work and familiar with the procedures guiding services. Where first responders are working with others (such as in a TCC or police station), it is important to define each party's roles and decision-making beforehand to ensure cooperation and coordination. First responders should also make sure that the service setting promotes a sense of both calm and safety, and that they maintain a calm presence.

2 Contact and engagement

First responders introduce themselves and explain their role, adapting approaches as needed for children, older women and persons with disabilities. Survivors should be afforded privacy and assured of the confidentiality of the service.

3 Safety and comfort

Ensure survivors' immediate physical safety, attend to physical comfort and minimise exposure to additional traumatic experiences and reminders. Assess the risk of further harm to children likely to return to the same environment where the abuse occurred. If concerned about the child's safety, first responders should alert a social worker or police officer able to initiate the process of removing a child. At this point, first responders should also explain the procedures that will be followed at the police station and/or TCC.

4 Stabilisation

Stabilise and orientate emotionally overwhelmed survivors. First responders should also assess how much information the survivor is able to take in at this point and not overwhelm those survivors who are having difficulty concentrating, or who are experiencing intense emotional reactions.

5 Information gathering

Establish current needs and concerns. Formal assessments are not appropriate in the acute stage of trauma but it is helpful at this point to identify immediate needs and concerns, especially in relation to ongoing threats, extreme feelings of guilt or shame and thoughts about causing harm to self or others. Where these concerns are highlighted, provide information on coping and referrals.

6 Practical help

Help survivors prioritise and clarify their various needs so that each can be dealt with in turn. This may include discussing action plans around each concern and acting to address these, such as bathing, or issuing clothing to replace those items lost or damaged during the attack. Safety may also be of concern to adult victims who can be assisted with safety planning, including referral to a shelter.

7 Connection with local support

Networks of social support – family and friends – can help substantially with recovery from traumatic events. First responders can help survivors to contact and seek help from primary support people. In the case of children, service providers must include the non-offending parent/care-giver in efforts to ensure the child's recovery. Where survivors are isolated, or family members are not available, first responders can go with survivors through the various criminal justice system procedures, as well as referring them to ongoing support.

8 Information on coping

Provide basic information about stress reactions, as well as ways of coping with these. It is particularly important that primary care-givers of children also be given this information, both for the child and for themselves.

9 Linking with collaborative services

By identifying current needs and concerns, first responders can make a note of what other assistance is needed and provide direct links and referrals to these services. First responders should familiarise themselves with these agencies and the individuals working there to make these referrals effective. Where possible, first responders should try to minimise the likelihood of survivors being dealt with by a succession of different people and having to repeat their story to each one. This can be done by providing a referral letter which briefly summarises events, as well as providing a hand-over to the service provider.

10 Delayed reporting

In some instances disclosure of the rape will be delayed and a report made some time after the attack(s) occurred. While most survivors presenting at this stage may not be in a state of acute stress, some of the steps of psychological first aid may be applied to these cases.

Supporting survivors with extra needs

Organisations can adapt their procedures and practices to make sure that their services are accessible to all survivors.

- Create a resource list with contact details for organisations providing services to people with disabilities and older persons. To assist migrants and refugees, the list should also include details for agencies providing interpreters for a range of languages, as well as legal services.
- When helping survivors with communication difficulties, first responders can use written communication if the survivor is literate and no interpreter is available.
- For the hearing impaired, first responders should ensure their faces are visible to facilitate lip reading and stand within a distance of between one to three meters of the person. They should face a light source with the survivor in front of them to improve the visibility of their faces.
- First responders should raise their voices without shouting and speak clearly and slowly, without exaggeration.
- Only one person should speak at a time and an effort should be made to reduce background noises when dealing with survivors with communication challenges, older persons, or survivors with intellectual disabilities.
- Touch or a visual sign may be used to gain the attention of persons with communication challenges. But bear in mind that survivors of rape may experience even a gentle touch as intrusive and it may remind them of the rape.
- When possible, enable persons with disabilities to be self-sufficient.
- First responders should offer blind/visually-impaired people their arm to help them move about in unfamiliar environments.
- First responders should not touch a blind person or make sudden noises without first introducing themselves or informing the blind person of their presence.
- First responders should address the person directly, rather than through their caregiver or assistant.
- When unsure of how to help, first responders should directly ask the person with disabilities what they can do to help them.
- When supporting transgender survivors, first responders should ask how they prefer being addressed ('she' or 'he' or another pronoun).
- In cases of child sexual abuse, first responders need to be very careful about using a family member to interpret as the family member may be the perpetrator or may not want to acknowledge the abuse.

