

# National Management Guidelines for Sexual Assault

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## **Foreword**

South Africa is said to have the highest incidence of sexual assault world-wide. The health sector response to this growing need has however not been optimal. In response to this growing concern, Cabinet announced on the 18<sup>th</sup> April 2002 that government would endeavour in provision of a comprehensive package of care for those who are survivors of sexual assault. The package would ensure that care for the survivors incorporates the best possible clinical, psychological and forensic care.

These guidelines are therefore particularly timely because of the growing concern of sexual assault in the country. The management guidelines have been produced to guide the provision of health care services as well as set the minimum acceptable standards for provision of quality care to the survivors of sexual assault.

The development of the guidelines involved consultation with experts in the field as well as extensive review of literature. I wish to thank the task team for the excellent work they have done as well as the departments and organisations that provided their inputs and comments/participated in the development of the guidelines. I would like to also thank all the health workers for their continued efforts to provide care to the survivors.

Our responsibility as the guardians of women's health cannot be overestimated. Every effort has to be made to minimise inflicting further trauma to the victims of sexual assault, we owe it to the women of South Africa to make violence against them unacceptable not only because of the physical damage it does but also, and perhaps even more so, because of the psychological scars it leaves.

I leave you with this thought in the words of one survivor of sexual assault: "The body mends soon enough. Only the scars remain... but the wounds inflicted upon the soul take much longer to heal. And each time I re-live these moments, they start bleeding all over again. The broken spirit has taken longest to mend; the damage to the personality may be the most difficult to overcome."

**DR MANTO TSHABALALA-MSIMANG  
MINISTER OF HEALTH**

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Human Rights watch  
Phoenix Assessment and Therapy Center?  
Childline

**Section not complete - Check attendance list at workshop**

## ACRONYMS AND ABBREVIATIONS

1.	AIDS	Acquired Immuno-Deficiency Syndrome
2.	ARV	Anti-Retroviral Therapy
3.	AZT	Zidovudine
4.	CIAC	Crime Information Analysis Centre
5.	COC	Combined Oral Contraceptive
6.	CSDG	Contraceptive Service Delivery Guidelines
7.	CTOP	Choice on Termination Of Pregnancy
8.	DNA	Deoxy-Ribonucleic Acid
9.	EC	Emergency Contraception
10.	ECP	Emergency Contraceptive Pill
11.	EDL	Essential Drug List
12.	EDTA	Ethylene Diamine Tetra-acetic acid
13.	HCF	Health Care Facility
14.	HIV	Human immuno-deficiency Virus
15.	IEC	Information, Education and Communication
16.	IUD	Intrauterine Device
17.	LNMP	Last Normal Menstrual Period
18.	MCS	Microscopy, Culture and Sensitivity
19.	OC	Oral Contraception
20.	PCR	Polymerase Chain Reaction
21.	PEP	Post-Exposure Prophylaxis
22.	POP	Progesterone Only Pill
23.	PTSD	Post Traumatic Stress Disorder
24.		
25.	RTS	Rape Trauma Syndrome
26.	RPR	Rapid Plasma Reagin
27.	RTS	Rape trauma syndrome
28.	SAEK	Sexual Assault Evidence Kit
29.	SAECK	Sexual Assault Evidence Collection Kit
30.	SAPS	South African Police Service
31.	STI	Sexually Transmitted Infection
32.	3TC	Lamivudine
33.	VCT	Voluntary Counselling and Testing
34.	VDRL	Venereal Disease Research Laboratory

# NATIONAL MANAGEMENT GUIDELINES FOR SEXUAL ASSAULT

## 1.0 INTRODUCTION

Health care for sexual assault patients has to a large extent been a neglected area of service provision. There are substantial gaps in services described in many parts of the country with repeated reports that the process of seeking health care and justice exposes patients to further trauma.

Sexual assault care in the health sector has to respond to the health needs of the patient. These include care for physical injuries; immediate and long-term psychological support; pregnancy prevention; STI prevention and treatment; HIV counselling and prevention; and social effects. They also include access to proficient medico-legal examination to gather evidence for the prosecution of cases. Sexual assault care providers are therefore challenged to provide comprehensive sexual assault care by looking beyond the medico-legal needs of patients to their mental and physical health needs.

These management guidelines aim to improve sexual assault care within the framework of a health service model, which puts the patient's health needs centrally.

These guidelines form part of the National sexual Assault Policy developed. They focus on the implementation of the policy framework wherever appropriate and will facilitate provision of high quality care for sexual assault patients.

## 2.0 RATIONALE

Health workers should be able to respond appropriately to the emotional status of the patient, recognise and treat life threatening injuries and offer adequate emergency prophylaxis against pregnancy, STIs and HIV. Health care practitioners should also be skilled and competent to document injuries and collect appropriate forensic evidence such that the courts are provided with high quality evidence to assist with the prosecution and conviction of perpetrators of sexual assault.

The responsibilities of a health care worker looking after a patient of sexual assault are more complex than they are when looking after a routine patient. They should ensure that the **long term** medical and social consequences of sexual assault are avoided or minimised by providing informed and competent services. The health care worker should also be able to interact and network with other professionals involved in the care and management of the victim as well as know when and to whom to refer.

### 2.1 Magnitude

Sexual violence is a common event in South Africa. According to the Crime Information Analysis Centre, there were 52,550 cases of rape and attempted rape reported in 2000 of which 21,438 were of minors under the age of 18 years. There were also 2,934 cases of indecent assault of men

reported. This highlights the fact that both male and female are affected by sexual assault, but the highest risk group for sexual assault are children and young women and a large proportion of the patients seen will therefore be in this age group.

Research however suggests that reported cases are the tip of the ice-berg of sexual assault in the country. In one representative community-based survey, there were 2 070 such incidents per 100 000 women per year in the 17 - 48 age group<sup>1</sup>.

## **2.2 Factors influencing reporting cases**

The magnitude of rape cases reported in community-based surveys is significantly higher than that reported to the police. This suggests major barriers to reporting rape to the police. These include:

- Fear of not being believed as well as fear of being blamed. This is a very important source of further trauma for sexual assault patients.
- Fear of retaliation by the perpetrator
- Difficulties with physical access to the police station or health facility
- Fear of the physical examination
- Fear of the legal processes, including experiencing rudeness and poor treatment.
- Fear of stigmatisation. Many sexual assault patients are concerned that if they seek care after sexual assault their reputations will be ruined because health workers and facilities do not respect confidentiality.
- Lack of empowerment: understanding of rights and options
- Dependency for care by perpetrator or family/friends of perpetrator
- Date or marital rape or sexual abuse of children are not always viewed as crimes
- It is also important to note that the sexual abuse of children within the family may not be reported because many of these incidents are perpetrated by bread-winners. Children are therefore often silenced by economic necessity. Health workers must be aware of the fact that social security provisions for destitute children are only available up to 9 years of age.

Many sexual assault survivors do not go to the police because of the perception that reporting is unlikely to result in punishment of the perpetrator. At present, it would seem that this is the most likely outcome of sexual assault complaints. According to police data, during the year 2000 only 45% of cases were referred to court, 47% of cases referred to court were withdrawn in court and only 16.5% resulted in a guilty verdict. A woman, man or child laying a rape or indecent assault charge only had a one in 13 chance of seeing their rapist convicted<sup>2</sup>.

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<sup>1</sup> Jewkes R, Abrahams N. (2002) The epidemiology of rape and sexual coercion in South Africa: an overview *Social Sciences & Medicine* 55, 153-166

<sup>2</sup> Crime Information Analysis Centre (2000) South African Police Service Crime Statistics

Societal attitudes and responses to male sexual assault survivors inhibit disclosure and reporting of these experiences. Health care workers are more likely to see young male sexual assault patients than adult male patients. There are circumstances, however, where male sexual assault survivors are prevalent, such as in prisons or the army. Whatever the age, gender or disability of the patient the health care worker should be competent and prepared to manage the case. How men respond to experiences of sexual assault is the same as women. They would be particularly concerned as well about their masculinity, sexuality, other people's opinions and the fact that they were not able to prevent the event.

High quality health services can alleviate many of the patients' fears and provide for basic health needs after sexual assault as well as perhaps increase reporting rates to the police. It is important to see fears as very real and highlight the need for sensitive services and confidentiality, privacy etc.

### **2.3 Medico-legal evidence**

South African courts rely very heavily on medico-legal evidence in many cases to support the patient's account of what happened. Conviction of perpetrators may be influenced by the assertion that coercion was used, placing the accused at the scene of the assault and the description of the extent of the harm suffered by the patient. Previously health care providers kept very few clinical notes in the patient's notes as most information was documented on the J88 form. A Case Record to be used with the J88 form<sup>3</sup>, has been developed to facilitate complete and comprehensive care of patients and avoid omissions. The Case Record will be kept in the patients file while the J88 will be submitted with the evidence collected to the police.

A new sexual assault evidence collection kit has been introduced to improve the collection of evidence<sup>4</sup>. Whilst high quality medico-legal evidence is important to assist with the prosecution and conviction of perpetrators of sexual assault, health workers should not see the legal responsibility as impinging on their duty, which is provision of health care to the patient. The health worker's role will be confined to that of meeting health needs and providing information to the patient unless the patient decides to report the incident to the police. It is not the responsibility of the health worker to determine whether a crime has or has not been committed and, if so, which crime has (or has not) been committed or to draw conclusions about the reasons why the sexual assault occurred.

It is very important that health workers ask the survivor if they want to report the incident to the police or not and document what the survivor has said at that time. The survivor's decision regarding involvement of the

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<sup>3</sup> J88 Form: Report by Authorised Medical Practitioner on the Completion of a Medico-legal Examination; Department of Justice and Constitutional Development (G.P-S. 003-0055)

<sup>4</sup> By the Forensic Science Laboratory of the South African Police Services

police should be respected at all times. In the case of the older person ( $\geq 60$  years), health care providers are obliged by law to report these cases to the Director General in the Department of Social Development. Dealing with the older person with dementia, who is a patient of sexual assault requires special skilled health care providers and legal assistance.

The legal definition of a child is a person under 18 years. However, for the purposes of the sexual assault examination a child can be clinically managed as an adult from the age of 14. It is however essential when considering psycho-social care to give consideration to the level of maturity of the child between the ages of 14 and 18 years. Children of this age may still require child appropriate services (nb. Consent is handled differently – see section 6.0). All child sexual abuse cases should be reported to the Department of Social Development. Health care providers should discuss reporting the case to the police with the family if it has not yet been reported. Child cases are handled by the Family Violence, Child Protection and Sexual Offences Unit or a specialist member of the police where no Family Violence, Child Protection and Sexual Offences Unit is available.

### **Obligations to report child abuse**

Both the Prevention of Family Violence Act, 1993 (Act No 133 of 1993) and the Child Care Act of 1983 (CCA) impose an obligation to report the suspected ill-treatment and the abuse of children.

- Section 42(1) of the CCA requires any person who examines, attends or deals with a child in circumstances giving rise to the suspicion that the child has been ill-treated or deliberately injured or suffers from a nutritional deficiency disease, should immediately notify the Director-General or any officer designated by him or her for this purpose, of those circumstances.
- Section 4 of the Prevention of Family Violence Act, 1993 (Act No 133 of 1993) provides that child abuse should be reported to the police official, commissioner for child welfare or a social worker.

**Failure to comply with these reporting obligations constitutes an offence**

## **2.4 Health consequences**

Sexual assault can profoundly affect the physical, emotional, mental and social well being of women, men and children. Genital and other bodily injuries often result from the force used in the rape. However, many patients may have no visible injuries because they are threatened and (particularly when weapons are used) their strategy for self-protection is to offer no physical resistance.