Legal duties

According to Section 110 (1) of the Children's Amendment Act of 2007 teachers, medical practitioners, psychologists, dentists, registered nurses, physiotherapists, speech therapists, occupational therapists, traditional health practitioners, legal practitioners, social workers, social service professionals, ministers of religion, religious leaders, members of staff at a partial care facility, shelter, drop-in centre or child and youth care centre, labour inspectors or police officials **must** report their suspicions of child sexual or physical abuse, as well as neglect. As individuals who come into contact with children and are in a position to observe their behaviour, as well as any unexplained changes to that behaviour, they must alert others to their suspicions of possible abuse. These suspicions may be reported to the provincial department of social development, a designated child protection organisation, police official or clerk of the children's court.

The Sexual Offences Act of 2007 also makes it mandatory to report child sexual abuse, but its provisions are slightly different to those of the Children's Act: any person who knows that a sexual offence has been committed against a child must report this to a police official. The same duty to report also applies to people with mental disabilities.

There is a legal duty to report the abuse of older persons. In Chapter 5 of the Older Person's Act of 2006:

"If any professional engaging with an older person observes that the older person is in need of care and protection, they must report this to the Director-General of the Department of Social Development. Any other person who thinks that an older person is in need of care and protection may report this to a social worker. If the follow-up investigation substantiates the report, the Director-General, or the social worker, may report this to a police official and ask them to take further action. In addition, if anybody suspects that an older person has been abused, or may be suffering from an abuse-related injury, they must immediately notify the Director-General or a police official of his or her suspicion."



First responders working with children have a legal responsibility to report sexual and other forms of abuse and ill-treatment of children. Family members need to be informed of this legal obligation.



SERVICES AT POLICE STATIONS

First responders working in police stations may be required to deal with all victims of crime and not only survivors of sexual offences. Psychological first aid may be used just as effectively with these victims. Those based in police stations should familiarise themselves with the South African Police Service's National Instruction 2/2012: Victim Empowerment, which guides the provision of services to victims, along with the establishment and maintenance of victim-friendly rooms.

- First responders based at police stations must check if their station is linked to a TCC. Where it is, they must develop good working relationships with the organisation based at the TCC to ensure smooth referral between the station and the hospital.
- The first responder's role at the police station is to ensure the survivor is taken to the hospital as soon as possible; and that police officials follow protocol. They should not delay this process by explaining procedures and thus duplicating the functions of the first responder based at the TCC.
- Where there is no access to a TCC, the first responder would play a more significant role in assisting the survivor. Depending on the time available they would apply psychological first aid and explain the procedures to be followed at the hospital and thereafter. Where resources permit, the first responder might accompany the survivor to the hospital.



RECOMMENDED STANDARDS

- ✓ At least one lockable counselling room is available at every police station on a continuous 24-hour basis, seven days per week, for the exclusive use of the survivor and first responder.
- ✓ The environment must be reassuring and the room accessible to people with disabilities.
- ✓ First responders are able to greet deaf survivors and can assist survivors with other disabilities.
- ✓ Every station-based service maintains a comprehensive and up-to-date referral list that includes contact details for local shelters and medium to long-term counselling services. In addition, the list contains information about specialised services for people with disabilities, LGBTI survivors, refugees and migrants and any other grouping which requires specialist assistance.
- ✓ Resource materials are available in all languages detailing how to cope with the psychological effects of rape.
- ✓ Organisations should work towards making services available on a continuous 24 hour basis, seven days per week.
- ✓ Organisations should work towards stationing two first responders per shift at the station.

SERVICES AT A TCC OR HEALTH FACILITY

Services to rape survivors in a health setting may be provided either through a TCC managed by the National Prosecuting Authority (NPA) or a crisis centre designated by the Department of Health (DoH), also called a Designated Rape Centre. Counsellors should be familiar with the Department of Health's *National Directives and Instructions on Conducting a Forensic Examination on Survivors of Sexual Offence Cases in Terms of the Criminal Law (Sexual Offences and Related Matters) Amendment Act, 2007*.



National Directives state that health services must be provided to survivors regardless of whether they have opened criminal cases or not.