In a series of 432 cases of rape examined in Johannesburg<sup>5</sup>

- 37% of rape patients had evidence of non-genital injury

<sup>5</sup> Martin L (1999) Violence against women: an analysis of the epidemiology and patterns of injury in rape homicide in Cape Town and in rape in Johannesburg. Unpublished MMed Forensic Pathology Thesis, University of Cape Town

- 38% had evidence of genital injury

Similarly whilst many patients demonstrate visible signs of distress after sexual assault, there are those that respond to the trauma with extreme composure or numbness. Caution should be taken not to interpret this as a sign of lack of impact. It is therefore very important that lack of injuries and lack of overt distress should not be interpreted as indications that a sexual assault complaint is unfounded or that the impact was insignificant.

All patients of sexual assault are at risk of a range of medium and long-term social and health problems irrespective of symptoms and signs present immediately after sexual assault. These include:

- Physical injuries
- STIs including HIV
- Psychological consequences
  - Depression
  - Post traumatic stress disorder
  - Psychosomatic complaints
  - Sexual dysfunctional disorder
  - Suicide
- Social consequences
  - Marital/relationship problems
  - Reduced contribution to society as well as to their own self-realisation
  - Stigma

In women unwanted pregnancy may result with associated possible sequelae may occur

-

### **3.0 OBJECTIVES OF THESE GUIDELINES**

It is against the background provided that the National guidelines on management of patients of sexual assault were developed. The aim of the guidelines is:

- To equip health care providers with tools to facilitate examination, treatment and management of sexual assault patients.
- To provide standards for provision of health care and collection of forensic evidence for sexual assault survivors
- This will facilitate examination and management of patients after sexual assault, and improve the quality and documentation of evidence collection.

The evidence collected may be used to confirm recent sexual contact. It may also show that force or coercion was used, identify the assailant and corroborate the patient's story.

Health workers at all levels of the health care system (looking after adult sexual assault patients) should be able to do the following:

- Recognise physical and sexual assault
- Document pertinent history
- Perform a thorough head to toe physical examination
- Document all injuries
- Collect forensic evidence as prescribed in the SAECK/SAEK
- Pre and post test counselling for HIV
- Screen for STI and HIV
- Treat physical injuries
- Prevent unwanted pregnancy
- Prevent and treat STIs
- Provide post exposure prophylaxis for HIV
- Provide psychological support
- Refer to appropriate resources
- Complete the J 88 form in police cases
- Present evidence in court

For child sexual assault at primary care level, the health worker should:

- Know when to suspect sexual abuse
- Recognise cases of sexual abuse and act appropriately
- Recognise urgent / life threatening complications of sexual abuse and act appropriately
- Refer the child for collection of data
- Offer post-exposure prophylaxis against HIV (antiretroviral) starter pack

For child sexual assault - The medical examination may be conducted by a doctor or trained nurses (nurse who has been trained in examining children who have been abused).

#### **4.0 GENERAL GUIDING PRINCIPLES**

The following guiding principles should govern the provision of sexual assault care.

- The health and welfare of the patient takes priority over medico-legal services. In other words, treatment of injuries and assessment and management of pregnancy and STIs is of primary importance. The welfare of patients includes ensuring that patients are able to maintain their dignity after the assault and do not feel humiliated and degraded

- Health care providers should be appropriately trained and skilled in managing sexual assault patients
- Services have to be (gender) sensitive to the needs of the sexually assaulted patient
- Children, the elderly, mentally impaired patients and patients with disability, have special needs. These must be understood so that each sexual assault patient receives the best possible care
- In the instances of child sexual assault patients, provision care and support should be extended to the parent/caretaker of the child who may be as, and sometimes more, traumatised as the child patient.
- Services should be available 24 hours a day, and sexual assault patients should be prioritised (forwarded to the front of the queue) irrespective of the nature of physical injuries.
- A quiet environment and private room should be provided for the management of sexual assault patients to ensure privacy and reduce anxiety (associated with disclosure of sexual assault and the examination)
- Confidentiality should be maintained and respected at all times
- The health care provider should always assume that the patient is providing true information. It is not the place of the health worker to question whether information given is true or not.
- The patient must be protected from secondary victimisation and further harm
- Consent for examining the patient and release of information for medico-legal and counselling services must be obtained. The patient should be informed about each step before proceeding
- Forensic evidence should be collected before treating injuries unless there is need to attend to injuries first (e.g. bleeding wound). NB. medical treatment can result in loss of potentially valuable biological evidence
- Information about reporting procedures should be provided if charges have not yet been laid with the police. Patients should be assisted if they wish to lay charges
- Respectful and non-judgemental attitudes as well as involvement of the patient in decision making are essential parts of high quality service
- Services should be mindful of the need to protect the chain of evidence at all times through preventing possibility of the perpetrator coming into contact with the patient and locking collected evidence away
- An attempt should be made for women/female children who have been sexually assaulted/abused to be seen by a trained female health worker. Where this is not possible, another woman should be present when a male trained health care provider examines the patient.
- The patient should be given the choice of having a friend or family member in the examination room
- In the instance of the child sexual assault victim, the presence of a parent or parenting figure is not always indicated during the examination especially where there is a strong cultural taboo on discussion of sexual matters between parents and children. The child should be consulted on this issue when sufficiently mature.

#### **4.1 Principles guiding the management of children under 14 years**

In addition to the general guiding principles which pertain to all sexual assault case management, the following pertain to the management of children:

- The best interests of the child shall be paramount
- Children have a right to express an opinion, to be involved in all decisions and to have their opinion taken seriously
- Children have the right to be present when decisions are made, except where their participation would not be in their best interests
- Children have a right to have processes explained to them in a manner in which they can understand
- Examinations should always be conducted with a third person present – preferably someone the child trusts

## **5.0 INFORMATION TO THE PATIENT**

Patient information is an important part of sexual assault care. Information should be provided in an appropriate language. If appropriate IEC materials are available, these should also be provided to reinforce information given in the consultation. Patients may be in shock and may not remember or understand everything that is discussed during the course of their interaction with the sexual assault health care provider. Hence, it may be necessary to repeat information several times and where appropriate and the patient is literate to provide written information.

The content of information to patients/guardians should include:

- What is involved in the examination and the processes surrounding it
- Health risks after rape and the need for testing and treatment
- HIV, pregnancy and STI risks
- Laboratory investigations and treatment regimens including their side effects
- Psychological impact and coping strategies
- Legal rights of the patient and procedure of giving evidence to the police
- Further support after sexual assault either in the community or through a telephone help-line
- Complaints mechanism
- The results of the examination, investigations and the follow up plan

## **6.0 CONSENT**

### **GENERAL GUIDELINES**

Written consent should be obtained using, for example, the SAP 308 form or a facility consent form. Getting informed consent should not be seen as a one off event when the form is signed at the start of the examination, but as a process running throughout. At each stage of management, information should be given and verbal consent obtained.

Any patient aged 14 years and above can consent to a medical examination. If a person of 14 years or above refuses the examination, this must be respected. Clearly explain the criminal justice consequences of this to the patient but do not insist that he or she undergo the examination. If the patient refuses the

examination they should still be counselled about pregnancy risk and prevention and treatment for STIs and HIV. They should also receive appropriate treatment. Written consent should be obtained for the following:

- To conduct medico-legal examination
- To take photographs (where a camera is available)
- To release the report and evidence collected to the police (for evidence in court) where cases have been reported
- To communicate with law enforcement (in situations where the case is not reported)
- To do a pregnancy test and test for HIV
- To provide treatment for pregnancy prevention and other treatment including PEP
- To release the necessary information to other referral agencies

### **6.1 Consent for the unconscious patient**

If the health care provider has reasonable grounds to suspect that sexual assault has occurred to the unconscious patient, medico-legal evidence should be collected. The following procedure should be followed:

If the patient is unconscious, the health care provider should attempt to contact a parent, guardian, or relative for consent to conduct a medico-legal examination. If no one can be contacted, (discuss with a colleague and/or contact superintendent) the examination should be conducted and document the efforts made to contact next of kin.

### **6.2 Consent for children under 14 years of age**

For children under 14 years consent must be obtained from a parent or guardian. If such a person is not available, or the only one available is suspected to be the abuser, the medical superintendent may give consent for the examination, tests and treatment. From the age of 14 consent should be sought from the child for everything except major surgery. However consent should also be sought from the child before and during the examination. This will considerably enhance the possibility of the child's cooperation during the examination process.

### **6.3 Consent for the patients with temporary mental incapacity (drunk, high on drugs)**

The patient may be under the influence of alcohol and/or other drugs. This may pose a challenge when obtaining consent for various aspects of care.

If the patient suffers from temporary mental incapacity, she/he should have an initial assessment for physical injuries, care being taken not to contaminate evidence. A blood sample should be taken immediately with patient's agreement and cooperation and a decision to test for drugs and/or alcohol can be made later. If no major injuries requiring immediate attention are found, the patient should be allowed to recover first (i.e. sleep it off in a secure room) and medico-legal examination conducted when lucid if the patient requests it after being given the options.

#### **6.4 Consent for the mentally incompetent patient**

No one should be denied treatment due to mental incapacity. A next of kin, guardian, medical superintendent or Magistrate can consent on behalf of the patient. It is not appropriate to obtain consent from the guardian if the guardian is reported to be the abuser.

#### **7.0 PATIENTS WHO DO NOT WANT TO REPORT THE INCIDENT TO THE POLICE**

There is no statutory obligation to report the sexual offence if the patient is an adult. In case of the patient who is uncertain about reporting the alleged assault, the health care provider **should listen to** the patient's fears and concerns to help the patient make the decision about reporting. If the patient is still uncertain about reporting or says she/he does not want to report, and the sexual assault occurred within 5 days, she/he should be encouraged to allow collection of evidence to be preserved in case she/he decides to report at a later date. The evidence should be kept at the health facility in a safe locked place with a register for minimum of 6 weeks.

The patient should be offered treatment of any physical injuries, STIs and HIV/AIDS prevention and, in case of female patients of reproductive age, pregnancy risk evaluation and prevention. The patient's right to decide should always be respected and honoured and the patient should never be coerced or forced to report the sexual assault or to undergo the medico-legal examination. If patient agrees to be examined but does not want evidence collected any injuries noted should still be documented in the Case Record.

#### **8.0 COUNSELLING AND PSYCHOLOGICAL SUPPORT**

Detailed counseling and support is not always appropriate in the acute phase (i.e. soon after the sexual assault). During the acute phase, counseling is usually restricted to an explanation of the examination, specimens needed and the risks of pregnancy/STIs and treatment/prophylaxis needed.

Information (and packs if available) should be provided on the following:

- What is involved in the examination and the process surrounding it
- Health risks after sexual assault and the need for testing and treatment
- HIV, pregnancy and STI risks
- Treatment regimens and their side effects
- The psychological impact of sexual assault and coping strategies (Rape Trauma Syndrome - RTS)
- The rights of the patient regarding reporting to the police and giving evidence in court
- Further support after sexual assault either in the community or through a telephone help-line
- Complaints mechanism

After the acute phase, ongoing detailed psychological support and counseling may be needed. This can be delayed for at least three days and should integrate

various aspects of care, which may be provided at different times. This primarily includes trauma counseling and pre and post-test HIV counseling. It should be noted though that during the immediate post trauma period when emotion is either blunted or very intense, patients/victims without immediate psychological support may become very self and other destructive.

With regard to child victims of sexual assault, it is important to note that as children do not understand the meaning attached to adult sexual behaviour, particularly very young children, after their physical discomfort has been attended to they may present with few obvious signs of trauma and distress. This does not mean that they do not require referral for psycho-social assistance. The need for psycho-social therapy should be assessed by the appropriate professional. It is also essential to note that the caretaker /parent of the child may present with more active evidence of trauma than the child.

## **8.1 Counselling on HIV**

Information about the risk HIV infection should be given during the acute phase consultation. Counselling for HIV testing may be particularly difficult in a person who has just gone through the ordeal of sexual assault and the patient may not be ready for the additional stress of HIV testing as well as receiving the outcome of the result. Counselling for HIV may therefore be delayed for at least three days if the emotional status of the patient indicates that she/he cannot take a positive test result.

The patient should be allowed to think about taking the HIV test and return after three days for the test or when ready. The HIV test can however be done in those willing to have the test in the acute phase. Book an appointment for the patient to return to see you for the return visit. Continuity of care by the same provider contributes to building trust and a sense of safety.

In the counselling for HIV testing, there should be a balance between the responsibility to provide information about the possibility of HIV exposure and sensitivity to the emotions of the patient. Regarding the emotional state of the patient, the following points about the patient should be taken into consideration when counselling him/her for HIV testing:

- Current level of trauma
- Ability to absorb information related to HIV risk
- Self-esteem/assertiveness skills, which may be lacking to refuse testing or delay a decision
- Possibility of information on HIV unduly exacerbating level of trauma
- Testing is optional, the patient may accept or refuse taking a test
- The health care provider is not obliged to report the HIV status to legal authorities. Never write an HIV test result on the J88 form

The advantages and disadvantages of HIV testing (or not) should be discussed as well as the implications of a positive or negative HIV test.

The objectives of pre-test counselling are:

- To ensure that the patient has all the information needed to make an informed decision
- To provide information about modes of infection and the window period
- To help the patient understand and assess own risk for HIV infection
- To provide information about testing procedures and interpretation of the results
- To help the patient prepare for a positive HIV test

**Post-test counselling** depends on the test results.

If the test is **negative**:

- Results of the test should be provided and interpretation of the results provided
- The window period discussion should be revisited and further testing advised if the patient is considered to be in the window period
- The patient should be encouraged/assisted with information on maintaining her/his negative status

If the test result is **positive**, the following issues need to be addressed:

- Results of the test and interpretation of the results
- Reaction to the test results, fears and concerns
- Current emotional state and plans
- Information about living positively
- Assurance that the HIV test results will not be disclosed to anyone (including legal authorities) without the patient's consent
- Referral for further HIV management

## 8.2 Psychological support

Crisis management involves containment and support of the patient with the intention of minimising the traumatic nature of the medical examination for the patient and avoiding secondary victimisation of the patient. If managed well the extent and duration of RTS symptoms may be minimised. Health care providers are not expected to provide counselling or psychotherapy. Crisis management involves re-establishing the patients' sense of control over her/his situation as well as her/his self-esteem, space should be allowed for the patient to vent her/his feelings. The patient must be treated with respect and assured of her/his safety. It is important to address concerns with understanding and empathy. If the patient is referred enquire on the return whether their expectations were met by that service.

### Support to the patient

Basic psychosocial and emotional care management of patients who access the health care system includes:

- An immediate response and urgent attention to the patient accessing the services. Prompt care should be offered
- You must ensure that privacy and confidentiality are maintained, even for the child patient

- Care should be holistic. You may be attending to the most visibly urgent need, which is physical, but psychological symptoms must be recognised and addressed. Emotional containment and support is critical for sexual assault patients.
- Identifying the patient and greet her/him directly, a calm and reassuring attitude throughout the intervention
- Acknowledgement of the patients' traumatic experience and a sympathetic response to the information given by the patient
- Believe what the patient tells you, do not assume to know better or be judgemental. Mutual trust is important, be honest. Do not push the patient to discuss her/his experience if they are not ready to
- A skilled examination with due attention to detail will increase the patient's confidence in the system
- Practical support in terms of assisting the patient with issues of physical comfort and assisting with contacting relatives, reporting to the police etc
- Support in terms of safety, ensuring the patient is not further exposed to the perpetrator in any way
- The provision of information on the following: The procedures through which the patient will go; Some post traumatic stress response and RTS symptoms in order to normalise these if they occur at a later date and the resources available to the patient
- Information regarding common symptoms of RTS should include the following:
  - *Intrusive symptoms*: These take the form of repeated, unwanted and uncontrollable thoughts of the trauma and can include nightmares and or flashbacks
  - *Symptoms of avoidance*: These result from a person's attempt to reduce her/his exposure to people and/or places that may elicit memories of the event (or intrusive symptoms). They include symptoms such as social withdrawal, emotional numbing, a sense of loss of pleasure and memory loss
  - *Hyper-arousal*: Psychological signs of increased arousal such as hyper vigilance, increased startle reactions, anger, increased aggressiveness and bad concentration/memory
- Because many sexual assault patients will be seen while they are in a state of shock, information should be kept brief and backed up by written information packages, which must be offered whenever they are available
- Referral to appropriate services with an explanation of the reasons for the referral and what can be expected from the service provider

### **Support to the child**

Signs of PTSD may be present at the time of presentation of the child to services if the abuse has been on going. It is less likely if the abuse has been ongoing because the child may have the view that this is normal behaviour, especially if the abuse has been gentle and sexualising. If the sexual abuser has been gentle and affectionate the child may even have experienced the abuse and accompanying affection as something

“special”. Children who present with positive feelings towards the abuser and the sexual abuse should be managed with great sensitivity and referred for psycho-social therapy. Often the long term psychological consequences of this form of abuse are severe and most disruptive of normal adult relationship adjustment.

- Symptoms of acute trauma include
  - Sleep disturbance
  - Altered appetite
  - Features of separation anxiety
  - General behavioural changes
- If symptoms are present, consider the use of medication to relieve anxiety. The decision to start medication for anxiety should be made by an expert practitioner
  - Such medication may be given for 10 – 14 days whilst waiting for the counselling to start
  - Consult a specialist at tertiary level or an experienced practitioner at secondary level before medication is started
  - Diazepam may be used as short term treatment as it acts rapidly. However, it should be used for a few days only
  - Tricyclic antidepressants may be used, but take one week to work
- Counselling should allow children to talk about what happened and how they feel about it.
- Make sure the child has been referred to a social worker in keeping with legal requirements and for counselling.

### **Support to the family and support persons of the patient**

The family members of the patient accessing the health care system should be offered basic support, care/management and emotional containment. This includes:

- At the request/with the consent of the patient, factual information about what happened as well as injuries sustained should be provided to the family members and support persons
- Be understanding of the stress that the situation places on the family and supporters. Offer support and containment where possible and exercise patience where necessary. The family members of child sexual assault patients may be particularly distressed and sometimes their distress causes further trauma to the child.
- Information on support services and referral to these services for further support if needed. Explain the reasons for the referral and what can be expected from the service provider
- Offer information on symptoms of RTS that the patient may experience and how they might offer support. This can be provided in written form when available

## **9.0 EVALUATION OF A PATIENT OF SEXUAL ASSAULT**

### **9.1 History**

#### **9.1.1 Approach to history taking**

A preliminary assessment should be made first to determine any potentially serious injury or illness before taking the full history. If serious physical injuries are found, they should be attended to first. After the medical condition has been stabilised or a decision made that immediate care is not required, medico-legal examination may begin.

In both adults and children, history taking should be unrushed and taken in a sensitive and non-judgemental manner. In the case of a child or people with communication disabilities, a proxy reporter may be required. In children, record the history in the child's words – do not translate the child's word into adult language.

An examination with detailed documentation and basic counselling may take up to 2 hours depending on both the emotional and physical condition of the patient and the knowledge and experience of the health care provider. Health care providers are therefore encouraged to budget time accordingly.

Points to remember:

- Introduce yourself – name and qualification. Explain to the patient (or caregiver – in the case of a child – and the child) what you are going to do and obtain consent. Health care providers should be sensitive to the experience that the patient has just been through and great care must be taken to ensure that secondary victimisation does not take place.
- The patient should be allowed to speak in the language of her/his choice. A translator should be made available if the health care provider is not proficient in the patient's language or a sign language facilitator or interpreter in the case of deaf people.
- The patient should be given information about the legal process and her/his right to lay charges. Details about the legal system at this stage is probably more than the patient can absorb but they require sufficient information to make a decision which will be appropriate for them.
- If the patient comes into the consultation room in a highly emotional or distressed state, she/he should have her/his level of anxiety reduced through reassurance, demonstration of the

safety of the environment, information and empathy before being given the physical examination. If necessary, the examination may need to be interrupted for a period and recommenced after some minutes or hours if the patient becomes very distressed.

- The physical examination for many patients may subjectively feel like the sexual assault in itself – sometimes experienced as even more intrusive as it occurs in good light, takes longer etc. It is important to be sensitive to this and to give gentle verbal reassurances throughout.
- The consultation should be conducted in an environment conducive to confidentiality, privacy, dignity and safety.
- Stay calm, act professionally and show empathy
- Perpetrators should not be examined in the same examination room in the health care facility (HCF) or allowed to wait in the same waiting room/area as the sexual assault patient.

With regard to the assault, it is advisable to confine to the medically relevant history only. However notes can be made of what is said in connection with the event. If these are used at the trial it should be made clear that the notes do not purport to be a full account of what occurred.

### **9.1.2 Content/scope of the history**

The history should elicit the following:

- Age/date of birth of the patient
- Location, date and time of assault (It is essential to document the time frame from the time of assault to the time of the medical examination).
- Circumstances of assault – identity and number of assailants
- Type of physical restraints used (weapon, drugs, alcohol)
- Details of sexual contact – actual or attempted penetration (penile, digital or object), route of penetration (vaginal, oral, anal), ejaculation (and sites), urination, use of condom and lubricants
- Activities of the patient after the assault (shower/bath, change of clothing, douching, use of tampon, urination, defecation) – these may destroy the evidence
- Details of any symptoms occurring after the assault (genital bleeding, discharge, itch, sores or pain; urinary symptoms; anal pain or bleeding; abdominal pain)
- Pertinent medical history – allergies, disease profile, disability
- Sexual/reproductive health history in teenagers and adults. In a female this will include LNMP (date, days, cycle and regularity), contraceptive use (method and date of last dose/injection), last consensual sexual encounter and pelvic surgery.

The history of the attack should be brief and should give the essential facts necessary to assess patient's risk of pregnancy or acquiring an STI or HIV, and guide the forensic examination in

respect of injuries and biological or trace evidence. Avoid asking detailed information of the circumstances of the assault as it might not be exactly the same as in the statement made to the police leading to problems/confusion in court. State on form that only relevant pertinent facts have been recorded, not a detailed statement.