Clients should be assisted in the language they understand and personnel should be trained to assist survivors in all their diversity.

If a call has been received from the police station that a survivor is on the way, the first responder should make certain that a separate examination room is available to prevent waiting in casualty and also check the availability of a doctor or forensic nurse to conduct the forensic examination.

Once the survivor arrives at the health facility these steps should be followed:

1. Implementation of psychological first aid and explanation of all procedures that will be followed, including registration for admissions/intake. (At some TCC sites the latter function may be performed by the site co-ordinator or the nurse.)
2. The completion of the forensic examination, which the first responder may attend at the survivor's request.
3. Where an agreement exists with the Department of Health and first responders have been adequately trained, first responders may provide pre- and post-test counselling and, in some instances, may also perform the test for HIV (HIV counselling and testing or HCT).

4. The investigating officer may take the survivor's statement, also in the presence of the first responder.
5. If the first responder is concerned about a child's safety, they must contact the statutory social worker responsible for removal and placement of children.
6. First responders must provide comfort packs to survivors, as well as referrals to a range of services, including shelter (where indicated) and longer-term counselling and support. Survivors, or their caregivers, must also be given information materials about HIV care and treatment, post-exposure prophylaxis (PEP), termination of pregnancy and coping with rape.
7. Depending on the arrangements at facilities, first responders may also be required to follow up on survivors' adherence to PEP.



RECOMMENDED STANDARDS

- ✓ The service is located within a reassuring environment and includes a private waiting area for families or friends.
- ✓ At least one private, lockable consulting room is available in the facility.
- ✓ Survivors are attended to by health staff within 45 minutes to one hour of their arrival.
- ✓ The first dose of post-exposure prophylaxis (PEP) is provided within two hours of the survivor reporting at the station or health facility. While PEP should ideally be taken within two hours of exposure, it is accepted that not all survivors may be able to report within two hours of the rape having taken place.
- ✓ Resource materials are available in all languages detailing HIV care and treatment, PEP, termination of pregnancy and coping with rape.
- ✓ Every facility maintains a comprehensive and up-to-date referral list that includes contact details for local shelters, medium to long-term counselling services, as well as the nearest clinic designated to dispense PEP. In addition, the list contains information about specialised services for people with disabilities, LGBTI survivors, refugees and migrants and any other grouping which needs specialist assistance.
- ✓ First responders' shifts are rotated to ensure they do not work double shifts. All first responders have access to regular and routine supervision and debriefing.
- ✓ All services work towards being available 24-hours a day, seven days a week.

SUPPORTING FIRST RESPONDERS

First responders are special people. They must be professional, compassionate and non-judgmental but also able to work well with a wide variety of people and be emotionally secure enough to deal with very distressing situations. They need adequate training, supervision and support to be able to provide a quality service to survivors.

Recruitment

The recruitment and selection of first responders must include interviews, police clearance and reference checking – against the national register for sex offenders *and* the national child protection register. Other considerations should include:

- The ability to work with a range of professionals, with different styles of interaction
- Recent emotional or psychological challenges or problems and how these have been addressed
- The presence of significant life changes or losses within the last six to 12 months
- Earlier significant losses or other negative life events
- Emotional maturity

Training

All first responders must attend in-depth training and have their competence assessed before working with survivors. Organisations should seek either to accredit their training, or to utilise accredited training materials.

At a minimum, training should include the following topics:

- Gender-based violence, gender and its intersection with other social inequalities
- Basic counselling skills and ethics
- Crisis intervention and trauma management skills
- HIV care and treatment and PEP adherence
- Other sexual and reproductive health issues such as sexually transmitted infections, emergency contraception and termination of pregnancy.



COMFORT PACKS

Age and gender-appropriate comfort packs should be provided to victims. Recommended standards for what these should contain:

- ✓ Underwear
- ✓ Sanitary pads for women and girls
- ✓ Toothbrush and toothpaste
- ✓ Soap
- ✓ A facecloth
- ✓ Food – a non-perishable snack

- Helping a diversity of survivors including older victims, victims with disabilities, victims who are drunk or intoxicated, victims with mental health problems, LGBTI victims, children, men, sex workers and refugee and migrant victims.
- Sensitisation to the broader economic, social and cultural context shaping violence and its consequences.
- Law relevant to violence against women, children and older persons such as the Domestic Violence Act, 118 of 1998; the Children’s Act, 38 of 2005; the Criminal Law (Sexual Offences and Related Matters) Amendment Act, 32 of 2007; the relevant portions of the Criminal Procedure Act, 51 of 1977 and its amendments; the Older Person’s Act, 13 of 2006; the Prevention and Combating of Trafficking in Persons Act, 7 of 2013; and all policies, guidelines and directives issued in support of these Acts.
- Personal development, self-care and stress management
- Record keeping and report writing

Skills and competence must be assessed continuously through the training, as well as on completion of the course. A variety of assessment methods should be employed including written and oral examinations, observation of counselling sessions, role-plays and post-course interviews. A probation period is also recommended.

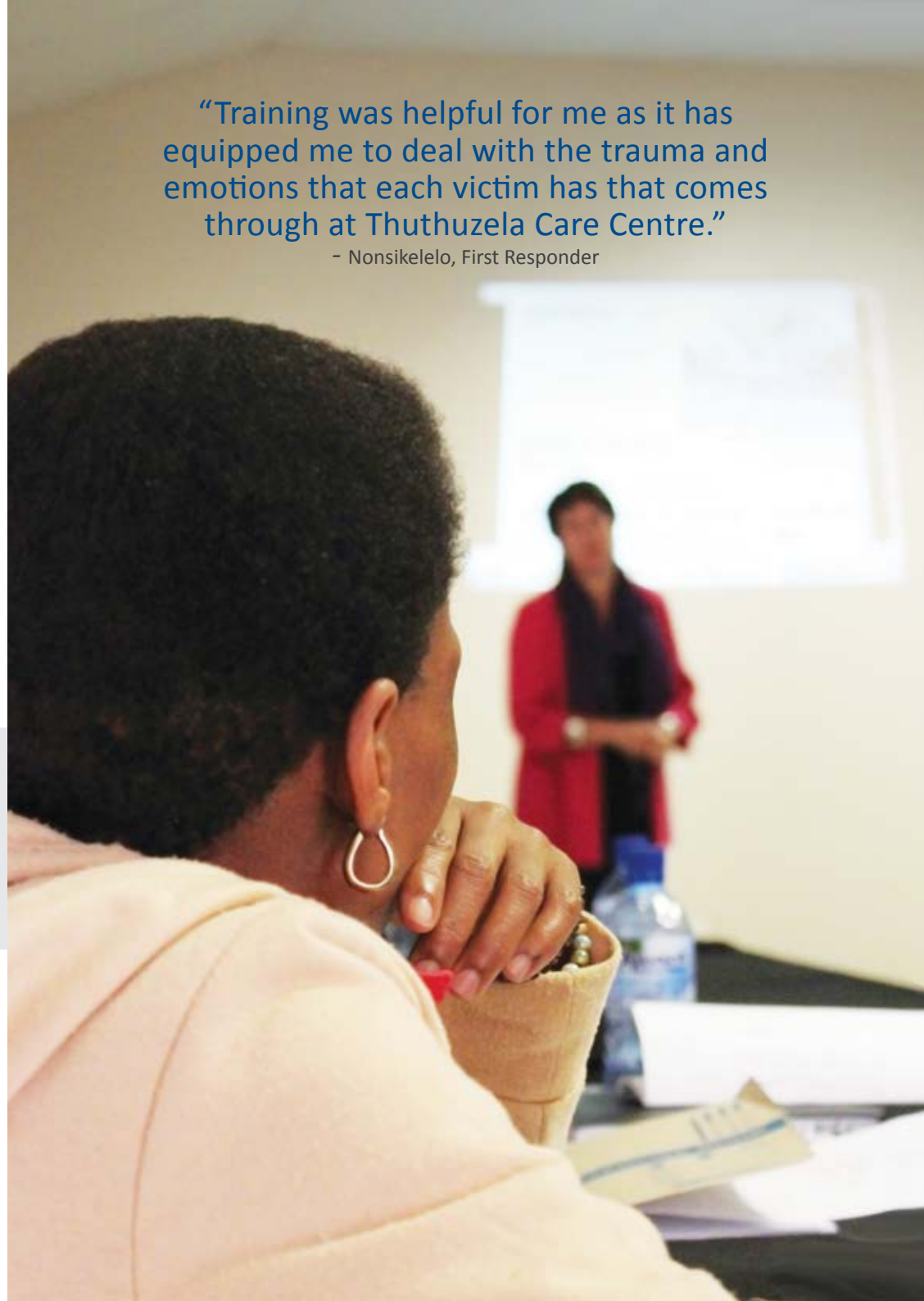


RECOMMENDED STANDARDS

- ✓ All first responders have attended a minimum of 60 hours of training.
- ✓ All first responders have been assessed and demonstrate the requisite levels of skill and knowledge.