### **9.1.3 Evaluation of children**

Health workers may see children in whom they or others suspect child sexual abuse, but where there is some uncertainty about whether this has occurred. The following are indications that sexual abuse has or may have occurred:

- Child complains of sexual abuse
- Sexually transmitted infections or vaginal discharge
- Painful urination, frequency of micturition (passing urine) or frequent urinary tract infections
- Pregnancy in children under the age of 16 years
- Pain, itching, bruises or bleeding from external genitalia or the anal area
- Sexualised behaviour or other unexplained behavioural problems
- Unexplained difficulty in walking or standing
- Recurrent unexplained abdominal pain
- Unexplained behavioural changes e.g. depression, anxiety disorders, aggression, fear, parasuicide, enuresis, encopresis, pseudoseizures

In addition to the history outlined above, the following should be documented:

- A general history of the social and environmental circumstances before, during and after the abuse should include the following:
  - Who the child stays with, who looks after the child, who was with the child at the time of injury,
  - Any previous admissions to hospital, any previous experiences of abuse

## **9.2 Examination**

### **9.2.1 General examination**

- The clothing must be examined and any abnormality documented if the patient has not changed. Clothing (if it has tears or stains) may be useful to prove that force was used, as a source of DNA as well as corroboration of the patient's story. If possible, clothing should be collected for forensic evidence. Stains on clothing can be swabbed, or cut out of the clothing with consent from the patient.
- The general appearance and emotional status/behaviour (e.g. controlled, fearful, listless, tense, sobbing etc) of the patient should be observed during the examination and documented.

- Examine the patient from head to toe including genito-urinary system. Digital vaginal examination is inappropriate in virgins. The following information about injuries sustained should be corroborated with the patient's account of what happened:
  - The age of the injury
  - How (mechanism by which) the injury was produced
  - The amount of force required to produce such an injury
  - The circumstances in which the injury was sustained
  - The consequences of the injury
- Careful assessment of injuries and documentation of the injuries is therefore important. Absence of injuries does not imply that force or coercion was not used and does not prove consent.
- It is advisable to start with the part of the body that does not appear to be severely injured. This may facilitate gaining the patient's trust. Alternatively WHO recommends starting with the hands examining injuries on hands or ligature marks on wrists. This is said to be also reassuring to the patient.
- Swabs of the oropharynx and mouth should be taken **routinely** if oral penetration (tongue or penis) is reported to have occurred.
- Document presence of extra genital injuries (hands, wrist, arms, mouth, throat, head, face, neck, breasts, chest, abdomen, buttocks, thighs and legs) looking for the number, size, shape, colour, contents, age, depth, **classification** and location of injuries, bite and scratch marks, bruises. Diagrams should be used to accurately portray the physical condition or photographs can be taken if the facility is available provided the patient consents.
- Collection of forensic (biological and trace) evidence from the body simultaneously with the examination as per SAECK/SAEK.
- Systemic examination should be conducted only if indicated.

### 9.2.2 Female genital examination: Adults and children > 14 years

Patients should be in lithotomy position for genital and anal examination. If necessary the left lateral position can be used.

External anal and genitalia examination – take specimens simultaneously with the examination in the following order – anal, rectal, external genital, deep vaginal, cervical. Look for swelling, redness, bruises, lacerations, tenderness, bleeding and discharge.

- Anal examination should be performed routinely prior to genital examination to avoid transfer of evidence during collection.

- Rectal examination – bleeding, discharge, sphincter tone when indicated
- Genital examination – collection of specimens should be performed at the same time when appropriate. Genital trauma is useful to show both recent sexual contact and force, however, the absence of genital trauma does not indicate consent.
- Inspection of the perineum, labia majora, labia minora, clitoris, hymen or hymenal remnants, vaginal orifice, urethral orifice, frenulum, prepuce and swab all areas.
- Careful palpation of all structures of the vulva in order to elicit tenderness or any other sign of injury
- Speculum examination with the right size speculum lubricated with warm water using good light source. Avoid use of K-Y jelly as it interferes with the enzymes and reagents used for PCR tests for DNA determination.
- Examine the vagina and cervix for injuries e.g. abrasions, ecchymosis and lacerations
- Take all required specimens according to the SAECK/SAEK
- On withdrawing the speculum assess for character and odour of discharge as well as vaginal wall trauma
- Bimanual examination, cervix, uterus, adnexa (location, position, shape size, tenderness and consistency) only if indicated (e.g. presence of STI/PID/pregnancy)
- Photographic documentation if facility is available and provided consent is obtained. Pictures of all injuries including genital injuries should be taken, labelled with the patient's name, date and time and a standardised measurement of instrument to indicate the size of the injury.

### 9.2.3 Children under the age of 14

- Preparation of the child - Very young children or severely traumatised children should be given sedation or a general anaesthetic before the examination. Gain the confidence of the child before the examination and accustom him or her to the instruments which are to be used.
- Young children should be examined whilst sitting on (preferably) their mother's lap with their back to their mother and their legs held by their mother. Older children should be given the choice of this or sitting in a chair or lying on a bed in the lateral position. The anus can be examined in a lateral position.
- A general examination of the child should be conducted to exclude signs of concomitant abuse or neglect and any childhood illnesses. The weight and height should be measured and recorded in the cases record as well as on the J88 so that the defence cannot later claim that the accused thought the child was an adult. Similarly, note signs of sexual development.
- Genital examination of a female child should **NEVER** include digital or bimanual examination or the use of a speculum. Full vaginal penetration of a pre-pubertal girl causes severe damage

and there is usually obvious trauma and bleeding. Children with such injuries are best examined under anaesthetic.

- If the abuse occurred within the previous 5 days use the contents of the SAECK/SAEK and follow the instructions.

#### **9.2.4 Older persons**

The vaginal mucosa is atrophic and friable in the elderly, therefore putting them at an increased risk of genital injury (WHO). Choice of speculum is important (long and thin). Speculum examination may have to be omitted. The older persons are at greater risk of physical injury and bruising.

#### **9.2.5 Male genital examination**

The same procedures for taking history, performing the physical examination, investigations should be followed. It should be noted that men most commonly experience sexual assault in the form of receptive anal intercourse, forced masturbation of perpetrator, receptive oral sex and forced masturbation of victim.

During the examination inspect the anus, foreskin, glans, meatus and frenulum. Look for swelling, redness, bruises, lacerations, tenderness, bleeding and discharge. Treatment for injuries, STI, PEP, tetanus and Hepatitis prophylaxis should be the same as for women.

### **10.0 INVESTIGATIONS**

#### **10.1 Sexual Assault Examination Kit (SAEK)/Sexual Assault Evidence Collection Kit (SAECK)**

- The sexual assault collection kit has a checklist of all the evidence needed to be collected for forensic purposes as well as instructions which should be followed carefully.
- A new series of evidence collection kits for the purpose of collecting evidence in a way so as to comply with all latest legal and scientific specifications was recently designed and implemented in South Africa. The "Sexual Assault Examination Kit" or SAEK<sup>®</sup> which forms part of these kits is regarded as the best kit currently available world-wide.
- Included in the kits is a bar coded consent form to be completed by the health care provider and signed by the patient, as well as clear instructions with detailed sketches for each step.
- All items are bar coded with a unique number that remains the same through all steps in the investigation, thus preserving the chain of evidence.
- Specimen containers are designed to allow for air drying of all specimens and are sealed with tamper safe seals provided in the kit.
- The collection of the forensic evidence needs to be carried out at the same time as the medical examination. Forensic evidence is not just the biological samples collected from the person's body but also any trace evidence found on the body e.g. fibres, hairs, etc. The specimens

that are collected are useless unless they are properly packaged and transferred. Even if there is lots of evidence that the person was sexually assaulted, improper storage and transfer may lead to the evidence being rejected in court.

#### **Forensic Evidence Collection**

- If commercial forensic kits are not available, make up your own by using ordinary throat swabs.
- Use envelopes for the particulate evidence, labelling them carefully
- Use paper bags for larger items of evidence
- Ensure all swabs are dried before re-sheathing, & remove stopper from end of tube
- Swabs should be air dried only
- Do not use preservatives.
- Photographs are also important evidence
- Ensure that (own) forensic evidence kits are sealed and kept in a locked and secure area and the chain of evidence is not broken

**10.2 Oral swabs** – collect in the event of oro-genital contact. Carefully swab under the tongue, along the gum line of the teeth, the cheeks and the palate. Use only one swab for the whole of the mouth area. If post-exposure prophylaxis (PEP) for HIV is to be given give the first dose immediately BUT ensure that an oral swab has been taken. This can be done at the beginning of the interview whilst informing the patient of the procedures to be performed and obtaining consent.

### **10.3 Clothing**

Do not take the patient's clothes if it is not possible to replace them. If the clothes are taken away, the patient has to understand that if the clothing goes to the laboratory and will not be returned to them.

The patient should undress on a big sheet of paper. The clothes should be shaken and the patient should shake herself over it. Then the sheet of paper should be folded up carefully and placed into the SAECK/SAEK. The examiner must also write down all the observations about the clothing, for example, the buttons were ripped or the underwear were torn or there is grass or blood present. If the patient has to go home in these clothes, give them a paper bag to put the clothes in and at the next opportunity give the clothes to the investigating officer who can then send them to the laboratory as evidence. There is a tiny paper bag in the collection kit into which the patient's underwear and sanitary towel (if applicable) can be put. The medical examiner must make certain that their own body hair etc does not contaminate the collection of this evidence. It may be important to assist children or patients who are seriously traumatised and unable to follow instructions.

#### **10.4 Evidence on patient's body**

Certain samples are provided for in the SAECK/SAEK, but this does not mean that additional samples cannot be taken by the health care worker if they so desire.

- Fingernails - If the patient says that, she/he may have scratched the assailant, then they should take samples from under the patient's finger nails with a swab.
- Saliva on skin - The examiner should ask the patient if the assailant had sucked/licked/kissed/bit her, and take a swab of that area. Visible bite marks should be similarly swabbed. (If the examiner has access to a forensic odontologist, they can be asked to identify the pattern of dentition and make an imprint).
- Semen or other stains on body – moisten swab and swab those areas.
- Head hair – must be combed through over the catch sheet and a sample of reference hair from the patient provided: specifically 20 hairs, five from all different areas pulled out.
- Pubic hair – comb the pubic hair downwards on to the catch paper that is placed under the patient's buttocks. Take a reference sample of cut pubic hair.
- The kit also contains evidence catch papers for other foreign debris on the body, e.g. soil, leaves, hairs, fibres, matted hair (cut out) and put in the piece of paper for forensic analysis.

Throughout this examination the patient should be dressed in a clinic gown not naked during the lengthy process.

#### **10.5 Ano-rectal swabs**

This step is done before the genital region is examined to avoid any contamination from the genital region such as fluid that may have collected there. Swab the anal area with the first swab and then rectum with the second swab. The patient may need to be encouraged to relax and the procedure must be clearly explained

#### **10.6 Genital specimens**

Minimum of 3 swabs

- External genital swab – thoroughly swab the external and internal surfaces of the labia majora and minora, the clitoral area, around the urethra, and introitus with the same swab.
- Collect tampon if in place
- Deep vaginal swabs – before any internal examination takes place, swab the vaginal fornix
- Cervical swabs – swab the cervix, usually under speculum examination
- Penile swabs?

## **10.7 Reference DNA specimen**

Blood must be taken from the survivor in an EDTA (purple top) tube as a control DNA sample. In the SAECK/SAEK a drop of blood must be placed into each of the 3 wells in the provided Marshal® cassette. Both the tube and the cassette must be placed into the prescribed padded envelope.

## **10.8 Drugs and alcohol**

If indicated by the history (e.g. drug facilitated rape), then a 10ml plain tube of blood should be taken for a drug screen. Blood for alcohol should be placed into a green top tube (containing sodium fluoride & calcium oxalate). [Urine for drug screen should also be collected see 10.12]

## **10.9 HIV Test**

This should be done using the rapid testing protocol in all patients who agree to have the test done. If this is not available, blood for HIV testing should be sent to the laboratory. This may be immediately on presentation after the reported sexual assault or after three days. For the patients who agree to an HIV test at initial presentation, the results of the HIV test may be provided immediately or provided after 3 days depending on the choice of the patient. Follow up tests should be done at 6 weeks, 3 months and 6 months.