“Training was helpful for me as it has equipped me to deal with the trauma and emotions that each victim has that comes through at Thuthuzela Care Centre.”

– Nonsikelelo, First Responder



Case supervision

Ongoing professional supervision is crucial to developing first responders' case management skills, as well as preventing vicarious traumatisation and burnout.

 No first responder should work without regular supervision.

The type and frequency of supervision is determined by the functions performed by first responders, as well as their level of experience. This may include:

- Weekly individual interviews and debriefing
- Monthly team meetings
- Peer group supervision

First responders should also have access to case debriefing and support outside of supervision, when needed, to help them with particularly difficult cases or cases that have a direct emotional impact on them.

Organisations can help to reduce stress by putting in place the following supports and policies:

- Limiting shifts to no more than 12 hours and encouraging work breaks
- Rotating first responders' tasks to ensure they are not constantly exposed to the most stressful activities.
- Ensuring time off
- Ensuring that people work with partners or in teams
- Encouraging staff to have appropriate boundaries to protect themselves from getting over-involved by, for example, taking victims home to stay with them.



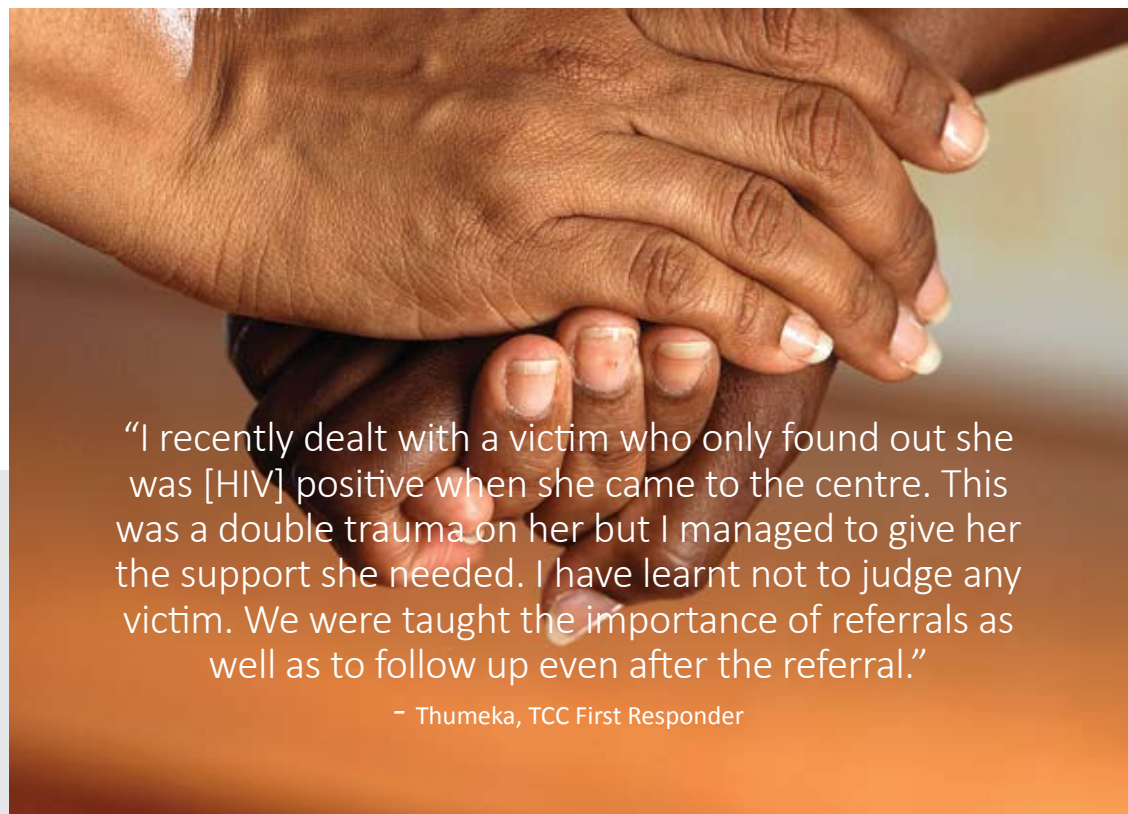
RECOMMENDED STANDARDS

- ✓ All first responders receive at least one session of supervision per month
- ✓ Senior staff are available to provide debriefing and support when needed and outside formal supervision sessions. This may include being on call in times of crisis.

WORKING WITH THE CRIMINAL JUSTICE SYSTEM

First responders, members of the South African Police Service and health workers are typically the first people rape survivors interact with. In a TCC, this group may also include the site coordinator appointed by the National Prosecuting Authority and victim assistance officers. It is important that each representative of their institution define and understand their roles in relation to each other.

Non-profit organisation staff should be familiar with the protocols guiding the work of each representative of the criminal justice system and should also seek to familiarise other role players with the scope and nature of their particular functions. Working relations may also be built and enhanced by participating in forums to improve services to survivors, such as the TCC implementation meetings.



“I recently dealt with a victim who only found out she was [HIV] positive when she came to the centre. This was a double trauma on her but I managed to give her the support she needed. I have learnt not to judge any victim. We were taught the importance of referrals as well as to follow up even after the referral.”

- Thumeka, TCC First Responder

RESTORING DIGNITY, PROMOTING JUSTICE

Don't make assumptions. Every survivor will react differently and have a unique set of personal circumstances – be flexible and let the survivor guide your response.



Caring, compassionate and professional support for survivors of sexual violence in the acute stage of trauma play a critical role in reducing the psychological impact of trauma, reducing secondary victimisation and preventing HIV and other sexually transmitted infections and unwanted pregnancies. By supporting survivors through the initial processes of forensic examination and the giving of statements, first responders are also helping to increase the reporting of rape and bring perpetrators to justice. Finally, by linking survivors and their families to other services, first responders are helping to stop the inter-generational cycle of violence in communities.

First responders are on the frontline of South Africa's response to unacceptably high levels of sexual violence. These guidelines and standards are dedicated to these heroes – and to providing them with the conditions and support they need to do their work.

GLOSSARY

Burnout – is associated with depression and vicarious traumatisation. It may arise from feeling either permanently overworked or under-challenged, being time-pressured, or having conflicts with colleagues. Over-commitment that leads people to neglect their own needs may also significantly contribute to burnout. It includes emotional exhaustion, a sense of alienation from work-related activities and reduced work performance.

Debriefing – Critical Incident Stress Debriefing (CISD), or psychological debriefing, is a technique that was initially widely used in the acute stage of trauma. Victims were typically required within the first 72 hours of the attack to provide a full narrative account of their experience, coupling this with identification of the emotional reactions evoked. Because it was found to have no effect on victims' well-being – and could even worsen the long-term effects of trauma – this form of debriefing is no longer recommended. In more general terms, debriefing also refers to the discussions between fellow counsellors, or counsellors and supervisors, of individual cases that may be particularly challenging, or have a strong emotional affect.

Secondary victimisation – the result of victim-blaming attitudes, behaviours and practices engaged in by family, friends or community service providers when dealing with rape survivors. It typically manifests in the form of beliefs that hold the victim responsible for the attack. It can also result in the unwillingness to treat rape victims, or reluctance to open criminal investigations, because the service provider does not believe the victim.

Supervision – a process of providing direction and support to a counsellor to ensure that survivors are provided with competent and ethical services. Services provided to victims are evaluated and adjusted, where necessary, to increase their benefits. Supervision also enables counsellors to develop their skills and knowledge on an ongoing basis.

Transgender (or trans) – is a term applied to people whose gender identity, or gender expression, is different to the sex they were assigned at birth.

Vicarious traumatisation – the cumulative effect of contact with victims of rape, other forms of violence or disaster. It is a process which may culminate in feelings of being burdened, overwhelmed and hopeless in the face of great need and suffering. It can also lead service providers to extend themselves beyond what is reasonable for their well-being, or the best long-term interests of survivors. Amongst other things, it may include emotional numbing, social withdrawal, feelings of despair and hopelessness and a negative view of the world.

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“I offer support and care to all the victims
by letting them feel loved when they
come in for help.”

- Queeneth, First Responder



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