Children under 15 months with penetrative sexual abuse:

- All children under the age of 15 months should have PCR performed to determine their HIV status.
  - Whilst awaiting PCR, prescribe an ARV starter pack.
  - If the test result is positive, discontinue the ARVs.
  - If the test is negative, provide a full course of ARVs.
- If PCR is not and will not be available, perform an HIV antibody test.
  - If the antibody test is negative, counsel the caregiver and provide ARVs.
  - If the antibody test is positive explain that it is not possible to determine whether the child is truly infected with HIV. Provide ARV PEP, after discussion and consultation with the caregiver.
  - Re-test the child as soon as PCR is available, or perform an HIV ELISA test at 18 months to determine the child's HIV status

## **10.10 Hepatitis screening**

Due to a high sero-prevalence of Hepatitis B antibodies in South Africa (), it is recommended that on examination of the victim, blood also be taken at the same time to screen for Hepatitis B antibodies.

**10.11 Urine for pregnancy test** in female children and women of child bearing age who are otherwise sexually active and not adequately covered by a contraceptive. It is important to rule out pregnancy as presence of a pregnancy might affect the type of treatment given and the woman will want to know whether the pregnancy preceded the rape.

**10.12 Urine for drugs screen** if there is a history given, then urine for drug screening should also be collected.

### **10.13 Additional investigations for children: Screening for STIs**

Although investigations for sexually transmitted infections are no longer recommended for the management of sexually assaulted adults, in children the presence of STIs may be diagnostic of sexual abuse and so investigations are needed. The following should be taken:

- A vaginal swab for microscopy, culture and sensitivity (mcs) – wet the swab in the culture media first to decrease pain and irritation
- Blood for syphilis, Hepatitis B and HIV (1 EDTA tube)

## **11.0 TREATMENT**

**11.1 Physical injuries** – For minor injuries, conservative treatment may be sufficient. Management of severe injuries which may require surgical repair should take precedence over all other aspects of treatment.

**11.2 Tetanus prophylaxis** if there is a break in the skin or mucosa contaminated by external debris.

**11.3 Pregnancy prophylaxis** if not pregnant – pregnancy resulting from rape presents additional trauma to the patient and an attempt should be made to prevent it at all times. Knowledge about, access to, and use of emergency contraception can prevent many unwanted pregnancies following sexual assault (Ref: CSDG).

### **11.3.1 Emergency contraceptive pills (ECP)**

Women should be counselled on:

- The correct regimen for ECP use: when to take the pills and how many to take.

**Two doses of ECPs must be taken 12 hours apart and within 5 days of unprotected intercourse.**

The first dose of ECPs should be taken as soon as possible taking into account the need to take the second dose within 12 hours. The timing of the initial dose is critical and should be given such that the next dose (12

hours later) can be easily accessed. For example, if initial dose is given at 15.00 hours, the next dose will be due at 03.00. It is better to delay the initial dose a little/by a few hours so that the next dose can be taken later in the morning when the patient is awake. Increasing the interval between doses exposes to increased risk of failure.

- There are pills specially packaged and registered for EC, however many of the hormonal pills that are commonly available for regular contraception may be used for EC.
- On possible side effects (particularly nausea and vomiting) with oestrogen containing pills and how to manage them (take the pills with food and repeat the dose if vomiting occurs within 2 hours of taking it). Antiemetics should be given with each dose
- On when to expect the next menses (a few days earlier or later than normal).
- If the woman is on any liver enzyme inducing drugs (such as rifampicin or anticonvulsant treatment), double the dose, use 4 tablets of EC containing 30 micrograms of ethinyloestradiol per dose (not 2).

### Recommended ECP regimens

<b>Content</b>	<b>1st dose within 5 days</b>	<b>2nd dose 12 hours later</b>
<i>Combined oral contraceptives (COCs)</i>		
50 micrograms ethinyloestradiol, 250 micrograms levonorgestrel	2 pills	2 pills
30 micrograms ethinyloestradiol, 150 micrograms levonorgestrel	4 pills	4 pills
<i>Progestogen-only pills (POPs)</i>		
750 micrograms levonorgestrel	1 pill	1 pill
30 micrograms levonorgestrel	25 pills	25 pills

Evidence is now available that levonorgestrel as an ECP can be given as a stat dose. Taking the two doses together (i.e. 1.5mg levonorgestrel) immediately has been shown to be as effective as taking them 12 hours apart obviating the risk of forgetting or delaying the second dose<sup>5</sup>. The 72-hour cut-off for starting ECP has also been shown to be unnecessary and there is a role for ECP for patients who present after 72 hours or in situations where there are no facilities for insertion of the IUD<sup>5</sup>.

It is also now recommended that regular contraception should be started at the same time as the ECP to reduce the number of pregnancies that occur while waiting for the next period<sup>5</sup>.

<sup>5</sup> Emergency contraception. BMJ 2003;326:775-776

### 11.3.2 Copper-bearing IUD

The use of IUD as an emergency contraceptive method is not recommended due to possible increased risk of HIV transmission if seminal fluid is present in the vagina.

### 11.3.3 Failure of emergency contraception

The patient should be made aware that in a small proportion of women emergency contraception may fail with resultant pregnancy. Provision of regular contraception at the same time as ECP will reduce the proportion of pregnancies that may result. If pregnancy results despite pregnancy prevention, counselling on termination of pregnancy (TOP) should be offered.

### 11.4 STI treatment in adults and children >14 years old (Ref EDL for Syndromic management)

Contracting an STI is a significant concern for the patients. STI cultures are expensive and time consuming for the patient who may have to return a few times. Some, if not most clients do not return. For these reasons it is recommended that STI cultures be omitted and syndromic treatment provided. Investigations for STI do not form part of the medico-legal examination except in children suspected of being abused. This should be provided to all including the asymptomatic patients.

### Treating sexually transmitted infections

#### *Syndromic management:*

#### *Non-pregnant women*

doxycycline 100mg b.d. for 7 days

ciprofloxacin 500mg po stat

metronidazole 2g po stat

- best to take tablets after meals

- warn of interaction of metronidazole and alcohol

#### *Pregnant women*

ceftriaxone 125mg imi stat

erythromycin 500mg q.i.d for 7 days

metronidazole 2g

All immediate treatment, testing and dispensing of medication must be performed in the consultation room.

### 11.5 Hepatitis B vaccine in adults and children >14 years old

- A considerable proportion of Hepatitis B infections are acquired through sexual transmission ().
- Hepatitis B vaccine should be offered to all sexual assault patients.

- A full vaccination course consists of 3 doses, which are given 1 month apart.
- The vaccine is given intramuscularly on the deltoid muscle.
- Due to a high sero-prevalence of Hepatitis B antibodies in South Africa, it is recommended that on examination of the victim, blood also be taken at the same to screen for Hepatitis B antibodies.
- The patient is asked to come back 1 month later. If the results show presence of antibodies no further vaccine doses are given. If the patient has no antibodies and thus not immune, the subsequent vaccine doses will be given.
- Health care providers should ensure that the cold chain has been maintained and particularly that the vaccine has not been frozen before administering the vaccine.
- The package insert should also be read carefully by health care providers.

### 11.6 PEP in adults and children >14 years old (ref annexure 1)

It is recommended that anti-retroviral therapy (ARV) be administered within 72 hours of exposure. There is no evidence that ARV will have any impact if taken more than 72 hours after the exposure. Patients presenting after 72 hours after being raped should be counselled about this and advised to return for a repeat HIV test at 6 weeks and again at 3 months.

Post Exposure Prophylaxis treatment should be offered to all patients presenting within 72 hours of the sexual assault. A 3-day starter pack should be offered to those patients who prefer not to test immediately, or those that are not ready to receive results immediately. The rest of the treatment should be given when HIV status of patient has been established as negative.

Treatment should be modified depending on HIV status of the patient. It should be stopped for those found to be HIV positive. This is because AZT and 3TC for 28 days in an HIV-infected patient is not adequate therapy and may lead to viral resistance.

For those patients who cannot return for their one-week assessment due to logistical or economic reasons, then a month's treatment supply with an appointment date should be given. This may be particularly relevant outside of the metropolitan areas.

- Patients who sero-convert during the course of treatment should discontinue taking the ARV and referred for long-term HIV care.
- While on PEP and until the three-month visit showing the patient is HIV negative, the patient should be advised to use condoms with partner.

#### **AZT and 3TC Regime**

**Dose of AZT: 300mg 12 hourly (or 200mg 8 hourly for 28 days check)**

**Dose of 3TC: is 150mg 12 hourly for 28 days**

### **Efficacy**

- The efficacy of AZT and 3TC in preventing HIV sero-conversion is not known, but there is strong non-experimental support (from occupational exposure) that the use of AZT and 3TC could be effective in preventing HIV transmission.

### **High risk exposure**

- A third drug lopinavir/ritonavir 400/100mg 12hourly, added to the above is recommended in patients who risk of infection is assessed as high. The risk of HIV transmission is regarded high under the following conditions
  - Where there have been multiple perpetrators
  - Anal penetration
  - Obvious trauma to the genital area
  - Known HIV positivity of one of the perpetrators

Not enough scientific evidence exists to support the three-drug regimen, but it is considered best practice in these circumstances.

### **Side effects/contraindications**

- Relative contra-indications to the use of AZT and 3TC include significant renal or liver impairment. Where in doubt about the use of AZT and 3TC in individual patients, contact your local physician or referral centre for advice.
- The common side effects of the drugs should be explained to the patient – tiredness, headache, malaise, flu-like symptoms, muscle pains, nausea and vomiting etc – and that most of these can be relieved with ordinary analgesia such as paracetamol. Patients should be informed that these are temporary, vary in intensity and that they do not cause long-term harm.

### **Compliance**

- Taking other medication such as those for pregnancy prevention and antibiotics may compound the side effects of AZT and 3TC. Patients should be advised to return to the health facility if symptoms occur rather than stop the drugs. The importance of compliance should be emphasised.
- Compliance has been shown to be very poor because of side effects of the drugs. Compliance can be improved by employing a number of strategies such as:
  - Always provide an anti-emetic with the treatment for at least one week or longer if symptoms persist
  - Home visits
  - Follow-up phone calls
  - Referral to NGOs
  - Support groups

### Use in pregnancy

- The use of AZT and 3TC in the first trimester of pregnancy has not been shown to be teratogenic. Experience on use of ZDV and/or 3TC from the USA makes it possible to conclude that the rate of birth defects in infants of mothers taking these drugs does not appear to be higher than that in the general population (~2 – 3%)<sup>6</sup>. It is not possible however to guarantee the safety of the drug regarding the foetus in the first trimester of pregnancy. Women who are less than 12 weeks pregnant should be informed of this and be allowed to make a choice as to whether they are prepared to use the drug or not.

### 11.7 Treatment of children <14 years

The treatment of children is very similar to that of adults after sexual assault. The following should be given:

- a) Anti-tetanus toxoid (ATT) for injuries covered by dirt, if the child is not fully immunized or was last immunized against tetanus more than 10 years ago.
- b) Ceftriaxone (or ciprofloxacin if the child is over 13 years), metronidazole and erythromycin
  - Ceftriaxone: if the child weights <25 kg 125mg IMI  
child weights >25 kg 250mg IMI
  - Ciprofloxacin: if child is over 13 years 500mg stat
  - Erythromycin: if child < 12 years 50mg per kg body weight per day in 4 doses  
if child >12 years 250mg 6 hourly for 14 days
  - Metronidazole: child 1-3 years: 50mg tds for 7 days  
child 4-7 years: 100mg bd for 7 days  
child 8-10 years: 100mg tds for 7 days  
child >10 years: 2 g per day for 3 days
- c) Anti-retroviral therapy (AZT & 3TC) for children who have been exposed to penetrative sexual abuse

Age range	Zidovudine Dose 12-hourly	Lamivudine Dose 12-hourly
6 months – 3 years	9 mg/Kg/dose	4mg / Kg / dose up to a maximum dose of 12.5ml (125mg) for children 10 – 11 years.
4 – 8 years	7.5mg/Kg/dose	
8-12 years	7 mg/Kg/dose	

<sup>6</sup> WHO, Scaling up antiretroviral therapy in resource-limited settings: Guidelines for a Public Health approach, 2002 - draft

All doses can be varied + or – 1mg / Kg and still fall within the recommended dosage range.	Children 12 years and older = adult dose – 1 tablet of 150mg
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**The maximum dose calculated per child should not exceed the adult doses, viz.  
Zidovudine 300mg 12-hourly and  
Lamivudine 150mg 12-hourly.**

- d) ECP with an antiemetic, as per the management of adults, should be given to all girls with signs of breast development who have a negative pregnancy test

Medication regimes may be routine and sound simple for health care providers, however to patients who are traumatised and stressed, enormous difficulty may be experienced in relation to remembering what must be taken when and why etc. Patients should be given simple clearly written instructions about taking medication.

## 12.0 DOCUMENTATION

- Documentation of evidence is a very important part of adequate medical care as well as the medico-legal examination. Sexual assault health care providers should document completely and precisely the physical and genital injuries, other forms of evidence and medical treatment.
- Full details of the case should be retained in the case notes for further medical management of the patient.
- The Case Record and J88 form (if reported to the police) should be completed accurately and with attention to detail in the health care provider's hand writing. Accurate reporting will ensure physical and genital injuries, and other forms of evidence are competently interpreted and this in turn will ensure professional presentation of evidence in court.
- A brief conclusion should be made on completion of the general examination as well as genital examination. It should be consistent with the medical findings. Examples:
  - "Injuries consistent with history given".
  - "Findings consistent with penetration of the vagina by a large object like a large stick"
  - "Absence of injuries does not exclude penetration".
  - Avoid using phrases such as "hymen not seen or absent ", legal penetration is past the labia majora not the hymen. If no physical injuries are observed do not write "no evidence of abuse".
- Case record - This document will provide a checklist for the health care provider to facilitate complete and comprehensive care of patients and avoid omissions. The report may be part of the legal record and can be submitted as evidence if the case goes to court.
- It is advisable to keep a copy of the completed J88 is made and keep it with the hospital records in case of docket loss by the police.

## 13.0 AFTER THE EXAMINATION

Wherever possible provide facility for showering and change of clothing. The patient may be afraid to return home alone. An attempt should be made to call the police (if she/he reports the case), a friend and or relative to accompany the patient home or to a place of safety.

Files of the sexual assault patients should be maintained separately from other patient files, in a locked cabinet, and access to these files be strictly controlled. A procedure should be outlined under which such files would be made available (for example the files be made available only if a request is made in writing and approved by the medical superintendent, or, where appropriate, the prosecutor or police).

After the examination the patient should be given some feedback about the results of the examination and the opportunity to ask any questions. This is particularly important for children.

#### **14.0 REFERRAL**

The patient should be given information about appropriate local support services. Written referrals should be provided if the patient requests this. These services may include:

- NGOs supporting women
- Rape crisis centres
- Shelters or safe houses
- Legal AID
- Support groups
- Social services
- Reproductive health services/TOP services for failed contraception

#### **15.0 FOLLOW UP**

On discharging the patient ensure that proper follow-up arrangements are in place. Clinical follow-up should be at 3 days, 6 weeks and 3 months. At the clinical follow-up examinations check the following:

##### **Clinical follow-up at 3 days**

- Counselling and HIV test for those that did not take the test initially – discontinue ARV if test positive. Counselling should be continued at each visit especially for those not tested for HIV initially.
- Results of HIV
- Provide rest of ARV if HIV negative
- Assessment of general physical state, healing of injuries
- Assess completion of medications
- Assessment of emotional state
- Look for post-traumatic stress disorder
- Contraception counselling if appropriate

### **Clinical follow-up at 6 weeks**

- Repeat HIV test if not tested at first visit
- Results of HIV
- Assessment of general physical state, healing of injuries
- Assess completion of medications
- Assessment of emotional state
- Look for post-traumatic stress disorder
- Pregnancy testing and counselling – possible referral for TOP
- Contraception counselling if appropriate

### **Clinical follow-up at 3 months**

- Repeat HIV test
- Results of HIV
- Assessment of general physical state, healing of injuries
- Assessment of emotional state
- Look for post-traumatic stress disorder

## **16.0 MAINTAINING CHAIN OF EVIDENCE/REPORTING TO THE POLICE**

- Until a trial takes place, access to the privileged confidential information contained in the J88 is restricted legally to the investigating officer and Justice Department.
- The J88 form and the sexual assault kit are to be given only to the investigating officer who must sign a register and the J88 form to acknowledge receipt.
- If SAPS officer is not present, the health care provider should keep the forms and kit under lock and key. These should not be given to anyone.
- The law is strict about the use of evidence in court. For that reason everyone involved in the collection, preservation, presentation and interpretation of the medico-legal evidence – the patient, health care provider, laboratory personnel, police and court officials - must take care to protect the evidence and follow the procedures laid down by the law to do so. Failure to follow the procedures may result in the magistrate or judge rejecting the evidence.
- Evidence is like a chain and should be passed from one custodian to another and not broken. Ideally the specimens should be handed over to SAPS immediately after the examination. If this is not possible they should be locked away in a dedicated cupboard, by a specific person-in-charge and this should be clearly documented in the patient's notes or protocol form and a register kept in the cupboard.
- Maintaining the chain of evidence is more of a challenge if evidence is to be kept in that facility for a period of time, in particular if it were to be kept in case a patient wanted to lay a charge at a later date.
  - It is essential that it is stored in a place where there is no possibility that it could be tampered with.
  - It also must be stored at an appropriate temperature so that specimens can be examined.
  - Each facility should have a large cupboard with a strong lock on it for storing sexual assault evidence.

- All keys should be carried by named responsible people at all times to prevent any possibility of unauthorised access to the evidence
- Register should be kept in the cupboard .

## **17.0 GIVING EVIDENCE IN COURT**

Sexual assault care practitioners should be able to confidently and correctly present their evidence in court and interpret the findings within the parameters of their expertise. Both doctors and nurses may give evidence in court in their capacity as ‘expert witnesses.’ An expert witness is someone who through education, training or experience possesses knowledge outside that of the layperson. Such a witness is called in order to assist the court in coming to a proper decision on complex technical or scientific matters.

The South African court procedure is based upon an adversarial legal system. This means that the opposing sides (the prosecution and defence) may each call their own witnesses (including experts) to provide evidence in court. Each side is also given the opportunity to test the other’s through the process of cross-examination. Once both sides have presented their evidence and arguments, it is then up to the judge or magistrate to pass judgement on whether or not the state has proven its case against the accused beyond reasonable doubt.

It is essential for the health care providers to prepare their testimony by reviewing all records and notes that they may have made regarding their examination of the sexual assault patient. Ideally the health care provider should also consult with the state prosecutor beforehand. This will enable them to explain the findings and their significance to the prosecutor and help them interpret the evidence. It is also possible to negotiate time and date of giving evidence to avoid delays and waiting for long periods in court.

When called to the stand, the prosecutor will begin leading evidence by asking the health care provider to describe her/his expertise to the court. This may include asking about qualifications, training and experience of examining sexual assault patients. Thereafter the provider will be asked to describe her/his findings to the court as detailed on the J88 form and/or the Case Record.

After the prosecutor has lead the health care provider’s evidence, it is then the turn of the defence attorney to cross-examine the provider. The purpose of the cross-examination is:

- To separate truth from lies
- To separate opinions from facts
- To establish what the witnesses heard as opposed to what they know
- To establish things that actually happened as distinct from what witnesses thought happened

Defence lawyers may dispute expertise by questioning the qualifications and/or experience of the health care provider. They may also put statements to the witness and then attempt the expert to agree with that statement. This is done to obtain concessions in the expert’s testimony and narrow or eradicate any conflict between the expert’s testimony and the defence’s case. In this way, the defence

attempts to create reasonable doubt. The expert witness must be prepared to defend the integrity of their findings and opinions against the questions of the cross-examiner.

### **Tips for giving evidence in court<sup>7</sup>**

- A sexual assault provider should look professional and dress accordingly
- Avoid using difficult words (medical jargon). When such language is unavoidable, explain terminology (jargon) as necessary. As far as necessary, use plain language.
- Do not provide more information than you are asked for out of a mistaken desire to be helpful
- Do not go outside of your area of expertise or experience and do not be afraid to say “I don’t know”
- Treat legal practitioners with respect even if you do not agree with their opinions or tactics
- Try to distinguish factual statements from opinions
- Do not give away concessions under cross-examinations out of fear or desire to be helpful
- When you are asked to give your opinion about how possible a particular scenario may be, also give your opinion as to the likelihood of such a possibility having occurred in the particular case you are testifying about. In other words, state your opinion whether or not such a possibility should be taken into account in this case, or whether it is so unlikely as to be of no significance.

## **18.0 SPECIAL GROUPS**

**People with disabilities** - The risk of sexual violence is increased in the presence of disabilities. Providing required information, taking the history and providing evidence, may be particularly a challenge especially for the deaf people, blind people, intellectually and mentally disabled people. Mentally disabled people are protected by the mental health care act and should be dealt with under the provisions of that act.

The following general measures should be adhered to when looking after the deaf and the blind people.

### **18.1 Blind people/people with low vision**

- Orientate the patient to their environment
- Offer the patient the option to touch the examination equipment so that they familiarise themselves with the equipment
- Explain to the patient what you are going to do, what you see, what you feel
- Guide/assist blind people to find their way to different services (pharmacy etc)

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<sup>7</sup>Adapted from Mcquoid-Mason and Dada, 1999

- Speak directly to the person and not through the third person
- Allow guide dogs into the facility to assist their owners
- Never touch a blind person or make sudden noises before introducing yourself or informing him/her of your presence

## **18.2 Deaf/hearing impaired**

- Use written communication if the person is literate and no interpreter is available - provide paper and pen if necessary for communication
- Speak with your face visible to facilitate lip-reading (~1-3 meters away from the person)
- Raise your voice without shouting and speak slower without exaggeration
- You must face a light source with the person in front of you to improve visibility of your face
- Only one person at a time should speak and avoid background noises
- Always make an effort to have an interpreter present if available
- Get the attention of the person by means of touch or visual sign

(Source: Principles and hints to be adhered to by reproductive health care providers in attending to people with disabilities, Directorate: Chronic diseases and Geriatrics, NDOH)

## **18.3 Mentally impaired**

- Use simple language and single concept sentences
- Gauge the level of disability and peg one's interaction with the patient at that level

## 19.0 GLOSSARY OF TERMS

### 19.1 Abrasion (graze)

A superficial injury to the skin caused by the application of blunt force. Abrasions are produced by a combination of contact pressure and movement applied simultaneously to the skin. Types of abrasions

- Scratches – e.g. produced by fingernails or thorns
- Imprint – whereby the pattern of the weapon may leave a characteristic abrasion on the skin
- Friction – grazes from contact with carpet or concrete

### 19.2 Child abuse:

– means any form of harm or ill-treatment deliberately inflicted, and includes

- intentional maltreatment of the child with the purpose of inflicting injury or harm
- Sexually abusing a child;
- Committing an exploitative labour practice in relation to a child; or
- Exposing or subjecting a child to behaviour that may psychologically harm the child
- failure to protect a child from harm

The nature of the maltreatment or harm can be physical, psychological, emotional, sexual, or willful neglect.

***This includes any of the following: withholding essential nutrition/feeds; medication / drugs or medical care, or routine care by persons responsible for the well being of the child or cultural practices that are abusive.***

Different types of abuse can overlap.

### 19.3 Contusion (bruise)

A contusion is an area of haemorrhage beneath the skin. It is also known as a haematoma or bruise. (Contusions may also occur within a body cavity or within an organ). Contusions follow blunt trauma and the discolouration is caused by leaking from ruptured blood vessels

### 19.4 Expert witness

An expert witness is someone who through education, training or experience possesses knowledge outside that of the layperson. Such a witness is called in order to assist the court in coming to a proper decision on complex technical or scientific matters.

### 19.5 Incised wound (cut)

Caused by the application of sharp force that in... the skin or underlying tissue e.g. knife

## **19.6 J88 Form:**

Report by Authorised Medical Practitioner on the Completion of a Medico-legal Examination; Department of Justice and Constitutional Development (G.P-S. 003-0055)

## **19.7 Laceration (tear)**

Ragged or irregular tears or splits in the skin, subcutaneous tissues or organs resulting from blunt trauma

## **19.8 Medico-legal examination**

Examination conducted for the purpose of collecting evidence to be used to investigate the police case and provide evidence in court

## **19.9 Mentally impaired person**

Means a person affected by any mental impairment irrespective of its cause, whether temporary or permanent, to the extent that she/he is or was unable to appreciate the nature and consequences of an indecent act or an act of sexual penetration, or is or was unable to resist the commission of any such act, or is or was unable to communicate her/his unwillingness to participate in any such act

## **19.10 Older person**

According to the Aged Person's Act, an older person is defined as any woman 60 years and older and males 65 years and older.

## **19.11 Patient**

A patient/patient of rape or sexual assault may be:

A **person (female/male)** of any age who claims to have been raped/sexual assaulted; or

A female/male on whose behalf another person claims that she/he was raped/sexual assaulted, where the patient is:

- A minor person under 18 years of age, or
- Mentally impaired, or
- A person under the influence of alcohol and/or drugs, or
- An unconscious person

## **19.12 Rape Trauma Syndrome**

The stress response pattern of a person who has experienced sexual assault. It may manifest as cognitive, psychological, behavioural or somatic symptoms. It usually has two phases: the acute phase and the long-term phase.

## **19.13 Sexual assault**

The term sexual assault is used in this document to encompass a range of acts involving unlawful sexual penetration or attempts at penetration. The health concerns regarding sexual assault refer to circumstances in which there is sexual penetration to any extent whatsoever by the genital organs of one person into the anus, mouth or genital organs of another person, or by any object, including any part of the body of an animal, or part of the body of one person into the anus, mouth or genital organs of another person.

This is the definition of sexual penetration found in the South African Law Commission's Discussion Document 'Sexual Offences: Process and Procedure' (2002). It is cited because it comprehensively describes the range of acts which a patient may have experienced before presenting to a health facility. Sexual assault may be experienced by women and men of all ages, it may involve penetration or attempts at penetration of a range of body orifices by a range of body parts or other objects.

#### **19.12 Sexual assault care**

Health care that addresses all the survivors health needs and does not focus on the examination for the collection of evidence only (i.e.Holistic care)

#### **19.16 Skilled Health care provider**

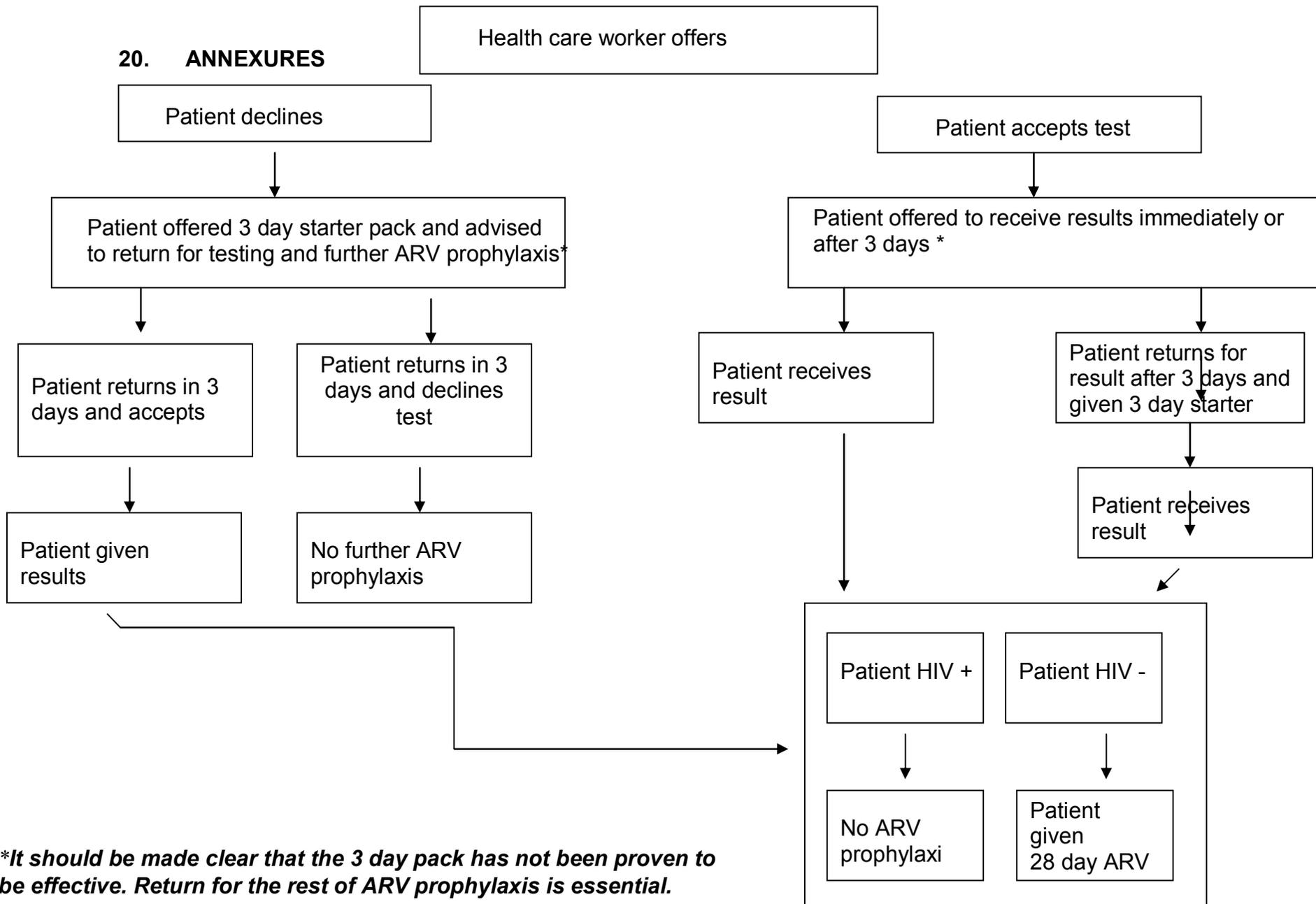
Health care practitioner is used to refer to a medical officer, specialist or nurse all of whom should have received the ***appropriate (necessary)*** training.

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# Testing Algorithm for sexual assault in adults

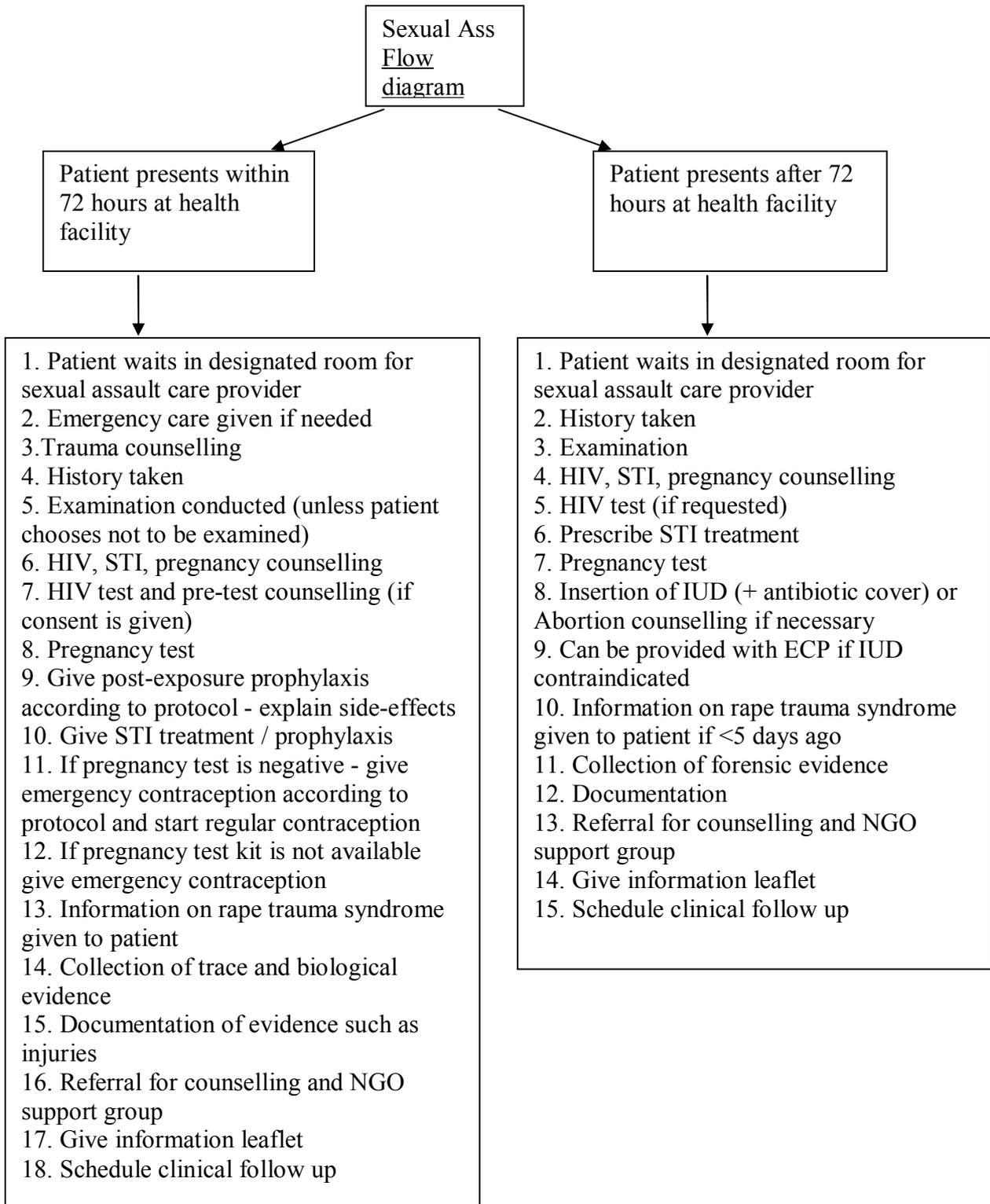
## 20. ANNEXURES



***\*It should be made clear that the 3 day pack has not been proven to be effective. Return for the rest of ARV prophylaxis is essential.***

## Annexure 2

### Flow diagram showing the management of patient presenting within the first 72 hours after sexual assault or after 72 hours



## **Annexure 3**

### **GENERAL CONSIDERATIONS IN COLLECTING BIOLOGICAL EVIDENCE**

**In the absence of a Crime Kit, evidence can be collected by means of standard throat swabs, blood specimen collection tubes, paper sheets and envelopes and paper bags or X Ray envelopes. In this case, all items must be clearly marked with patient's name, address, ID number or date of birth and details of practitioner, sealed and stored in a safe, locked area until a police investigation has been confirmed.**

- The first contact with a health professional may be the only opportunity ever to capture valuable evidence.
- Evidence not captured at this occasion is most likely lost forever.
- Explain the need for collecting the evidence to the patient and obtain informed consent.
- Discuss the logistics of making the evidence available for police investigation.
- It remains the choice of the victim to lay charges.
- All gunshot incidents must be reported to the police and all bullets must be collected and handed over to the police irrespective of the patient's decision.
- Never cut through evidence on the patient's clothing when removing clothes for treatment purposes. Air dry and put in a large paper bag, cardboard box or X ray envelope.
- Never store any biological evidence in plastic containers. Specimens must be allowed to air dry to prevent decay and bacterial contamination.
- When collecting the evidence, the examiner must always wear a clean pair of disposable gloves to prevent specimen contamination with his/ her own DNA.
- If ordinary throat swabs are used, the plug at the closed end must be removed or the tube cut open .
- Hair samples and biological foreign material (grass, dirt) can be collected on a sheet of paper and sealed in a paper envelope.
- Glass slides with oral, vaginal and semen swab smears are no longer collected by the Forensic Laboratory.
- Reference semen and saliva specimens are not needed for forensic purposes.
- All necessary reference DNA specimens are collected by means of venous blood from the victim or perpetrator/ accused and must be collected in an EDTA (orange cap) specimen tube. Never use KY™ jelly prior to collecting genital and anal specimen

#### **Genital specimens(3)**

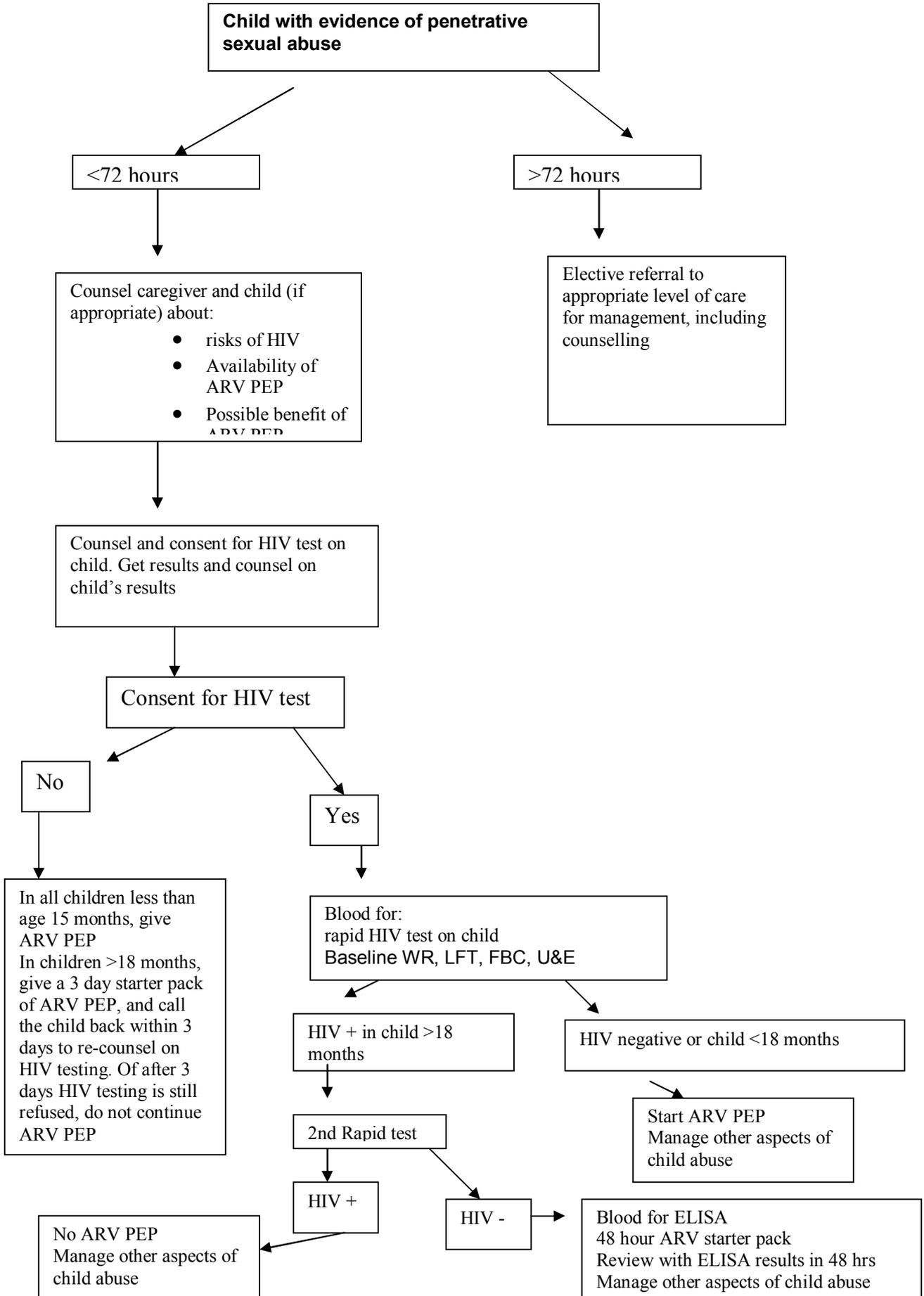
- Also collected routinely in all cases of sexual assault irrespective of ejaculation, presence of condom or foreign object penetration.
- In case of a young child and a virgin , only the external genitalia and hymen are swabbed.
- Vaginal swabs must be taken irrespective of washing, douching and bathing up to 5 – 7 days after the sexual assault.

**Reference DNA specimen.**

- Blood from the victim must always be taken in order to have a DNA profile available against which to compare DNA from all other specimens obtained.
- Reference blood must also be obtained from the alleged perpetrator as well as any person with whom the victim had consensual vaginal or anal intercourse during a three – five day period prior to the assault.
- Blood is collected on a so called “Marshall cassette”<sup>©</sup> which was especially designed in South Africa to comply with the needs of the new automated Forensic Laboratory.
- The blood collection tube along with the pamphlet inserts and plastic packaging material are the only items that can be discarded by the doctor and not returned to the kit.
- All other specimen containers and any bar coded items , whether used or not must be returned to the kit before sealing. Using “left overs” from one kit for a subsequent client can be disastrous and have serious legal and ethical consequences.
- All evidence collection kits must be handed to the investigating officer who has to sign for receipt on the J88 or patient file. Evidence may never be given to the patient, parent or other party.

(Source: Olivier N The role of DNA in the Investigation of Crime: A Case Study of South Africa Investigators [www.profiling.org/journal/vol1\\_no1/jbp\\_ed\\_january2000\\_1-1.html](http://www.profiling.org/journal/vol1_no1/jbp_ed_january2000_1-1.html) )

**APPENDIX VI: ARV PEP IN CHILDREN**



## APPENDIX VII: HIV PEP FOR SEXUALLY ABUSED CHILDREN

### PROPOSED DOSE SCHEDULE

The use of Zidovudine and Lamivudine for the prevention of transmission in children is not yet fully documented. Their use is predicted on reasonable scientific extrapolation. The oral liquids are currently not available on contract, but can be procured by approved centres where there is a likelihood of paediatric clients. Supplies and counselling should be handled in the same manner as for adults, with special considerations considering the age of the child.

#### Zidovudine 135 - 270mg/m<sup>2</sup>/dose twice daily

- As the body surface area is very difficult to calculate, the table provides guidelines for doses in mg per kilogram body weight:
- Dosage forms available:
  - Syrup containing 50mg/5ml = 10mg /ml
  - Capsules containing 100mg each

#### Lamivudine 4mg/kg/dose 2x daily

- Dosage forms available:
  - Oral Solution: 10mg/ml
  - Tablets containing 150mg each

Age range	Zidovudine Dose 12-hourly	Lamivudine Dose 12-hourly
6 months – 3 years	9 mg/Kg/dose	4mg / Kg / dose up to a maximum dose of 12.5ml (125mg) for children 10 – 11 years. Children 12 years and older = adult dose – 1 tablet of 150mg
4 – 8 years	7.5mg/Kg/dose	
8-12 years	7 mg/Kg/dose	
All doses can be varied + or – 1mg / Kg and still fall within the recommended dosage range.		

The maximum dose calculated per child should not exceed the adult doses, viz.  
Zidovudine 300mg 12-hourly and  
Lamivudine 150mg 12-hourly.

## **Monitoring and evaluation of the program**

Auditing services is an essential component of care and involves collection of data about the care given, the use of data to identify problems and provide solutions to the identified problems. Monitoring and evaluation of the sexual assault program should be conducted using measurable indicators of achievement for various aspects of service delivery and their relationship to medical outcomes and outcomes.

This should include:

- Total number of patients seen with a complaint of sexual assault
- Number of survivors accepting HIV testing
- Number of patients receiving ARV (3 day starter pack and complete course of ARV)
- Number of patients completing ARV course
- Number of patients who sero-convert (at 6 and 12 weeks) according to whether they did or did not take ARV
- Number of patients receiving emergency contraception (EC)
- Number of patients who fall pregnant despite EC
- Number of survivors who return for the follow-up visits at each visits (one-week, 6-week and 3-month visit)
- Number of patients given 3 drug STI treatment
- Number of times staff from the facility give evidence in court

## Check list of equipment and drugs essential for provision of sexual assault care

### Equipment and supplies

1. Sexual assault evidence collection kit
2. Throat swabs
3. Envelopes
4. Paper bags
5. Clothing – underwear, T-shirts, pants etc. (all sizes)
6. HIV rapid test kits
7. Blood collecting tubes (FBC, LFTS, Green topped tube containing sodium fluoride and calcium oxalate, EDTA tubes for syphilis, HIV and hepatitis B)
8. Culture medium
9. Syringe
10. Needles
11. Canulae
12. Bandages
13. IV fluids
14. Giving sets
15. Cabinet for storage of evidences
16. Lock and key
17. Case records
18. Consent forms
19. Registers
20. Stationery
21. Examination couch
22. Chairs (~3 – 4)
23. IEC materials
24. Light source
25. Patient folders
26. Forms – consent, case record, blood request forms, referral forms,
27. Desk
28. Linen
29. Thermometer
30. BP machine
31. Stethoscope
32. Speculum
33. Artery forceps
34. Cotton Swabs
35. Gloves
36. Suture materials
37. Stitch scissors
38. Needle holder
39. Dissecting forceps
40. Kidney dish
41. Gallipot
42. Colposcope
43. Condoms
44. Urine pregnancy test kits
45. Sharp containers
46. Cleaning (antiseptic) solution
47. Garbage bags
48. ?? Resuscitation equipment laryngoscope, Ambu bag, ET tube, Face mask, Oxygen

### Drugs

1. Antibiotics
2. Emergency contraception
3. Antiemetics
4. ARVs
5. Resuscitation drugs
6. Analgesia
7. Sedatives?
8. Hepatitis B vaccine
9. Tetanus toxoid
10. Antiallergy

